Trust Board (Open)

Meeting held on Wednesday 6th December 2023 at 9.30 am to 12.30 pm
Via MS Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	**2.**	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 8th November 2023	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	No outstanding actions	
20 mins	**6.**	Chief Executive's Report – November 2023	Information	Mrs T Bullock	Enclosure	
10:15		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (30-11-23)	Assurance	Prof A Hassell	Enclosure	**1**
10 mins	**8.**	Infection Prevention Board Assurance Framework	Assurance	Mrs AM Riley	Enclosure	**1**
10 mins	**9.**	Care Quality Commission Action Plan Update	Assurance	Mrs AM Riley	Enclosure	**1**
10 mins	**10.**	Maternity Quality Governance Committee Assurance Report (22-11-23) & Maternity Dashboard	Assurance	Prof A Hassell Mrs S Jamieson	Enclosure	**1**
10 mins	**11.**	Maternity Serious Incident Report	Assurance	Mrs S Jamieson	Enclosure	**1**
11:00 – 11:15 COMFORT BREAK						
11:15		**RESOURCES**				
5 mins	**12.**	Performance & Finance Committee Assurance Report (28-11-23)	Assurance	Dr L Griffin	Enclosure	**5, 7, 8**
11:20		**PEOPLE**				
5 mins	**13.**	Transformation & People Committee Assurance Report (29-11-23)	Assurance	Prof G Crowe	Enclosure	**2, 3, 4, 6, 9**
10 mins	**14.**	Workforce Race Equality Standards Report	Assurance	Mrs J Haire	Enclosure	**3**
11:35		**RESPONSIVE**				
40 mins	**15.**	Integrated Performance Report – Month 7	Assurance	Mrs AM Riley Mr S Evans Mrs J Haire Mr M Oldham	Enclosure	**1, 2, 3, 5, 8**
12:15	**GOVERNANCE**					
10 mins	**16.**	EPRR Annual Assurance Statement	Assurance	Dr M Lewis	Enclosure	
12:25	**CLOSING MATTERS**					
5 mins	**17.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
	18.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 4th December to** Nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:30	**DATE AND TIME OF NEXT MEETING**					
	19.	**Wednesday 3rd January 2024, 9.30 am, via MS Teams**				

Trust Board (Open)

Meeting held on Wednesday 8th November 2023 at 9.30 am to 12.15 pm
Via MS 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												
Mrs T Bowen	TBo	Non-Executive Director						Obs						
Mrs T Bullock	TB	Chief Executive												
Mr S Evans	SE	Chief Operating Officer	PB	PB	KT				KT	KT				
Prof G Crowe	GC	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director												
Ms A Gohil	AG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Dr M Lewis	ML	Medical Director					ZD	ZD						
Prof K Maddock	KM	Non-Executive Director												
Professor S Toor	ST	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse												

Non-Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Ms H Ashley	HA	Director of Strategy												
Mrs C Cotton	CC	Director of Governance	NH											
Mrs A Freeman	AF	Director of Digital Transformation												
Mrs J Haire	JH	Chief People Officer												
Prof A Hassell	AH	Associate Non-Executive Director												
Mrs A Rodwell	AR	Associate Non-Executive Director												
Mrs L Thomson	LT	Director of Communications												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI												

In Attendance:

Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mr R Irving	RI	Freedom to Speak Up Guardian (item 11)
Mrs S Jamieson	SJ	Director of Midwifery (item 7)
Mrs S Thomson	ST	Clinical Director of Pharmacy and Medicines Optimisation (item 1)
Miss G Tringham	GT	Rotational Pharmacist (item 1)

Members of Staff and Public: 2

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Staff Story**	
147/2023	Mrs Haire introduced Mrs Thomson and Miss Tringham to the Board. Miss Tringham described how she had undertaken a four-year pharmacy degree after which she had completed her pre-registration year at UHNM and a GP surgery which was her first choice. She explained how she was grateful for the opportunity	

to undertake the split role which she felt provided her with a rounded perspective of what being a pharmacist entailed. She described her successful submission and presentation of a poster of an audit she had undertaken and explained that she felt she had experienced a positive pre-registration year, whereby she had shared the learning from what she felt had gone well.

Miss Tringham explained that she qualified in August 2023 and had since gained a permanent role with the Trust as a Rotational Pharmacist. She explained that being newly qualified created some pressure, in terms of being asked for advice but felt that the structure supported her in making decisions and providing advice. She explained that she had received employee of the month and was grateful for being recognised and described the ongoing training provided. She welcomed being part of a large team and particularly enjoyed working in a large tertiary centre as this provided various opportunities, which she felt should be promoted more widely, in terms of recruiting and retaining pharmacists.

Mr Wakefield welcomed the enthusiasm Miss Tringham demonstrated and congratulated her on her successful poster presentation.

Professor Maddock congratulated Miss Tringham and welcomed the comments she had made regarding the portfolio career route. She queried Miss Tringham's thoughts on recruitment in secondary care and joint posts to which Miss Tringham explained that gaining experience in both primary and secondary care was useful but this in turn could create pressure on the rotas. Professor Maddock queried how Miss Tringham felt about being on-call and Miss Tringham explained that this was something which newly qualified pharmacists worried about, but she would only be required to undertake 1 to 2 a month. She added that further education could be provided to staff in terms of what scenarios constituted the reason for contacting a pharmacist on call.

Ms Bowen congratulated Miss Tringham on her progress so far and suggested that the Communications and People teams use some of her messages and journey in future recruitment and retention campaigns.

Professor Crowe queried Miss Tringham's thoughts on how the Trust could work with primary care to improve working relationships. Miss Tringham suggested joint education given that pharmacists in primary care are often on their own. Mrs Thomson referred to the work already underway to build networks and provide cross-sector working, as well as considering additional portfolio roles. She added that 14 pre-registration pharmacy technicians were in place within the ICS.

Professor Hassell queried the mentorship available for a newly qualified pharmacist and Miss Tringham stated that staff rotated every 4 months and received support from the lead for the area as well as having a line manager which enabled her to refer any issues / questions to them as appropriate. In addition, she highlighted that she had monthly meetings whereby objectives were set, and competencies were agreed.

Mr Wakefield welcomed the comments provided in terms of the split role creating a rounded perspective, the perspective provided from working in the community and how isolating this could be, as well as the importance of building relationships across the hospital and introduction of guidance for on-call.

The Trust Board noted the staff story.

Mrs Thomson and Miss Tringham left the meeting.

2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
148/2023	Mr Wakefield welcomed members to the meeting and introduced Ms Gohil to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate.	
3.	**Declarations of Interest**	
149/2023	There were no declarations of interest raised.	
4.	**Minutes of the Previous Meeting held 4th October 2023**	
150/2023	The minutes of the meeting held 4th October 2023 were approved as a true and accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
151/2023	There were no further updates required to the action log.	
6.	**Chief Executive's Report – October 2023**	
152/2023	Mrs Bullock highlighted several areas from her report. Mr Wakefield referred to the new consultant posts and queried whether these were affected by the double lock process. Mrs Bullock stated that as these had already been planned, they were within budget. She explained that if any posts were to be introduced which worsened the position, they would need to be considered via the double lock. Mrs Bullock thanked Mrs Thorpe for standing in as Interim Chief Operating Officer in Mr Evans' absence. Professor Hassell welcomed the feedback from the international medical graduates which had been included within the report. Mrs Rodwell referred to the test of change in Frail Elderly and queried how many beds it was anticipated to free up. Mrs Bullock stated that the test of change aimed to determine what could be delivered and Dr Lewis added that the pilot involved a lot of disciplines and initial improvements in discharges had been seen, but the key was to ensure an evaluation was undertaken before implementing any further changes. Ms Bowen referred to sexual safety charter and queried when an associated question would be included within the monthly staff survey. Mrs Bullock stated that a question had been included in the national staff survey and Mrs Haire added that evaluation of the question within the national staff survey would be undertaken and further consideration was required as to including a question within the staff voice. Mr Wakefield thanked the staff for their continued efforts in helping to deal with recent operational pressures. **The Trust Board received and noted the report and approved e-REAFs 12649 and 11556.**	

HIGH QUALITY

7.	**Quality Governance Committee Assurance Report (02-11-23) & Maternity Dashboard**	
153/2023	Professor Hassell highlighted the following: • Well-structured reports were provided on vulnerable patients, safeguarding children, and safeguarding adults with some areas of challenge identified; fewer learning disability specialists relative to demand, the time required of colleagues in preparing statements for court and the number of children held under the Mental Health Act within Trust whilst waiting for tier 4 placements. However, good progress had been made in terms of mental health training, good practice in sharing child protection information and progress with improvement actions following the Care Quality Commission (CQC) notice • C-difficile infections were above the upper acceptable limit with various actions in place including an ongoing commitment to undertake ribotyping • The maternity dashboard had been simplified and this identified some further challenges in the wait for inductions and the time to be seen in the maternity assessment unit. It was highlighted that the number of vacancies were 21.5 WTE not % as referred to in the report, and encouraging progress was being made • PRactical Obstetric Multi-Professional Training (PROMPT) training was on target and fetal monitoring had improved • The Committee noted the need to collate and learn from triangulating information from a range of sources Mr Wakefield queried if there was a connection between acuity and the number of vacancies and Mrs Jamieson stated that acuity status chart was a snapshot at a point in time and for the delivery suite the chart demonstrated how many midwives the department was short against the birthrate+ establishment at that time. Mrs Riley highlighted the positive reduction in terms of the percentage of cases where the department was 2 or more midwives short which had reduced from 14% to 3%. Ms Bowen commented on service user feedback and whilst she recognised the work being done, she queried when it was expected to have further assurance in terms of obtaining more feedback. Professor Hassell explained that had he had met with the Chair of the Maternity and Neonatal Voices Partnership (MNVP) and had invited them to attend a future Maternity Quality Governance Committee meeting. **The Trust Board received and noted the assurance report and maternity dashboard for September 2023.** Mrs Jamieson left the meeting.	
RESOURCES		
8.	**Performance & Finance Committee Assurance Report (31-10-23)**	
154/2023	Dr Griffin highlighted the following: • The Committee focussed on financial issues and noted that capital was slightly below plan, although a number of capital schemes were ongoing, and the Committee were reasonably assured that expenditure should catch up as planned • The risk in relation to financial sustainability had increased on the Board Assurance Framework (BAF) • The Committee received an update in terms of EPRR assurance which was being considered by NHS England and further work was to be undertaken to provide further assurance to the Board	

	Professor Maddock referred to capital which was circa £3 m behind plan and queried the mitigation in place to catch up. Mr Oldham highlighted that a Capital Investment Group regularly reviewed the forecast, and the plan was rebased as required, although it was expected to catch up. Mrs Whitehead explained that Estates were utilizing external project managers to provide additional capacity to complete the programme given its size. **The Trust Board received and noted the assurance report.**	
9.	**System Recovery Programme**	
155/2023	Mr Oldham highlighted the following: • The system had collectively submitted a plan with a potential £75 m deficit • At month 6 a number of risks which had not been built into the financial position had materialised i.e. inflationary pressures, growth, and industrial action. As a result, the projected deficit had increased to £141 m, unmitigated • A recovery programme had been put in place covering the high-level issues which were driving the position and the main opportunity was addressing continuing healthcare costs • Key milestones and trajectories were yet to be identified and the impact needed to be considered in terms of the position for month 7 • Benchmarking opportunities were being considered and a programme of work was in place for the main areas of opportunity Professor Hassell queried what were UHNM's contribution and challenges in respect of delivering the plan and Mr Oldham stated that it was key to ensure the discharge hub was working effectively, whilst continuing to be involved in each of the workstreams. Mrs Bullock reiterated that the Trust was engaged in the programmes and leading on key pieces of work such as the discharge hub, test of change for frailty and non-elective programmes. Mrs Rodwell referred to a recent NHS England workshop and different approaches to risk across the system and queried how this was addressed within the system plan in terms of ensuring alignment. Dr Lewis referred to the standard process for referral/admission which had been identified to decompress the Emergency Department when it was overwhelmed in addition to the introduction of Your Next Patient which balanced risk across the Trust and in the community. In terms of the system, he referred to the work undertaken to compare the risk to patients at different points in their journey and the ongoing work to look at escalation plans and risk appetite across partner agencies. Professor Crowe queried how progress would be measured. Mrs Bullock stated that a system transformation and delivery unit was in place which monitored the effectiveness of actions with reports provided to the system performance and finance group. In addition, reporting was provided to the Provider Collaborative and system Chief Executives. She added that system priorities had previously been agreed and as such work on some priorities may need to be paused to focus on the recovery plan. Mr Oldham added that a recovery director was being appointed to oversee the programme. Mr Wakefield summarised that the plan was ambitious and there was a need to work collaboratively to ensure it delivered, in particular the Trust needed to ensure it delivered what was promised from a UHNM perspective and to support the system schemes as appropriate. He added that the issue of risk was important	

	and there remained work to be done to measure and manage that in addition to ensuring progress was measured and communicated. **The Trust Board received and noted the system recovery programme.**	
PEOPLE		
10.	**Transformation and People Committee Assurance Report (01-11-23)**	
156/2023	Professor Crowe highlighted the following: • There had been significant activity and progress in terms of speaking up and black history month, aimed at creating the right culture and climate in UHNM • The fundamentals of clinical leadership course was welcomed • Whilst the Committee were encouraged by the focus and progress of the speaking up agenda, there were some issues which needed to be addressed particularly to ensure the environment was conducive to raise concerns and staff did not feel it was futile to do so • There continued to be improvements made in closing the vacancy gap Mr Wakefield queried whether the Trust was expecting an improvement in staff scores following the work which had been done. Mrs Haire stated that the Trust had seen a higher response rate to the Staff Survey this year and as such this would provide a more representative view of employee experience. She added that there had been a lot of engagement work undertaken and the impact of this would be assessed through the staff survey results and other measures such as retention. **The Trust Board received and noted the assurance report.**	
11.	**Speaking Up Board Brief Q2**	
157/2023	Mr Irving highlighted the following: • A review of the training package had been completed whereby the Trust aimed to consolidate the current statutory and mandatory training, whilst ensuring these remained in line with requirements • There had been an increase in the number of reporters referring to detriment despite having a zero-tolerance approach to this, and the reasons behind the rise were being established to consider if they believed they had received detrimental treatment as part of concern or as a direct result of raising the concern • Consideration was being given as to how to deal with and identify detriment and this was to be included within the revised policy • A steady increase in the number of concerns being raised was highlighted, which was due in part to addressing the gap in service and continued awareness raising. Speaking up month was held in October, and this created a further increase in the number of concerns raised • The current speaking up system was being reviewed, given there had been a reduction in the number of associate guardians • A recent national guardian survey had identified that since 2016 futility was now on par with fear as the main barrier to speaking up and this needed further consideration in terms of ensuring feedback was provided to reporters in terms of the actions taken as a result of the concern Mrs Rodwell offered congratulations on the work which had been done to date and referred to the types of incidents raised and increase in bullying and queried how this compared to benchmark information from other Trusts. Mr Irving stated that	

	the categorization of concerns was difficult to assess as this was subjective. He stated that particular patterns had been identified and it was likely that the increase related to a number of similar concerns. Mrs Cotton added that quarter 1 benchmarking data was included in the report provided to the Transformation and People (TAP) Committee and this demonstrated that the Trust benchmarked higher in terms of concerns regarding bullying and harassment. She added that triangulation of a variety of data sources was to be undertaken, to identify any correlation between concerns and other indicators so that this could be reviewed more holistically. Mr Wakefield stated that while there was more activity taking place to promote speaking up, which would result in more concerns he hoped that the effect of initiatives such as being kind would provide a reduction in concerns in due course. **The Trust Board received and noted the board brief in relation to speaking up.** Mr Irving left the meeting.	
RESPONSIVE		
12.	**Integrated Performance Report – Month 6**	
158/2023	Mrs Riley highlighted the following in relation to quality and safety performance: • Majority of metrics were within expected limits • Sepsis periodic deep dives had been undertaken and provided to the Quality Governance Committee (QGC) Mr Wakefield referred to timely observations and queried what had changed. Mrs Riley stated that there had been a change in practice as some areas did not need to complete these as often. Mr Wakefield referred to the rise in medication incidents and queried if this was cause for concern. Mrs Riley stated that Trust reporting had previously been lower than the national average and therefore efforts had been made to increase this. She stated that despite the increase there had been no associated increase in incidents causing harm, which was the focus. Mr Wakefield referred to c-difficile and antibiotic prescribing and queried whether these were monitored. Mrs Riley confirmed that this was considered via the antimicrobial stewardship group and one antibiotic in particular was being monitored. She added that the Trust was not unique in seeing an increase and this continued to be reviewed. Mrs Thorpe highlighted the following in relation to urgent care performance: • 4 hour performance had deteriorated over the last 3 weeks, driven by the reduction in non-admitted performance at Royal Stoke • Ambulatory CDU was due to open 27th October but a leak in the roof had delayed the opening, and this was due to open 13th November, and was expected to improve non admitted performance Mr Wakefield referred to the winter plan and queried whether the delay in opening CDU had affected the ability to achieve the 72% target. Mrs Thorpe stated that the delay would have an impact on the trajectory, but she was unsure of the totality. Ms Bowen referred to the work being undertaken in relation to capacity and demand and the use of progress chasers and requested an update on those areas	

of work. Mrs Thorpe stated that the dashboard was scheduled to be implemented on the 17th November and this was on track. She stated that progress chasers had been pushed back to 24th November due to annual leave and sickness as well as some delays in recruitment.

Dr Griffin referred to non-admitted performance and queried what was driving this. Mrs Thorpe stated that this was a combination of how patients were being treated and the impact of the delay in the ambulatory unit.

Mr Wakefield queried the progress made with the non-elective plan and discussion with stakeholders. Mrs Thorpe stated that this was being refreshed to ensure it aligned with key actions and the undertakings.

Mrs Thorpe highlighted the following in relation to RTT performance:

- Significant work was continuing in endoscopy and the Trust had been provided with additional cancer alliance funding
- There was 1 patient breach in relation to 104 weeks, which was due to patient choice and the patient had since been treated
- In terms of 78 week performance, at the end of October there were 136 patients waiting with a prediction of 88 patients for November

Mr Wakefield queried if the focus on 65 weeks was impacting on 78 week performance and Mrs Thorpe stated that this was not having an impact as the majority were in non-admitted cohorts whereas 78 week patients were in admitted cohorts.

Dr Griffin referred to the discussion at Performance and Finance Committee (PAF) and the overall waiting list position, Mrs Thorpe stated that whilst the 65 week position was reducing, as patients got to the admitted part of pathway there were challenges in ensuring treatment happened in time.

Mrs Thorpe highlighted the following in relation to cancer performance:

- In terms of the combined cancer standards the current October provisional position for 31 day was 82.7%, 62 day at 45.8% and faster diagnostic standard at 65.4%
- The September 62 day backlog was 520 and this had reduced to 427 in October

Mr Wakefield referred to the backlog and queried what was the underlying position and when this would catch up. Mrs Thorpe stated that the faster diagnostic standard aimed to target cohorts of patients as well as additional funding having been received to target areas such as colorectal and urology. She added that in terms of the trajectory, this was reported on a weekly basis through tier 1 monitoring with NHS England and the Trust was on track with this.

Mrs Haire highlighted the following in relation to workforce performance:

- Turnover was in a good position at 8.3% and vacancies were tracking below the metric which was positive
- The monthly staff voice staff engagement metric had been paused during the national staff survey although going into September responses were lower and this was due to the preparations for the national survey
- Within 4 months, over 8000 colleagues had been trained in respect of Being Kind which was a great achievement and demonstrated the commitment to the importance of the training
- Work continued in respect of the sexual safety campaign, with a 4-part plan in place to deliver 10 commitments. A formal launch of the sexual safety charter was to be undertaken in November

Dr Griffin welcomed the reduction in vacancies and turnover and queried the national position. Mrs Haire stated that there had been some improvement in retention across the NHS and the Trust compared well with the level of system vacancies.

Ms Bowen referred to in month sickness and queried whether this was tracking well compared to the forecast. Mrs Haire stated that the Trust had made improvements in terms of sickness absence, but this was expected to increase over winter. She added that the normalised position for sickness absence was expected to be in region of 5%.

Mr Oldham highlighted the following in relation to financial performance:

- Month 6 slightly improved with a deficit of £7.2 m although this was £10.4 m off plan. The improvement was due to the receipt of the wage award and the funding having been backdated for the establishment
- The variance continued to be driven by cost improvement savings, industrial action, and the cost of escalation capacity
- Capital was £2.9 m below plan due to slippage and work ongoing to catch up
- Cash was slightly lower than planned but this was expected given the financial performance to date

Mr Wakefield queried if the Trust had received payment for escalation capacity and if there had not been any industrial action, whether the Trust would be in a surplus position. Mr Oldham stated that the position would be thereabouts the breakeven position and agreed this was important narrative.

Professor Crowe queried the recurrent / non recurrent split of cost improvements as well as the grip and control in place for agency spend. Mr Oldham stated that the main variance and challenge was the recurrent underlying position. He stated that agency spend was above trajectory and working was being undertaken with Divisions in November to develop improvement trajectories and plans for reduction.

Mr Oldham added that in terms of the year end position, with balance sheet releases and assumptions of income the best-case position was breakeven, however if elective recovery fund monies were not available a £10 m deficit was expected.

The Trust Board received and noted the integrated performance report.

GOVERNANCE

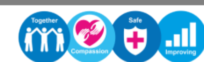
13. Audit Committee Assurance Report (02-11-23)

159/2023

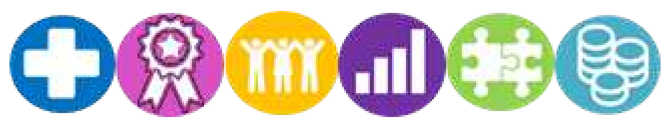
Professor Crowe highlighted the following:

- The Committee endorsed the improvements to the Board Assurance Framework (BAF) and recognised the further work required in respect of providing assurance for risks 4 and 9
- Historic salary overpayments remained an area of focus and further work was required to ensure compliance with the process to further reduce these
- Two internal audit reports had been undertaken, both of which concluded with partial assurance
- The process for obtaining up to date policies was being reviewed
- An update on triangulation between incidents, complaints etc was to be provided at the next meeting

	Mrs Thorpe referred to the waiting list management internal audit which identified a number of issues which were similar to those which had been identified within the external review, therefore the actions were aligned to both reports. **The Trust Board received and noted the assurance report.**	
14.	**Q2 Board Assurance Framework (BAF)**	
160/2023	Mrs Cotton highlighted the following: • A summary version had been provided but the full document would be considered by the Board twice a year • Actions had been identified within the Committees, to further develop BAF 4 and BAF 9 • The document included the introduction of the system strategic risk map which referred to quarter 1 risk scores. Work was ongoing with partners to further develop their BAFs Mr Wakefield welcomed the introduction of the system risk map and summary of Committee challenge. Professor Crowe welcomed the summary for each risk and highlighted the need to request further assurance in terms of the actions and their ability to mitigate the risk and achieve the trajectory. Ms Bowen referred to the heat map and the difference in rating between UHNM and the system. Mrs Cotton explained that considering risks across the system, had exposed different risk scoring matrices. She highlighted that the partners across the system had therefore been asked to undertake an impact assessment to consider moving to the same matrix, particularly given that a new model was being promoted nationally. Mr Wakefield congratulated Mrs Cotton and the team for being shortlisted for Corporate Governance Institute Governance Project of the Year. **The Trust Board received and noted the quarter 2 Board Assurance Framework.**	
15.	**Undertakings**	
161/2023	Mrs Bullock highlighted that the Trust had previously had a set of undertakings which were issued at the time of being put into Financial Special Measures (FSM). She stated that as the Trust had exited FSM, NHS England had updated the undertakings and aligned these to the new provider licence as well as including reference to the change in rating for maternity following the CQC inspection. She highlighted that in terms of reporting, the metrics were reported as part of the NHS Oversight Framework and within the IPR. Mr Wakefield queried the reason for the majority of areas not having a deadline. Mrs Bullock stated that some elements required the development of a plan, part of which would include a trajectory as well as some things already having trajectories identified. **The Trust Board received and noted the confirmed undertakings.**	
16.	**Calendar of Business 2024/25**	



162/2023	**The Trust Board approved the calendar of business for 2024/25.**	
17.	**Board Seminar Programme Update**	
163/2023	Mr Wakefield queried whether the Board should consider a session with system partners in relation to back-office functions. Mrs Bullock stated that a key role of the system Provider Collaborative was to consider back office functions and that Mr Paul Brown, System Chief Finance Officer was the lead for this and reported directly to the Provider Collaborative Board. Mrs Rodwell referred to learning from other acute trusts in terms of how they addressed and tackled challenges and queried whether something could be included in that respect as well as including a session to provide future assurance on BAF 9. Mrs Cotton referred to the plan to schedule deep dives into each BAF risk at Committees and added that these would focus on the less developed risks first. Mrs Bullock confirmed that learning from other Trust was considered routine and gave examples where this was recently taking place such as ambulance holds, urgent care and OPAT services. She stated that this was routine and was also supported by the production of national reports. **The Trust Board received and noted the updated Board Seminar programme.**	
CLOSING MATTERS		
18.	**Review of Meeting Effectiveness and Review of Business Cycle**	
164/2023	No further comments were made.	
19.	**Questions from the Public**	
165/2023	No questions from the public had been received.	
DATE AND TIME OF NEXT MEETING		
20.	**Wednesday 6th December 2023, 9.30 am, via MS Teams**	



Chief Executive's Report to the Trust Board

November 2023

Part 1: Contract Awards and Approvals

2.1 Contract Awards and Approvals

Since 14th October to 14th November 2 contract awards over £1.5 m were made, as follows:

- **Same Day Emergency Care (SDEC) Acute Medical Rapid Assessment Unit (AMRAU)** supplied by IHP Vinci Construction (capital bid 6837), at a total cost of £10,926,083.24, approved on 08/11/23
- **Staff Rostering Software for Medics and Nursing Staff** supplied Softcat (Subcontract to Allocate), for the period 28.11.23 – 31.03.26, at a total cost of £1,539,414.67, providing savings of £95,161.53, approved on 08/11/23

In addition, the following eREAFs were approved at the Performance and Finance Committee on 28th November. These require Trust Board approval due to the value:

Link Bus Service between Royal Stoke Hospital and County Hospital (e-REAF 12840)

Contract Value £1,622,668.00 incl. VAT
Duration 01/02/2024 – 31/01/2027
Supplier D&G Bus Ltd

Electronic Patient Records Contract - Contract Extension (e-REAF 12797)

Contract Value £9,444,727.50 incl. VAT
Duration 01/01/2024 - 30/09/2027
Supplier System C Ltd

The Trust Board is asked to approve the above eREAFs.

2.2 Consultant Appointments – November 2023

The following provides a summary of medical staff interviews which have taken place during November 2023:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Neurologist	Vacancy	TBC	TBC
Restorative Dentistry Consultant	New	Yes	TBC

The following provides a summary of medical staff who have joined the Trust during November 2023:

Post Title	Reason for advertising	Start Date
Consultant in Obstetrics and Gynaecology	Vacancy	01/11/2023
Locum Consultant Oncologist – Head & Neck, Thyroid and UGI Cancers	Extension	01/11/2023
Consultant Neonatologist	New	06/11/2023
Locum Consultant Intensivist	Vacancy	01/11/2023
Locum Consultant - Neuro-Diagnostic Radiologist	New	10/11/2023

The following provides a summary of medical vacancies which closed without applications/candidates during November 2023:

Post Title	Closing date	Note
Locum Consultant - Winter Pressures	10/11/2023	No Applications
Locum Consultant Paediatrician	11/11/2023	No Applications
Consultant Paediatric Radiologist	23/11/2023	No Applications

2.3 Internal Medical Management Appointments – November 2023

The following table provides a summary of Medical Management interviews which have taken place during November 2023:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Lead for Diabetes & Endocrinology	New	TBC	TBC
Clinical Director - Maternity, Neonates & Gynaecology	Vacancy	TBC	TBC

No Medical Management have joined the Trust during November 2023.

The following table provides a summary of medical vacancies which closed without applications / candidates during November 2023:

Post Title	Closing Date	Notes
Clinical Director for Paediatrics	22/11/2023	No applications

Part 2: Highlight Report

High Quality Responsive People Improving & Innovating System & Partners Resources

National / Regional

3.1 Staff Survey

The National Staff Survey closed on 25th November, and I am pleased to report that we have considerably improved on the numbers of UHNM colleagues completing the survey, when compared to 2022, although we do want to improve this further. We were keen to hear as many voices as possible through the survey, to provide a balanced view, and we look forward to working with colleagues on the actions to be taken in 2024 to improve the experience for our staff. Whilst UHNM's Staff Voice paused in recent months, this will recommence in January 2024, providing further opportunities for staff to share their views and thoughts on how we can make UHNM a great place to work.

3.2 Disability History Month

As we reach the midpoint for Disability History Month, as part of our commitment to being inclusive we have launched a new Reasonable Adjustments Policy, and whilst our latest Workforce Disability Equality Standard metrics demonstrate that 67% of colleagues feel they have been provided with workplace adjustments to carry out their work we would like to improve on this. The policy standardises the approach for colleagues and their line managers to discuss any adjustments required, using a Tailored Adjustments Plan (TAP).

3.3 Sexual Safety Charter

I have previously highlighted our commitment to sexual safety at work and how we had signed up to the Sexual Safety Charter. As part of our focus on NO-vember, we have continued to take a proactive and systematic zero-tolerance approach to sexual misconduct and violence and keeping our patients and colleagues safe. We have commenced implementation of the ten core principles and actions to achieve this, including writing to all line managers and sharing resources and guidance in relation to inappropriate behaviours and how to raise concerns.

3.4 NHS Healthcare Supply Association (HCSA) Awards

I am pleased to report that our North Midlands and Black Country Procurement Group (NMBC) recently won the Cross Functional Collaboration Award at the HCSA Awards in Manchester, for the innovative Pan ICS Group Procurement Organisation (GPO) shared service model. There were seventeen entries within this highly contested category which recognises NHS procurement/supply chain management teams and their partner organisations in the development of a collaborative partnership. My congratulations go to all the team, well done!

System Focus

3.5 Operational Pressures

We have continued to experience significant pressures across our hospitals during October and November, particularly the congestion within our Emergency Department at Royal Stoke and the number of ambulances waiting longer than we would like. Our teams continue to take quick steps to help improve patient flow and to decongest our Emergency Department, in order to keep our patients safe. There is no silver bullet, but we know that continuing to do the basics and do them well.

In response to the number of patients in our beds who do not need acute care and could likely access other services that either we or our system partners have available, we are continuing to hold 'Getting to Know You' drop-in sessions at Royal Stoke and County Hospital, showcasing services such as Acute Hospital at Home, CRIS and Virtual Wards.

3.6 Executive to Executive Meeting – North Staffordshire Combined Healthcare

On Tuesday 7th November we held an Executive to Executive meeting with colleagues from North Staffordshire Combined Healthcare NHS Trust where we were able to consider our respective organisational challenges, opportunities as well as discussing our roles within the Integrated Care System.

Organisational Focus

3.7 Covid 19 and Vaccination Programme

Following a brief spike in Covid 19 numbers, these are now coming down again, although we have continued to experience additional pressures brought about by the colder weather recently. Our vaccination programme is continuing, and we are urging all staff to have both the Flu and Covid 19 vaccination in order to protect themselves, our patients and their families. So far 3,196 of our staff have received the flu vaccination and 2,875 staff have received their Covid19 vaccination.

3.8 Breast Screening Quality Assurance Review

We were delighted to receive the feedback from the NHS Screening Quality Assurance Service (SQAS) recently, following a visit to our Breast Screening Service. The review considered our administration processes and involved a right results walkthrough, providing assurance that our administration functions were operating within NHS breast screening programme guidance. The review team also commented on the team who were "extremely accommodating, open and honest in their approach to the review", well done to all those involved.

3.9 40 Years of County Hospital

We have recently started our celebrations of the 40th anniversary of County Hospital, which opened in 1983. This includes highlighting 40 stories via Social Media, so please keep an eye out for these.

3.10 Honorary Professorship

Our congratulations go to Dr Kamaraj Karunanithi, Consultant Haematologist, who has recently been awarded Honorary Professor in Haematology within the School of Medicine at Keele University, after establishing his expertise in cancer research, specifically in myeloma at UHNM. He has been principal investigator for more than 30 national and international clinical trials, and I look forward to hearing about the new state-of-the-art cancer treatments he is seeking to develop for our patients.

3.11 CNST Maternity Incentive Scheme (MIS) Year 4

In June 2023 the CQC published their report into our Maternity services which saw them downgraded from Good to Requires Improvement. As a result of this, we subsequently received a letter from NHS Resolution who wished to re-review the evidence and assurances that we had made to when we signed off compliance against the Maternity Incentive Scheme (MIS) standards. I am pleased to say that on the 27th November we received a letter from NHS Resolution following their further review of our evidence confirming that all 10 Safety actions for year 4 of the MIS were met with no further action required. My thanks go to the team involved in the review process.

NHS
University Hospitals of North Midlands
NHS Trust

Quality Governance Committee Chair's Highlight Report to Board

30th November 2023

! Matters of Concern of Key Risks to Escalate

For information:

- There continues to be a lack of capacity for resuscitation training with ongoing actions being taken in respect of identifying the appropriate levels of training for staff. In addition, the number of staff not attending booked training was discussed and the way in which non-attendance was followed up.
- The Care Quality Commission action plan update highlighted 15 actions which had been archived following previous agreement. The main area of continuing concern relates to the actions for speech and language therapy. In addition, the actions arising from the Section 29A notice for patients with mental health needs continued to be monitored
- 1 never event was reported in October which was related to a historically retained guidewire, and this was being reviewed utilising the new patient safety incident investigation (PSII) response template, with the final report and safety recommendations to be presented to the Committee
- 30 day readmissions were higher than expected with the key drivers being related to paediatrics (although previous assurance had been provided to the Committee in terms of this being due to the neonatal jaundice pathways in place) and elective admissions. The Committee noted the focus on six diagnostic groups to explore the reasons for readmission and it was agreed to provide an update to a future meeting in relation to the reasons for re-admission within colorectal surgery, urology, and emergency medicine

Major Actions Commissioned / Work Underway

- To take forward a conversation with regards to addressing the issue of Datix reporting for every 2222 cardiac arrest call, to determine the most appropriate reporting mechanism
- Continued roll out of a new prescription chart in medicine to assist in the reduction of the number of venous thrombo-prophylaxis (VTE) and anticoagulant prescribing and administration incidents
- To communicate the improvements made with yellow card reporting more widely
- To receive an update on medical reviews being performed in line with the Birmingham Symptom Specific Obstetric Triage System (BSOTS) requirements, at the next Maternity Governance Committee
- Neonatal integrated action plan report to be discussed divisionally before being presented to the Committee
- To clarify the governance route for consideration and receipt of the Trust's response to the Thirlwall Inquiry
- To obtain assurance from mortality leads with regards to the appropriate grading of SJRs, identification of further learning and confirmation of the outcome of the quality control exercise
- Serious incidents no longer to be reported on Strategic Executive Information System (STEIS) from December, aligned to the system approach and the move to Patient Safety Incident Response Framework (PSIRF), although incidents would continue to be reported to the Committee
- To communicate the introduction of PSIRF more widely within the organisation
- To review the number of neonatal readmissions and identify the number readmitted due to neonatal jaundice
- To provide responses in relation to the completion of recommendations made as part of the Clinical Risk Management – PSIRF Internal Audit to a future Committee

✓ Positive Assurances to Provide

- The annual update in terms of resuscitation highlighted 10% improvement in terms of training undertaken
- Medicines optimisation highlighted a number of positive assurances, such as a contingency programme being in place for the procurement of medicines, being on target with CQUIN performance, and the improvement in yellow card adverse drug reaction reporting, which had moved UHNM from 17th to being the top reporter within the Midlands region. In addition, the risk in relation to aseptic workforce had de-escalated
- A new format generic Infection Prevention Board Assurance Framework was presented which highlighted 40 areas which were fully compliant and the remaining 14 rated as partially compliant
- The mortality report highlighted improvements in the completion of outstanding Structured Judgement Reviews (SJRs), including completion of all learning disabilities related reviews which linked into Learning Disabilities Mortality Reviews (LeDeR). Mortality indices were generally positive or as expected and there had been a reduction in crude mortality
- There had been a continued reduction in the number of new Serious Incidents and an increase in the number of investigations being closed
- Quality performance highlighted an increase in adverse incident reporting with fewer incidents reported with moderate harm and falls remained below target

Decisions Made

- No decisions were required to be made

Comments on the Effectiveness of the Meeting

- Members welcomed the papers presented, in the particular the transparency of information provided.

1. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Resuscitation Annual Report	BAF 1	ID26815		Assurance	7.	Serious Incident Report Q2 2023/24	BAF 1	ID9783		Assurance
2.	Medicines Optimisation and Safety Report Quarter 2 2023-24	BAF 1	ID25152 ID293121 ID28382 ID21719 ID24181 ID23506 ID23500		Assurance	8.	Quality Performance Report – Month 7 23/24	BAF 1	Ext 16		Assurance
3.	CQC Action Plan	BAF 1	Ext 16		Assurance	9.	Readmissions Analysis	BAF 1	Ext 16		Assurance
4.	Infection Prevention Board Assurance Framework	BAF 1	Ext 16		Assurance	10.	Internal Audit Reports: Clinical Risk Management – Patient Safety Incident Response Framework (PSIRF)	BAF 1	Ext 16	-	Assurance
5.	Neonatal Update	-		-	Information	11.	Quality & Safety Oversight Group Highlight Report	BAF 1	Ext 16	-	Assurance
6.	Mortality Assurance Report Q2 2023/24	BAF 1	Ext 16		Assurance						

2. 2023 / 24 Attendance Matrix

No.	Name	Job Title	A	M	J	J	A	S	O	N	D	J	F	M
1.	Prof A Hassell	Associate Non-Executive Director (Chair)	KM											
2.	Mr S Evans	Chief Operating Officer	PB											
3.	Prof K Maddock	Non-Executive Director												
4.	Mr J Maxwell	Head of Quality, Safety & Compliance												
5.	Dr M Lewis	Medical Director				ZD		AMM						
6.	Mrs AM Riley	Chief Nurse	JHo			JHo	JHo		FH					
7.	Mrs C Cotton	Director of Governance			NH	NH		NH		NH				
8.	Prof S Toor	Non-Executive Director												
9.	Mrs J Haire	Chief People Officer				KM								
10.	Mrs A Gohil	Non-Executive Director												

Attended | Apologies & Deputy Sent | Apologies

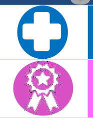
Executive Summary

Meeting:	Trust Board (Open)	Date:	6th December 2023
Report Title:	Infection Prevention Board Assurance Framework	Agenda Item:	8.
Author:	Helen Bucior, Infection Prevention Lead Nurse		
Executive Lead:	Mrs Ann-Marie Riley, Chief Nurse/DIPC		

Purpose of Report

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

Alignment with our Strategic Priorities

	High Quality	✓		People			Systems & Partners	
	Responsive			Improving & Innovating			Resources	✓

Executive Summary:

Situation

To update Trust Board on the self-assessment against the new Infection Prevention Board Assurance Framework (IPBAF).

The new IPBAF has replaced the respiratory BAF. This has been aligned with the refreshed Health and Social Care Act 2008: code of practice on the prevention and control of infections and the National Infection Prevention and Control Manual NIPCM.

The worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format. A compliance rating column allows for the selection of a RAG rating for each criteria using a drop down list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Use of the framework is not compulsory but should be used by organisations to ensure compliance with infection prevention standards (unless alternative internal assurance mechanisms are in place). In addition, not all of the criteria outlined in the framework will be relevant or applicable to all organisations or settings.

Whilst the gathering of assurance/evidence continues, sections may be rated as partially compliant until evidence has been confirmed.

Background

The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures. 10 criteria have been identified, which are further divided info further standards:

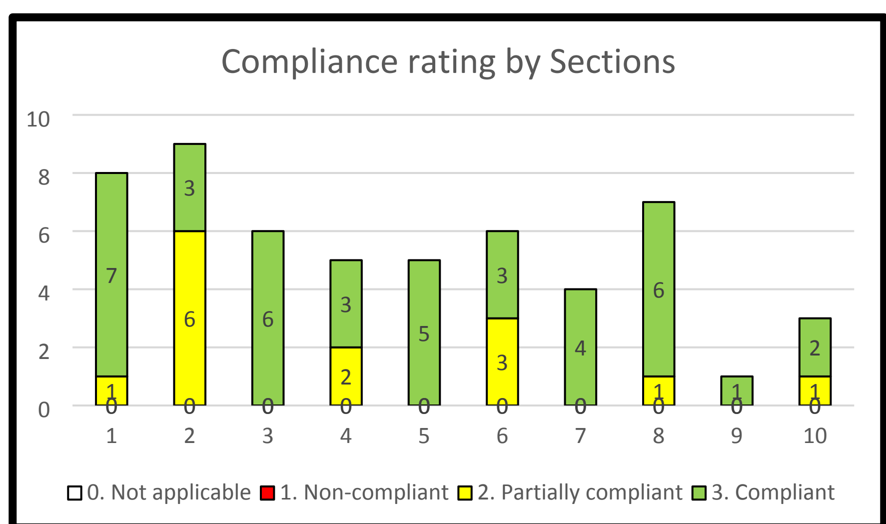
- Criteria 1 - Systems to manage and monitor the prevention and control of infections. These systems use risk assessment and consider the susceptibility of service users and any risks their environment and other users may pose to them.
- Criteria 2 - Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
- Criteria 3 - Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance.
- Criteria 4 - Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion.
- Criteria 5 - Ensure early identification of individuals 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 others.
- Criteria 6 - Systems are in place 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.

- Criteria 7 - Provide or secure adequate isolation precautions and facilities.
- Criteria 8 - Provide secure and adequate access to laboratory/diagnostic support as appropriate.
- Criteria 9 - Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.
- Criteria 10 - Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Assessment

Sections rated as partial compliance and work in progress are:

- Compliance rates for IP level 2 mandatory training is amber. An update on compliance is next due at IPCC January 2024 and a request has been made for Divisions to ensure staff groups are undertaking the correct level of IP training; Level 1 or Level 2.
- In terms of the nursing cleaning responsibilities element of the National Standard for Cleanliness, the Matron for Estates has been identified as action lead and the next meeting is scheduled for December 2023
- The Trust Cleaning Policy, EF29 is awaiting ratification.
- Ventilation: Ambulance cohort at ED Royal Stoke, update on progress to be requested. The Directorate Manager for Emergency Care has commenced the process of commissioning a feasibility study to determine the cost and other implications of permanently changing the use of the ambulance cohort room to make it fit for purpose.
- Provision of laundry – visit to off-site laundry facilities planned for Q3 2023/24. This will be led by Deputy Head of Soft FM and will remain as amber until the visit has been completed
- Work ongoing with regards to waste segregation at ward level
- Food safety training for clinical staff - food hygiene training is commensurate with the duties of facilities staff as per food hygiene regulations. Food safety training is already available on ESR, however currently not mandatory or essential to role for clinical staff. This is listed as an agenda item at the food safety meeting with the next meeting scheduled for February 2024.
- IP leaflets revision - these have now been updated and awaiting review by the patient group.
- FFP3 masks - resilience and mask fitting team. Interviews held October 2023, recruitment process and checks in progress with an expected date for the team to be in place by January 2024
- Clinical staff who undertake procedures that require clinical skills - device insertion. There is evidence that staff are trained to an agreed level although an overarching policy is required. This is being led by the Lead Nurse for Workforce Development and Education
- Blood culture turnaround times for County Hospital are to be considered at the November IPCC meeting
- Occupational Health needs – an update on staff MMR immunity status is to be provided at the November IPCC meeting



Key Recommendations:

The Trust Board are asked to note the update and the ongoing work being undertaken. The full self-assessment will continue to be provided on a quarterly basis to the Quality Governance Committee.

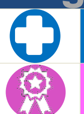
Executive Summary

Meeting:	Trust Board (Open)	Date:	6th December 2023
Report Title:	Care Quality Commission Action Plan Update	Agenda Item:	9.
Author:	Debra Meehan, Lead Nurse Quality & Safety, Nicola Hassall, Deputy Associate Director Corporate Governance		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

	High Quality	✓		People	✓		Systems & Partners
	Responsive	✓		Improving & Innovating			Resources

Risk Register Mapping

ID15788	Delivery of RTT Performance	Extreme 16	ID23842	RTT Outpatient Capacity / Wait Times	Extreme 16
ID27696	Consultant Obstetricians workforce	Extreme 16	ID15993	Maternity Assessment Unite Triage	High 12
ID9738	Nursing Training - Medicine	High 12	ID24028	Lack of flow across the Trust leading to congestion of ED (both sites) and UEC standards unable to be met	High 12
ID25682	Unstructured records management	High 12	ID13419	Midwifery safe staffing	High 12
ID9783	Incident Investigation	High 12	ID23361	Number of open adverse incidents and root cause analysis investigations	High 12
ID9782	Reporting of Patient Safety Incidents	High 8	ID8580	Medical staffing for the Emergency Department	Moderate 6
ID8543	Lack of facilities for storage of patient records in ED	Moderate 4	ID16645	Statutory & Mandatory Training, Medicine	Low 2

Executive Summary

Situation

Following the previous Care Quality Commission (CQC) inspections, actions for improvement were identified. This report provides assurance to the Trust Board on the progress made to date against the must do and should do recommendations.

Background

The CQC inspected UHNM in August 2021, visiting and rating Urgent and Emergency Care (Requires Improvement) and Medicine (Good) at Royal Stoke and Medicine (Requires Improvement) and Surgery (Good) at County Hospital. A Well Led inspection took place in October 2021.

Following the initial inspection, the Trust was served a Section 29A Warning Notice under the Health and Social Care Act 2008, notifying the Trust that the CQC had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health need in medicine at County Hospital required significant improvement. Remedial actions were required to be completed by the end of November 2021 and evidence to support the completed actions have been submitted to the CQC.

In October 2022, the CQC conducted an unannounced visit to UHNM to review immediate actions taken. Although the CQC were satisfied that the Trust had made significant improvements in relation to medical staffing in urgent and emergency care at Royal Stoke, they continued to have serious concerns about the assessment, recording and mitigation of risks associated with acute mental health concerns in medicine at

County Hospital and subsequently issued a further Section 29A Warning Notice under the Health and Social Care Act 2008. The Trust was required to provide evidence of significant improvement in relation to the Section 29A warning notice by 26th January 2023, which was submitted to the CQC. A portfolio of evidence is currently being collated to demonstrate sustained improvements at County Hospital and will be submitted in November 2023.

Although the CQC rated the safe and effective domains for medical care at County Hospital as Inadequate, the overall ratings for both County Hospital and the Trust overall remained as 'Requires Improvement'. Overall, the Trust also saw improvement in two domains:

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

The CQC also conducted a focussed visit to Maternity Services in March 2023 and concerns were raised in two areas; timeliness of maternity triage and management of induction labour. This resulted in the Trust being served with a Section 29A Warning Notice under the Health and Social Care Act 2008.

Immediate mitigating actions were put in place and the Trust was required to provide evidence of significant improvement in relation to the Section 29A warning notice by 30th June 2023, which was submitted and is currently under review by the CQC.

The inspection of Maternity Service concluded with the following ratings:

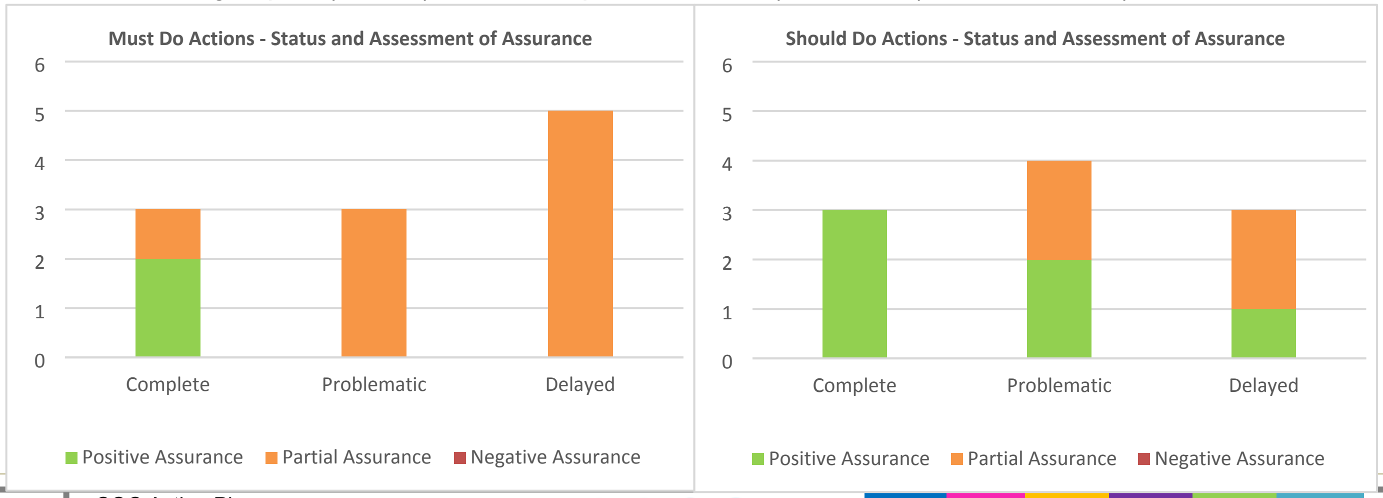
- Overall Rating: Requires Improvement
- Are Services Safe: Inadequate
- Are Services Well Led: Requires Improvement

Assessment

Following feedback from the Quality Governance Committee (QGC) and Internal Audit during early 2023, work was undertaken to review all completed actions and ensure that they addressed the concerns raised by the CQC. As a result, some duplicate actions were removed, and additional columns were added to capture ongoing assurance of sustained improvement against the completed actions including any additional actions required to provide positive assurance.

In August 2023, the QGC also agreed to archive 15 actions:

- As the CQC have confirmed that they were satisfied with the Trust's response to the recommendations in terms of Emergency Department staffing and 15 minute assessment, and as such had removed the Section 31 and 29A warning notices, the associated actions A1, A2 and A3 have been archived.
- Actions which had a clearly defined monitoring process, which is Business as Usual through existing governance, have been archived. An example of this are actions relating to statutory and mandatory training compliance, which are monitored through Executive and Divisional Performance Review Meetings and reported through the relevant UHNM Committee. As such actions B1, B4, B8, B13, B15, B18 and B19 have been archived.
- "Should do" actions could be archived where the Trust had progressed the actions as far as possible in the current circumstances; actions B3 (storage of patient records), B7 (ED layout), B10 (medical wards storage space), B11 (structure of patient records) and B28 (use of force act).



Areas of Concern
Of the remaining open actions, those relating to the following issues are causing concern:

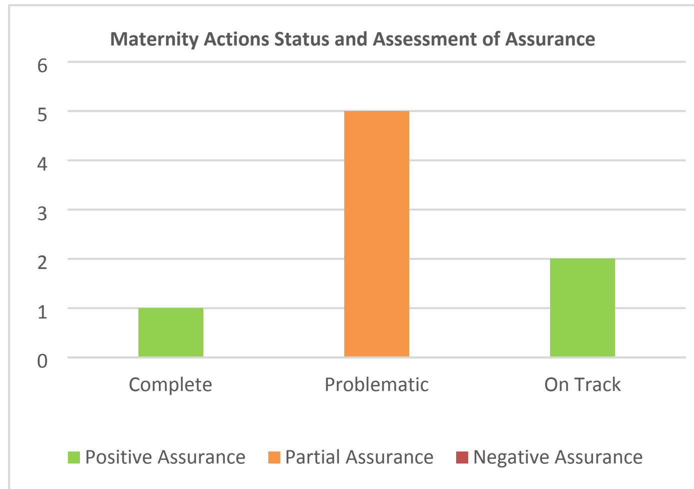
<u>Speech and Language Therapy (SLT) provision at County Hospital</u>

- Further work has been commissioned by Quality and Safety Oversight Group to inform the SLT Deep Dive in preparation for presentation at Quality Governance Committee
- Service Review of SLT Team underway by Chief Allied Health Practitioner
- Outputs of training of MNP's/ANP's currently being evaluated as the situation has not improved
- Audit data currently being collated to inform the service review.

<u>Section 29A the risk management of patients with mental health needs in medicine at County Hospital</u>

- Focussed education and awareness-raising is taking place at County Hospital.
- Audits were completed in October 2023 (sample size 15). Although there has been a significant improvement in the nursing team completing the mental health assessment triage tool in ED, there are still occasions where medics have not completed their section of the form. In order to improve compliance, paper documentation is now being removed and Divisional Management Teams and Medical colleagues are supportive of the changed process.
- Where the tool was not fully completed, the patients had a full mental health review by the Liaison Team, which were documented on I-Portal
- A case review in November 2023, of assessment and management of a Patient with acute Mental Health needs on AMU has demonstrated good practice
- An audit of the total number of Mental Capacity Assessments completed via the structured note across UHNM shows an improving trend for October 2023

Maternity Action Plan
The report stipulated 6 Must Do Actions and 2 Should Do Actions.



Areas of Concern
Of the problematic actions, those relating to the following issues are causing concern:

- Safeguarding training compliance
- Staff PDR compliance

Key Recommendations

The Trust Board is asked to note the update and that the Quality Governance Committee will continue to review the detail of each action plan on a quarterly basis.

Maternity Quality Governance Committee Chair's Highlight Report to Board

22nd November 2023

! Matters of Concern of Key Risks to Escalate

For information:

- In terms of delivery suite staffing, 1-1 care was challenged for October, and there was one instance where this was at risk, although the actions taken had resolved the situation and 1-1 care was provided.
- The re-audit of consultant attendance at required situations identified a reducing trend in 4 areas and these cases were to be used in future training sessions, and the Committee requested an update on this at the next meeting
- An update in relation to medical workforce was provided which highlighted a number of business cases in train to address a number of areas of concern. In addition, changes to the directorate management team were highlighted whereby recruitment was underway.
- It was noted that some of the mitigation taken as a result of learning from serious incidents, included business cases for obstetrics and gynaecology

Major Actions Commissioned / Work Underway

- To circulate future quarterly feedback reports from the MNVP to the Committee
- To provide the completed Thirlwall Inquiry questionnaire to a future Quality Governance Committee
- To consider the Neonatal Mortality Action Plan at a future Committee
- To consider the wider implications of compensatory rest following non-resident on-call for the wider workforce, including identifying any potential corporate risk
- To discuss the issue in relation to UHNM not being the host employer for the smoking service, and challenging whether the Trust could be exempt due to the service being in place and working well
- To receive minutes from the SMOAG meeting
- Future maternity and neonatal reports to be signed off by the Division prior to submission, seeking Executive approval as required.

