University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 6th March 2024 at 9.30 am to 12.35 pm
Vis 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 7th February 2024	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	**6.**	Chief Executive's Report – February 2024	Information	Mrs T Bullock	Enclosure	
10:15		**HIGH QUALITY**				
10 mins	**7.**	Maternity Quality Governance Committee Assurance Report (21-02-24) & Maternity Dashboard – January 2024	Assurance	Prof A Hassell Mrs S Jamieson	Enclosure	1
10 mins	**8.**	Maternity Serious Incident Report	Assurance	Mrs AM Riley	Enclosure	1
5 mins	**9.**	Quality Governance Committee Assurance Report (29-02-24)	Assurance	Prof A Hassell	Enclosure	1
10 mins	**10.**	Q3 Infection Prevention Board Assurance Framework	Assurance	Mrs AM Riley	Enclosure	1
10 mins	**11.**	Care Quality Commission Action Plan Update	Assurance	Mrs AM Riley	Enclosure	1
11:00 – 11:10 COMFORT BREAK						
11:10		**RESOURCES**				
5 mins	**12.**	Performance & Finance Committee Assurance Report (27-02-24)	Assurance	Ms T Bowen	Enclosure	5, 7, 8
11:15		**PEOPLE**				
5 mins	**13.**	Transformation & People Committee Assurance Report (28-02-24)	Assurance	Ms T Bowen	Enclosure	2, 3, 4, 6, 9
10 mins	**14.**	Q3 Speaking Up Summary	Assurance	Mrs C Cotton	Enclosure	3
11:30		**RESPONSIVE**				
40 mins	**15.**	Integrated Performance Report – Month 10	Assurance	Mrs AM Riley Mr S Evans Mrs J Haire Mr M Oldham	Enclosure	1, 2, 3, 5, 8
12:10		**SYSTEMS AND PARTNERS**				
10 mins	**16.**	Population Health and Wellbeing Strategy	Approval	Ms H Ashley	Enclosure	
12:20	**GOVERNANCE**					
10 mins	**17.**	Revised Performance and Accountability Framework	Approval	Mrs C Cotton	Enclosure	
12:30	**CLOSING MATTERS**					
5 mins	**18.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
	19.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 4th March to** Nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:35	**DATE AND TIME OF NEXT MEETING**					
	20.	**Wednesday 3rd April 2024, 9.30 am, via MS Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 7th February 2024 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									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 A Griffiths	Dietetic Team Leader (item 1)
Ms C Harris	Dietitian (item 1)
Mrs N Hassall	Deputy Associate Director of Corporate Governance (minutes)
Mrs S Jamieson	Director of Midwifery (item 7)

Members of Staff and Public: 3

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Staff Story**	
015/2024	Mrs Haire introduced Ms Charlotte Harris who had been invited to the Trust Board to describe her apprenticeship journey in light of National Apprenticeship Week. Ms Harris highlighted that after she had completed her undergraduate studies in nutrition, she applied for a dietetic assistant job in 2017. After some time, she recognised that she wanted to progress as a dietitian, but this required further study. As such she took part in an apprenticeship, after the Trust became a	

trailblazer in writing a specification for a dietitian apprenticeship. Ms Harris explained that she was included within the first cohort of the first course in the UK, which commenced in January 2022, working 3 days a week at the Trust and 2 days a week on her apprenticeship. She thanked Mrs Griffiths, Head of Dietetics, for the support provided to her and highlighted the challenges of completing the apprenticeship virtually. Ms Harris highlighted that she had three placements during the latter stage of her apprenticeship; at the Trust, Haywood and South Staffs and before she was due to graduate, she successfully gained employment at the Trust within oncology. She highlighted that she was waiting for Health and Care Professions Council (HCPC) approval and once that had been confirmed she would become a dietician. Mrs Griffiths highlighted that the role Ms Harris had gained was a Band 5 aspiring to Band 6 and that the apprenticeship degree was in dietetics and leadership.

Mr Wakefield highlighted that prior to the Board meeting the Non-Executive Directors had suggested receiving an update on the success of the apprentice scheme and therefore welcomed Ms Harris sharing her story and particularly for the enthusiasm shown. Ms Harris highlighted she had not wished to become a full time student again after her undergraduate studies, and therefore she enjoyed the ability to learn whilst also continuing to work and added that the apprenticeship provided hands on experience and support which she felt would not have been as forthcoming if she was a full time student.

Dr Griffin referred to the importance of apprenticeships and queried whether there was anything which Ms Harris would change about the programme. In addition, he asked Mrs Griffiths whether she felt the balance of supporting apprenticeships was manageable. Ms Harris stated that there was an issue of being unable to take annual leave during the 12 week placement which had been raised with her tutor. In addition, she highlighted that it seemed that lecturers sometimes forgot that the apprentices were working and therefore needed down time.

Mrs Griffith stated that the ability to provide the opportunity for talented assistants to progress as professional registrants had helped to ease recruitment difficulties. In addition, she added that the other challenge in supporting apprenticeships was the ability to cover the workforce when the apprentices were concentrating on their studies, and this had been addressed by providing backfill.

Mrs Bullock asked Ms Harris what motivated her to stay with the Trust and Ms Harris explained that she had made friends for life and the support from the management and team was the main factor in her deciding to stay at the Trust. In addition, she highlighted that she liked the variety of work at the Trust in terms of the acute side and specialist areas.

Mrs Riley highlighted that Mrs Griffiths had looked at creative ways to generate the future workforce in an innovative way and this needed to be considered for other areas. In addition, she highlighted that the money for the apprenticeships and back fill was not adding any extra cost.

Mr Evans referred to Ms Harris completing her undergraduate studies and queried, if she had heard of the programme earlier, whether she would have done the course straight away. Ms Harris explained that she was unaware of dietetics when she completed her studies in nutrition and felt that having the experience as an assistant helped her. She welcomed the route she had taken and the way in which this supported the development of her knowledge and skills.

Mr Oldham referenced the support provided by Mrs Griffiths and he welcomed the initiative taken from her to introduce the apprenticeship.

	Mr Wakefield congratulated Mrs Griffiths for being innovative in introducing a new course to support recruitment and progression of staff. He welcomed her enthusiasm and the support provided by the team to their apprentices and noted the actions to further improve the pathway for future students. **The Trust Board noted the staff story.**	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
016/2024	Mr Wakefield welcomed members to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate.	
3.	**Declarations of Interest**	
017/2024	There were no declarations of interest raised.	
4.	**Minutes of the Previous Meeting held 3rd January 2024**	
018/2024	The minutes of the meeting held 3rd January 2024 were approved as a true and accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
019/2024	There were no further updates to the post meeting action log.	
6.	**Chief Executive's Report – December 2023**	
020/2024	Mrs Bullock highlighted a number of areas from her report. Mr Wakefield referred to apprenticeships and requested an update at a future meeting to be provided, in terms of how the success of the programme was being measured. Ms Bowen congratulated the progress made in terms of the Net Zero project and the difference this was making. In addition, she congratulated the recruitment team and the particular reduction in time to hire. Professor Hassell welcomed the progress made on the new car park which was aiming to be completed 3 months early. Mr Wakefield recorded his thanks to Mrs Bullock, in light of the announcement of her retirement, and the positive impact she had had on the Trust. He referred to the feedback in the Health Service Journal which was a great testament to her career. Mr Wakefield highlighted that he was due to complete his last term at the Trust in March 2024, but due to the retirement of Mrs Bullock this had been extended by NHS England for a further 2 years. He explained that the process for Chief Executive recruitment had commenced, and applications were due to close on 16th February. **The Trust Board approved eREAFs 13216, 13122 and 13003 and received and noted the report.**	

HIGH QUALITY		
7.	**Maternity Dashboard – December 2023**	
021/2024	Mrs Jamieson highlighted the following: • In terms of training compliance, there remained fluctuations although an annual plan was in place and overall compliance was being maintained, currently at 90% • Further progress with induction of labour had been made, following changes in approach, and the target for December had been achieved. It was highlighted that performance for January was expected at 98% • Maternity Assessment Unit (MAU) triage within 15 minutes was not quite achieving the trajectory, although there was a month-on-month improvement, with further improvement expected in January • Following regional presentation across the East and West Midlands, the Trust had been recognised for its improvements, and the inpatient matron had been asked to Chair the Birmingham Symptom Specific Obstetric Triage System (BSOTS) group • The CNST standards had been achieved as previously agreed by the Board and the ICB and these had been submitted to NHS Resolution • Midwifery staffing had 21.53 WTE vacancies, and good progress continued to be made, whereby the number of instances of positive acuity was 66% Ms Bowen referred to the improvements in reducing vacancies and the aim to reduce from 10 to 12 and queried whether this was on track. Mrs Jamieson highlighted that she expected this to be between 12 to 15. She stated that there had been an increase in appointing Band 6 midwives which was positive in that the Trust was attracting midwives from elsewhere. Dr Griffin referred to the staffing levels and the positive progress made and welcomed the achievement made. Mr Wakefield referred to the escalation triggers and queried how that worked in reality. Mrs Jamieson stated that the new escalation point was that when the unit reached 2 or more women requiring triage, this was escalated in order to get the women seen so that the department did not move to 3 requiring triage, as this would result in the department being unable to catch up. Mrs Riley highlighted the positive improvements made in staff retention. Mrs Jamieson stated that the Trust was the highest against peers with 100% retention of newly qualified midwives. She referred to the initiatives in terms of continuing to support midwives once they had become Band 6. She added that in terms of the regional position, the Trust ranked the highest in the region for retention of maternity staff. Professor Hassell referred to the positive impact from Mrs Jamieson and thanked her for the progress made. Mr Wakefield queried if the Care Quality Commission (CQC) were to visit the unit, what they would expect to see. Mrs Jamieson stated that they would see the improvement in MAU triage, the physical change in the environment and after talking to staff, recognising the change in responsiveness. She stated that the team continued to implement changes in response to promoting the best outcomes and care. **The Trust Board received and noted the dashboard.**	

RESOURCES		
8.	**Extraordinary Performance & Finance Committee Assurance Report (29-01-24)**	
022/2024	Mrs Bowen highlighted that a further session had been agreed to be held with Non-Executive Directors to further consider the EPR outline business case, although it had been agreed to commence soft market testing in the interim. Mr Wakefield requested that the additional meeting included all the Board members and this was agreed. **The Trust Board received and noted the assurance report.**	
9.	**Digital Strategy Update**	
023/2024	Mrs Freeman highlighted the following: • The report referred to the progress made in terms of delivering the digital strategy and provided a list of programmes completed and those which remained in train • 36 projects had been delivered and 39 were planned, which varied in size and complexity • A number of initiatives were coming through the pipeline and had been included for information Ms Bowen congratulated the good progress made and suggested that future reports provided assurance as to whether the Trust was on track to deliver future projects. Dr Griffin was pleased to welcome the inclusion of patients in driving forward changes, i.e. Patient Knows Best and changing pathways. Mrs Freeman stated that she was proud of the programme, which had utilised the basic capabilities using national monies with further clinically driven enhancements. Mr Wakefield referred to the impact of Industrial Action and critical incidents and queried how this had impacted the ability to deliver the strategy. Mrs Freeman stated that as part of planning for Industrial Action and times critical incidents, any planned changes were assessed regarding whether they were low risk or essential and were able, could be paused so as not to distract from the critical incident. As such, there needed to be flexibility within the plan to be able to swap and change the priorities of updates accordingly. Professor Hassell queried how at risk future projects were in terms of delivery due to the financial controls in place and Mrs Freeman stated that this was a significant risk, particularly for the EPR project. Mr Wakefield referred to the financial constraints and stated that it was unlikely that the Trust would have money to spare and queried whether contingency plans were in place to enable works to be undertaken as planned. Mrs Freeman referred to the risk in relation to the expiry of the current EPR system which would not be extended due to the Standing Financial Instructions, and an alternative route was being considered. She stated that opportunities to negate the risk were being explored. Mr Wakefield stated that the Board needed to understand how the Trust was navigating the risk of lack of finance and the impact on digital transformation, via the Transformation and People Committee.	

	Ms Ashley referred to the 2024/25 priorities for all enabling strategies which were to be highlighted at the Board Seminar in March. **The Trust Board received and noted the update.**	
RESPONSIVE		
10.	**Integrated Performance Report – Month 9**	
024/2024	Mrs Riley highlighted the following: • There had been a sustained reduction in incidents of moderate harm and above and the number of serious incidents, when compared to last winter • No maternity serious incidents had been reported for December • 1 never event had occurred in relation to a retained swab which was under investigation and would be discussed in due course at Quality Governance Committee (QGC) • A Medicines and Healthcare Products Regulatory Agency (MHRA) alert regarding calcium gluconate had been closed • There remained further work required in terms of the friends and family test and responses within the Emergency Department which were considered to be as a result of the sustained pressures within the Department • In terms of timely observations an A3 had been undertaken to consider any systemic issues and leader standard work was being reviewed to inform future improvements and this would be discussed at a future QGC meeting • VTE compliance for maternity was not currently included in reporting and this was to be included going forwards as part of the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) findings Professor Hassell referred to sepsis performance and queried current performance and how this was impacted by the pressures within the Emergency Department. Mrs Riley stated that performance had been impacted by the pressures due to levels of occupancy. Mr Wakefield referred to the improvements with tissue viability and links to Your Next Patient (YNP) and queried what was driving the improvements. Mrs Riley stated that the risk had been recognised by teams who had put a number of interventions in place to mitigate the risk, including frequently reviewing patients on the corridor. Mr Evans stated that the Quality Impact Assessment in relation to YNP had been reviewed and escalation mechanism were in place to reduce pressure damage. Mr Wakefield queried if patients were being monitored for pressure damage while on an ambulance or in the corridor and it was noted that these patients were managed via frailty assessments. Mr Evans highlighted the following in relation to urgent and emergency care: • The majority of indicators during December and January were at a steady state rather than having improved • Industrial action resulted in a mixed impact during December and January, with some areas of improvement but also deteriorations due to increases in demand • The Trust had maintained its zero tolerance approach to ambulance handovers, and even on the most extreme days in December, there had been a significant reduction in long handover delays which continued to be discussed via the Tier 2 meetings. It was noted that the Trust had significantly improved on this area when compared to 2022/23 although further improvements were required • There remained concerns around admission avoidance which were to be considered via the Performance and Finance (PAF) Committee	

- The forecast was that the Trust would not make the improvements it had anticipated, until towards the end of January, and work continued to focus on ambulance handovers and re-energising the work on achieving 76% 4 hour performance

Mr Wakefield queried the reasons for there being 1000 more ambulance conveyances than the previous December and the impact on the bed gap and Mr Evans referred to the fluctuating performance of acute care at home during December and January and the seasonal shift whereby the Trust had moved to an overall shortfall of 30 beds a day. He highlighted that workforce and behavioural changes were required to keep patients in the community when appropriate.

Professor Hassell queried what 'call before convey' meant and Mr Evans highlighted that West Midlands Ambulance Service (WMAS) were able to telephone practitioners who had knowledge of the different services available and were able to advise the best place for the patient to be cared for. He explained that once the practitioner had identified the services, they would arrange for the patient to be seen so that the ambulance crew could move on. He stated that further work was required on the timeliness, operating hours, and capacity of these services in order to able to respond during peak demand.

Mr Wakefield referred to the 76% target and queried if it was anticipated whether the Trust could achieve the target. Mr Evans stated a conscious decision to reduce performance recently had been made, on the balance of risk. In addition, he highlighted that some patients could be seen quicker at County and the increased throughput had also impacted performance. He referred to the need to reduce congestion and improve flow to improve performance. Mr Evans confirmed that the aspiration was to achieve the 76% target whilst noting the challenges. Mr Wakefield stated that the Trust would accept possible failure of the target, if everything was being done to keep patients safe.

Dr Griffin referred to the actions being taken at the front door and queried progress in terms of discharges. Mr Evans stated that the non-elective improvement programme focussed on simple and timely discharges and that programme of work was the highest priority. He stated that the improving together methodology was being utilised and work was also being undertaken by a consultancy to provide additional capacity to fully embed other discharge principles. He stated that the number of discharges needed to increase in order to decompress the Emergency Department.

Ms Bowen referred to the schemes to reduce length of stay and queried when a debrief on the winter plan was expected. Mr Evans stated that an initial debrief and review of critical incident measures was to be undertaken on 27th February. He stated that this debrief would provide an indicative view and learning would be built into Bank Holiday planning for the Easter period. He stated that a full brief would take place at the end of April and Mr Wakefield requested that a summary of how winter went and what happened this year be provided to Board members.

Mr Evans continued to highlight the following in relation to planned care:

- The number of patients waiting over 78 weeks continued to reduce, and progress had continued to be made in respect of the zero trajectory by 31st March. 3 specialties were struggling to reduce the waiting list and this included waiting for some mutual aid for spinal patients, additional insourcing capacity for endoscopy and general/ colorectal surgery
- The Trust remained in the worst quartile for long wait patients when compared to region / peers

- In terms of 104 week waits, there remained 1 patient on the pathway which had been worked through. It was noted that as the Trust reduced the number of 78 week patients, 104 week waits should be viewed as a never event
- It was highlighted that fewer patients were 'popping up' as a result of improved data quality
- The backlog for 62 day patients had improved despite industrial action
- The lower GI pathway had made particular progress but diagnostics for cancer remained a concern and this would continue to impact on the ability to reduce the backlog of cancer treatments

Mr Wakefield queried the plans to make improvements for diagnostics and Mr Evans stated that the Community Diagnostic Centre (CDC) aimed to provide additional capacity, but in the interim the Trust needed to run its present services at full capacity. He added that endoscopy challenges were being experienced at a national level which was why these had been added into the CDC programme. Ms Ashley added that demand and capacity modelling for the CDC had suggested that additional endoscopy capacity was not required until March 2025 therefore it should not curtail progress being made before that time.

Ms Bowen referred to endoscopy and welcomed the measures taken to address the challenges. She queried when it was expected to see an improvement in performance and Mr Evans highlighted the different areas in which it was expected to improve and stated that he anticipated the improvements would not be sustained until after a year. He added that further detail would be considered at a future PAF meeting.

Dr Griffin referred to the patients in the 65 week position and queried the actions taken to avoid these moving into the 78 week position. He queried how confident the Trust was, that it could achieve the 78 week and sustain that level of performance. Mr Evans stated that the position was reviewed with regulators on a weekly basis which included a forward look.

Ms Bowen referred to the ethnicity page within the report and stated that this did not provide adequate assurance. Ms Ashley agreed to provide an update to all board members on the revised NHS England guidance on what should be reported on in terms of ethnicity. **HA**

Mrs Haire highlighted the following in relation to workforce performance:

- Turnover and vacancies continued to perform well and the Trust needed to continue to build momentum in reducing vacancies. The campaign 5 Reasons to Join UHNM had been launched in January and was proving to become a very successful campaign to attract applicants.
- Sickness absence had increased in month as was anticipated, but the rolling 12 month position continued to show an improvement as the December 2023 sickness absence was lower than December 2024.
- There had been a slight improvement in Personal Development Reviews (PDR) and the PDR paperwork had been refreshed and launched throughout the organisation.
- Statutory and mandatory training performance remained slightly below 95% target.
- The Staff Voice monthly survey had re-opened with a report on progress to be provided in February.
- The raw scores from the national staff survey had been reviewed although the results were embargoed until March and data was being reviewed against individual service lines

	Ms Bowen referred to staff sickness and queried whether the Trust should revisit the target as 3.39% had never been achieved and this had a resourcing impact. Mrs Haire recognised that the target was historic and realistically the Trust had been tracking at 5% for the past 3 years. She stated that a more realistic target would be between 4% and 5%. Mr Wakefield queried if staff absence levels were planned on 3.39% or 5% basis and Mrs Haire stated that nurse establishment was based on 3.39% absence. Mr Oldham referred to the need to ensure that staff were being rostered at safe staffing levels, and added that as cover was not in establishment, bank or agency workers were being used rather than reducing the number of nurses on the wards. It was agreed to consider further this at a future TAP / PAF meeting. Mr Oldham highlighted the following in relation to financial performance: • The monthly position demonstrated a £1.7 m cumulative deficit although the forecast remained at break even • Capital was £6.6 m behind plan and work was ongoing to bring forward schemes in order to meet the Capital Resource Limit (CRL) • Cash was £14.5 m lower than plan but the Trust had since received £9 m as a contribution to Industrial Action which will improve the position in addition to drawing down of Public Dividend Capital (PDC) • The system target deficit stood at £91.4 m which had been accepted nationally, with UHNM's contribution being to break even although it was recognised that further Industrial Action may affect this • The 2024/25 planning guidance had not been received and challenges regarding non-recurrent savings had been considered given the Trust was due to commence 2024/25 with a £54 m underlying deficit and an underlying system deficit of £230 m. He stated that when considering possible assumptions for cost improvement, this equated to £290 m for 2024/25 which was in excess of 10% and was not achievable. As such a 1.1% efficiency target was expected with 1.3% conversion rate and 1% target for pressures, with the aim of delivering 3.4% at a provider level, with anything beyond that requiring system transformation Mr Wakefield queried if the approach to dealing with the system deficit was based on 2 to 3 years rather than a single year and Mr Oldham stated that it was recognised that addressing the deficit was not achievable in one year, but an acceptable and realistic pace of change was required. Dr Griffin queried the level of confidence in the ability to spend the capital by the year end, in addition to there being capacity within the estates team to deliver the 2023/24 plan. Mr Oldham highlighted that whilst the Trust was confident of the ability to be able to catch up, as the system had overcommitted by £2 m, if this was not achieved it would help the overall system position. Dr Griffin referred to the challenges for the system for 2024/25 and lack of planning guidance and queried whether the Trust was ready for cost improvement reductions to be made from Month 1. Mr Oldham stated that meetings were taking place with each Division, supported by the Project Management Office in identifying opportunities, particularly around premium costs. **The Trust Board received and noted the report.**	
GOVERNANCE		
11.	**Audit Committee Assurance Report (01-02-24)**	

025/2024	Dr Griffin highlighted the following: • Partial assurance had been provided for two internal audit reports and issues in relation to these audits were to be considered at QGC and PAF • Positive assurance had been provided on the data quality audit • There remained a number of internal audits to be delivered as per the plan • The Committee welcomed deep dives into the Board Assurance Framework (BAF) Mr Oldham highlighted that some of the issues in relation to the financial controls audit was due to timing rather than not being done as well as there being some transactional issues to be addressed. Mrs Riley highlighted that in terms of mental capacity audit, paper documents remained in place whilst the Trust transitioned from paper to iportal. She agreed to discuss this further with internal audit as well as providing an update to QGC. **The Trust Board received and noted the report.**	
12.	**Board Assurance Framework (BAF)– Quarter 3**	
026/2024	Mrs Cotton highlighted that the BAF and a number of specific risks had been scrutinised by Committees, via a deep dive with a general consensus that the sessions provided members with a better understanding of the areas of focus as well it helping to plan for 2024/25 risks. Mr Wakefield referred to the lower scores for BAF 6 and 8 and the issue between the focus on short term delivery and long-term focus and as such it had been suggested to include a two tier score for those BAF risks. **The Trust Board received and noted the summary Board Assurance Framework for Quarter 3.**	
13.	**Board Development Programme Update**	
027/2024	Mrs Cotton highlighted that the Trust had delivered the majority of its schedule of Board Seminars as planned, with a number of areas to be carried forward to 2024/25. Mr Wakefield requested board members to note the date of future Board Seminars within their diaries to avoid cancelling future sessions, given that these are set in advance. **The Trust Board received and noted the update.**	
14.	**Risk Management Policy**	
028/2024	Mrs Cotton highlighted the following: • The policy had been reviewed as part of the 3 yearly cycle • Nothing major had been changed, and any changes had been informed by the learning from NHS Providers • Changes had been made to reflect changes in the governance structure as well as providing areas of clarification based on feedback from Risk Owners Mr Wakefield welcomed the identification of accountabilities and the format of the policy. Ms Bowen queried whether the role of Non-Executive Directors should be referred to within the policy and Mrs Cotton suggested that the duties for Committees could	**NH**

	be expended to clarify that these related to Committees chaired by a Non-Executive Director. Ms Bowen queried whether the policy should reference the approach for risk management at a system level and Mrs Cotton stated that a separate system risk management strategy was in place whereby the system had adopted the Trust's risk appetite and other key components. She stated that each organisation had their own policy in place and that the system approach related to strategic risks whereas this policy focussed on operational and day to day management of risk. Mr Oldham referred to the risk appetite and suggested that a statement be included in relation to the Trust not being willing to risk patient safety as a result of financial constraints and it was agreed to amend the policy to include this. **The Trust Board approved the revised policy, subject to the above amendments.**	**NH**
CLOSING MATTERS		
15.	**Review of Meeting Effectiveness and Review of Business Cycle**	
029/2024	No further comments were made.	
16.	**Questions from the Public**	
030/2024	Mr Syme thanked Mrs Bullock for her leadership whilst at UHNM, and her role as a leader within the ICS. Mr Syme asked the following questions: **1. Maternity and Finance** The ICB despite being the Commissioner for the vast majority of Maternity Services for its catchment population, could not provide him with a breakdown of its spend despite NHS England knowing the global national spend, therefore he asked the Trust: a. Does UHNM have a 'budget' i.e. projected spend for the Maternity Services it provides and if so, what is that 'spend' for the fiscal year 2023/24? Mr Oldham highlighted that a budget for maternity was in place, which included neonatal and equated to £50.8 m for 2023/24 although this was not ringfenced. b. Is UHNM's Maternity Service subject to Cost Improvement Programmes (CIP) for the fiscal year 2023/24 and has the Maternity Service been subject to CIPs in any of the previous 5 years? Mr Oldham stated that maternity had not transacted any CIPs during the past 5 years although the Directorate was subject to CIPs. He added that Quality Impact Assessments were undertaken for any CIP. In 2022/23 investment into maternity of £2.5 m had been made, £1.7 in relation to Ockenden and £0.6 m in relation to British Association of Perinatal Medicine (BAPM) standards, in addition to receipt of non-recurrent monies. In 2023/24 a further £1.6 m was invested; £1 m for Ockenden and Birthrate plus and a further £0.5 m non-recurrent. In 2024/25 two cases had been through the double lock process for £2.6 m relating to obstetrics and gynaecology rotas to enable improvements in triage times as well as additional staffing in neonatal. c. What is the overspend/underspend/projected break-even situation regarding the Maternity spend?	

	Mr Oldham highlighted that for 2022/23 the underspend was £1.9 m and for 2023/24 there was a £600,000 underspend. **2. UHNM Board Minute 007/2024 Maternity Dashboard:** Mr Syme referred to the minute in relation to the drop in performance for induction of labour which was due to a change in guidance. He explained that the guidance referred to was not recently changed and was published in November 2021 (NG207). He stated that following queries and questions being raised regarding backlogs of induction of labour he had been made aware that the Trust did not incorporate the guidance into its standardisation of maternity care until April 2023, a month after the CQC Maternity Inspection at Royal Stoke in March 2023. He asked: a. Given national significance finally being given to quality and safety of Maternity Services why did it take the Trust 17 months to incorporate the guidance and only after a CQC Maternity Inspection? Mrs Riley referred to the improvement work since the guidance was published and advised that the guidance was incorporated within the Maternity improvement plan since that time. However, she noted there was no intent to fully implement the guidance from the outset as this could only be achieved once the workforce was in place to do so. Mrs Riley also noted that the implementation of this guidance started significantly prior to the CQC visit. Mr Syme referred to midwifery red flags if women were 30 minutes late for their induction of labour and Mrs Riley stated that the number of red flags was improving. b. What, if any, modifications and reviews of NICE guidance changes and incorporation by The Trust are being undertaken to hopefully ensure that a similar hiatus was unlikely to recur? Dr Lewis highlighted the process in place, whereby an officer reviews the NICE programme for daily updates and any new/updated guidance which is subsequently circulated to the relevant clinical lead(s). In addition, any audit requirements are assessed and delivered. He added that the NICE database was reviewed regularly. Dr Lewis referred to the review of the clinical effectiveness function which was seeking to make improvements to ensure that effectiveness was embedded in Divisions. **3. Diagnostics** Perpetual endoscopy capacity issues have been recurring since 2017 and Mr Syme queried when the issue was likely to be resolved? Mr Evans stated that between 2018 and Covid the Trust performed well for endoscopy. He stated that since that time the growth in demand had outstripped capacity. In addition, the priorities for cancer and planned care had also changed and therefore the Trust had obtained external funding. He stated that additional capacity had been identified although the gap was sizable and as such the Trust would need to utilise Independent Sector support. He added that it would take one year to recruit additional staff to deal with level of demand and going forwards a different model was required.	
DATE AND TIME OF NEXT MEETING		
17.	**Wednesday 6th March 2024, 9.30 am, via MS Teams**	

Trust Board (Open)

Post meeting action log as at 29 February 2024

CURRENT PROGRESS RATING		
B	Complete / Business as Usual	Action completed
GA / GB	On Track	A. Action on track – not yet completed *or* B. Action on track – not yet started
A	Problematic	Due date has been moved once. Revised due date provided.
R	Delayed	Due date has been moved twice or more. Revised due date provided.

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/585	06/12/2023	Infection Prevention Board Assurance Framework	To update future reports to include an assessment as to whether the Trust is on track with the trajectory of improvement	Ann-Marie Riley	06/03/2024	27/02/2024	IPC BAF update included on March's agenda.	B
PTB/586	03/01/2024	Integrated Performance Report – Month 8	To provide an update on admission avoidance schemes at a future Performance and Finance Committee.	Simon Evans	~~27/02/2024~~ 26/03/2024		To be covered as part of the surge plan update which is to be provided to Performance and Finance Committee in March.	A
PTB/588	07/02/2024	Integrated Performance Report - Month 9	To provide an update to all board members on the revised NHS England guidance on what should be reported on in terms of ethnicity.	Helen Ashley	03/04/2024		Action not yet due.	GA
PTB/589	07/02/2024	Risk Management Policy	To make the suggested amendments to the policy prior to final ratification	Nicola Hassall	06/03/2024	27/02/2024	Complete. Amendments made to the policy and published.	B

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

February 2024

Part 1: Contract Awards and Approvals

2.1 Contract Awards and Approvals

Since 14th January to 14th February 2024, 3 contract awards over £1.5 m was made, as follows:

- **NHS Blood Service (e-REAF 13216)** supplied by NHS Blood and Transplant Service, for the period 01.04.24 - 31.03.25 at a total cost of £4,100,000.00, approved on 09/02/2024
- **SCCL 23/24 Additional Trust-wide Annual Expenditure including HCTED (e-REAF 13122)** supplied by Supply Chain Coordination Limited, for the period 01.04.23 - 31.03.24 at a total cost of £14,806,059.00, providing Cost reduction savings of £837,256, cost avoidance £170,213 and Negated Inflation £728,800, approved on 09/02/2024
- **SCCL 24/25 Trust wide Annual Expenditure including HCTED (e-REAF 13003)** supplied by Supply Chain Coordination Limited, for the period 01.04.24 - 31.03.25 at a total cost of £59,419,241.00, providing target cost reduction of £335,000, Target negated inflation £750,000, approved on 09/02/2024

In addition, the following eREAFs were approved at the Performance and Finance Committee on 27th February. These require Trust Board approval due to the value:

Cytotoxic Dose Banded - Chemo, Immunotherapy and Monoclonal Medicines (e-REAF 13289)
Contract Value £14,000,000 incl. VAT
Duration 01.07.24 – 30.06.25
Suppliers Baxter, Qualasept Bath ASU, Sciensus Pharma, Quantum Pharmacutica
Savings To be confirmed

Services of Junior Doctors via Health Education England Contract with St Helens & Knowsley Hospitals (e-REAF 13326)
Contract Value £3,480,000.00 incl. VAT
Duration 01.04.24 to 31.03.25
Suppliers St Helens & Knowsley Hospitals Teaching NHS Trust
Savings N/A

Breast Care Unit (e-REAF 13402)
Contract Value £1,511,967.14 incl. VAT
Duration Capital Bid 6743
Suppliers IHP Vinci Construction Ltd
Savings N/A

Holistic Cancer Centre - Final design and construction works (e-REAF 13417)
Contract Value £3,059,570.51 incl. VAT
Duration Capital Bid 6714
Suppliers IHP Vinci Construction Ltd
Savings N/A

Supply Chain Coordination Limited (SCCL) - Trust wide Annual Expenditure - Amendment for outstanding 23/24 invoices (e-REAF 13502)
Contract Value £8,000,000 incl. VAT
Duration 01.04.23 - 31.03.24
Suppliers Supply Chain Coordination Limited (SCCL)

The Trust Board is asked to approve the above eREAFs.

2.2 Consultant Appointments – February 2024

The following provides a summary of medical staff interviews which have taken place during February 2024:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Respiratory Consultants with Specialist Interests	Vacancy	Yes	TBC
Locum Consultant Gastroenterologist	Vacancy	Yes	TBC
Consultant Neonatologist	New	No	Candidate withdrawn

The following provides a summary of medical staff who have taken up positions in the Trust during February 2024:

Post Title	Reason for advertising	Start Date
Locum Consultants Obstetrician & Gynaecologist	Maternity	02/02/2024
Locum Consultants Obstetrician & Gynaecologist	Extension	02/02/2024
Consultant Paediatric Orthopaedic Surgeon	New	15/02/2024
Consultant Orthopaedic Pelvic and Acetabular Surgeon	Vacancy	26/02/2024
Locum Consultant Interventional Cardiologist	Extension	20/02/2024

The following table provides a summary of medical staff vacancies which closed without applications / candidates during February 2024:

Post Title	Closing Date	Notes
Consultant in Microbiology or Infectious Disease / Microbiology	12/02/2024	No Applications

2.3 Internal Medical Management Appointments – February 2024

The following provides a summary of medical management interviews which have taken place during February 2024:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Lead - Gastroenterology	Vacancy	TBC	TBC

No medical management have taken up positions in the Trust and no medical management vacancies closed without applications / candidates during February 2024.

Part 2: Highlight Report

High Quality | Responsive | People | Improving & Innovating | System & Partners | Resources

National / Regional

2.1 CQC Maternity Survey

On 9th February, the CQC published their Maternity Survey report. The survey included women who had used our maternity services between January and February 2023 and results recognised staff for their kindness and compassion with 96% of women saying they were and 94% saying had confidence and trust in staff during their labour and birth.

Most improved scores since the previous year were in areas including partners being able to stay; women offered a choice of where to have their baby and more women given enough support for mental health during pregnancy. We will continue to focus on developing our service for the future in line with the feedback we have received.

The survey results are much improved on previous years and the full results will go through our usual governance routes to the appropriate sub board committee.

2.2 Fuller Inquiry: Phase 2

An Independent Inquiry was established in November 2021 at the request of the Secretary of State for Health and Social Care to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuaries at Maidstone and Tunbridge Wells NHS Trust and why they went apparently unnoticed for so long.

The first phase of the Inquiry, on matters relating to Maidstone and Tunbridge Wells NHS Trust, concluded in November 2023 with the publication of the Phase 1 Report. The Trust has already responded to the recommendations from the phase 1 report and this was reported through trust governance.

Phase 2 of the Inquiry will look at the broader national picture and consider if procedures and practices in other hospital and non-hospital settings, where deceased people are kept, safeguard the security and dignity of the deceased.

As the next step in its investigations, the Fuller Inquiry is conducting a short survey of Trusts. Whilst the survey is not mandatory, we recognise the importance of taking part so that the Inquiry can secure the best learning outcomes for the future and I have asked Matthew Lewis, Medical Director to act as our internal Inquiry lead to support this.

2.3 National Hip Fracture Database

The National Hip Fracture Database (NHFD) is a mandatory national clinical audit commissioned by the Healthcare Quality Improvement Partnership (HQIP) and managed by the Royal College of Physicians (RCP) as part of the Falls and Fragility Fracture Audit Programme (FFFAP), with representation from the British Orthopaedic Association (BOA) and British Geriatrics Society (BGS).

I was pleased to receive news that in 2023, our figures have demonstrated extremely good performance in comparison to our peers (meeting NICE guidelines 93% of the time compared to other trusts who are achieving 67%) which means that not only are we treating our patients in line with best practice, but we are also keeping our costs down as far as possible in doing so. As a result of this, we have been invited to provide a showcase of our good practice, so that others can learn from it.

2.4 PAFTA's

I was thrilled to receive the news that our own neonatal unit team had won this year's Paediatric Awards for Training Achievements' (PAFTA) Best Training Unit in the West Midlands. In addition to this accolade, several individuals were highlighted for their work. Congratulations go to Lucy Preston, neonatal dietician, who won the title best Allied Health Professional (AHP) in the region. Well done also to those nominated for awards who included Dr Julia Uffindell and Dr Jyoti Kapur, Sharon Turnock nominated for best Advanced Neonatal Nurse Practitioner (ANNP), Dr Rizma Moosa for best senior trainee and Georgina Dennehey for best non-clinical training hero. What a massive achievement and it is fantastic to see the amazing work they all do being recognised across the region.

System Focus

2.5 Right Care Right Person

Staffordshire Police have changed the way they respond to calls related to health and social care concerns. This new policy is called Right Care Right Person and aims to ensure that vulnerable people in Staffordshire and Stoke-on-Trent who are experiencing a deterioration in their health, receive support from those most appropriately trained to deliver it. This does mean some changes for us, and we have provided staff with information on these.

Organisational Focus

2.6 Home Care is Best Care

There is often an assumption, by both clinicians and families, that admission to an inpatient hospital bed represents the safest option for frail elderly patients. However, there are a range of potential harms from admission which should be considered as part of their risk assessment. In addition, many patients would prefer to be looked after outside hospital if that option was available to them.

Advanced care planning, including ReSPECT, can help to create a unique package for every patient. Any decision to admit should be based on evidence that demonstrate the benefits outweigh the risk and should be part of informed, shared decision-making with patients and families. More information to support shared decision making and risks to admission can be found under Home Care is Best Care on the intranet.

2.7 Estate Developments

I am delighted that work started on the exciting £4 million development to improve the entrance to our Royal Stoke Cancer Centre. This development, which is due to be finished in December, includes an improved coffee area, holistic services and pharmacy services. Another great achievement for our estates team is the new staff car park which is due to be completed three months ahead of schedule and brings car parking onsite for many more of our colleagues. Work is also progressing on our additional facility to support our emergency services outside the emergency department at Royal Stoke and planning work is well on the way for our new breast care unit at County Hospital. Despite the financial pressures we are continuing to invest and support improvements to patient safety and care.

2.8 Equality and Diversity

There have been a lot of activities in support of our positive approach to inclusion during the month. As part of Race Equality Week teams and colleagues shared their stories and commitment to tackling race issues and making this a safe place to work for everyone. One of UHNM's key strengths is the diversity of the workforce and it was great to see so many different experiences. Thank you to everyone who got involved to spread the important messages about race equality and inclusion.

2.9 2023 Patient Led Assessments of the Care Environment (PLACE) Inspection Results

I am delighted to report that the Trust achieved an amazing set of scores following the PLACE Inspections which took place in 2023, at both Royal Stoke and County Hospital, where we received scores above the national average across all eight elements assessed. This is testament to the hard work and dedication of our non-clinical teams and the support of our infection prevention, dietetic, and nursing colleagues and it also reflects our collective recognition of how vitally important our environment and our services are to patient care/experience and to creating a great place to work at UHNM.

Congratulations and huge thanks to all who have supported the achievement of such excellent results.

University Hospitals of North Midlands NHS Trust

Maternity Quality Governance Committee

Highlight Report to Trust Board

21st February 2024

1 Escalations Summary

Matters of Concern / Key Risks to Escalate

- Medical compliance with safeguarding training remains a concern for the team and forms part of the CQC action plan
- PDR compliance remains a challenge although the team have a targeted plan to improve this which aligns with their workforce modelling
- 3 serious incidents (SI) reported during Q3 which have been investigated and lessons learned
- Audit of consultant attendance at required situations highlighted sepsis and MEOWS scores as areas of concern; actions identified for improvement

Major Actions Commissioned / Work Underway

- Further work on cultural improvement to be undertaken in areas which have been harder to reach
- Participation in a detailed assessment of services as part of the Thirlwall Inquiry and further requests for information are now ongoing with further surveys anticipated over the coming weeks
- Assurance on VTE compliance to be included on the dashboard as it was highlighted as a key factor in the MBRACE report and has become a watch metric
- Serious incident report to be refreshed to easily identify lessons learned, issue identified, action taken and further monitoring
- Mortality reporting / governance to be reviewed to ensure that there is no duplication / inconsistencies
- Work continues to progress towards Saving Babies Lives compliance which needs to be at 100%
- Review of risk associated with compliance with national guidelines for BMI / consultant attendance
- Consideration to be given to development of service overview for birth trauma / perineal trauma
- Quality review process being implemented as a result of discussions at system level
- Consideration to be given to what data around ethnicity / equality can be drawn into the papers

Positive Assurances

- Clinical Director of Maternity, Neonates & Gynaecology reappointed
- Lots of achievements through a structured approach to improve culture including business case implementation, safety huddles, celebration of achievements, Vitality Team Leadership and Behaviours programme – improvements have been seen in staff feedback and maternity survey and they have been asked to showcase their success specifically around workforce recruitment and retention
- Above national trajectory for smoking at the time of delivery with consistent improvements being made from 10.34% in Q1 to 7.55% in Q3
- Significant focus on Induction of Labour through use of Improving Together tools / methodology which was above trajectory in January
- No serious incidents or moderate harm incidents reported in January
- Very positive approach taken to learning from incidents in line with the new PSIRF
- 100% compliance with all standards within Safety Action 1
- UHNM in the top 5 Trusts within the region for compliance with Saving Babies Lives
- Excellent progress with vacancy reduction and attrition
- Under national target of 6% term admissions to the NICU and consistently achieving the stretch target of under 5% (Q3 at 3.98%)
- CNST achieved for 2023 and additional funding received as a result of those organisations who had not achieved the requirements

Decisions Made

There were no items requiring decision.

Review of Meeting Effectiveness

- Effectiveness review to be undertaken as it was clear that there were a number of papers which had already been considered at the Executive Group and there was likely to be lots of duplication

University Hospitals of North Midlands NHS Trust

Maternity Quality Governance Committee

Highlight Report to Trust Board

21st February 2024

2 Summary Agenda

1	Leadership & Culture Update	Assurance	7	Midwifery Workforce Report	Assurance
2	Thirlwall Inquiry	Information	8	ATAIN Q3 2023/24	Assurance
3	Maternity Dashboard Q3 / Jan 24	Assurance	9	Re-audit of Consultant Attendance	Assurance
4	Maternity & Neonatal New Serious Incident Report Q3 2023/24	Assurance	10	Medical Workforce Highlight Report	Assurance
5	Perinatal Mortality Report Q3 2023/24	Assurance	11	Maternity & Neonatal Quality and Safety Group Assurance Report	Assurance
6	Saving Babies Lives Care Bundle V3 UHNM Compliance	Assurance	12	System Maternity Oversight & Assurance Group (SMOAG) Minutes	Information

3 Attendance Matrix 2023/2024

Attended | Apologies / Deputy Sent | Apologies / Did Not Attend

Members		Aug	Sep	Nov	Feb
Andrew Hassall	Non-Executive Director (Chair)				
Claire Cotton	Director of Governance	NH	NH	NH	
Simon Evans	Chief Operating Officer	OW			
Jane Haire	Chief People Officer	RC			
Matthew Lewis	Medical Director				
Katie Maddock	Non-Executive Director				
Jamie Maxwell	Head of Quality, Safety & Compliance				
Ann-Marie Riley	Chief Nurse		JH	JH	
Sunita Toor	Non-Executive Director				

In attendance:

- Sarah Jamieson, Director Midwifery
- Caroline Meredith, Divisional Operations Director
- Simon Cunningham, Clinical Director
- Donna Brayford, Governance Lead

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th March 2024
Report Title:	Maternity Dashboard: January 2024	**Agenda Item:**	7.
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	●	Improving Together		
Responsive	●	Improving & Innovating	●	Resources	●			

Risk Register Mapping

ID	Title	Risk level
15993	Maternity Assessment Unit Triage	12
13419	Midwifery safe staffing (entered following Birth Rate Plus establishment review 2019)	9
13420	Lack of activity at Freestanding Midwifery Birth Unit (FMBU), County leading to suspension of intrapartum care	6
11518	No current operational Midwifery Continuity of Care team	6

Executive Summary

Situation

The Maternity Dashboard report provides an overview of the Maternity performance for January 2024.

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 targets have now been achieved.
- Work continues to improve maternity triage times.
- Work continues to reduce the induction of labour breaches.

Key Recommendations

The Trust Board is asked to receive this report.

NHS
University Hospitals of North Midlands
NHS Trust

Maternity Monthly Dashboard

7th February 2024 (January report)

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. (safety action 9)
- Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set (figure 1).
- Demonstrate an effective system of midwifery planning to the required standard. (safety action 5)

Figure 1: Minimum Data Set

1. The number of incidents logged, graded as moderate or above and what actions are being taken.
2. Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training.
3. Findings of review of all cases eligible for referral to HSIB
4. Service User Voice feedback
5. Staff feedback from frontline champions and walkabouts
6. HSIB/NHSR/CQC or other organisation with a concern or request for action, made directly with the Trust
7. Coroner Reg 28 made directly to the Trust
8. Progress in achievement of CNST 10
9. 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
10. Findings of review of all perinatal deaths using real time data monitoring tool

2. Assessment

1. Incidents logged and graded as moderate or above and the actions taken

No serious incidents or incidents graded as moderate harm were reported in January.

2. Training compliance for all maternity staff groups

We are very pleased to confirm that the target for 90% compliance for PROMPT emergency training has been achieved and this data has been submitted as evidence of achieving this element on CNST safety action 8.

December figures indicate a slight fluctuation in the percentage, this is as people become out of date within the rolling year.

All training is now prebooked by the ward managers.

Figure 2 - Staff Training Figures Virtual PROMPT Training

The 90% training target for skills day 3 including fetal monitoring and saving babies lives has been met as required at the end of November, there was no fetal monitoring training in December. The training recommenced in January with a rolling dashboard of attendance maintained.

(FEBRUARY 2023 – JANUARY 2024 inclusive (compliance 100% staff)

	Doctors	Obs consultants	Obs trainees	Anaesthetist	Anaes consultants	Anaes trainees	Midwives/Bank	CSW	TOTAL THEATRE NOT INC	Theatre
*Total number staff	65	17	48	58	27	31	334	107	564	7
Staff trained Linc PROMPT Trainers)	61	14	47	53	26	27	300	95	509	6
*Current compliance	93%	82%	97%	91%	96%%	87%	89%	88%	90%	85%

FEBRAURY 2023 – JANUARY 2024 inclusive (compliance 100% staff)

	Doctors	Obs consultants	Obs trainees	Midwives/Bank	TOTAL
*Total number staff	52	16	36	334	386
Staff trained (inc PROMPT Trainers)	48	15	33	299	347
*Current compliance	92%	93%	91%	90%	90%

3. Findings of review of all cases eligible for referral to HSIB

There were no HSIB referrals in January.

4. Service User Voice feedback.

Feedback received from patients in ward 206 (post-natal)

"The staff were AMAZING!"
"They were so understanding, no-one could have done anymore, all the staff were FANTASTIC. Thank you all"

5. Staff feedback from frontline champions and walkabouts

Suni Toor, Non-Executive Director and Safety Champion completed a safety champion walkabout on 26th January

"It was busy across the service at the time of my walkabout. MAU had sought support to ensure timely treatment and transfer of a lady to the ward. Delivery suite was very busy but the flow-co had everything in hand and raised no concerns although I noted they were late to take a break and the senior team who were also on delivery suite offered to cover so she could take a break.

The wards were also busy but again no concerns were raised -very positive comments were made around teamwork and how the team supported each other. A discussion was taking place between senior leaders and ward staff re the recent changes to the induction of labour pathway and the senior team were actively seeking feedback and considering further improvements that could be made"

6. HSIB/NHSR/CQC or other organisation with a concern or request for action, made directly with the Trust

Following a CQC regulatory visit in March 2023, a section 29a safety warning was issued. This was in relation to MAU safety and the Induction of Labour process.

There have been no referrals to HSIB in January

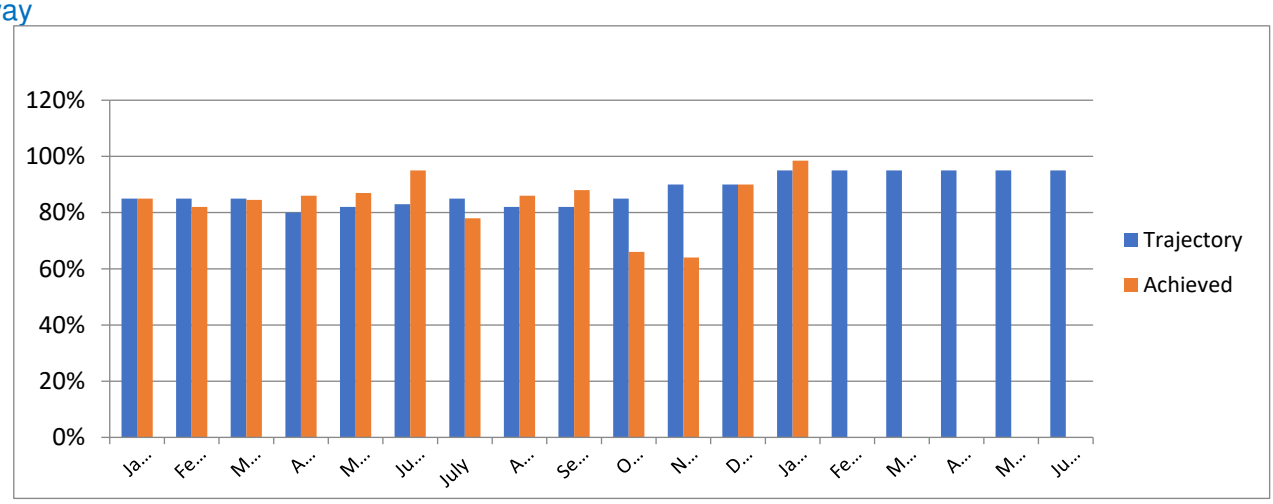
6.1 As part of the actions for this Maternity Assessment Unit Midwifery triage times are audited and monitored daily.

6.2 To provide assurance in regard to the induction of labour process, breaches against maternity guidance are monitored each month.

6.3 Induction of labour

We continue to monitor the birthing people booked for induction of labour and the percentage that breach current guidance. There has been a steady improvement in the percentage of people commencing induction of labour in line with guidance and in January it was above the trajectory.