✓ Positive Assurances to Provide

- An update was provided by the Staffordshire and Stoke on Trent Maternity and Neonatal Voices Partnership (MNVP) highlighting the role of the partnership and the ways in which they sought engagement and feedback
- An update in relation to neonatal workforce highlighted that 31 new nurses recruited in the past 12 months. Neonatal Qualified in Speciality (QIS) compliance had reduced due to the influx of newly qualified nurses, but actions had been taken towards achieving 70% compliance by December 2024 Attrition for 2021/22 was 17.9% and this was predicted for 2022/23 to be 2.9% and it was highlighted that the transitional care unit re-opened on 17th November 2023
- The Committee received assurance of the process in place to review maternity and neonatal safety at Quad Board Safety Champions Meetings
- In terms of maternity training, there had been improvements for both PRactical Obstetric Multi-Professional Training (PROMPT) and fetal monitoring training which were both above 90%
- There had been a reduction in the number of open maternity serious incidents, whereby 10 serious incidents remained under review with 1 new serious incident reported in August.
- CNST action 1 in relation to perinatal mortality, continued to be 100% compliant
- The Trust was 70% compliant with Saving Babies Lives Care bundle. Compliance was expected to further increase within the next month due to actions which had since been completed and full compliance was expected to be achieved at 100% by March 2024
- The midwifery workforce report highlighted that of the 271.88 WTE establishment, the vacancy rate had reduced to 21 WTE, a reduction from 71 in 2022. In addition, attrition was lower than the national rate
- The Committee received the training needs analysis for maternity in addition to the 3-year training plan and associated action plan for 'live' drills
- The Trust continued to be below the 6% national average for term admissions to the neonatal intensive care unit at 4.12% for quarter 2
- The re-audit into consultant presence on ward rounds had demonstrated a positive improvement

Decisions Made

- The Committee received and approved the Standard Operating Procedures and actions in relation to Criteria for Employing Short-term and Long-term Locum Doctors in Obstetrics & Gynaecology and Criteria for Compensatory Rest for Consultants and Senior SAS Doctors in Obstetrics & Gynaecology following Non-Resident On-call Activity

Comments on the Effectiveness of the Meeting

- The Committee welcomed the discussion held in particular the management of time to sufficiently cover the agenda. In addition, members welcomed the quality of presentations and reports

1. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Maternity Voices Partnership Update	BAF 1		●	Information	10.	Perinatal Mortality Report Q2 2023/24	BAF 1		●	Assurance
2.	Neonatal Mortality Report	BAF 1		-	Assurance	11.	Saving Babies Lives Care Bundle V3 – UHNM Compliance	BAF 1		●	Assurance
3.	Neonatal Workforce Paper	BAF 1, 2	28944 22651	●	Assurance	12.	Midwifery Workforce Report	BAF 1, 2	13419	●	Assurance
4.	Criteria for Employing Short-term Locum Doctors in Obstetrics & Gynaecology	BAF 1, 2		-	Approval	13.	Maternity Training Needs Analysis and Skills Drills Training Update September 2023 - Three Year Training Plan	BAF 1	13419	●	Assurance
5.	Criteria for Employing Long-term Locum Doctors in Obstetrics & Gynaecology	BAF 1, 2		-	Approval	14.	ATAIN (Avoiding Term Admissions into the Neonatal Unit) Q2 2023/24	BAF 1	22651	●	Assurance
6.	Criteria for Compensatory Rest for Consultants and Senior SAS Doctors in Obstetrics & Gynaecology following non-resident on-call activity	BAF 1, 2		-	Approval	15.	Re-audit of Consultant Presence on Ward Rounds & Re-Audit of Consultant Attendance at Clinical Situations	BAF 1		● ●	Assurance
7.	Quad Board Safety Champions Meeting Q2	BAF 1		-	Approval	16.	Medical Workforce Highlight Report	BAF 2		●	Assurance
8.	Maternity Dashboard: October 2023	BAF 1, 2	13420 11518 13419 15993 16432	● ●	Assurance	17.	Maternity & Neonatal Quality & Safety Oversight Group Assurance Report	BAF 1		-	Assurance
9.	Maternity and Neonatal New Serious Incident (SI) Report Q2 2023/24	BAF 1	13419 23361	●	Assurance	18.	System Maternity Oversight & Assurance Group	BAF 1		-	Information

2. 2022 / 23 Attendance Matrix

Attended | Deputy Sent | Apologies Received

Members:			May	August	November	February
Prof A Hassell	AH	Associate Non-Executive Director (Chair)				
Mrs C Cotton	CC	Director of Governance	NH	NH	NH	
Mr S Evans	SE	Chief Operating Officer	OW			
Mrs J Haire	RV	Chief People Officer	RC			
Dr M Lewis	ML	Medical Director				
Dr K Maddock	KM	Non-Executive Director				
Mr J Maxwell	JM	Head of Quality, Safety & Compliance				
Mrs AM Riley	AM	Chief Nurse		JHo	FH	
Prof S Toor	ST	Non-Executive Director				

Executive Summary

Meeting:	Trust Board (Open)	Date:	6th December 2023
Report Title:	Maternity Dashboard: October 2023	Agenda Item:	10.
Author:	Sarah Jamieson - Director of Midwifery & Jill Whitaker – Deputy Director of Midwifery – Workforce & Gynaecology		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

High Quality	✓	People	✓	Systems & Partners	✓
Responsive	✓	Improving & Innovating	✓	Resources	✓

Risk Register Mapping

ID	Title	Risk level
13419	Midwifery safe staffing (entered following Birth Rate Plus establishment review 2019)	16
13420	Lack of activity at Freestanding Midwifery Birth Unit (FMBU), County leading to suspension of intrapartum care	15
11518	No current operational Midwifery Continuity of Care team	15
15993	Maternity Assessment Unit Triage	15
16432	COVID 19 & compliance with CNST maternity safety actions	15

Executive Summary

Situation

The Maternity Dashboard report provides an overview of the Maternity performance for October 2023.

Background

The Maternity incentive scheme - year 5 requires evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board using a minimum data set. The measures within the dataset are included and additional information provided.

Based on the CQC report released 23.6.23, UHNM Maternity is rated “requires improvement”.

Though not part of the maternity support programme, UHNM is part of SMOAG (System Maternity Oversight Assurance Group) which provides additional support and guidance.

Assessment

- Midwifery staffing continues to be a challenge but is improving gradually.
- CNST training is on target.
- Work continues to meet CNST targets.
- Work continues to improve maternity triage times.

Key Recommendations

The Trust Board is asked to receive this report.

Maternity Monthly Dashboard

2nd November 2023

1. Introduction

The Maternity incentivisation scheme - year 5 requires the Trust to:

- Demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues
- Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set (figure 1).

Figure 1: Minimum Data Set

- **Findings of review of all perinatal deaths using real time data monitoring tool**

Report on:

- The number of incidents logged, graded as moderate or above and what actions are being taken
- Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training
- Minimum safe staffing in maternity services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover, versus actual prospectively

- **Findings of review of all cases eligible for referral to HSIB**
- **Service User Voice feedback**
- **Staff feedback from frontline champions and walkabouts**
- **HSIB/NHSR/CQC or other organisation with a concern or request for action, made directly with the Trust**
- **Coroner Reg 28 made directly to the Trust**
- **Progress in achievement of CNST 10**

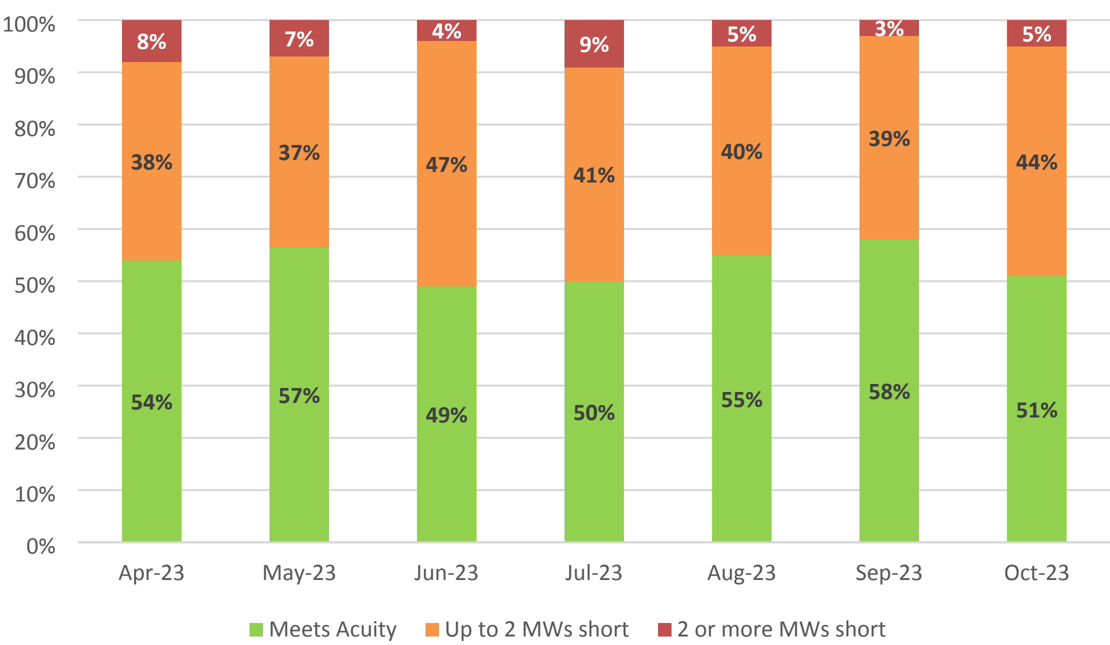
2. Assessment

Midwifery Staffing

The Birthrate Plus data for October confirms that all women received one to one care in labour (as has been the case since April 2023) although there was one occasion where this position was at risk; on 17th October at 14.00 hrs. The shift coordinator escalated a peak in activity and the escalation policy was initiated. Community work was rescheduled, and the staff deployed to the delivery suite, members of the management team were pulled to work clinically, and the situation was quickly resolved, and the woman received one to one care in labour. The delivery suite coordinator remained supernumerary throughout.

Positive acuity was achieved for 51% of the month, 44% of the month was up to 2 midwives short to meet the acuity on the ward and 5% of the month there were 2 or more midwives short.

Staffing Acuity



Medical staffing cover on the delivery suite has been maintained, 7 days a week with a Senior Registrar, Junior Registrar and SHO/F2. Consultant presence is in place Monday to Friday between 8.30 am and 10.00 pm with Consultant presence on Saturdays and Sunday between 8.30 am and 5.00 pm. In addition, a Consultant non-resident is on-call who takes over from the end of the shifts.

Training

PRactical Obstetric Multi-Professional Training (PROM)PT) continues with 79% of midwives and 70% of consultants and 87% of obstetric trainees now compliant. Anaesthetic staff is now at 77%. Support staff compliance has risen 79%.

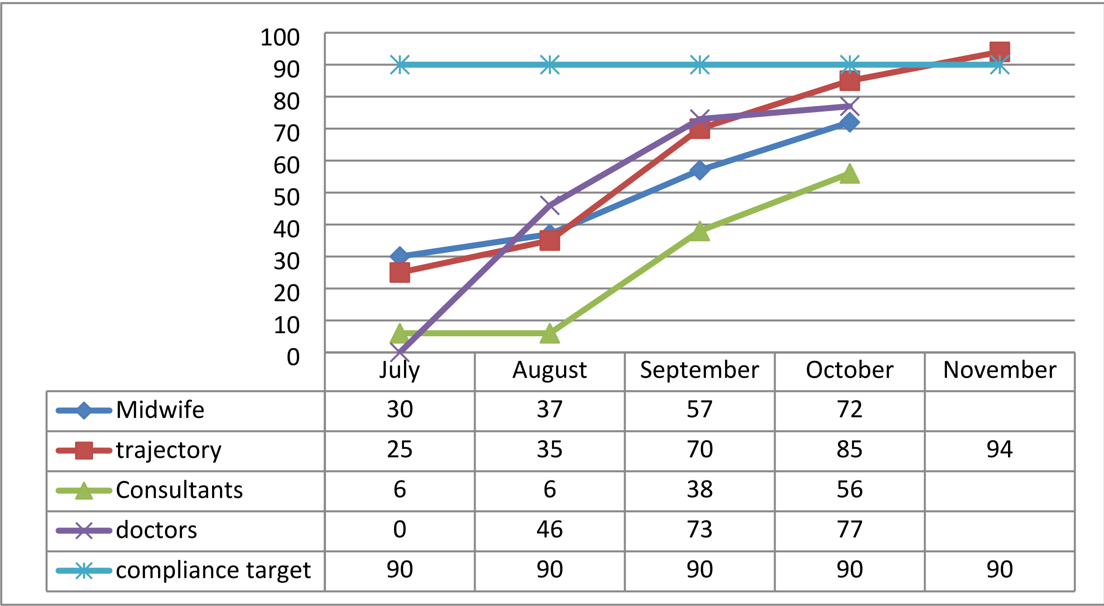
(DECEMBER 2022 – NOVEMBER 2023 inclusive (minus November – compliance 100% staff)

	Doctors	Obs consultants	Obs trainees	Anaesthetist	Anaes consultants	Anaes trainees	Midwives/Bank	CSW	TOTAL
*Total number staff	65	17	48	49	27	22	313	109	536
Staff trained (inc PROMPT Trainers)	54	12	42	38	18	20	249	87	428
*Current compliance	83%	70%	87%	77%	66%	90%	79%	79%	79%
November bookings 02/11/23 16/11/23	10	5	5	9	8	1	37	14	92%
Trajectory %	98%	100%	97%	95%	96%	95%	91%	92%	

Fetal monitoring training remains a priority although current compliance has reduced because 2022 training is now due for renewal. The current position is Consultants 56%, Doctors 85% and Midwives 72%. As at 3rd November 2023 the current position is 73% overall.

Of note a total of 363 staff members have been trained in fetal monitoring. A planned trajectory is in place which will be monitored by the training team and the weekly CQC progress meeting.

Fetal heart monitoring training trajectory



Maternity Assessment Unit

In October, 1774 women were seen in the maternity assessment unit (MAU) of which 341 were not seen by the midwife within the required 15 minutes, this gives a percentage of 19% who breached guidance. There were no adverse outcomes for those who breached.

There is a significant increase in the number of patients seen in September (1487) but despite this, the rate of breaches against the 15 minute review time target has reduced slightly.

As part of our work in this area we have identified that the process of triage is much improved when core staff are working. To support this we have recently increased the core establishment, the aim is to promote confidence and stability amongst the MAU midwifery team.

We continue to monitor and review the breaches on a daily basis within our safety huddle. Work continues to reinforce the midwifery and medical escalation policy.

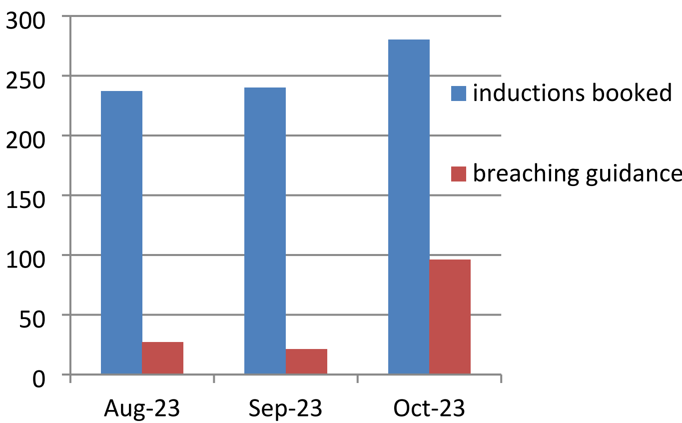
Induction of labour

We continue to monitor and audit the induction of labour process, in particular breaches against current guidelines.

In October there were 96 beaches against guidance, this is a significant increase from last month. This is out of a total of 280 women booked for induction of labour in October. However, there were no adverse outcomes from the cases that breached guidance for induction of labour.

66% of women who were induced were within guidance.

A review of the data shows a significant number of women who required induction of labour in October compared to previous months.



PMRT

4 PMRT meetings were held in October and 100% of these were commenced within 2 months of deaths. There were no emerging themes from the cases reviewed.

Serious/Moderate harm Incidents

- There were no serious or moderate harm events in maternity in October.
- There have been no Coroners regulation 28 in October.
- There have been no HSIB referrals in October.

Progress against CNST10

Perinatal review tool	
Maternity service data set	
Transitional care service	
Clinical workforce	
Midwifery workforce	
Saving babies lives V2.0	
Maternity services partnership	
Training	
Trust Safety Champions	
HSIB	

Complaints

There were 2 maternity complaints raised in October, 1 was in regards to care on the Maternity Assessment Unit and 1 was around decision making on Delivery Suite. Both cases are still under review.

The first meeting of the post natal improvement group is scheduled for November as is the task and finish group to improve friends and family response rates.

Service user feedback

The following feedback was received on the UHNM Facebook page.

"My pregnancy care was absolutely excellent, *by Genie412 - Posted on 24 October 2023*
I just wanted to say that my pregnancy care was absolutely excellent at Royal Stoke University Hospital. Initially, I was marked as low risk but disclosing my mental health issues changed that to high risk. I had growth scans and physically everything was fine right up until 36 weeks where I was diagnosed with obstetric cholestasis with wildly deranged ALT results and then blood pressure issues and proteinuria. I came in for some blood results only to be triaged with really high blood pressure and admitted. The staff managed to get me a side room due to my mental health but when my waters broke unexpectedly they had meconium in them. I was then rushed for an emergency induction which didn't work after 15 hours of trying so I needed a caesarean. As you can imagine,

this was horrifically traumatic and I was in a really bad way afterwards- I was in hospital for a week and my blood pressure was really difficult to stabilise. Honestly I couldn't have had better care. Everything was so frightening but the midwives reassured me and made me feel safe. From the MAU to the wards, everyone was so kind and supportive even when I literally broke down wanting to go home. I was a mess after my c- section and I the midwives and doctors were so incredibly kind. I had to have a lot of blood tests with really poor veins which was really emotionally difficult as I have a lot of trauma around it- but I always felt the staff were trying to be understanding. Things could have gone so badly for me and my daughter, and my birth was so frightening. I'm always going to be grateful I was in the right place when everything went down"

Staff feedback

As part of our staff cultural work we encourage feedback, the following was received from the communications team.

Hi
I am not sure if this is the right way to do this but I wanted to give some feedback after starting at UHNM 2 weeks ago.

I previously worked in another trust for 28 years but trained here at UHNM a long time ago! I returned 2 weeks ago to start working on transitional care unit on ward 205 maternity.

Wow! What a breath of fresh air all the staff are on this ward. Each and every one of the midwifery team, receptionist, sodexo workers have been so welcoming.

Everyone gives you a warm welcome, smiles and offers help and advice when it is needed from a new member of staff like me!. I have not been treated like this in a long time in the NHS.

The midwifery team on this ward are constantly busy yet go about the care with a wonderful attitude and go above and beyond and I am really looking forward to working alongside them.

I also want to thank my colleague Claire Bailey who is new to the trust as a senior staff nurse but I know she will be a huge asset to transitional care.

Heather Mcmaster NICU Clinical educator has been nothing but helpful, guiding us and offering help and support when needed.

Sarah Roberts NCOT lead and the NCOT team also based on ward 205 have been welcoming to the team.

Thank you once more and ward 205 deserve a massive medal for their amazing attitude and commitment.

I could not find any staff feedback forms on the intranet so thought I would try to give the feedback this way, but happy if you can advise me further.

Kind regards
Teresa

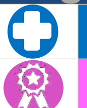
Executive Summary

Meeting:	Trust Board (Open)	Date:	6th December 2023
Report Title:	Maternity and Neonatal New Serious Incident (SI) Report Quarter 2 (1st July – 30th September 2023)	Agenda Item:	11.
Author:	Donna Brayford, Deputy Director of Midwifery - Governance		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

	High Quality	✓		People			Systems & Partners	
	Responsive	✓		Improving & Innovating	✓		Resources	

Risk Register Mapping

13419	Midwifery Safe Staffing	High (12)
23361	Number of open adverse incidents and root cause analysis investigations	High (12)
15593	Maternity Assessment Unit Triage	High (10)

Executive Summary

Situation

This report provides a summary of the numbers and types of serious incidents reported by maternity and neonatal Services.

Background

Following the publication of the Ockenden review, Trust Boards are to have specific sight of Maternity Serious Incidents on a quarterly basis.

Assessment

No of open maternity and neonatal Serious Incidents	**10**
Investigation in progress	4 (2 Healthcare Safety Investigation Branch Investigations & 2 Perinatal Mortality Review Tool/ Root Cause Analysis)
Investigations completed/awaiting to be presented and closed by Risk Management Panel and ICB SI Group	6 (1 awaiting ICB closure & 5 awaiting Trust approval)

No of overdue open serious incidents	2

The Ockenden Final Report states all serious incident actions must be completed within 6 months.

In Q2, 1 new serious incident was reported:

July	2023	0 incident
August	2023	1 incident
September	2023	0 incident

Category of Incident:
1 Root Cause Analysis

There has been a reduction in Q2 of the number of open and overdue serious incidents.

Recommendations:

All new serious incidents will include details and date of immediate actions to provide assurance of meeting Ockenden recommendation of implementing actions within 6 months of the incident.

Key Recommendations

The Trust Board is asked to accept this report for assurance .

Performance and Finance Committee Chair's Highlight Report to Board

28th November 2023

! Matters of Concern of Key Risks to Escalate

For information:

- Month 7 financial performance demonstrated a £7.8 m deficit which was £10.9 m behind plan, the key drivers for which remained the same as previous months. It was noted that the Trust was not expected to be able to improve the financial position any further than break-even
- In terms of agency usage, there was a risk that the 3.7% target would not be met, given the Trust's average performance of 4.5%. Actions taken included meetings with all Divisions, and identifying trajectories for improvement in particular reviewing highest paid and longest serving individuals
- Overall, urgent and emergency care performance had deteriorated with particular challenges in 4 hour performance and ambulance handovers, whereby previous assumptions in regards to performance for October were realised due to capacity constraints.
- Although diagnostic performance had slightly improved for October, the main area of challenge was endoscopy performance which had also impacted on the 28 day faster diagnosis standard, and this was subject to a large programme of improvement
- Drug expenditure had forecast £114 m spend for 2023/24 80% of which comprised high cost drugs; the drivers being NICE Health Technology Assessments (HTAs), with 24 having been issued in the last 6 months. The continued fragility of the pharmaceutical supply chain was also highlighted
- Theatre productivity demonstrated a static number of operations undertaken each month although improvements had been made to reduce late starts and cancellations and it was noted some procedures had moved to other areas such as STS at County
- The EPRR core standards assessment identified overall non-compliance. Improvement actions included creating additional capacity within the team and quick wins with longer-term actions being identified within a two year workplan

Major Actions Commissioned / Work Underway

- To provide updated figures in terms of throughput to the Enhanced Primary Care and Out of Hours Service
- To identify the potential fall back position on pharmacy savings so that these could be taken into account for 2024/25
- Further assurance to be provided in respect of the key actions being taken to improve theatre productivity
- To prioritise the actions required in respect of the EPRR Annual Assurance statement
- To confirm the sample utilised (validated versus unvalidated) for the Internal Audit into Planned Care Waiting List Management
- To review the proposed agenda for December's meeting

✓ Positive Assurances to Provide

- Initiatives to improve operational performance were highlighted, including ambulatory clinical decision unit, changes to the frailty pathway, outpatient antibiotic treatment delivery and integrated discharge unit
- In terms of long waits, one patient remained outstanding for 104 weeks due to the complexities of treatment and requirement to wait for specialist equipment. In addition, there had been a continued reduction with 78 week waits
- Cancer performance demonstrated a reduction in backlogs aligned with trajectories, with the focus remaining on skin and urology.
- The review of the business case associated with purchase of the modular building demonstrated the purchase of the building was in line with the planned spend
- Forecast Trust procurement savings stood at £5.85 m which was better than plan and procurement performance was highlighted as 3rd best across the NHS
- Pharmacy financial savings were identified associated with the Commercial Medicines Unit (CMU) contract and use of Exend® monitoring software

Decisions Made

- The Committee approved the Board Assurance document in respect of the 2023-24 plan in addition to noting the trajectories identified
- The Committee approved business case BC-0543 NHS England Frontline Digitalisation Investment which was to be considered by the Trust Board
- The Committee approved e-REAFs 12724, 12797, 12840 and 12922

Comments on the Effectiveness of the Meeting

- No further comments were made

1. Summary Agenda

No.	Agenda Item	BAF Mapping: BAF No.	BAF Mapping: Risk	BAF Mapping: Assurance	Purpose
1.	Finance Report – Month 7 2023/24	BAF 8	High 12		Assurance
2.	Performance Report – Month 7 2023/24	BAF 1 BAF 5	Ext 16 Ext 20		Assurance
3.	NHSE Plan Board Assurance and 2023-24 Plan Update	BAF 5	Ext 20	-	Approval
4.	NHSE Frontline Digitalisation Investment Business Case	BAF 6	ID28451 ID9036 ID28595	-	Approval
5.	Business Case Review – BC-0511 Purchase of Modular Building to provide Enhanced Primary Care at UHNM	BAF 5	Ext 20		Assurance
6.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	-	Approval

No.	Agenda Item	BAF Mapping: BAF No.	BAF Mapping: Risk	BAF Mapping: Assurance	Purpose
7.	Quarterly Procurement Report	BAF 8	High 12		Assurance
8.	Pharmacy Directorate Medicines Procurement, Finance and Supplies Report Month 1-6 2023-24	BAF 8	ID24181		Assurance
9.	Theatre Productivity Plan 2023-2025 Progress Update	BAF 5	Ext 20		Assurance
10.	EPRR Core Standards Assurance	-	-		Assurance
11.	Planned Care Improvement Group Highlight Report	BAF 5	Ext 20	-	Assurance
12.	Internal Audit Reports: Data Quality – Planned Care Waiting List Management (Part 1)	BAF 5	Ext 20	-	Assurance

2. 2023 / 24 Attendance Matrix

No.	Name	Job Title	A	M	J	J	A	S	O	N	D	J	F	M
1.	Dr L Griffin (Chair)	Non-Executive Director												
2.	Mr P Akid	Non-Executive Director												
3.	Ms H Ashley	Director of Strategy												
4.	Ms T Bowen	Non-Executive Director			Chair									
5.	Mrs T Bullock	Chief Executive												
6.	Mr S Evans	Chief Operating Officer	PB	KT	KT/OW	KT			OW					
7.	Mrs C Cotton	Director of Governance		NH	NH	NH		NH	NH	NH				
8.	Mr M Oldham	Chief Finance Officer												
9.	Mrs S Preston	Strategic Director of Finance												
10.	Mrs A Rodwell	Associate Non-Executive Director												
11.	Mr J Tringham	Director of Operational Finance												
12.	Ms A Gohil	Non-Executive Director												

Attended | Apologies & Deputy Sent | Apologies

Transformation and People Committee Chair's Highlight Report to Board

29th November 2023

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• 83 reports including and 4 'immediate safety concerns' reported during Q2 Guardian of Safe Working Report; however, upon response, the 4 concerns were not 'immediate' of nature although were responded to within 1 hour and were in relation to workload • 11% increase in BAME colleagues reporting harassment, bullying or abuse from patients, service users, their relatives, or the public; also deteriorated by 2% for white colleagues. Alongside, slight deterioration in appointment of BAME applicants for roles when compared to white applicants. Areas of deterioration will be improvement priorities over next 18 months. • Not all incidents of abuse of staff are reported; a plan is in place to improve the communication around a zero-tolerance approach, and it is anticipated that the staff survey findings will provide greater detail in terms of areas of concern. • Essential to role training compliance remains a concern and below the 90% target; a particular area of concern is resuscitation training and a business case to request additional resource is underway. • Sickness absence is a particular concern within the Surgical Division, who have this as a driver metric. People Business Partners are focussing on the biggest areas of impact and increasing actions / support in those areas. Another area is Medical Division with the same focus. • Reviews of postgraduate training provision within areas of concern continue with formal responses to areas of concern submitted and improvement plans in place. • Recruitment and retention of tutors is becoming an increasing challenge • Data, Security and Protection Group escalated matters in relation to problems with widely used clinical systems, EPRR, cyber security, training and increases in FOI requests	• A task and finish group is in place to support the career progression of overseas nurses although it was agreed that a further review would be undertaken around the volume of BAME applications progressing to shortlist; initial observations that there are high volumes of speculative applications that do not reach the minimum person specification • A review of trends arising from resolution cases will be undertaken to determine the effectiveness of the Resolution Policy • A gap analysis has been undertaken against the best practice framework for agency use and several additional grip and control measures have been introduced to drive reduction towards the target of 3.7% - a discussion will take place outside the meeting to confirm the governance across the two key Committees • Raw data from the Staff Survey will be received end of December / early January for analysis and interpretation • A deeper dive into the Culture Heat Map is being undertaken and a key focus is around sexual safety within the organisation • Corporate and divisional vacancy control panels have been established • Consideration will be given as to how the Chief People Officer's report can continue to be refined so that assurance can be provide, priorities / thresholds are agreed, and the business rules continue to be adhered to • A case will be developed for analyst support for postgraduate training experience • Work will be undertaken to refresh the Research and Innovation Strategy for 2025 and beyond; meanwhile work will focus on bringing CENREE / Innovation into the reporting and the roadmap will be set out for the Committee
✓ Positive Assurances to Provide	**Decisions Made**
• A network of Guardians of Safe Working has been established across the country to share best practice, support, and learn from each other • There has been improvement against the majority of Workforce Race Equality Standard (WRES) metrics when compared to the previous year • The number of informal resolutions is increasing, and the cases being handled by the People Directorate are the more serious concerns; this indicates that issues are being tackled • Staff Survey closed with a response rate of 45% which was the highest since 2019, with significant support from colleagues across the organisation • Vacancy rate is better than target with significant progress being made with recruitment • Training scores show modest improvement (8th to 7th) with UHNM improving in ranking when compared to other major acute providers • A new college tutor in radiology has been appointed and a deputy is also being recruited • Undergraduate Physician Associate programme students regularly receive high level pass rates and the consultant body commitment and engagement with students is excellent. • Rollout of Office 365 is progressing very well	• There were no items requiring decision.

Comments on the Effectiveness of the Meeting

- No specific matters were raised although recognition was given to the progression of the research strategy and the success in response rate to the Staff Survey

1. Summary Agenda

No.	Agenda Item	BAF Mapping: BAF No.	BAF Mapping: Risk	BAF Mapping: Assurance	Purpose	No.	Agenda Item	BAF Mapping: BAF No.	BAF Mapping: Risk	BAF Mapping: Assurance	Purpose
1.	Guardian of Safe Working Report Q2	BAF 2	ID28655 ID24272 ID18842		Assurance	8.	Medical School Quality Report 2022-23	BAF 2/3	Ext 15 High 12		Assurance
2.	2023 Workforce Race Equality Standard Report and Action Plan	BAF 3	High 12)		Assurance	9.	Research and Innovation Strategy Update	BAF 9	High 12	-	Assurance
3.	Agency Report – November 2023	BAF 2	Ext 16	-	Assurance	10.	Executive Research & Innovation Group Highlight Report	BAF 9	High 12	-	Assurance
4.	Chief People Officer Report M7 & M8	BAF 2 BAF 3	Ext 16 High 12		Assurance	11.	Executive Digital and Data Security & Protection Group Highlight Report	BAF 6	Ext 16		Assurance
5.	Postgraduate Medical Education Quality Assurance	BAF 2/3	ID16652		Assurance	12.	Improving Together Countermeasure Summary	-	-		Assurance

2. 2022 / 23 Attendance Matrix

No.	Name	Job Title	A	M	J	J	A	S	O	N	D	J	F	M
1.	Prof G Crowe	Non-Executive Director (Chair)				NO MEETING HELD								
2.	Ms H Ashley	Director of Strategy and Transformation												
3.	Ms T Bowen	Non-Executive Director												
4.	Mrs T Bullock	Chief Executive												
5.	Mr S Evans	Chief Operating Officer	PB											
6.	Mrs C Cotton	Director of Governance	NH	NH				NH						
7.	Mrs J Haire	Chief People Officer		RC				KM						
8.	Dr M Lewis	Medical Director						ZD						
9.	Prof K Maddock	Non-Executive Director												
10.	Mrs A Riley	Chief Nurse					JHo							
11.	Prof S Toor	Non-Executive Director												

Attended | Apologies & Deputy Sent | Apologies

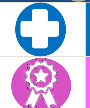
Executive Summary

Meeting:	Trust Board (Open)	Date:	6th December 2023
Report Title:	2023 Workforce Race Equality Standard Report and Action Plan	Agenda Item:	14.
Author:	OD, Culture & Inclusion Business Partner		
Executive Lead:	Chief People Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

	High Quality	✓		People	✓		Systems & Partners	
	Responsive			Improving & Innovating	✓		Resources	

Risk Register Mapping

BAF 2	If we are unable to achieve a sustainable workforce, then we may not have colleagues with the right skills in the right place at the right time, resulting in an adverse impact on colleague wellbeing, recruitment and retention, increasing premium costs and potentially compromising the quality of care for our patients	Ext 16
BAF 3	If we are unable to live our values and improve the culture of the organisation to make UHNM a place where all colleagues are treated with respect and have the opportunity to build a fulfilling career, then colleagues may experience unacceptable behaviours and a climate of bullying, harassment and inequality, resulting in an adverse impact on colleague wellbeing, recruitment, retention and performance, ultimately reducing the quality of care experienced by patients.	High 12

Executive Summary:

Situation

As set out in the NHS People Plan, respect; equality and inclusion are central to changing culture and are at the heart of the NHS. The Workforce Race Equality Standard (WRES), mandated through the NHS Contract is a set of 9 measures (metrics) that enable NHS organisations to compare the workplace and career experiences of Black, Asian and Minority Ethnic (BAME) staff compared to their white colleagues, using the information to develop and publish an action plan to address inequalities. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of race equality.

Background

The national evidence shows that Black, Asian and Minority Ethnic (BAME) colleagues in the NHS are less well represented at senior levels, have measurably worse day to day experiences of life in NHS organisations, and have more obstacles to progressing in their careers.

The Workforce Race Equality Standard (WRES) aims to enable NHS Trusts to understand what they need to do to improve workforce race equality and to embed the WRES within their organisations. This year also includes metrics for Bank and Medical workforce in the organisation disaggregated by ethnicity.

Assessment

There has been improvement against the majority of metrics compared to the previous year. However, on a number of metrics this improvement should be viewed in the context of our comparator peer group.

Priority areas where we have seen little positive movement or deterioration in our performance will be key work streams for the next 18 months. These include the metrics on workforce experience of harassment, bullying and abuse; experience of discrimination and belief in equal opportunities for career progression or promotion.

Whilst there has been a notable increase in overall representation, our Black, Asian and Minority Ethnic colleagues continue to be under-represented in senior roles and a spotlight on recruitment processes, particularly for Band 8A and above roles, and access to career development opportunities will be fundamental to our inclusive recruitment actions.

In summary, our 2023 WRES data shows:

- 3% increase in Black, Asian and minority ethnic representation across the organisation recorded on ESR compared to last year. BAME representation at UHNM has increased by 10% in the 7 years of participating in the WRES.
- BAME colleagues continue to be less likely than white colleagues to enter the formal disciplinary process and within recommended
- 0.7% reduction in the percentage of BAME colleagues reporting experience of bullying, harassment or abuse from other staff
- Improvement of 1.7% in the percentage of BAME colleagues that believe that the Trust offers equal opportunities for career progression or promotion
- 2.0% improvement in BAME colleagues reporting discrimination at work from a team leader/line manager.
- An improvement in board member ethnic diversity representation
- No significant change in the likelihood of BAME colleagues accessing continued professional development with a likelihood ratio of 1.04.

Metrics that have deteriorated are:

- An 11% increase in the percentage of BAME colleagues reporting experiencing harassment, bullying or abuse from patients/service users, their relatives or the public. This metric has also deteriorated for white colleagues, which has increased by 2%.
- Deterioration of 0.2 in the likelihood ratio of BAME applicants being appointed from shortlisting compared to white applicants.

We recognise that our cultural improvement journey will take time and the actions we have identified below build on the work we have already started whilst recognising the areas of concern that this year's WRES metrics identify. During 2023-24 we will focus on:

- Continued focus on living our Being Kind Compact and embedding the Being Kind approach to the early and lasting resolution of issues
- Demonstrate organisational commitment to anti-racism and the elimination of race discrimination and embed this into our leadership development and people practices
- High profile campaign on the responsibilities of individuals to address harassment bullying and abuse from patients, service users and members of the public by ensuring education, training and processes effectively protect our colleagues
- Implementation of the UHNM inclusive talent management strategy and the actions we have identified to de-bias recruitment and selection processes. Effectively monitor progress using the EDI dashboards
- Implementation of our Race Equality Code action plan

Progress will be measured by improved metric results in the 2023 Staff Survey, 2024 WRES submission, divisional EDI dashboards and the monitoring of other relevant metrics including the Employee Voice feedback and the lived experiences of our Ethnic Diversity Staff Network membership.

In response to the assurance questions and our assessment as set out above, our proposed assurance assessment is set out below:

Assurance Assessment		
Significant Assurance	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable Assurance	General confidence in delivery of existing mechanisms / objectives	
Partial Assurance	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	x
No Assurance	No confidence in delivery	

Key Recommendations:

This report has been presented to Transformation & People Committee and Executive Workforce Assurance Group. Trust Board is requested to review this report and the associated action plan, which identifies actions against each metric to improve the workplace experiences of our Black, Asian and Minority Ethnic workforce and reduce the disparity between BAME and white colleagues.

Workforce Race Equality Standard (WRES)

2023 Report

1. Introduction

The NHS was established on the principles of social justice and equity, but evidence tells us that the treatment of our colleagues from Black, Asian and Minority Ethnic (BAME) groups can fall short. Inequalities in any form are at odds with the values of the NHS and we know that the fair treatment of our staff is directly linked to better clinical outcomes and better experience of care for our patients.

The national evidence from each WRES report over the years has shown that BAME colleagues are less well represented at senior levels, have measurably worse day to day experiences of life in NHS organisations, and have more obstacles to progressing in their careers.

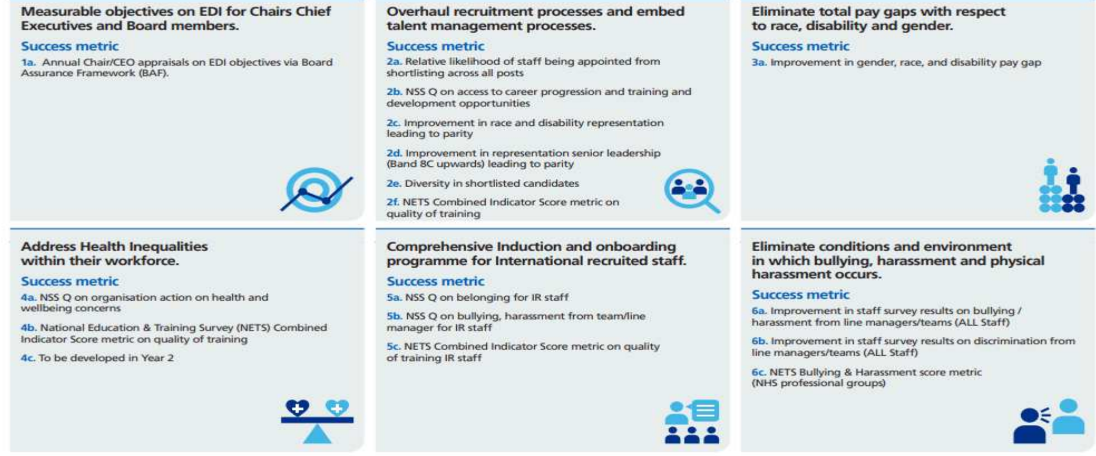
The WRES has been designed to deliver tangible and lasting improvements in race inclusion. NHS providers are expected to show progress against a number of indicators of workforce equality. The WRES is intended to provide a platform and direction to encourage and help NHS organisations to:

- Reduce the differences in the treatment and experience between BAME and white staff in the NHS
- Compare not only their progress in reducing the gaps in treatment and experience but to make comparisons with similar organisations about the overall level of such progress over time
- Identify and take necessary remedial action on the causes of ethnic disparities in the metric outcomes
- The WRES is mandated annually as part of the NHS Standard Contract. NHS Organisations are required to publish their data and action plan on their public facing website.

Note on Terminology: The terms Black, Asian and Minority Ethnic (BAME) and ethnically diverse will be used throughout this report to describe colleagues from ethnically diverse backgrounds. We should recognise however that experiences can vary between different ethnic groups.

NHS EDI Improvement Plan

The NHS People Plan sets out the priorities and specific actions for improving the sense of 'belonging' of our people in the NHS. This NHS EDI Improvement Plan, launched in June 2023 builds on the People Promise and the People Plan, using the latest data and evidence to identify six high impact actions organisations across the NHS can take to considerably improve equality, diversity and inclusion.



2. WRES Metrics and UHNM Performance

The WRES comprises of 9 Metrics that incorporate data from the following primary sources: the NHS Electronic Staff Record (ESR), the NHS National Staff Survey and local HR and recruitment systems.

Four of the WRES metrics are drawn from the annual NHS Staff Survey. The UHNM response rate for the 2022 staff survey was 33.2%, with 16.1% of respondents (589 people) stating that they are from a Black, Asian and Minority Ethnic (BAME) background. This compares to the peer average of 17.7%.

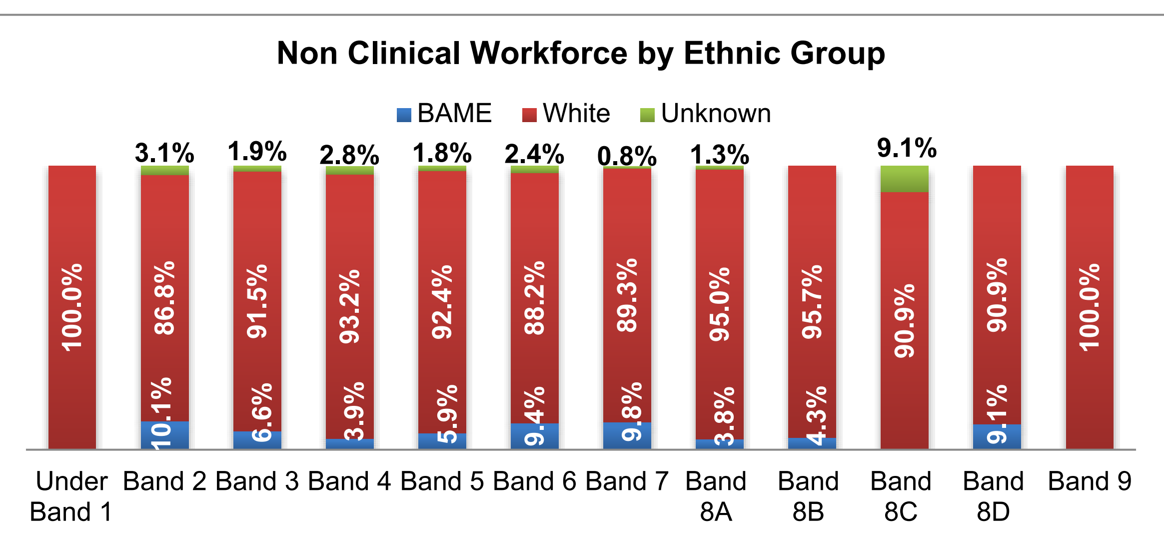
Metric 1 - Percentage representation by ethnicity at each AfC pay band, amongst non-clinical staff, clinical staff and within the Medical & Dental professional group

UHNM uses the ESR system to capture and record employee ethnicity. The Trust regularly encourages our workforce to update their ESR record and the number of records where colleagues have not disclosed their ethnicity status is only 2.6%. We have seen year on year increases in the ethnic diversity of our UHNM workforce, with 23.5% of colleagues being from Black, Asian and Minority Ethnic backgrounds as recorded on ESR at 31st March 2023.

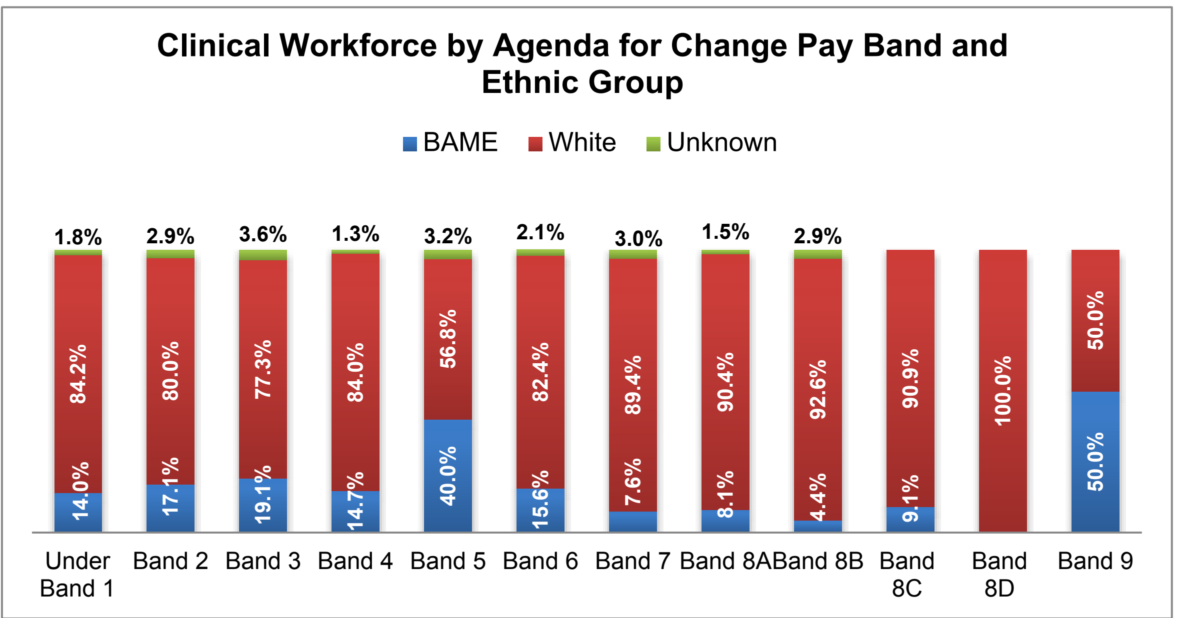
Ethnicity Group	Headcount	%
BAME	2773	23.5%
White	8729	73.9%
Unknown	309	2.6%
Total	**11,811**	**100%**

7.4% of non-clinical and 21.3% of the clinical workforce (excluding doctors) are recorded as being from a BAME background on ESR with 66.1% of doctors and dentists. This compares to the most recent national picture of 24.2% BAME representation, with 16.3% in non-clinical roles and 24% in clinical roles (excluding doctors) and 44.3% representation in medical and dental roles in 2022.

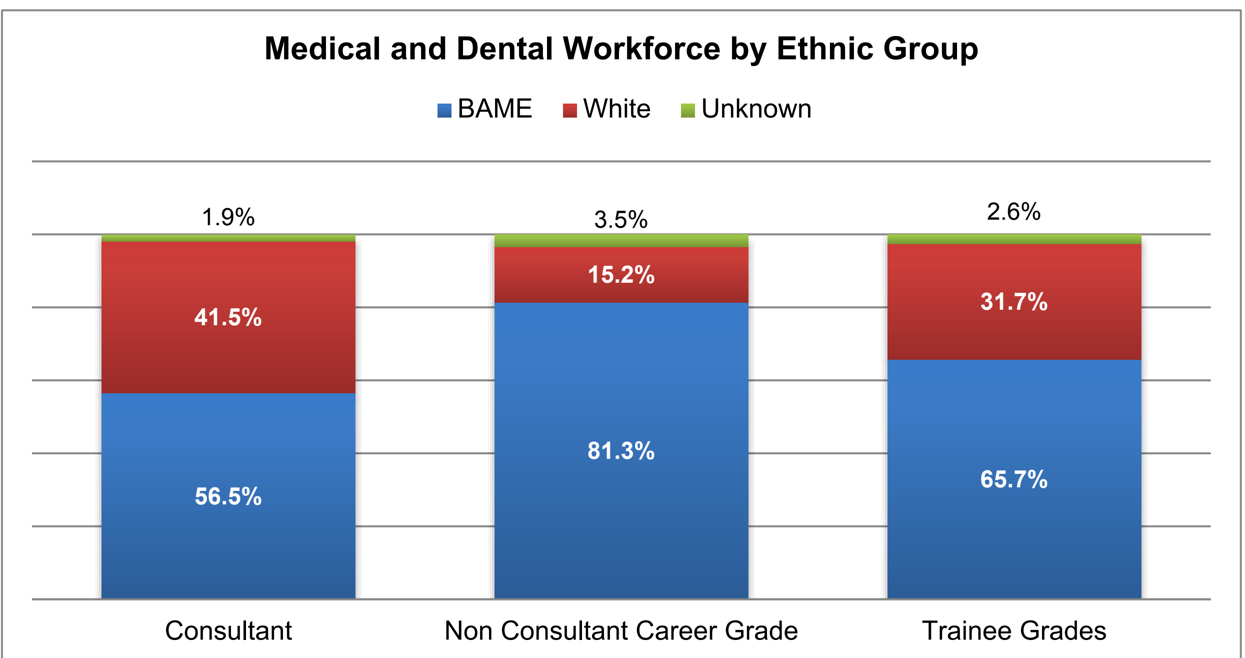
UHNM Workforce Group	BAME %	White %	Unknown %
Non-clinical	7.4%	90.2%	2.4%
Clinical (excluding Medical & Dental)	21.3%	76.0%	2.7%
Medical & Dental	66.1%	31.3%	2.6%



Ethnic Group	Under Band1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9
BAME	0	92	38	20	10	16	12	3	2	0	1	0
White	10	788	526	467	157	150	109	76	44	20	10	14
Unknown	0	28	11	14	3	4	1	1	0	2	0	0
Total	10	908	575	501	170	170	122	80	46	22	11	14



Ethnic Group	Under Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9
BAME	8	324	106	58	804	265	56	27	3	1	0	1
White	48	1514	428	331	1142	1404	656	303	63	10	11	1
Unknown	1	55	20	5	64	35	22	5	2	0	0	0
Total	57	1893	554	394	2010	1704	734	335	68	11	11	2



Ethnic Group	Consultant Headcount	Non consultant Career Grade Headcount	Trainee Grades Headcount
BAME	320	304	302
White	235	57	146
Unknown	11	13	12
Total	566	374	460

The following table and graphs demonstrate BAME representation across Agenda for Change (AfC) pay bands and Medical and Dental workforce:

WRES Metric	Pay Band	2019	2020	2021	2022	2023	Movement
Percentage of BAME staff in each of the AfC Bands 1 – 9 or medical and dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	Under Band 1:	0.0%	11.1%	6.1%	18.9%	11.9%	↑
	Band 1:	20.4%	5.0%	5.1%	3.2%	-	-
	Band 2:	9.9%	11.6%	11.9%	13.3%	14.8%	↑
	Band 3:	4.8%	5.2%	5.1%	5.9%	12.7%	↑
	Band 4:	10.4%	10.7%	11.9%	10.2%	8.7%	↓
	Band 5:	23.8%	24.4%	26.2%	30.7%	37.3%	↑
	Band 6:	10.5%	11.0%	12.4%	13.7%	15.0%	↑
	Band 7:	4.0%	4.8%	4.3%	5.8%	7.9%	↑
	Band 8a:	5.9%	6.4%	6.9%	6.5%	7.2%	↑
	Band 8b:	2.4%	2.3%	4.3%	5.1%	4.4%	↓
	Band 8c:	6.5%	6.5%	6.1%	5.3%	3.0%	↓
	Band 8d:	0.0%	0.0%	0.0%	0.0%	4.5%	↑
	Band 9:	0.0%	0.0%	8.3%	0.0%	0.0%	↔
	VSM:	0.0%	0.0%	0.0%	0.0%	10.0%	↑
	Medical & Dental	55.6%	58.4%	60.8%	63.6%	66.1%	↑

Race Disparity Ratio

The Race Disparity Ratio, introduced in June 2021, is a reflection of workforce distribution in terms of representation in the AfC pay bands, comparing BAME and white colleagues. It is presented at three tiers. A ratio of 1 reflects parity of progression, and values higher than '1' reflect inequality, with a disadvantage for BAME staff.

- Bands 5 and below ('lower')
- Bands 6 and 7 ('middle')
- Bands 8a and above ('upper')

Tier	2023	2022
Disparity ratio - lower to middle	1.79	1.62
Disparity ratio - middle to upper	2.16	2.14
Disparity ratio - lower to upper	3.88	3.46

The Race Disparity Ratio does not include medical and dental staff

Our data tells us:

- Lower to Middle tier progression: White staff are 1.79 times more likely to progress through our organisation than BAME staff
- Middle to Upper tier progression: White staff are 2.16 times more likely to progress through our organisation than BAME staff
- Lower to Upper tier progression: White staff are 3.88 times more likely to progress through our organisation than BAME staff

Trends nationally show that in non-clinical roles, the gap between BAME and white representation has been decreasing each year in terms of the lower to upper levels. However, in clinical roles (outside of medicine), the gap between BAME and white progression has been widening over the past three years, particularly in terms of the lower to middle levels.

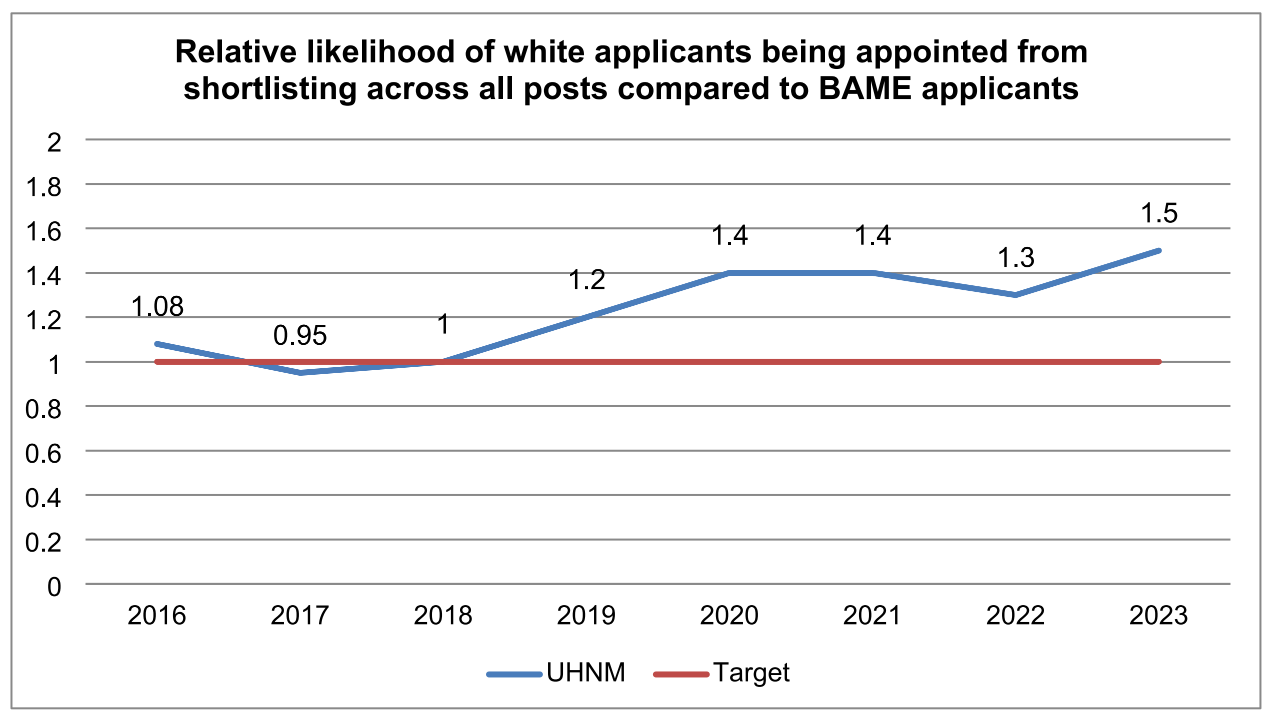
The image below demonstrates ethnicity representation in clinical and non-clinical Agenda for Change roles, and demonstrates that BAME representation is increasing in all tiers compared to the previous year. (Figures for 2022 in brackets):

AfC Bandings	White % 2023	BAME % 2023	Unknown % 2023
1 to 5	76.5% (79.6%)	20.6% (16.8%)	2.8% (3.6%)
6 and 7	84.9% (86.3%)	12.8% (11.3%)	2.3% (2.5%)
Band 8a+	91.7% (92.6%)	6.4% (5.8%)	1.6% (1.6%)
Grand Total	**79.6% (82.0%)**	**17.7% (14.8%)**	**2.6% (3.2%)**

Progress against our Model Employer Aspirational Targets for BAME representation in senior leadership roles continues in a positive trajectory (previous year figures in brackets). Each division monitors their race disparity ratio (the differential in representation between white and BAME colleague progression rates) as part of their EDI Dashboard.