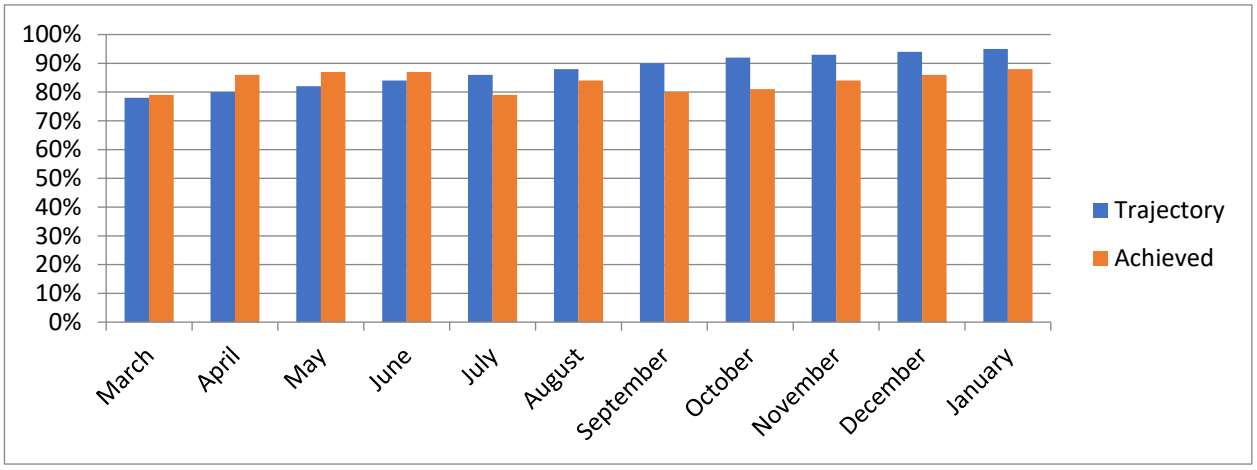
Figure 3- The percentage of people who commence their IOL within the specific guideline for their pregnancy pathway



6.4 Midwifery triage within 15 minutes

The monitoring of midwifery triage times continues. The steady improvement continues in the percentage of people triaged within 15 minutes.

Figure 4 - Percentage of birthing people who present at MAU who are triaged within 15 minutes



7. Coroner Reg 28 made directly to the Trust
No Coroner regulation 28 were made to the trust in January.

8. Progress in achievement of CNST 10

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	

All elements of CNST10 have been achieved and agreed by the ICB and Trust Board.

9. Demonstrate a systematic, evidence-based process to calculate midwifery staffing establishment is completed

Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

A full birthrate plus review was undertaken at UHMN in 2022, the recommendations were approved and implemented following that report.

10. Minimum staffing in maternity services

Based on 25.99% uplift the minimum staffing in maternity services for UHNM is 271.88 whole time equivalent midwives and 29.91 non-clinical/specialist midwife roles.

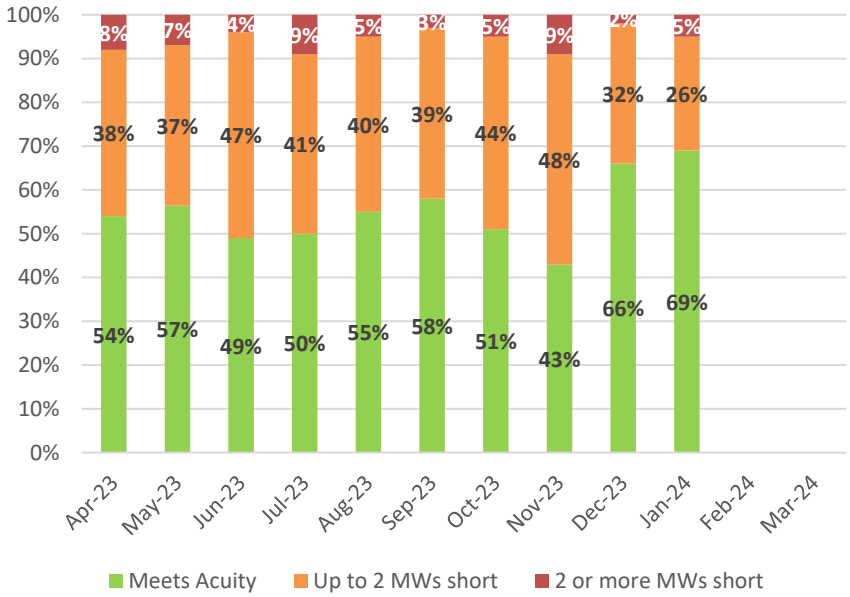
11. Details of planned versus actual midwifery staffing levels to include evidence of mitigation/ escalation for managing a shortfall in staffing

Budgeted Establishment (clinical) (WTE)	Actual in post (WTE)	Vacancy (WTE & %)
271.88	**250.35**	**21.53 (7.9%)**

We now have seven international recruits in the unit, 1 is now working independently as a band 5, 4 have passed their OSCE's and are working in a supervised capacity, 2 are booked to take their OSCE's in April. We are also supporting an internationally educated midwife, who was working as a health care assistant in another area of the organisation, to undertake her OSCE. This will further reduce the vacancy by 7 WTE midwives.

Midwifery staffing acuity

The chart below shows acuity on the delivery suite.



The escalation policy was used in times of negative acuity. This involves moving midwives from other areas and escalating to community teams where necessary.

12. The midwife to birth ratio

The recommended overall ratio for University Hospitals of North Midlands NHS Trust of 24.8 births to 1wte (Birthrate Plus 2022). January's average birth to midwife ratio was 25.1 births to 1wte. This is expected to fall as recruitment continues with the aim that ratios will be in line with Birthrate Plus recommendations when we are fully established.

13.The percentage of specialist midwives employed

The 2022 Birthrate plus report recommended the appropriate levels of specialist midwives based on the activity within the unit:

Total Clinical WTE	271.88
Non-Clinical	29.91
Clinical, Specialist	301.79

Currently there are 28.43 WTE specialist/ Management positions in Maternity.

14.The Trust can report compliance with this standard if this is a one-off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time

The Birthrate Plus data for January confirms that all women received one to one care in labour. The delivery suite coordinator remained supernumerary at all times.

15. Medical staffing

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.

16. PMRT, Stillbirths and Neonatal Deaths

In January 10 PMRT were completed. 7 of the reports have been published and graded, all of which were graded A +/or B.

Case 1	A+A
Case 2	B+A
Case 3	B+B
Case 4	B+B
Case 5	B+A+A
Case 6	B+A
Case 7	B+A+A

Categories used to grade the different aspects of care for each death.
A. No issues with care identified.
B. Care issues that would have made no difference to the outcome.
C. Care issues which may have made a difference to the outcome.
D. Care issues which were likely to have made a difference to the outcome.

For January we had no stillbirths under 37 weeks and 2 stillbirths over 37 weeks. There were 2 neonatal deaths and 2 neonatal deaths.

All cases will be reviewed using the PMRT tool.

17. Complaints

4 complaints regarding maternity services were received in January, these are being reviewed.

Summary and discussion

There is a direct link between adequate staffing levels, outcomes, and performance. Following the Birthrate Plus report and recommendations in 2022 the service has increased its midwifery budgeted establishment following a successful business case. Vacancies against Birthrate Plus recommendations in early 2022 were 74.67 WTE. With a consistent and targeted approach to recruitment and retention this vacancy has now decreased to 21.53 WTE. There is a continuing plan to reduce the vacancy rate to around 10 – 12 WTE by late 2023/early 2024. This will of course depend upon successful recruitment.

Minimum safe staffing levels in line with Birthrate Plus will enable adequate midwifery and maternity support worker resources which in turn will enable better flow throughout the unit, facilitating improvements in maternity triage times and induction of labour delays.

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th March 2024
Report Title:	Maternity and Neonatal New Serious Incident (SI) Report Quarter 3 (1st October – 31st December 2023)	**Agenda Item:**	8.
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

15593	*Maternity Assessment Unit Triage*	***High (12)***
13419	*Midwifery Safe Staffing*	***High (9)***
23361	*Number of open adverse incidents and root cause analysis investigations*	***High (8)***

Executive Summary

Situation

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

No of open maternity and neonatal serious incidents:	10
Investigation in progress:	0
Investigations completed/awaiting to be presented and closed by Risk Management Panel:	4
Investigations completed/awaiting to be closed by ICB:	6

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

Background

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

Assessment

In Q3 - 3 new serious incidents were reported:

October 2023 0 incident
November 2023 1 incident
December 2023 2 incidents

Category of Incidents:
1 Root Cause Analysis
2 Perinatal Mortality Review Tools (PMRT)

There has been a reduction in Q3 of the number of open and overdue serious incidents.

Recommendations:
To consider how the existing serious incident report will fit into the new PSIRF framework.

Key Recommendations

The Trust Board accepts and is assured by the report.

Highlight Report

Quality Governance Committee (29th February) to Trust Board

! Matters of Concern / Key Risks to Escalate

For information:

- The number of clostridium difficile cases remained above the upper limit in quarter 3, with 141 cases compared to the trajectory of 76. A task and finish group remained in place to oversee the actions required to reduce the number of cases within the West Building in addition to ongoing work in relation to antimicrobial stewardship
- The infection prevention board assurance framework highlighted 12 areas rated as partial compliance, and actions had been identified to address the areas of non-compliance
- A potential future risk in relation to using printed prescription charts with old information was highlighted within the HAT deep dive, which could be addressed by the implementation of the Electronic Prescribing and Medicines Administration (EPMA) system
- Areas of focus in relation to actions within the Care Quality Commission Action Plan continued to relate to Speech and Language Therapy provision at County Hospital and the Section 29A notice in relation to mental health. The number of red rated actions was queried and it was clarified that these related to areas of non-compliance which were already reported to Committee and Board i.e. training compliance
- A number of concerns had been raised in respect of 4 / 11 CQUINs and these continued to be monitored by the CQUIN leads with quarterly audits taking place
- Two never events had been reported within quarter 3 in relation to retained object / swab

Major Actions Commissioned / Work Underway

- To provide a further update in relation to the timeline and KPIs associated with the roll out of the national Paediatric Early Warning Score (PEWS) tool
- To provide additional information in respect of the number of confirmed measles cases within the Trust in addition to including number of cases in future Infection Prevention HAI Reports, in addition to including additional information in respect of antimicrobial stewardship
- Infection Prevention Board Assurance Framework to include high level information in respect of staff MMR vaccination status / immunity
- A further review of cases was to be undertaken in relation to the Mental Capacity Act framework by internal audit, to ensure that the data presented was accurate and based on current practice. Further discussions were to be held with the Internal Audit team in addition to discussing this further with the Chair of the Audit Committee to agree the way forward
- To clarify the number of incidents reported in relation Your Next Patient and whether these were separate to patients waiting longer than expected

✓ Positive Assurances to Provide

- No hospital acquired infections were reported within Quarter 3
- Inpatient areas achieved sepsis targets within Quarter 3 with the main area of focus continuing to be the Emergency Department at Royal Stoke
- An update following the deep dive into Hospital Associated Thrombosis (HATs) was provided which highlighted that the increase in cases between December 2022 and February 2023 mainly affected patients over 60 years old with up to 3 weeks length of stay and respiratory complaints, whereby covid was expected to have been a contributory factor. However, no single cause for the increase was identified and it was confirmed that prophylaxis guidance was followed in each case. In addition, the number of cases had since reduced, and this continued to be monitored via the VTE Steering Group
- 7 / 11 CQUIN schemes were on track to deliver improvements
- There had been a reduction in the number of open serious incidents and further reports would focus on the implementation of Patient Safety Incident Response Framework (PSRIF) and reporting of Patient Safety Incident Investigations (PSII)
- The Trust's Summary Hospital-level Mortality Index (SHMI) remained in line with expected range, the Hospital Standardised Mortality Ratio (HSMR) was slightly better than expected range whilst the crude HSMR remained in line with the national rate
- An update in relation to progress of the actions undertaken following the internal audit into PSRIF was provided and a follow up review was to be undertaken by Internal Audit before the year end

Decisions Made

- The Committee approved the proposal for quality metrics which were to be reported to the Board and Committee from April 2024

Comments on the Effectiveness of the Meeting

- Committee members welcomed the quality of Executive Summaries and papers provided

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Paediatric Sepsis Screening	BAF 1	High 12	-	Assurance	8.	Serious Incident Report Q3	BAF 1	High 12	●●	Assurance
2.	Infection Prevention HAI Report Q3 23/24	BAF 1	High 12	●●	Assurance	9.	Mortality Assurance Report Q3 2023/24	BAF 1	High 12	●	Assurance
3.	Infection Prevention Board Assurance Framework	BAF 1	High 12	●	Assurance	10.	Quality Performance Report – Month 10 23/24	BAF 1	High 12	-	Assurance
4.	Deep Dive into Hospital Associated Thrombosis	BAF 1	High 12	●●	Assurance	11.	Quality Metrics 2024/2025	BAF 1	High 12	-	Approval
5.	CQC Action Plan Update	BAF 1	High 12	●	Assurance	12.	PSIRF Internal Audit Report Update	BAF 1	High 12	●	Assurance
6.	Internal Audit Report: MCA Framework	BAF 1	High 12	-	Assurance	13.	Care Excellence Framework Summary Q2 23/24	BAF 1	High 12	-	Information
7.	Commissioning for Quality and Innovation (CQUIN) Scheme for 2023/24 Q3 Update	BAF 1	High 12	●●	Assurance						

2023/2024 Attendance Matrix

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Prof A Hassell	AH	Associate Non-Executive Director (Chair)										DEEP DIVE UNDERTAKEN		
Mrs C Cotton	CC	Director of Governance			NH	NH		NH		NH	NH		NH	
Mr S Evans	SE	Chief Operating Officer	PB											
Ms A Gohil	AG	Non-Executive Director												
Mrs J Haire	JH	Chief People Officer				KMy								
Dr M Lewis	ML	Medical Director				ZD		AM						
Prof K Maddock	KM	Non-Executive Director												
Mr J Maxwell	JM	Head of Quality, Safety & Compliance												
Mrs A Riley	AR	Chief Nurse	JHo			JHo	JHo		FH					
Prof S Toor	ST	Non-Executive Director												

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th March 2024
Report Title:	Infection Prevention Board Assurance Framework	**Agenda Item:**	10.
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 x	**Negative**

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 1	*Patient Outcomes and Experience*	*12 (High)*

Executive Summary

Situation

To update Trust Board on the self-assessment new IP Board Assurance Framework (BAF) document.

The IP BAF published 13th September 2023 replaced the original 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 Board Assurance Framework 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.

The 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, compliant.

Use of the framework is not compulsory but should be used by organisations to ensure compliance with infection prevention (IP) 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.

Self- Assessment and gathering of assurance/evidence using the IP BAF continues sections may be rated as partial compliant whilst completing work.

The National IP Manual for England and IP BAF as published by NHSE can be found here:

NHS England » National infection prevention and control

Background

The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures.

The 10 criteria main headings are as follows; each criterion is 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 post 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.

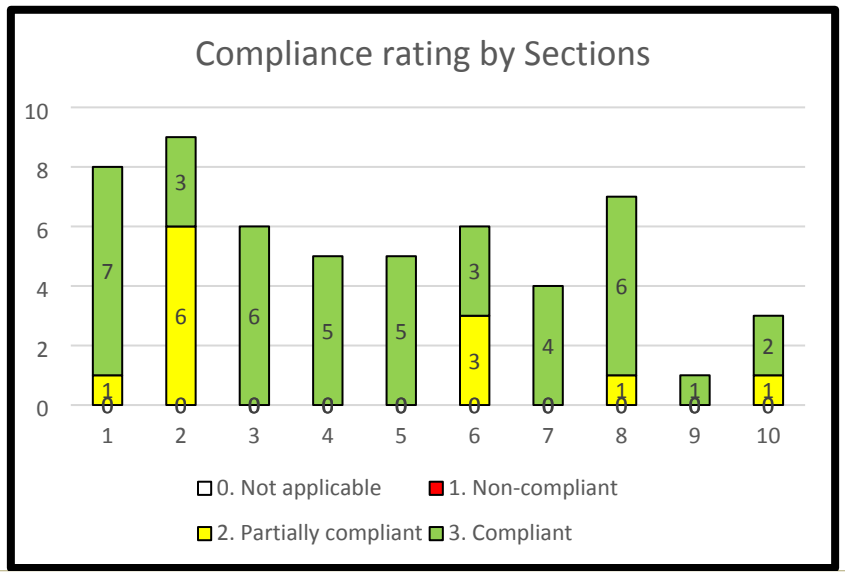
Criteria 8 - Provide secure and adequate access to laboratory/diagnostic support as appropriate.

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

The Trust maintains compliance in all aspects of the BAF but declares partial compliance in relation to criteria 1, 2, 6, 8 and 10. Actions in relation to these areas of non-compliance have been presented to the Quality Governance Committee and progress will continued to be monitored by the Committee.



Key Recommendations

The Trust Board is asked to note the document for information and note the on-going work being undertaken.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th March 2024
Report Title:	Care Quality Commission Action Plan Update	**Agenda Item:**	11.
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 20**	ID23842	RTT Outpatient Capacity / Wait Times	**Extreme 16**
ID27696	Consultant Obstetricians workforce	**Extreme 16**	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**
ID9783	Incident Investigation	**High 12**	ID13419	Midwifery safe staffing	**High 9**
ID23361	Number of open adverse incidents and root cause analysis investigations	**High 8**	ID9782	Reporting of Patient Safety Incidents	**High 8**
ID15993	Maternity Assessment Unit Triage	**Moderate 6**	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:

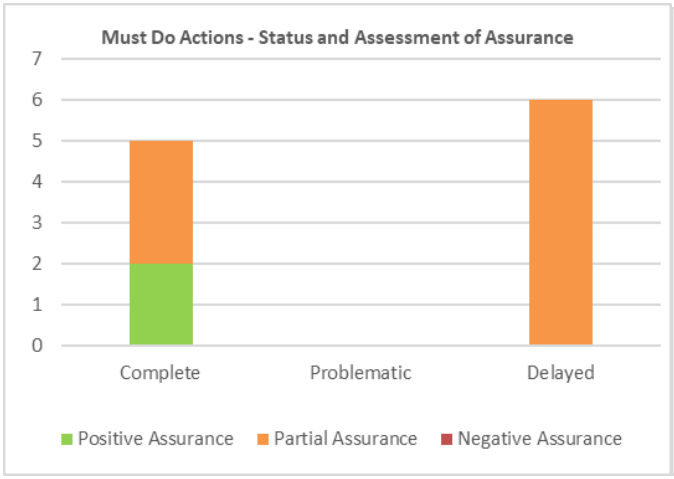
- Overall Rating: Requires Improvement
- Are Services Safe: Inadequate
- Are Services Well Led: Requires Improvement

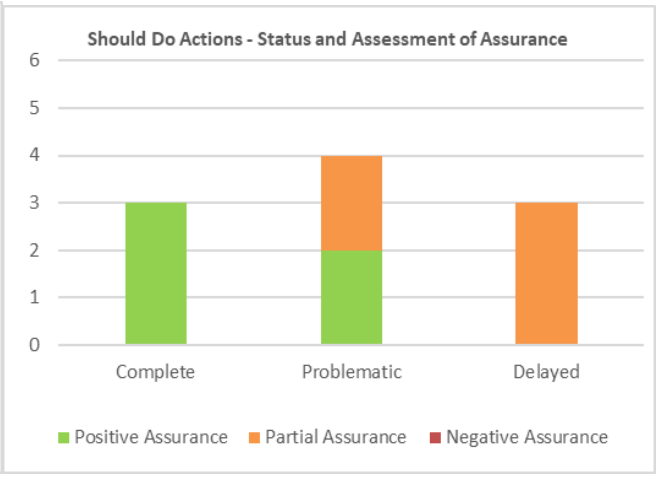
Assessment

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, which had either been fully completed, had a clearly defined monitoring process or had been progressed as far as possible. All archived actions have been mapped to a Risk on the Risk Register, where appropriate.

Current status is as follows:





On review of the updated action plan in February 2024, further assurance is to be obtained for 2 must do and 3 should do areas, as these have no outstanding actions and are to be considered as to whether these can be archived and managed via Business as Usual, with any outstanding risks monitored via the Risk Register. This will be considered by the Quality Governance Committee in due course.

Areas of Concern

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

Speech and Language Therapy (SLT) provision at County Hospital

Since the previous update to QGC, further short term, medium term and long term actions have been agreed by the Network Services Division as follows:

Short Term Mitigation

- Increased SLT workforce presence to 3 days per week to support County.
- Upskill existing SLT workforce to allow for additional presence at county.
- Capture incident reports where timely reviews not undertaken.

Medium Term

- Develop digital dashboard for reporting of SLT activity, responsiveness and interventions.
- develop service specification (based on local and national guidance)
- Undertake SBAR service review (reporting to Networks Divisional Board & QSOG).
- Identify SLT as key Divisional Priority for 24/25 investment.
- Obtain permission to proceed to full Business case through TEC.
- Develop Business case for investment following service review.

Long Term

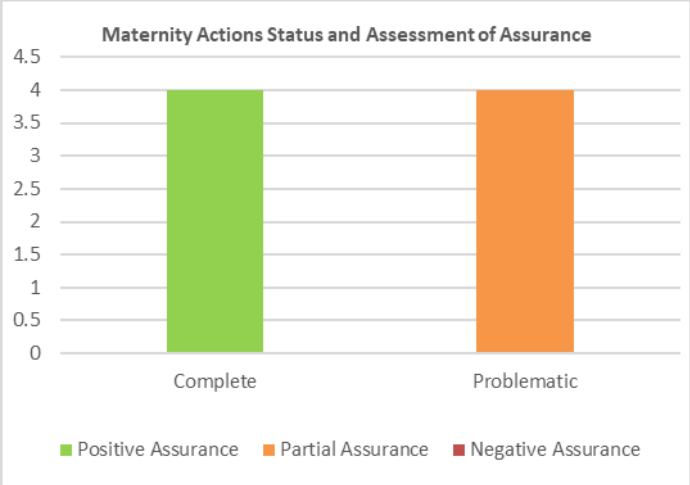
- Digitalisation of reporting for SLT
- BI-Annual reporting of Activity, responsiveness, interventions and risks.

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

- Focussed education and awareness-raising is taking place at County Hospital.
- Evidence of improvements has been collated and sent to CQC in December 2023, awaiting a response
- 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
- Recent audit data in January 2024 demonstrates compliance with completion of the Vulnerable Persons checklist to be 76.6% and full completion of the Mental Health Risk assessment to be 83.3%

Maternity Action Plan

The report stipulated 6 Must Do Actions and 2 Should Do Actions. Current status is as follows:



Areas of Concern

Of the problematic actions, those relating to the following issues are still requiring focussed improvement (safeguarding training compliance and staff PDR compliance).

Key Recommendations

The Trust Board is asked to note the updated action plan and progress made to date.

CQC Action Plan - Must Do's

As at 29 February 2024

CURRENT PROGRESS RATING
Completed: Improvement / action delivered with sustainability assured.
Improvement on trajectory either: On track – not yet completed *or* On track – not yet started
Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement - **target date moved once**
Off track / trajectory – milestone / timescales breached. Recovery plan required - **target date moved twice or more**

Date of Visit	Action Number	Division	Core Service	Observation / Issue	Outstanding Actions and Progress	Executive Lead	Initial Target Date for Completion	Revised Target Date	Number of Times Target Date has Changed	Current Progress Rating (Against Target Date for Completion not Revised Target Date)	Actions Completed	Assurance Statement Against Completed Actions (Green = positive assurance / Amber =Partial assurance or awaiting sign-off Red = negative assurance)	If Negative or Partial Assurance Identified, what further actions are being taken?	Target Date for Further Actions
Aug-21	A4	**Medicine**	**Urgent and Emergency**	The Trust MUST ensure patients are kept safe from infection and avoidable harm and staff receive appropriate guidance and support to enable them to do this. **Regulation 12 (1) (2) (h)**	No actions outstanding	Chief Nurse	NA	NA	NA	**Actions Complete**	• Infection Prevention poster describing correct PPE for red and green areas displayed through ED from June 2022 • Staff receive updates in PPE training/mask fit training, according to latest National Guidance, from October 2022 • Weekly CEF reviews include equipment cleaning checks from June 2022	• Segregation of Emergency Department now discontinued post Covid-19 Pandemic •Infection Prevention training compliance as of February 2024: Level 1 is 95.74%, level 2 is 80%. • Monitoring of Stat/Mand Training and support for compliance is now deemed Business as Usual within Performance Review Meeting (PRM) process •4* Environmental audits sustained in February 2024 (an increase from an initial 3*) • Action plans in place in response to IPC audits		
Aug-21	A5	**Medicine**	**Urgent and Emergency**	The Trust MUST ensure all risks are appropriately identified, assessed and mitigation put in place where possible. **Regulation 17 (1)**	No actions outstanding	Chief Nurse / Medical Director	NA	NA	NA	**Actions Complete**	• Risk register updated to include all current risks relating to the ED Department • Harm review process identified and in place to review harm for patients who have been subject to a long wait (i.e. 12 hour breaches, ambulance handover delay, Your Next Patient and Corridor Care) • CQC and ICB Chief Nurse visit to the Trust in January 2023 to review safety measures for Corridor Care and Your Next Patient resulted in positive feedback	•Regular well attended governance meetings with minutes available •New Nurse governance lead •PRM Regular meetings with individual owners of risks •Regular Emergency Portal meetings to ensure SOPs correctly followed. •Current compliance, as of February 2024, with sepsis screening is 80% and antibiotic treatment within 1 hour is 61% •Positive Quality Visit by ICB conducted on 30th November 2023 to review progress with Sepsis Pathway •A deep dive of patients developing Hospital acquired Thrombosis has been completed including the incidence of VTE in patients undergoing long waits	•Continue to monitor and report patient harm on a monthly basis •Process for review of harm in patients who have experienced 12 hour breaches and 7 hour ambulance handover delays has now been agreed with the ICB. Process to be implemented in March 2024 •Sepsis screening and treatment compliance in ED has been added as a scheduled agenda item for Quality Governance Committee, to provide additional assurance •Identification of an ED Consultant to drive necessary improvements in sepsis screening and Antibiotic Treatment within 1 hour	Apr-24
Aug-21	A6	**Medicine**	**Medical Care**	The Trust must ensure associated with acute mental health needs are assessed, recorded and mitigated. **Regulation 12 (1) (2) (a) (b)**	No actions outstanding	Chief Nurse	NA	NA	NA	**Actions Complete**	•ED Mental Health Assessment Tool revised in June 2022 to accompany the patient on admission and facilitate ongoing mental health assessment in assessment and ward areas • Review of the ward risk assessment booklet undertaken and all of the checklists relating to Mental Health, Dementia, Learning Disability and Autism have been simplified and amalgamated and sit under the Vulnerable patient banner, at the front of the booklet. This includes Vulnerable Patient trigger questions and a nursing risk assessment related to mental health. This assessment supports the Registrant to make a judgement regarding whether the patient will require close supervision due to harm to themselves or potential harm to others. • The Trust report and monitor the number of mental health referrals via the Mental Health & Learning Disability Trust Group, which has representation from all clinical divisions, the mental health liaison team and psychiatric liaison team. Areas of escalation and assurance provided to the Trust Quality and Safety Oversight group. • Trust-Wide Harm Free Care Alert developed February 2022 • Corporate audit process in place • Head of Nursing - County Hospital recruited in order to continue to embed significant improvements in the assessment, recording and mitigation of risks associated with acute mental health concerns. The post holder will be responsible for conducting spot checks and initiating relevant actions to improve practice with regard caring for patients with acute mental health concerns, vulnerabilities and requirements for an interpreter	• Evidence of improvements has been collated and sent to CQC in December 2023 • 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 •Recent audit data in January 2024 demonstrates compliance with completion of the Vulnerable Persons checklist to be 76.6% and full completion of the Mental Health Risk assessment to be 83.3%	•Senior Nursing Team to continue monthly audit schedule in order to monitor compliance and drive improvements •Mental Heath Assessment County ED SOP developed to define responsibility for mental Health Assessment of Patient presenting in ED. Currently being ratified	Apr-24
Aug-21	A7	**Medicine**	**Medical Care**	The Trust MUST ensure nutritional risk assessments and care plans are completed in line with their policy. **Regulation 12 (1) (2) (b)**	No actions outstanding	Chief Nurse	NA	NA	NA	**Actions Complete**	• In January 2023 the Trust relaunched a training programme emphasising key learning around assessing, managing and monitoring patients nutrition • Nutrition and Hydration awareness training delivered within new NA programme. • Update training delivered at County by dietetics team. • Ward based training targeted to AMU and FEAU at Royal Stoke. Now complete and will be offered refresher training • Training programme delivered in key admission areas, presentation added to Dietetics section of intranet • Focus Group convened in October 2022 to review the current Nutrition bundle • Nutrition bundle updated and in place, including nutrition care plans • Process for sharing Vital Pac reports detailing MUST compliance identified with Ward teams in October 2022 and Nutrition Dashboard live within UHNM Report Centre • Tendable roll-out to County with first audit submitted by 31st December 2022 • Tendable rolled out to Royal Stoke January / February 2023 •Over 800 MUST training contacts have been completed since April 2023	• Senior Nursing team/Dietetic Team continue to monitor compliance of timely MUST Assessments via Vitals and Tendable Audits • A Training Video is now available on Trust Intranet •The Vitals Dashboard currently shows that over the last 12 months County Hospital Wards have been static at circa 82-84% compliant with completion of MUST assessments within 24 hours of the patient's admission.	• To monitor and report compliance of timely MUST Assessments at Ward level via Nutrition Steering Group • An audit of MUST completion/Nutritional Bundle completion is underway (Sample Size 100)	Apr-24
Aug-21	A8	**Medicine**	**Medical Care**	The Trust MUST ensure patients receive timely swallow assessments. **Regulation 12 (1) (2) (a) (b)**	•MNP/ANP nurse swallow screening training to be implemented at RSUH to support service provision. Consider rollout at County Hospital. •Training has not been offered to County ANP's to date due to ongoing limited SLT resources over at County. There has been recent recruitment within SLT which will support this development. Target date amended to reflect the delay in providing the training at County. •Due to ongoing concerns about delay in achieving this action, a Deep Dive into SLT services was presented at QSOG in July 2023	Chief Nurse	Sep-22	Mar-25	5	**Delayed Actions - due date moved more than once**	• Position paper presented at the Acute Patient Flow group in April 2022 highlighting the shortfalls in the service provision to inpatient medical wards, across both sites • Education programme developed in October 2022 to support ward teams regarding 'what makes a good referral' and how to escalate referrals • MNP training at RSUH took place in January 2021 and was completed successfully. • ANP training was undertaken in September 2021	• Following presentation of the SLT Deep Dive at QSOG in July 2023, further work has been commissioned to gather data on the current levels of incidents reported in relation to insufficient referrals, the number of rejected referrals and delays in responding to referrals in order to define solutions. Service review of SLT Team underway by Chief AHP and Divisional Nurse Director.	•Short Term Mitigation * Increased SLT workforce presence to 3 days per week to support County. * Upskill existing SLT workforce to allow for additional presence at county. * Capture incident reports where timely reviews not undertaken. Medium Term * Develop digital dashboard for reporting of SLT activity, responsiveness and interventions. * develop service specification (based on local and national guidance) * Undertake SBAR service review (reporting to Networks Divisional Board & QSOG). * Identify SLT as key Divisional Priority for 24/25 investment. *Obtain permission to proceed to full Business case through	Mar-25

Date of Visit	Action Number	Division	Core Service	Observation / Issue	Outstanding Actions and Progress	Executive Lead	Initial Target Date for Completion	Revised Target Date	Number of Times Target Date has Changed	Current Progress Rating (Against Target Date for Completion not Revised Target Date)	Actions Completed	Assurance Statement Against Completed Actions (Green = positive assurance / Amber =Partial assurance or awaiting sign-off Red = negative assurance)	If Negative or Partial Assurance Identified, what further actions are being taken?	Target Date for Further Actions
					•To explore the options available to obtain data from OrderComms, so that assurance can be provided that timely swallowing assessments are being undertaken. • Due to ongoing concerns about delay in achieving this action, a Deep Dive into SLT services was presented at QSOG in July 2023	Chief Nurse	Mar-23	Mar-25	4	**Delayed Actions - due date moved more than once**			TEC. * Develop Business case for investment following service review. Long Term * Digitalisation of reporting for SLT * BI-Annual reporting of Activity, responsiveness, interventions and risks.	
Aug-21	A9	**Medicine**	**Medical Care**	The Trust MUST ensure Mental Capacity Act Assessments are consistently completed in a timely and responsive manner. **Regulation 11 (1) (2) (3)**	The Trust will undertake a baseline review of current training compliance in relation consent training and a trajectory of improvement will be developed and monitored. A review of the current training packages will be undertaken to ensure that any training around the provision of care to vulnerable patients, includes MCA information	Medical Director / Chief Nurse Chief Nurse / Medical Director	Apr-22	Jun-24	5	**Delayed Actions - due date moved more than once**	• Clinical Audit Programme reviewed in June 2022 to ensure that all audits relating to the delivery of care include questions around whether mental capacity should have/was assessed • Audit of the Mental Capacity Act and Deprivation of Liberty prioritised on the Trust Clinical Audit programme to monitor compliance with Trust Policy • Template to remind / guide staff through the MCA assessment process introduced in October 2022 • A structured note re MCA assessments went live on iportal in April 2023	• Evidence of improvements has been collated and sent to CQC in December 2023 •A total of 20 patients were identified by the vulnerable adults team in January 2024 whose presentation would indicate that they potentially lacked capacity, with regards to the decision of care and treatment whilst admitted to UHNM. It is expected that a Mental Capacity Assessment had been undertaken and evidenced within 20 cases. Evidence that a Mental Capacity Assessment had been completed were found in 18 cases (90%) • Internal audit into mental capacity assessment undertaken and presented to Audit Committee January 2024. Concluded with partial assurance and 5 actions agreed.	• The Education Team have facilitated a communication campaign including Grand Round to ensure all staff are aware of the importance of documenting the initial level of mental health risk and mental capacity and the importance of completing the Mental Health assessment Booklet •Meetings in place to develop A3 • To implement the 1 high, 3 medium and 1 low actions following the internal audit.	Jun-24
Oct 2022	A10	**Medicine**	**Medical Care**	The Trust MUST ensure that where required, mental capacity assessments and Deprivation of Liberty Safeguards applications are made in line with the trust policy and legal frameworks. **Regulation 11 Need for Consent)**	•A weekly status exchange will be introduced to gain assurance of compliance with completion of MCA, DoLS applications and MH proforma. • Safeguarding team are completing monthly audits on the wards at County. Audit outcomes are shared with HON for County and Medicine Division	Chief Nurse/Medical Director	Jun-23	Jun-24	4	**Delayed Actions - due date moved more than once**	•Monthly audit programme in place •A3 under development to drive improvements			
Oct 2022	A11	**Medicine**	**Medical Care**	The Trust MUST ensure that all required assessments including the mental health proforma and within 'seven-day patient risk assessment booklet' are completed as per trust processes. **Regulation 12 Safe Care and Treatment**	No actions outstanding	Chief Nurse	N/A	N/A	N/A	**Actions Complete**	•The Patient Risk Assessment booklet has been reformatted to clarify the required assessments and move them to the front of the booklet for ease of use	•Redesigned booklet is now in use	.	
Oct 2022	A12	**Medicine**	**Medical Care**	The Trust MUST ensure that where enhanced or therapeutic observations have been identified as necessary within patient care plans, staff are sourced to cover these. **Regulation 18 Staffing**	The Trust will ensure that shifts with patients requiring enhanced observations are red flagged on Safe Care (E-Roster) and that additional staffing is requested by the Nurse Bank. Unfilled shifts will be escalated to relevant matron	Chief Nurse	Jul-23	Aug-24	2	**Delayed Actions - due date moved more than once**	•Data collated on staffing template to support redistribution of staff and measure improvement	•Partial assurance as although information is recorded on staffing template, red flag facility on Safe Care/E-Rostering is not utilised	•Meeting to be convened with Head of Nursing County and Matrons to plan approach to increasing utilisation of red flags.	Aug-24
Oct 2022	A13	**Medicine**	**Medical Care**	The Trust MUST ensure they maintain oversight of performance and risks in relation to the medicine core service when supporting patients with acute mental health needs or cognitive impairment. In particular, the Trust MUST ensure that all risks relating to the care of patients with mental health conditions or symptoms are captured on the risk register for the service and staff follow trust policies and processes. The service must also ensure that learning from serious case reviews, audits and incidents is shared and embedded across the Trust. **Regulation 17 Good Governance.**	Risks associated with supporting patients with acute mental health needs or cognitive impairment will be discussed on a monthly basis at Directorate/Divisional Governance Meetings	Chief Nurse	May-23	Jun-24	2	**Delayed Actions - due date moved more than once**	•Monthly audits undertaken since October 2023 •Risks discussed on a monthly basis at Directorate and Divisional Governance Meetings	• Evidence of improvements has been collated and sent to the CQC December 2023 • A case review in November 2023, of assessment and management of a Patient with acute Mental Health needs on AMU has demonstrated good practice.	•PSIRF methodology being introduced to review any Serious Incidents • Medical Division highlight report to QSOG to include summary of relevant risks and incidents and the actions taken / lessons learnt	Jun-24

CQC Action Plan - Should Do's

As at 29 February 2024

CURRENT PROGRESS RATING	
	Completed: Improvement / action delivered with sustainability assured.
	Improvement on trajectory either:On track – not yet completed *or* On track – not yet started
	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement - **target date moved once**
	Off track / trajectory – milestone / timescales breached. Recovery plan required - **target date moved twice or more**

Date of Visit	Action Number	Division	Core Service	Observation / Issue	Outstanding Actions and Progress	Executive Lead	Target Date for Completion	Revised Target Date	Number of Times Target Date has Changed	Current Progress Rating (Against Target Date for Completion not Revised Target Date)	Actions Completed	Assurance Statement Against Completed Actions (Green = positive assurance / Amber =Partial assurance or awaiting sign-off /Red = negative assurance)	If Negative Assurance Identified, what further actions are being taken?	Target Date for Future Actions
Aug-21	B2	**Corporate**	**Trust wide**	The Trust SHOULD ensure all complaints are reviewed, investigated and responses are managed in a timely manner and in line with Trust policy	•The Trust are reviewing the current formal complaints process to improve the quality and timeliness of reports and to streamline the sign off process • Electronic sign off process under development •Pilot of Matron early involvement in formal complaint process commencing in Network Services Division in May 2023	Chief Nurse	Oct-22	Aug-24	4	**Delayed Actions - due date moved more than once**	• Complaint triage process in place •Electronic process in place for corporate nurse sign off •Pilot project with matrons to promote early engagement with complainants •Consideration of alternative ways to resolve complaints such as co-production communication project with vulnerable patients	• The average time taken to resolve formal complaints, closed in Q3, was above the Trust's 40 day target for all clinical divisions.	•Continue to develop and monitor progress with actions and report to QGC on a quarterly basis • To stratify response times according to complexity of complaint • Network Services have adopted timeliness of complaints response as a driver metric	Aug-24
Aug-21	B5	**Medicine**	**Urgent and Emergency**	The Trust SHOULD ensure all staff follow best practice when completing care records to ensure they are an accurate record of care and treatment provided	The Trust will introduce digitalised care records to ensure the provision of individualised, accurate care plans.	Chief Digital Information Officer	Mar-23	Apr-24	1	**Problematic actions - due date moved once**	• Combined work with digitalisation of ED Records *Weekly Tendable Documentation reviews *ED Focus weeks for staff education and development	•Senior Nursing Team involvement in completion of Tendable Audit- Actions on track at present	•Monitored through Directorate Governance Meetings as Business as Usual	Apr-24
Aug-21	B6	**Medicine**	**Urgent and Emergency**	The Trust SHOULD consider how they can improve information management for certain patient groups	A review of current documentation will be undertaken to ensure the provision of standardised templates for electronic referrals and Medical/Nursing handovers	Chief Nurse	Oct-23	Apr-24	1	**Problematic actions - due date moved once**	•Tendable Documentation audit results will identify themes for improvement and communicated as required •ED Cas card updated to support accurate/relevant documentation •IPS process embedded well within the department - any relevant learning completed	•Senior Nursing Team involvement in completion of Tendable Audit-actions on track at present	•Monitored through Directorate Governance Meetings as Business as Usual	Apr-24
Aug-21	B9	**Medicine**	**Medical Care**	The Trust SHOULD ensure that all wards display up to date audit results such as results from hand hygiene audits	Up to date audit results to form part of Tendable Ward audit system	Chief Nurse	Jul-22	Aug-24	4	**Delayed Actions - due date moved more than once**	• Tendable has been rolled out to County. First audit submitted by 31st December 2022 • Tendable rolled out to Royal Stoke January / February 2023	•Tendable roll out now complete • Hand hygiene audits incorporated into Tendable.	•Tendable reporting ability being explored to consider best option for display.	Aug-24
Aug-21	B16	**Medicine**	**Medical Care**	The Trust SHOULD consider taking action to ensure key information about patients care in consistently recorded. For example, ensuring clear wound care plans are in place for all patients with a wound	No outstanding actions	Medical Director / Chief Nurse	NA	NA	NA	**Actions Complete**	• Clinical Audit programme reviewed in June 2022 to ensure that appropriate documentation audits are in place to review the standards of patient documentation and identify areas for improvement • Wound Care Document finalised in January 2023	• Clinical Audit Programme in Place • Wound Care Document being rolled out		
Aug-21	B17	**Medicine**	**Medicine Care**	The Trust SHOULD consider making the speech and language therapy service provision equitable across County Hospital	MNP/ANP nurse swallow screening training will be implemented at RSUH to support service provision. Consider rollout at County Hospital • ANP training for Respiratory ANP's was completed by SLT. A meeting is being arranged to discuss competency assessment process. •Training has not been offered to County ANP's to date due to ongoing limited SLT resources over at County. There has been recent recruitment within SLT which will support this development. •Due to ongoing concerns about delay in achieving this action, a Deep Dive into SLT services to be presented at QSOG in May 2023	Chief Nurse	Sep-22	Mar-25	5	**Delayed Actions - due date moved more than once**	• Position paper presented at the Acute Patient Flow Group in April 2022 highlighting the shortfalls in the service provision to inpatient medical wards, across both sites • Education programme to support ward teams developed in October 2022 regarding 'what makes a good referral' and how to escalate referrals • SLT presence at County has increased from twice weekly to three times per week.	• Following presentation of the SLT Deep Dive at QSOG in July 2023, further work has been commissioned to gather data on the current levels of incidents reported in relation to insufficient referrals, the number of rejected referrals and delays in responding to referrals in order to define solutions, which will be presented to QGC. * Junior workforce are in their development stage and will be upskilled by June 2024. * Prioritisation has been agreed within the Division of Network Services as part of executive submission 24/25. * Development of service specification has commenced. * Head of SLT in place to support service developments and transformation.	**Short Term Mitigation** * Increased SLT workforce presence to 3 days per week to support County. * Upskill existing SLT workforce to allow for additional presence at county. * Capture incident reports where timely reviews not undertaken. **Medium Term** * Develop digital dashboard for reporting of SLT activity, responsiveness and interventions. * develop service specification (based on local and national guidance) * Undertake SBAR service review (reporting to Networks Divisional Board & QSOG). * Identify SLT as key Divisional Priority for 24/25 investment. *Obtain permission to proceed to full Business case through TEC. * Develop Business case for investment following service review. **Long Term** * Digitalisation of reporting for SLT * BI-Annual reporting of Activity, responsiveness, interventions and risks.	Mar-25
Oct-22	B20	**Medicine**	**Medical Care**	The Trust SHOULD consider reviewing the mental health training needs of staff so that they are assured they have the skills to meet the needs of patients.	No outstanding actions	Chief Nurse	NA	NA	NA	**Actions Complete**	• Trust wide mental health ambassador training launched January 23 • Trust wide TEAS enhanced and therapeutic observation Training launched January 23 • Trust wide Dementia Tier 2 face to face training launched January 23	• Training provision in place and compliance monitored on a monthly basis • County Hospital Training Compliance as of the 31st December 2023: Mental Health Awareness 93.6% Dementia Awareness 97.6% Learning Disability & Autism 91.5% MCA/DOLS 93.5%		
Oct-22	B25	**Medicine**	**Medical Care**	The Trust SHOULD ensure they consistently check and record where a person has a power of attorney for health and welfare on behalf of the patient if that patient lacks capacity to consent for their own care and treatment.	Appropriate training programmes to be provided	Chief Nurse	Sep-23	Mar-24	1	**Problematic actions - due date moved once**	• Trust Policy in Place	•Spot Check audit to be completed in order to seek assurance	•Spot Check audit to be completed in order to seek assurance	Mar-24
Oct-22	B26	**Medicine**	**Medical Care**	The Trust SHOULD ensure that all patients requiring an interpreter are provided with one as soon as is reasonably practical prior to undertaking care and treatment.	The Trust will promote available Interpreter services available and monitor provider performance	Chief Nurse	Sep-23	Mar-24	1	**Problematic actions - due date moved once**	•Monthly meetings undertaken Capita Contracts Manager to discuss performance • Communications issued to ward teams	• Spot Check audit to be completed in order to seek assurance • Translator on Wheels introduced on both Hospital Sites	•Spot Check audit to be completed in order to seek assurance	Mar-24
Oct-22	B27	**Medicine**	**Medical Care**	The Trust SHOULD ensure staff are consistently supported following incidents of violence and/or aggression.	The Divisional Management Team will ensure that sufficient staff are trained in CISM debrief	Chief Nurse	Sep-23		0	**Actions Complete**	• Training Programmes available for CISM • Staff formally supported regarding the incident which the CQC were referring to	• Training provision in place and compliance monitored on a monthly basis		

CQC Action Plan - Maternity

As at 29 February 2024

CURRENT PROGRESS RATING	
	Completed: Improvement / action delivered with sustainability assured.
	Improvement on trajectory either: On track – not yet completed *or* On track – not yet started
	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement - **target date moved once**
	Off track / trajectory – milestone / timescales breached. Recovery plan required - **target date moved twice or more**

Date of Visit	Action Number	Division	Core Service	Observation / Issue	Outstanding Actions and Progress	Executive Lead	Target Date for Completion	Revised Target Date	Number of Times Target Date has Changed	Current Progress Rating (Against Target Date for Completion not Revised Target Date)	Actions Completed	Assurance Statement Against Completed Actions (Green = positive assurance / Red = negative assurance)	If Negative Assurance Identified, what further actions are being taken?	Target Date for Further Actions
Mar-23	A1	**W,C & CSS**	**MATERNITY**	The service must ensure that systems are in place to ensure effective triage and escalation processes are in place to reduce risk of patient harm **Regulation (12) (2) (b)**	Update of Business Continuity Plan	Chief Nurse	Dec-23	Mar-24	1	**Problematic actions - due date moved once**	Feb 2023 A3 completed, monthly review at PRM, currently not meeting trajectory. With effect from 14th March 2023, prioritization of inductions of labour takes place daily prior to 09:00hrs Safety Huddle, so the risks can be discussed by the MDT at the Safety Huddle. This process previously took place after the safety huddle. Safety huddle SOP revised. UHNM Escalation guideline and Induction of labour guideline updated in line with regional midlands escalation policy , which includes trigger point for divisional and regional escalation and mutual aid request. Induction of labour breach SOP completed. Monthly monitoring of compliance of prioritisation prior to Safety huddle. Monthly monitoring of compliance of daily safety netting call to deferred inductions of labour. MAU 15 minute triage assessment and medical review in line with BSOTS is a directorate driver metric - monitored monthly at Trust Performance Review. Business Case for increased obstetric medical workforce approved.	In January, 98 % of birthing people were induced within guidance. In January, 88% of women were triaged within 15 minutes. In January, 30 % of medical reviews were performed in line with BSOTS prioritisation.	Business Continuity Plan to be completed.	Mar-24
Mar-23	A2	**W,C & CSS**	**MATERNITY**	The service must ensure staff are up to date with maternity mandatory training modules, including safeguarding adults and child protection training. **Regulation (12) (1) (c)**	Reach target trajectory for Level 3 adult safeguarding and Level 3 child safeguarding.	Chief Nurse	Nov-23	Mar-24	1	**Problematic actions - due date moved once**	Feb 2023 Establish compliance for safeguarding adults and child protection training for medical staff. Training Plan in place for adult and child protection training. Revised date set. Implementation of Bi-monthly Maternity Education Team Meeting. Monthly monitoring of compliance by directorate and LMNS.	90 % of all staff groups are trained on PROMPT skills drills and the fetal monitoring day. Child safeguarding - Level 3 - 61% Adult safeguarding- Level 3 - 41.3 %	Target Trajectory set for all relevant staff groups for Level 3 Safeguarding adults and child protection training by 31/3/24.	Mar-24
Mar-23	A3	**W,C & CSS**	**MATERNITY**	The service must ensure that staff complete regular skills and drills training **Regulation 12 (1) (2) (c)**	No outstanding actions.	Chief Nurse	N/A	N/A	N/A	**Actions Complete**	Nov 2023 Monthly monitoring of compliance by directorate and LMNS. Trajectory target set for 90% by 26.11.23. Further training days arranged to reach target.	90% of all staff groups are trained on PROMPT skills drills and the fetal monitoring day.		
Mar-23	A4	**W,C & CSS**	**MATERNITY**	The service must ensure the environment used to care for and treat service users is adequate for the needs the women and birthing people using them and that any identified risks are mitigated **Regulation 12 (2) (b)**	No outstanding actions.	Chief Nurse	N/A	N/A	N/A	**Actions Complete**	Nov 2023 -New waiting room and triage room built enabling clinical supervision of patients waiting to be reviewed. Immediate relocation of Maternity Assessment Unit (MAU) waiting area in order to increase visibility.	Increased budget establishment for additional 3.1 WTE Ward clerk and 5.6 WTE Maternity Support worker approved for 24/7 support for the new triage and waiting area.		
Mar-23	A5	**W,C & CSS**	**MATERNITY**	The service must ensure systems or processes in place operating effectively in that they enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular risks identified with current maternity triage processes and effective oversight such as emergency equipment checks. **Regulation 17 (2) (b)**	No outstanding actions.	Chief Nurse	N/A	N/A	N/A	**Actions Complete**	Nov 2023 Elective Daycare Clinic relocated to Ante-natal Clinic. 2 ACP's commenced September 2023. Increased midwifery budgeted establishment allocated to MAU. A3 completed, monthly review at PRM. Currently not on trajectory. UHNM MAU Triage guidance changed from 30 minutes initial assessment to 15 minutes. Full team safety huddle at 09:00 hrs now extended to 7 days a week rather than 5 days, with effect from 11th March 2023. New MAU safety huddle introduced at 15:00hrs daily 7 days a week, attended by MAU midwife in charge, flow co-ordinator and inpatient matron. The huddle now includes breach of triage assessment and the breach of medical review by priority rating tool. 2 hourly oversight walkabouts/assurance audit on MAU by the flow-coordinator daily, 7 days a week. Clinical Education team allocated to deliver re enforcement of BSOTS training (delivered to MAU core staff, consultant Obstetricians, intra partum band 7s) Implementation of A-I-D - clinical situation and escalation communication tool. Implementation of central electronic fetal monitoring Review of MAU patient waiting board Monthly monitoring of MAU targets through divisional driver metric - 15 minute triage assessment / medical review in line with BSOTS priority rating	In January, 88% of women were triaged within 15 minutes. Regional Target to be agreed. In January, 30 % of women were medically reviewed in line with guidance.		
Mar-23	A6	**W,C & CSS**	**MATERNITY**	The service must ensure persons employed in the provision of a regulated activity received training, professional development, supervision, and appraisal as was necessary to enable them to carry out their duties they were employed to perform. **Regulation 18 (2) (a)**	ESR hierarchies to be checked and corrected Refresher training for all managers Trajectory developed to reach target of 95 %.	Chief Nurse	Dec-23	Mar-24	1	**Problematic actions - due date moved once**	NOV 23 - A3 completed, reviewed monthly at divisional PRM. Trajectory set.	Current PDR compliance : Ward 205 - 68% Ward 206 - 63% Maternity Assessment Unit - 64.2 % Midwife Birth Centre - 80 % Delivery Suite - 51 % Ante-natal Clinic - 85 %		Mar-24
Mar-23	A7	**W,C & CSS**	**MATERNITY**	The service should ensure the correct level of harm is reported and reviewed when incidents are reported in line with national guidance **Regulation 17 (2) (b)**	No outstanding actions.	Chief Nurse	N/A	N/A	N/A	**Actions Complete**	Spot check completed, all harm recorded in line with Trust Guidance.			
Mar-23	A8	**W,C & CSS**	**MATERNITY**	The service should review current safeguarding processes in place to ensure staff complete safeguarding risk assessments at every appointment **Regulation 12 (2) (a) (b)**	Review of definition of safeguarding risk assessment To implement safeguarding risk at each assessment	Chief Nurse	Dec-23	Mar-24	1	**Problematic actions - due date moved once**		Safeguarding risk assessment to be defined - action on track.	Safeguarding Lead to define safeguarding risk assessment in line with Ockenden Recommendation.	Mar-24