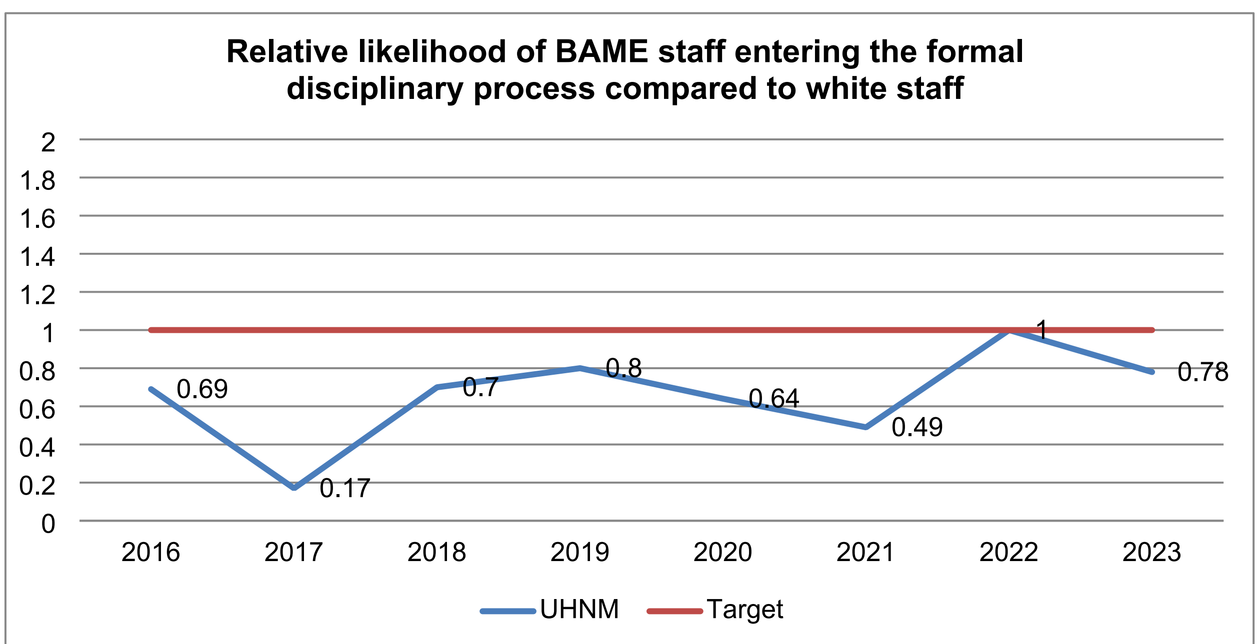
	BAME Headcount at 31.03.23	Model Employer Target for 2022-23
Band 8A	32 (25)	31
Band 8B	6 (5)	7
Band 8C	1 (2)	3
Band 8D	1 (0)	1
Band 9	0 (0)	1
VSM	1 (0)	1

Metric 2: Relative likelihood of BAME staff compared to White staff being appointed from shortlisting across all posts



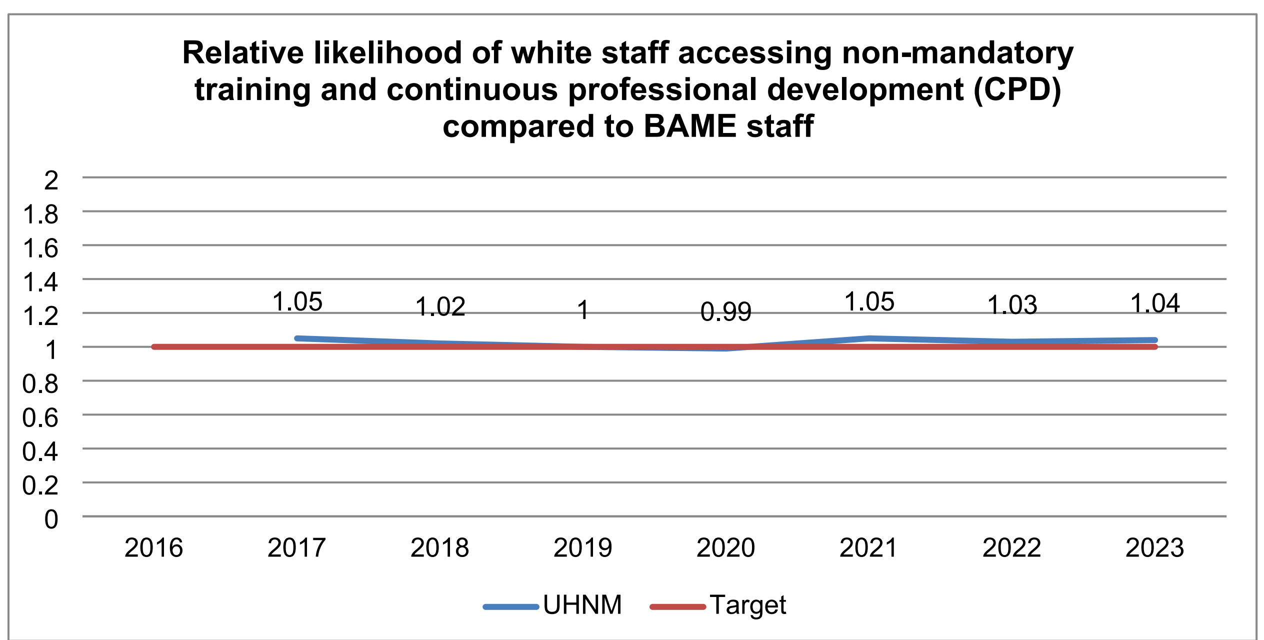
This metric has deteriorated compared to last year, but is similar to the Midlands (1.5); Acute average (1.58) and national figure of 1.59.

Metric 3: The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff



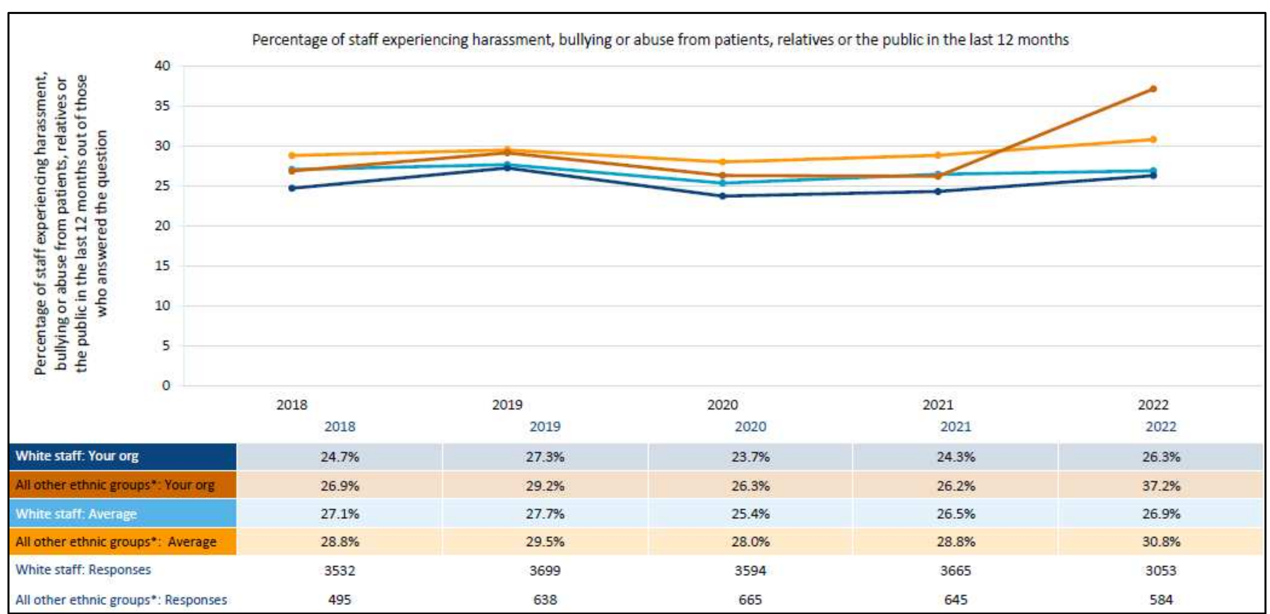
UHNM is in the top 25 percentile nationally for this metric.

Metric 4: The relative likelihood of white staff accessing non–mandatory training and CPD compared to BAME staff



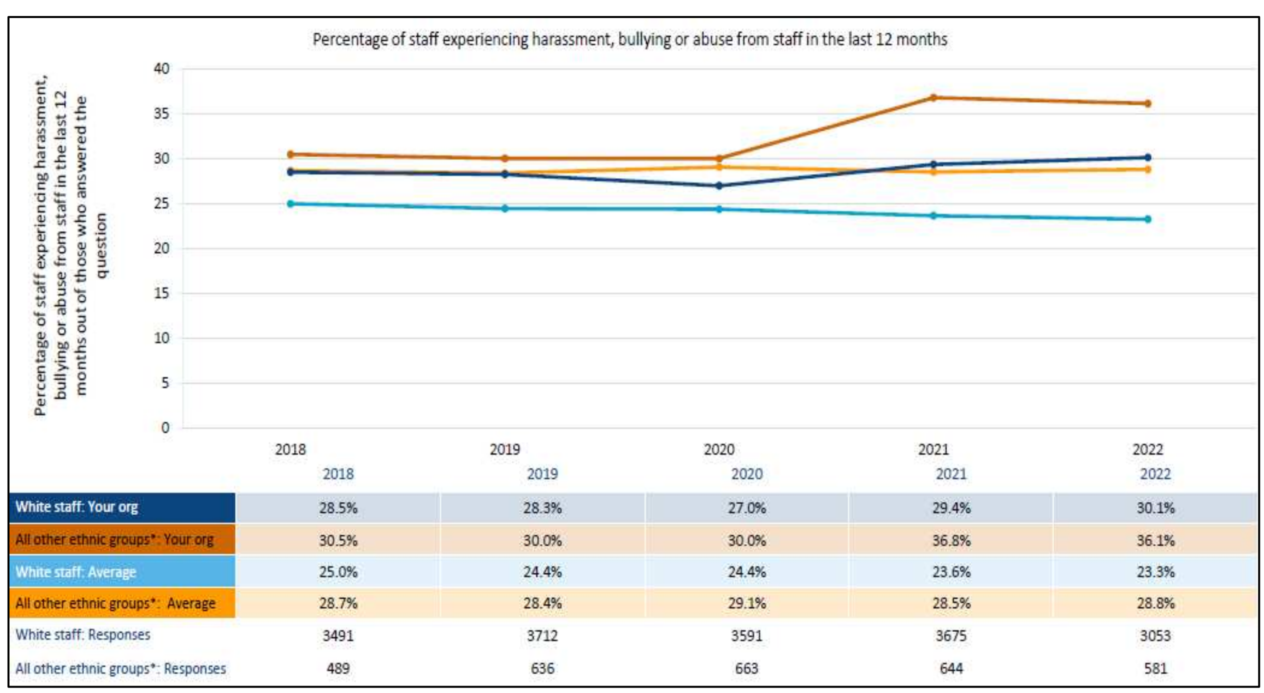
The midlands figure for this metric is 0.97; the average for the acute sector is 1.02 and nationally it is 1.12.

Metric 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months:



	2018	2019	2020	2021	2022
White staff: Your org	24.7%	27.3%	23.7%	24.3%	26.3%
All other ethnic groups*: Your org	26.9%	29.2%	26.3%	26.2%	37.2%
White staff: Average	27.1%	27.7%	25.4%	26.5%	26.9%
All other ethnic groups*: Average	28.8%	29.5%	28.0%	28.8%	30.8%
White staff: Responses	3532	3699	3594	3665	3053
All other ethnic groups*: Responses	495	638	665	645	584

Metric 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months:

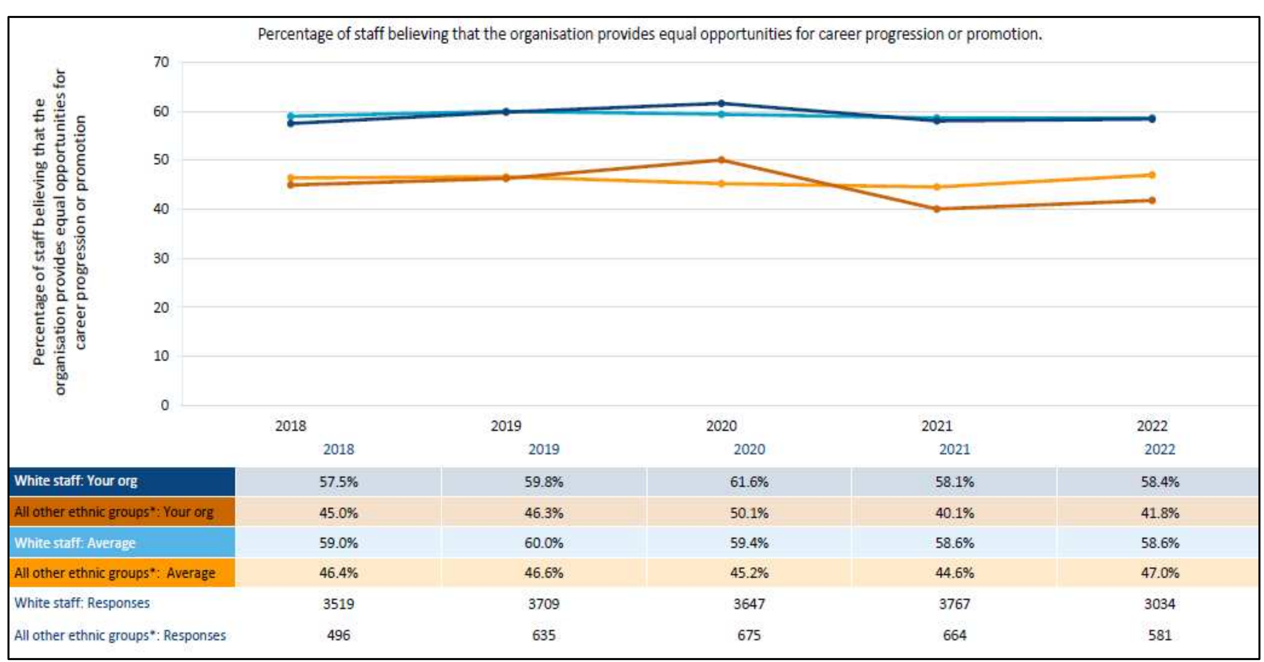


	2018	2019	2020	2021	2022
White staff: Your org	28.5%	28.3%	27.0%	29.4%	30.1%
All other ethnic groups*: Your org	30.5%	30.0%	30.0%	36.8%	36.1%
White staff: Average	25.0%	24.4%	24.4%	23.6%	23.3%
All other ethnic groups*: Average	28.7%	28.4%	29.1%	28.5%	28.8%
White staff: Responses	3491	3712	3591	3675	3053
All other ethnic groups*: Responses	489	636	663	644	581

There is a significant increase on the previous year for BAME colleagues reporting experience of harassment, bullying and abuse from patients, relatives or the public and whilst this may be a reflection of a relaxing of covid-19 restrictions in visiting, this increase is not reflected to such an extent by white colleagues at UHNM or within our peer comparator group.

There has been slight improvement of BAME colleagues reporting harassment, bullying or abuse from colleagues, and a slight deterioration for white colleagues, but both remain consistently higher than the peer group average for white and BAME staff.

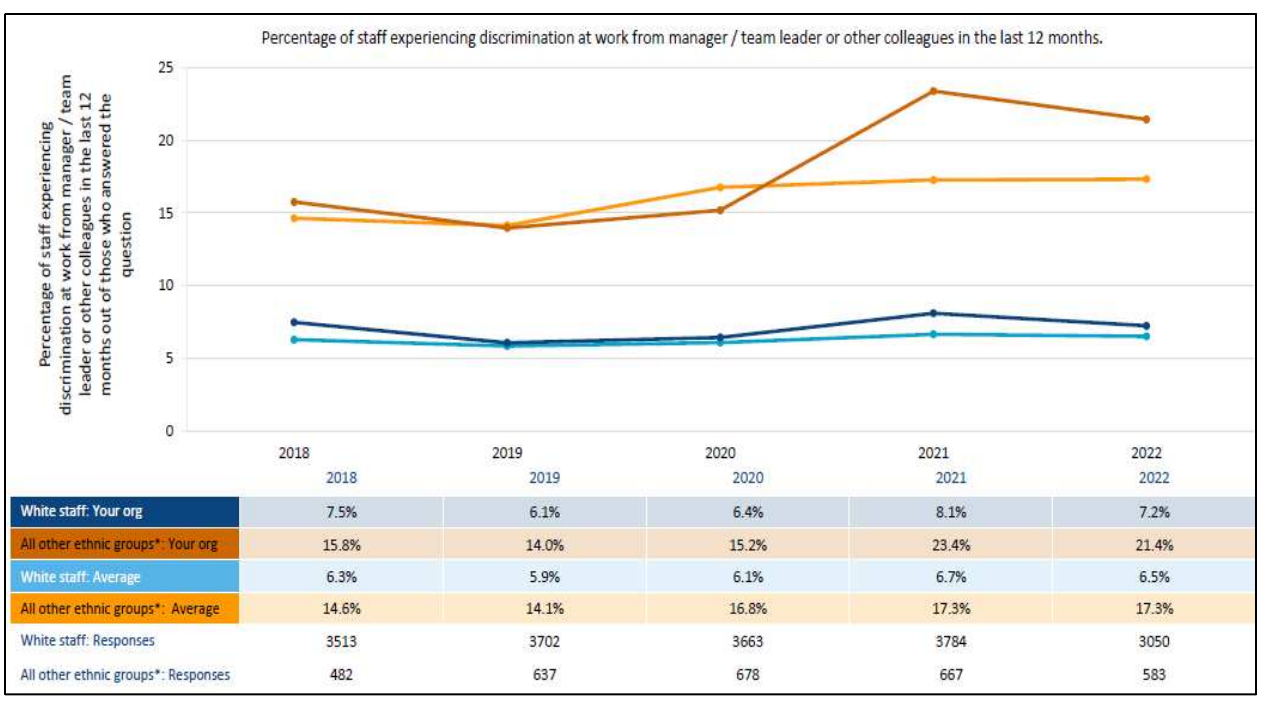
Metric 7: Percentage of staff believing that their trust provides equal opportunities for career progression or promotion



	2018	2019	2020	2021	2022
White staff: Your org	57.5%	59.8%	61.6%	58.1%	58.4%
All other ethnic groups*: Your org	45.0%	46.3%	50.1%	40.1%	41.8%
White staff: Average	59.0%	60.0%	59.4%	58.6%	58.6%
All other ethnic groups*: Average	46.4%	46.6%	45.2%	44.6%	47.0%
White staff: Responses	3519	3709	3647	3767	3034
All other ethnic groups*: Responses	496	635	675	664	581

Despite an improvement in this metric of 1.7%, our BAME colleagues are 16.6% less likely that white colleagues in the organisation to believe that the trust provides equal opportunities for career progression or promotion, and 5.2% than the peer group average.

Metric 8: Percentage of staff experiencing discrimination at work from a manager/team leader or other colleagues in the last 12 months:



	2018	2019	2020	2021	2022
White staff: Your org	7.5%	6.1%	6.4%	8.1%	7.2%
All other ethnic groups*: Your org	15.8%	14.0%	15.2%	23.4%	21.4%
White staff: Average	6.3%	5.9%	6.1%	6.7%	6.5%
All other ethnic groups*: Average	14.6%	14.1%	16.8%	17.3%	17.3%
White staff: Responses	3513	3702	3663	3784	3050
All other ethnic groups*: Responses	482	637	678	667	583

There has been a 2.0% reduction (improvement) of BAME colleague reports of discrimination from a line manager/supervisor compared to the previous years, and whilst nationally reports of discrimination have increased over recent years UHNM is higher than average for white and BAME colleagues.

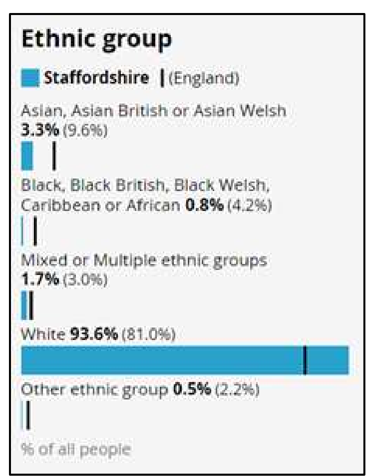
Metric 9: The representation of BAME people amongst board members

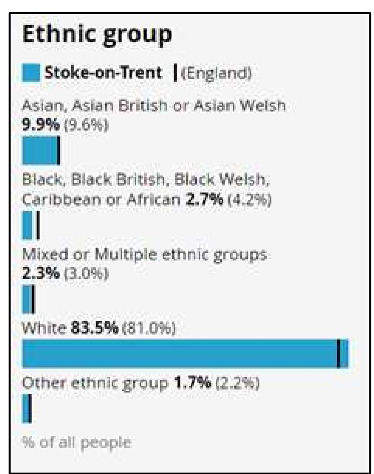
This metric measures the difference between the ethnicity composition of our Board membership compared to the overall organisation. Boards are expected to be broadly representative of their workforce. UHNM BAME representation is 23.5%, compared to the board BAME representation being 11.1%. The percentage difference between the organisations BAME Board membership and its organisations overall BAME workforce is therefore -12.4%.

BAME Board Representation	2023
Difference Total Board : Overall Organisation	-12.4%
BAME Board Membership	11.1%
BAME Executive Board Membership	10%

Ethnicity in our local communities:

The 2021 census shows the breakdown of ethnic group representation in Staffordshire and Stoke on Trent:





3. The actions we have taken to advance race equality during 2022/23

During 2022/23, we have undertaken the following actions and activities to ensure the voice of ethnically diverse colleagues are heard, and delivered against our agreed Trust EDI priorities which are to:

Priority 1: To listen to, understand and learn from the experience of all staff
Priority 2: To respect and value all colleagues and their contribution and have a strategic focus on dignity and respect
Priority 3: To develop a culture of inclusive and compassionate leadership
Priority 4: To ensure that people are recruited, trained and promoted according to their abilities and in the proportions one would expect for the populations represented

- **Race Equality Code Accreditation**

We were delighted to be awarded the prestigious RACE Equality Code Quality Mark in recognition of our work to support race equality and ability along with our determination to eliminate all discrimination in the workplace. The RACE Code stands for Reporting, Action, Composition and Education and is based on current laws, reports, charters and pledges, meaning the Trust's work has been based on recognised best practice.

The Race Code is designed to support organisations identify ways in which they can continue to improve diversity and race equality within their services – ensuring employees and service users feel both valued and understood.

To be awarded the mark, an in-depth assessment was required, looking at how inclusive UHNM is of staff and patients, as well as the work being undertaken to further improve and support our diverse workforce. We are including the actions identified within the Race Equality assessment within our WRES action plan.

- Each of our executive Board members have been given specific equality, diversity and inclusion objectives.

- We launched our ***People Strategy – Making UHNM a Great Place to Work*** which sets out our ambitious 3-year work programme through four key domains:

We will look after our people by supporting our people to be healthy and well, both physically and psychologically, and when unwell ensuring they are supported.	We will grow and develop our workforce for the future by attracting, recruiting and retaining our people.	We will create a sense of belonging where we are kind and respectful to each other by creating a positive and inclusive culture which is reinforced through our Being Kind programme.	We will develop our people practices and systems by promoting and using new technologies and equipping our people with digital awareness and skills.

- Introduced Staff Voice, a new anonymous monthly staff survey designed to help us understand key issues important to our colleagues about wellbeing, inclusion and to enable improvements in the workplace and patient care. Staff Voice is open to all staff to complete during the first 10 days of each month and gives everyone the opportunity to feedback how they feel about working at UHNM in less than 5 minutes.

- We have introduced new electronic dashboards and culture heat map that measure changes in employee experience based on the feedback from the Staff Voice and in turn we share the learning and changes made in Trust and Divisional "You Said, We Did" communications.

- We have created EDI dashboards for each of our Divisions so that they can monitor key EDI metrics and use these to identify EDI priorities in their areas. Metrics include BAME representation in senior roles, divisional race disparity ratio and likelihood of appointment from shortlisting; belief in equal opportunities for career development/promotion and experience of bullying and harassment.

- Our Being Kind approach to creating a kind, respectful and inclusive culture was launched in October 2022 at the UHNM Leadership Conference. The Being Kind approach includes our Being Kind Behaviour Compact, created with our staff, and includes guides for colleagues and managers. The Being Kind approach is supported by our new Resolution Policy also launched in 2022. The Being Kind Compact is built into our ENBALE leadership development programme and Belonging in the NHS inclusivity master class.

- We started our second cohort of reciprocal mentoring in early 2023, where a senior leader is mentored by a colleague from a protected group. This form of mentoring can be effective in supporting culture change by establishing greater awareness of organisational, cultural, leadership and social inequalities which prevent career progression and development for those in underrepresented groups. It flips the usual mentoring relationship on its head, so that senior leaders have the opportunity to listen, learn and co-create a more inclusive culture for the benefit of our staff and patients.

- A key strand of our cultural development programme has been the introduction of a new leadership programme for line managers that has been designed to embed appreciative, compassionate and inclusive leadership within UHNM, entitled Enable. The programme was successfully launched at the beginning of April 2022. In the first year of activity we have trained over 600 staff. The programme

has a focus on increasing awareness and understanding of diversity and inclusion, and creating a culture where everyone who works at UHNM feels valued and included.

- UHNM was awarded the NHS Pastoral Care Quality Award. This award recognises the commitment UHNM has made towards international recruitment and for providing high quality pastoral care to internationally educated nurses and midwives during the recruitment processes and their employment.

- Two training sessions were held during December for 20 new Employee Support Advisors to add to our existing team. ESA's are voluntary roles offering confidential and impartial peer support to colleagues experiencing disrespectful behaviours at work. ESA's help to guide colleagues through our resolution process and are a sympathetic listening ear.

- UHNM participants have completed the Staffordshire New Futures programme, which is a targeted development programme for aspiring BAME leaders. On-going access to coaching with a qualified coach, undertaking a work style inventory – 'Strengths Deployment Inventory' (SDI), and a talent management career conversation – 'Scope 4 Growth' are part of the Alumni support. The programme will track career progress of participants who continue to be encouraged and empowered to make self-motivated progression. Cohort 5 of the programme commenced in March 2023, with over 30 UHNM colleagues successfully gaining a place.

- We introduced a new resource for colleagues explaining what microaggressions are, with examples of how they can manifest against different groups and the impact this can have. The resource also links with our Being Kind Compact and how we all have a role in creating an inclusive culture and environment in which microaggressions are not accepted as normal and are challenged appropriately.

- We launched a campaign to pronounce people's names correctly, using a range of tools such as the UHNM designed email footer (created with our Ethnic Diversity Staff Network) or the nationally available 'Name Coach' and 'My Name is' voice recording tools.

- Cultural Calendar events during the year included:

Race Quality Week – we marked the week with a social medial campaign with quotes from our colleagues about what race equality means to them. We also promoted the race equality week challenge, which was a 5 day challenge where participants accessed short educational and awareness about racial equality each day of the week.

We celebrated **Black History Month** with a month-long calendar of events, which included the unveiling of our new inclusion banner at Royal Stoke Hospital and County Hospital by CEO Tracy Bullock and Ethnic Diversity Staff Network Chair Joe Orosun. The banner shows 108 flags representing all the different nationalities that work at UHNM. As part of Black History Month celebrations, we invited staff to wear red on the 22nd October to show their support for the annual Show Racism the Red Card event.

Ramadan - for the first time, our partner organisation Sodexo at Royal Stoke University Hospital launched a Ramadan Meal Deal as well as a Daily Iftar Menu to celebrate Ramadan – for patients, visitors and staff. In addition, we supported colleagues observing Ramadan with FAQ's and a guide.

More information on these initiatives and our wider EDI work can be read in our Equality, Diversity and Inclusion Annual Report.

4. Conclusions

There has been improvement against the majority of metrics compared to the previous year. However on a number of metrics this improvement should be viewed in the context of our comparator peer group where we remain worse than the average.

Priority areas where we have seen little positive movement or deterioration in our performance will be key work streams for the next 18 months. These include the metrics on workforce experience of harassment, bullying and abuse; experience of discrimination and belief in equal opportunities for career progression or promotion.

Whilst there has been a notable increase in overall representation our Black, Asian and Minority Ethnic colleagues continue to be under-represented in senior roles and a spotlight on recruitment processes, particularly for Band 8A and above roles, and access to career development opportunities will be fundamental to our inclusive recruitment actions.

In summary, our 2023 WRES data shows:

- 3% increase in Black, Asian and minority ethnic representation across the organisation recorded on ESR compared to last year. BAME representation at UHNM has increased by 10% in the 7 years of participating in the WRES.

- BAME colleagues continue to be less likely than white colleagues to enter the formal disciplinary process.

- No significant change in the likelihood of BAME colleagues accessing continued professional development with a likelihood ratio of 1.04.

- 0.7% reduction in the percentage of BAME colleagues reporting experience of bullying, harassment or abuse from other staff.

- Improvement of 1.7% in the percentage of BAME colleagues that believe that the Trust offers equal opportunities for career progression or promotion.

- 2.0% improvement in BAME colleagues reporting discrimination at work from a team leader/line manager.

- An improvement in board member ethnic diversity representation.

Metrics that have deteriorated are:

- A significant 11% increase in the percentage of BAME colleagues reporting experience of harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months. This metric has also deteriorated for white colleagues, which has increased by 2%

- Deterioration of 0.2 in the likelihood ratio of BAME applicants being appointed from shortlisting compared to white applicants.

We recognise that our cultural improvement journey will take time and the actions we have identified below build on the work we have already started whilst recognising the areas of concern that this year's WRES metrics identify. During 2023-24 we will focus on:

- Continued focus on living our Being Kind Compact and embedding the Being Kind approach to the early and lasting resolution of issues
- Demonstrate organisational commitment to anti-racism and the elimination of race discrimination and embed this into our leadership development and people practices

- High profile campaign on the responsibilities of individuals to address harassment bullying and abuse from patients, service users and members of the public by ensuring education, training and processes effectively protect our colleagues
- Implementation of the UHNM inclusive talent management strategy and the actions we have identified to de-bias recruitment and selection processes. Effectively monitor progress using the EDI dashboards
- Implementation of our Race Equality Code action plan

Progress will be measured by improved metric results in the 2023 Staff Survey, 2024 WRES submission, divisional EDI dashboards and the monitoring of other relevant metrics including the Employee Voice feedback and the lived experiences of our Ethnic Diversity Staff Network membership.

Appendix 1: UHNM WRES Action Plan 2023-24

WRES Metric	Action	Time-scale	KPI	Progress Rating
Percentage of BAME staff in each of the AfC Bands 1 – 9 or medical and dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	• Continue with Inclusive Recruitment work to de-bias processes in line with 'No More Tick Boxes' and the NHS EDI Improvement Plan this will include tightening requirements for secondments, fixed term and aspiring role opportunities and the introduction of assurance controls for senior roles • Ensure widening participation activity targets under-represented communities with particular emphasis on promoting non-clinical role opportunities at every level from entry via career pathways / apprenticeships • Produce and communicate our Ethnicity Pay Gap • Race Disparity Ratio and EDI dashboards to be updated to a digital dashboard within the Culture Heat Map to become part of division performance review progress monitoring	Q4 Q4 Q4 Q4	% of BAME staff in pay bands and professional groups/ Model Employer/ Race Disparity Ratio	GA
Relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants	• Continue Inclusive Recruitment work, as above • Establish an audit process of recruitment decisions, beginning with Band 8a and above roles	Q4 Q4	Race Disparity Ratio Model Employer Within 0.8-1.25 WRES Metric 2	GB
Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	• Review disciplinary and speaking up processes based on learning from the Michelle Cox tribunal findings	Q3	Within 0.8 – 1.25 WRES Metric 3	GB
Relative likelihood of white staff accessing non-mandatory training and (CPD) compared to BAME staff	• Launch the Inclusive Talent Management Strategy • Continue to promote leadership development opportunities through the Employee Experience Network (e.g. New Futures and High Potential Scheme) • Promote access to coaching and career conversations available through the system wide pool of diverse coaches • Continue to monitor the diversity of participants in UHNM non mandatory learning and development recorded on ESR and include in divisional EDI dashboards	Q4 In place	Improved Staff Survey performance at least matching acute sector average on q15	B GB

WRES Metric	Action	Time-scale	KPI	Progress Rating
Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	• Targeted action to significantly improve colleague exposure to racist and abusive behaviours from patients, relatives and members of the public. To include task and finish approach to implement the NMC and GMC guidance	Q4	Improved Staff Survey performance at least matching acute sector average on q14a	GB
Percentage of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months	• Embed Being Kind approach and the promotion of early informal/personal action • ENABLE inclusive leadership programme for line managers • Bespoke interventions in hot spot areas • Increase understanding of microaggressions through the Toolkit • Launch of the See ME First badge pledge	Q3	Improved Staff Survey performance at least matching acute sector average on q14b&c	GA
Percentage of BAME staff believing that the Trust provides equal opportunities for career progression or promotion	• Embedding of the Inclusive Leadership Development Strategy • Introduce the revised Performance & Development Review to encompass a more strength based development and forward looking annual appraisal • Promote access to career conversations and coaching • Task & Finish Group focused on career progression of overseas recruits • Race Disparity Ratio by directorate	In place Q3 Q3	RDR / Model Employer Targets met Improved Staff Survey performance at least matching acute sector average on q15	GA
Percentage of BAME staff experiencing discrimination at work from a manager, team leader or other colleagues in the last 12 months	• All line managers to attend the ENABLE leadership programme • Monthly sessions of Silver Programme Our NHS People inclusivity masterclass • Anti-racist inclusion masterclass developed for Gold and Platinum Connects programme 2023 • Being Kind approach included in the Medical Leadership Programme • Celebration of Cohort 2 of the UHNM Reciprocal Mentoring Programme and the learning	In place Q3 Q3 Q4	ENABLE attendance rates Improved Staff Survey performance at least matching acute sector average on q16b	B GA
Percentage difference between the organisations' board voting membership and its overall workforce	• Continue with strong board leadership internally and externally on race inclusion and engagement with UHNM Staff Diversity Networks • Ensuring EDI in our governance and decision making spaces in line with our Race Equality Code governance framework	In place 2025	Board ethnic diversity representation matches that of the organisation – 23.5%	B GA

WRES Metric	Action	Time-scale	KPI	Progress Rating
Organisational commitment to Race Equity	• Implement and embed the NHS EDI Improvement Plan High Impact Actions and the UHNM RACE Code governance framework action plan over a period of 2 years • System wide WRES Champions Programme • Publish our Anti-Racist Statement • Raise awareness through the diversity events calendar of the Trusts commitment to zero tolerance of discrimination, including Show Racism the Red Card Events and individual responsibility of Allyship with the introduction of 'See ME First' badges • Continue to promote the Ethnic Diversity Network to all colleagues and new starters to the organisation by introducing a targeted welcome email with details about our EDI employee voice networks. Utilise the Employee Experience Network to promote EDI at a local level • Ensure that colleagues are enabled to attend meetings and that the network is appropriately resourced	2025 Q3 Q3 Q3 Q3 Q4		GA

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

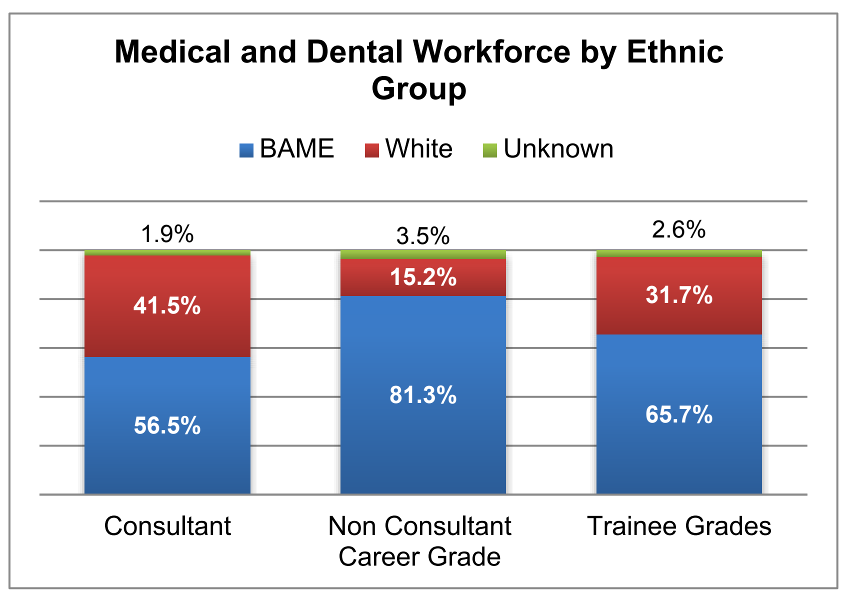
Appendix 2: UHNM Medical and Bank WRES 2023 Metrics

Medical WRES (MWRES)

Ethnicity / Role	White	Black	Asian	Other	Not Known
Medical Directors	75%	0	25%	0	0
Clinical Directors	60%	0	40%	0	0

Ethnicity / CEA Status	White	Black	Asian	Other	Not Known
Eligible	202	15	209	36	11
Applied					
Awarded	202	15	209	36	11

Ethnicity / Consultant Recruitment status	White	Black	Asian	Other	Not Known
Applied	109	14	219	80	54
Shortlisted	66	7	95	31	48
Appointed	28	3	39	15	44
% appointed from S/L	42.4%	42.9%	41.1%	48.4%	91.7%



Nationally within Medicine BAME representation was at 44.3% overall in 2022. Representation peaked in non-consultant grades at 57.5%, falling to 39.0% amongst Consultants, falling further to 31.0% amongst senior medical managers.

Clinical Excellence Award (CEA) payments recognise and reward NHS consultant medical staff who perform ‘over and above’ the standard expected of their role and who can demonstrate achievements in developing and delivering high quality care, and commitment to the continuous improvement of the NHS. There are two award types - Local and National. Both have eligibility criteria which means that not all consultants can apply (the criteria is explained in our Clinical Excellence Award Policy HR47). Due to the pandemic the scheme was amended to an automatic allocation of the award which is paid to all eligible consultants in March of 2020, 2021 and 2022. At March 2022 there were 440 eligible consultants all receiving the same monetary allocation.

Our recruitment data is undertaken on the TRAC system, and this indicates that there is no negative differential in likelihood of appointment from shortlisting based on ethnicity, where this is disclosed.

Bank WRES

BWRES metrics are related to representation and Bank worker entry into formal disciplinary and capability processes, disaggregated by ethnicity. UHNM does not apply formal HR processes to Bank workers. We await the national recommendations arising from this first BWRES and will identify actions for the organisation.

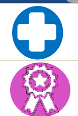
Executive Summary

Meeting:	Trust Board	Date:	6th December 2023
Report Title:	Integrated Performance Report, Month 07 2023/24	Agenda Item:	15.
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & Safety; Operational Performance: Warren Shaw, Strategic Director of Performance & Information; Matt Hadfield, Associate Director of Performance & Information. Workforce: Jason Ahern, Assistant Director of Workforce Information; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Simon Evans: Chief Operating Officer Jane Haire: Chief People Officer Mark Oldham: Chief Finance Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

	High Quality		People		Systems & Partners	
	Responsive		Improving & Innovating		Resources	

Risk Register Mapping

Executive Summary

Situation

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

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

Quality & Safety

The report provides latest (October 2023) update on the different Quality Indicators. There have been updates to the report to include, where possible, peer benchmarking against various quality indicators. These indicators, where applicable, utilise SPC charts and to allow for comparisons allowing for activity and benchmarking, the rate per 1000 bed days. The use of rates per 1000 bed days allows comparison between organisation and national targets/benchmarking by allowing for different activity levels and not just the comparison of raw total numbers. The charts/indicators with only raw total numbers are used to provide internal analysis of the indicators so can also compare different months to set target totals i.e. C Diff Cases, E Coli cases, MRSA which have set target per month already calculated and set nationally for the organisation.

Some of the indicators used in the report have different activity based rates which are those used nationally for benchmarking i.e. Hospital Associated Thrombosis rate per 10000 admissions or Complaints per 10,000 spells.

All the indicators have now included benchmark for assurance purposes. These benchmarks are either agreed targets set nationally or locally utilising agreed target/benchmark.

This latest report has included the newly agreed Assurance Matrix and has also reordered the indicators and dashboard so that indicators are grouped together appropriately.

Assessment

The number of reported patient safety incidents is above the long term mean and has increased this month although the rate per 1000 bed days has continued to remain relatively stable and is within normal variation limits and above the mean rate. The rat is also above the NRLS mean rate during October. It should be noted that an increase in reported incidents and near misses should be seen as negative but can reflect a positive reporting culture. The breakdown of incidents by harm reflects this and that the increase in reported incidents relate to increases in no harm and near misses.

Moderate harm or above incidents, both raw numbers and rate per 1000 bed days continue significant downward trend for the last 7 consecutive months below the mean figures and targets.

It is key to note that during October 2023 there has been 1 'Your Next Patient' related incidents reported that's related to patient not being administered the prescribed analgaesia by paramedic team whilst held on ambulance. The incident has been shared with WMAS for wider learning.

The largest categories for reported PSIs excluding Non-Hospital Acquired Pressure Ulcers are Medication, Patient Flow, Patient Falls, Clinical Assessment and Treatment related incidents. Medication related incidents continue to be the largest category after Tissue Viability in October 2023 but otherwise no significant changes in these categories compared to previous months.

There have been reductions in incidents relating to 'Your Next Patient' with 14 during October (34 during September 2023, 76 in August, 110 in July, 102 in June, 97 in May, 117 in April, 157 in March, 170 in February and 228 in January 2023) which accounts for 0.57% (1.76% in September, 3.6% in August, 5.1% in July, 4.8% in June and May, 6.21% in April, 7.4% in March, 9.8% in February and 12% in January 2023) of total patient safety incidents. This is significant reduction in the number of reported incidents relating to the YNP processes. 28.6% (35.3%, 30.4% and 28.2% previous months) were Tissue Viability. However, 75% (3 out of 4) of these were NOT hospital acquired but recording pressure damage on admission/attendance at UHNM. Only 1 case identified as deteriorating within Trust's care.

Patient falls rate has continued to show positive trend, not yet statistically significant, with monthly reductions in both total falls rate and the falls with harm remain within target rate of 1.6 in October 2023.

Medication related incidents have increased slightly this month and continue to be higher than same period last year as part of the ongoing drive to improve reporting of medication errors/incidents. However, there has been decrease in October (at time of the report) in the percentage of these incidents that have been reported as resulted in moderate harm or above. This is reflective of the improving and positive reporting culture with increased reporting but level of harm reducing and mirrors the profile for all patient related safety incidents. These incidents will be reviewed at Medicines Optimisation & safety Group to assess the impact on patients and also identify and share learning.

Serious incident numbers and rates continue to show longer term reduction trend which supports the noted reductions in incidents with moderate harm of above and overall patient safety incident reporting. Falls continue to be the main reason for serious incidents being reported during 2023/2024, but October saw 2 diagnostic related and treatment related incidents including a never event.

There has been 1 new Never Event reported during October 2023 which related to a retained guidewire following the insertion of a chest drain in ED. This incident is being reviewed utilising new PSII response template and led by newly trained Patient Safety Investigator. The final report and safety recommendations will be presented to QGC as part of the Trust's agreed PSIRP.

Duty of Candour compliance has improved during October and there was 1 case that had not recorded compliance with the internal 10-day target. All letters that were noted as late have subsequently been provided. Continued promotion and support to clinical teams is being provided and the importance of being open and sharing information is shared with teams.

The current position for received patient Safety Alerts shows that there are now zero overdue Patient Safety Alerts.

There were 0 new alerts received during October 2023 and 1 has already been closed and the second remains open within timescale at the of compiling the report.

Pressure Ulcer developed under UHNM care with lapses in care, despite in month increase in lapse of care, remains well within normal variation. The increases in total numbers are related to increases in number of Category 2 pressure ulcers in recent months along with increase in DTIs during October following previous months of reducing DTI numbers. The new PSIFT Tissue Viability toolkit has been introduced and amended to allow more involvement in clinical areas for developing responses and embedding of learning and sustained improvement.

Friends & Family Test for A&E remains below the 85% target of patients recommending the service. The October figure has fallen below the mean rate but there has been an increase in the responses received but the rate has remained stable at 9%. UHNM is 33rd out of 124 Trusts nationally for response rate, which is improvement from previous4ly reported 37th. However, UHNM is 87th for the percentage pf positive results. To promote and increase the response rate the FFT questionnaires are continuing to be handed out to all patients on arrival to ED and the QR codes have been made more visible throughout the department. In addition, a 'You said, we did' board has been put up in the Waiting Area to demonstrate changes to patient/relatives' comments in a bid to further promote and increase the responses received.

Inpatient FFT results remain above the 95% target. The response rate has dipped slightly to 21% in October 2023. There were 2512 (2489 in September) responses returned in October 2023 from 68 different inpatient and day case areas across UHNM. UHNM have the 17th highest response rate out of the 154 acute trusts reporting FFT for inpatient areas which is an improvement from previously reported 23rd. There are key improvement initiatives identified previously are continuing and focus on key priorities identified within the FFT returns.

There has been in month improvement for Maternity FFT but remains just below the 95% target at 84.5%. October 2023 saw 97 (85 previously) completed surveys returned and 21 completed from the Birth touchpoint which are lower than previous months returns. Compared to the latest national data available (July 2023) out of 113 Trusts, UHNM were 54th for number of responses for antenatal, 39th for number of responses for birth, 63rd for post-natal ward and 38th for post-natal community which shows improvement in all areas. FFT Task & Finish Group for post natal care established, Maternity services have introduced QR codes in some areas to increase response rates. My Pregnancy Notes, launched in July, provides a direct link to Friends and Family for women to complete and now using the data from the QR codes.

Complaints rate remains below the target/benchmark rate of 35 and within normal variation. Complaints Team are continuing to review the complaints triage process to ensure that it is effective and that the number of PALS escalated to formal complaints does not rise. This is included in the quarterly Patient Experience Reports along with detailed reviews of trends and themes from received complaints.

Mortality indices remain within expected ranges and compare well with our peers and other acute trusts.

VTE Risk assessment compliance has started to improve and is again above the 95% target as use of Tendable continues to be improved.

Hospital Associated Thrombosis rate is noted as above the long term mean in October 2023 with 25 cases and a rate of 1.19 per 10,000 admissions. The use of mechanical thromboprophylaxis for patients attending Theatres is being reviewed following 2 incidents whereby devices were applied despite a contraindication and/or prescription. Refresher training is being provided and early discussions regarding changing the practices of applying intermittent pneumatic compression (IPC) are taking place.

Timely Observations are continuing to improve across the Trust. There remain 2 wards/departments with less than 50% of patients having timely observations recorded on VitalPack and these are same areas have remained below 50% for last 5 months at least. Medicine, Surgery and Network Services have all now included Timely Observations as Driver Metrics and focussing as priority to improve compliance. There have been data anomalies identified with the Vitals system including the impact of system downtime and Wi-Fi connection issues affecting the timely recording of patient observations which are being updated and actions taken by the Trust's IM&T

C Diff numbers have reduced during October with 11 cases confirmed. There have been number of key actions taken during the past month including West Building campaign to send urine samples for suspected UTI to target appropriate antibiotic use, Terminal cleans of all wards in West Building and the Back-to-Basics bed super clean.

Sepsis screening and IV Antibiotics continue to be below targets within Royal Stoke Emergency Department. Other emergency portals are achieving these targets. Sepsis Team continue to work with RSUH ED Teams to try and improve compliance and staff are following correct sepsis guidance. Specific targeted actions in ED include having a Deteriorating Patient Reviewer (DPR) in place and managed by Emergency Physician in Charge in ED. There will be

a specific clinician assigned and dedicated to log in DPR VOCERA device at the beginning of their shift to review and provide timely assessment, treatment and escalation of patients who triggers for medium to high-risk sepsis.

The audited missed screening cases in Children and Maternity did not result in any harm and related to lack of or incomplete documentation.

All data used in this report is as recorded on 8th November 2023 and figures may change following further review/investigation/update

Operational Performance

Situation

UHNM has been assessed as NHS Oversight Framework (NOF) Segmentation 3 and as such, a series of 'Exit Criteria' have been agreed which are aimed at making and sustaining the improvements needed across a range of oversight themes / metrics. This includes Elective Care, Urgent and Emergency Care (UEC) and Cancer.

In addition to this, UHNM have been issued Undertakings by NHS England, outlining steps that must be taken across UEC, Elective Care, Cancer, Maternity and Governance. The proposed UHNM Undertakings require the Trust Board to receive and approve a highlight report that describes progress against agreed action plans on key performance domains.

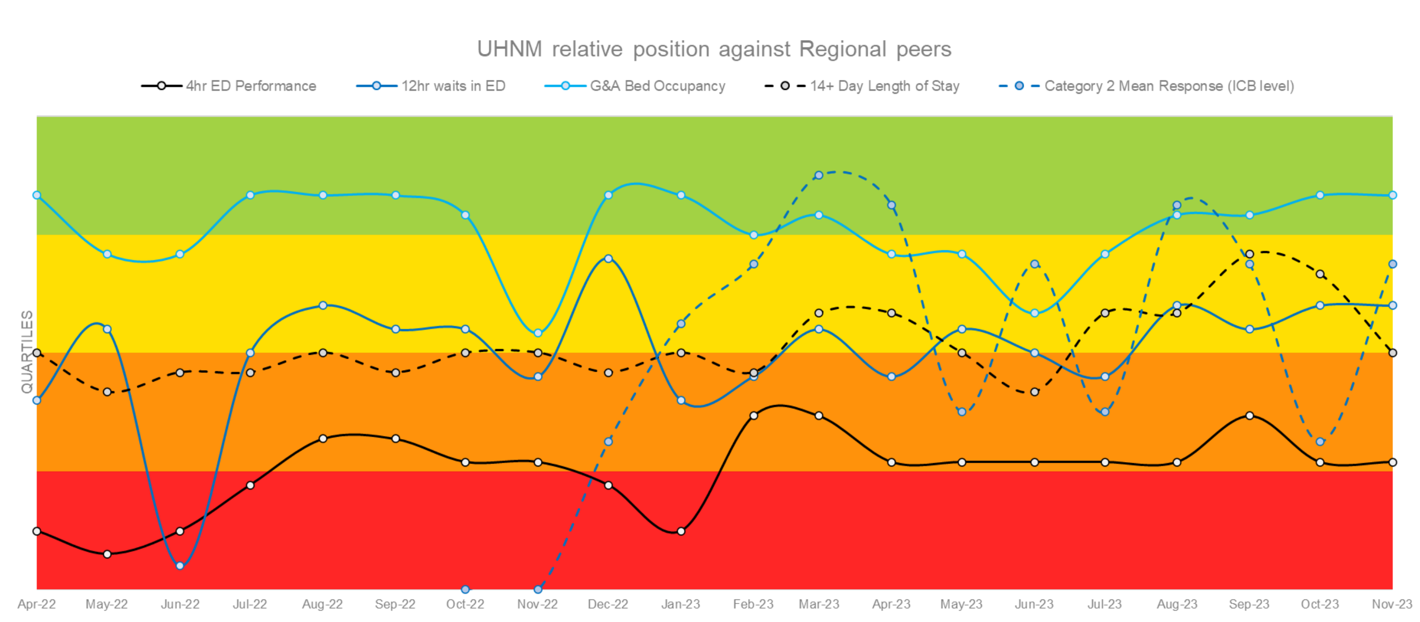
This report describes the activities undertaken to improve performance against four areas of National Constitutional Standards. Those four areas are:

- Urgent and Emergency Care: including the A&E 4 hour target, 12 hour waits and Ambulance Handover Delays
- Diagnostic standard (6 week)
- Referral To Treatment (RTT) Elective Care Standards
- Cancer combined Standards for Treatment (31day), Faster Diagnosis (28 day) and total pathway (62 day)

Assessment

1. Urgent and Emergency Care

- October saw a deterioration of the Four Hour Standard with a significant reduction in WMAS Category 2 Response Times. While September to October saw a broad maintenance of NOF UEC Exit Criteria relative performance WMAS Category 2 Response Times was an outlier to this trend and fell to a monthly position in the third quartile and two individual weeks in the bottom quartile. It can be seen that in the first week of November this performance improved and performance rebounded back to above the median nationally and 4/11 ICS regionally. This returns to the September position of above median performance for all NOF UEC exit Criteria with the persistent exception of Four Hour Performance.



- Four Hour Performance continues to maintain a significant amount of focus and oversight with the weekly Four Hour Recovery Cell meetings now handing over to the be chaired by the Chief Operating Officer. The three previously described high impact initiatives continue to progress with upcoming GIRFT, ECIST, NHSE, and Peer Visits taking a requested focus on non-admitted performance on the RSUH site in order to support identification of the next tranche of development initiatives and to check and challenge current progress and practice.

  - The Ambulatory Clinical Decisions Unit (ACDU) is now open and functional to eight reclining chairs. Utilisation has been under target for the first week but will improve as the model and pathways are embedded.

  - Following the weeklong overnight productivity audit completed by the UEC Clinical Director it was determined that overnight teams are operating above national productivity benchmarks and are sufficiently resourced. Therefore, the priority should be ensuring as small a backlog as possible for the night shift:
    - Revised staffing model providing a minimum of x2 Senior Decision Makers and x3 at times of peak demand with a supporting dedicated CED rota which will ensure allocated SDM are able to remain in their designated area. This went live in late October and will continue to embed.
    - In order to drive performance improvement during the late afternoon and early evening time period the capacity of Ambulatory Emergency Care will be increased to enable greater streaming. This will be achieved by creating two additional treatment rooms (January) which is frequently a rate limiting factor of flow, and additional medical support from 16:00 – 22:00 to drive throughput (December).

  - The Capacity & Demand tool is now in its final stages of development with an expected trial date of 24-Nov which will support the alignment of departmental staffing to expected demand and provide an operational view of expected bottlenecks and risks to performance.