Highlight Report

Performance and Finance Committee (27th February 2024) to Trust Board

! Matters of Concern / Key Risks to Escalate

For information:

- In terms of capital, the programme was £4.8 m below plan, although it was expected that the programme would be delivered
- The financial outlook for 2024/25 identified a potential UHNM underlying deficit of £47.1 m although this remained under discussion with system colleagues in terms of an additional share associated with the system deficit
- Urgent and emergency care indicators deteriorated in January as forecast. It was highlighted that at times of the critical incidents, actual demand had exceeded the assumptions within the original surge plan. The Committee requested further assurance in respect of bed occupancy and simple and timely discharges which was provided
- There had been a deterioration in the 78 week wait position due to Industrial Action and the Trust was forecast to clear all 78 week patients by April 2024 as opposed to the end of March 2024
- 11 business case reviews were overdue, 7 of which were within the Surgical Division and action had been taken to not progress any further business cases until the reviews had been undertaken. The Committee expressed their disappointment in respect of the delays incurred for some of the cases and requested further assurance in respect of actions being taken to strengthen the current process to ensure timely review of cases

Major Actions Commissioned / Work Underway

- To provide assurance to the Committee in respect of the plans to move away from external mail and printing in light of e-REAF 12696
- To provide an update to a future meeting on the move towards a national framework for chemotherapy drugs
- The management actions identified following the Data Quality – ICB Metrics internal audit were underway and would be monitored by the Committee

✓ Positive Assurances to Provide

- Month 10 financial performance identified a deficit of £2.1 m which was in line with the break-even forecast and further annual leave accrual was to be released
- In terms of cancer performance for January, the Trust had kept to its trajectory for the 62 day backlog
- Additional capacity for endoscopy was expected to be secured for Q1 2024/25
- The review of the business case in relation to international recruitment of nurses was provided which demonstrated a positive reduction in vacancies and use of agency staff in addition to positive retention rates
- The Committee received the Data Quality – ICB Metrics internal audit which concluded with reasonable assurance

Decisions Made

- The Committee approved the following eREAFs: External mail and printing (12696), Clinical Waste; Sharps, Reusable Sharps, Containers & Related Waste Services (13160), Cytotoxic Dose Banded - Chemo, Immunotherapy and Monoclonal Medicines (13289), Services of Junior Doctors via Health Education England Contract with St Helens & Knowsley Hospitals (13326), Breast Care Unit (13402), Holistic Cancer Centre - Final design and construction works (13417), Day Case Unit at County Hospital (13422), County Network Switch Hardware Refresh (13465), Sub-Contract for Endoscopy Diagnostic Services (13485), Supply Chain Coordination Limited (SCCL) - Trust wide Annual Expenditure - Amendment for outstanding 23/24 invoices (13502) and Royal Stoke Switch Hardware (13554)
- The Committee approved the addendum to the Pharmacy Workforce Business Case (BC-0545)
- The Committee approved the proposed responsive and resource metrics for 2024/25 which were to be incorporated into the Accountability and Performance Framework, although these were subject to change upon receipt of the Planning Guidance

Comments on the Effectiveness of the Meeting

- Committee members welcomed the discussion held and the items of business covered

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Finance Report – Month 10 2023/24 & Financial Outlook	BAF 8	High 9	🔴 🟢	Assurance	5.	Review of Business Cases – International Recruitment of Nurses	BAF 2	Ext 16	🟢	Assurance
2.	Performance Report – Month 10 2023/24	BAF 5	Ext 20	🔴 🟢	Assurance	6.	Business Case Review Update	-	-	🔴	Assurance
3.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	-	Approval	7.	Responsive & Resource Metrics 2024/2025	BAF 5 BAF 6 BAF 8	Ext 20 High 12 High 9	-	Approval
4.	BC-0545: Addendum to Pharmacy Workforce Resource Requirement to support the current Medicine Division in-patient bed base and activity	BAF 2	Ext 16	-	Approval	8.	Internal Audit Report: Data Quality – ICB Metrics	BAF 4/5	Ext 20	🟢	Assurance

Attended | Apologies & Deputy Sent | Apologies

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							Chair	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	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												

Highlight Report

Transformation and People Committee (28th February) to Trust Board

!	Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• A response had been provided to the Health & Safety Executive following their recent inspection although they had sought further clarification on the action plan in relation to resourcing, which had been provided • Further detail needed in relation to the Strategic Planning Framework for 2024/2025 including delivery of the previous year's priorities and explanation of changes; noted that this will form part of the Annual Plan and would be covered at the Board Seminar • Workforce challenges within the Research teams were escalated; new leadership team in place working through these challenges • Continued challenges with response to Freedom of Information requests (65%) – digital solution being explored • Continued challenges with electronic prescribing programme which has added further delays; consideration of solutions being overseen through the Project Board • 89% Data Security & Protection Training against 90% target; training approach being reconsidered with Organisational Development Team • Electronic patient record funding for 2025/26 not yet identified and unlikely to be confirmed for a further 6 to 9 months	• The results from the 2023 National Staff Survey were discussed in detail although this remains under embargo until 7th March. The report for UHNM will be considered at the April meeting. • A whole organisation Training Needs Analysis is being developed in relation to awareness of Sexual Safety; key is to ensure adequate support mechanisms are in place as a result • Divisional priorities are being developed, aligned with the Strategic Planning Framework for 2024/2025 which sets out the metrics / objectives and initiatives planned although further consideration being given to a Royal Stoke Initiative – to be further discussed at the Board Seminar • Metrics for Improving & Innovating, System & Partners and Digital are being included within the Accountability & Performance Management Framework • Further development and wider engagement on Our Strategy in the lead up to it being finalised although the timescales may need to be reviewed • A review of the Improving Together approach has been undertaken in view of NHS Impact and work being undertaken across the system and in other organisations; this has led to a number of proposals being made in taking the programme forward over the next 3 years • A Board Development Session will be scheduled in relation to Improving Together with consideration as to how this aligns with the Well Led Framework • Discussions are underway regarding the preparation of a bid for national monies in respect of creating a dedicated research and innovation space • Further consideration to be undertaken amongst Executive Directors around innovation including the strategy and associated governance • Policy on Artificial Intelligence (AI) being drawn up and a new VPN solution being tested; further consideration of the risks associated with AI needed

✓	Positive Assurances to Provide	Decisions Made
	• National funding had been provided for the recruitment of a 'People Promise Manager' to support delivery of plans arising from the Staff Survey along with existing workstreams • Sexual Safety work has been recognised nationally as good practice with colleagues being asked to join the NHS England Working Group as a result of this work. • Governance arrangements for Shadow IT within Divisions have been strengthened • Successful rollout of the Office 365 with significant effort made by the team and no major issues identified	• No items requiring decision

Comments on the Effectiveness of the Meeting

• No specific comments on effectiveness

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance	
1.	Staff Survey Report	BAF 2 BAF 3	Ext 16 High 12	●	Assurance
2.	Strategic Framework Priorities 24/25	Various		●	Discussion
3.	Trust Strategy	Various		-	Discussion
4.	Review, Refresh and Reframe – Improving Together a 3-year Forward Plan		ID27153	-	Assurance
5.	Executive Research & Innovation Group Highlight Report	BAF 9	High 9	●	Assurance
6.	Executive Digital & DSP Group Highlight Report (18-01-24 and 15-02-24)	BAF 6	High 12	●●	Assurance

2023/2024 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)												
2.	Ms H Ashley	Director of Strategy and Transformation												
3.	Ms T Bowen	Non-Executive Director											Chair	
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												

NO MEETING HELD

DEEP DIVE SESSION

Attended | Apologies & Deputy Sent | Apologies

Freedom to Speak Up
Your voice matters at UHNM

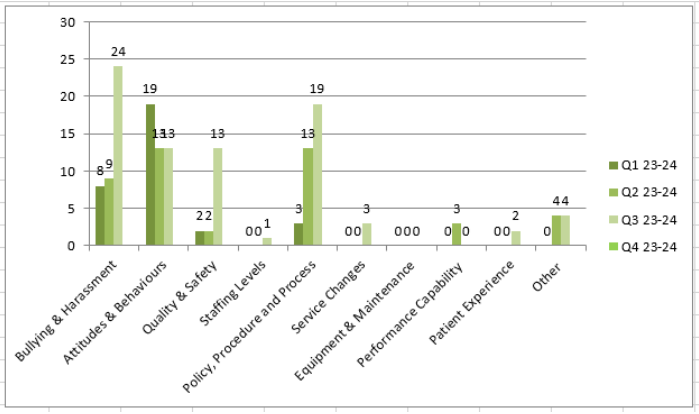
Speaking Up
Board Brief – Quarter 3, 2023/24

1. Headlines

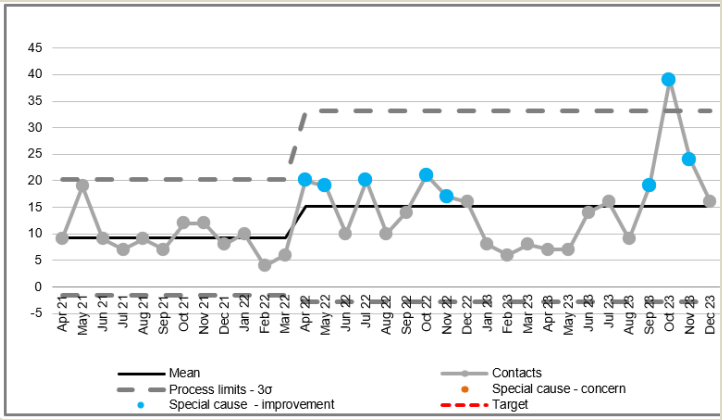
- 79 concerns raised through the Freedom to Speak Up (FTSU) Guardian's Office during Quarter 3 2023/24
- 'Bullying and Harrassment' is the highest theme accounting for 30% concerns raised during the quarter
- Highest reporting staff group was Registered Nurses and Midwives (27 concerns, 34%)

2. Summary of Concerns Raised During the Quarter

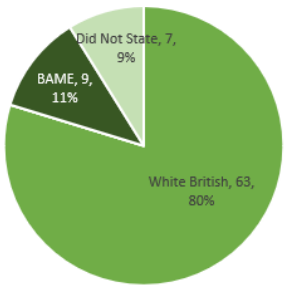
Types of Concerns Raised 2023/24



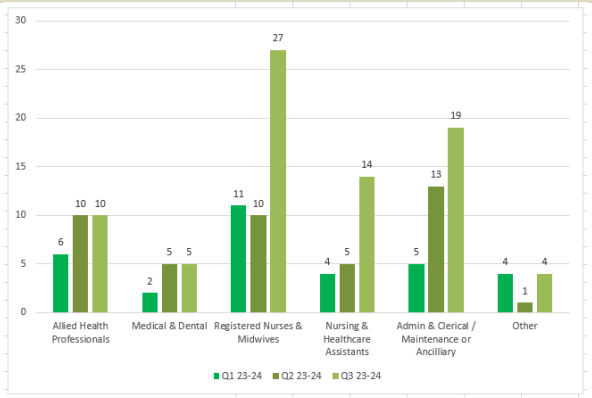
SPC – Concerns Raised April 2021 to December 2023



Ethnicity of Reporters Q3 23/24



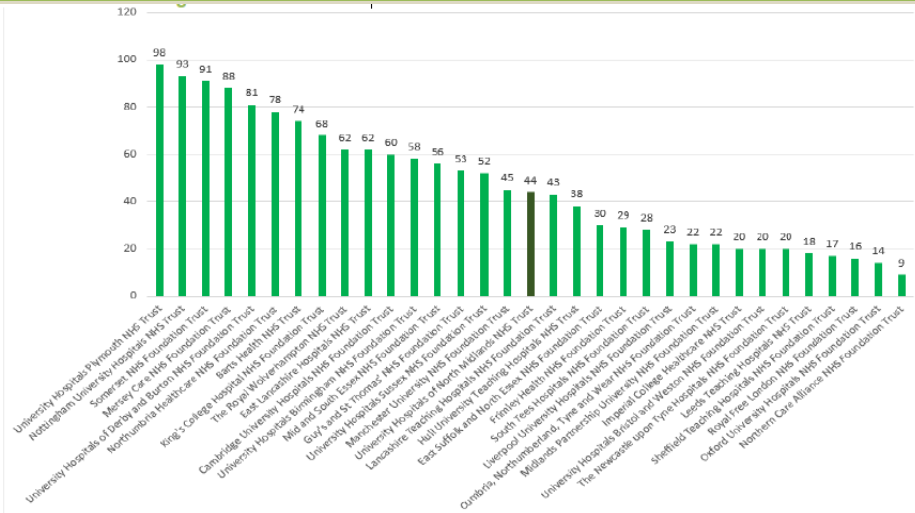
Type of Staff Raising Concerns 2023/2024



Overview

- 79 concerns raised during the quarter, partly attributed to increased promotional activity during Speaking Up Month
- In comparison to the same quarter in 2022/2023 it is an increase of 45%

National Benchmarking – Quarter 2 2023/24



- UHNM ranked just below average (46) for number of concerns during the quarter in the national benchmarking
- Below average for concerns relating to patient safety, worker saety and inappropriate attitudes and behaviour
- Above average for anonymous cases and detriment as a result of speaking up

Detriment	
	• Of the 79 cases reported during Quarter 3, seven cases were reported as there being detriment as a result of raising their concern. • This is a reduction from the previous quarter where 10 cases were reported • All of these cases are discussed with the Non-Executive Director for Speaking Up • Materials to provide further details of detriment have been developed

3. Key Developments During the Quarter

Local Developments			
	Finalisation of the Trust Policy in line with the National policy.		Continued sharing of good practice and support across the system via the Speaking Up Network.
	Significant promotional activity during Speaking Up Month including Wear Green Wednesdays.		Review of lessons learned and NGO actions associated with the Letby outcome.
	Further work on our Self-Reflection Tool following our Board Development Session.		Attendance at the regional concerence focussed upon culture and human factors.

4. Priorities for the Next Quarter

No.		Strategic Priorities	Action
	1.		Establishment of a Network of Champions to provide signposting for concerns raised.
	2.		Further development of improved electronic case tracking.
	3.		Case management, given the increased number of concerns raised.
	4.		Approval of revised Policy in January 2024.
	5.		Commencement of Internal Audit into Speaking Up arrangements.

5. Key Conclusions

	Matters relating to behaviours remain one of the highest categories of concern. Our Cultural Improvement Programme is designed to tackle attitudes and behaviours of staff and the issues contained within this report will be used to influence and inform further improvement activities.
	Whilst we no longer have a 'heat map' of concerns, following our Board Seminar, the lead Guardian is meeting with key corporate colleagues to highlight themes and identify actions for improvement.
	A review of training has been completed and the impact of this will be monitored through future reports.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th March 2024
Report Title:	Integrated Performance Report, Month 10 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**	✓		

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 (January 2024) 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.

The report includes the Assurance Matrix and reordered indicators and dashboard so that indicators are grouped together appropriately.

Assessment

The number of reported patient safety incidents remains above the long term mean but has increased this month as well as the rate per 1000 bed days. Both are showing positive trends and remain within normal variation limits and above the mean rate. The rate is also above the NRLS mean rate during January 2024. It should be noted that an increase in reported incidents and near misses should not be seen as negative hence positive rating for variation indicator) but can reflect a positive reporting culture. The breakdown of incidents by harm reflects this and that there have been increases in reported incidents with no harm and near misses.

Moderate harm or above incidents, both raw numbers and rate per 1000 bed days have also shown initial increase during January 2024 at the time of reporting but are still under review and the final figure may change. Despite the in month increase noted the previous trend had been decreasing.

It is key to note that during January 2024 there have been 3 'Your Next Patient' related incidents reported with moderate harm and that there had been increases overall as the Trust faced increased, exceptional operational pressures during January 2024

The largest categories for reported PSIs excluding Non-Hospital Acquired Pressure Ulcers continue to be Patient Falls, Medication, Patient Flow, Clinical Assessment and Treatment related incidents. Patient Falls incidents remain the largest category after Tissue Viability in January 2024 compared to Medication related in November 2023 but otherwise no significant changes in these categories compared to previous months.

Patient falls rate has continued to show longer term positive trend, but January 2024 has noted a slight increase to 5.9 and there was also a slight increase in falls with harm rate of 1.7 during January compared to 1.5 in December but is lower than 1.9 in November.

Medication related incidents have decreased this month but continue to be higher than same period last year as part of the ongoing drive to improve reporting of medication errors/incidents. There has been an increase in January (at time of the report) in the percentage of these incidents that have been reported as resulted in moderate harm or above. These incidents will be reviewed at Medicines Optimisation & safety Group to assess the impact on patients and also identify and share learning.

From December 2023 the Trust no longer reported incidents via the Serious Incident Framework following the introduction of the new national Patient safety Incident Review Framework (PSIRF). However, the Trust has logged and notified the ICB of 4 incidents during January 2024 on STEIS but under the PSIRF response.

There have been 2 new Never Event reported during January 2024. This incident related to a retained swab and a wrong site surgery (incorrect lesion) and are both subject to Patient Safety Incident Investigation (PSII) under new PSIRF proportionate response to incidents. The final report will be presented at Divisional Forums, Risk Management Panel, QSOG and QGC for sign off.

Duty of Candour compliance during January has improved for verbal notification at 100% and increase in compliance with the internally set 10-day target with 88.5%. There were 26 cases recorded as formally triggering duty of candour. 23 of the 26 cases have recorded written follow up being provided within the 10-day target but 3 other not complying with the timeframe. It is noted however that all of the cases have subsequently completed the written follow up and the Trust is compliant with the statutory duty of candour regulations.

The current position for received patient Safety Alerts shows that there is 1 overdue Patient Safety Alert (at time of report). There were 2 new alert received during January and the 1 overdue alert has been actioned and is being led by the ICB on behalf of the wider ICS.

Pressure Ulcer developed under UHNM care have increased however, the pressure ulcers with lapses in care during January 2024 have decreased and remains below the long-term mean. Category 2 pressure ulcer with lapses in care continue to be the largest category with Category 3, DTI all showing reductions during January 2024. There has been slight increase in number of Unstageable Pressure Ulcers identified with lapses in care. The new PSIRF Tissue Viability toolkit is in use and allows 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 but there has been an improvement in the raw number of responses received but with increased activity the rate has remained at 8%. 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 have increased above the 95% target with 95.7%. The response rate has also improved in January with 22% compared to December with19% and 21% in November 2023. There were 2677 (2142 in December, 2341 in November and 2512 in October) responses returned in January 2024 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.

Maternity FFT but remains below the 95% target at 90.9%. January 2024 saw improvement with 110 (104 in December, 85 in November and 97 in October) completed surveys returned and 40 (37 in December, 25 in November and 21 in October) completed from the Birth touchpoint. The antenatal touchpoint scored 92% recommendation which is a significant increase from previous month's 40%. Compared to the latest national data available (December 2023) out of 113 Trusts, UHNM were 73rd for number of responses for antenatal, 41st for number of responses for birth, 37th for post-natal ward and 57th for post-natal community which shows improvement in all areas. FFT Task & Finish Group for post-natal care established and work is ongoing with the Maternity Voices for improving feedback.

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. Included for the first time in the report are the average monthly response times with January 2024 recording median response time of 63 working days (against target of 40 working days)

Mortality indices remain within expected ranges and compare well with our peers and other acute trusts. SHMI is showing significant improvement with 9 consecutive months of reductions. HSMR has also reduced for third month in succession.

VTE Risk assessment compliance has improved during January and is back above the 95% target. The new VTE Risk assessment has been introduced across surgical wards.

Hospital Associated Thrombosis rate is noted as returning below the long term mean in January 2024 with a rate of 0.83per 10,000 admissions.

Timely Observations are continuing to improve across the Trust with current performance at 73%. There remains 1 ward with less than 50% of patients having timely observations recorded on VitalPack. As previously noted, Medicine, Surgery and Network Services have all now included Timely Observations as Driver Metrics and focussing as priority to improve compliance.

C Diff numbers have decreased during January and remains lower than January 2023 with 12 cases confirmed. There have been number of key actions taken during the past month including the addition of the CUR-95 score has now been added to the CAP antimicrobial Microguide to support clinicians in treatment decisions.

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 February 2024 and figures may change following further review/investigation/update

Operational Performance

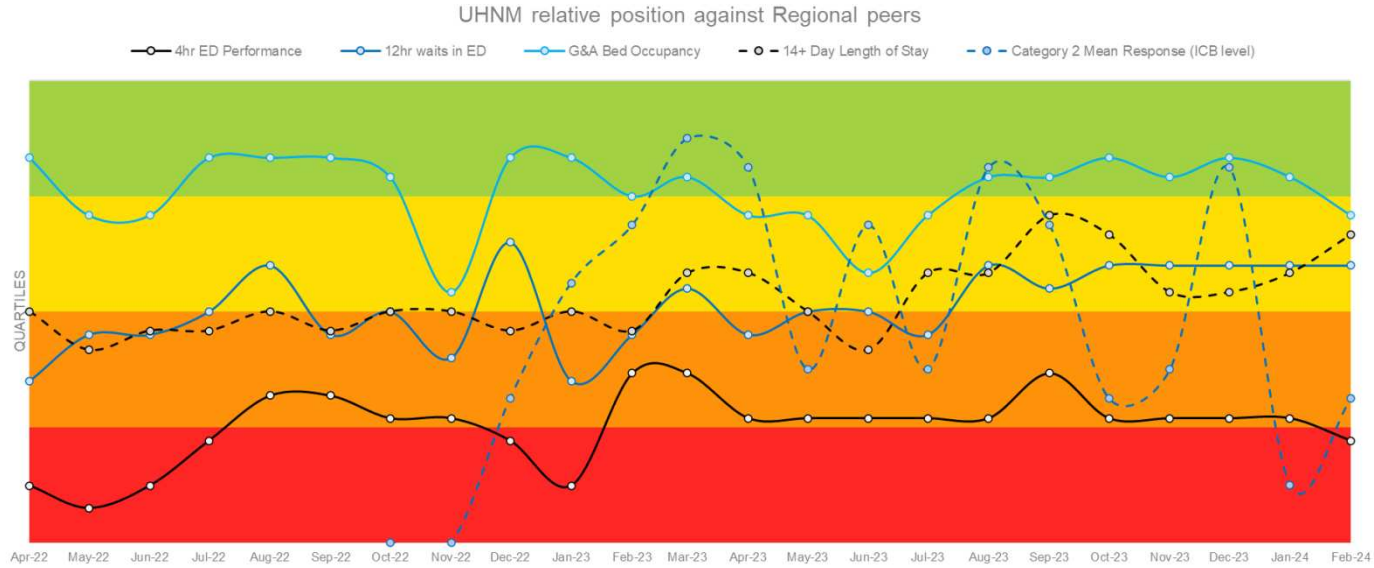
This executive summary highlights key operational challenges in two groups. Urgent and Emergency Care performance (non-elective care) will be described initially and then Planned care, Cancer and Diagnostics services (elective care) will be grouped into a second summary. UHNM has been assessed as NHS 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 themes / metrics. Two separate improvement plans have been developed to respond to these using this same split between Emergency Care and Planned Care, Cancer and

Diagnostics.

Section 1: Urgent and Emergency Care Performance (Non-Elective Care)

How are we doing against our trajectories and expected standards?

Urgent and Emergency Care Indicators have deteriorated between December 2023 and January 2024. As previously reported performance against the 76% 4-hour standard has been deprioritised in order to focus on ambulance handover and safety measures. This strategy is in keeping with the Trusts zero tolerance approach to extreme handover delays.



Despite this deterioration in real term performance both the 4-hour and 14+Day length of stay indicators used in performance tiering system improved relative to other regional peers. Bed Occupancy has increased in real terms (high bed occupancy is worse) and this reflects the increased use of Stafford County hospital to balance the pressure on emergency services.

On 30th January 2024 the Trust declared a Critical Incident as a result of pressures on the Emergency Care pathway. Driven by overcapacity, trolley wait delays in the Emergency Department and in releasing ambulances reached levels that required exceptional multi-organisational response. The Critical Incident was stood down 48 hours later having completed actions that reduced pressure back to acceptable levels.

What is driving this?

January 2024 forecast anticipated a challenging suite of demands on services with the peak of infection rates for seasonal Influenza and COVID anticipated for the 15th January. However in addition to this BMA Industrial Action added to the complexity of planning post bank holiday.

Whilst the Industrial Action planning was safely and effectively delivered the period immediately after Industrial Action was particularly challenging with reduced discharges and periods of increased demand. Whilst the overall forecast bed deficit for the month was almost within expected parameters as an average the variation over this period was more significant. The range of gap between beds available and demand was from as little as 18 bed deficit at its lowest point up to >75 bed gap at its peak during the Critical Incident. The later being in addition to mitigation strategies such as cancellation of elective procedures and other demand management and admission avoidance strategies.

It is likely that on top of a structural deficit in inpatient capacity (as was articulated in both surge plan and in the subsequent Emergency Care Intensive Support Team visits) that the Industrial Action itself had an impact in both the demand on services as well as the Trusts ability to respond to these demands. In essence this improved performance flow and safety for a period beyond expected trajectory only for it to then deteriorate to a much greater extent than anticipated.

A review of both surge plan actions and subsequent command and control interventions put in place to respond to deterioration in emergency access is taking place on the 22nd February 2024. This will pull together intelligence on both the initial planning for winter period as well as additional responses and improvement schemes in order to aid recovery in March and to better plan for holiday periods and winter going forward.

What are we doing to correct this and mitigate against any deterioration?

The Non-Elective Improvement plan has continued as part of its response to NOF3 and Undertakings. This plan articulates 4 workstreams described in more detail in the performance report. These workstreams articulate focus of improvement efforts now reduced from the 5 previous workstreams.

In January and February 2024, considering increased Industrial Action and winter pressures, additional focus has been put into a smaller range of improvement activities with the expectation of more sustainable progress than the previous much broader programme of work. Once Industrial Action activities cease in March the full range of improvement programme will restart.

Specific areas of feedback:

Admission Avoidance and Length of Stay reduction through Acute Care at Home

- The service still operates with a 33% vacancy rate and recruitment continues alongside elements of mutual aid to maximise capacity.
- Development of the Call Before Convey services continues with reenforced communication strategies
- Agreement on the next stage of Call Before Convey to include Category 2 Ambulance Calls has been established and work is commencing on protocol and resourcing to intervene in this important cohort of patients conveyed to hospital. (An intervention during Critical Incident identified of 19 ambulances in delay 9 could have received care in the community without being conveyed to hospital.)

Non-Admitted Performance (RSUH)

- Conscious decisions to use Non-admitted capacity to support ambulance handover have continued to support the ambulance handover response of the Trust overall.
- County Hospital increased demand with diverts and increased intelligent conveyance in order to support RSUH site – resulting in a drop in performance – this was identified in the recent external review from ECIST/GiRFT team and was anticipated.

Winter Preparation

- Winter/surge plan actions continued through January and are expected to be in place until mid-April before any services reduce to pre-winter levels.
- The review of actions taken and winter measures in February will inform continuation of items to Easter and where necessary the mainstreaming of elements of the seasonal plan.

Workstream Priority – Workstream 2 Standard Work (RSUH)

- Improvement in ward discharges on Simple and Timely discharges has a potential to free up to 70 beds.
- Use of the SAFER Care bundle Red to Green and Reason to Reside tools will reduce constraints to discharge and reduce unwarranted variation in discharge behaviours.
- KPMG support will continue until the end of March 2024 to enable intensive improvement cycles whilst using the Trusts Improving Together Methodology.

What can we expect in future reports?

The mitigation and improvement actions being undertaken in January and into February are likely to result in positive impact in March 2024 where there is still ambition to achieve sizable improvement in ambulance handover delays, trolley waits within in ED and against the 4-hour standard.

In addition to those improvement activities described above, two additional tactical interventions are being planned to supplement process improvement. The introduction of a new discharge lounge at the Royal Stoke site is being developed as a rapid intervention to be in place by March 2024. Whilst this will not increase bed capacity it is expected that this would have a strong positive impact on reducing daytime constraints and support patients accessing the right ward first time in a more timely manner.

The second intervention is a contingency action in the event of the emergency pathway continuing to operate over capacity. The cancellation of elective surgery for all patients that require inpatient admission and do not have suspected cancer or have very long waits would enable an increase in capacity for medical specialties. This action can only be temporary in nature but may afford the necessary mitigation whilst other improvement activities increase their impact and address the cause of increase in length of stay and reduce admissions.

Section 2: Planned Care, Cancer and Diagnostics (Elective Care)

How are we doing against our trajectories and expected standards?

Diagnostic performance deteriorated in January with the largest contribution to this coming from Endoscopy delays. Diagnostic capacity was reduced during Industrial Action and this combined with additional bank holidays has created

much of the increase in delays.
The number of patients waiting 78 weeks or more increased for the first time in 8 months as a result of Industrial Action and increased bank holidays in December. As a Tier 1 trust NHSE region and national and regional teams have weekly oversight of improvement trajectories. Trajectories originally had factored in a reduction of capacity in January with the ambition of 0 patients waiting by March. As further Industrial Action is forecast in February this trajectory has been updated to reflect a reduction down to 0 patients waiting by April 2024. There remained 3 patients waiting over 104 weeks for treatment at the end of January with an expectation that this reduces back to 0 by the end of March 2024.

Cancer treatment backlog numbers have continued to reduce in line with trajectory and latest performance at the close of January have numbers on trajectory, this is with the impact of the Christmas period. This performance reflects an improvement in several tumour sites however the most notable and with greatest impact is lower GI (Colorectal) which has seen an improvement to better than trajectory performance. Until backlog reduces to the level set in trajectory overall cancer performance % against the standard will not be the focus of performance reporting.

Cancer diagnostic performance remains a challenge and January performance did not see the required improvement. Although SPC charts show a sustained improvement from August point it was not in line with trajectory and further improvement is required to meet national milestones. Endoscopy is the largest single factor contributing to this shortfall.

What is driving this?

As previously reported Endoscopy performance is contributing to both planned care and cancer standards. Backlogs in cancer are now reducing and the service is increasing its capacity however the recovery period will be staged initially recovering cancer 28 day faster diagnostics standard and then planned care 6 weeks standard. Additional capacity has been secured in Q4 2024 and this will be required throughout 2024/25 with business cases being developed to right size the service permanently.

Industrial Action and bank holiday periods have reduced capacity during December and into January, which combined with increased numbers of patients choosing not to have treatments in the early new year has resulted in a deterioration of waiting times for patients waiting 78 weeks or more. This capacity has been replanned and initial performance expectations was complete reduction down to 0 patients waiting by March. This will now be April.

Cancer treatment backlog reduction (62 day) continue at high levels and capacity has been protected above all other areas of elective care. Increases in capacity supported by West Midlands Cancer Alliance (Lower GI Surgery in particular) have seen a significantly positive impact.

What are we doing to correct this and mitigate against any deterioration?

Endoscopy services continue their three part improvement plan for the resolution of demand versus capacity. In Q4 the additional funding to support additional capacity will be fully deployed using support from independent sector insourcing. This is being used to expand capacity and is the final funding position available to us this financial year. The second part of the plan uses external support brought into endoscopy to help improve utilisation and productivity. This will also include work with the leadership teams to fully mobilise the digital system now implemented and to improve processes and booking practice. This final element will ensure that the service is sustainable into 2025 and will be the longer term recruitment and workforce strategy to deliver a permanent service that responds to patients needs across SSOT.

Productivity in elective services, and especially outpatient services are part of the wider planned care improvement plan. Utilising the GiRFT methodologies the Trust will focus on specialties that have particularly long waiting lists and work with the national GiRFT *Further Faster* programme. This clinically developed set of improvement tools has been used in a number of areas nationally and will support the focussed recovery of those specialties with gaps in demand and capacity and that have long waiting lists.

Cancer performance and the protection of capacity for cancer recover will remain a focus during the winter (Surge Plan). It is expected that despite the increased winter pressure and impact from emergency overflow, cancer services will remain protected. This will include the ring fencing of funding for cancer improvement which if mobilised should deliver performance in line with our trajectories.

What can we expect in future reports?

As discussed in previous months IPR narrative diagnostics and planned care will not be met by March 2024. The full impact of this is still being analysed however the timing of the action is such that it is unlikely any suitable alternatives

for the lost capacity will be available when required and Q1 will be the earliest these targets will be met.
Cancer services have the greatest protection of services (including cancer diagnostic services) and recovery trajectories are still expected to be delivered. Currently they remain on trajectory in early January however a record increase in referrals as a result of national celebrities and members of the royal family are likely to put unplanned stress on services. Ongoing discussions are taking place with regulators on both undertakings and NOF3 exit criteria which now must be considered in relation to the Industrial Action.

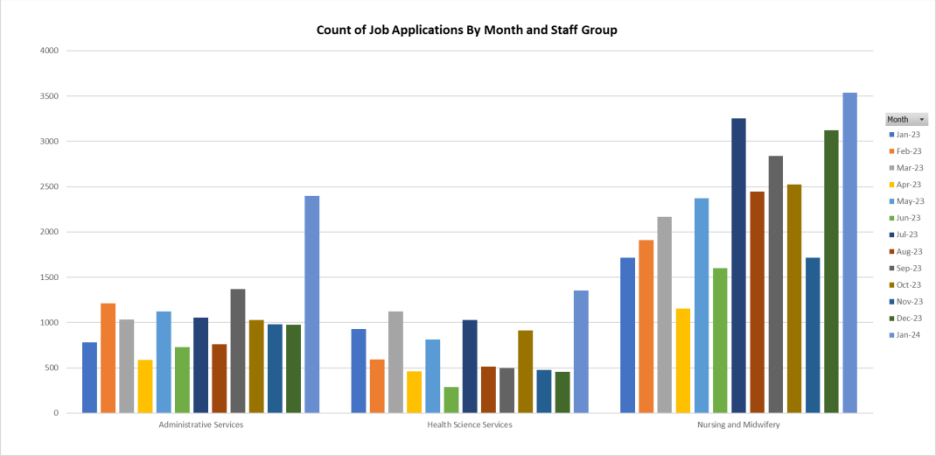
Workforce

How are we doing against our trajectories and expected standards?

- **Turnover** and **vacancy** metrics continue to perform well against our expected standards. The turnover rate in January 2024 has shown a small improvement to 8.2% and this remains well below the Trust's 11% target. The vacancy metric has improved to 8.46% which also remains within our expected standard of 10%. The main driver of the vacancy % is due to an increase in the total FTE for actual people in post.
- **Sickness absence** continues to be above the Trust expected standard of 3.39%. In month we have seen a fractional 0.09% decrease to 5.84%. The 12-month cumulative rate has increased fractionally to 5.22% from 5.20%. The main driver of this continues to be stress and anxiety, although this has improved for the second consecutive month. Chest and respiratory conditions remain the second reason for absence, which correlate with the increase in covid cases.
- **Performance Development Reviews (PDR's)** continue to be below the Trust target of 95%. In month we have seen a slight decrease from 82.8% to 82.1%. The refreshed PDR paperwork, to support colleagues in achieving their potential, was published in January 2024, with twelve drop-in sessions taking place, to complement the new guides and electronic training materials which have been made available on the Intranet.
- **Statutory and Mandatory Training** (core for all subjects) remains just below the Trust target of 95% and declined by 0.89% to 93.5% in January 2024 from 94.4% in December.

What are we doing to correct and mitigate against any deterioration?

- In January we have launched our "5 Reasons to Join UHNM" social media campaign to continue to attract applicants and promote our organisation as a great place to work. January saw a 245% increase in job applications for Admin & Clerical positions, with increases also seen in Healthcare science and Nursing & Midwifery, as well.



- Divisional and Directorate Management Teams continue to manage sickness absence in line with the Trust Policy.
- The refreshed PDR paperwork was released, as planned, in January 2024, supported by multiple drop-in sessions, as mentioned above.
- We are continuing to watch the statutory and mandatory training performance to ensure that we maintain the strong position on this metric.

What can we expect in future reports?

- The local Staff Voice Survey was re-opened from 1-10th January 2024, which achieved an engagement score of 6.84, with 269 responses, which is 63 more responses than September 2023's results, prior to being paused during the national staff survey period.

- Key themes from the NHS National Staff Survey raw data are being analysed in readiness for the formal launch of the national reports at the end of Quarter 4. We will report on the findings at the April Trust Board meeting.
- We should anticipate that sickness absence in month may continue to increase given the seasonal ailments, although static in the last two months

Finance

Key elements of the financial performance for the year to date are:

- For Month 10 the Trust has delivered a year-to-date deficit of £2.1m against a planned surplus of £0.8m; this adverse variance of £2.9m is primarily driven by underperformance against the Trust's in year CIP target and unfunded additional winter escalation capacity that remained open through the year.
- The Trust has received £9.0m additional funding towards the cost of industrial action and other cost pressures for Month 1 to 7; this additional income was recognised in the Month 8 position. No additional funding has been received to cover industrial action costs incurred in December although for Performance Management purposes the Trust's yearend target has been adjusted to breakeven plus the impact of Industrial Action in December and January.
- The Trust has incurred £5.0m of costs relating to winter escalation capacity remaining open to Month 7 partially funded by £2.1m of additional funding from the local ICB. Winter and escalation costs from Month 8 are funded as part of the Trust's winter plan.
- To date the Trust has validated £37.0m of CIP savings to Month 10 against a plan of £45.8m. The Trust has recognised £4.3m of CIP due to an assumed reduction in the annual leave provision delivering 50% of the NR ICB stretch CIP target; the balance is expected to be delivered from a further reduction in the provision. 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.
- The Month 10 actual performance of a £0.9m surplus is in line with the Trust's Month 8 breakeven forecast for the year presented to the Committee in November.
- There has been £53.1m of Capital expenditure which is £4.8m below plan.
- The cash balance at Month 10 is £68.2m which is £3.8m lower than plan.

Key Recommendations

The Trust Board is requested to note the performance against previously agreed trajectories.

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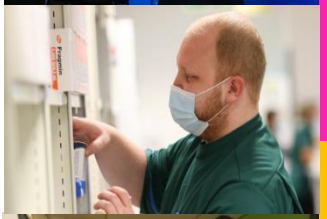


Integrated Performance Report

Month 10 2023/24

Delivering Exceptional Care with Exceptional People

Contents

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

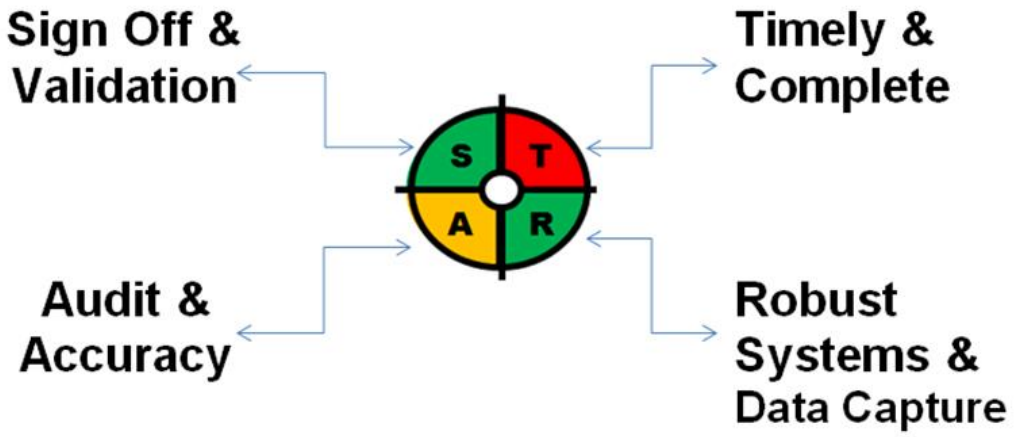
Assurance - how assured of consistently meeting the target can we be?

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**

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Quality

Caring and Safety

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

Quality Spotlight Report

NHS
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The Trust achieved the following standards in January 2024:

- Hospital Associated Thrombosis has continued to remain below the mean rate and is within normal variation and cases are under review.
- 100% verbal Duty of Candour compliance recorded in Datix.
- Trust rolling 12-month HSMR continues to be within expected range at 97.91
- Trust rolling 12-month SHMI 98.44 and is Band 2 – as expected. There has been continued improvement in SHMI
- Zero avoidable MRSA Bacteraemia cases reported.
- Pressure Ulcers per 1000 bed days with lapses in care developed under UHNM care is now 0.39 and below the target rate 0.5
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- E. Coli Bacteraemia cases on trajectory with 19 in January compared to target of 16.
- VTE Risk Assessment completed during admission has improved and above 95% target with 96.2% recorded in December (via Tendable)
- Inpatient sepsis Screening and Sepsis IVAB within 1 hour achieved 100% and 88.9% respectively and meeting the 90% target rate
- Children's Sepsis Screening compliance achieved the 90% target with 100% during December.
- Friend & Family (Inpatients) 95.5% and exceeds 95% target.
- The rate of complaints per 10,000 spells is 26.69 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:

- Falls rate was 5.9 per 1000 bed days for January 2024 and above benchmark rate.
- Rate of falls reported that have resulted in harm to patients currently at 1.7 per 1000 bed days and continues to be within the control limits and normal variation.
- 88.5% 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
- There were 17 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 2 Never Events
- 1 overdue Patient Safety Alerts which is awaiting final approval and sign off (as at end of January 2024 and this is being led by the ICB)
- Timely Observations remain below the 90% target but has seen further improvement during January 2024 with 73%.
- C Diff YTD figures above trajectory with 12 against a target of 8.
- Friend & Family (A&E) remains below 85% target at 67.4%
- Friend & Family (Maternity) 90.9% and below 95% target.
- Sepsis Screening compliance in Emergency Portals improved to 80% but remains below the target 90%.
- Emergency Portals Sepsis IVAB improved to 80% but remains below the 90% target for audited patients.
- Maternity Sepsis Screening compliance remain below 90% target at 45.5%
- Maternity IVAB compliance improved to 40% but remains below the 90% target for audited patients

During January 2024, the following quality highlights are to be noted:

- Total number and rate of Patient Safety Incidents increased in month and continues to show increased reporting
- Total incidents with moderate harm or above and the rate of these incidents within normal variation levels during January and noted increase in month (incidents are currently under review)
- Medication related incidents rate per 1000 bed days is 6.1 which above the target and the long term mean rate as is patient related at 5.7. 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 increased for January 2024 and incidents remains under review.
- PSIRF adopted and therefore no Serious Incidents reported. 4 incidents reported in January 2024 and under review using Patient Safety Incident Investigation (PSII) process
- Largest reason / category of complaints in January 2024 continue to relate to clinical treatment with 36% of complaints received relating to issues with clinical treatment.

University Hospitals of North Midlands NHS Trust

Quality Performance Report (QPR) | Assurance Grid

Failing NHS

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

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

August 2023	Pass	Hit and Miss	Fail
Variance – Special Cause - Improvement	All Children's IVAB in 1 hour VTE Risk Assessment	Patient Safety Incidents PSI rate per 1000 bed days PSI's per 1000 bed days no harm PSI rate Moderate Harm and above PSI's per 1000 bed days near miss days Medication Incidents per 1000 bed days Patient Medication Incidents per 1000 bed Contracted Adult Inpatient Sepsis Screening All children sepsis screening Hospital acquired Thrombosis Rate Inpatient Sepsis Screening Approval Lead Time Sickness	Rolling 12 month SHMI Timely Observations Avoidable MRSA
Variance – Common Cause	Rolling 12 month HSMR	Falls rate per 1000 bed days Medication incident % moderate harm + Pat Medication incident % moderate harm PU's rate per 1000 bed days Serious Incidents & Rate of SIs Lapses in care PU per 1000 bed days Cat 2 PU with Lapses in care Cat 3 PU with lapses in care Deep Tissue injuries lapses in care Unstageable PU lapses in care DoC compliance formal verbal & written HAI and COHA cases of C Diff toxin Friends and Family Inpatient & Maternity Complaints Rate Other Emergency Portal Screening Average Usability	Family and Friends ED RS ED IV Abx in 1 hour Other Emergency Portals IV Abx in 1 hour Patients will receive a variable experience
Variance – Special Cause - Concern	Inpatient IVAB within 1 hour	PSI's per 1000 bed days low harm Never Events reported 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	All Maternity sepsis screening All Maternity IVAB in 1 hour

Worsening

Quality Dashboard

NHS
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Metric	Benchmark	Previous	Latest	Variation	Assurance
Patient Safety Incidents	2000	2065	2387		
Patient Safety Incidents per 1000 bed days	50.70	51.02	55.96		
Patient Safety Incidents per 1000 bed days with no harm	34	34.07	37.11		
Patient Safety Incidents per 1000 bed days with low harm	13	14.43	15.38		
Patient Safety Incidents per 1000 bed days reported as Near Miss	2	2.05	2.32		
Patient Safety Incidents with moderate harm +	20	18	16		
Patient Safety Incidents with moderate harm + per 1000 bed days	0.60	0.44	1.13		
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		
Patient Falls per 1000 bed days	5.6	5.0	5.9		
Patient Falls with harm per 1000 bed days	1.5	1.9	1.6		
Medication Incidents per 1000 bed days	6	6.7	5.8		
Medication Incidents % with moderate harm or above	0.50%	0.73%	1.28%		
Patient Medication Incidents per 1000 bed days	6	6.0	4.9		
Patient Medication Incidents % with moderate harm or above	0.50%	0.83%	1.52%		

Metric	Benchmark	Previous	Latest	Variation	Assurance
Serious Incidents / PSIIs reported per month	0	3	4		
Serious Incidents / PSIIs Rate per 1000 bed days	0	0.07	0.09		
Never Events reported per month	0	1	2		
Duty of Candour - Verbal/Formal Notification	100%	92.3%	100.0%		
Duty of Candour - Written	100%	85%	88.5%		
All Pressure ulcers developed under UHNM Care	60	86	76		
All Pressure ulcers developed under UHNM Care per 1000 bed days	1.6	1.68	2.48		
All Pressure ulcers developed under UHNM Care lapses in care	12	20	16		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.52	0.40		
Category 2 Pressure Ulcers with lapses in Care	8	7	7		
Category 3 Pressure Ulcers with lapse in care	4	1	2		
Deep Tissue Injury with lapses in care	0	9	6		
Unstageable Pressure Ulcers with lapses in care	0	3	4		

Quality Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Benchmark	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	68.6%	67.4%		F
Friends & Family Test - Inpatient	95%	94.7%	95.7%		?
Friends & Family Test - Maternity	95%	92%	90.9%		?
Written Complaints per 10,000 spells	35	19.09	26.69		?
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	96.52	95.45		P
Rolling 12 Month SHMI (4 month time lag)	100	99.33	99.27	L	F
VTE Risk Assessment Compliance	95%	93.8%	96.2%		
Hospital Associated Thrombosis Rate per 10,000 Admissions	N/A	1.50	1.39		
Timely Observations	90%	71.0%	73.0%	H	F
Reported C Diff Cases per month	8	14	12		?
Avoidable MRSA Bacteraemia Cases per month	0	0	0	L	?
HAI E. Coli Bacteraemia Cases per month	16	16	19	H	?

Metric	Benchmark	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	98.0%	100.0%	H	?
Inpatient IVAB within 1hr (Contracted)	90%	100%	88.9%	L	P
Children Sepsis Screening Compliance (All)	90%	100%	100.0%	H	?
Children IVAB within 1hr (All)	90%	N/A	N/A	H	P
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	83.0%	78.0%	L	?
Emergency Portals IVAB within 1 hr (Contracted)	90%	61.54%	80.0%	L	?
Maternity Sepsis Screening (All)	90%	84%	45.5%	L	F
Maternity IVAB within 1 hr (All)	90%	33%	40.0%	L	F

Delivering Exceptional Care with Exceptional People

Reported Patient Safety Incidents

NHS
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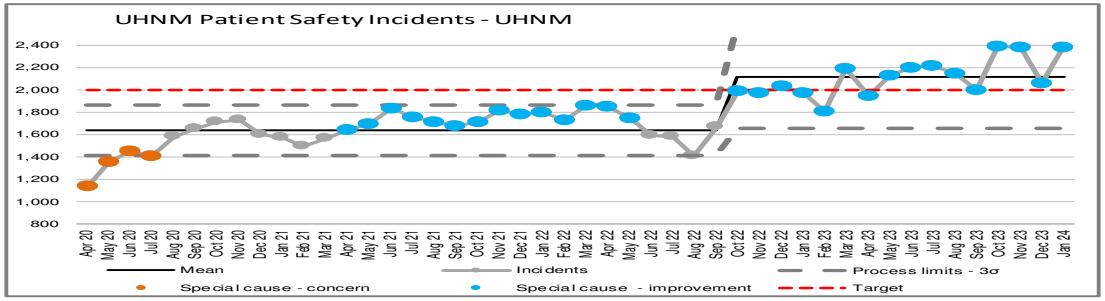
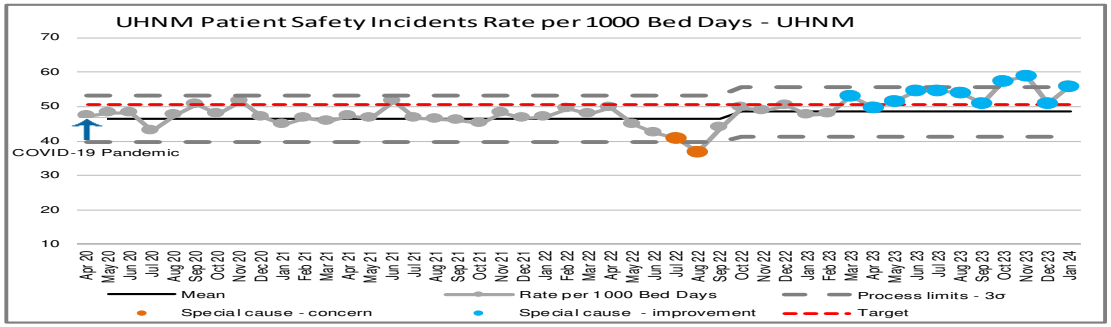


Variation	Assurance
	

Target	Nov 23	Dec 23	Jan 24
2000	2386	2065	2387

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Nov 23	Dec 23	Jan 24
50.70	58.96	51.02	55.96

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The January 2024 total remains above the mean total. The rate per 1000 bed days has also increased and continues to be above the NRLS mean rate.