- The increased pressure throughout October and into November reflects predicted capacity and demand deficit in the Winter Plan modelling. October and November were expected to operate at an approximate -40 bed deficit, however in addition to this planned deficit a further 29 beds worth of additional community based schemes not coming online as planned further deteriorating the expected deficit to an approximate -70. This has been partially mitigated but remains a significant challenge.

- The Outpatient Antibiotic Treatment Delivery Plan has now been confirmed with a trajectory of five equivalent acute beds a month from December to March from a baseline of ten. This is supported by numerous recruitment efforts including permanent, secondment, and bank workforce. In order to support clinical pathway development a peer visit has been agreed with Nottingham University Hospitals NHS Trust who report a rolling patient load of 60-70 patients (5-6 times the size of our current service) with investment approved to expand to 90.

- The Integrated Discharge Unit formally Ward 80 (MFFD) and FEAU Test Of Change (TOC) is progressing with extremely positive results. Early outputs have so far indicated a 133% increase in TOC referrals (which were previously delayed), a 157% increase in discharges, a fivefold increase in reinstatements, and a zero tolerance to transfer to the MFFD deep bed base were evidence suggests LOS is lengthened. This TOC is continuing to understand and embed these improvements with an expansion currently in scoping in order to maximise the improvement opportunity. It was anticipated that KPMG support would be allocated to provide additional capacity to drive this transformational change however a decision at NHSE level on whether this can commence remains outstanding.

- The refresh of the Trust NEL Improvement Plan (NELIP) for 2024/25 is now in its final stages working with system partners and aligned to our Undertakings requirements. This will produce a more integrated and targeted plan than in previous years with the likely arteas of focus being RSUH non-admitted performance, County Hospital, Frailty, and Ward Standard Work. The plan is expected to be signed off prior to the end of November.

2. Diagnostic Standard:

During October Diagnostic activity remained above 19/20 levels.
Diagnostic performance against the 6 week standard was 76% overall in October, an improvement of 1.1% from September (74.9%). UHMN performance nationally is 92nd out of 156 Trusts.
Endoscopy performance is the main contributor to this performance. It has a large programme of work and improvement teams are designing an intensive improvement cycle in addition to extra Independent Sector capacity to ensure that trajectories for improvement are met and standard reached by March 2024. The priority remains the Cancer Diagnostics standard.

3. Referral to Treatment (RTT) Planned Care and Elective Recovery

At the end of October the number of patients waiting more than 104 weeks was 1 – a patient who chose a date for surgery in November. The current prediction for the end of November is 1; this is a different patient awaiting a custom shoulder being made currently in Italy.

The validated number of 78 week breaches for end of October is 138, an improvement on September (170). This is predicted to be 88 for November. UHNM performance nationally is 154th out of 171 Trusts.

National focus has now moved to patients waiting 65 weeks or more with an expectation to reduce them to below 200 patients by end of March 2024. In addition to this, there is a further expectation nationally that all patients wating for their first outpatient appointment for more than 65 weeks are seen by the end of October. We will achieve this by the end of December as per the request from NHSE. There are a number of specialties as part of our recovery plan that have mitigated challenges in achieving this including Spines, Ophthalmology, MaxFac, Plastics, Paediatric Orthopaedics, Gastroenterology, Respiratory and Neurology. The number of patients waiting for more than 65 weeks position for October was 1264.

UHNM are now part of the national GIRFT programme 'going further faster' to support or elective recovery.

There are a number of key workstreams which impact on and support elective recovery. These are highlighted as follows:

Theatres:

- Day Case activity and Elective Activity have moved from delivering 83% and 82% respectively for September to 82% and 82% for October, as a percentage of 19/20 activity.
- Day case as a % of all elective work is currently 87.4%. Both of these schemes seek to increase the number of patients being treated within existing resources and thereby reduce waiting lists.
- Capped utilisation in October was 76.3%, a slight deterioration from Septembers 77.1%, this is in normal variation.

Outpatients:

- Assessment on referral management, PIFU, Advice & Guidance and productivity are the key areas of focus within the improvement programme.
- There are clinical workstreams in place aligning to the OP GIRFT guidance in addition to the wider more general improvement schemes above. These receive additional support from specialists outside the organisation at NHSE and as part of the GiRFT programme. For example in Orthopaedics and Spinal services.

4. Cancer

The reduction of patients waiting more than 62 and 104 days (backlog) must be tackled prior to the 62 day performance standard in order to maintain timely treatment for patients. At Q4 when the backlog trajectory looks to reduce to under 400 patients focus will move from this indicator to the % of patients waiting for 62 days or more, however until Q4 we will continue to focus on the reduction of patients who already have been waiting for more than 62 days or more.

- The trajectory which has been agreed through the tier 1 meetings with NHSE is included on slide 26 of the performance pack.
- In October the backlog ended at 420, a reduction from Septembers 520. This position is now tracking in line with trajectory. The backlog position is of particular issue in Colorectal, with some slippage in Skin. Colorectal representing 47% of total backlog,
- Most recent submitted Cancer Waiting Times position is September 52.1% for 62 day performance. October is currently predicted to be 53.4% although this will improve post validation, this is due to the number of treatments for our longest waiting patients increasing.

The 28 Day Faster Diagnosis Standard;

- This was 59.8% for all referral routes combined in September. The October position is currently incomplete and will be validated once Pathology confirms cancer or non cancer on high volume pathways such as Skin. This is currently 60.3%.
- Areas of best practice consistently achieving the standard are Breast, Upper GI and Skin. Performance to trajectory is monitored in the weekly Tier 1 calls with NHSE, those areas of best practice are aligned to our requirements

Workforce

Key messages

- The 12m turnover rate in October 2023 decreased fractionally to 8.2% (8.3% in September) which remains below the trust target of 11%.
- M7 vacancies increased to 8.98% (8.59% in September), influenced by changes to budgeted establishments for the Winter Workforce Plan. Medical and Dental vacancies increased by 4.77% because of 8 additional Consultant vacancies associated with the Winter Workforce Plan, with the remainder resulting from Deanery increases in commissioned FY1 and ST3 posts. Divisions continue to report good progress on their recruitment pipeline to close the gap on vacancies.
- For M7, the in-month sickness rate increased by 0.29% to 5.52% (5.23% in September 2023). The 12-month cumulative rate decreased to 5.26% (5.32% in September 2023), because October 22's higher value of 6.28% was no longer affecting the 12-month average.
- Stress and anxiety continues to be the top reason for sickness in October, which saw a decrease of 0.5% in the last month to 24.3% (24.8% in September). Chest & respiratory problems saw an in-month increase of 1.7% to 15.0% (13.3% in September 2023), and cold & flu to 8.7% (4.7% in September) moving cold & flu from 7th position in September, to 3rd position, in October.
- 3 covid-related absences were recorded on ESR for October 2023, (3 in September 2023), following the cessation of symptomatic covid testing, since May 2023. Employees may report covid-like symptoms on Empactis, but Managers are then recording this as either chest & respiratory, or cold & flu, on ESR, as detailed above, in the absence of a formal lateral flow test.
- October 2023's PDR Rate remained unchanged at 82.6% (82.6% in September 2023). Work continues on refreshing PDR paperwork to support colleagues in achieving their potential.
- Statutory and Mandatory training rate on 31st October increased by 0.4% to 93.9% (93.5% on 30 September 2023). This compliance rate is for the 6 'Core for All' subjects only.
- The Staff Voice trust survey has been paused during October and November, while the NHS National Staff Survey runs.
- The Being Kind sessions continued in October with 1,045 colleagues in attendance. Overall, 8,912 people have attended the training, either in person, virtually, or online, via the ESR virtual training session.
- The National Staff Survey ends on 24th November 2023, with the Trust's overall response rate of 45%, with all staff groups surpassing their 2022 return rates.

Finance

Key elements of the financial performance year to date are:

- For Month 7 the Trust has delivered a year to date deficit of £7.8m against a planned surplus of £3.1m; this adverse variance of £10.9m is primarily driven by underperformance against the Trust's in year CIP target, the impact of industrial action and unfunded additional winter escalation capacity that remains open.
- The Trust has incurred £5.0m of costs relating to winter escalation capacity remaining open; the Month 7 position includes £2.1m of additional funding from the local ICB.
- The industrial action (IA) by Medical staff has cost the Trust £4.1m in backfill arrangements. The Trust will be receiving an allocation of £9m to cover this and the wider costs of industrial action.
- From 31/3/20 to 30/9/23 the Trust's total workforce (Substantive, bank and agency) has grown from 10,390 to 11,760 representing a growth of 1,370 (13.2%); during this time the planned workforce has increased by 884 and vacancies have reduced by 486.
- To date the Trust has validated £26.7m of CIP savings to Month 7 against a plan of £32.1m. The Trust has recognised £3.0m of CIP due to an assumed reduction in the annual leave provision; this delivers 50% of the NR ICB stretch CIP target. Schemes of £48.3m have been identified for delivery in 2023/24. The PMO is currently working with scheme leads to develop robust plan to deliver these savings. The £8.0m divisional schemes remain unidentified.
- There has been £31.5m of Capital expenditure which is £3.7m below plan.
- The cash balance at Month 7 is £82.0m which is £4.0m lower than plan.

Key Recommendations

The Trust Board is requested to note the performance against previously agreed trajectories.
The Trust Board is requested to approve narrative within the IPR as an appropriate highlight report; satisfying the requirements of the Trusts undertakings from November 2023 onwards.

Integrated Performance Report

Month 07 2023/24

Delivering Exceptional Care with Exceptional People

Contents

Section		Page
1	Introduction to SPC and DQAI	3
2	Quality	5
3	Operational Performance	30
4	Workforce	82
5	Finance	89

A note on SPC

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

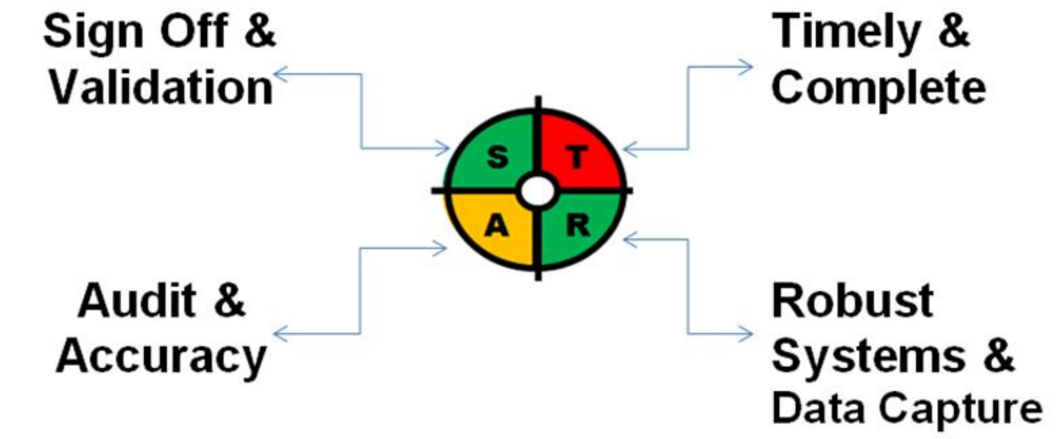
Assurance - how assured of consistently meeting the target can we be?

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

- 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

The Trust achieved the following standards in October 2023:

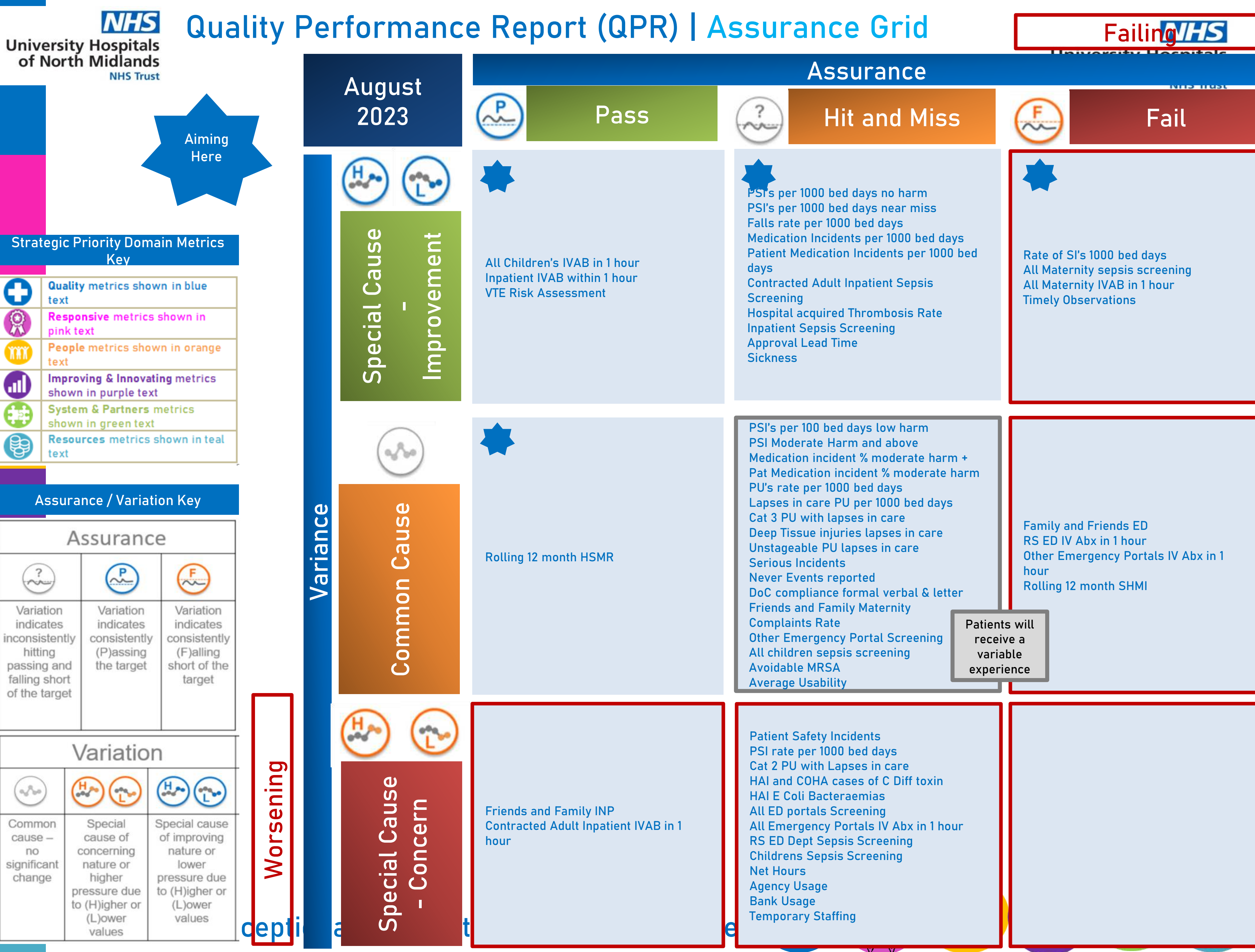
- Falls rate was 5.3 per 1000 bed days for October 2023, 4th consecutive month below benchmark rate
- Rate of falls reported that have resulted in harm to patients currently at 1.6 per 1000 bed days and continues to be within the control limits and normal variation.
- Hospital Associated Thrombosis has continued to remain below the mean rate for the past 7 months and is within normal variation and cases are under review.
- Trust rolling 12 month HSMR continue to be within expected range.
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- VTE Risk Assessment completed during admission remains above 95% target with 95.9% (via Tendable)
- Inpatient sepsis Screening and Sepsis IVAB within 1 hour achieved 96.6% and 100% respectively and meeting the 90% target rate
- Children's IVAB within 1 hour achieved 100%
- Maternity IVAB compliance 100% and above the 90% target for audited patients
- Zero overdue Patient Safety Alerts
- Friend & Family (Inpatients) 95.5% and exceeds 95% target.
- The rate of complaints per 10,000 spells is 27.64 and remains below the target of 35 and long term mean rate but within normal variation

The Trust did not achieve the set standards for:

- 1 Never Event
- 94.4% verbal Duty of Candour compliance recorded in Datix
- 94.4% compliance with Duty of Candour 10 working day letter performance following formal verbal notification and under review for completion and upload of letter on Datix
- Pressure Ulcers per 1000 bed days with lapses in care developed under UHNM care is now 0.74 and above the target rate 0.5.
- There were 31 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- Timely Observations remain below the 90% target but has seen further improvement during October
- E. Coli Bacteraemia cases above trajectory with 23 in October compared to target of 16.
- C Diff YTD figures above trajectory with 11 against a target of 8.
- Friend & Family (A&E) has declined and remains below 85% target at 63.8%
- Friend & Family (Maternity) improved to 94.7% but below 95% target
- Sepsis Screening compliance in Emergency Portals increased to 78% but remains below the target 90%.
- Emergency Portals Sepsis IVAB improved to 71.7% but remains below the 90% target for audited patients
- Children's Sepsis Screening compliance failed to achieve the 90% target with 71.4% during October.
- Maternity Sepsis Screening compliance remain below 90% target at 70%

During October 2023, the following quality highlights are to be noted:

- Total number and rate of Patient Safety Incidents increased in month
- Total incidents with moderate harm or above and the rate of these incidents within normal variation levels during October and have continued to reduce with significant trend / improvement below the mean.
- Medication related incidents rate per 1000 bed days is 7.2 which is higher than previous month and patient related 6.4 which is also higher than previous month. The monthly variation is within the normal expected variation and above the NRLS national rates. The % of medication incidents reported with moderate harm or above has decreased for October 2023.
- 8 Serious Incidents reported during with 3 Falls related, 2 Diagnostic related 2 treatment related and 1 healthcare associated infection
- Majority of complaints in October 2023 continue to relate to clinical treatment.
- SHMI 101.3 and is Band 2 – as expected. There has been improvement in SHMI



Quality Performance Report (QPR) | Assurance Grid
University Hospitals of North Midlands NHS Trust
August 2023
Assurance
Pass
Hit and Miss
Fail
Aiming Here
Strategic Priority Domain Metrics Key
Quality metrics shown in blue text
Responsive metrics shown in pink text
People metrics shown in orange text
Improving & Innovating metrics shown in purple text
System & Partners metrics shown in green text
Resources metrics shown in teal text
Variance
Special Cause - Improvement
All Children's IVAB in 1 hour
Inpatient IVAB within 1 hour
VTE Risk Assessment
PSI's per 1000 bed days no harm
PSI's per 1000 bed days near miss
Falls rate per 1000 bed days
Medication Incidents per 1000 bed days
Patient Medication Incidents per 1000 bed days
Contracted Adult Inpatient Sepsis Screening
Hospital acquired Thrombosis Rate
Inpatient Sepsis Screening
Approval Lead Time
Sickness
Rate of SI's 1000 bed days
All Maternity sepsis screening
All Maternity IVAB in 1 hour
Timely Observations
Common Cause
Rolling 12 month HSMR
PSI's per 100 bed days low harm
PSI Moderate Harm and above
Medication incident % moderate harm +
Pat Medication incident % moderate harm
PU's rate per 1000 bed days
Lapses in care PU per 1000 bed days
Cat 3 PU with lapses in care
Deep Tissue injuries lapses in care
Unstageable PU lapses in care
Serious Incidents
Never Events reported
DoC compliance formal verbal & letter
Friends and Family Maternity
Complaints Rate
Other Emergency Portal Screening
All children sepsis screening
Avoidable MRSA
Average Usability
Patients will receive a variable experience
Family and Friends ED
RS ED IV Abx in 1 hour
Other Emergency Portals IV Abx in 1 hour
Rolling 12 month SHMI
Worsening
Special Cause - Concern
Friends and Family INP
Contracted Adult Inpatient IVAB in 1 hour
Patient Safety Incidents
PSI rate per 1000 bed days
Cat 2 PU with Lapses in care
HAI and COHA cases of C Diff toxin
HAI E Coli Bacteraemias
All ED portals Screening
All Emergency Portals IV Abx in 1 hour
RS ED Dept Sepsis Screening
Childrens Sepsis Screening
Net Hours
Agency Usage
Bank Usage
Temporary Staffing
Assurance / Variation Key
Assurance
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
Variation
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

Quality Dashboard

Metric	Benchmark	Previous	Latest	Variation	Assurance
Patient Safety Incidents	1900	1997	2284		
Patient Safety Incidents per 1000 bed days	50.70	50.64	54.78		
Patient Safety Incidents per 1000 bed days with no harm	32	33.80	37.58		
Patient Safety Incidents per 1000 bed days with low harm	13	14.00	14.58		
Patient Safety Incidents per 1000 bed days reported as Near Miss	2	2.28	2.04		
Patient Safety Incidents with moderate harm +	20	17	24		
Patient Safety Incidents with moderate harm + per 1000 bed days	0.60	0.43	0.58		
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		
Patient Falls per 1000 bed days	5.6	5.0	5.3		
Patient Falls with harm per 1000 bed days	1.5	1.5	1.6		
Medication Incidents per 1000 bed days	6	6.7	7.2		
Medication Incidents % with moderate harm or above	0.50%	2.33%	1.94%		
Patient Medication Incidents per 1000 bed days	6	5.7	6.4		
Patient Medication Incidents % with moderate harm or above	0.50%	1.33%	0.75%		

Metric	Benchmark	Previous	Latest	Variation	Assurance
Serious Incidents reported per month	0	5	8		
Serious Incidents Rate per 1000 bed days	0	0.13	0.19		
Never Events reported per month	0	0	1		
Duty of Candour - Verbal/Formal Notification	100%	90.0%	94.4%		
Duty of Candour - Written	100%	65%	94.4%		
All Pressure ulcers developed under UHNM Care	60	59	96		
All Pressure ulcers developed under UHNM Care per 1000 bed days	1.6	1.50	2.30		
All Pressure ulcers developed under UHNM Care lapses in care	12	22	31		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.56	0.74		
Category 2 Pressure Ulcers with lapses in Care	8	9	11		
Category 3 Pressure Ulcers with lapse in care	4	0	2		
Deep Tissue Injury with lapses in care	0	8	18		
Unstageable Pressure Ulcers with lapses in care	0	3	1		

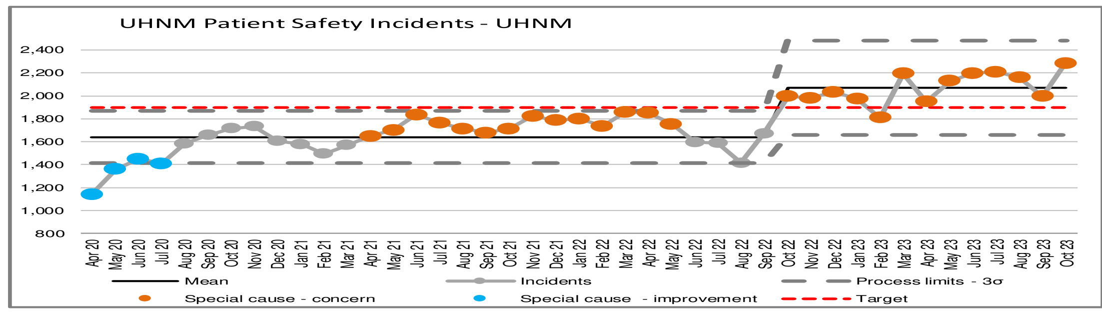
Quality Dashboard

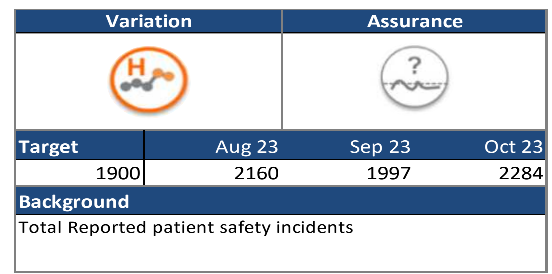
Metric	Benchmark	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	71.6%	63.8%		
Friends & Family Test - Inpatient	95%	96.2%	95.5%		
Friends & Family Test - Maternity	95%	95%	84.5%		
Written Complaints per 10,000 spells	35	35.10	27.64		
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	100.00	100.39		
Rolling 12 Month SHMI (4 month time lag)	100	101.78	101.30		
VTE Risk Assessment Compliance	95%	97.4%	95.9%		
Hospital Associated Thrombosis Rate per 10,000 Admissions	N/A	1.08	1.19		
Timely Observations	90%	71.0%	73.1%		
Reported C Diff Cases per month	8	20	11		
Avoidable MRSA Bacteraemia Cases per month	0	0	0		
HAI E. Coli Bacteraemia Cases per month	16	24	23		

Metric	Benchmark	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	92.1%	96.6%		
Inpatient IVAB within 1hr (Contracted)	90%	100%	100.0%		
Children Sepsis Screening Compliance (All)	90%	57%	71.4%		
Children IVAB within 1hr (All)	90%	100%	100.0%		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	83.0%	78.0%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	50.00%	71.7%		
Maternity Sepsis Screening (All)	90%	79%	70.0%		
Maternity IVAB within 1 hr (All)	90%	100%	100.0%		

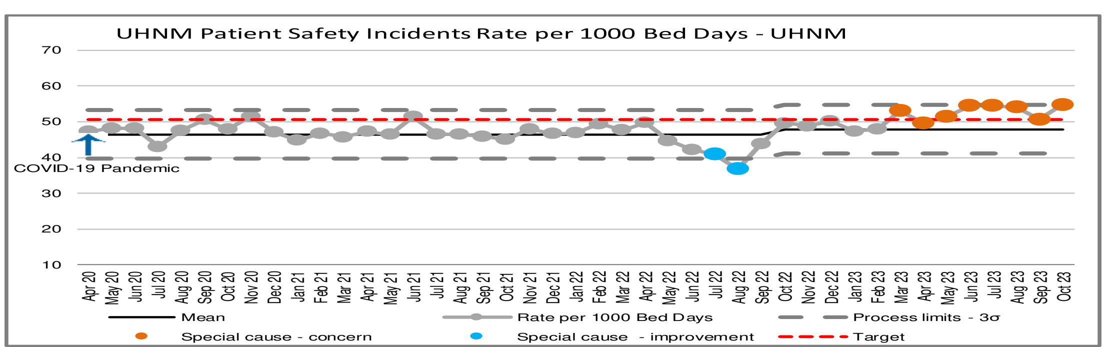
Delivering Exceptional Care with Exceptional People

Reported Patient Safety Incidents





Variation		Assurance	
Target	**Aug 23**	**Sep 23**	**Oct 23**
1900	2160	1997	2284
Background			
Total Reported patient safety incidents			



Variation		Assurance	
NRLS Mean	**Aug 23**	**Sep 23**	**Oct 23**
50.70	54.07	50.64	54.78

What is the data telling us:

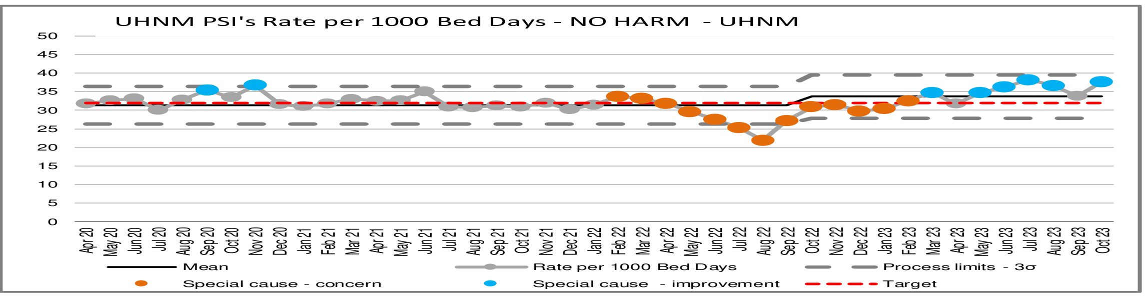
The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The October 2023 total is above the mean total. The rate per 1000 bed days has also increased and is above the NRLS rate.

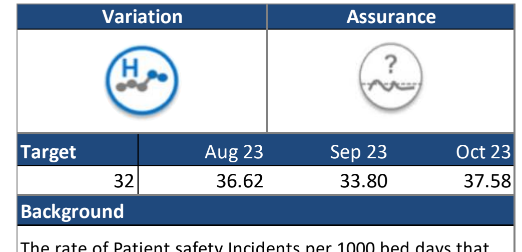
However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers are Medication, Patient Flow, Patient Falls, Clinical Assessment and Treatment related incidents. Medication related incidents continue to be the largest category after Tissue Viability in October 2023.

There have been reductions in incidents relating to 'Your Next Patient' with 14 during October (34 during September 2023, 76 in August, 110 in July, 102 in June, 97 in May, 117 in April, 157 in March, 170 in February and 228 in January 2023) which accounts for 0.57% (1.76% in September, 3.6% in August, 5.1% in July, 4.8% in June and May, 6.21% in April, 7.4% in March, 9.8% in February and 12% in January 2023) of total patient safety incidents. This is significant reduction in the number of reported incident relating to the YNP processes. 28.6% (35.3%, 30.4% and 28.2% previous months) were Tissue Viability. However, 75% (3 out of 4) of these were **NOT** hospital acquired but recording pressure damage on admission/attendance at UHNM. Only 1 case identified as deteriorating within Trust's care.

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

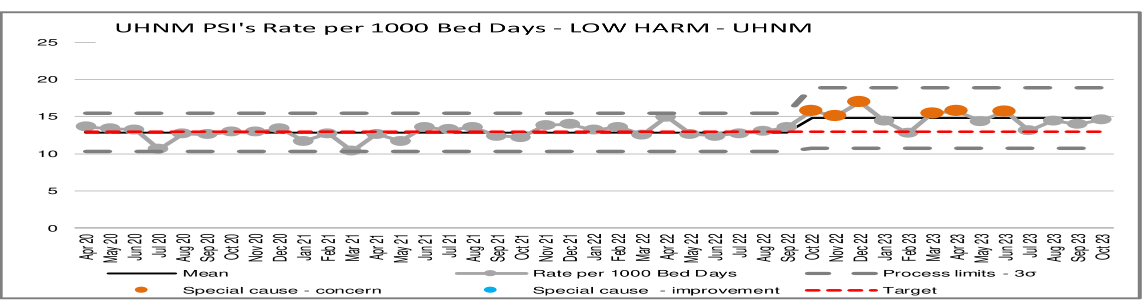




Variation	Assurance		
Target	Aug 23	Sep 23	Oct 23
32	36.62	33.80	37.58

Background

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



Variation	Assurance		
Target	Aug 23	Sep 23	Oct 23
13	14.47	14.00	14.58

Background

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

UHNM PSI's Rate per 1000 Bed Days - NEAR MISSES - UHNM

Variation	Assurance		
Target	Aug 23	Sep 23	Oct 23
2.0	2.28	2.28	2.04

Background

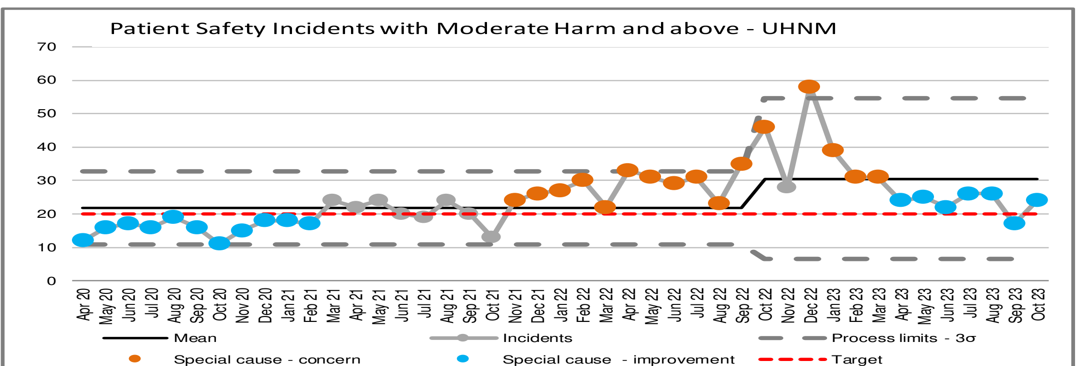
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

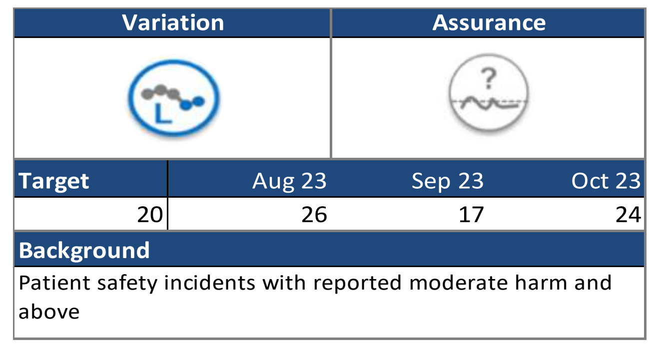
What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm and near misses have seen rates increase in recent months with decrease in recent months in low harm.

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

Reported Patient Safety Incidents with Moderate Harm or above



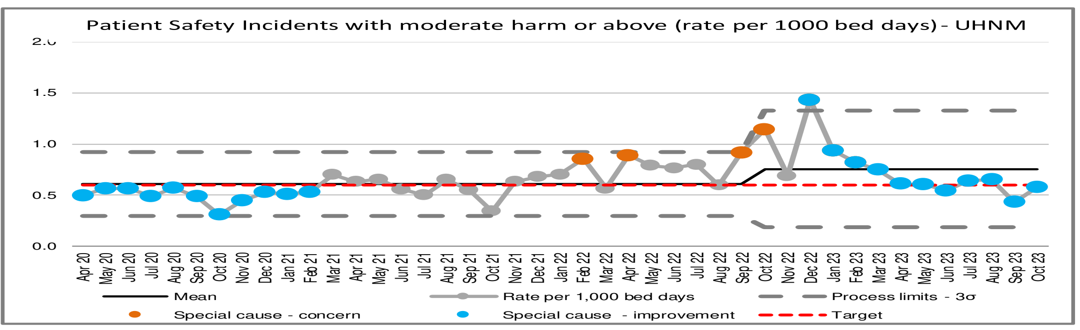


Variation	Assurance

Target	Aug 23	Sep 23	Oct 23
20	26	17	24

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Aug 23	Sep 23	Oct 23
0.60	0.65	0.43	0.58

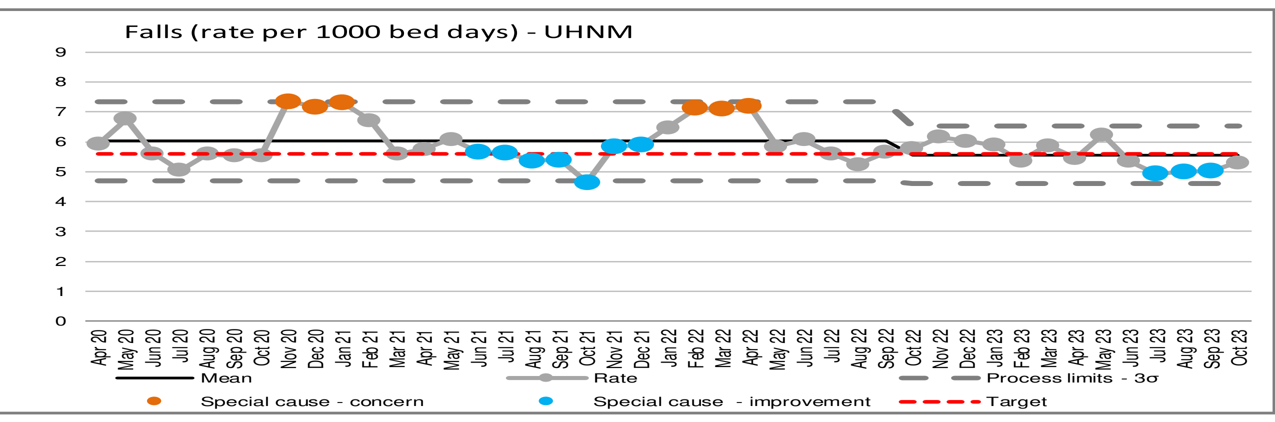
What is the data telling us:

The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within control limit but has shown decreasing total numbers and rate for the past 9 months.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 9 Treatment/Procedure related, 3 Falls, 2 Medication, Clinical Assessment and Care related

One of these moderate harm and above incidents were noted as relating to **'Your Next Patient'** and was Treatment related when patient being held on ambulance was not administered analgesia by paramedics as prescribed. Case referred to WMAS for further review.

Patient Falls Rate per 1000 bed days



Variation		Assurance	
Target	Aug 23	Sep 23	Oct 23
5.6	5.0	5.0	5.3

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

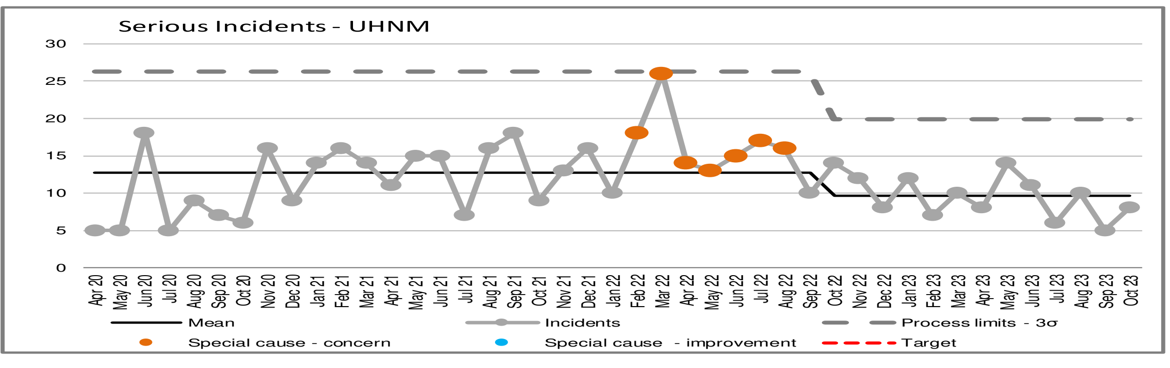
The Trust's rate of reported patient falls per 1000 bed days between July & October 2023 has been below average but within normal variation

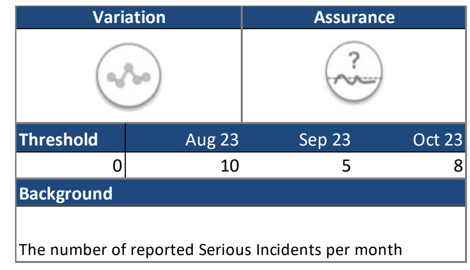
The areas reporting the highest numbers of falls in October 2023 were:
Ward 110 – 11 falls, County AMU– 10 falls, Royal Stoke ECC – 10 falls

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

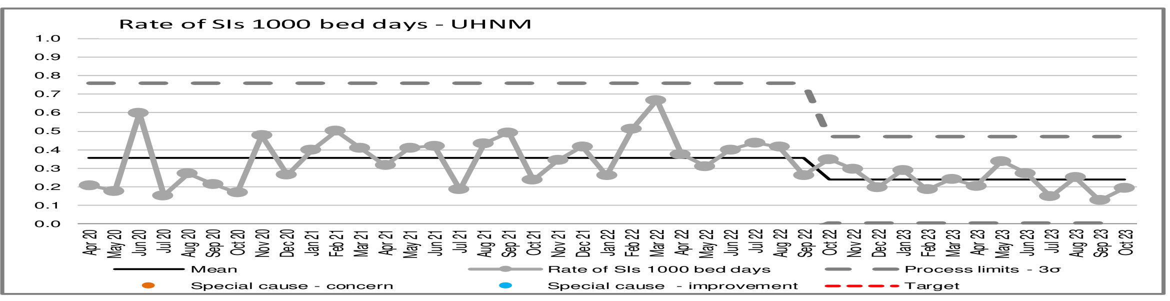
- Audits/spot checks continue to take place.
- 1:1 education has been delivered by Q&S recently to Ward 110 and County AMU. The staff have been educated about documentation, interventions to prevent falls and discussions around deconditioning.
- Ward 110 and ECC have had new falls champions trained recently in order to cascade training to their teams.
- Ward 110 frequently appear in the top reporting falling wards. These patients have had limb amputations and therefore are adapting the way in which they can mobilise.
- All of the above wards although the falls rate is high, none have reported any serious incidents

Serious Incidents per month





Variation		Assurance	
Threshold	Aug 23	Sep 23	Oct 23
0	10	5	8
Background			
The number of reported Serious Incidents per month			



Variation		Assurance	
Target	Aug 23	Sep 23	Oct 23
0	0.25	0.13	0.19
Background			
The rate of Serious Incidents Reported per 1000 bed days			

What is the data telling us:

Monthly variation is within normal limits. Target has been set at 0 for serious incidents but this remains under review to develop trajectory for reducing serious incidents across UHNM. October 2023* saw 8 incidents reported:

- 3 Falls related incidents
- 2 Diagnostic related incidents
- 1 Healthcare associated Infection related
- 2 Treatment related (including 1 Never Event)

The rate of SIs per 1000 bed days has varied consistently within confidence limits but the past 10 months have shown significant improvement with rate below the previous long term mean of 0.4. The confidence limits have been recalculated from October 2022 to reflect the significant changes. The current rate is 0.19.

**Reported on STEIS as SI in October2023, the date of the incident may not be October 2023.*

Serious Incidents Summary

Summary of new Maternity Serious Incidents

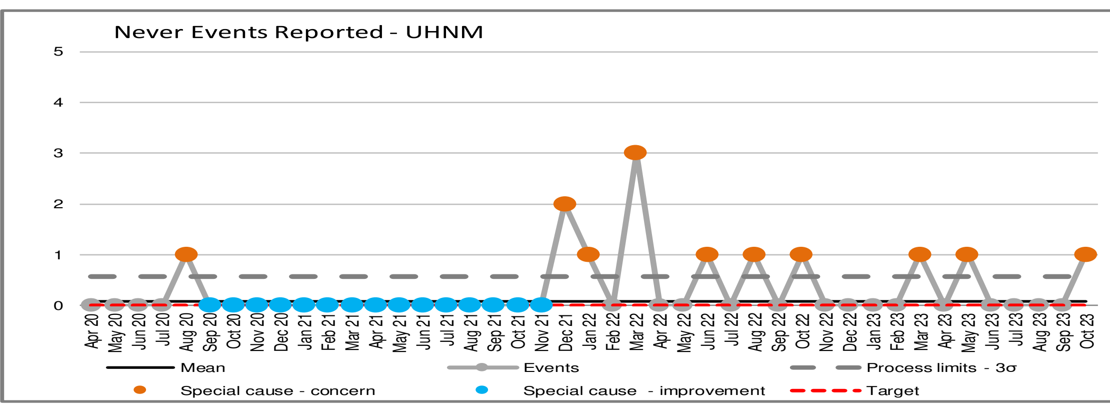
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during October 2023. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary of numbers and categories.

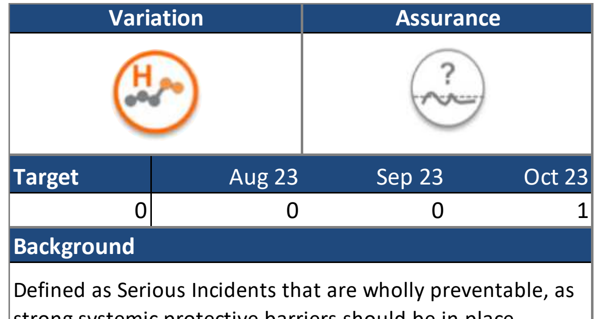
All Serious Incidents will continue to be are reported and investigated and the final Root Cause Analysis presented at Divisional meetings and Risk Management Panel for review and agreement prior to sharing with CCGs for closure.

There was 0 Maternity related Serious Incidents reported on STEIS during October 2023

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

Never Events





Variation	Assurance

Target	Aug 23	Sep 23	Oct 23
0	0	0	1

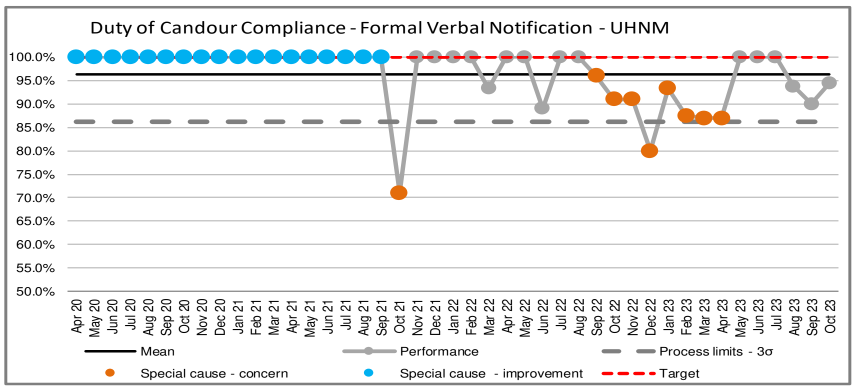
Background

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

There has been 1 Never Event reported in October 2023. The target is to have 0 Never Events.

Log No.	Never Event Category	Description	Target Completion date
2023/18751	Retained Foreign Object post procedure	Chest Drain inserted within ED following Trauma Call during October 2021. On most recent imaging Guide Wire is clearly visible following insertion in 2021. This has been found on up to date imaging whilst the patient is in Critical Care now following a new admission. Seen by Cardio-Thoracic Surgeon on 14th September 2023 and reviewed by Registrar, note specifies patient to be seen electively on discharge from current admission because the Wire has been in the Chest for 2 years+.	29/12/2023

Duty of Candour Compliance



Duty of Candour Compliance - letter sent within 10 working days - UHNM

Divisional Escalation process implemented

Mean · Performance · Process limits - 3σ · Special cause - concern · Special cause - improvement · Target

Target	Aug 23	Sep 23	Oct 23
100%	93.8%	90.0%	94.4%

Background

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

Target	Aug 23	Sep 23	Oct 23
100%	82.4%	65.0%	94.4%

Background

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

What is the data telling us:

During October there were 18 incidents reported and identified that have formally triggered the Duty of Candour. 94.4% (17 out of 18) have recorded that the patient/relatives been formally notified of the incident in Datix and within normal variation.

Confirmed Follow up Written Duty of Candour compliance* (i.e. receiving the letter within 10 working days of verbal notification **and recorded in Datix**) during October 2023 has improved to 94.4% as of 8th November 2023 including those letters that are completed within timescale and not yet exceeded the timeframe.

** The 10-day target is noted as internal target*

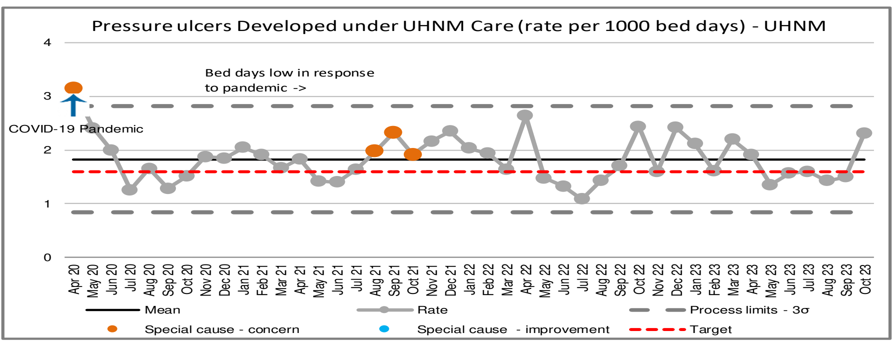
Actions taken:

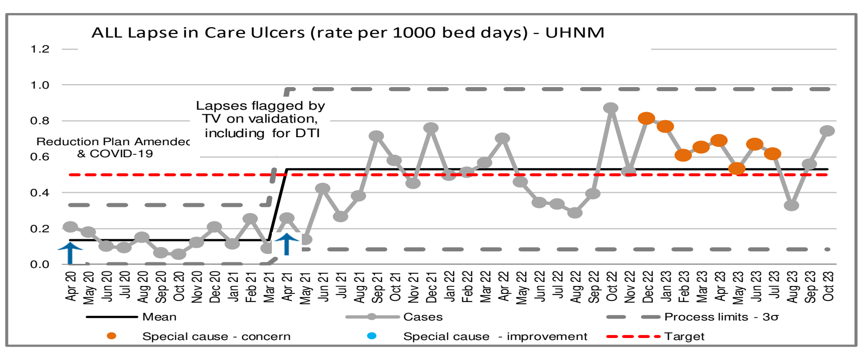
Divisions are continuing to work with and support clinicians and Q&S teams to raise further awareness and education on how and why Duty of Candour is to be completed.

Monitoring of compliance and update with evidence takes place at day 5 and 7 with a escalation process in place which is in the process of being formalised across the Divisions

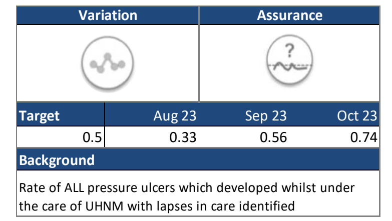
Compliance is included in Divisional reports for discussion and action and escalations are made prior to deadline to support completion as much as possible.

Pressure Ulcers developed under care of UHNM per 1000 bed days





Variation	Assurance		
Target	Aug 23	Sep 23	Oct 23
1.6	1.43	1.50	2.30
Background			
Rate of Deep Tissue injuries and Category 2-4 and Unstageable pressure ulcers which developed under the care of UHNM			



Variation	Assurance		
Target	Aug 23	Sep 23	Oct 23
0.5	0.33	0.56	0.74
Background			
Rate of ALL pressure ulcers which developed whilst under the care of UHNM with lapses in care identified			

What the data is telling us

The rate of pressures ulcers reported as developed under UHNM care was within expected limits in October. The rate of cases with lapses in care identified was also within expected range in October.

Where a patient can not be repositioned due to acuity, this must be documented, otherwise a potential lapse in care may be identified.

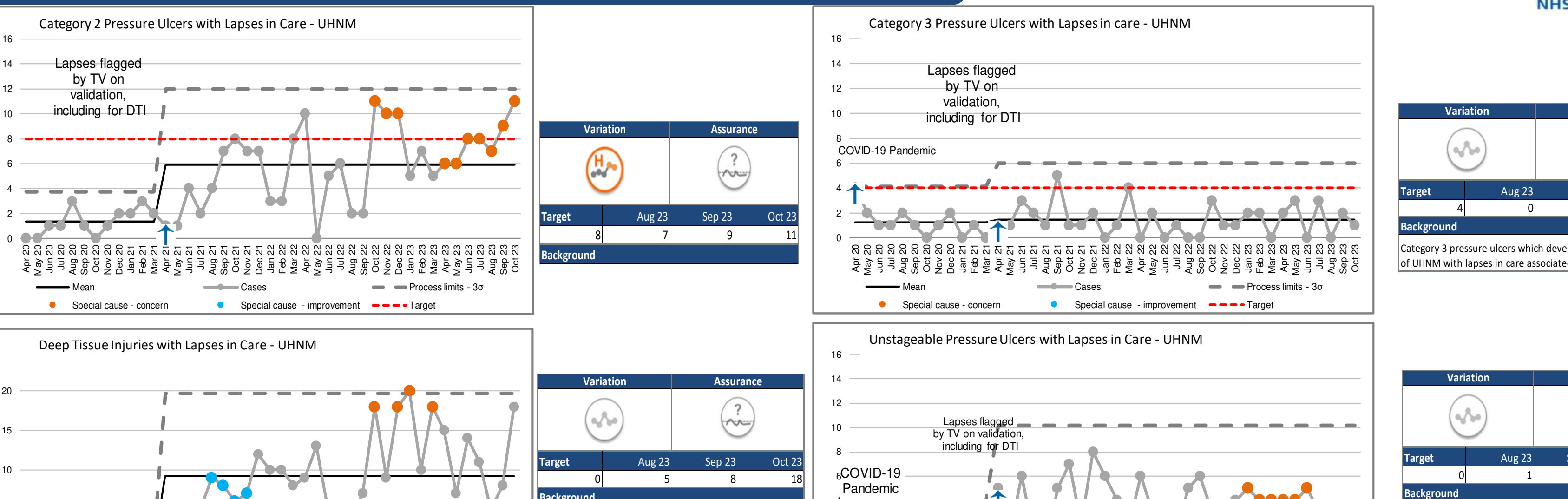
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.

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

Actions

- Training continues for NA induction, Preceptorship days, overseas nurses, and ED agency paramedics. Sessions are being held for newly qualified staff as part of induction
- Education is being delivered in pressure prevention, continence, categorisation, lower limb, and wound assessments.
- ESR approved by Stat & Mand Training group has been approved and underway now the guidelines for categorisation have been released from the NWCS.
- A3 for reduction of pressure ulcers for driver lane and scorecard being developed in line with Trust strategy
- Stakeholder group for patient seating have approved patient chair and will now look at recliner chairs and bariatric options
- Trust wise audit on mattresses completed with DHC support.
- Stop The Pressure planning for November will include videos, education, and ward walking
- Cascade education to be delivered for the implementation of Purpose T in the risk assessment booklet
- Amendments made to the risk assessment booklet to capture patient preference and support improvements in CQIUN audit

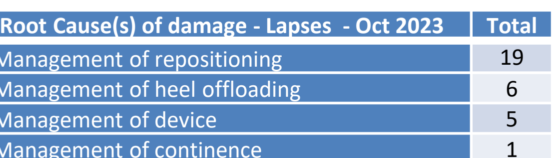
Pressure Ulcers with lapses in care



What is the data telling us:

The charts above show numbers within expected limits for all individual categories of pressure damage with lapses, although the number of Category 2 ulcers with lapses in care has been above average for 10 of the past 13 months. The higher numbers have been associated with Category 2's and in October Deep Tissue Injuries.

The table below shows the most common lapses identified last month.