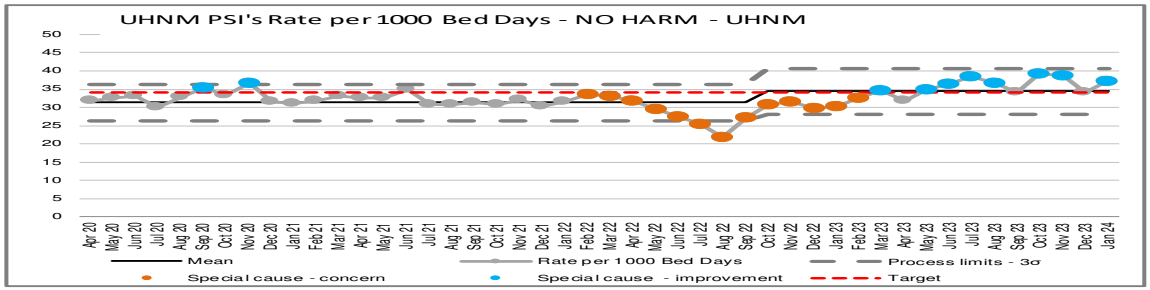
However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers are Patient Falls, Medication, Patient Flow, Treatment related and Clinical assessment incidents. Falls related incidents are the largest category after Tissue Viability in January 2024.

There has been increase in the number of incidents relating to 'Your Next Patient' with 23 during January reflecting increased operational pressures (14 during December, November and 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 0.96% (0.68% in December, 0.61% in November, 0.57% in October, 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. The January 2024 YNP related incidents are significantly lower than January 2023. Therefore, despite the in-month increase there continues to be significant reduction in the number of reported incident relating to the YNP processes. 9 of the 23 incidents were directly patient flow related and where patients were being moved to AMU or wards

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

NHS University Hospitals of North Midlands NHS Trust

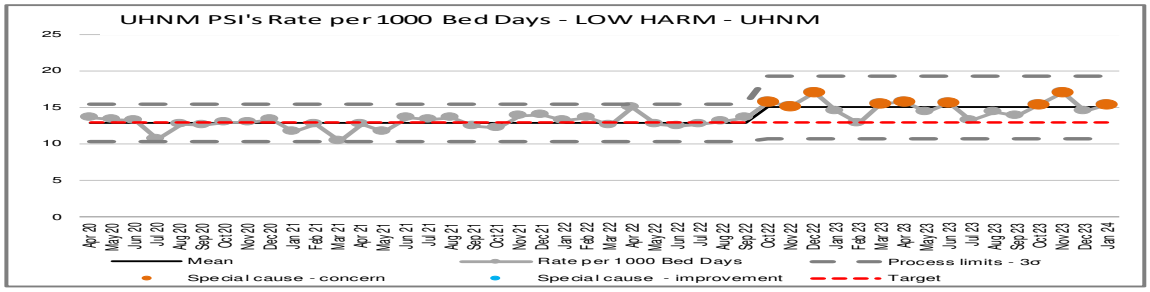


Variation	Assurance
H	?

Target	Nov 23	Dec 23	Jan 24
34	38.65	34.07	37.11

Background

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

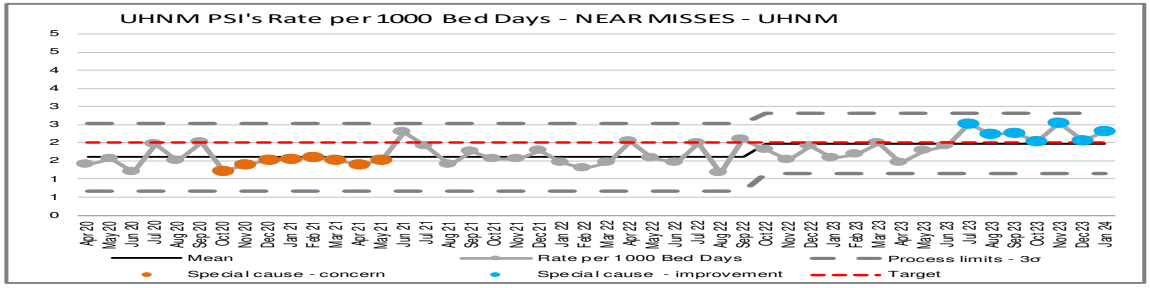


Variation	Assurance
H	?

Target	Nov 23	Dec 23	Jan 24
13	17.02	14.43	15.38

Background

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



Variation	Assurance
H	?

Target	Nov 23	Dec 23	Jan 24
2.0	2.55	2.05	2.32

Background

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

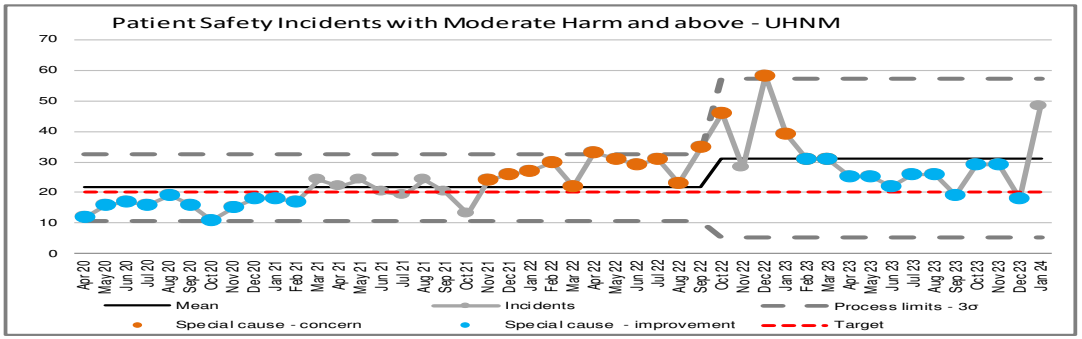
What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm and near misses have seen rates remain above the long term mean and target rates with improvements during January 2024. Low harm increased slightly in month but is around the mean rate.

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

NHS University Hospitals of North Midlands NHS Trust

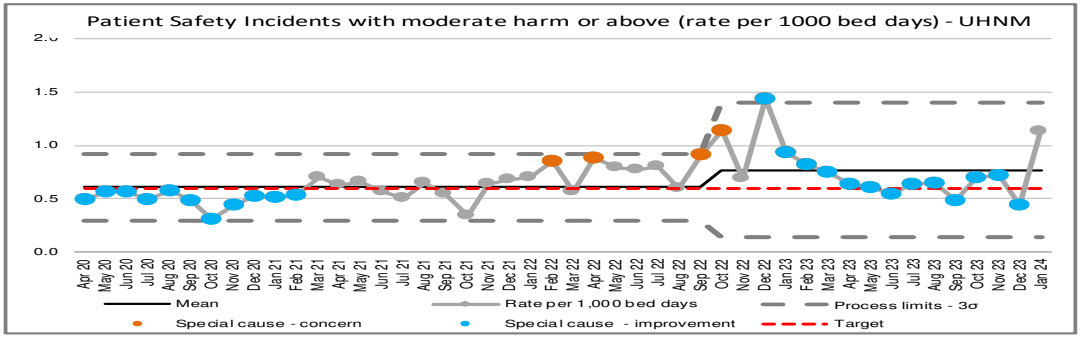


Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
20	29	18	48

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
0.60	0.72	0.44	1.13

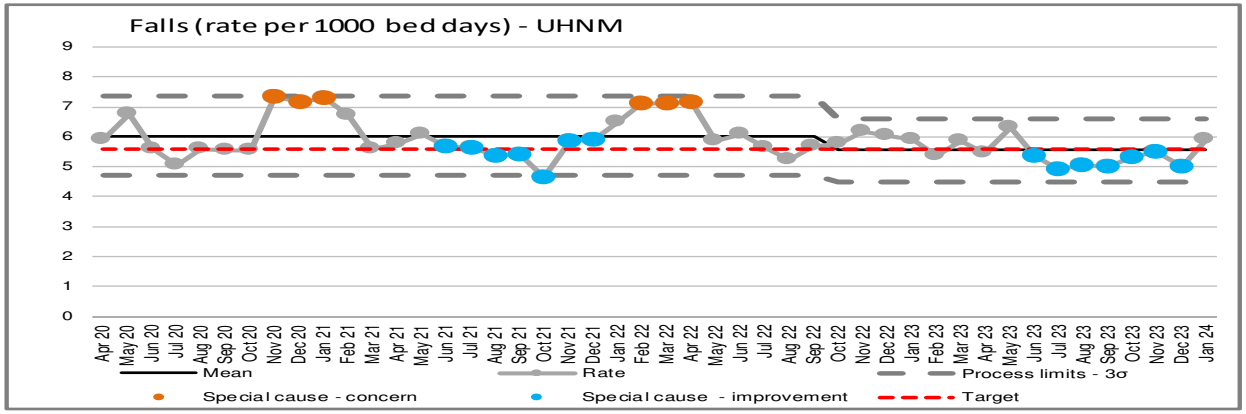
What is the data telling us:

The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within normal control limits but has shown increase total numbers and rate for January 2024 but these remain under review and may alter following completion of the reviews. Prior to January, the last 13 months had seen reducing trends and below the mean rate which was recalculated in October 2022.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with Medication (8), Tissue Viability (3) and Treatment/Procedure (8) related incidents.

3 of these moderate harm and above incidents were noted as relating to **'Your Next Patient'.** 2 of these incidents relate to the same patient and potential delay in treatment/diagnosis and are linked as part of the After-Action review being undertaken. The third incident related to patient awaiting wheelchair prior to discharge when MFFD. Awaiting alternative wheelchair provision from supplier/contract provider

Patient Falls Rate per 1000 bed days



Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
5.6	5.5	5.0	5.9

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

The Trust's rate of reported patient falls per 1000 bed days was within expected range in January.

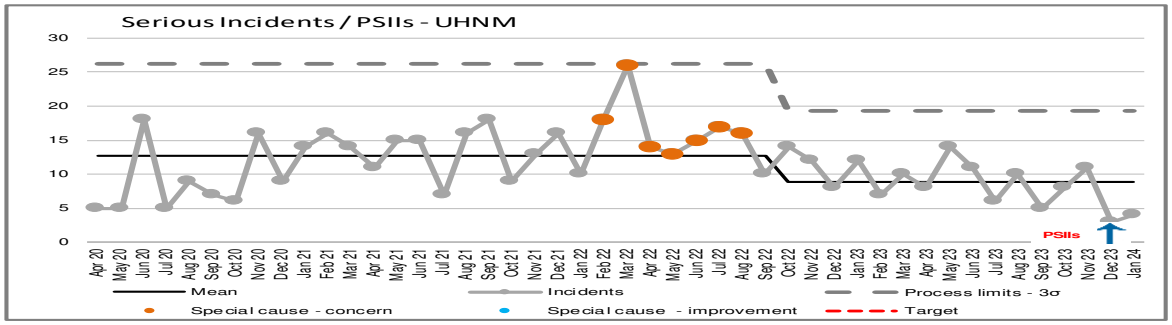
The areas reporting the highest numbers of falls in January 2024 were:-
Royal Stoke AMU – 21 falls, Royal Stoke ECC – 16 falls, County AMU – 12 falls

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

- From the 49 falls across the 3 areas there was unfortunately 1 injury which was a metacarpal fracture. PSIRF toolkit was completed in conjunction with the ward and improvements and actions were discussed.
- Falls audits have been completed on the above wards and areas of good practice were noted. Areas of improvements were timely comfort rounds required and call bells not within reach of the patients. Finding were given to the nurse in charge at the time of the visit and then emailed to the ward and matron of the area.
- DQSM have recently taken the audit results to the directorate governance meetings for discussion.
- New N/A induction training has taken place.
- New falls champion training and existing refresher training has been advertised.
- The Quality & Safety team continue to work closely with both ECC and AMU due to the constant high number of falls.

Serious Incidents / PSIIs per month

NHS University Hospitals of North Midlands NHS Trust

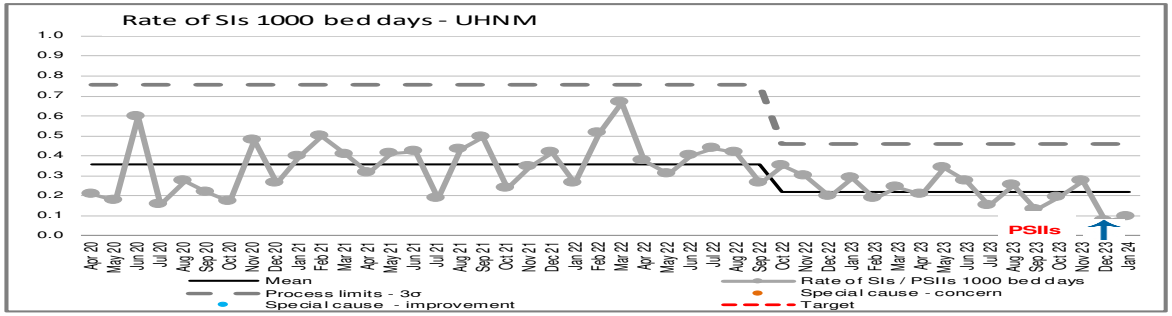


Variation	Assurance

Threshold	Nov 23	Dec 23	Jan 24
0	11	3	4

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
0	0.27	0.07	0.09

Background

The rate of Serious Incidents / PSIIs Reported per 1000 bed days

What is the data telling us:

In December 2023, UHNM stopped reporting incidents under the Serious Incidents Framework and adopted the new Patient Safety Incident response Framework (PSIRF). Whilst UHNM moves towards LFPSE implementation, the interim arrangement is to report on STEIS incidents that previously noted as SIs. During January 2024, UHNM reported 4 incidents that are being reviewed using the new Patient Safety Incident Investigation (PSII) methodology

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. January 2024* saw 4incidents reported:

- 1 unexpected death
- 1 related to missed dose of antibiotics
- 1 retained swab
- 1 wrong site surgery

The rate of SIs per 1000 bed days has varied consistently within confidence limits but the past 11 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 0.09.

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

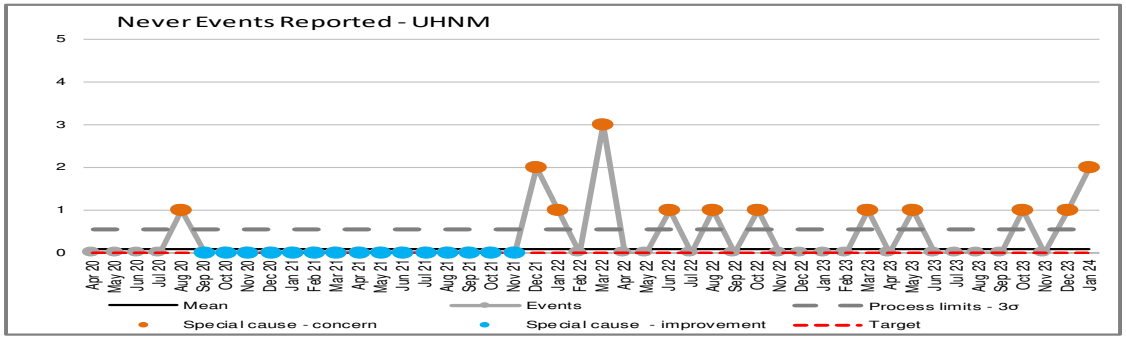
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during January 2024. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary of numbers and categories.

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

There were 0 Maternity related Serious Incidents reported on STEIS during January 2024

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

Never Events



Variation	Assurance
H	?

Target	Nov 23	Dec 23	Jan 24
0	0	1	2

Background

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

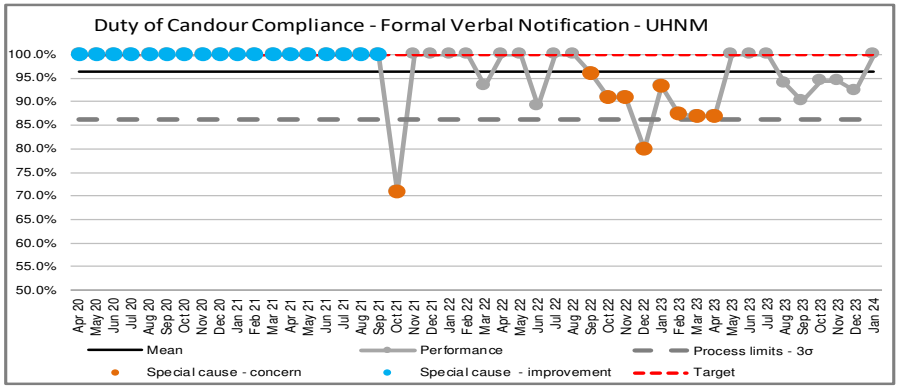
There have been 2 new Never Event reported in January 2024. The target is to have 0 Never Events.

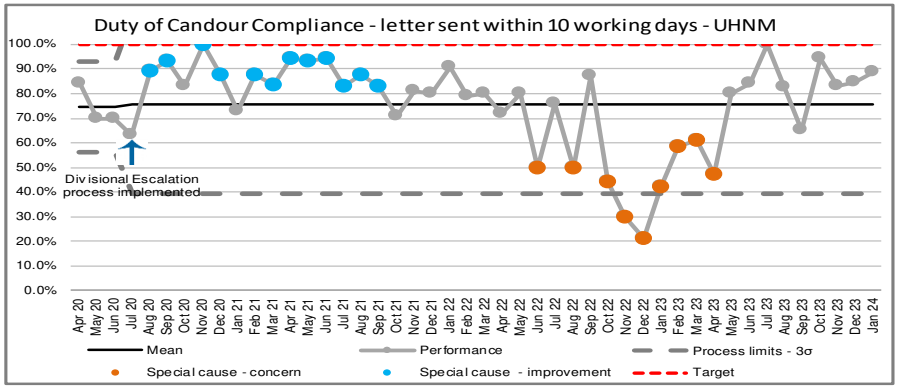
Whilst these are Never Event Category it is now reported via the PSIRF approach and will have a PSII undertaken.

Log No.	Never Event Category	Description
2024/1527	Retained foreign object post procedure	Robotic Assisted Radical Prostatectomy On final count theatre team identified that 2x mastoid swabs were still inside the pelvis. Wounds had already been closed. Patient was still intubated, on the operating table and remained under anaesthesia.
2024/1537	Wrong site surgery	Patient attended the Dermatology department on 29/01/2024 where he underwent a wide local excision with 5mm margins. On 30/01/2024 the patient contacted the Dermatology department as he believed the wrong scar site had been excised. The patient, at the request of the Junior Sister, attended the department and was reviewed. On examination and through reference to the initial Telederm photographs it was concluded that this was wrong site surgery. The scar that was excised during the procedure on 29/01/2024 was an old scar from an excision the patient had in 2017.

Duty of Candour Compliance

NHS
University Hospitals of North Midlands
NHS Trust





Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
100%	94.4%	92.3%	100.0%

Background

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

Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
100%	83.3%	84.6%	88.5%

Background

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

What is the data telling us:

During January there were 26 incidents reported and identified that have formally triggered the Duty of Candour. 100% (26 out of 26) 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 January 2024 is 88.5% as of 8th February 2024 including those letters that are completed within timescale and not yet exceeded the timeframe. 3 cases were outside the 10-day timeframe but have still been completed.

100% of the identified cases have had Duty of Candour completed.

* *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.

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

Head of QSC has been undertaking additional sessions at Directorate & Specialty Meetings to discuss Duty of Candour and staff responsibilities.

Patient Safety Alerts

University Hospitals of North Midlands NHS Trust

New Patient Safety Alerts received:

During January 2024 there have been 2 new alerts received through the Central Alert System (CAS) – national web based cascading system for issuing patient safety alerts and other safety critical information and guidance to the NHS. Alerts available on the CAS website include NHS England and NHS Improvement Patient Safety Alerts (PSA) and Estates Alerts, MHRA Dear Doctor letters, Medical Device Alerts (MDA) and Drug Alerts, Chief Medical Officer (CMO) Alerts, and Department of Health & Social Care Supply Disruption alerts.

Alert Type	CAS Status	Alert Reference Number	Alert Title	Date Issued	Date Completed	Deadline Date
NHS PSA	**Open**	Nat/PSA 2024 001 DHSC	Shortage of GLP-1 receptor agonists (GLP-1 RA) update. This alert supersedes Nat/PSA 2023 008 DHSC.	03/01/2024		28/03/2024
NHS PSA	**Open**	Nat/PSA 2024 002 NHSPS	Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks.	31/01/2024		31/01/2025

Currently there are 5 open alerts on the CAS system for UHNM

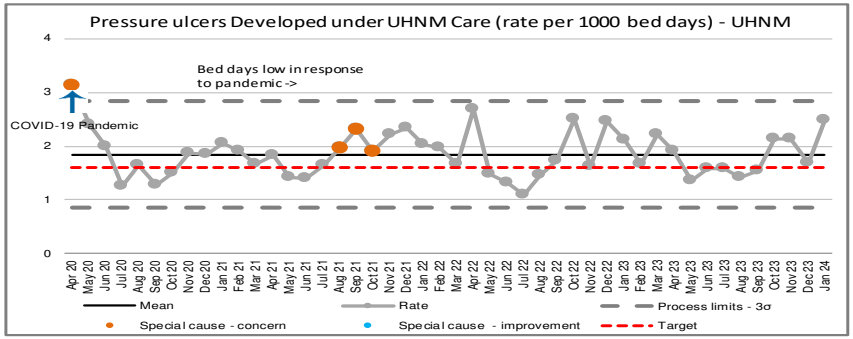
Alert Type	CAS Status	Alert Reference Number	Executive Lead	Alert Title	Date Issued	Deadline Date
NHS PSA	**Open**	Nat/PSA/2023/010/MHRA	Chief Nurse	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls	31/08/2023	01/03/2024
NHS PSA	**Open**	Nat/PSA/2023/013/MHRA	ICB Lead	Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients.	28/11/2023	31/01/2024
NHS PSA	**Open**	Nat/PSA/2023/014/MHRA	Chief Nurse	Identified safety risks with the Euroking maternity information system.	07/12/2023	07/06/2024
NHS PSA	**Open**	Nat/PSA 2024 001 DHSC	Medical Director	Shortage of GLP-1 receptor agonists (GLP-1 RA) update. This alert supersedes Nat/PSA 2023 008 DHSC.	03/01/2024	28/03/2024
NHS PSA	**Open**	Nat/PSA 2024 002 NHSPS	Medical Director / DeputyMD	Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks.	31/01/2024	31/01/2025

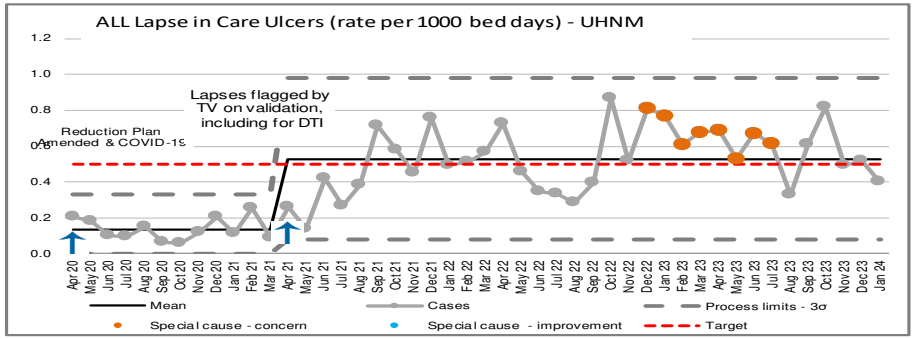
Overdue Patient Safety Alerts: There is currently 1 overdue alert.

Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Deadline Date	Comments
NHS PSA	**Open**	Nat/PSA/2023/013/MHRA	Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients.	31/01/2024	Meetings between UHNM and ICB regarding pregnancy prevention programme and a system wide meeting of the valproate group. ICB will lead on response to this alert. Feedback/responses being collated at ICB level, going through Meds Safety Group once completed by the ICB lead, awaiting feedback as deadline date has now passed.

Pressure Ulcers developed under care of UHNM per 1000 bed days

University Hospitals of North Midlands NHS Trust





Variation	Assurance
	

Target	Nov 23	Dec 23	Jan 24
1.6	2.13	1.68	2.48

Background

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

Variation	Assurance
	

Target	Nov 23	Dec 23	Jan 24
0.5	0.49	0.52	0.40

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 January. The rate of cases with lapses in care identified was also within expected range in January.

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

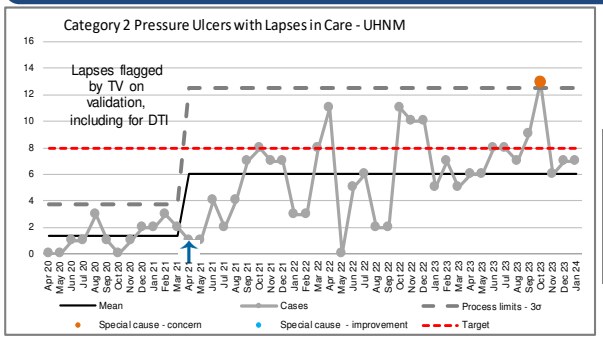
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.