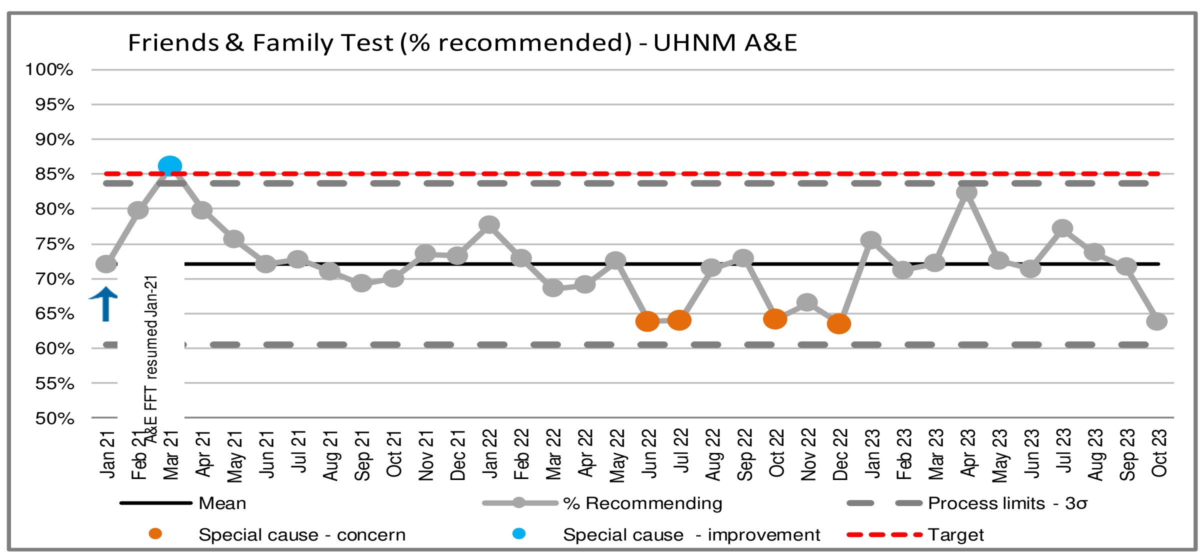
Root Cause(s) of damage - Lapses - Oct 2023	Total
Management of repositioning	19
Management of heel offloading	6
Management of device	5
Management of continence	1

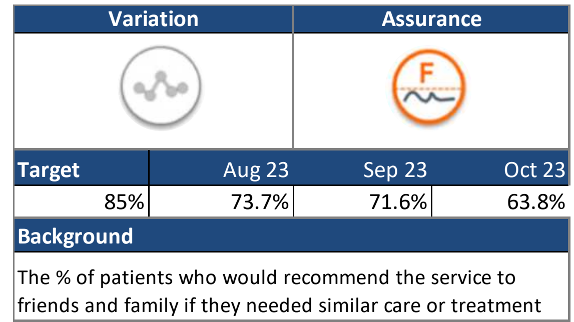
Locations with more than 1 lapse in October 2023 were: **ED Stoke (5), AMU Stoke (3), FEAU (2) , SSCU (2), Ward 102 (2)**

Actions:

- PSIRF toolkit being amended to gather more involvement from clinical areas
- Staff attendance for education will be an action when an incident is reported. Education plan is being developed
- High reporting wards and wards of concern are visited by Quality and Safety using improving together strategies and delivering education. For Stop The Pressure day, multiple reporting areas will be included
- Visits from Quality and Safety following completion of PSIRF toolkit to gain assurances of learning
- Tendable questions have been updated and support for completion of the audit being given to highlight immediate actions. Audits have been completed by Quality and Safety team to support areas of accurate auditing

Friends & Family Test (FFT) – A&E





Variation		Assurance	
Target	Aug 23	Sep 23	Oct 23
85%	73.7%	71.6%	63.8%

Background

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

- The overall satisfaction rate for our EDs remains somewhat below our internal target at 63.8% for October 2023.
- The Trust received 934 responses which is slight increase on the previous month, however the response rate percentage remained static at 9% response rate overall. The Trust's overall satisfaction rate is lower than the national average of 82% (NHS England August) at 64%. UHNM is 33rd out of 122 Trusts for the number of responses in ED (NHS England August 2023), and 87th out of 122 Trusts for the percentage positive results.
- Feedback from patient experience of using 111First and the kiosks continues to be monitored. 23% of respondents in October 2023 reported to have used 111First prior to attending ED, which is an increase on previous months. Key themes from October 2023 are around poor communication, patients feeling abandoned, staff attitude, long waits, pain relief especially related to Royal Stoke.

Actions :

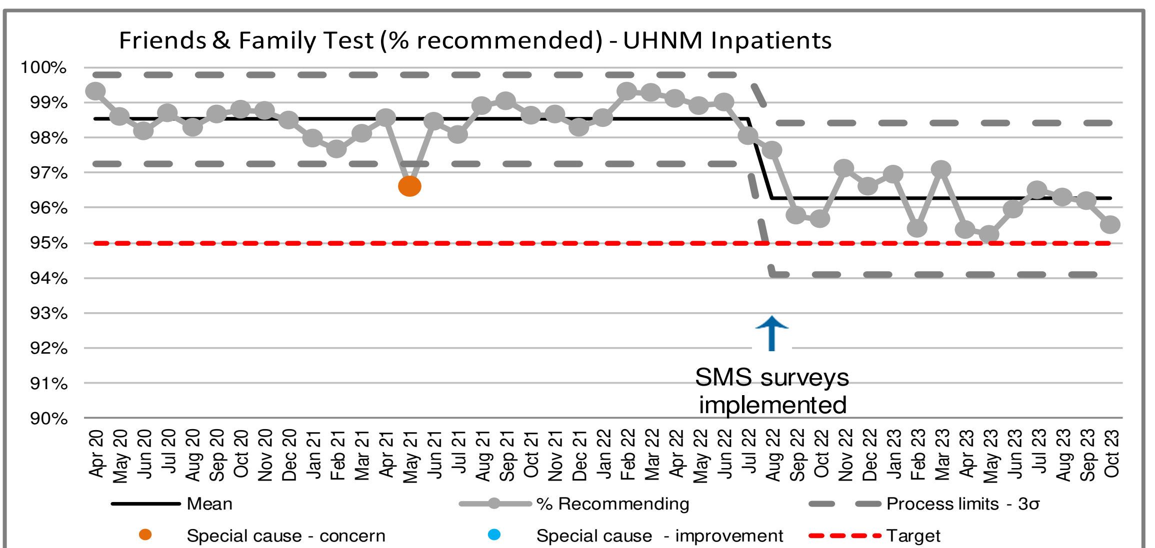
FFT push – handed out to all patients on arrival to ED.

QR code made visible throughout the department.

QR code put onto all future FFTs.

You said we did board in waiting room.

Friends & Family Test (FFT) - Inpatient



Variation	Assurance

Target	Aug 23	Sep 23	Oct 23
95%	96.3%	96.2%	95.5%

Background

Percentage of Friend & Family Tests that would recommend UHNM Inpatient Services

What do the results tell us?

- The monthly satisfaction rate for inpatient areas continue to exceed both the internal target rate of 95% and the national average of 94% (August 2023 NHS England) at 95.5% for October 2023.
- In October 2023 a total of 2512 responses were collected from 68 inpatient and day case areas (11777 discharges) equating to a 21% return rate which is slightly lower than last month and lower than the internal target of 30%. UHNM have the 17th highest response rate for all reporting Trusts in the country (153) NHS England August 2023.

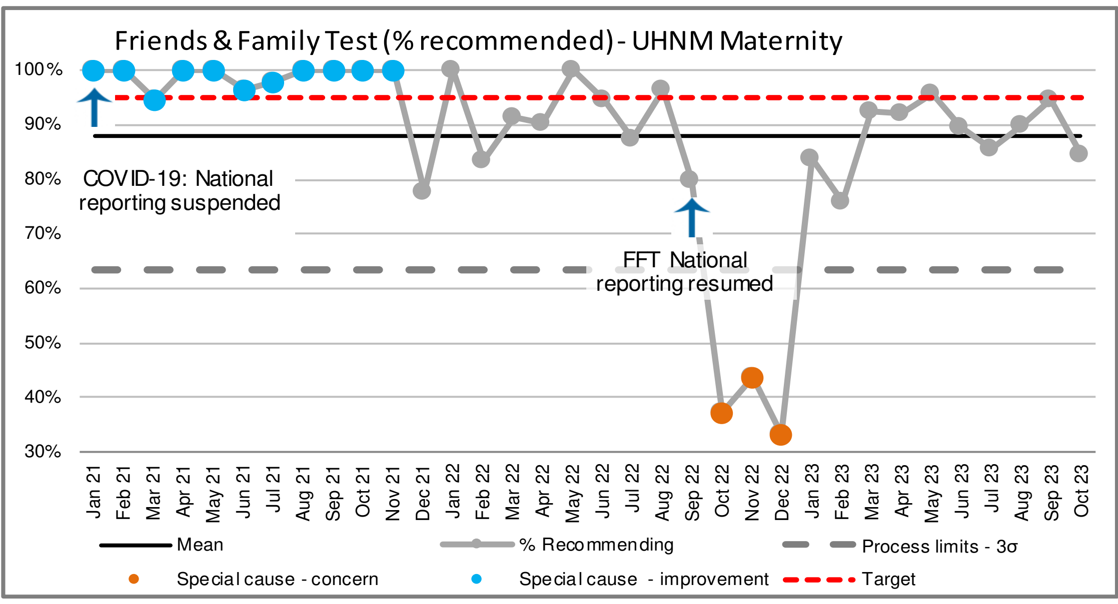
Actions:

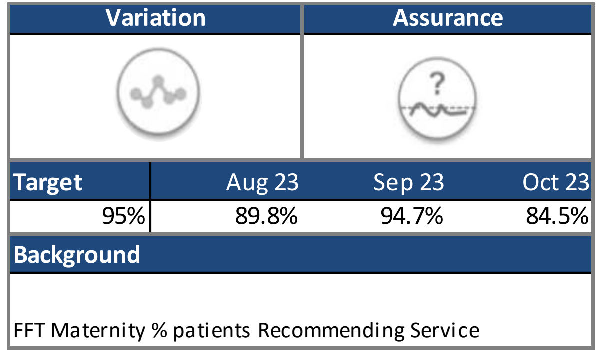
- Support individual areas to ensure they're using the most up to date version of the surveys.
- Continue to focus on Medicine and Surgery to increase response rate.

Work continues around a suite of patient priorities based on patient feedback:

- Timely medications
- Pain management
- Involvement in care and decision making
- Improving the experience of our oncology patients

Friends & Family Test (FFT) - Maternity





Variation	Assurance		
Target	Aug 23	Sep 23	Oct 23
95%	89.8%	94.7%	84.5%

Background

FFT Maternity % patients Recommending Service

What do these results tell us?

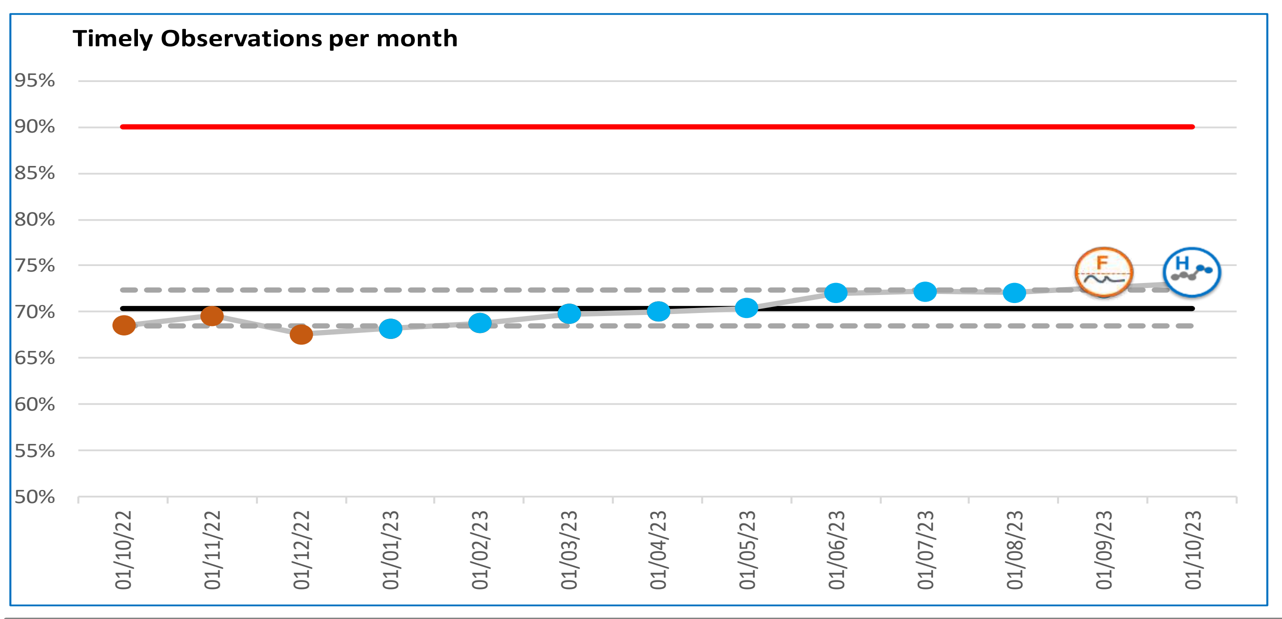
- There were a total of 97 surveys were received in October across all 4 touch-points (ante-natal, birth, post natal ward; post natal community) with 21 of these being collected for the "Birth" touch-point, providing a 5% response rate (based on number of live births) and 95% satisfaction score, both of which are a slight decrease on the previous month's figures.
- The Antenatal touch point scored 82% recommendation and the post-natal ward touch point scored 79% satisfaction rate, both are a decrease on the previous month.
- Compared to the latest national data available (August 2023) out of 111 Trusts, UHNM were 54th for number of responses for antenatal, 39th for number of responses for birth, 66th for post-natal ward and 38th for post-natal community which shows decreases in all areas.

Actions:

- Continue to monitor the efficacy of collecting feedback via text message
- Work is on-going with Maternity Voices regarding additional feedback for induction of labour
- Look at incorporating the questions from the National Maternity Survey which requires the most improvement in to the FFT survey.
- Discuss with management team with regards to increasing survey completion for post-natal community.

Delivering Exceptional Care with Exceptional People

Timely Observations



What do these results tell us?

Compliance remains well below the 90% target in October 2023 but has been slowly improving since January 2023. The current mean rate is 70.4% and result for October 2023 is 73.1% (upper control limit is 72.3%)

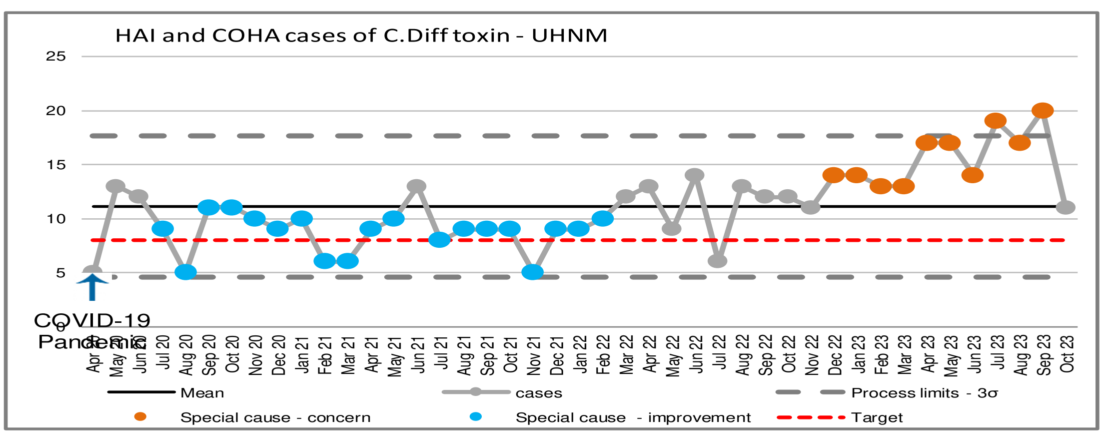
Individual Wards and Departments continue to be reviewed and monitored as part of the monthly Performance Review process and actions are identified to improve compliance.

Medicine, Surgery and Network Divisions have timely observations as a Driver metric.

There are 2 wards / departments with Timely Observations recorded at 50% or less during October. These 2 wards are Ward 78 (48.7%) and Ward 230 (44%). Both of these wards have seen improvements in their latest monthly results but are still below 50%.

Delivering Exceptional Care with Exceptional People

Reported C Diff Cases per month



Variation		Assurance	
Target	Aug 23	Sep 23	Oct 23
8	17	20	11

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

Number of C Diff cases are outside SPC limits and normal variation

There have been 11 reported C diff cases in October 2023. 10 HAI and 1 COHA

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

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

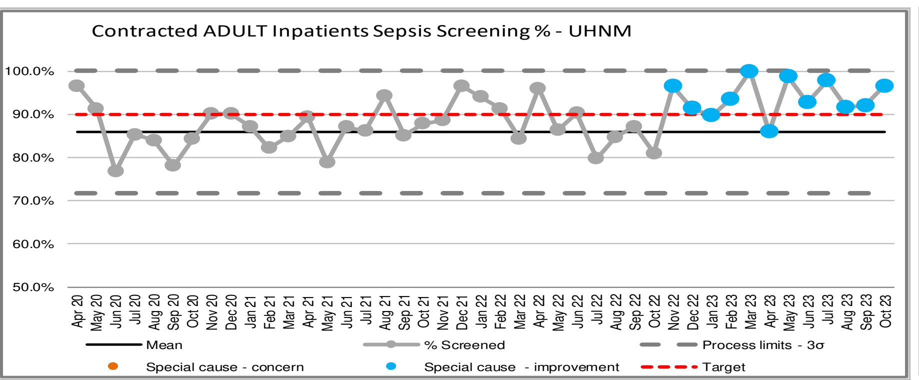
There has been three clinical areas with more than one Clostridium *difficile* case within in a 28 day period triggered in October . Where ribotypes are different person to person transmission is unlikely.

- FEAU - Awaiting ribotypes
- Ward 14 – Awaiting ribotype from 1 sample
- Ward 124 – Different ribotypes

Actions:

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- Recruitment to the C Diff Nurse role has been successful and commenced 20th February 2023. This role is 50% patient reviews/50% staff training
- Task and Finish Group for West Building in place
- CURB -95 score added to CAP antimicrobial Microguide
- Campaign commenced in West Buildings to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- AMU and FEAU also targeted as antibiotics are generally started in the admission portals
- Terminal clean of all wards in West Building completed
- Back to bed basics bed super clean 20th October
- Consultant Microbiologist presented to ED and Elderly Care Doctors on Cdiff and antibiotic guidelines
- Consultant Microbiologist continues rounds on the Elderly care wards in West Building

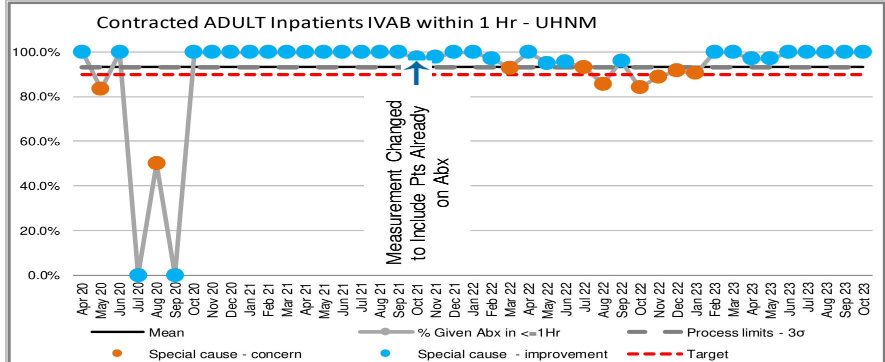
Sepsis Screening Compliance (Inpatients)



Variation	Assurance		
Target	**Aug 23**	**Sep 23**	**Oct 23**
90%	91.7%	92.1%	96.6%

Background

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



Variation	Assurance		
Target	**Aug 23**	**Sep 23**	**Oct 23**
90%	100.0%	100.0%	100.0%

Background

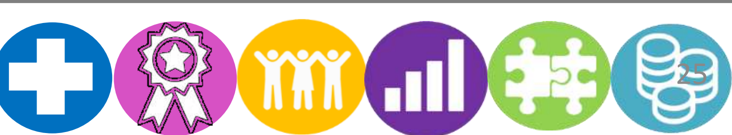
The percentage of adult inpatients identified during monthly spot check audits receiving IV Antibiotics within 1 hour for Sepsis Contract

What is the data telling us:

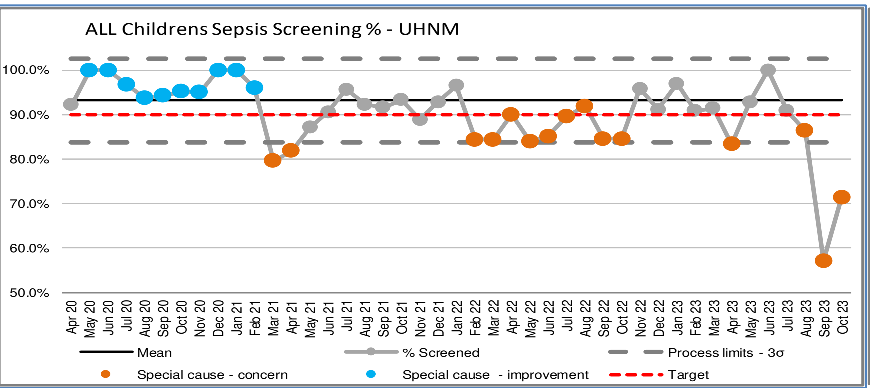
Inpatient areas achieved the screening and the IVAB within 1 hour target for October 2023. There were 118 cases audited with 4 missed screening from different ward areas or divisions. Out of 118 cases audited, 89 cases were identified as red flags sepsis with 49 cases having alternative diagnosis and 48 were already on IVAB treatment and the remaining 1 had IV antibiotics administered within 1 hour.

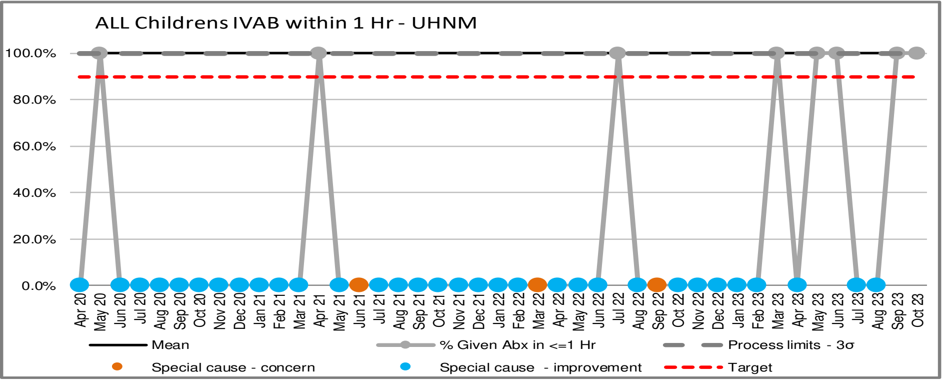
Actions:

- Sepsis sessions/ kiosks continue to all levels of staff in the clinical areas that required immediate support
- The Sepsis Team continue to raise awareness the importance of sepsis screening and IVAB compliance by being involved in HCA, students and new nursing staff induction programmes; on-going
- The Sepsis team continue to promote sepsis awareness in both sites and will prioritise areas to visit with the sepsis clinical lead consultant; on-going



Sepsis Screening Compliance ALL Children

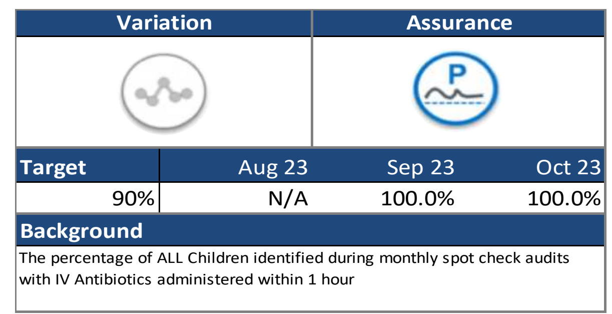




Variation		Assurance	
Target	**Aug 23**	**Sep 23**	**Oct 23**
90%	86.4%	57.1%	71.4%

Background

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



Variation		Assurance	
Target	**Aug 23**	**Sep 23**	**Oct 23**
90%	N/A	100.0%	100.0%

Background

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

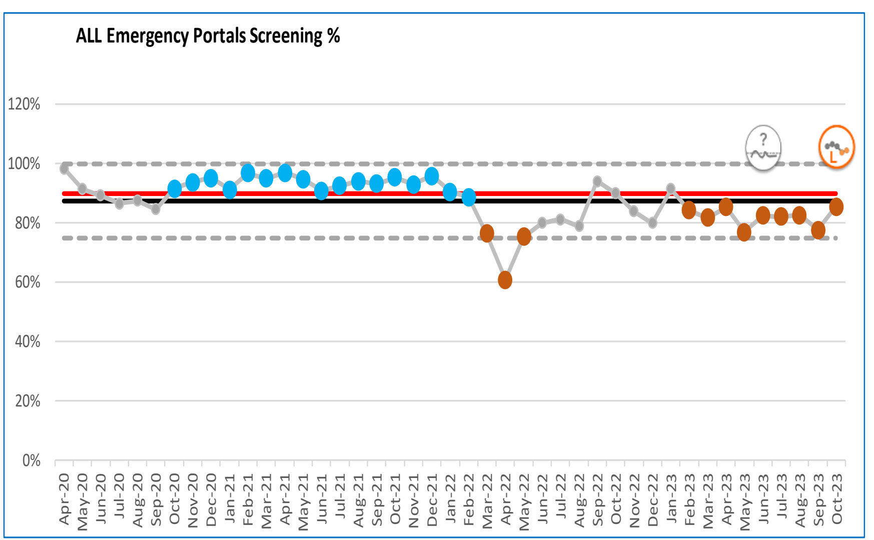
What is the data telling us:

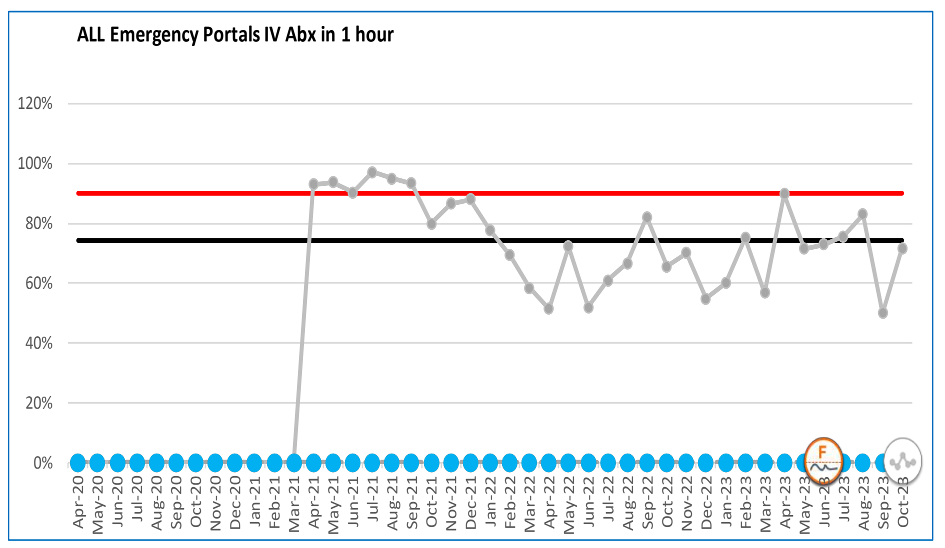
Children's Services target rate of > 90% was not achieved for September 2023. We are still seeing a small numbers of children trigger with PEWS > 5 & above in Inpatients areas. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks). There were 21 cases audited for emergency portals and inpatients areas with 8 missed screening. No true red flag sepsis was identified from the randomise audits in inpatients and emergency portals.

Actions:

- Children emergency portal is in the process to go paperless for their sepsis screening tool documentation, work is underway via electronic system (iPortal)
- The Sepsis Team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective; on-going
- Plan of collaborative work with Children education lead and aiming to deliver Induction training and ward based sessions in the next few weeks; on-going

Sepsis Screening Compliance (Emergency Portals Contract)





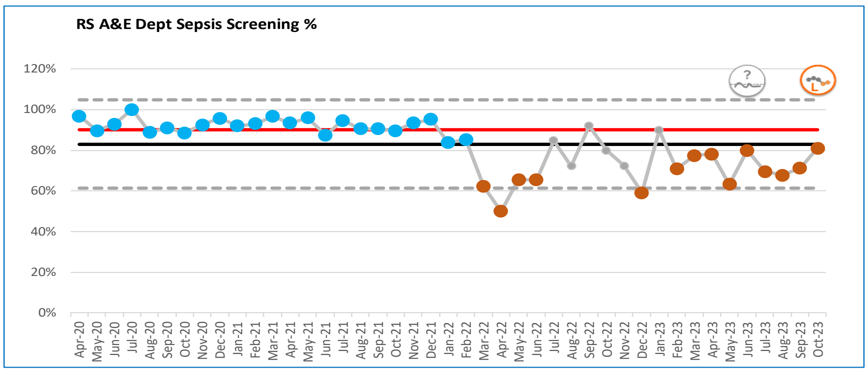
What is the data telling us:

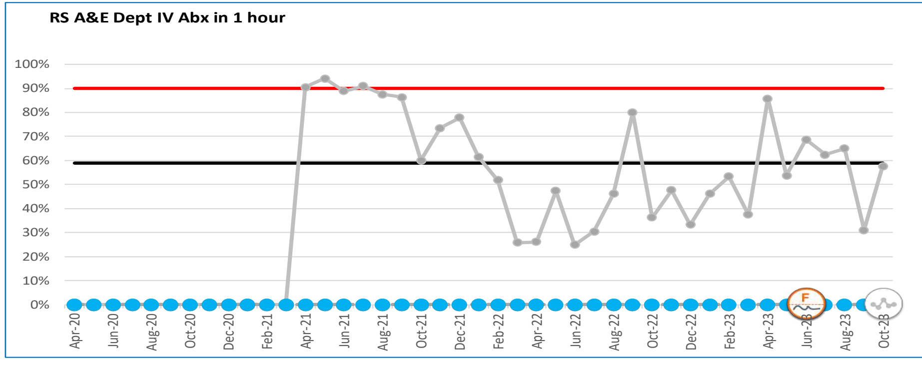
Adult Emergency Portals screening did not meet the target rate for October 2023. There were 69 cases audited with 10 missed screening in total from the emergency portals. The performance for IVAB within 1 hour achieved 71.7 %. Out of 69 cases, there were 63 red flags sepsis in which the 10 cases already on IVAB, 36 cases were newly identified sepsis and 17 cases have alternative diagnosis. There were 13 delayed IVAB. Missed screening contributed by A&E at both sites.

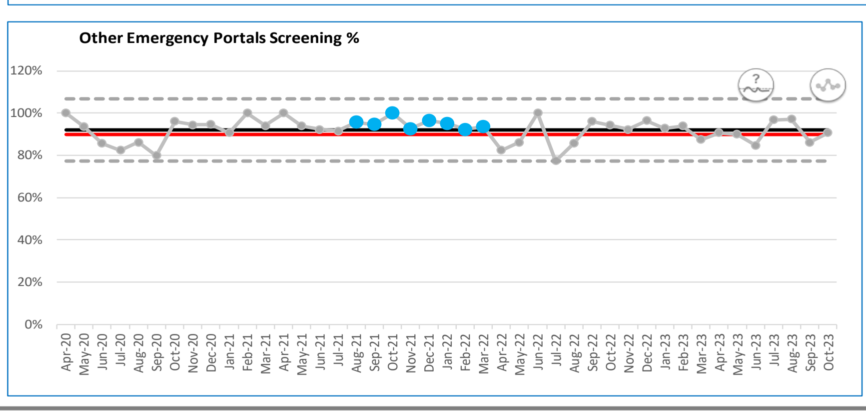
Actions:

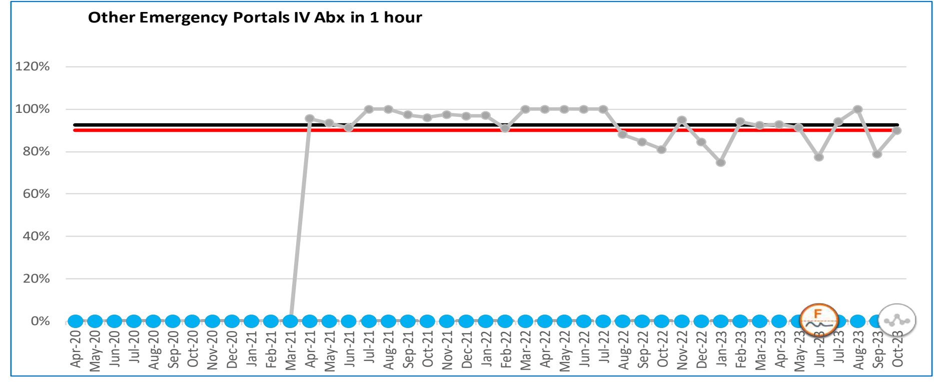
- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E regularly. Provide sepsis session when staffing and acuity allows.
- Face to face A&E sepsis induction/ training for new nursing staff, nursing assistant and medical staff will continue
- Monitoring impact of long ambulance waits on timely assessment and treatment of sepsis; on-going
- Sepsis Champion Day training is organised for both ED sites this November

Sepsis Screening Compliance (Emergency Portals RSUH ED & Other Portals)









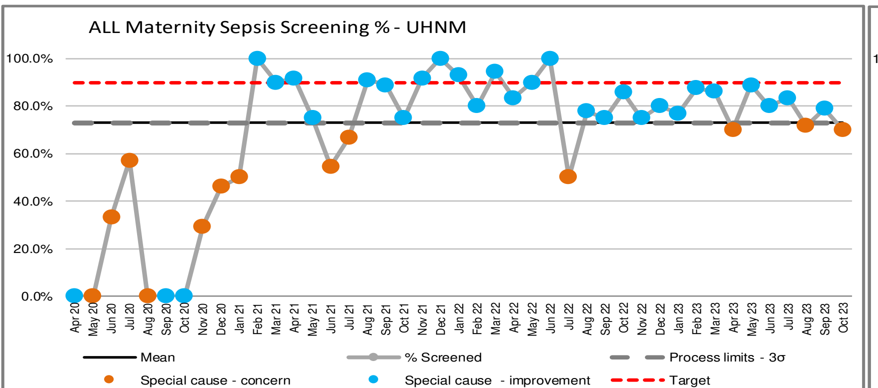
What is the data telling us:

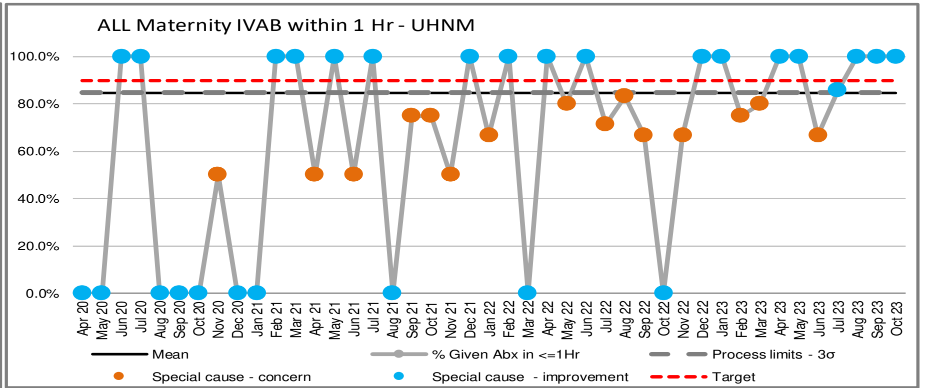
The Emergency Department at RSUH remain below target rate for both screening and IVAB within the 1 hour for October 2023 but other sites achieved both targets.

Actions:

- To continue to provide sepsis kiosks in ED focusing the importance of sepsis screening documentation and urgent escalation for true red flag sepsis triggers
- Deteriorating Patient Reviewer (DPR) is currently in place and managed by Emergency Physician in Charge in ED. There will be a specific clinician assigned and dedicated to log in DPR VOCERA device at the beginning of their shift to review and provide timely assessment, treatment and escalation of patients who triggers for medium to high risk sepsis.

Sepsis Screening Compliance ALL Maternity





Variation		Assurance	
Target	Aug 23	Sep 23	Oct 23
90%	71.8%	78.9%	70.0%

Background

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

Variation		Assurance	
Target	Aug 23	Sep 23	Oct 23
90%	100%	100%	100%

Background

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

What is the data telling us:

Maternity audits in screening compliance is below target this month achieving 70% for emergency portals. However, they achieved 100 % for IVAB within the 1 hour. Inpatient areas is just below target for screening at 88% however they achieved 100% for IVAB within 1 hour. This compliance score is based on a small number, however a regular spot checks audit is being conducted monthly.

There were 10 cases audited from emergency portal (MAU) and inpatients with 4 missed screening. There were 3 true red flags identified from the randomise audits, and all cases received IVAB within 1 hour.

Actions:

- Maternity antibiotic PGD has been drafted and is currently under review by the Pharmacy Team; still awaiting finalisation
- Maternity educator is supporting the sepsis team by conducting independent / in-depth sepsis audits in the whole Maternity department , staff who had missed the screening documentation will be given constructive feedback and offered support/ training; on-going
- Monthly Maternity sepsis skills drill is now replaced with ad hoc sepsis sessions in each clinical areas

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

Non-Elective Care

- Context
  - ED Conversion increased slightly from 31.4% in September to 32.4% in October
  - 12 Hour Trolley Waits deteriorated from 811 in September to 1059 in October
  - Type 1 A&E Attendances increased slightly from 14005 in September to 14436 in October

- Driver Metrics
  - Four Hour Performance decreased in October to 65.3% from 69.9% in September
  - 12+ Hours In ED deteriorated to 2185 in October from 1691 in September
  - Ambulance Handovers <60 Minutes also significantly deteriorated to 69.1% in October from 85.8% in September

Diagnostics Summary

- DM01 activity in October remained above 19/20 levels.
- DM01 performance was 76% overall in October, an improvement of 1.1% from September (74.9%).
- Endoscopy performance is the main contributor to this performance being below the national target of 99%
- The DM01 position for non obs ultrasound has achieved the trajectory and delivered DM01

Endoscopy:

- Insourced weekend service continues until end Jan 2023 following external funding; further opportunities available for County site and a modular build; long term trajectory and business case under review prior to submission
- October saw first reduction in total number of patients waiting above their target date
- Service team continuing to work on demand management strategies and productivity measures to improve utilisation and appropriateness (including clinical audit, admin and clinical validation)
- Improved booking performance for lower cancer PTL patients – now 2-3wks notice (was 3 days)
- Booking team recruitment ongoing – 2 WTE vacancies following promotion within the team
- Improvement plan ongoing and workstream leads progressing actions

Spotlight Report from Chief Operating Officer

Referral to treatment (RTT Planned Care and Elective Recovery

- At the end of October the validated numbers of >104 patients was 1. The current prediction for end of November is 1 (a different patient).
- The validated number of 78 week breaches for end of October was 138, an improvement on September (170). This is predicted to be 88 for November, this takes into account the impact of industrial action – without IA the prediction was 0.
- The focus has moved to 65 week. There are a number of specialties which are challenged however there are plans being put in place to mitigate these. The un-validated 65 week position for October was 1,264, slightly up from September's 1,230 (validated).
- The overall Referral To Treatment (RTT) Waiting has decreased this month to 81,240 (unvalidated) from 82,469 in September.
- Day Case activity and Elective Activity have moved from delivering 83% and 82% respectively for September to 82% and 82% for October. The Trust has now launched the national standard 6-4-2 process within theatres with support from the regional theatres team. Day case as a % of all elective work is currently 87.4%.

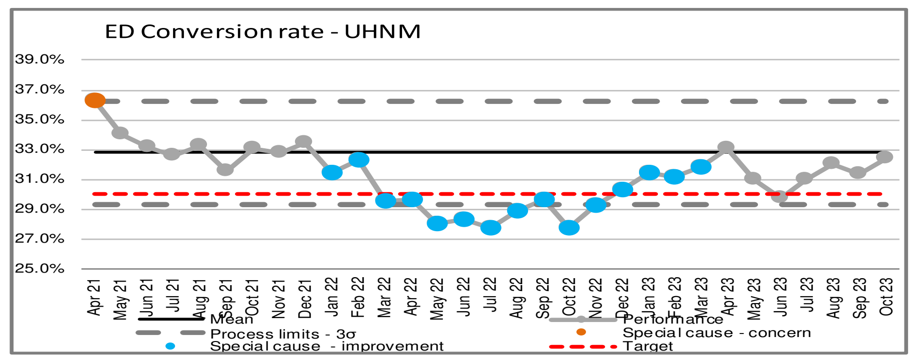
Cancer

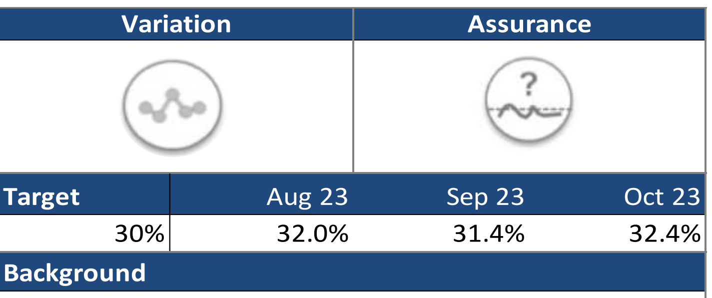
- Trust overall 2WW Performance achieved 95.7% in Sept 23 – un-validated 94.9% for October. This sustained improvement is as a result of schemes such as the Lower GI Community Referral hub and Community Tele-dermatology pathways being successfully implemented.
- Breast symptomatic (where cancer is not suspected) achieved at 93.8% in Sept and is predicted to achieve the target again in October.
- The 62 Day Standard achieved better than predicted in September at 52.8%. The current provisional position for October is 50.4%. This is an un-validated and incomplete position that is expected to change as pathology confirms or excludes cancer for treated patients. Contributing factors include treatment and diagnostic capacity, with robust plans in place to tackle the most challenged specialties (LGI) over the next quarter.
- The 31 Day Standard achieved 89.1% for September. It is predicted to land at 89% in October.
- The 31 day Subsequent Radiotherapy achieved 97% in September and is expected to achieve 95.1% in October.
- The 28 Day Faster Diagnosis Standard achieved 60.3% for all referral routes combined in September. The October position is currently incomplete and will be validated once Pathology confirms cancer or non cancer on high volume pathways such as Skin. Areas of best practice consistently achieving the standard are Breast and Upper GI and Skin.
- The total GP referred suspected cancer PTL sits around 3600 in total currently; a reduction of 600 since last month.
- The number of patients waiting over 62 days on an open pathway as of 05/11/23 was 420 – a reduction of 100 patients since the previous month.
- UHNM has received record 2WW referral volumes moving into the summer months, more than usual seasonal demand plus the predicted growth, with some weeks exceeding 1000 referrals received.
- From October, Cancer Waiting Times standards will be amalgamated in to three simplified metrics; 28 Day Faster Diagnosis set at 75%, 31 Day Decision to Treat to Treatment set at a 96%, and 62 Day Referral to Treatment set at 85%
- Shadow monitoring performance against the new merged standards using August reported data:
- In September UHNM achieved 60.3% against a combined 28 day FDS standard, 86.6% against a combined 31 Day standard, and 58.8% against a combined 62 Day standard.

Section 1: Non-Elective Care

Headline Metrics

Non-Elective Care – monthly *(context)*

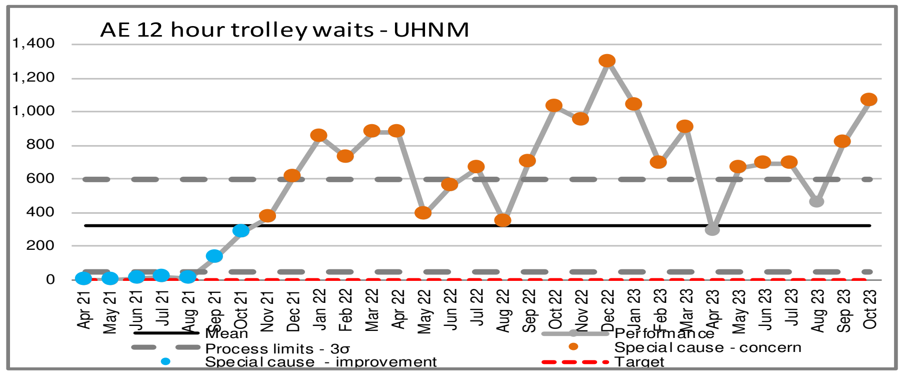




Variation		Assurance	
Target	**Aug 23**	**Sep 23**	**Oct 23**
30%	32.0%	31.4%	32.4%

Background

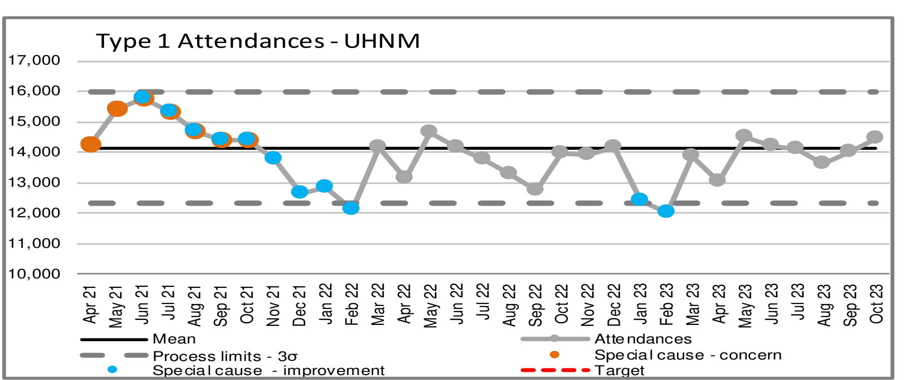
The percentage of patients who having attended the ED are admitted.



Variation		Assurance	
Target	**Aug 23**	**Sep 23**	**Oct 23**
0	456	811	1059

Background

Number of patients waiting 12 hours or more in A&E from the decision to admit time to the time of actual admission.

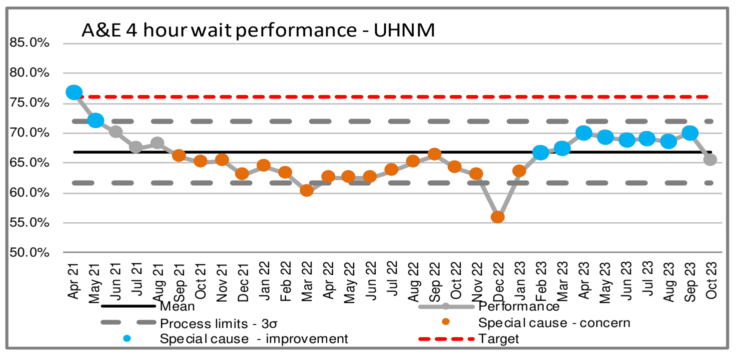


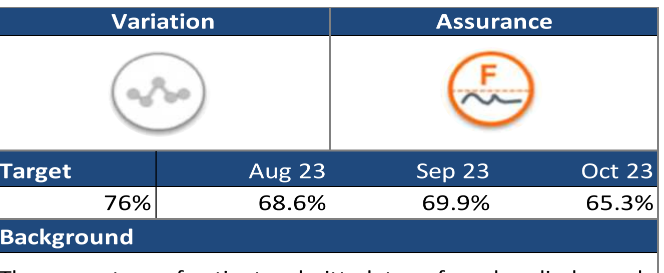
Variation		Assurance	
Target	**Aug 23**	**Sep 23**	**Oct 23**
N/A	13634	14005	14436

Background

Total ED attendances to Type 1 sites (Royal Stoke & County)

Non-Elective Care – Headline Metrics



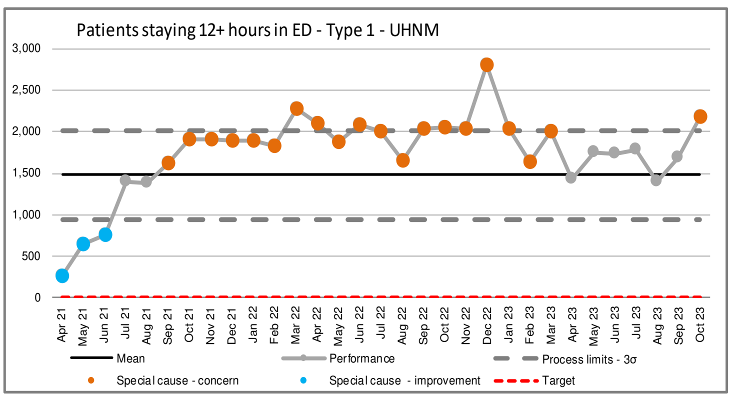


Variation		Assurance	
Target	**Aug 23**	**Sep 23**	**Oct 23**
76%	68.6%	69.9%	65.3%

Background

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

4 hour performance remains below the 76% target and has dropped below the two year average, but remains above October 2022 levels.



Variation		Assurance	
Target	**Aug 23**	**Sep 23**	**Oct 23**
0	1400	1691	2185

Background

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

What is the data telling us?

Patients waiting over 12 hours in ED increased by 29% in October compared to September and exceeded levels seen in October 2022.

Ambulance Handovers within 60 minutes - UHNM

Mean — Performance — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Variation		Assurance	
Target	**Aug 23**	**Sep 23**	**Oct 23**
95.0%	92.1%	85.8%	69.1%

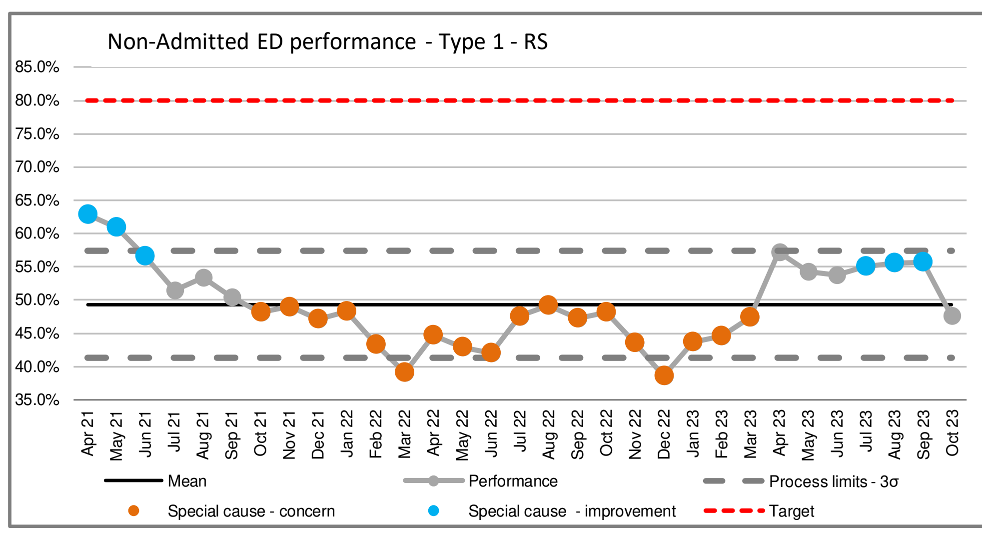
Background

The percentage of ambulance handovers completed within 60 minutes.

Ambulance handovers within 60 minutes performance dropped considerably in October. Whilst seeing a significant drop, this is similar to levels seen in October 2022.

Delivering Exceptional Care with Exceptional People

Workstream 1; Acute Front Door
RSUH ED Non Admitted 4 Hour Performance



Variation		Assurance	
Target	Aug 23	Sep 23	Oct 23
80%	55.6%	55.7%	47.6%

Summary

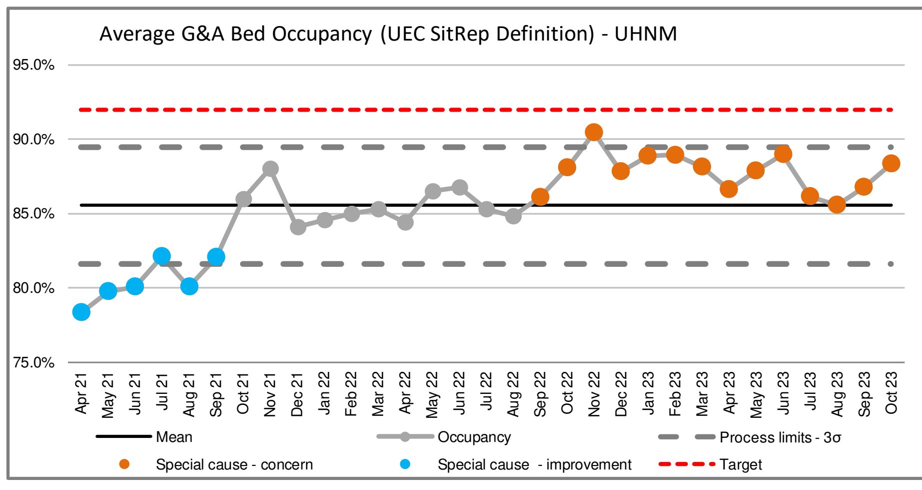
The 4-Hour Non-Admitted Performance was a financial year low of 47.6% for October impacted by the operational pressures and extreme departmental congestion which precipitated a Business Continuity Incident. This has improved following the completion of recent actions and the last reported week as of writing was 54.4% including a daily high of 67.0%.

Following the weeklong overnight manual productivity audit completed by the UEC Clinical Director it was determined that overnight teams are operating above national productivity benchmarks and are sufficiently resourced. Therefore, the priority should be ensuring as small a backlog as possible for the night shift.

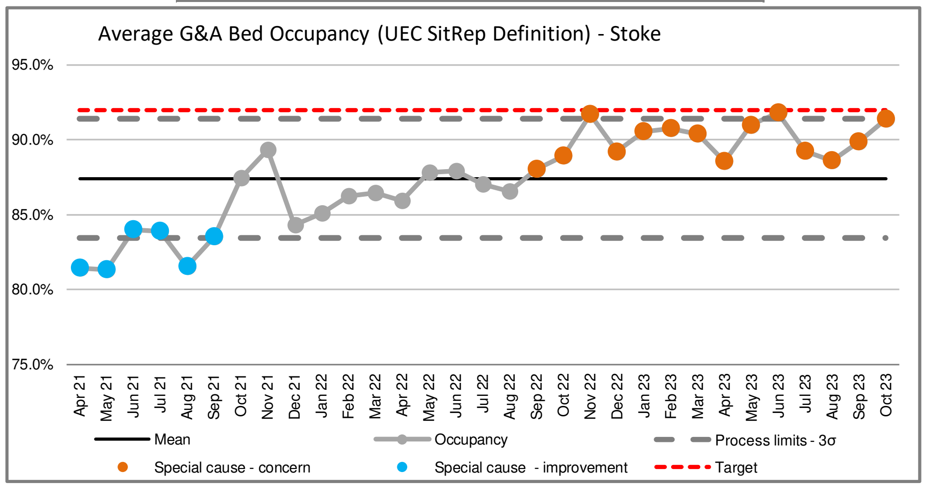
Actions

1. The Ambulatory CDU is now open to eight spaces for patients likely to be discharged but requiring additional investigatory time. While utilisation has been low it is expected that as this pathway embeds this will improve throughout November and December.
2. Progress Chasers have now been fully recruited to in order to provide 24/7 ED coverage with a focus on the Ambulatory area. Start dates are currently awaiting confirmation with December as the target month.
3. The Capacity & Demand tool is now in its final stages of development which will support the alignment of departmental staffing to expected demand and provide an operational view of expected bottlenecks and risks to performance.
4. Revised staffing model providing a minimum of x2 SDM and x3 at times of peak demand with a supporting dedicated CED rota which will ensure allocated SDM are able to remain in their designated area. This has gone live this week following a pilot in the week prior and will continue to embed.
5. In order to drive performance improvement during the late afternoon and early evening the capacity of AEC will be increased to enable greater streaming. This will be achieved by creating two additional treatment rooms (January) which is frequently a rate limiting factor of flow, and additional medical support from 16:00 – 22:00 to drive throughput (December).

Workstream 2; Acute Patient Flow
UHNM G&A Bed Occupancy



Variation			Assurance
Target	Aug 23	Sep 23	Oct 23
92%	85.6%	86.8%	88.3%



Summary

UHNM G&A Bed Occupancy achieved 88.3% for October. This is in line with the submitted Annual Operational Plan trajectory of 88.6% and continues to place UHNM in the upper quartile regionally supported by County Hospital and Paediatric occupancy.

14+ Day LOS, 12 Hour Performance, and Category 2 Response Time (all closely linked to G&A Bed Occupancy) remain in the second quartile regionally demonstrating relative strong performance for patient flow particularly when factoring in Trust size.

It should be noted that it is expected that in December there will be an excepted further improvement to occupancy as the final winter escalation capacity comes online. This will be a relatively small increment given the large Trust denominator but should support continued alignment to trajectory.

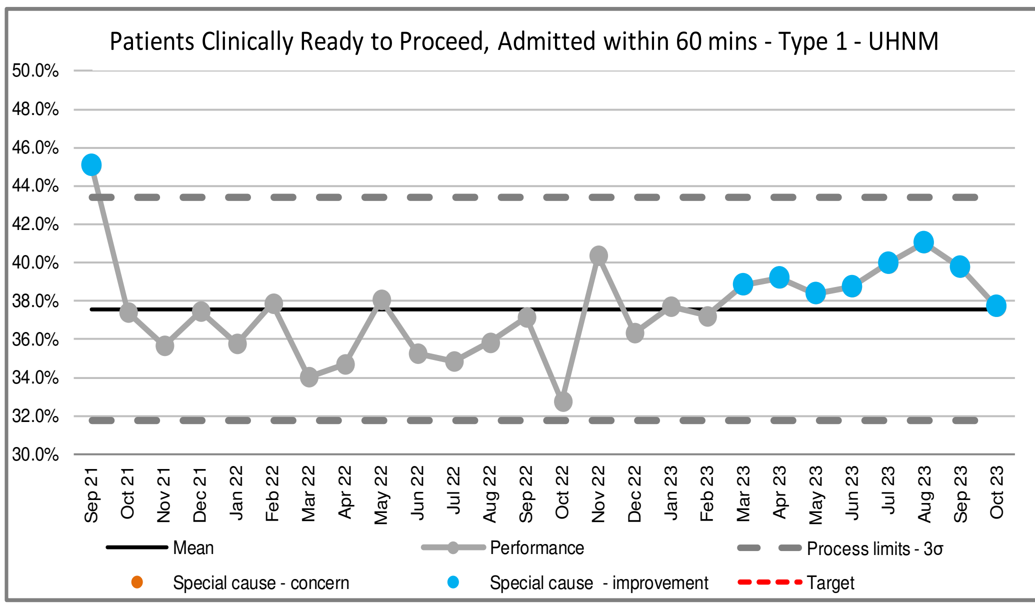
Actions

1. It has been announced that two years of non-recurrent funding is available to support Trust Bed Management. Options are currently under discussion for how to best utilise this sizeable opportunity.

2. The OPAT development as an agreed project plan targeting an additional acute bed equivalent benefit of fives beds per month through to March with further expansions in the new financial year. This is to be facilitated by a peer visit to Nottingham University Hospitals that currently have provision for 60 patients with a planned expansion for up to 90 patients.

3. Complete the NELIP Refresh exercise which includes a focus on Ward Standard Work. This will build on the existing Workstream 2 and ultimately target LOS and early discharges.

Workstream 3; Acute Portals & Navigation
CRTP+1



Variation		Assurance	
H		F	
Target	Aug 23	Sep 23	Oct 23
90%	41.0%	39.8%	37.7%

Actions

1. Retrospective audit underway of 45 frailty attendances to ED who were admitted to identify themes. Frailty ANP supporting the audit which is aimed to be completed by the end of November.

2. Each Division has refreshed CRTP+1 trajectories based on the Winter Plan. This has now been completed with the exception of Medicine who are in the process and aimed to complete in the first week of December.

3. Development of standard process for management and completion of discharge summary letters and TTO on AMU which is aimed to be completed by the end of November to support expedited and early discharge

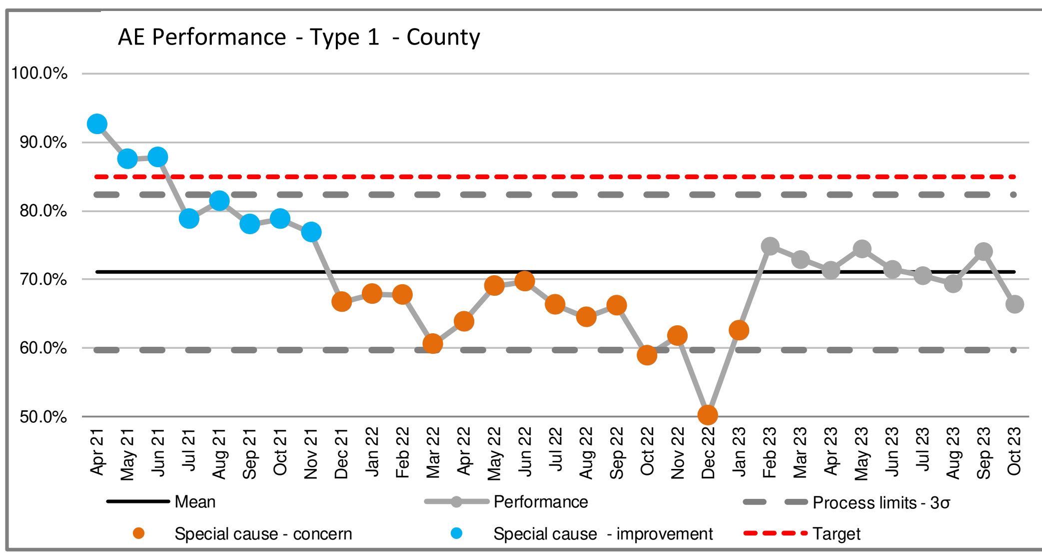
4. This Frailty TOC is continuing to understand and embed early improvements with an expansion currently in scoping in order to maximise the improvement opportunity. It was anticipated that KPMG support would be allocated to provide additional capacity to drive this transformational change however a decision on whether this can commence remains outstanding.

Summary

CRTP+1 performance was 37.7% in October from 39.8% in September and follows declining trend in performance seen in recent months following in similar fashion to last winter and aligned to congestion as a result of the known capacity and demand deficit. SDEC utilisation however continues to remain high in line with capacity expansion described in the Winter Plan.

The Integrated Discharge Unit formally Ward 80 (MFFD) and FEAU Test Of Change (TOC) is progressing with extremely positive results. Early outputs have so far indicated a 133% increase in TOC referrals (which were previously delayed), a 157% increase in discharges, a fivefold increase in reinstatements, and a zero tolerance to transfer to the MFFD deep bed base were evidence suggests LOS is lengthened.

Workstream 4; County Hospital UEC
County Hospital Four Hour Performance



Variation	Assurance		
Target	**Aug 23**	**Sep 23**	**Oct 23**
85%	69.4%	74.1%	66.4%

Actions

1. Review of AMU specific actions continues and is led by new the Clinical Champion and supported by Management Lead. Insights from this review will amend actions and drive improvement with Nursing and Clinical engagement.
2. 111 trial is implemented to support maximising streaming potential with ongoing monitoring and feedback in place via County Management Lead.
3. LOS reviews continue for long stay patients as part of wider LOS improvement standard work focussing on EDD, frailty scoring, and criteria to reside.
4. Following the insights session, it was agreed to explore the triage data to identify any further countermeasures, which is being explored/updated by the information team.
5. Review undertaken of all completed and open actions with revisions documented in revised A3 alongside outputs from the insights exercise.
6. CRTP+1 daily check and challenge is in place with management support at the huddles (Matron and support management).

Summary

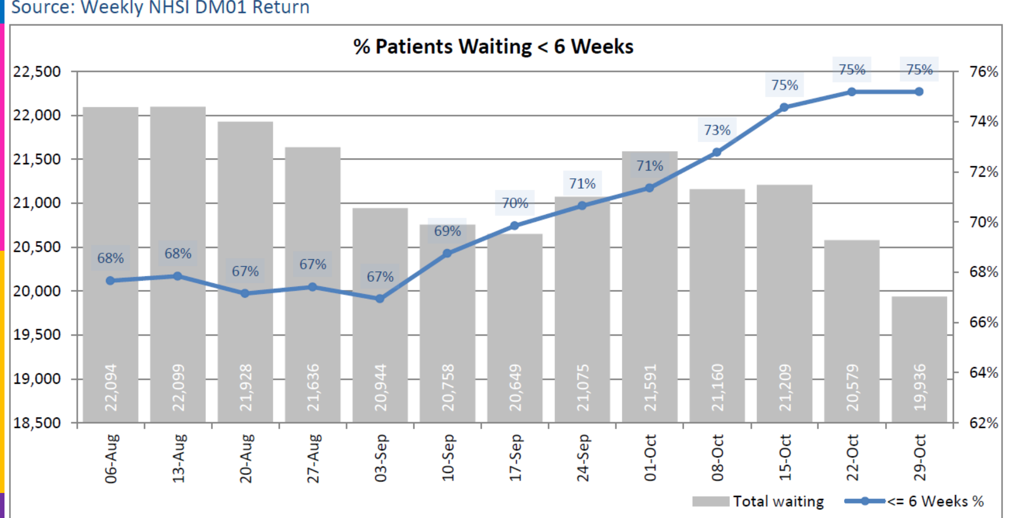
The driver metric of County Hospital Four Hour Standard for October was 66.4% against a trajectory of 85%. The actions identified will support accelerating potential improvement with a focus on triage times in the ED, and pre-noon discharges from the ward base, which are both key to unlocked improved Four-Hour Performance.

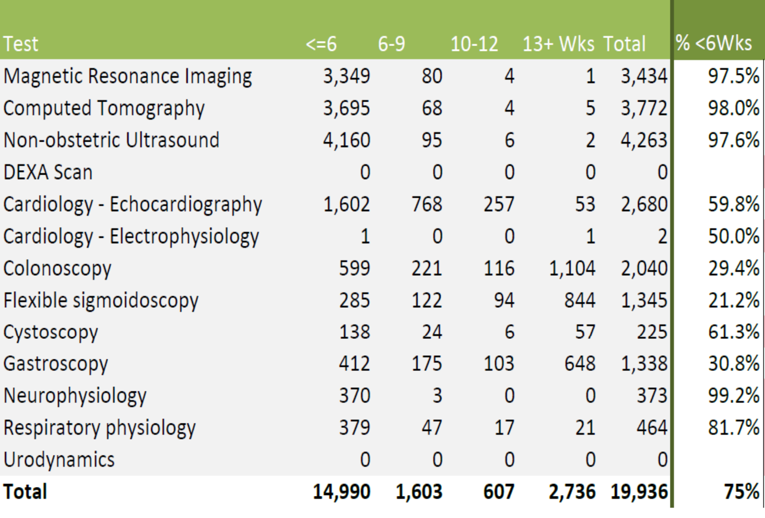
Section 2: ELECTIVE CARE

Planned Care - *Diagnostics*

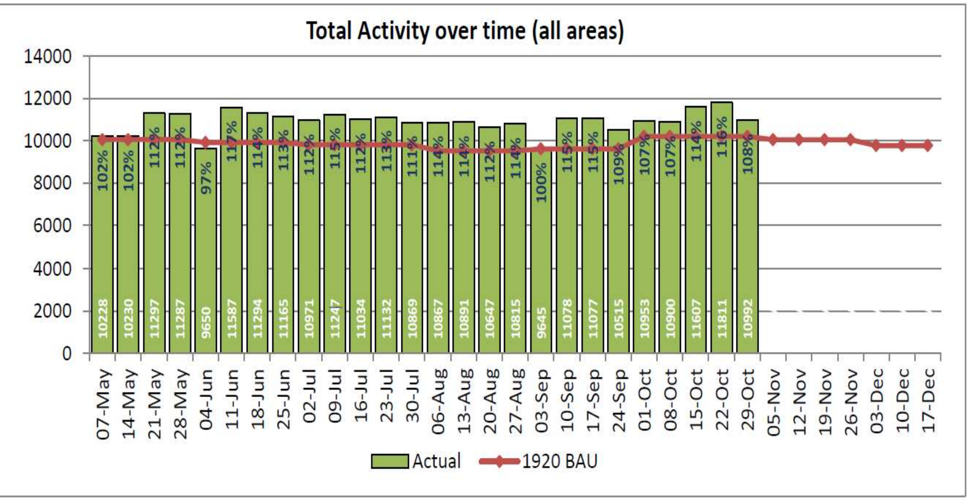
Diagnostic Waiting Times within 6 Weeks

Source: Weekly NHSI DM01 Return





Test	<=6	6-9	10-12	13+ Wks	Total	% <6Wks
Magnetic Resonance Imaging	3,349	80	4	1	3,434	97.5%
Computed Tomography	3,695	68	4	5	3,772	98.0%
Non-obstetric Ultrasound	4,160	95	6	2	4,263	97.6%
DEXA Scan	0	0	0	0	0	
Cardiology - Echocardiography	1,602	768	257	53	2,680	59.8%
Cardiology - Electrophysiology	1	0	0	1	2	50.0%
Colonoscopy	599	221	116	1,104	2,040	29.4%
Flexible sigmoidoscopy	285	122	94	844	1,345	21.2%
Cystoscopy	138	24	6	57	225	61.3%
Gastroscopy	412	175	103	648	1,338	30.8%
Neurophysiology	370	3	0	0	373	99.2%
Respiratory physiology	379	47	17	21	464	81.7%
Urodynamics	0	0	0	0	0	
Total	**14,990**	**1,603**	**607**	**2,736**	**19,936**	**75%**



Pathology*:*

The following represents performance as at 31st October 2023;

- **Urgent** (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day 15 (Previously Day 14), with 80% of cases reported by Day 9 (No Change)
- **Accelerated** (include all Cancer Resections): 95% reported at Day 25 (Previously Day 26), with 80% of cases reported by Day 15 (Previously Day 17)
- **Routine** (all Specimens not in above categories): 95% Day reported at 31 (No Change), with 80% of cases reported by Day 19 (Previously Day 17)

Our 7 day reporting turnaround time (TAT) for Urgent cases is at 62.3% against the Royal College of Pathologists' target of 80% within 7 days (67% previously)

Planned care - *Diagnostics*

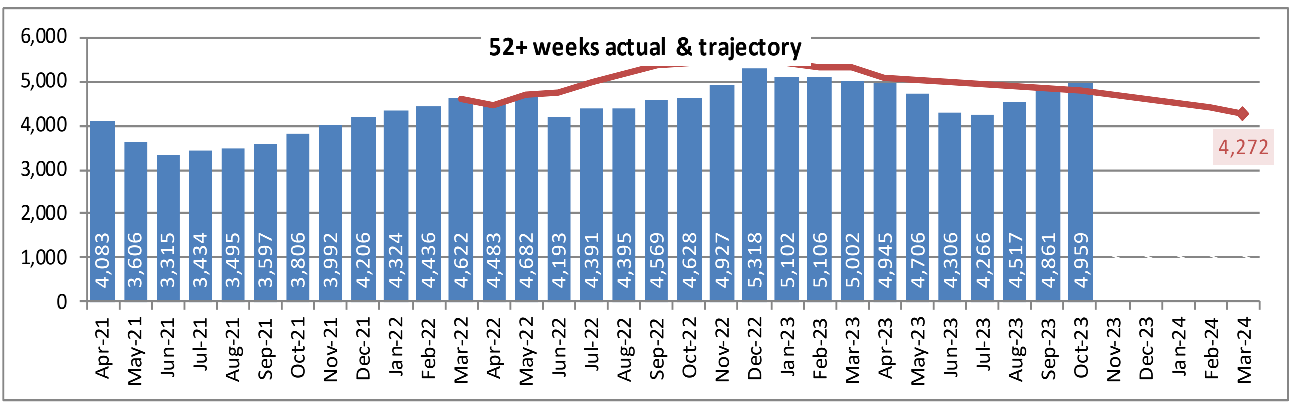
Diagnostics Summary

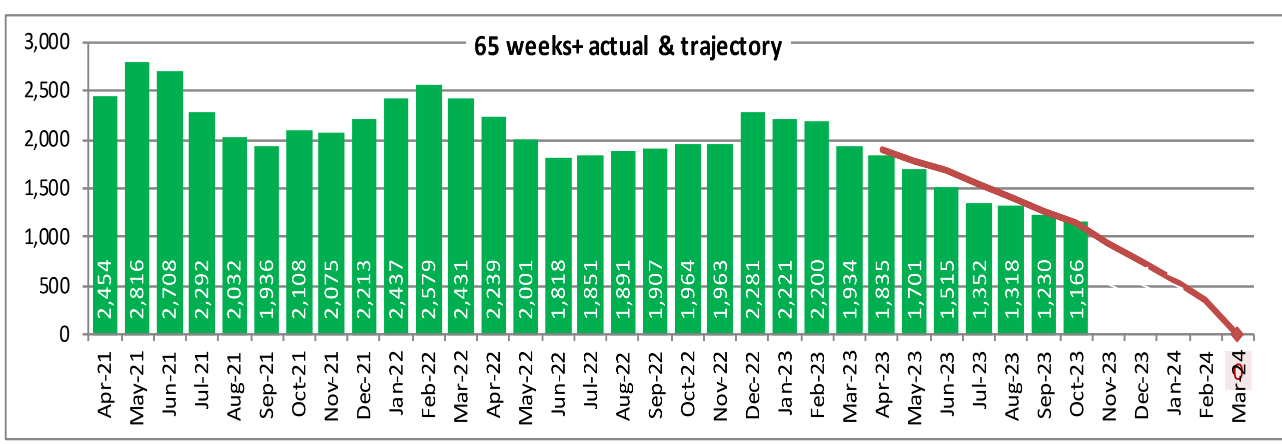
- DM01 activity in October remained above 19/20 levels.
- DM01 performance was 76% overall in October, an improvement of 1.1% from September (74.9%). Endoscopy performance is the main contributor to this performance being below the national target of 99%
- In pathology 7 day reporting turnaround time (TAT) for Urgent cases is at 62.3% against the Royal College of Pathologists' target of 80% within 7 days (67% previously)
- The DM01 position for non obs ultrasound has achieved the trajectory and delivered DM01

Endoscopy remains the highest impact on diagnostic pathways. The specialty has now been taken into internal special measures with a turnaround lead being allocated and a number of actions in place:

- Insourced weekend service continues until end Jan 2023 following external funding; further opportunities available for County site and a modular build; long term trajectory and business case under review prior to submission
- October saw first reduction in total number of patients waiting above their target date
- Service team continuing to work on demand management strategies and productivity measures to improve utilisation and appropriateness (including clinical audit, admin and clinical validation)
- Improved booking performance for lower cancer PTL patients – now 2-3wks notice (was 3 days)
- Booking team recruitment ongoing – 2 WTE vacancies following promotion within the team
  - Improvement plan ongoing and workstream leads progressing actions

Planned Care – *RTT*

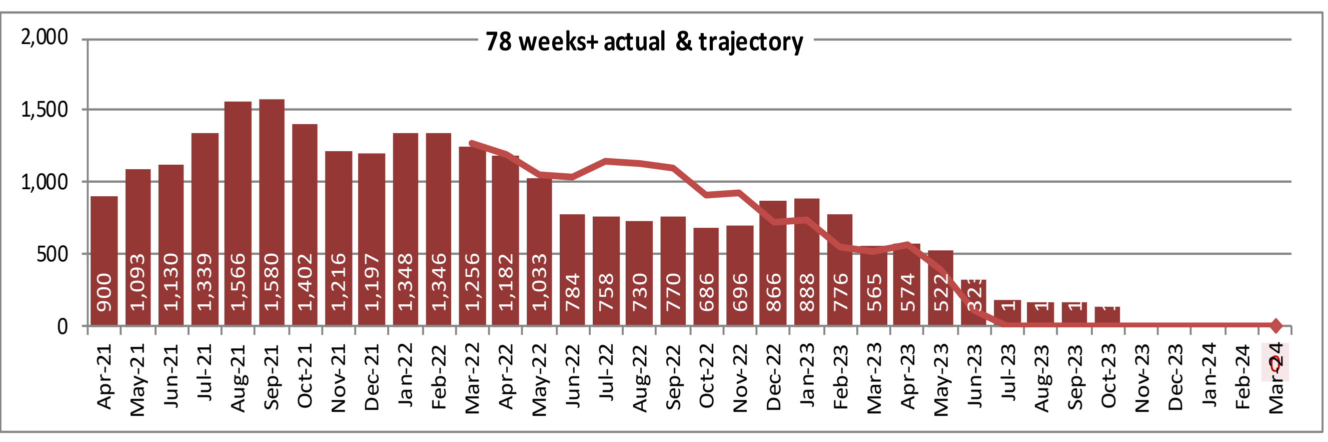




Patients waiting 52+ weeks increased further in October and exceeded the trajectory for the first time.

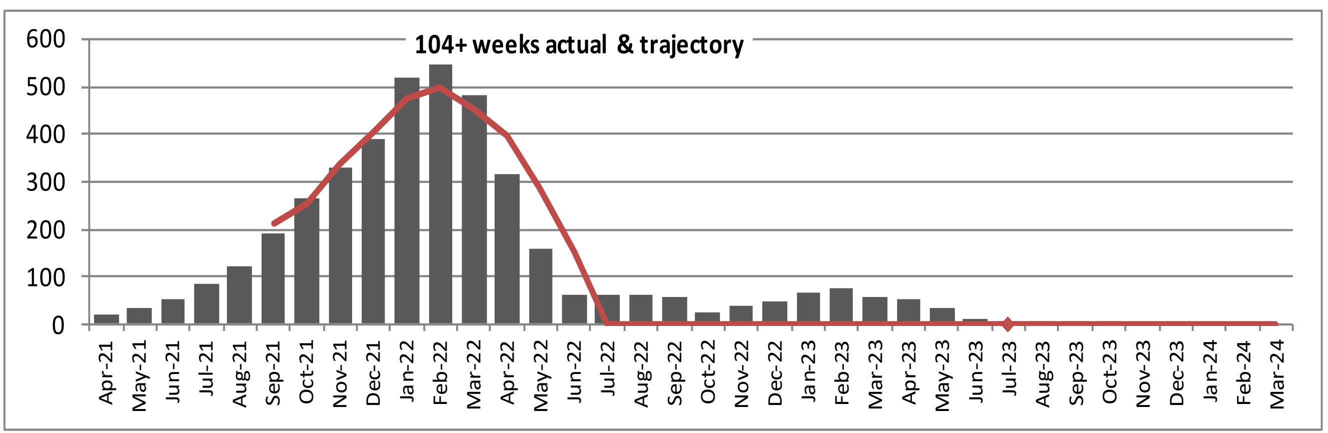
65+ week waiters continues to see a slow reduction and remains within trajectory.

Planned Care – *RTT Long Waiters*



The number of patients waiting over 78 weeks reduced by 34 in October, at 136.

October data is unvalidated.



There is one patient who has been waiting 104+ weeks in October.

Planned care - *RTT*

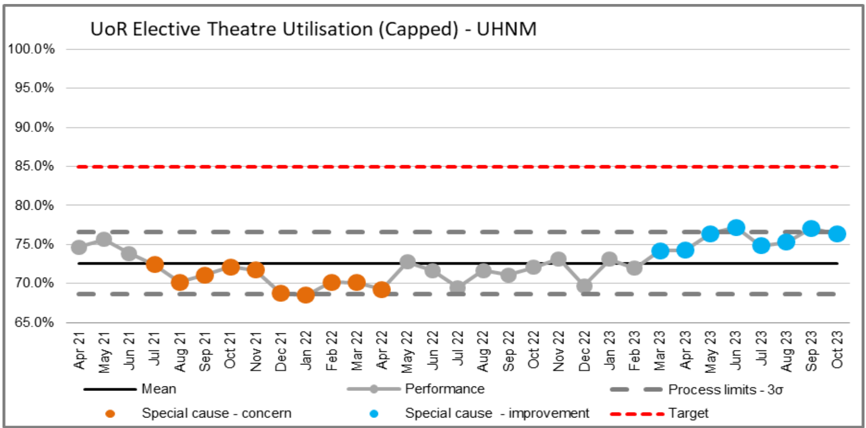
Summary

- 52+ week patients increased during October to 4,959.
- 78+ patients have been gradually reducing, but had reached a plateau in July at 186, this reduced to 177 for August, 170 for September and the validated number for October was 138.
- The trust did not achieve the national ask of eliminating 78 weeks waits by end of March 2023. Plans are in place to minimise the number of breaches, so that only patients who choose not to be treated before end of March or who have a highly complex case are still waiting at 78+ weeks. Trajectories have been shifting due to industrial action.
- The overall Referral To Treatment (RTT) Waiting list now sits 81,240 end of October (unvalidated).
- The focus continues on 78w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 65 week+ patients with the introduction of a weekly elective management oversight group.
- At the end of October the number of > 104 weeks was 1.
- The IS have taken over 700 patients from Orthopaedics & Spinal (out of over 1000 considered), with a further 120 patients being worked through to contact & transfer.

RTT

- Validation has increased slightly with some additional resource in the short term. The team are currently looking at validation capacity to provide an accurate picture of the resource required in the medium term to reduce the list, this includes electronic solutions.
- RTT Performance sits at 50.40% , a deterioration on 50.68% in September.
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.
- The Trust is currently at 85.2% of all pathways over 52 weeks having been validated within the last 12 weeks. This is a slight deterioration from 88.5% in September. The next national ask was to have all patients waiting longer than 12 weeks validated by 28th April 2023. The number currently not validated in the last 12 weeks is currently 40,775 , down from 42,824 in September.
- 31,068 eligible patients waiting 12+ weeks were sent a validation form in October 2023, with 1,532 patients confirming they no longer wish to continue their pathway. 2,990 patients said their condition had changed since their referral. These are being worked through by the clinical divisions.
- Trust wide revamp of validation & training underway, the IST are supporting the Trust with events in September – December to train all admin staff working with RTT.
- NHSE's RTT training lead to deliver lecture style training and engagement sessions with specialty groups to enhance shared knowledge and address issues where national rules are not always followed. Sessions commenced September 18th.
- RTT Training now available on 'Articulate' eLearning software.
- RTT Training Strategy to be refreshed and re-launched starting in January 2024.
- Active reporting focus on ensuring the right patients (urgent and longest waiters) are the patients booked into all available capacity so that the limited resource available continues to be used for the right patients by clinical need. This is being scrutinised through a divisional weekly meeting with COO/Deputy
- Patient by patient monitoring by each specialty and by the corporate team on the patients at risk of the breaching 104 and 78 weeks by end of month, and month following.
- Key enablers to the continued focus on long waiting patients are ring fencing of beds for Orthopaedics at RSUH, modular theatre at County and improvement in theatre utilisation and booking.
- Increased focus on non-admitted patients and increasing outpatient & diagnostic capacity, improving utilisation and business processes to move patients to a decision to admit.
- Roll-out of Palantir's Foundry platform underway, with working group to be up and running, expected to go-live November 21st.
- External validation support sought from MBI, commenced 4th October

Planned Care – *Theatres*

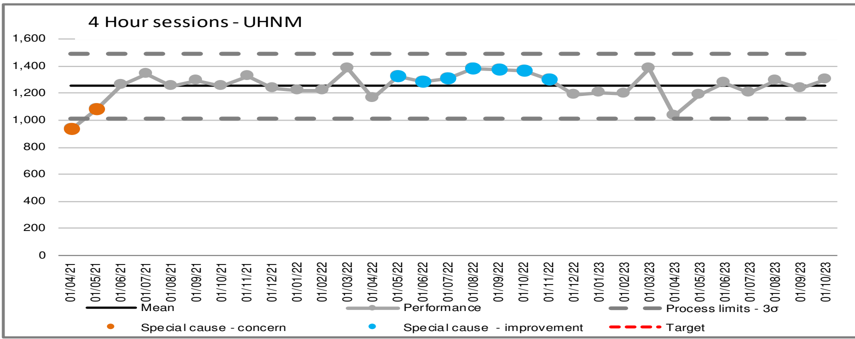


Variation	Assurance		
Target	Aug 23	Sep 23	Oct 23
85%	75.3%	77.1%	76.3%

Background

The percentage of theatre time used (capped).

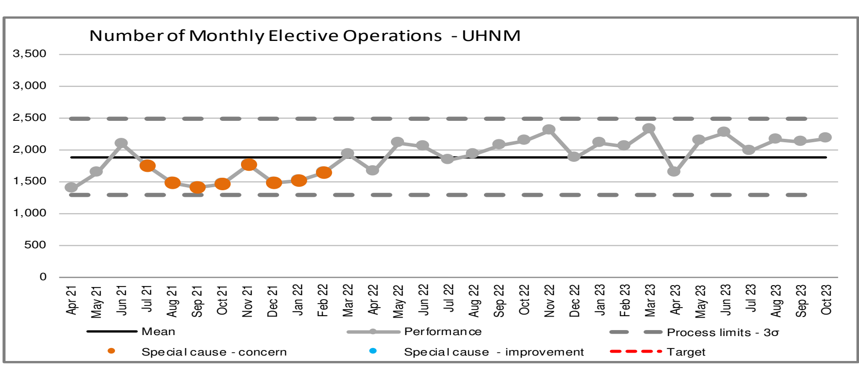
What is the data telling us?



Variation	Assurance		
Target	01/08/23	01/09/23	01/10/23
N/A	1292	1233	1302

Background

The number of 4 hour sessions during the month.



Variation	Assurance		
Target	01/08/23	01/09/23	01/10/23
N/A	2151	2125	2184

Background

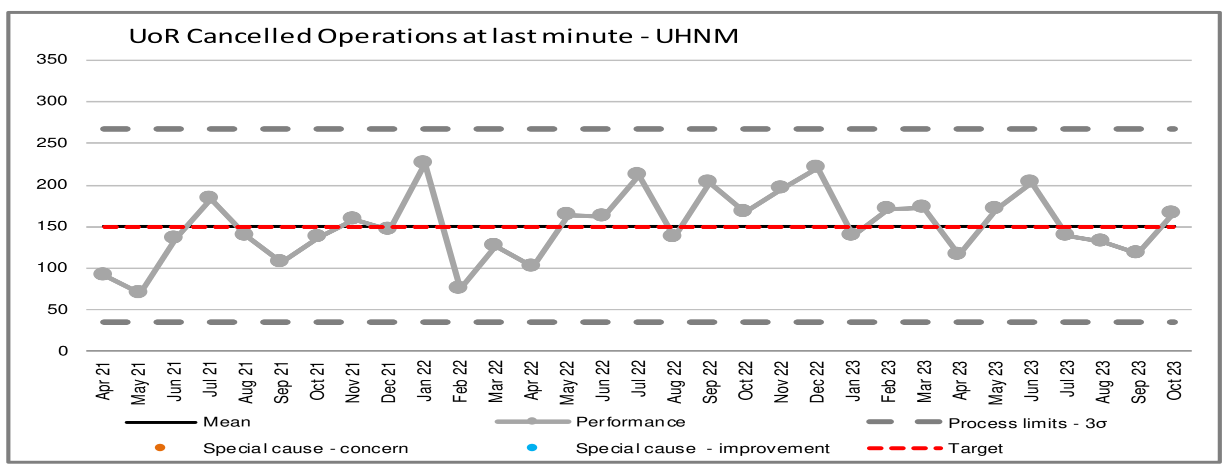
The total number of elective operations during the month.

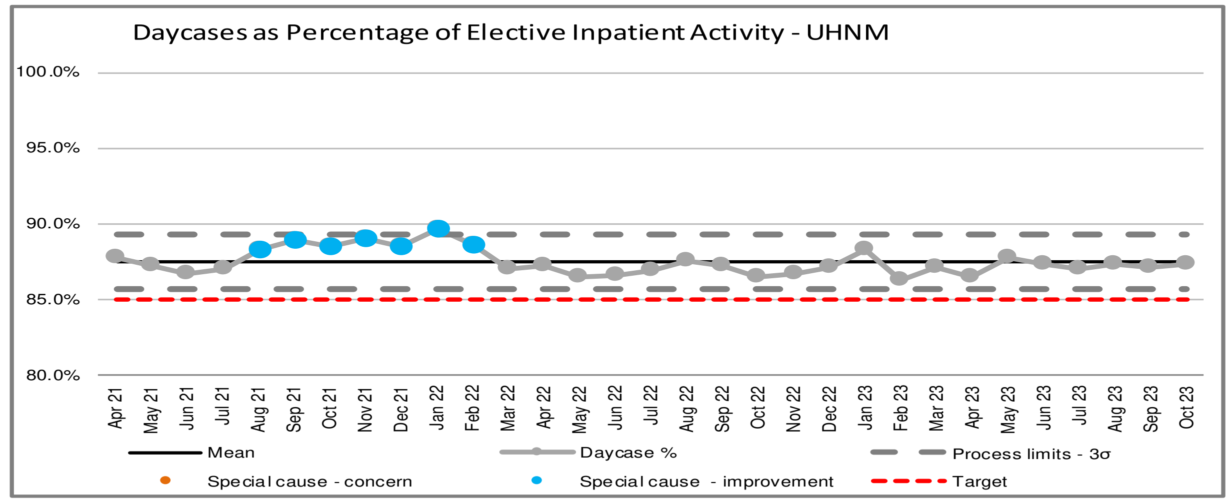
October saw a slight drop in Capped Theatre Utilisation at 76.3% against an 85% target and remains within control limits.

The number of 4 hour sessions has been relatively stable since May 2023 with levels aligned to the two year average.

Elective Operations have remained relatively flat since May and above the two year average.

Planned Care – *Theatres*





Following a reducing trend through the middle of 2023, October saw a 40% increase on September.

The proportion of Daycase activity continues to remain above the 85% target, *(total Trust split)*.

Planned Care - *Theatres*

University Hospitals of North Midlands NHS Trust

Elective inpatients Summary

- Capped utilisation & Case numbers remain above the annual mean although utilisation dropped slightly in October to 76.3%. Focused actions on scheduling and as part of High performing Theatre work are having positive effect.
- Benchmarking to MHS demonstrated improved performance with period w/e 8th October above national mean in quartile 3. Subsequent report shows an unexplained downturn believed to be an anomaly in reporting which is under investigation.
- Case numbers through theatres increased in October to 2184, above annual mean. Reported now excludes Plastics weekend SHS supported activity having moved to CTS

Actions

- 3rd Supported performance week w/c 5th November focusing on Data Quality and Theatre Flow / PACU delays . Aims to identify constraints and opportunities for further improvements in productivity.
- NHSE/UHNM combined Theatre Productivity Action plan continues to be developed and managed through fortnightly meetings.
- Introduction of “Standby” patient process in discussion with Urology
- NMHU activity now included in reported theatre data consistently demonstration >100% capped utilisation
- 2nd Theatre Scheduler taken up post in October provider greater opportunity for oversight of scheduling process.
- 6-4-2 oversight group established providing insight into 6-4-2 compliance

Planned Care – *Outpatients*

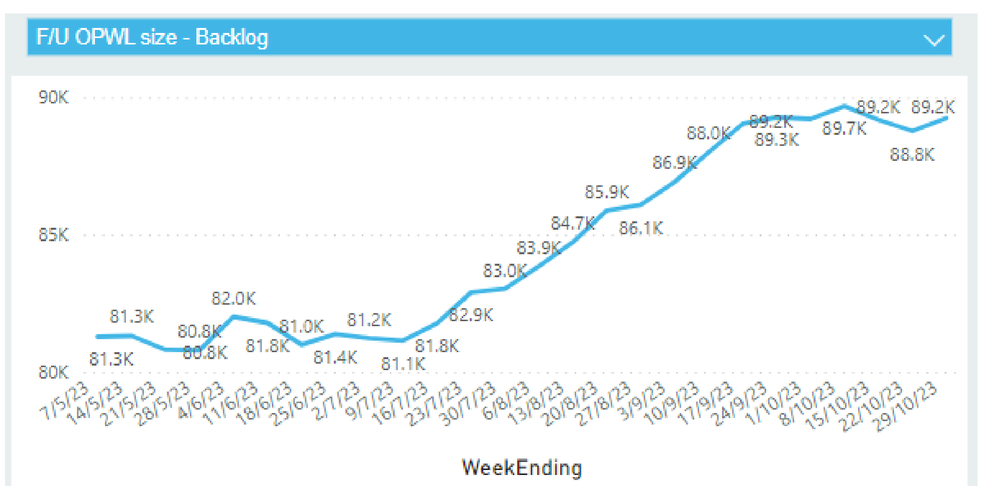
University Hospitals of North Midlands NHS Trust

New Outpatient Performance to Plan

2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10
97.97%	104.24%	89.37%	104.56%	101.20%	104.74%	87.16%	100.19%	98.31%	96.60%	95.13%	95.10%	92.64%

Follow Up Outpatient Performance to Plan

2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10
105.65%	113.36%	95.62%	108.56%	102.97%	104.33%	97.88%	111.50%	105.47%	100.49%	103.01%	100.78%	97.57%



New Outpatient activity performance was 92% of plan in October and 95% YTD. Outpatient Follow Up performance was 97% in October with YTD at 103%.

The Follow Up Backlog waiting list throughout October has remained relatively flat.

Planned care – *Outpatients*

Actions

- **OP Cell Programme Structure** - revised and reframed to focus on reducing follow ups without a procedure by 25%, reflecting the latest Elective Recovery Guidance ambition. Meetings with NHSE have confirmed main elements covered. OP Cell following A3 format, monitoring identified countermeasures. Key actions from Elective Care Review are incorporated, updates for these are reported to newly formed Elective Steering group.

  Risks: Business plans signed off include increase in follow ups, in part to clear follow up backlog.

  Clinically Led challenge required to facilitate clinical conversations and encourage engagement.

  Lack of pace on schemes linked to System Partners, escalated at Planned Care Improvement Board.

  PKB functionality to support waiting list validation and 2 way SMS: timeline risk

  Impact of Industrial Action (IA); cancelled OP sessions / attendances

- **Referral Management / Variation**

  Advice & Guidance - System Care Optimisation Steering Group re-launched. Referral Optimisation Data Pack from NHSE has been reviewed and validated with specialty data packs drafted for Cardiology, Derm, Gastro and Respiratory. UHNM supporting national discussions on the commissioning of Specialist Advice. System T&F group being set up (to include UHNM representation) relating to System Wide FAQ document for use of A&G, and related behaviours.

- **Activity Management / Variation**

  Patient Initiated Follow up (PIFU) - Benchmarking vs national median September – UHNM: 34th of 142 providers (4.3% vs 2.9%). Position Oct 2023: 5.1% following dip to 4.5% from July 2023 onwards; (relates to Unoutcomed activity in 2 specialties) post-reporting >5%. Clarifying reporting requirements for new CDS during 23/24 (will be OP only).

  'PIFU by Default' initiative – with NHSE support; clinical workshop held November 7th with Medical Director & Clinical Leads, incl reducing F Ups context. Well attended, with positive discussions – next steps include circulating pathways widely, and clinical discussion with 4 initial priority specialties.

  Outcomes; DQ are supporting, and have created clear escalation process. Tail broadly cleared, good progress on backlog of respiratory device pts (known temporary issue where cohort not high risk) and cardiology pacing patients. New iportal Outcomes form live 25th July 2023, supporting capturing of OP Procedures. Deputy Medical Director directive to clinicians for completion of all clinic outpatient outcomes via iportal by October unless agreed exception.

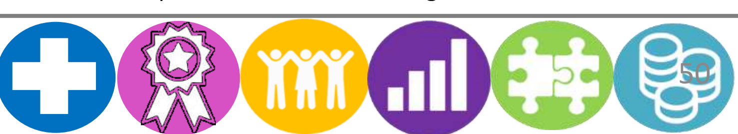
  OP Productivity; OP Cell Dashboard, plus booking & DNA Divisional / UHNM target & trajectories. Utilisation October 89.2% vs 90% plan. Focussed utilisation review at session code level with each specialty continues, plus review of clinic flag process. 2 Way Messaging will help DNA reduction (see risks).

- **Key Enablers**

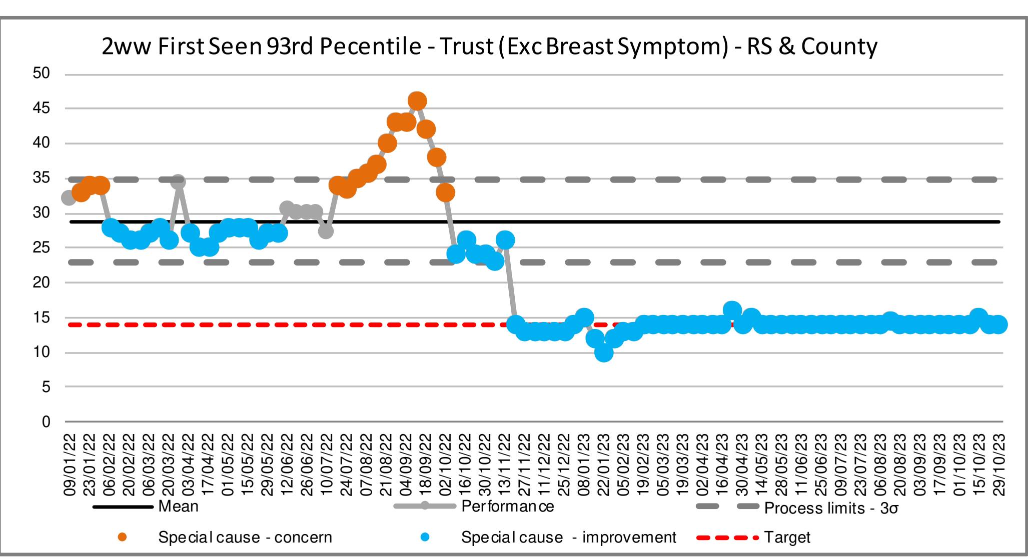
  GIRFT Further, Faster – UHNM participating as a cohort 2 Trust. Sharing handbooks and onboarding meetings with clinical & mgt specialty teams. Will include progress to date vs OP GIRFT Specialty Guidance, PIFU by Default approach & potentially 'Super Clinics'.

  Digital Enablers

  - **Robotic Process Automation (RPA); OP Outcomes** c.200K attendances annually with 'simple' outcomes eg discharge, could be completed via RPA. Robot-funding discussions with IM&T for RPA. Business Case being drafted, clarifying best way forward. & **RPA; PIFU Discharge Letters (at Review Date) –** Controlled go-live successful in Urology, live from September; specialty-by-specialty rollout plan agreed with Divisions & BI by Feb/March 2024.
  - **Patient Portal (PKB)**; IM&T included at OP Cell for updates. Digital letters live from June 2023 with patient letter to encourage enrolment.



Cancer – Headline metrics



Variation	Assurance

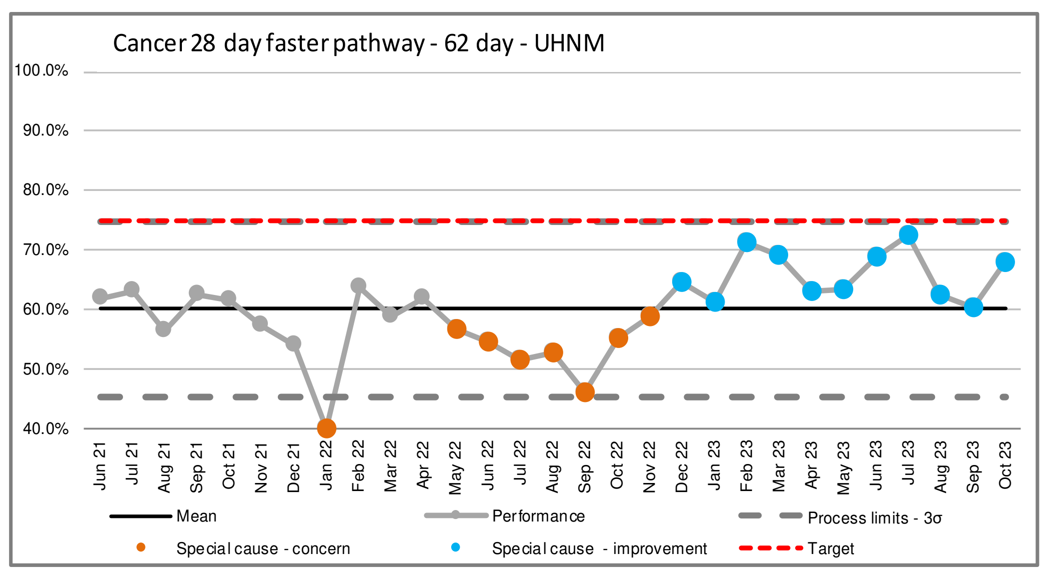
Target	15/10/2023	22/10/2023	29/10/2023
14	15	14	14

Background

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

What is the data telling us?

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



Variation	Assurance

Target	Aug 23	Sep 23	Oct 23
75%	62.6%	60.3%	67.9%

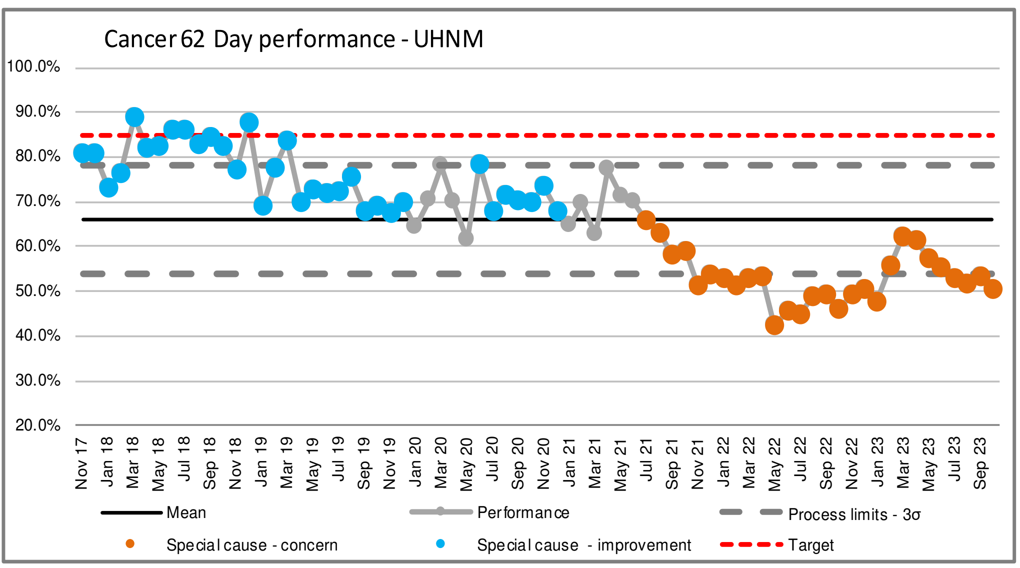
Background

Performance of confirmation or exclusion of cancer communicated with patients within the 28 day timeframe.

What is the data telling us?

The FDS performance remains stable with pockets of good practice. E.g. Breast, Lung and Upper GI all achieve the standard . The September position landed at 60.3% - October is currently incomplete.

Cancer – Headline metrics



Variation	Assurance

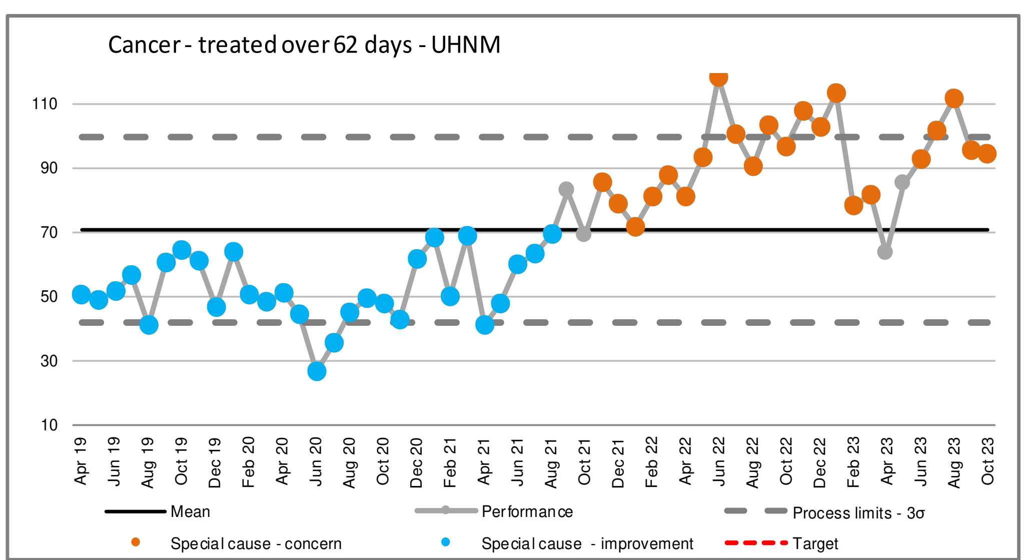
Target	Aug 23	Sep 23	Oct 23
85%	51.7%	53.2%	50.4%

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 significantly challenged and below standard for the past 12 months with a steep decline in May21 and landed at 52% in September 23, the October 23 position is still being validated.



Variation	Assurance

Target	Aug 23	Sep 23	Oct 23
N/A	112.0	96.0	94.5

Background

The number of patients treated over 62 days

What is the data telling us?

Demonstrates total volume of patients who have been treated beyond day 62 is a cause for concern and has been rising over the past 12 months. As the trust has significantly reduced the backlog of patients waiting, the volume of patients treated over 62 days has reduced in September 23.

Cancer Actions

- The impact of strike action is demonstrated across all pathways and has lengthened most activity in-between referral to treatment.
    - Radiology reporting capacity - CT / CTC / MRI waits have grown to 4 weeks
    - Pathology reporting capacity – 95% of cancer specimens are reported by day 19
    - Waits for consultants to review results have grown as their capacity is impacted by IA
    - Reduced outpatient capacity due to IA has impacted high volume tumour sites such as Skin
    - MDT discussions have been rearranged or deferred, lengthening pathways
    - Increasing administration burden on Ops and cancer service teams due to above
- NHSE National Cancer team deepdive at UHNM provided feedback on a well structured governance process for managing PTLs. The team reported good data analytics available to guide discussions and escalations relating to cancer patients and their priority across the trust.
- Cancer navigators have been implemented across the trust to be the first point of contact for patients on a cancer pathway and streamline the referral to treatment timelines.
- Granular analysis of BPTP milestones achievement has been completed by cancer services to inform targeted pathway improvement efforts. The analysis breaks down turn around times on each element of the pathway i.e. from test request, to test performed, to test reported. This shows 'hot spots' of the pathway will support PRM conversations and additional capacity business cases / bids.
- Support has been enlisted from the National Cancer Team (NHSE) to support a deep dive in to Colorectal and skin specific pathways, due 18/10, with the aim of spotting any further improvement opportunities.
- Across relevant pathways, front end referral triage has been implemented, with 7 day KPIs met for most patients.
- For increased Radiology reporting capacity to support cancer pathways, TIs are being offered, in addition recruitment is underway for an additional fellow, plus a review of outstanding reports and allocation / escalation is continuous.
- There are a growing number of patients waiting for surgical treatment on the Urology pathway. Surgical capacity for RALPs at SaTH is being utilised. Further to this, mutual aid and internal theatres solutions such as reallocation, are being explored.
- The Elective Oversight framework supports theatre allocation with exec scrutiny on pressured pathways.
- There is an expected bottleneck in demand for colorectal surgical procedures, as the endoscopy booking backlog is cleared. To tackle this, additional activity plans have been submitted to meet the increasing pace in Endoscopy. E.g Surgical TIs / weekend lists to run the remainder of the year.
- FDS improvement plan, with support from commissioners, focusing on improved direct access to pre-requisite tests for GPs and referral optimisation is being worked through. There is the opportunity to expend the LGI referral hub to include all cancer referrals, requiring local ICB agreement.
- WMCA funding has been requested to support all of the above recovery initiatives with a focus on most pressured areas; Endoscopy, Radiology, Colorectal, Skin and Urology. Bids have been approved for all of the above and spending plans are being enacted.
- PTL meetings continue to highlight and escalate pressures and support the prioritisation of patients through pathways across the trust.
- Analysis on patients who are FIT negative but sent for Colonoscopy has been completed. Around 25% of referrals received on the lower GI 2WW pathway are FIT negative however are within the exclusion criteria agreed with commissioners (IDA, Rectal Bleeding), demonstrating appropriate use of the pathway and endoscopy capacity.

Cancer Trajectories

- National planning guidance 23/ 24 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. This was based on a fair share total allocated to Trusts, shown in green on the graph below. An internal PTL Backlog trajectory for UHNM is shown by the green dotted line below, which was revised and modelled to bring us back in line with the fair share target by March 24, taking into account the unpredicted workforce challenges in Endoscopy.
- The actual total of patient waiting over 62 days on a 2WW pathway are shown in blue below, and are a snap shot in time of the PTL position. This is for the week ending 05.11.23.
- UHNM provide assurance to the regional NHSEI team, with detailed plans on a weekly basis. Tiered Progress to date:
    - The 62 day backlog has reduced to a current position of 420.
    - The number of days waited for 1st OPA (93rd Percentile) has reduced to within target of 14 days.
    - The total PTL has reduced by around 2300 since August. 22 and is currently at around 3600.
    - The number of patients waiting over 104+ has halved to a current position of 128.
    - The Faster Diagnosis Standard was submitted at a final September 23 position of 62%

Trust 62+ Trajectory

600
500
400
300
200
100
0

30/04/2023 31/05/2023 30/06/2023 31/07/2023 31/08/2023 30/09/2023 31/10/2023 30/11/2023 31/12/2023 31/01/2024 29/02/2024 31/03/2024

Trust Backlog
Trust Fair Share
Trust Revised Trajectory

Inpatient and Outpatient Decile & Ethnicity

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

Inpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.01%	9.81%	9.23%	7.66%	7.77%	11.15%	11.99%	10.37%	13.31%	6.99%	0.70%
Weeks Waited- 78-104	13.10%	11.76%	8.02%	9.63%	7.49%	11.76%	9.36%	10.61%	11.50%	5.97%	0.80%
Weeks Waited- 52-77	14.11%	11.14%	10.48%	9.81%	7.98%	11.18%	9.35%	8.45%	10.98%	5.12%	1.40%
Weeks Waited- Under 52	13.58%	11.23%	10.24%	9.03%	7.36%	11.01%	10.48%	9.06%	11.15%	5.53%	1.33%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	10.65%	9.74%	9.19%	9.00%	7.84%	11.03%	11.50%	10.11%	13.29%	6.57%	1.08%
Weeks Waited- 78-104	11.70%	10.72%	9.65%	8.74%	7.65%	10.83%	11.36%	9.72%	12.09%	6.08%	1.45%
Weeks Waited- 52-77	12.76%	10.77%	10.07%	8.84%	7.86%	11.12%	10.36%	9.24%	11.65%	6.05%	1.28%
Weeks Waited- Under 52	13.34%	11.42%	10.10%	8.88%	7.50%	10.47%	10.49%	9.08%	11.30%	5.95%	1.48%

Inpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.17%	0.48%	0.08%	0.39%	0.34%	0.64%	0.03%	0.11%	0.25%	0.39%	0.45%	0.20%	0.03%	92.90%	0.36%	1.01%	1.87%	0.31%
Weeks Waited- 78-104	0.18%	0.62%	0.09%	0.62%	0.62%	0.89%	#N/A	#N/A	0.09%	0.53%	0.89%	0.18%	#N/A	90.73%	0.53%	1.25%	1.16%	1.25%
Weeks Waited- 52-77	0.40%	0.77%	0.40%	0.83%	0.47%	1.53%	0.10%	0.10%	0.10%	0.43%	1.66%	0.43%	0.07%	86.09%	0.40%	2.46%	1.70%	#N/A
Weeks Waited- Under 52	0.51%	0.76%	0.27%	0.74%	0.55%	1.64%	0.16%	0.22%	0.14%	0.51%	1.57%	0.28%	0.18%	83.84%	0.31%	2.64%	2.21%	3.23%

Outpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.31%	0.41%	0.24%	0.43%	0.51%	0.86%	0.16%	0.13%	0.13%	0.59%	1.42%	0.29%	0.14%	0.16%	88.37%	0.39%	2.35%	1.95%	1.19%
Weeks Waited- 78-104	0.51%	0.47%	0.20%	0.67%	0.65%	1.35%	0.11%	0.11%	0.17%	0.66%	1.23%	0.28%	0.17%	0.15%	86.26%	0.40%	2.52%	1.94%	2.18%
Weeks Waited- 52-77	0.38%	0.70%	0.19%	0.62%	0.60%	1.12%	0.17%	0.13%	0.18%	0.56%	1.69%	0.35%	0.14%	0.21%	83.41%	0.27%	3.16%	2.62%	#N/A
Weeks Waited- Under 52	0.58%	0.72%	0.23%	0.66%	0.60%	1.31%	0.16%	0.17%	0.14%	0.66%	1.85%	0.33%	0.17%	0.24%	82.50%	0.28%	3.23%	2.57%	#N/A

APPENDIX 1

Operational Performance

Constitutional star

Metric	Target	Latest	Variation	Assurance	DQAI
Percentage ... Handovers within 15 minutes			L		
Ambulance handovers greater than 60 minutes	1	1	L	F	
Time to Initial Assessment - percentage within 15 minutes	85%	53.50%		F	
Average (mean) time in Department - non-admitted patients	180	286		F	
Average (mean) time in Department - admitted patients	180	412	H	F	
Clinically Ready to Proceed	90	514	H	F	
12 Hour Trolley Waits	0	1059	H	F	
Patients spending more than 12 hours in A&E	0	2185	H	F	
Median Wait to be seen - Type 1	60	115		F	
Bed Occupancy	92%	88.35%			
Cancer 28 day faster pathway	75%	67.92%	H	F	
Cancer 31 Day Combined	96%	87.46%		F	S T A R
Cancer 62 Day Combined	85%	57.01%		F	
2WW First Seen (exc Breast Symptom)	93%	94.86%	H	?	

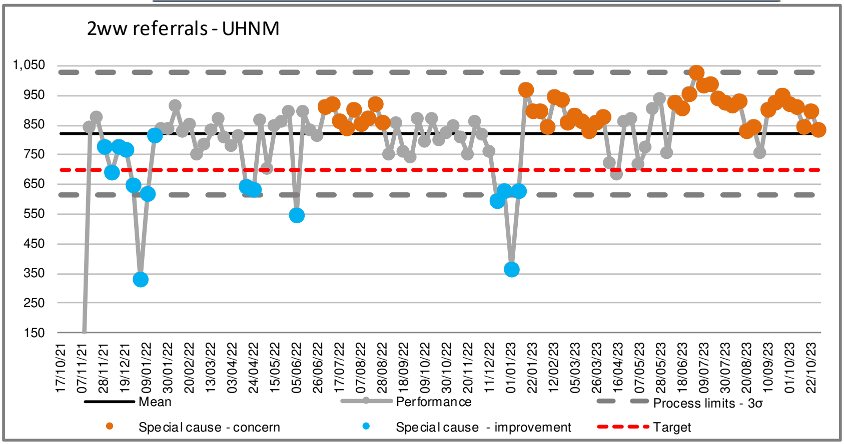
	Metric	Target	Latest	Variation	Assurance
	...of	7%	7.5%	L	?
Use of Resources	Cancelled Ops	150	165		?
	Theatre Utilisation	85%	80.5%		
Inpatient / Discharge	Same Day Emergency Care	30%	36%	H	?
	Super Stranded	183	178	L	?
	MFFD	100	95	L	?
	Discharges before Midday	25%	20.4%		F
	Emergency Readmission rate	8%	10.6%	L	F
Elective waits	RTT incomplete performance	92%	51.06%	L	F
	RTT 52+ week waits	0	4959	H	F
	Diagnostics	99%	75.97%	H	F

Cancer – 62 Day

Target	Aug 23	Sep 23	Oct 23
700	845	894	833

Background

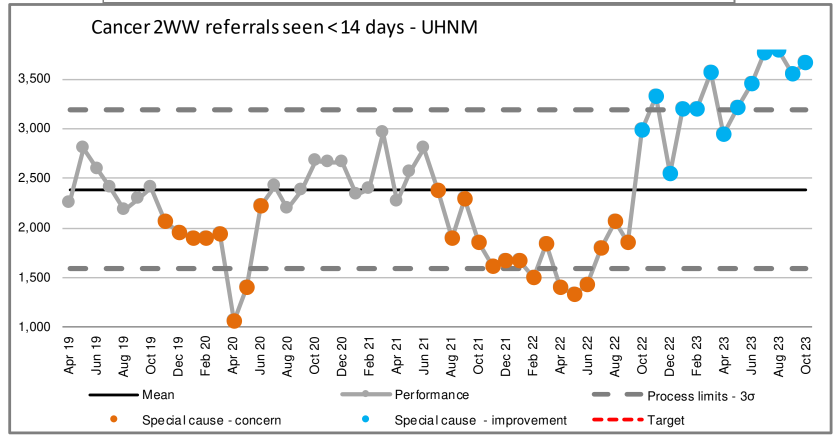
The number of patients referred on a cancer 2ww pathway.



Target	Aug 23	Sep 23	Oct 23
N/A	3797.0	3556.0	3671.0

Background

The percentage of patients waiting over 18 weeks for treatment since their referral.



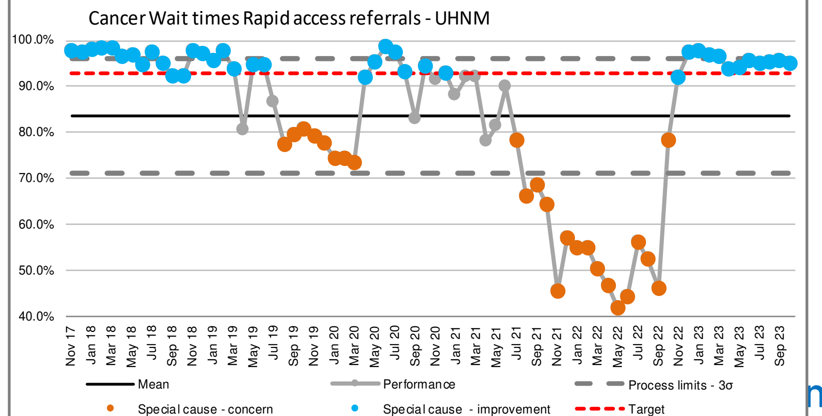
Target	Aug 23	Sep 23	Oct 23
93%	95.4%	95.7%	94.9%

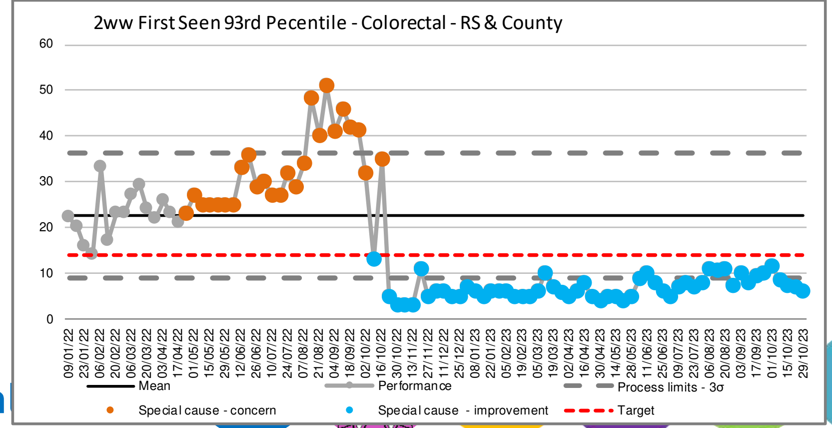
Background

% patients referred on a cancer 2ww seen by a specialist within 2 weeks of referral from GP

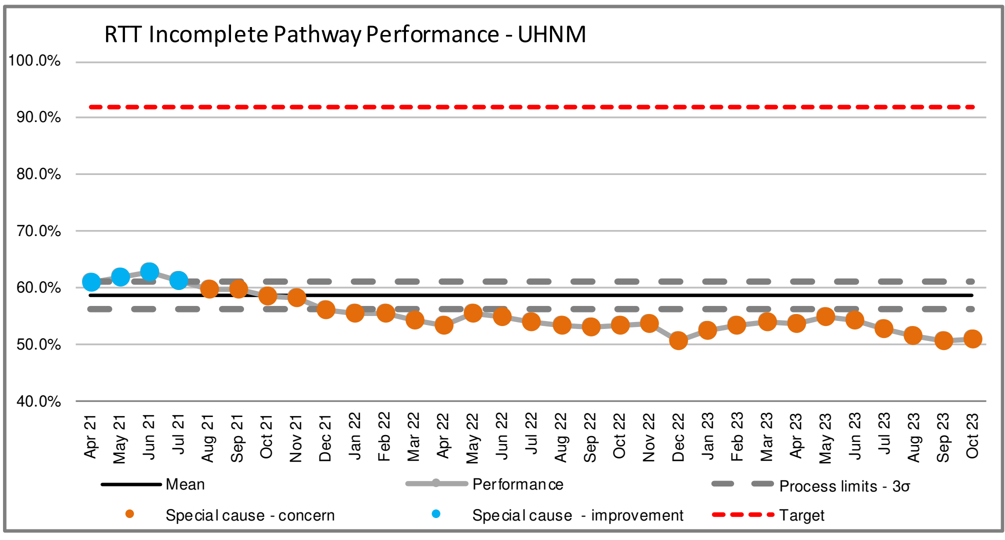
Variation	Assurance

Target	Oct 23	Oct 23	Oct 23
14	7	7	6





Referral To Treatment



Variation	Assurance

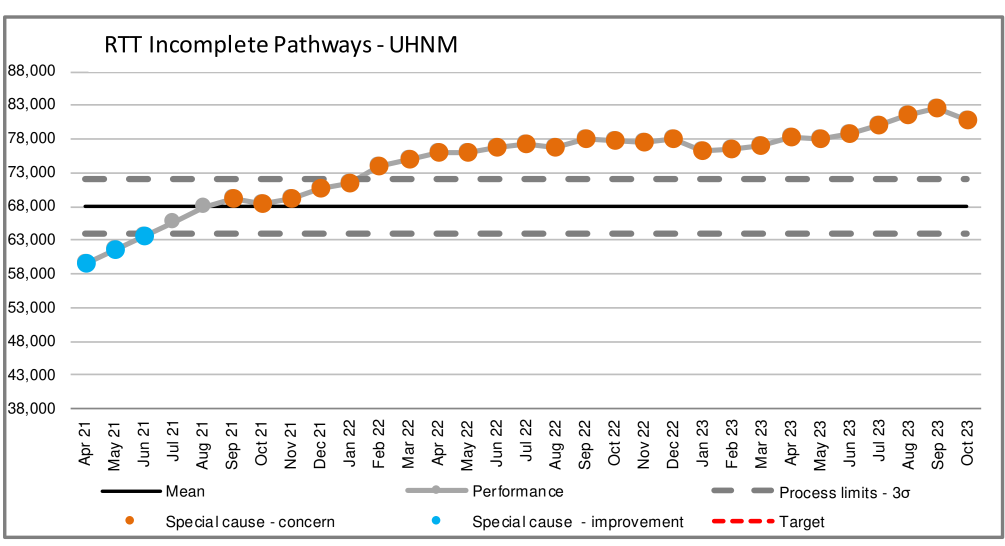
Target	Aug 23	Sep 23	Oct 23
92%	51.6%	50.7%	51.1%

Background

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

What is the data telling us?

RTT performance improved marginally in October following a deteriorating trend throughout the summer period.



Variation	Assurance

Target	Aug 23	Sep 23	Oct 23
N/A	81510	82469	80848

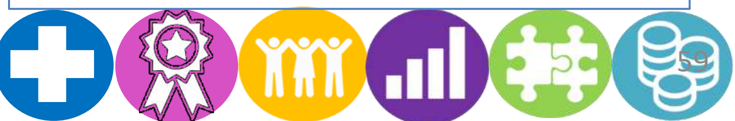
Background

The number of patients waiting over 18 weeks for treatment since their referral.

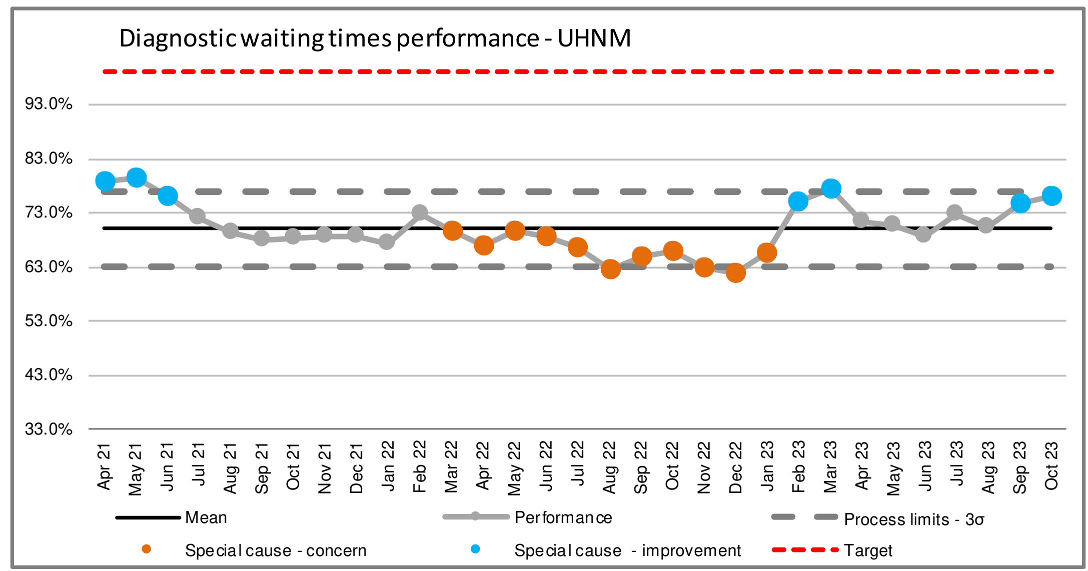
What is the data telling us?

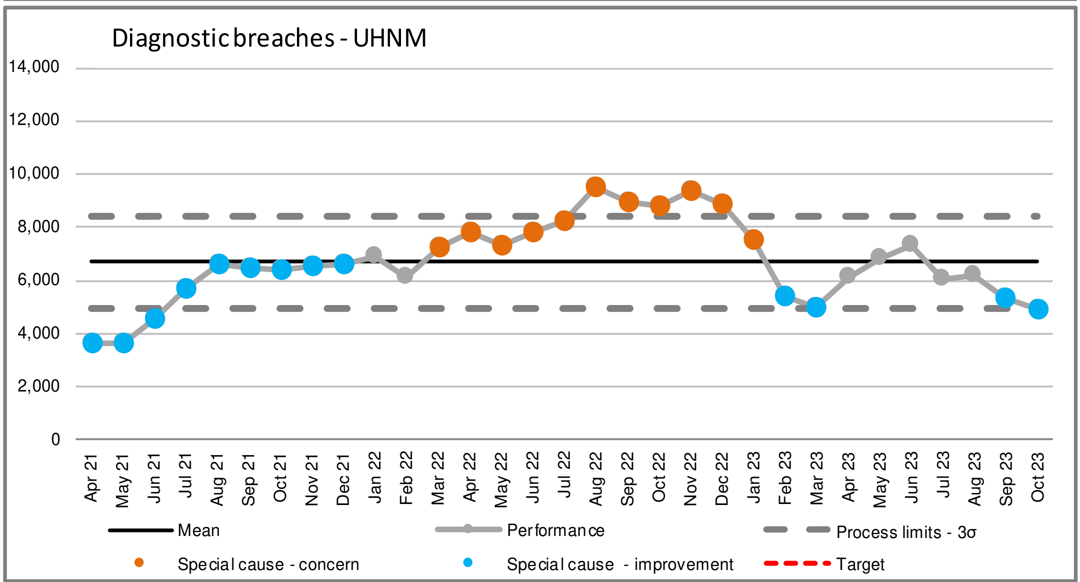
Following an increasing trend during 2023, October saw a reduction for the first time. Reduction of c1600 cases since September.

Delivering Exceptional Care with Exceptional People



Diagnostic Standards





Variation	Assurance
H	F

Target	Aug 23	Sep 23	Oct 23
99%	70.3%	74.9%	76.0%

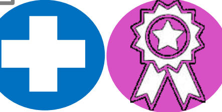
Background

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

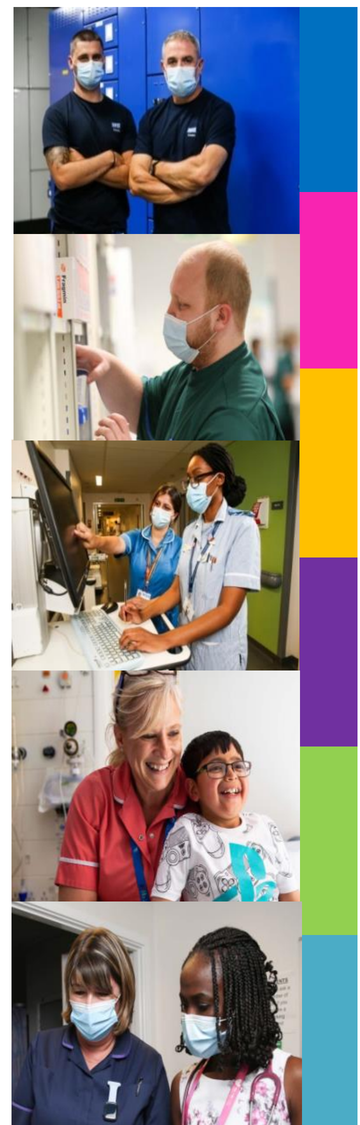
What is the data telling us?

Waiting time performance saw a further improvement in October, reaching the upper control limit.

The volume of breaches has seen a reducing trend which has continued in October.



UHNM Benchmarked Performance



Contents

Section		Page
1.	Quick guide ➢ Understanding the Tables ➢ Understanding the charts	2
2.	Urgent Care	4
3.	Cancer	11
4.	Referral To Treatment	15
5.	Diagnostics	19

Delivering Exceptional Care with Exceptional People

UHNM Benchmarked Performance – *understanding the Tables*

Performance

Key Performance Indicator	Period	Target	🏆	SPC	
A&E - 4 Hour Standard	Apr 22	95.00%	62.5%	L	19
A&E - DTA to Admission >4 Hours	Apr 22	10.00%	36.9%	H	52
A&E - Left Without Being Seen	Mar 22	5.00%	8.6%	H	17
A&E - Time to Initial Assessment	Mar 22	15.0	9.0	H	61
A&E - Time to Treatment	Mar 22	60.0	106.0	H	35

What Percentile is my Trust in?
100 = best
1 = worst

quartiles are colour coded also

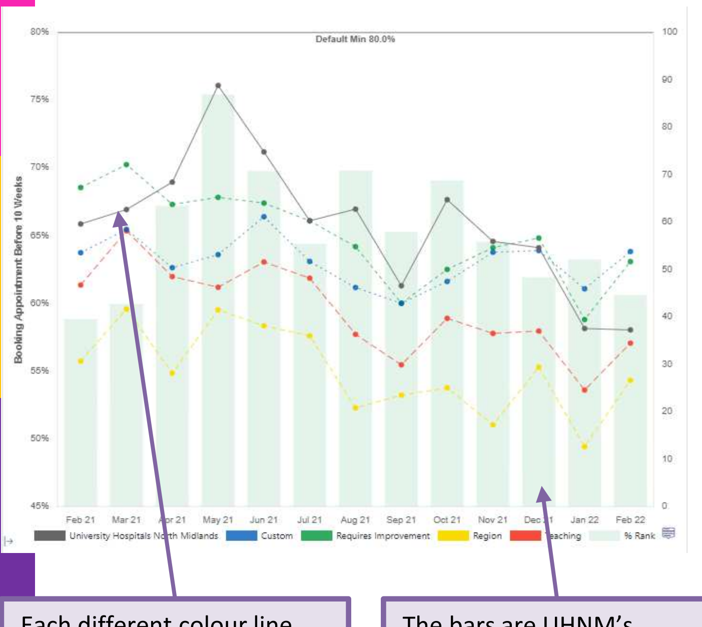
Which specific KPI is being looked at?

Latest data published for national / peer benchmarking

Is UHNM seeing special cause variation?
Blue = Improvement
Orange = Deterioration

The same methodology as used in the IPR

UHNM Benchmarked Performance – *understanding the Charts*



Each different colour line represents a different group of Peers. These relate to the left hand axis.

The bars are UHNM's National ranking over time and correspond to the right hand axis number.

UHNM and 4 differing peer groups for comparison

The chart allows us to compare UHNM performance (black line) with four different peer groups. These groups are listed below;

University Hospitals North Midlands	➢ My Trust
Recommended	➢ A recommended group of Trusts based on combination of size, finance and activity (used in Model hospital/HED)
Requires Improvement	➢ All Trusts with a CQC rating of Requires improvement
Region	➢ All Local Trusts within the region (Midlands and East)
Teaching	➢ All Teaching hospitals

The selected Trusts for "recommended";

Recommended

- University Hospitals Coventry and Warwickshire NHS Trust
- University Hospitals of Derby and Burton NHS Foundation Trust
- Nottingham University Hospitals NHS Trust
- University Hospitals Birmingham NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- East Kent Hospitals University NHS Foundation Trust
- York & Scarborough Teaching Hospitals NHS Foundation Trust
- East Suffolk and North Essex NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust

Urgent Care - 4 hour standard

- 4 hour performance across all peer groups has been on a declining trend since July 2023.
- UHNM saw a sharp deterioration between September and October than other peer groups.
- UHNM were at the top of quartile 3, however this has deteriorated to the lower half of quartile 3.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Sep 23	1.0%	12.2%	
A&E - 4 Hour Standard	Oct 23	76.00%	65.3%	
A&E - 4 Hour Standard (Type 1)	Oct 23	76.0%	45.9%	
A&E - 4 Hour Standard (Type 2 or 3)	Oct 23	95.0%	97.0%	
A&E - Conversion Rate	Oct 23	25.0%	26.3%	
A&E - DTA to Admission >12 Hours	Oct 23	0.0%	17.3%	
A&E - DTA to Admission >12 Hours#	Oct 23	0.0	1,057.0	
A&E - DTA to Admission >4 Hours	Oct 23	10.00%	32.4%	
A&E - Left Without Being Seen	Sep 23	5.00%	5.2%	
A&E - Reattendance Rate	Sep 23	5.0%	9.1%	
A&E - Time to Initial Assessment	Sep 23	15.0	7.0	
A&E - Time to Treatment	Sep 23	60.0	73.0	
A&E - Total Time in A&E	Sep 23	160.0	169.0	
A&E - Total Time in A&E (Admitted)	Sep 23	180.0	-	
A&E - Total Time in A&E (Non-Admitted)	Sep 23	140.0	147.0	

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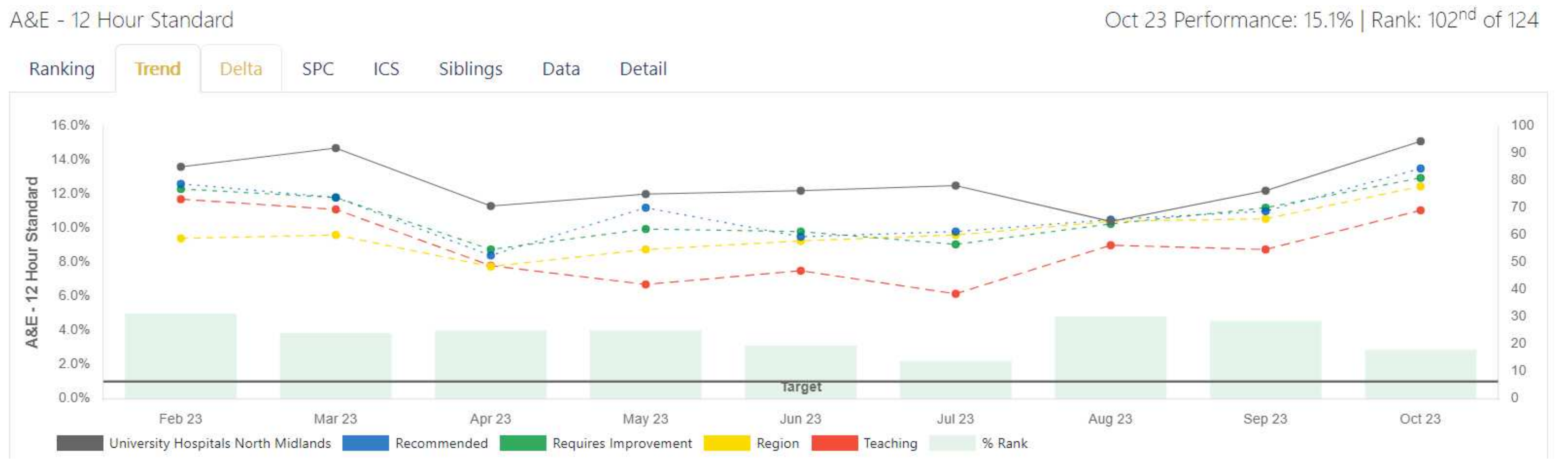
Urgent Care - 12 hour standard



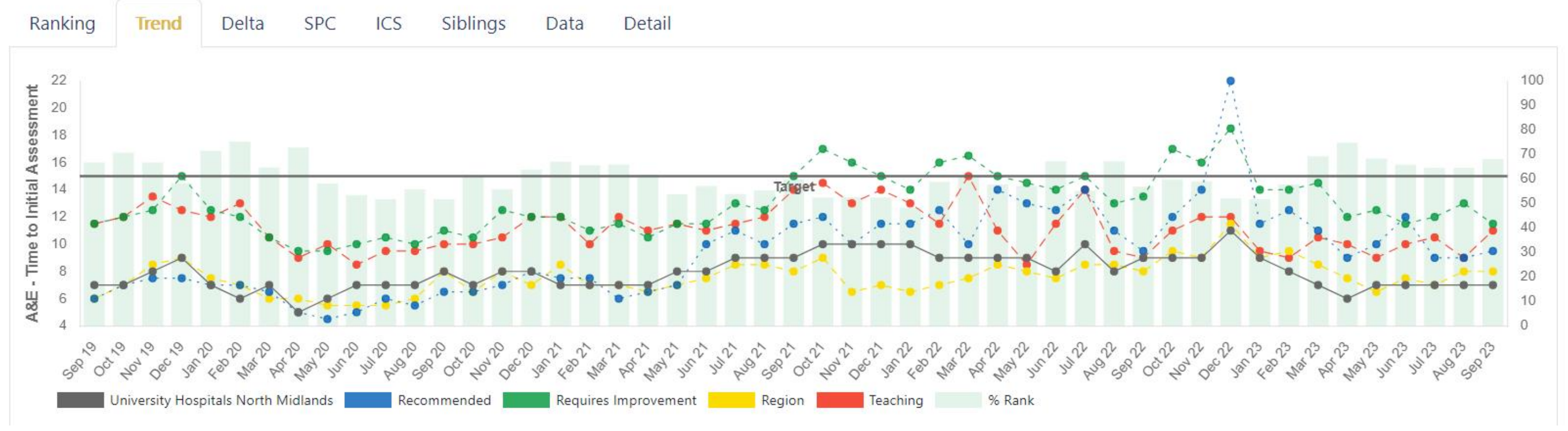
- All peer groups have followed a similar trend since February.
- Although all peers increased in October, UHNM saw a greater increase.
- UHNM have moved to the bottom quartile since the last report where they were in the 3rd quartile.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Oct 23	1.0%	15.1%	
A&E - 4 Hour Standard	Oct 23	76.00%	65.3%	
A&E - 4 Hour Standard (Type 1)	Oct 23	76.0%	45.9%	
A&E - 4 Hour Standard (Type 2 or 3)	Oct 23	95.0%	97.0%	
A&E - Conversion Rate	Oct 23	25.0%	26.3%	
A&E - DTA to Admission >12 Hours	Oct 23	0.0%	17.3%	
A&E - DTA to Admission >12 Hours#	Oct 23	0.0	1,057.0	
A&E - DTA to Admission >4 Hours	Oct 23	10.00%	32.4%	
A&E - Left Without Being Seen	Sep 23	5.00%	5.2%	
A&E - Reattendance Rate	Sep 23	5.0%	9.1%	
A&E - Time to Initial Assessment	Sep 23	15.0	7.0	
A&E - Time to Treatment	Sep 23	60.0	73.0	
A&E - Total Time in A&E	Sep 23	160.0	169.0	
A&E - Total Time in A&E (Admitted)	Sep 23	180.0	-	
A&E - Total Time in A&E (Non-Admitted)	Sep 23	140.0	147.0	

Urgent Care – Initial Assessment

A&E - Time to Initial Assessment

Sep 23 Performance: 7.0 | Rank: 39th of 120



- UHNM average time to initial assessment (ambulance cases only) has remained static since May 2023, where other peer groups have fluctuated and are performing better.
- All peers including UHNM continue to be below the 15 minute target.
- UHNM remain in the 3rd quartile.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Sep 23	1.0%	12.2%	
A&E - 4 Hour Standard	Oct 23	76.00%	65.3%	
A&E - 4 Hour Standard (Type 1)	Oct 23	76.0%	45.9%	
A&E - 4 Hour Standard (Type 2 or 3)	Oct 23	95.0%	97.0%	
A&E - Conversion Rate	Oct 23	25.0%	26.3%	
A&E - DTA to Admission >12 Hours	Oct 23	0.0%	17.3%	
A&E - DTA to Admission >12 Hours#	Oct 23	0.0	1,057.0	
A&E - DTA to Admission >4 Hours	Oct 23	10.00%	32.4%	
A&E - Left Without Being Seen	Sep 23	5.00%	5.2%	
A&E - Reattendance Rate	Sep 23	5.0%	9.1%	
A&E - Time to Initial Assessment	Sep 23	15.0	7.0	
A&E - Time to Treatment	Sep 23	60.0	73.0	
A&E - Total Time in A&E	Sep 23	160.0	169.0	
A&E - Total Time in A&E (Admitted)	Sep 23	180.0	-	
A&E - Total Time in A&E (Non-Admitted)	Sep 23	140.0	147.0	

Urgent Care – DTA waits over 12 hours

A&E - DTA to Admission >12 Hours

Oct 23 Performance: 17.3% | Rank: 92nd of 129

Ranking | Trend | Delta | SPC | ICS | Siblings | Data | Detail

A&E - DTA to Admission >12 Hours

25% 20% 15% 10% 5% 0%

100 90 80 70 60 50 40 30 20 10 0

Target

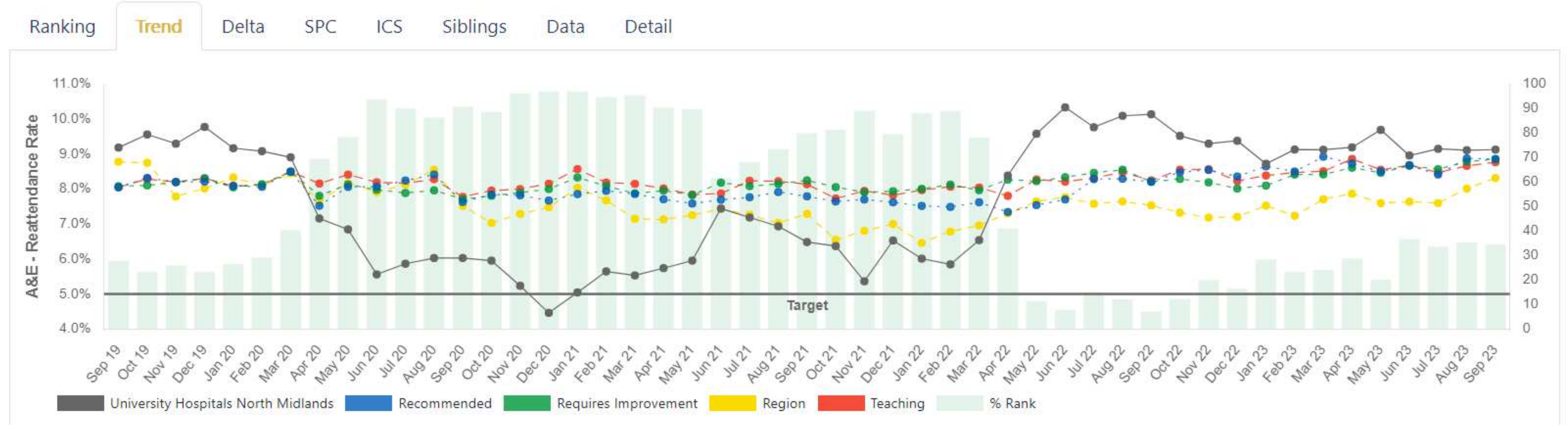
Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23

University Hospitals North Midlands | Recommended | Requires Improvement | Region | Teaching | % Rank

- All peer groups have seen an increase in the proportion of patients waiting over 12 hours to be admitted since August.
- UHNM are following the same trend line as all peer groups except the 'Region' group.
- UHNM have sustained their position in quartile 3, following movement from quartile 4 in the last pack.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Sep 23	1.0%	12.2%	
A&E - 4 Hour Standard	Oct 23	76.00%	65.3%	
A&E - 4 Hour Standard (Type 1)	Oct 23	76.0%	45.9%	
A&E - 4 Hour Standard (Type 2 or 3)	Oct 23	95.0%	97.0%	
A&E - Conversion Rate	Oct 23	25.0%	26.3%	
A&E - DTA to Admission >12 Hours	Oct 23	0.0%	17.3%	
A&E - DTA to Admission >12 Hours#	Oct 23	0.0	1,057.0	
A&E - DTA to Admission >4 Hours	Oct 23	10.00%	32.4%	
A&E - Left Without Being Seen	Sep 23	5.00%	5.2%	
A&E - Reattendance Rate	Sep 23	5.0%	9.1%	
A&E - Time to Initial Assessment	Sep 23	15.0	7.0	
A&E - Time to Treatment	Sep 23	60.0	73.0	
A&E - Total Time in A&E	Sep 23	160.0	169.0	
A&E - Total Time in A&E (Admitted)	Sep 23	180.0	-	
A&E - Total Time in A&E (Non-Admitted)	Sep 23	140.0	147.0	

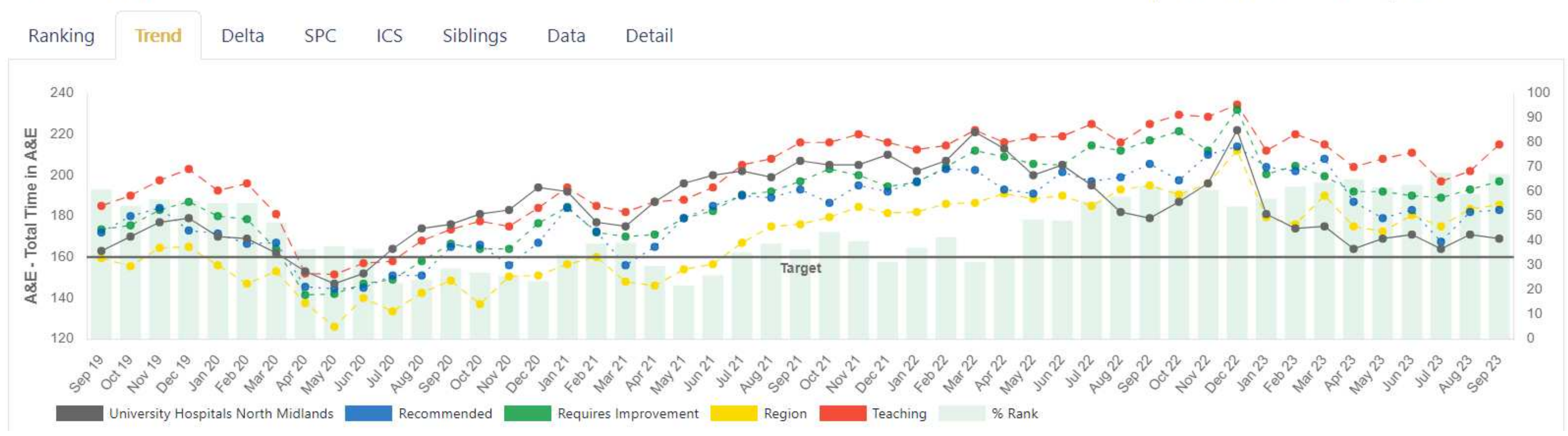
Urgent Care – Re-attendance Rate within 7 days



- UHNM continue to have a higher reattendance rate than all peer groups, however this has reduced for the fourth consecutive month.
- UHNM levels have been closer to peer groups during 2023, albeit remain above peers.
- UHNM remain in the 3rd quartile.

	Key Performance Indicator	Period	Target	🏆	SPC
1200	A&E - 12 Hour Standard	Sep 23	1.0%	**12.2%**	
14	A&E - 4 Hour Standard	Oct 23	76.00%	**65.3%**	
60	A&E - 4 Hour Standard (Type 1)	Oct 23	76.0%	**45.9%**	
61	A&E - 4 Hour Standard (Type 2 or 3)	Oct 23	95.0%	97.0%	
62	A&E - Conversion Rate	Oct 23	25.0%	**26.3%**	
63	A&E - DTA to Admission >12 Hours	Oct 23	0.0%	**17.3%**	
64	A&E - DTA to Admission >12 Hours#	Oct 23	0.0	**1,057.0**	
34	A&E - DTA to Admission >4 Hours	Oct 23	10.00%	**32.4%**	
33	A&E - Left Without Being Seen	Sep 23	5.00%	**5.2%**	
65	A&E - Reattendance Rate	Sep 23	5.0%	**9.1%**	
52	A&E - Time to Initial Assessment	Sep 23	15.0	7.0	
53	A&E - Time to Treatment	Sep 23	60.0	**73.0**	
54	A&E - Total Time in A&E	Sep 23	160.0	**169.0**	
66	A&E - Total Time in A&E (Admitted)	Sep 23	180.0	-	
67	A&E - Total Time in A&E (Non-Admitted)	Sep 23	140.0	**147.0**	

Urgent Care – Total time in ED



- UHNM have consistently performed better than peer groups during 2023.
- Between August and September all peer groups saw an increase in the time spent in ED, where UHNM saw a slight improvement.
- For UHNM this is predominantly due to good performance for Non Admitted patients.
- UHNM remain in the 2nd quartile.

	Key Performance Indicator	Period	Target		SPC
1200	A&E - 12 Hour Standard	Sep 23	1.0%	12.2%	
14	A&E - 4 Hour Standard	Oct 23	76.00%	65.3%	
60	A&E - 4 Hour Standard (Type 1)	Oct 23	76.0%	45.9%	
61	A&E - 4 Hour Standard (Type 2 or 3)	Oct 23	95.0%	97.0%	
62	A&E - Conversion Rate	Oct 23	25.0%	26.3%	
63	A&E - DTA to Admission >12 Hours	Oct 23	0.0%	17.3%	
64	A&E - DTA to Admission >12 Hours#	Oct 23	0.0	1,057.0	
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65	A&E - Reattendance Rate	Sep 23	5.0%	9.1%	
52	A&E - Time to Initial Assessment	Sep 23	15.0	7.0	
53	A&E - Time to Treatment	Sep 23	60.0	73.0	
54	A&E - Total Time in A&E	Sep 23	160.0	169.0	
66	A&E - Total Time in A&E (Admitted)	Sep 23	180.0	-	
67	A&E - Total Time in A&E (Non-Admitted)	Sep 23	140.0	147.0	

Urgent Care – Conversion Rate

A&E - Conversion Rate

Oct 23 Performance: 26.3% | Rank: 117th of 144

Ranking | Trend | Delta | SPC | ICS | Siblings | Data | Detail

A&E - Conversion Rate (36% to 16%; % Rank 100 to 0), Oct 19 – Oct 23, with Target line

University Hospitals North Midlands | Recommended | Requires Improvement | Region | Teaching | % Rank

- The proportion of patients attending A&E who are admitted at UHNM continues to remain significantly higher than all peer groups.
- UHNM remain above the target of 25%, whilst all peers are currently below this.
- UHNM remain in the bottom quartile.
- UHNM admit significantly more emergency patients than other peer groups.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Sep 23	1.0%	12.2%	
A&E - 4 Hour Standard	Oct 23	76.00%	65.3%	
A&E - 4 Hour Standard (Type 1)	Oct 23	76.0%	45.9%	
A&E - 4 Hour Standard (Type 2 or 3)	Oct 23	95.0%	97.0%	
A&E - Conversion Rate	Oct 23	25.0%	26.3%	
A&E - DTA to Admission >12 Hours	Oct 23	0.0%	17.3%	
A&E - DTA to Admission >12 Hours#	Oct 23	0.0	1,057.0	
A&E - DTA to Admission >4 Hours	Oct 23	10.00%	32.4%	
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A&E - Total Time in A&E	Sep 23	160.0	169.0	
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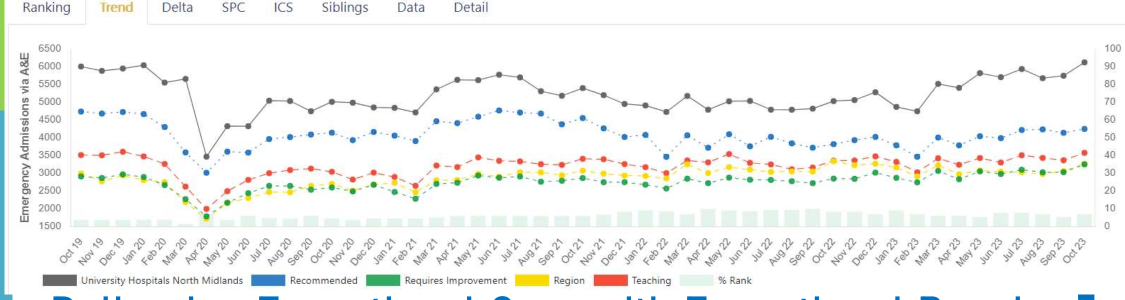
A&E - Total Time in A&E (Non-Admitted)	Sep 23	140.0	147.0	



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Cancer

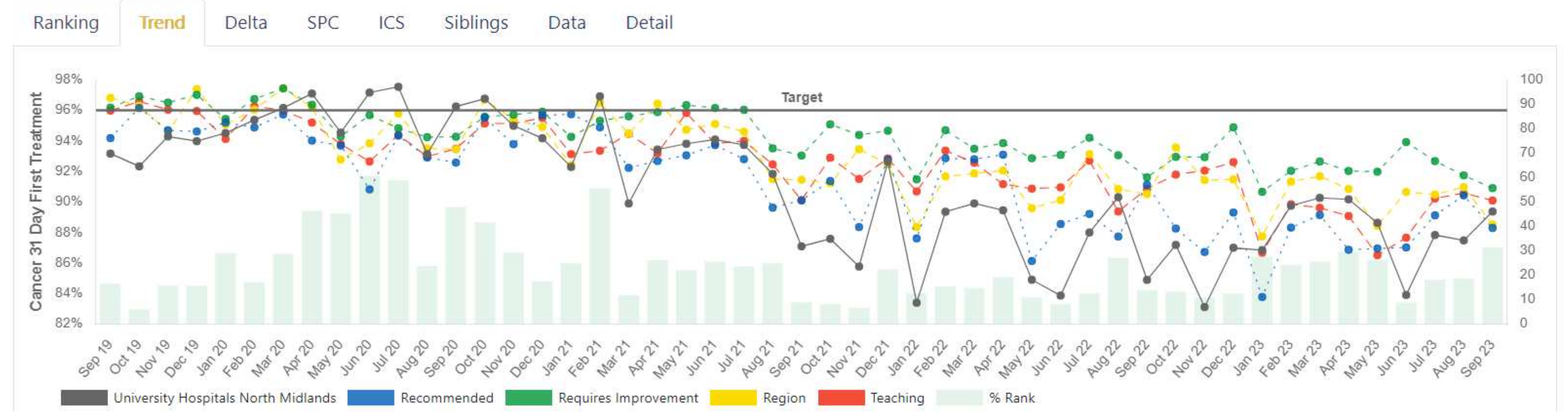
Key Performance Indicator	Period	Target		SPC
Cancer - 28 Day Faster Diagnosis	Sep 23	75.0%	60.3%	
FDS Acute Leukaemia	Sep 23	75.0%	-	
FDS Brain Tumours	Sep 23	75.0%	50.0%	
FDS Breast Cancer	Sep 23	75.0%	88.7%	
FDS Breast Symptoms	Sep 23	75.0%	91.8%	
FDS Children's Cancer	Sep 23	75.0%	84.6%	
FDS Gynaecological Cancer	Sep 23	75.0%	48.6%	
FDS Haematological Malignancies	Sep 23	75.0%	33.3%	
FDS Head & Neck Cancer	Sep 23	75.0%	66.0%	
FDS Lower Gastrointestinal Cancer	Sep 23	75.0%	18.8%	
FDS Lung Cancer	Sep 23	75.0%	77.3%	
FDS Missing or Invalid	Sep 23	75.0%	-	
FDS Other Cancer	Sep 23	75.0%	-	
FDS Sarcoma	Sep 23	75.0%	28.6%	
FDS Skin Cancer	Sep 23	75.0%	72.7%	
FDS Testicular Cancer	Sep 23	75.0%	80.0%	
FDS Upper Gastrointestinal Cancer	Sep 23	75.0%	84.2%	
FDS Urological Malignancies	Sep 23	75.0%	44.1%	

- The 28 Day Faster Diagnosis position for UHNM continues to be below all peer groups.
- All peer groups have seen a deterioration over the last three months. For UHNM this deterioration is more significant.
- Lower GI and Sarcoma have deteriorated the most since July.
- UHNM remain in the bottom quartile.

Cancer

Cancer 31 Day First Treatment

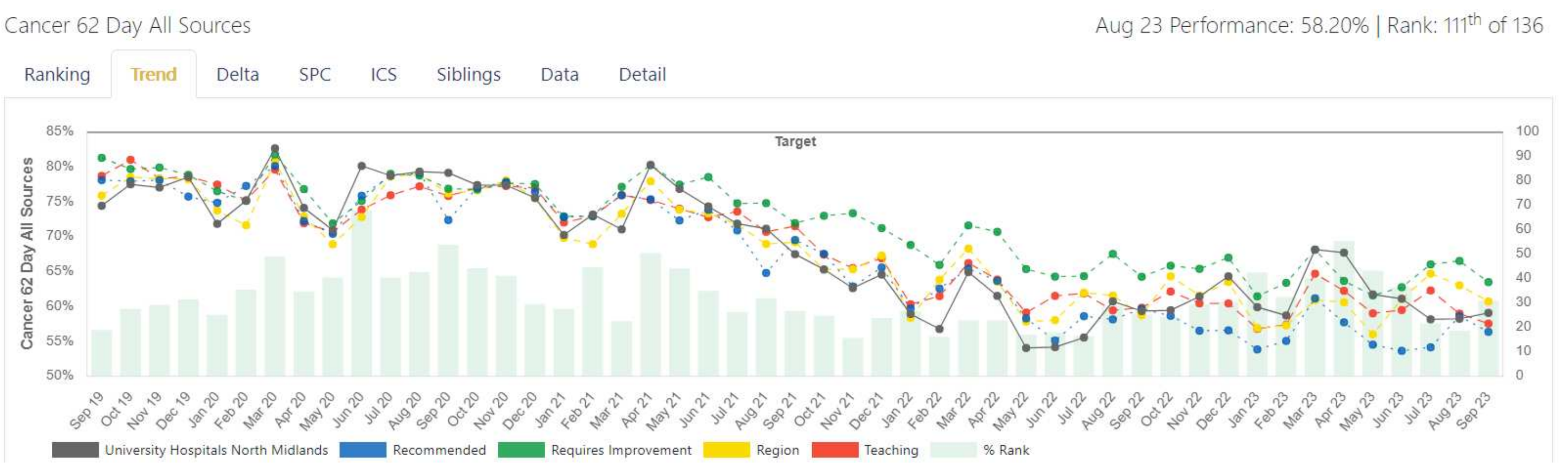
Sep 23 Performance: 89.36% | Rank: 93rd of 135



- Since June 2023, UHNM performance has seen an improving trend, whilst not all peer groups are seeing this same improvement.
- In September, UHNM are now mid point between peers.
- UHNM have moved from the bottom quartile to the 3rd quartile.

	Key Performance Indicator	Period	Target	🏆	SPC
45	Cancer 2 Week Wait	Sep 23	93.00%	95.7%	
99	Cancer 2 Week Wait Breast Symptomatic	Sep 23	93.0%	93.8%	
46	Cancer 31 Day First Treatment	Sep 23	96.00%	**89.4%**	
120	Cancer 31 Day Subsequent Treatment	Sep 23	96.0%	**82.9%**	
51	Cancer 62 Day All Sources	Aug 23	85.00%	**58.2%**	
100	Cancer 62 Day Consultant Upgrade	Aug 23	85.0%	**71.2%**	
35	Cancer 62 Day Screening	Sep 23	90.0%	**44.4%**	
118	Cancer Sub Treat Drugs	Sep 23	96.0%	**92.9%**	
119	Cancer Sub Treat Radiotherapy	Sep 23	96.0%	97.0%	

Cancer



- All peer groups are currently performing at similar levels.
- Whilst peer groups have seen a downward trend since July, UHNM have seen an improving trend.
- UHNM are in the 3rd quartile.

	Key Performance Indicator	Period	Target		SPC
45	Cancer 2 Week Wait	Sep 23	93.00%	95.7%	
99	Cancer 2 Week Wait Breast Symptomatic	Sep 23	93.0%	93.8%	
46	Cancer 31 Day First Treatment	Sep 23	96.00%	**89.4%**	
120	Cancer 31 Day Subsequent Treatment	Sep 23	96.0%	**82.9%**	
51	Cancer 62 Day All Sources	Aug 23	85.00%	**58.2%**	
100	Cancer 62 Day Consultant Upgrade	Aug 23	85.0%	**71.2%**	
35	Cancer 62 Day Screening	Sep 23	90.0%	**44.4%**	
118	Cancer Sub Treat Drugs	Sep 23	96.0%	**92.9%**	
119	Cancer Sub Treat Radiotherapy	Sep 23	96.0%	97.0%	

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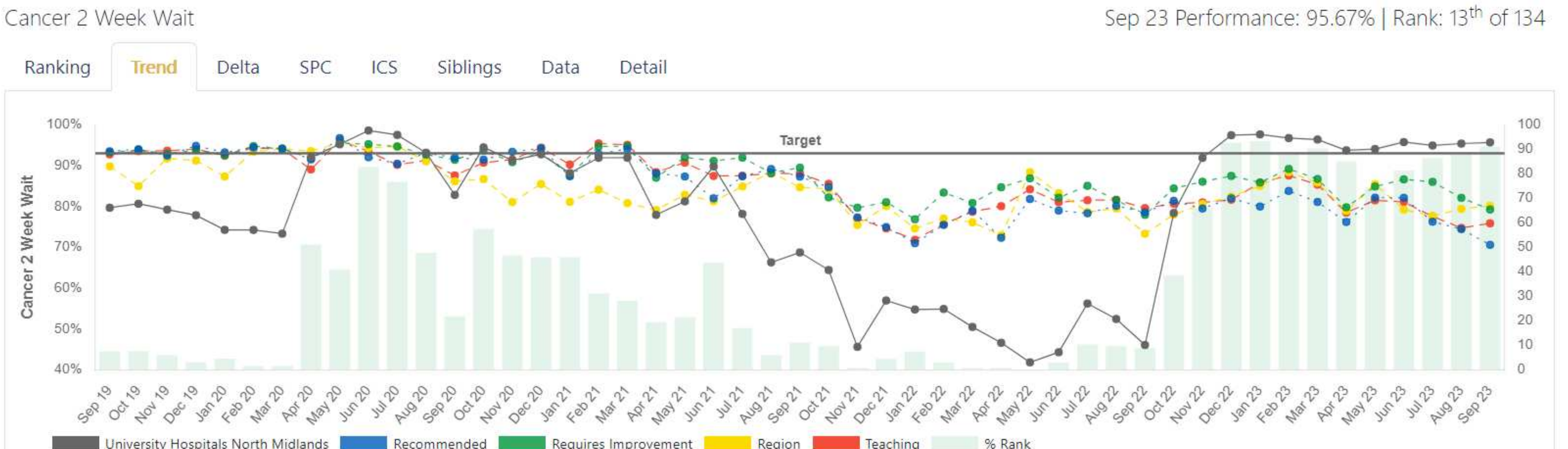
Cancer



- UHNM continue to perform well in this area and have remained above target since December 2022.
- All peer groups are consistently below target and have seen a deteriorating position since July 2023.
- UHNM have improved further in the national ranking, moving from 16th to 13th since the last report and remain in the top quartile.

	Key Performance Indicator	Period	Target	🏆	SPC
45	Cancer 2 Week Wait	Sep 23	93.00%	95.7%	
99	Cancer 2 Week Wait Breast Symptomatic	Sep 23	93.0%	93.8%	
46	Cancer 31 Day First Treatment	Sep 23	96.00%	89.4%	
120	Cancer 31 Day Subsequent Treatment	Sep 23	96.0%	82.9%	
51	Cancer 62 Day All Sources	Aug 23	85.00%	58.2%	
100	Cancer 62 Day Consultant Upgrade	Aug 23	85.0%	71.2%	
35	Cancer 62 Day Screening	Sep 23	90.0%	44.4%	
118	Cancer Sub Treat Drugs	Sep 23	96.0%	92.9%	
119	Cancer Sub Treat Radiotherapy	Sep 23	96.0%	97.0%	

RTT

RTT Total Incompletes

Sep 23 Performance: 82,329 | Rank: 147th of 171

- UHNM saw relatively stable volumes from 2022 to June 2023, whilst other peers continued to see an upward trend.
- Since June, UHNM have seen a steeper increase.
- UHNM remain in the bottom quartile.

Key Performance Indicator	Period	Target		SPC
RTT 104 Week Breach	Sep 23	0	**1**	
RTT 52 Week Breach	Sep 23	0	**4,850**	
RTT 65 Week Breach	Sep 23	-	1,226	
RTT 78 Week Breach	Sep 23	0	**169**	
RTT 95th Percentile Admitted Waiting Time	Sep 23	18.0	**75.1**	
RTT 95th Percentile Non-Admitted Waiting Time	Sep 23	18.0	**58.1**	
RTT Admitted Treatment Within 18 Weeks	Sep 23	90.0%	**55.6%**	
RTT Average (Median) Admitted Waiting Time	Sep 23	9.0	**13.9**	
RTT Average (Median) Non-Admitted Waiting Time	Sep 23	5.0	**8.9**	
RTT Average Wait for Incomplete	Sep 23	7.00	**17.6**	
RTT Incomplete 92nd Percentile	Sep 23	-	49.1	
RTT Incomplete Pathways With a DTA	Sep 23	25.0%	15.1%	
RTT Non-Admitted Treatment Within 18 Weeks	Sep 23	95.0%	**68.2%**	
RTT Total Clock Starts	Sep 23	-	15,740	
RTT Total Clock Stops	Sep 23	-	14,274	
RTT Total Incompletes	Sep 23	-	82,329	

RTT

RTT 78 Week Breach

Sep 23 Performance: 169 | Rank: 154th of 171

Ranking | Trend | Delta | SPC | ICS | Siblings | Data | Detail

RTT 78 Week Breach: 0–1600 (left axis); % Rank: 0–100 (right axis)

Months: Apr 21 – Sep 23

Legend: University Hospitals North Midlands, Recommended, Requires Improvement, Region, Teaching, % Rank

Target

Key Performance Indicator	Period	Target		SPC
RTT 104 Week Breach	Sep 23	0	1	
RTT 52 Week Breach	Sep 23	0	4,850	
RTT 65 Week Breach	Sep 23	-	1,226	
RTT 78 Week Breach	Sep 23	0	169	
RTT 95th Percentile Admitted Waiting Time	Sep 23	18.0	75.1	
RTT 95th Percentile Non-Admitted Waiting Time	Sep 23	18.0	58.1	
RTT Admitted Treatment Within 18 Weeks	Sep 23	90.0%	55.6%	
RTT Average (Median) Admitted Waiting Time	Sep 23	9.0	13.9	
RTT Average (Median) Non-Admitted Waiting Time	Sep 23	5.0	8.9	
RTT Average Wait for Incomplete	Sep 23	7.00	17.6	
RTT Incomplete 92nd Percentile	Sep 23	-	49.1	
RTT Incomplete Pathways With a DTA	Sep 23	25.0%	15.1%	
RTT Non-Admitted Treatment Within 18 Weeks	Sep 23	95.0%	68.2%	
RTT Total Clock Starts	Sep 23	-	15,740	
RTT Total Clock Stops	Sep 23	-	14,274	
RTT Total Incompletes	Sep 23	-	82,329	

- After seeing a considerably drop in the volume of patients waiting 78+ weeks during 2023, volumes in July and August have plateaued and remain above all peers.
- UHNM remain in the bottom quartile.

RTT

RTT 65 Week Breach

Aug 23 Performance: 1,314 | Rank: 152nd of 170

Key Performance Indicator	Period	Target	🏆	SPC
RTT 104 Week Breach	Aug 23	0	3	
RTT 52 Week Breach	Aug 23	0	4,506	
RTT 65 Week Breach	Aug 23	-	1,314	
RTT 78 Week Breach	Aug 23	0	176	
RTT 95th Percentile Admitted Waiting Time	Aug 23	18.0	74.1	
RTT 95th Percentile Non-Admitted Waiting Time	Aug 23	18.0	60.6	
RTT Admitted Treatment Within 18 Weeks	Aug 23	90.0%	54.9%	
RTT Average (Median) Admitted Waiting Time	Aug 23	9.0	14.4	
RTT Average (Median) Non-Admitted Waiting Time	Aug 23	5.0	7.9	
RTT Average Wait for Incomplete	Aug 23	7.00	17.1	
RTT Incomplete 92nd Percentile	Aug 23	-	48.3	

- All peer groups have seen a downward trend from December 2022 to July 2023, including UHNM.
- August saw all peer groups increase, whilst UHNM continued to se a reduction.
- UHNM remain in the bottom quartile.

RTT

RTT Average (Median) Admitted Waiting Time

Sep 23 Performance: 13.9 | Rank: 77th of 138

Ranking | Trend | Delta | SPC | ICS | Siblings | Data | Detail

RTT Average (Median) Non-Admitted Waiting Time

Sep 23 Performance: 8.9 | Rank: 71st of 166

Ranking | Trend | Delta | SPC | ICS | Siblings | Data | Detail

- The average wait (median) for patients at UHNM on an RTT admitted pathway has been higher than all peers since early 2022. Since July 2023, this improved significantly and has since been aligned to peer groups.
- Those patients on a non admitted RTT pathway has been consistently below all peer groups since early 2022. Since August all peers including UHNM have seen a worsening position.

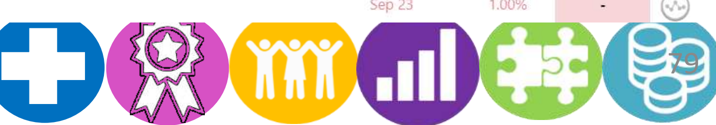
Diagnostics

Diagnostics - 6 Week Standard

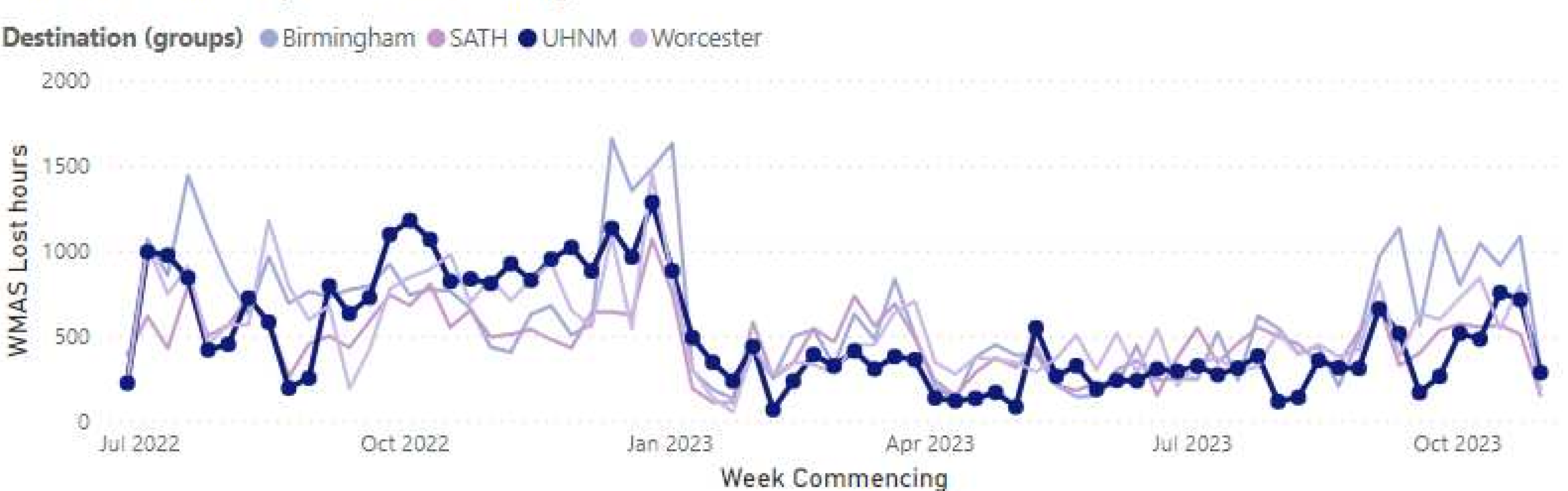
Sep 23 Performance: 25.16% | Rank: 92nd of 156

- All peer groups are performing at a similar level, with UHNM in the middle of all groups.
- All groups including UHNM remain significantly above the 1% national target.
- Endoscopy and Echo modalities are seeing the biggest deterioration.
- UHNM remain in the 3rd Quartile.

	Key Performance Indicator	Period	Target		SPC
	Audiology	Sep 23	1.00%	7.7%	
	Colonoscopy	Sep 23	1.00%	64.5%	
	Computed Tomography	Sep 23	1.00%	1.5%	
	Cystoscopy	Sep 23	1.00%	4.6%	
	DM01 Waiting <13 Weeks	Sep 23	100.00%	90.0%	
16	Diagnostics - 6 Week Standard	Sep 23	1.00%	25.2%	
	Diagnostics - 6 Week Standard Reversed	Sep 23	99.00%	74.8%	
	Echocardiography	Sep 23	1.00%	50.1%	
	Electrophysiology	Sep 23	1.00%	100%	
	Flexi Sigmoidoscopy	Sep 23	1.00%	72.6%	
	Gastroscopy	Sep 23	1.00%	68.4%	
	Magnetic Resonance Imaging	Sep 23	1.00%	2.6%	
	Neurophysiology	Sep 23	1.00%	0.0%	
	Non-obstetric Ultrasound	Sep 23	1.00%	14.8%	
	Sleep Studies	Sep 23	1.00%	14.3%	
	Urodynamics	Sep 23	1.00%	-	



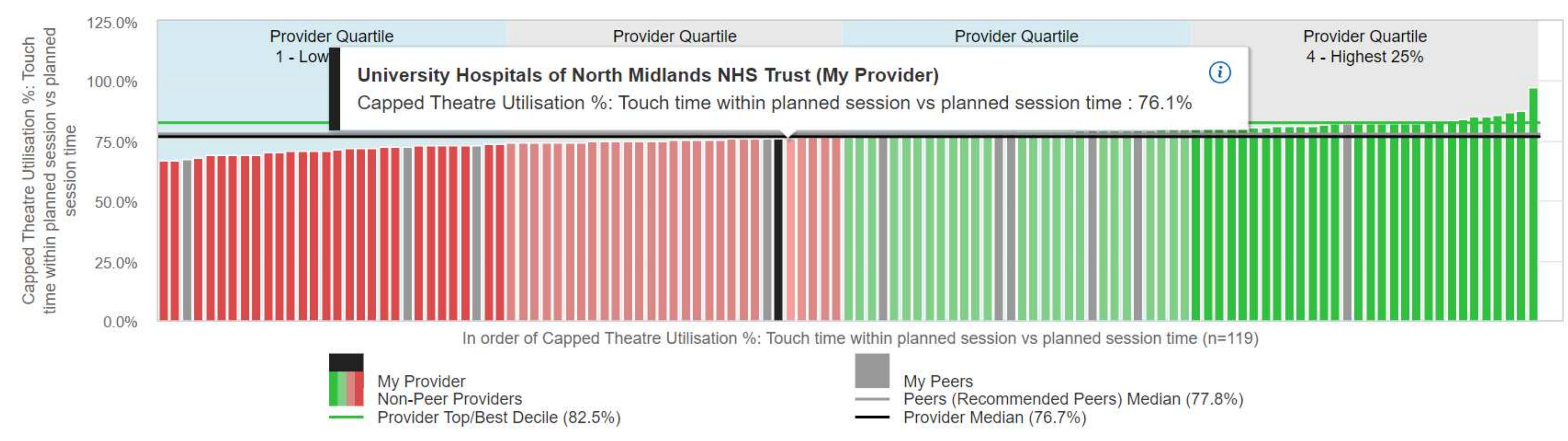
Urgent Care – Ambulance Handover Delays



- WMAS Ambulance handover delays over 60 minutes apportioned to four Trusts.
- During October UHNM have seen a worsening trend, but remains below/within peer trusts.

Data source: WMAS 09/11/23

Theatres - Benchmarked



- UHNM have improved since last month from 70% to 76% and have moved from the bottom quartile to the third quartile.

Source data: Model Hospital 05/10/23

Delivering Exceptional Care with Exceptional People

Workforce

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

Workforce Spotlight Report

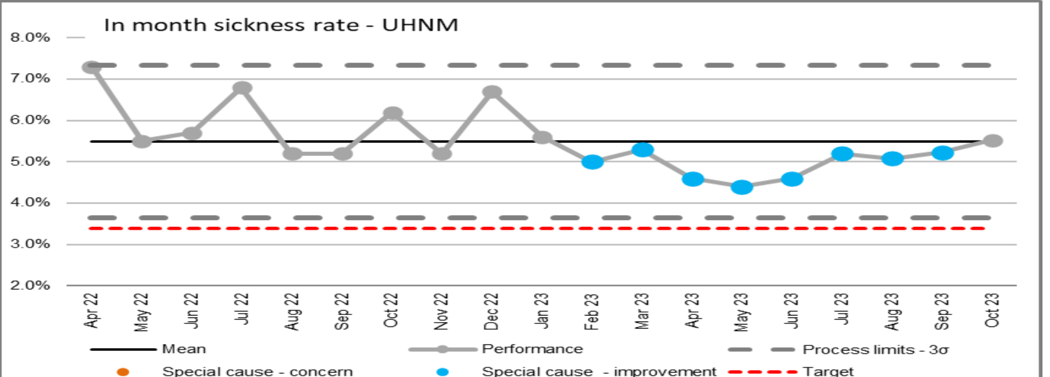
Key messages

- The 12m turnover rate in October 2023 decreased fractionally to 8.2% (8.3% in September) which remains below the trust target of 11%.
- M7 vacancies increased to 8.98% (8.59% in September), influenced by changes to budgeted establishments for the Winter Workforce Plan. Medical and Dental vacancies increased by 4.77% because of 8 additional Consultant vacancies associated with the Winter Workforce Plan, with the remainder resulting from Deanery increases in commissioned FY1 and ST3 posts. Divisions continue to report good progress on their recruitment pipeline to close the gap on vacancies.
- For M7, the in-month sickness rate increased by 0.29% to 5.52% (5.23% in September 2023). The 12-month cumulative rate decreased to 5.26% (5.32% in September 2023), because October 22's higher value of 6.28% was no longer affecting the 12-month average.
- Stress and anxiety continues to be the top reason for sickness in October, which saw a decrease of 0.5% in the last month to 24.3% (24.8% in September). Chest & respiratory problems saw an in-month increase of 1.7% to 15.0% (13.3% in September 2023), and cold & flu to 8.7% (4.7% in September) moving cold & flu from 7th position in September, to 3rd position, in October.
- 3 covid-related absences were recorded on ESR for October 2023, (3 in September 2023), following the cessation of symptomatic covid testing, since May 2023. Employees may report covid-like symptoms on Empactis, but Managers are then recording this as either chest & respiratory, or cold & flu, on ESR, as detailed above, in the absence of a formal lateral flow test.
- October 2023's PDR Rate remained unchanged at 82.6% (82.6% in September 2023). Work continues on refreshing PDR paperwork to support colleagues in achieving their potential.
- Statutory and Mandatory training rate on 31st October increased by 0.4% to 93.9% (93.5% on 30 September 2023). This compliance rate is for the 6 'Core for All' subjects only.
- The Staff Voice trust survey has been paused during October and November, while the NHS National Staff Survey runs.
- The Being Kind sessions continued in October with 1,045 colleagues in attendance. Overall, 8,912 people have attended the training, either in person, virtually, or online, via the ESR virtual training session.
- The National Staff Survey ended on 24th November 2023, with the Trust's overall response rate of 45%, with all staff groups surpassing their 2022 return rates.

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.52%		F
Staff Turnover	11%	8.19%	L	?
Statutory and Mandatory Training rate	95%	93.86%		F
Appraisal rate	95%	82.57%	H	F
Agency Cost	N/A	3.55%		P

Sickness Absence



Variation	Assurance

Target	Aug 23	Sep 23	Oct 23
3.4%	5.1%	5.2%	5.5%

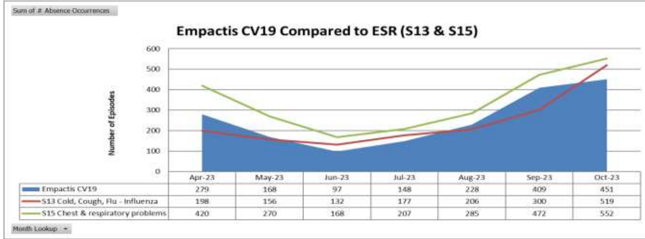
Background

Percentage of days lost to staff sickness

Summary

Org L2	Divisional Trajectory - March 2024	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trajectory
205 Central Functions	3.39%	3.58%	4.87%	4.01%	4.03%	3.61%	2.80%	2.37%	2.81%	3.54%	3.45%	3.44%	3.81%	↑
205 Division of Network Services	5.25%	5.07%	6.56%	4.99%	4.51%	4.64%	3.90%	3.76%	3.97%	4.35%	4.81%	4.51%	5.34%	↑
205 Division of Surgery, Theatres and Critical Care	5.25%	5.79%	7.38%	6.37%	5.93%	6.48%	5.50%	4.90%	5.24%	6.62%	6.15%	6.12%	6.05%	↓
205 Estates, Facilities and PFI Division	5.25%	6.09%	7.55%	5.98%	5.65%	6.30%	6.00%	5.32%	5.09%	4.69%	5.11%	4.87%	6.25%	↑
205 Medicine and Urgent Care	5.25%	5.59%	7.26%	5.67%	5.01%	5.20%	5.04%	4.79%	4.73%	5.67%	5.33%	6.07%	6.15%	↑
205 North Midlands & Cheshire Pathology Service (NMCPS)	4.50%	5.94%	6.35%	5.60%	5.49%	5.61%	4.71%	4.68%	5.30%	4.67%	4.37%	4.82%	5.40%	↑
205 Women's, Children's & Clinical Support Services	5.25%	5.41%	6.69%	6.05%	5.05%	5.18%	4.72%	4.73%	5.16%	5.09%	5.03%	4.95%	4.97%	↑

- For M7, the in-month sickness rate increased by 0.29% to 5.52% (5.23% in September 2023).
- The 12-month cumulative rate decreased to 5.26% (5.32% in September 2023), because Oct-22's higher value of 6.28% was no longer affecting the 12-month average.
- Stress and Anxiety continues to be the top reason for sickness in October, but saw a decrease of 0.5% in the last month to 24.3% (24.8% in September).
- Covid 19 cases reported on Empactis, by the employee, may be recorded as either chest & respiratory, or cold and flu, on ESR, by the manager, in the absence of a formal lateral flow.
- Both ESR reasons have seen a marked increase, consistent with Empactis.



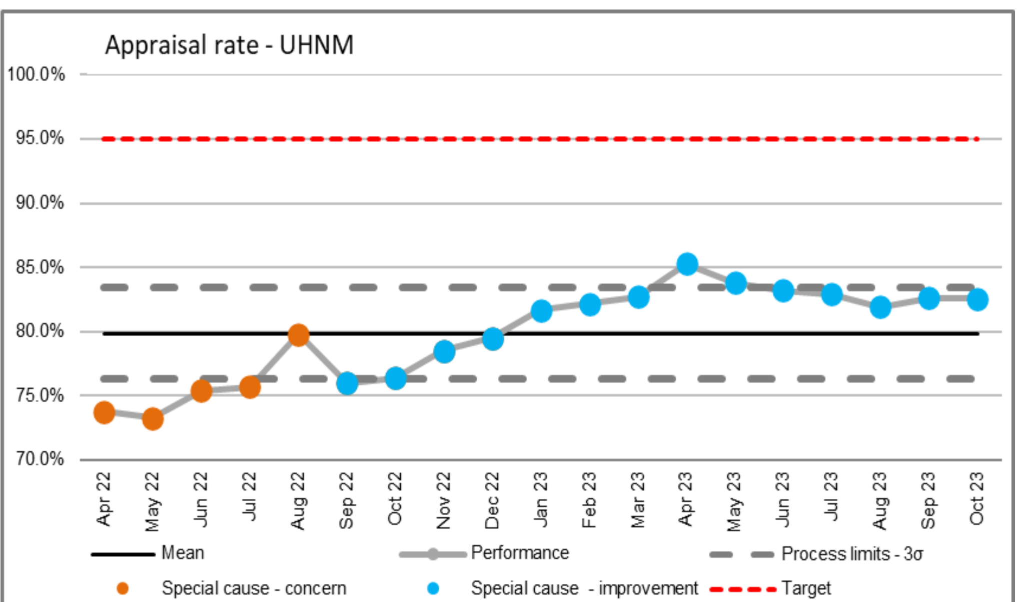
Sickness rate is consistently above the target of 3.4%.

Actions

- For areas of high sickness daily monitoring of absences continues
- **Medicine Division** - sickness absence continues to be monitored at directorate performance reviews. Areas with over 8% or of concern are supported by the People Advisor focusing on long term sickness cases
- **Surgery Division** – assessment of hotspot areas for long and short term absences to provide targeted support including re-training
- **Network Division** - commenced sickness assurance meetings.
- **Women's Children's and Clinical Division** - Deep dives into hot spot/high absence areas to target interventions as well as continuing absence surgeries.

Appraisal/Performance Development Review (PDR)

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Aug 23	Sep 23	Oct 23
95%	82.0%	82.6%	82.6%

Background

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

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

Summary

- On 31st October 2023, the PDR Rate remained unchanged at 82.6%, compared to September 2023.
- This figure remains below the overall target and divisions have been asked to review key issues and actions to work towards meeting target.
- The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance and making the process enhance employee experience.

Actions

The focus on ensuring completion of PDRs is continuing with:

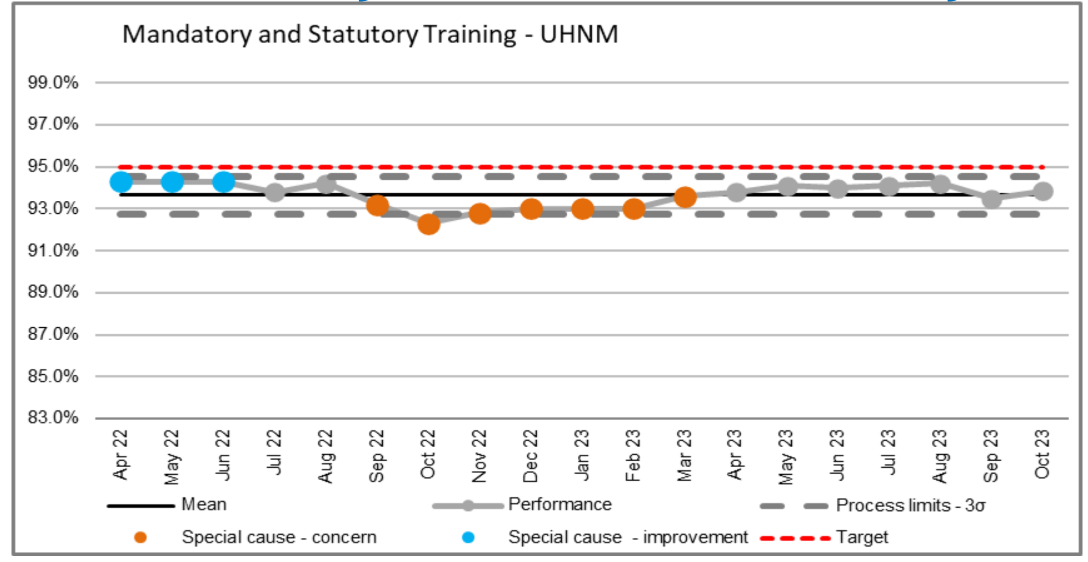
NMCPS - All out of date PDR's to be scheduled with line managers, and ESR hierarchy changes and training gaps to be identified.

Network Division - Hold a dedicated weekly PDR compliance hotspot and assurance meetings

Surgery Division – Monthly compliance report, with a focus on hotspots

Medicine Division – Weekly updates reports on compliance. With focused assistance on those areas with the lowest compliance.

Statutory and Mandatory Training



Variation	Assurance
	F

Target	Aug 23	Sep 23	Oct 23
95%	94.2%	93.5%	93.9%

Background

Training compliance.

At 93.5%, the Statutory and Mandatory Training rate remains just below the Trust target for the core training modules

Summary

Statutory and Mandatory training rate on 31st October 2023 increased by 0.4% to 93.9% (93.5% on 30 September 2023). This compliance rate is for the 6 'Core for All' subjects only.

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|LOCAL|Security Awareness - 3 Years|	11581	11581	10844	93.64%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years	11581	11581	10910	94.21%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	11581	11581	10819	93.42%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Y	11581	11581	10886	94.00%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	11581	11581	10991	94.91%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Y	11581	11581	10767	92.97%

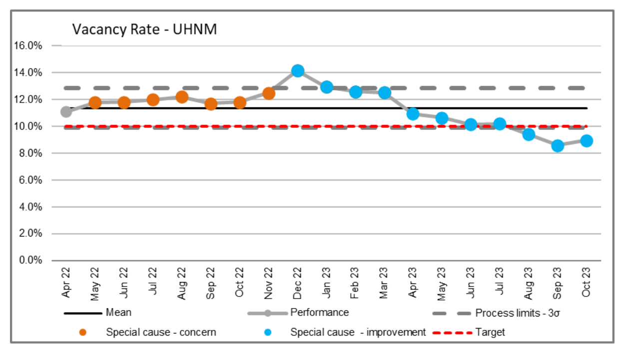
Compliance rates for the Annual competence requirements were as follows:

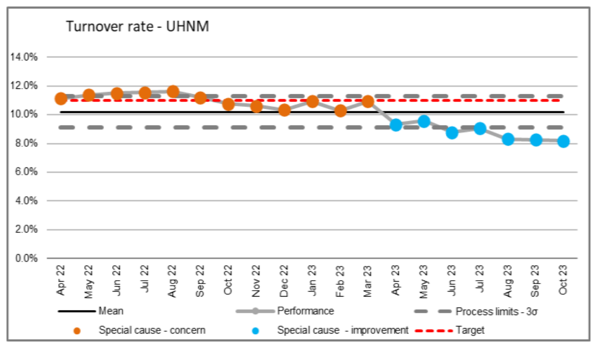
Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	11581	11581	8871	76.60%
NHS|CSTF|Information Governance and Data Security - 1	11581	11581	10332	89.22%

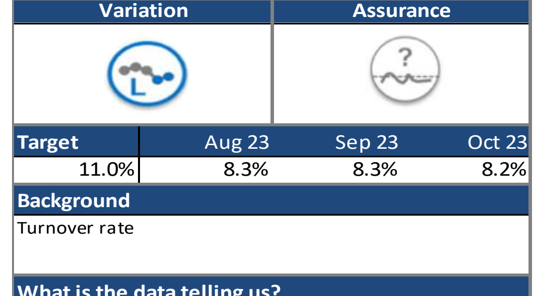
Actions

- We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.
- Compliance is monitored and raised via the Divisional performance review process.
- The Being Kind sessions continued in September with 1,805 colleagues in attendance. Overall, 8,091 people have attended the training, either in person, virtually, or online, via the ESR virtual training session.

Workforce Vacancies and Turnover







Target	Aug 23	Sep 23	Oct 23
11.0%	8.3%	8.3%	8.2%

Background

Turnover rate

What is the data telling us?

The turnover rate for October 2023 remains below the trust target of 11%.

Vacancy rate when measured against total establishment increased to 8.98% from 8.59% last month.

Vacancy rate when measured against substantive budgets only, increased to 1.92% from 0.17% last month, resulting mainly from Medical & Dental and other Winter Workforce Planning changes.

The overall Trust vacancy rate calculated as Budgeted Establishment. The vacancy rate is influenced by changes to budgeted establishment for Winter Workforce Plan and approved business cases, as well as changes to staff in post.

Summary

- The 12m Turnover rate in October 2023 sat at 8.2% which remains below the trust target of 11%.
- The summary of vacancies by staff groupings highlights a 0.39% decrease in the vacancy rate over the previous month.
- M7 vacancies increased to 8.98% (8.59% in September). Colleagues in post increased in October 2023 by 149.11 FTE, budgeted establishment increased by 214.34 fte, as a result of moving Winter Pressures monies out of reserves and into the appropriate budgets which increased the vacancy fte by 65.23 FTE overall [*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 31/10/23]

Vacancies at 31-10-23	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,674.77	1,416.37	258.40	15.43%	10.66%
Registered Nursing	3647.70	3272.96	374.74	10.27%	12.96%
All other Staff Groups	6638.59	6197.42	441.17	6.65%	5.68%
Total	11,961.06	10,886.75	1,074.31	8.98%	8.59%

Actions

- Significant amount of recruitment events targeting specific roles across multiple divisions.
- Continued targeted social media campaign. Recruitment are actively updating LinkedIn pages and have created a new UHNM recruitment Facebook group.
- Targeted spotlight on UHNM colleagues continue and supplement the recruitment campaigns

Finance

2025 Vision “Ensure efficient use of resources”

Delivering Exceptional Care with Exceptional People

Finance Spotlight Report

Key elements of the financial performance year to date are:

- For Month 7 the Trust has delivered a year to date deficit of £7.8m against a planned surplus of £3.1m; this adverse variance of £10.9m is primarily driven by underperformance against the Trust's in year CIP target, the impact of industrial action and unfunded additional winter escalation capacity that remains open.
- The Trust has incurred £5.0m of costs relating to winter escalation capacity remaining open; the Month 7 position includes £2.1m of additional funding from the local ICB.
- The industrial action (IA) by Medical staff has cost the Trust £4.1m in backfill arrangements. The Trust will be receiving an allocation of £9m to cover this and the wider costs of industrial action.
- From 31/3/20 to 30/9/23 the Trust's total workforce (Substantive, bank and agency) has grown from 10,390 to 11,760 representing a growth of 1,370 (13.2%); during this time the planned workforce has increased by 884 and vacancies have reduced by 486.
- To date the Trust has validated £26.7m of CIP savings to Month 7 against a plan of £32.1m. The Trust has recognised £3.0m of CIP due to an assumed reduction in the annual leave provision; this delivers 50% of the NR ICB stretch CIP target. Schemes of £48.3m have been identified for delivery in 2023/24. The PMO is currently working with scheme leads to develop robust plan to deliver these savings. The £8.0m divisional schemes remain unidentified.
- There has been £31.5m of Capital expenditure which is £3.7m below plan.
- The cash balance at Month 7 is £82.0m which is £4.0m lower than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	92.5		
	Expenditure - Pay	variable	54.2	H	F
	Expenditure - Non Pay	variable	36.9	H	F
Activity	Daycase/Elective Activity	variable	9,390	H	?
	Non Elective Activity	variable	11,461	H	P
	Outpatients 1st	variable	29,467		?
	Outpatients Follow Up	variable	44,531		?

Income & Expenditure

Income & Expenditure Summary Month 07 2023/24	Annual Budget £m	In Month Budget £m	In Month Actual £m	In Month Variance £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Variance £m
Income From Patient Activities	1,002.9	84.4	84.7	0.4	583.6	584.1	0.5
Other Operating Income	86.9	7.4	7.8	0.4	51.2	51.8	0.6
Total Income	1,089.9	91.7	92.5	0.8	634.9	635.9	1.1
Pay Expenditure	(670.1)	(56.8)	(54.2)	2.6	(385.8)	(382.4)	3.4
Non Pay Expenditure	(393.4)	(32.8)	(36.9)	(4.1)	(230.6)	(247.7)	(17.1)
Total Operational Costs	(1,063.5)	(89.6)	(91.1)	(1.5)	(616.4)	(630.1)	(13.7)
EBITDA	26.3	2.1	1.4	(0.7)	18.4	5.8	(12.6)
Interest Receivable	2.9	0.3	0.5	0.3	1.7	3.4	1.7
PDC	(10.3)	(0.9)	(0.9)	0.0	(6.0)	(6.0)	0.0
Finance Cost	(19.0)	(1.6)	(1.6)	0.0	(11.1)	(11.0)	0.0
Other Gains or Losses	0.0	0.0	(0.0)	(0.0)	0.0	0.0	0.0
Total	0.0	(0.1)	(0.6)	(0.5)	3.1	(7.8)	(10.9)

Key issues to note within the Month 7 position include the following.

- The overspend of £10.9m is mainly driven by.
  - an under delivery of CIP by £5.4m
  - additional capacity costs of £5.0m have been incurred to Month 7; additional funding of £2.1m has been agreed with the Staffordshire and Stoke on Trent ICB and this has been reflected in the Month 7 position.
  - costs relating to industrial actions of £4.1m
- The two main CIP schemes behind plan at Month 7 are the ICB non-recurrent stretch of £3.0m and the recurrent divisional schemes of £4.7m.

Capital Spend

UHNM Capital Expenditure Plan	2023/24 Plan/forecast £000	Movement £000	2023/24 Revised Plan/forecast £000	YTD Plan M07 £000	YTD Actual M07 £000	Variance M07 £000
Total PFI & Loan Commitments	(19.6)	-	(19.6)	(11.1)	(11.1)	-
Pre-committed investment items (ICB allocation)						
PFI enabling costs	(0.2)	-	(0.2)	-	-	-
Project Star	(20.7)	-	(20.7)	(13.6)	(13.1)	0.5
Emergency Department (restatement costs)	(0.2)	-	(0.2)	(0.1)	(0.1)	(0.0)
Air heat boiler replacement Trust Contribution	(0.7)	-	(0.7)	-	-	-
Wave 4b Funding - Lower Trent Wards	(0.2)	0.2	-	-	-	-
EPMA (Electronic Prescribing) BC	(0.7)	-	(0.7)	(0.3)	(0.3)	0.1
Pathology LIMS BC (Trust funded)	(0.6)	0.6	-	-	-	-
Pathology MSC Siemens refresh	(0.1)	-	(0.1)	-	-	-
Patient Portal roll out costs (BC 462)	(0.4)	-	(0.4)	(0.2)	(0.1)	0.1
Bi plane enabling (BC 425)	(0.2)	-	(0.2)	(0.2)	-	0.2
CT8 enabling works	(0.6)	-	(0.6)	(0.6)	(0.6)	-
Network and Communications (BC 510)	(1.2)	-	(1.2)	-	-	-
Pharmacy Robot BC487 - equipment	(0.5)	0.5	-	-	-	-
Pharmacy Robot BC487 - enabling and other	(0.8)	0.8	(0.0)	(0.0)	(0.0)	-
Electronic Patients records BC/specification	(0.8)	0.1	(0.7)	(0.3)	(0.0)	0.3
ED ambulance drop-off - enabling ward moves	(0.7)	-	(0.7)	(0.5)	(0.2)	0.3
Endoscopy works - 22/23 PDC ICB allocation	(0.4)	-	(0.4)	(0.1)	(0.0)	0.1
Remaining 2022/23 commitments	(0.3)	0.0	(0.3)	(0.2)	(0.2)	0.1
County CTS equipment (TIF) remaining equipment	(0.2)	-	(0.2)	(0.2)	(0.1)	0.0
County Modular remaining equipment	(0.1)	-	(0.1)	(0.1)	(0.1)	(0.0)
Investment funding - minor cases	(0.4)	(0.1)	(0.5)	(0.0)	(0.1)	(0.0)
Central Contingency & risk	-	(0.3)	(0.3)	-	-	-
Total Pre committed Investment items	(30.0)	1.9	(28.1)	(16.5)	(14.8)	1.6
UHNM Capital Expenditure Plan	2023/24 Plan/forecast £000	Movement £000	2023/24 Revised Plan/forecast £000	YTD Plan M07 £000	YTD Actual M07 £000	Variance M07 £000
IMT Sub Group Total Funding	(2.3)	-	(2.3)	(1.5)	(0.5)	1.0
Medical Devices Sub Group Total Funding	(2.4)	-	(2.4)	(1.8)	(1.1)	0.8
Estates Sub Group Total Funding	(3.6)	-	(3.6)	(0.9)	(0.7)	0.3
Health & Safety compliance	(0.2)	-	(0.2)	(0.1)	(0.1)	0.0
Net zero carbon initiatives	(0.1)	-	(0.1)	(0.0)	-	0.0
Central funding beds, mattresses, hoists	(0.1)	-	(0.1)	(0.1)	(0.0)	0.0
Total Sub Groups	(8.7)	-	(8.7)	(4.4)	(2.3)	2.1
New IFRS16 leases (previously classified as operating leases and charged to revenue)						
Lease liability re-measurement	(0.2)	(0.1)	(0.4)	(0.4)	(0.4)	-
IFRS 16 leases	(0.9)	(0.8)	(1.7)	(0.3)	(0.3)	-
Community Diagnostic Centre lease	-	(5.0)	(5.0)	-	-	-
IFRS16 funding offset	1.1	5.9	7.1	0.6	0.6	-
Total Internal Capital Expenditure programme	(58.2)	1.9	(56.4)	(31.9)	(28.2)	3.7
Additional CRL / Externally Funded PDC						
Wave 4b Funding - Lower Trent Wards	(1.6)	-	(1.6)	(0.1)	(0.1)	-
TIF 2 PDC CTS phase 1 - enabling slippage	(0.4)	-	(0.4)	(0.4)	(0.4)	-
TIF 2 PDC (Day Case Unit)	(2.7)	-	(2.7)	(0.3)	(0.3)	-
TIF 2 PDC (Women's Hospital)	(1.2)	0.6	(0.7)	(0.0)	(0.0)	-
PDC - additional General & Acute beds	(13.4)	-	(13.4)	(0.5)	(0.5)	-
PDC - Community diagnostic centre phase 1	(0.4)	(1.0)	(1.4)	(0.2)	(0.2)	-
PDC - Pathology LIMS	-	(1.3)	(1.3)	(0.5)	(0.5)	-
PDC - CDC phase 2 endoscopy	-	(2.7)	(2.7)	-	-	-
PDC - Frontline digitalisation EPR	-	(3.5)	(3.5)	-	-	-
PDC brokerage into 2024/25	-	6.2	6.2	-	-	-
Required NHSE plan re-phasing adjustment	7.2	(7.2)	-	-	-	-
Air heat boiler replacement PSDS Grant BC 510	(2.9)	-	(2.9)	(0.2)	(0.2)	-
Charitable funded expenditure	(2.1)	-	(2.1)	(1.2)	(1.2)	-
Total Additional CRL / PDC Funded expenditure	(17.5)	(9.0)	(26.4)	(3.3)	(3.3)	-
Total Capital Expenditure	(75.7)	(7.1)	(82.8)	(35.2)	(31.5)	3.7
Planned (under)/over spend	5.9	0.7	6.6			

The table above sets out the revised capital plan for 2023/24. The initial planned overspend of £5.9m (and matching £5.9m underspend in 2024/25) was reduced from the initial plan submission of £13.6m, as the ICB was required to submit a balanced capital plan over 2 years (within the allowable 5% over commitment). The revised plan included a re-phasing of £7.2m between the two financial years which has not been allocated against specific schemes. NHSE previously acknowledged the capital pressures facing the ICB and indicated that this would be managed as part of the regional position over financial years.

The main reasons for the year-to-date underspend of £3.7m relate to the following schemes:

- Project Star is £0.5m behind plan based on costs from the latest statement of works, which showed an underspend in month 7. As a result, a review of the forecast for the remainder of the financial year is being undertaken.
- Bi-plane enabling works are £0.2m behind plan, this is expected to be completed by the end of the calendar year.
- Electronic Patient Records business case is £0.3m behind plan due to contractual delays with the scheme and 2 months of the expenditure will slip in to 2024/25; and
- ED ambulance drop-off - enabling ward moves is £0.3m behind plan due to delays in finalising costs and the scope of work within the available funding.
- The IM&T sub-group is showing an underspend of £1.0m at Month 7, which is mainly due to delays in the radiation oncology equipment scheme (£0.75m) forecast with expenditure now expected in Month 9.
- The Medical Devices sub-group is showing an underspend of £0.8m at Month 7 mainly due to the phasing of the roll-out of the monitor fleet replacement that is expected to take place in Month 8.
- The Estates sub-group is showing an underspend of £0.3m at Month 7 due to the re-phasing of a number of schemes in the first part of the year.

Balance sheet

Balance sheet as at Month 7	31/03/2023 Actual £m	31/10/2023 Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment *	627.6	635.8	633.7	(2.1)	Note 1
Right of Use Assets	18.8	16.7	17.0	0.3	
Intangible Assets	18.4	15.0	14.9	(0.1)	
Trade and other Receivables	1.4	1.4	1.4	0.0	
Total Non Current Assets	666.1	668.9	666.9	(2.0)	
Inventories	16.8	16.8	17.2	0.3	
Trade and other Receivables **	57.9	40.7	40.4	(0.3)	
Cash and Cash Equivalents **	84.0	86.0	82.0	(4.0)	Note 2
Total Current Assets	158.7	143.5	139.5	(4.0)	
Trade and other payables **	(134.0)	(127.1)	(131.4)	(4.3)	Note 3
Borrowings	(14.0)	(14.0)	(13.8)	0.2	
Provisions	(5.6)	(5.6)	(5.6)	0.0	
Total Current Liabilities	(153.5)	(146.7)	(150.8)	(4.1)	
Borrowings	(256.8)	(249.3)	(249.3)	0.0	
Provisions	(2.7)	(2.7)	(2.6)	0.1	
Total Non Current Liabilities	(259.5)	(251.9)	(251.8)	0.1	
Total Assets Employed	411.7	413.8	403.8	(10.0)	
Financed By:				-	
Public Dividend Capital	665.0	665.0	665.0	-	
Retained Earnings *	(427.5)	(425.5)	(435.4)	(10.0)	Note 4
Revaluation Reserve *	174.2	174.2	174.2	-	
Total Taxpayers Equity	411.7	413.8	403.8	(10.0)	

The deferred income balance also includes significant balances relating to cash received relating to high cost devices (£5m) and digital pathology (£1.6m).

Note 4. Retained earnings are showing a £10m variance from plan which reflects the revenue variance from plan of £10.8m at Month 7. This is partly mitigated by higher than planned capital donated income of £0.8m (relating to donated capital expenditure).

Variances to the plan at Month 7 are explained below:

Note 1. The year-to-date slippage is partly offset by higher than planned depreciation including the acceleration of depreciation on assets that are no longer in use which were donated to the Trust by UKHSA as part of the Covid response.

Note 2. At Month 7 the cash balance was £82m, which is £4m lower than the revised plan of £86m. Cash received is overall £4.4m higher than plan mainly due to other income and VAT reimbursements being £2.8m and £1.4m ahead of plan respectively.

Payments are £8.4m ahead of plan at Month 7. General and payroll payments are £5.4m and £0.9m ahead of plan respectively and partly reflect the current revenue overspend position. The general payments position in month reflects the payment of high value invoices relating to pharmacy and managed service contracts.

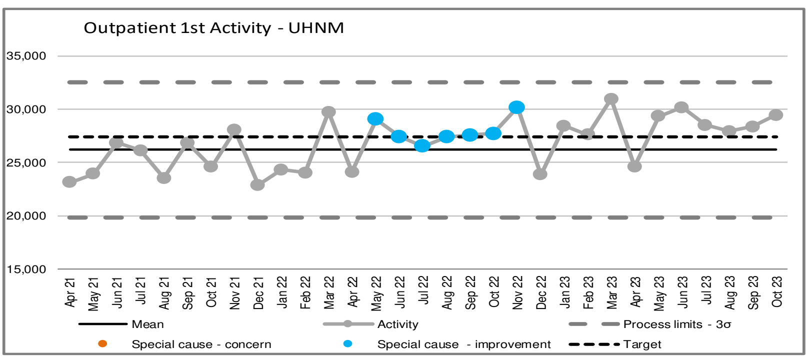
Note 3. Payables are £4.3m higher than plan mainly due to increases in deferred income at Month 7. In comparison to 31 March 2023, deferred income has increased by £21.5m to £37.1m and by £6m in comparison to Month 6.

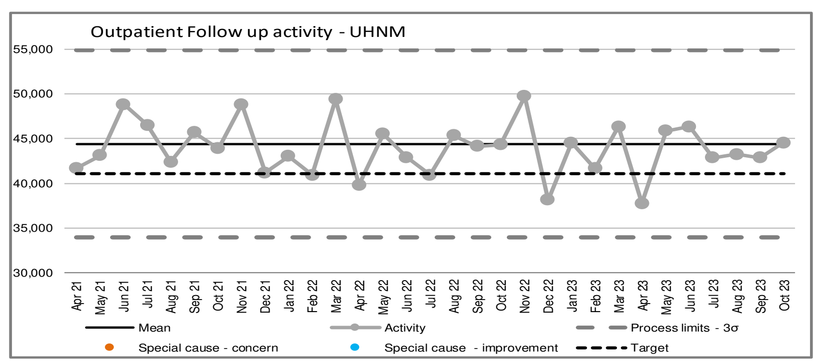
The main increase in deferred income compared to 31 March 2023 relates to Stoke and Staffordshire ICB where the Trust has a deferred income balance at Month 7 of £16.8m, an increase of £13.8m from 31 March 2023. This mainly relates to 23/24 non-recurrent income for Elective Recovery Fund (ERF) Marginal Gains Transfer where the income for the entire financial year has been received. In Month 7 the receipt of £2.2m Covid reimbursement funding for the entire financial year has increased the deferred income balance by £0.9m.

The main area of increase in-month has been relating to Education Contract training income with £8.9m of income deferred; this is due to £12.3m cash received in Month 7 relating to the period to 31 January 2024 resulting in £7.5m of this income being deferred at the end of Month 7.

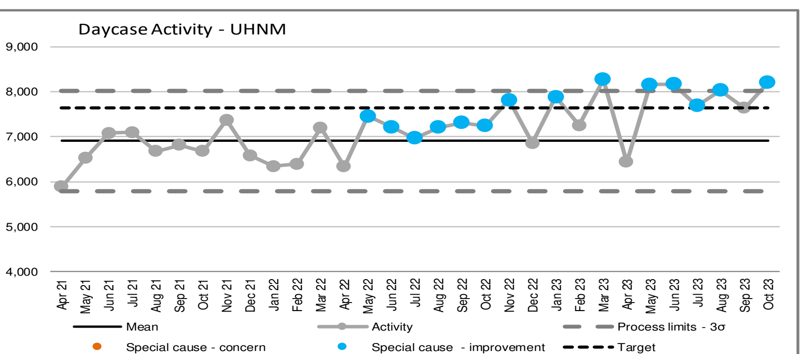
Activity

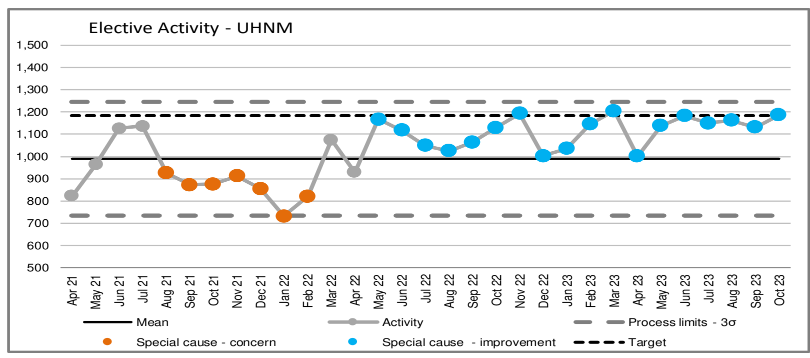
Planned care Outpatient



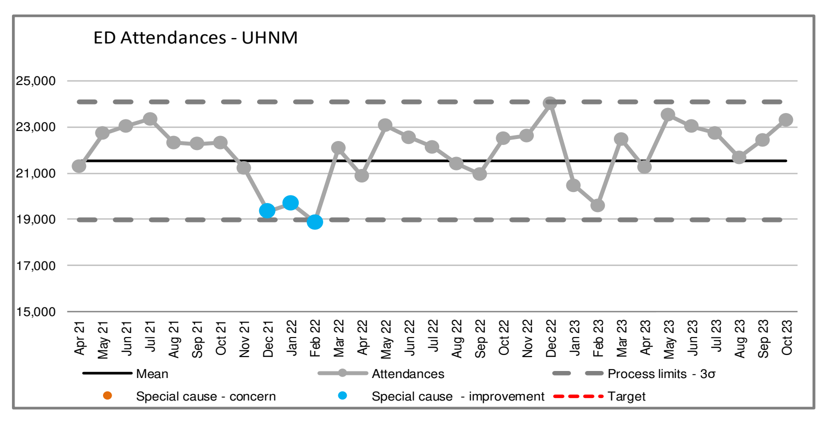


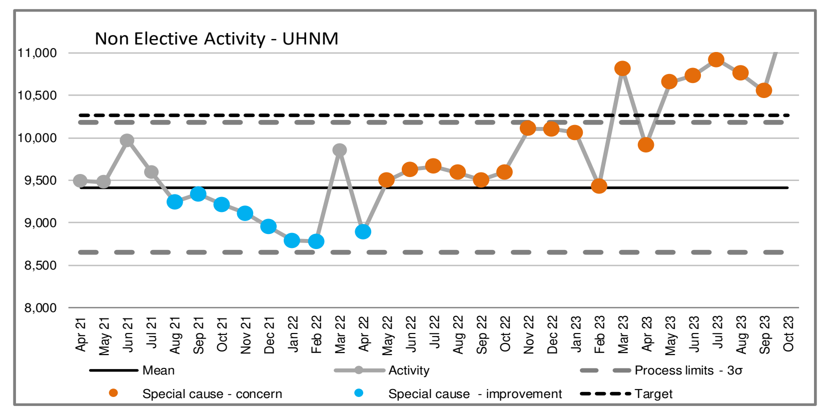
Planned care Inpatient





Urgent Care





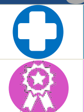
Executive Summary

Meeting:	Trust Board (Open)	Date:	6th December 2023
Report Title:	EPRR Core Standards Assurance	Agenda Item:	16.
Author:	John Dodds Head of EPRR		
Executive Lead:	Matthew Lewis EPRR AEO		

Purpose of Report

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

Alignment with our Strategic Priorities

	High Quality			People			Systems & Partners	✓	
	Responsive	✓		Improving & Innovating			Resources		

Risk Register Mapping

Executive Summary

Situation

- To ensure Trusts are appropriately delivering Emergency Preparedness, Resilience and Response (EPRR), a set of core standards has been developed and each Trust is asked to self-assess against the annual NHSE Core Standards for EPRR.
- UHNM was required to submit annual assurance to the Integrated Care Board (ICB) and NHS England (NHSE) against the NHSE Core Standards for EPRR by 31st August 2023 and met this deadline.

Background

- The assessment document for EPRR is a total of 62 individual core standards, split over 10 domains:
- The compliance level for each standard is defined as:

Compliance Level	Definition
Fully Compliant	Fully compliant with the core standard
Partially Compliant	Not compliant with the core standard but organisation's EPRR work programme demonstrates evidence of progress, and an action plan is in place to achieve full compliance within the next 12 months
Non-Compliant	Not compliant with the core standard but in line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months

- ICB & NHSE requested additional supporting evidence 11th October, which was submitted 18th October (note only documents produced prior to 31st August 2023 can be used as further evidence).
- The check and challenge process with the Trust, ICB and NHSE took place on 10th November 2023.
- The final and agreed report was submitted from the Trust to the ICB and NHSE on 10th November, for ratification at the Local Health Resilience Partnership (LHRP) scheduled for the 28th November 2023.

Assessment

- Since 2021, NHSE and the ICB have undertaken a more rigorous assessment against the core standards for EPRR than previous years, utilising a more focused audit methodology based on ISO Internal Auditing Standards, including annual review of plans, rather than three yearly cycles, and ensuring all organisational names are current (e.g. UKHSA and not PHE).

- The more rigorous auditing process has resulted in many NHS Trusts, both within the Midlands region, and nationally, attaining significantly lower ratings than in previous years.
- The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with:

Organisational Rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards (62/62 Core Standards)
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS Core Standards (55 – 61 of 62 Core Standards)
Partial	The organisation is fully compliant against 77-88% of the relevant NHS Core Standards (47 – 54 of 65 Core Standards)
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS Core Standards (less than 47 of 65 Core Standards)

- UHNM have agreed a final position statement with NHSE and the ICB.
- UHNM originally submitted a self-assessment core standards assurance rating on 31st August 2023, indicating Full Compliance against 5/62 (8%) of core standards (Overall Organisational Rating: Non-Compliant), but this was subsequently found to have been based on some missing evidence, and the newly appointed substantive Head of EPRR agreed a further opportunity with ICB and NHSE to reevaluate the core standards assessment, based on a further submission of additional evidence.
- Following the second confirm and challenge process, UHNM have agreed with ICB and NHSE that their reported position is 21/62 (34%) (Overall Organisational Rating: Non-Compliant).

Non-compliant	Below 76% -	21 / 62 Core Standards (34%)

- Feedback from NHSE and anecdotal evidence from other Trusts suggest that several have submitted core standards ratings and had overall organisational scores downgraded.
- It should be noted that substantive Head of EPRR and COO appointments, will ensure more consistent leadership going forward.
- Numerous positive learning outcomes from the process have been identified, including closer collaborative working with the ICB, and continuous feedback opportunities with the ICB.

Key Recommendations

The Trust Board is asked to note the update, whereby the detailed breakdown of the reasons for partial compliance have been provided to the Performance and Finance Committee. To ensure lessons are incorporated and that substantial compliance is achieved for 2024, a comprehensive Annual Work Plan has been created which targets each domain and individual core standards including exercising, planning, training, reviews, renewals, debriefing, and team recruitment, which will be shared with the AEO for assurance and approval.

Trust Board

2023/24 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 5	May 3	Jun 7	Jul 5	Aug 2	Sep 6	Oct 4	Nov 8	Dec 6	Jan 3	Feb 7	Mar 6	Notes
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse		Staff		Staff				Staff			Staff		
Quality Governance Committee Assurance Report	Director of Governance													
Quality Strategy Update	Chief Nurse													To be considered at the Trust Board Time Out - November 2023
Clinical Strategy	Director of Strategy													To be considered at the Trust Board Time Out - November 2023
Care Quality Commission Action Plan	Chief Nurse													Deferred to December pending further consideration by the Executive & Committees
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													To be considered in January after discussion at TAP in December
Quality Account	Chief Nurse													
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													
Infection Prevention Board Assurance Framework	Chief Nurse	Q3		Q4		Q1				Q2			Q2	
RESPONSIVE														
Integrated Performance Report	Various	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													Deferred to December due to ongoing discussions
PEOPLE														
Transformation and People Committee Assurance Report	Director of Governance													
Gender Pay Gap Report	Chief People Officer													
People Strategy Update	Chief People Officer													To be considered at the Trust Board Time Out - November 2023
Revalidation	Medical Director													
Workforce Disability Equality Report	Chief People Officer													
Workforce Race Equality Standards Report	Chief People Officer													
Staff Survey Report	Chief People Officer													
Raising Concerns Report	Director of Governance					Q4 & Q1			Q2			Q3		
IMPROVING AND INNOVATING														
Research Strategy	Medical Director													To be considered at the Trust Board Time Out - November 2023
SYSTEM AND PARTNERS														
System Working Update	Chief Executive / Director of Strategy													
RESOURCES														
Performance and Finance Committee Assurance Report	Director of Governance													

Title of Paper	Executive Lead	Apr 5	May 3	Jun 7	Jul 5	Aug 2	Sep 6	Oct 4	Nov 8	Dec 6	Jan 3	Feb 7	Mar 6	Notes
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above	Director of Strategy	N/A	N/A			N/A			N/A					
Digital Strategy Update	Chief Digital Information Officer													
Going Concern	Chief Finance Officer													
Estates Strategy Update	Director of Estates, Facilities & PFI													To be considered at the Trust Board Time Out - November 2023
Annual Plan	Director of Strategy													
Board Approval of Financial Plan	Chief Finance Officer													Approved at PAF April 2023
Final Plan Sign Off - Narrative/Workforce/Activity/Finance	Chief Finance Officer													Approved at PAF April 2023
Activity and Narrative Plans	Director of Strategy													Approved at PAF April 2023
Capital Programme 2022/23	Chief Finance Officer													Approved at PAF April 2023
Standing Financial Instructions	Chief Finance Officer													Next due for review February 2026
Scheme of Reservation and Delegation of Powers	Chief Finance Officer													Next due for review February 2026
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Director of Governance													
Audit Committee Assurance Report	Director of Governance													
Board Assurance Framework	Director of Governance		Q4			Q1			Q2			Q3		
Accountability Framework	Director of Governance													
Annual Evaluation of the Board and its Committees	Director of Governance													Board review considered at Trust Board Seminar in July
Annual Review of the Rules of Procedure	Director of Governance													
G6 Self-Certification	Chief Executive													
FT4 Self-Certification	Chief Executive													
Board Development Programme	Director of Governance													
Well-Led Self Assessment	Director of Governance													Timing TBC - proposal being considered November 2023
Risk Management Policy	Director of Governance													
Complaints Policy	Chief Nurse													Next due for review June 2024