Actions

- Training continues for NA induction, Preceptorship days, and ED new starters.
- Education plan for 2024 which will include pressure prevention, categorization, continence, lower limb, woundcare, and negative pressure. Conference arranged for March 2024. External companies are visiting to delivery education regarding catheters.
- ESR approved by Stat & Mand Training group has been approved and being developed. The guidelines for categorisation have been released from the NWCS, just awaiting the resources which will hopefully be February / March 2024.
- Protocol for matrons and senior nurses for management of category 2 at ward level. This will allow the team to see patients timely who need a review.
- 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 standard patient chair and will now look at recliner chairs and bariatric options.
- Discussions with procurement to have all alternating mattresses in the Trust.
- Increase in clinical caseload leading to longer wait times. This has been added to the risk register.
- Concerns that pressure damage reported has been incorrectly reported (miscategorisation)

Pressure Ulcers with lapses in care

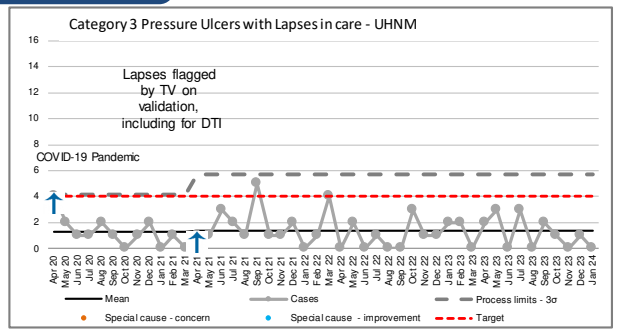
University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Nov 23	Dec 23	Jan 24
8	6	7	7

Background

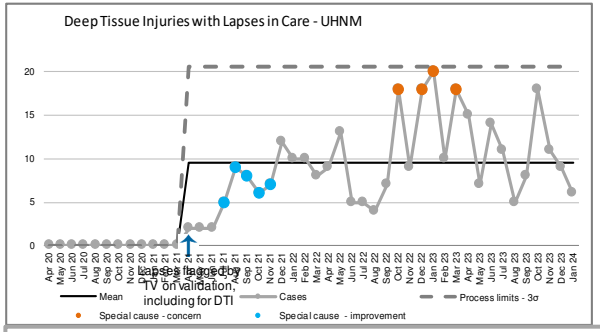


Variation	Assurance
	

Target	Nov 23	Dec 23	Jan 24
4	0	1	0

Background

Category 3 pressure ulcers which developed under the care of UHNM with lapses in care associated

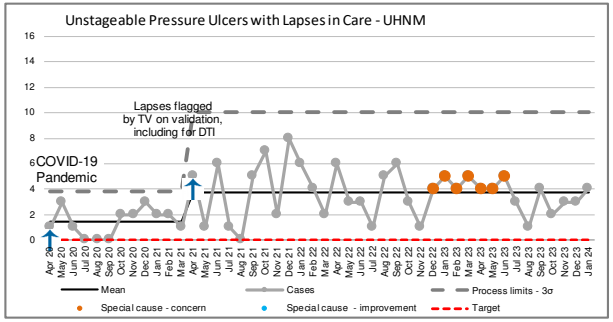


Variation	Assurance
	

Target	Nov 23	Dec 23	Jan 24
0	11	9	6

Background

Deep Tissue Injuries which developed under the care of UHNM with lapses of care associated



Variation	Assurance
	

Target	Nov 23	Dec 23	Jan 24
0	3	3	4

Background

unstageable ulcers which developed under the care of UHNM with Lapses in care associated

What is the data telling us:

The charts above show numbers within expected limits for all individual categories of pressure damage with lapses. The table below shows the most common lapses identified last month.

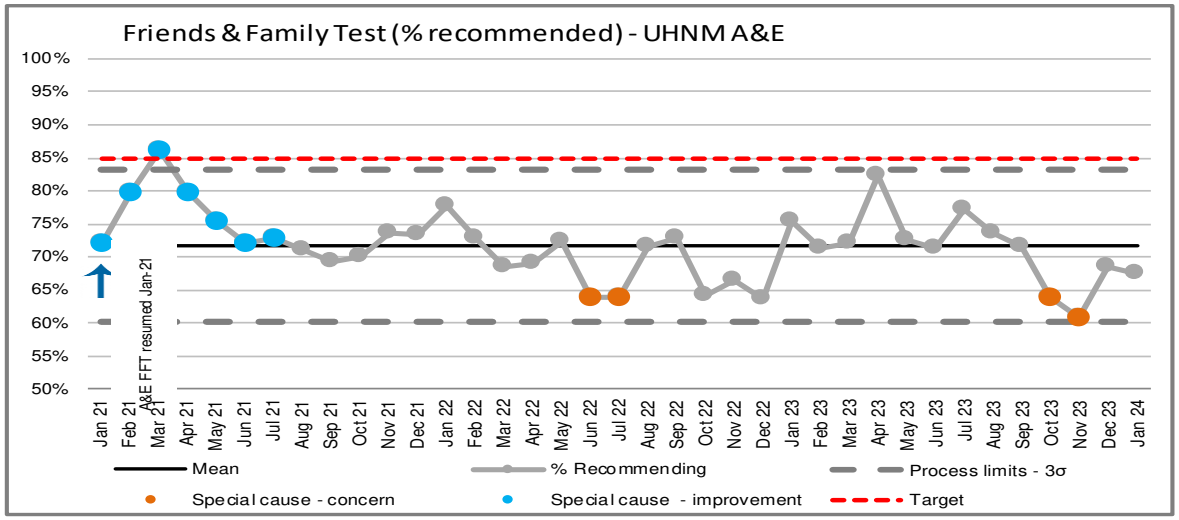
Locations with more than 1 lapse in January 2024 were: **ED Stoke (4), AMRA (2), Ward 227 (2)**

Root Cause(s) of damage - Lapses - Jan 2024	Total
Management of repositioning	9
Management of heel offloading	4
Management of device	3
Clinical condition	1

Actions:

- PSIRF toolkit will be sent to wards following reporting HAPU to identify leaning and share this timely.
- High reporting wards and wards of concern are visited by Quality and Safety using improving together strategies and delivering education. Areas will also be asked to attend an assurance panel so any further support can be offered.
- 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 and plan to share the information with Matron.
- Looking to develop and empower link nurses to support with improvements.
- Increase in complaints and coroners around pressure damage and wounds and finding documentation issues.

Friends & Family Test (FFT) – A&E



Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
85%	60.9%	68.6%	67.4%

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 was within expected limits in January 2024.
- The Trust received 1393 responses which is an increase on the previous month and the response rate percentage 9% overall. The Trust's overall satisfaction rate is lower than the national average of 78% (NHS England December 23) at 67% which is a decrease on last month. UHNM is 40th out of 122 Trusts for the number of responses in ED (NHS England December 2023), and 84th 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 January 2024 reported to have used 111First prior to attending ED, which is equal to the previous few months. Key themes from January 2024 continue 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.

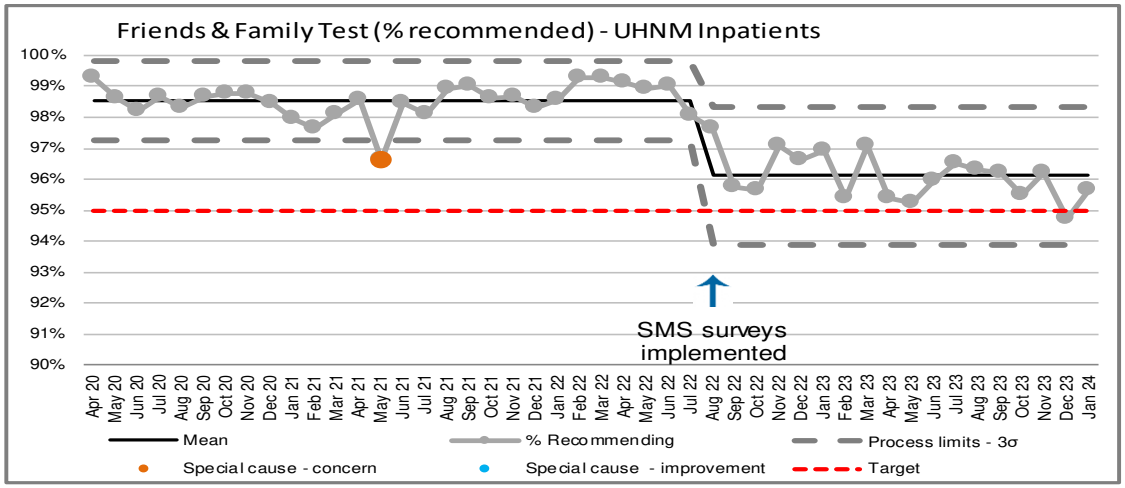
QR code made visible throughout the department.

QR code put onto all future FFTs.

You said we did board in waiting room.

Friends & Family Test (FFT) - Inpatient

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
95%	96.2%	94.7%	95.7%

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 was within expected limits in January and remains above the national average of 94% (December 2023 NHS England).
- In January 2024 a total of 2677 responses were collected from 68 inpatient and day case areas (12084 discharges) equating to a 22% return rate which is higher than last month but lower than the internal target of 30%. UHNM have the 20th highest response rate for all reporting Trusts in the country (151)and are 84th for percentage positive responses (NHS England December 2023)

Actions:

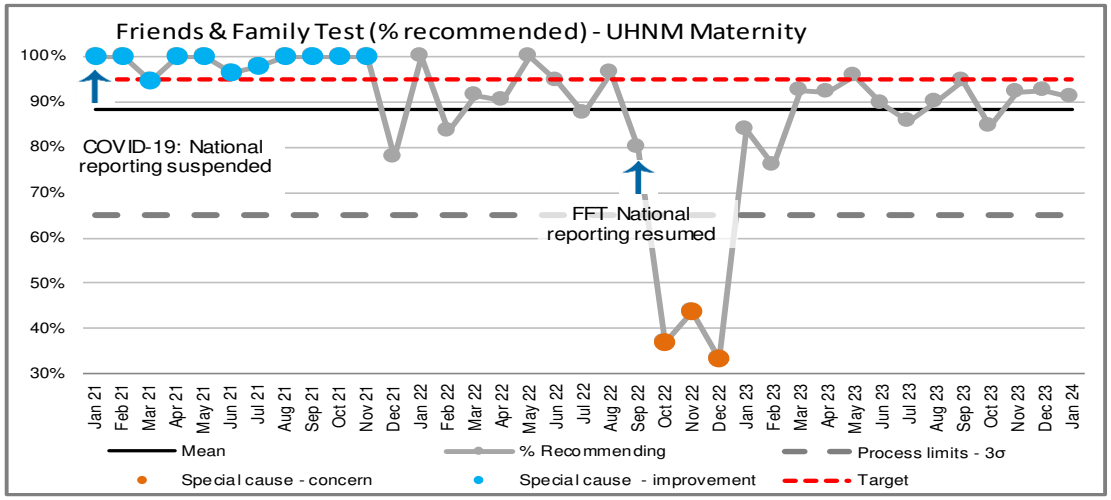
- Support individual areas to ensure they're using the most up to date version of the surveys.
- Continue to focus on Medicine and Surgery to increase response rate.

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

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Nov 23	Dec 23	Jan 24
95%	92.0%	92.3%	90.9%

Background

FFT Maternity % patients Recommending Service

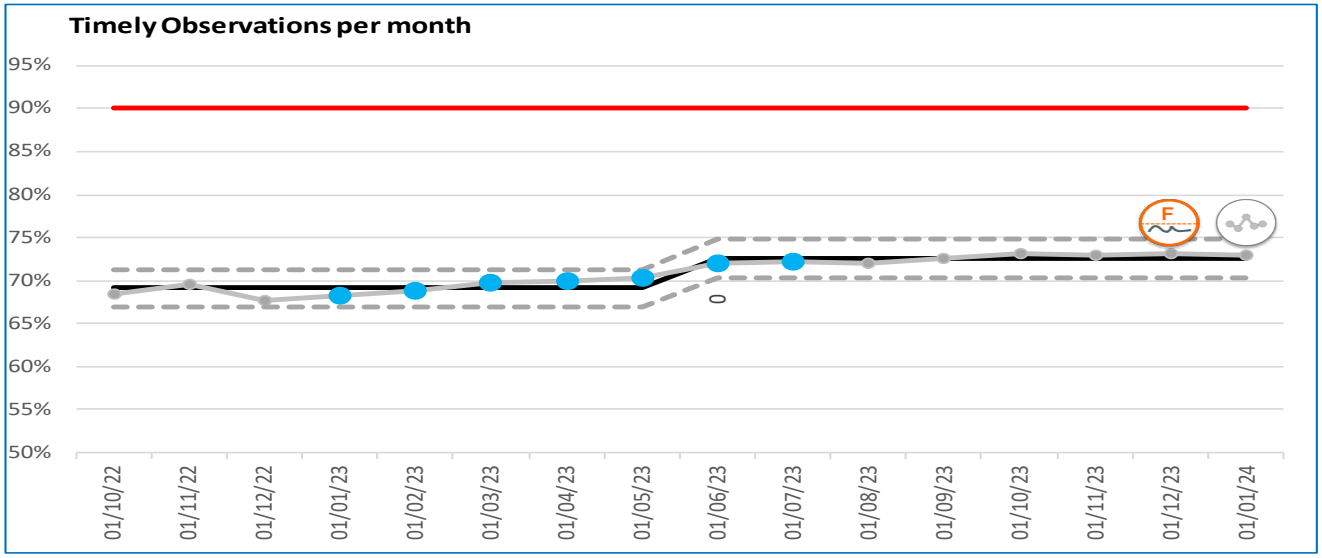
What do these results tell us?

- There were a total of 110 surveys were received in January 2024 across all 4 touch-points (ante-natal, birth, post natal ward; post natal community) with 40 of these being collected for the "Birth" touch-point, providing an 8% response rate (based on number of live births) and 93% satisfaction score which is a increase on the previous month's figures.
- The Antenatal touch point scored 92% recommendation (26 surveys) which is a significant increase on the previous month (40%). The post-natal ward touch point scored 89% satisfaction rate (38 surveys) which is a decrease in both response rate and satisfaction percentage from the previous month.
- Compared to the latest national data available (December 2023) out of 111 Trusts, UHNM were 73rd for number of responses for antenatal, 41st for number of responses for birth, 37th for post-natal ward and 57th for post-natal community.

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.

Timely Observations



What do these results tell us?

Compliance remains well below the 90% target in January 2024. A small improvement has been sustained since mid 2023, but little further progress has been since. Compliance for January 2024 was 73%.

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.

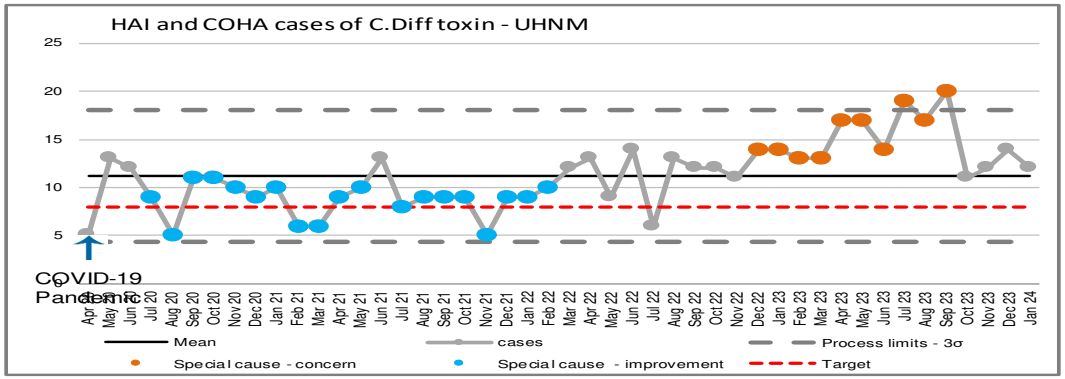
Medicine, Surgery and Network Divisions have timely observations as a Driver metric and there is a corporate A3 Improvement Project underway considering additional actions required to improve overall compliance/performance. This is being led by the Deputy Chief Nurse and CNIO.

No wards had Timely Observations recorded at 50% or less during January.

6 wards had compliance between 50 – 60%: Ward 113, Ward 128, Ward 78, Ward 230, Ward 123, Ward 124.

Reported C Diff Cases per month

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
8	12	14	12

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 20 reported C diff cases in September 2023 15 HAI and 5 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 four clinical areas with more than one Clostridium *difficile* case within in a 28 day period. Where ribotypes are different person to person transmission is unlikely.

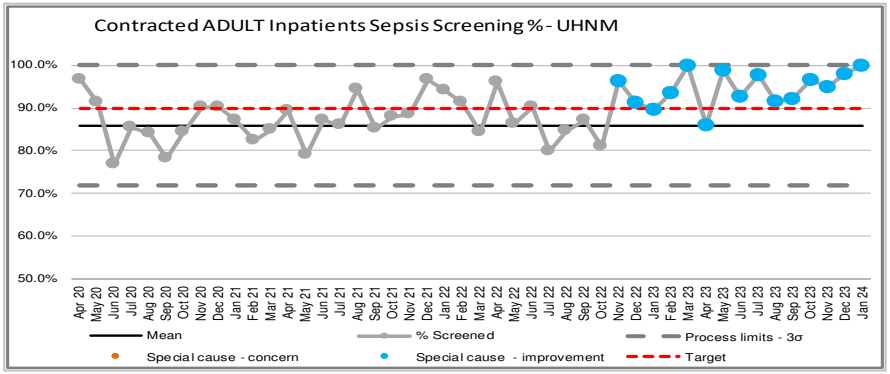
- AMU Royal – awaiting ribotype results
- Ward 110 – different ribotypes
- Ward 201 – 2 samples have different ribotypes, awaiting 3rd sample result
- Ward 14 – different ribotypes

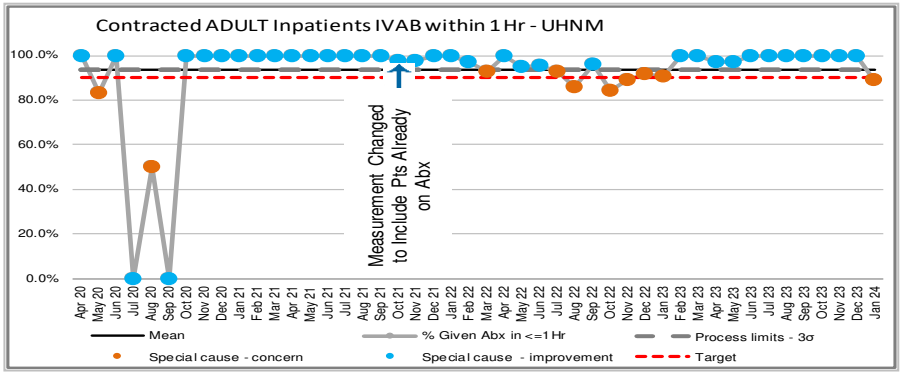
Actions:

- 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.
- Ensure appropriate choice of antibiotic for treatment of UTI
- To remind clinical areas to send urine samples when UTI is suspected
- Task and Finish Group for West Building in place and plan in progress to terminal clean West Building Wards before the winter
- RCAs continue to be reviewed by ICB in relation to avoidability

Sepsis Screening Compliance (Inpatients)

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
H	?

Target	Nov 23	Dec 23	Jan 24
90%	95.1%	98.0%	100.0%

Background

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

Variation	Assurance
L	P

Target	Nov 23	Dec 23	Jan 24
90%	100.0%	100.0%	88.9%

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:

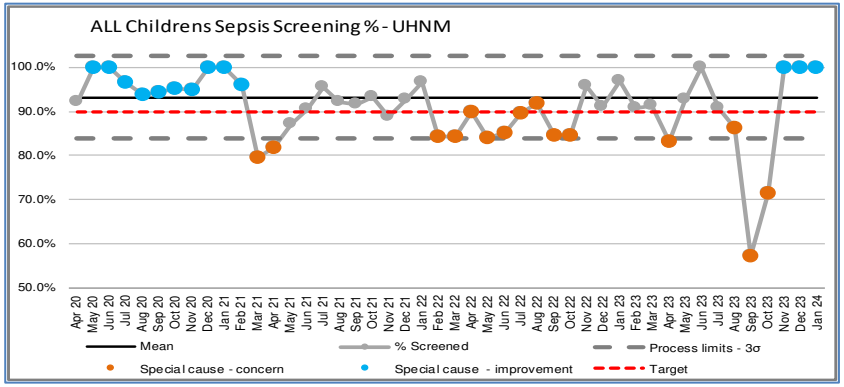
Inpatient areas achieved the screening and the IVAB within 1 hour target for January 2024. There were 87 cases audited with 0 missed screenings. Out of 87 cases audited, 56 cases were identified as red flags sepsis with 40 cases having alternative diagnosis and 15 were already on IVAB treatment, 1 patient received IVAB within 1 hour.

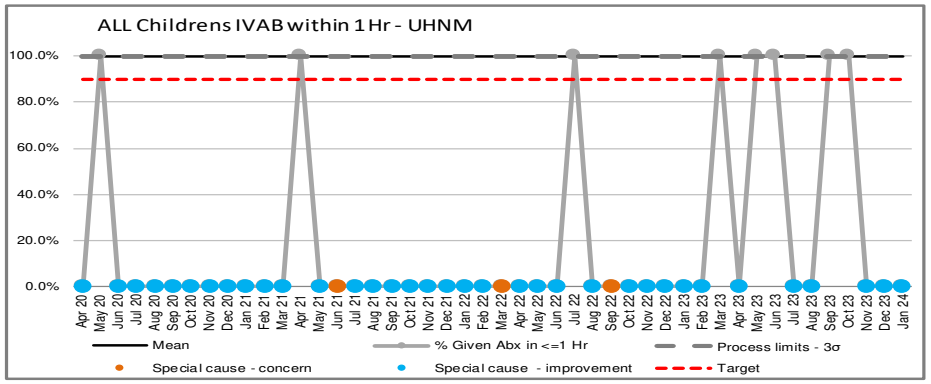
Actions:

- Sepsis sessions/ kiosks continue to all levels of staff in the clinical areas that required immediate support: on-going
- 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

Sepsis Screening Compliance ALL Children

NHS
University Hospitals of North Midlands
NHS Trust





Variation	Assurance
H	?

Target	Nov 23	Dec 23	Jan 24
90%	100.0%	100.0%	100.0%

Background

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

Variation	Assurance
H	P

Target	Nov 23	Dec 23	Jan 24
90%	N/A	N/A	N/A

Background

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

What is the data telling us:

Children's Services target rate of > 90% was achieved for January 2024. 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 11 cases audited for emergency portals with 0 missed screening. No true red flag sepsis was identified from the randomised audits in inpatients and emergency portals. A continued improvement.

Actions:

- Children emergency portal sepsis screening and documentation is now available electronically
- 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 when required: on-going

Sepsis Screening Compliance (Emergency Portals Contract)

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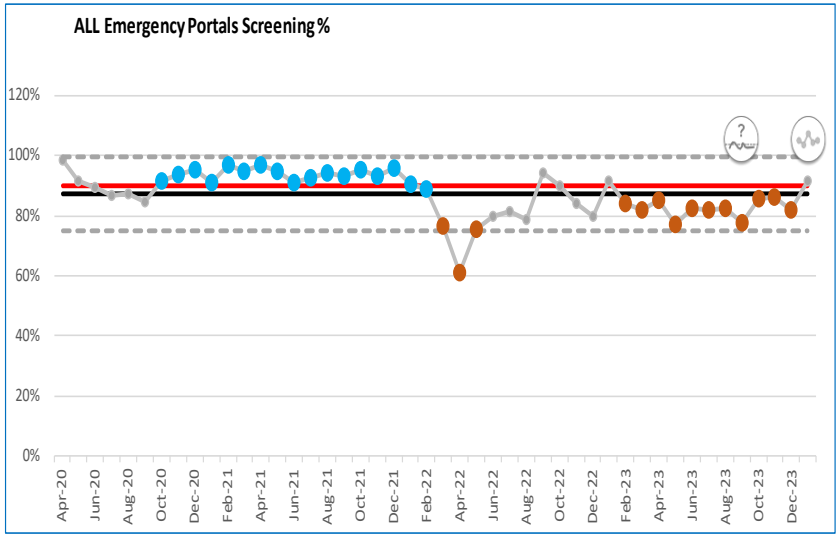

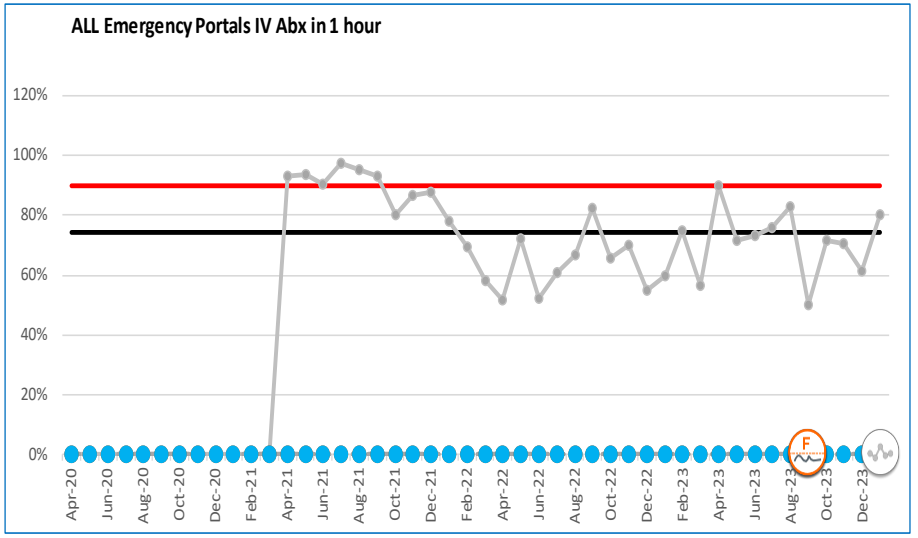

What is the data telling us:

Adult Emergency Portals screening did not meet the target rate for January 2024. There were 83 cases audited with 7 missed screening (patients are escalated but no documentation available in the screening tool) in total from the emergency portals. The performance for IVAB within 1 hour achieved 80 %. Out of 83 cases, there were 61 red flags sepsis in which the 13 cases already on IVAB, 32 cases were newly identified sepsis and 16 cases have alternative diagnosis. There were 9 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: currently re-arranged to early next year due to winter/ capacity pressure
- Deteriorating Patient Reviewer (DPR) Vocera in ED, enable the assigned clinician to review and provide timely assessment, treatment and escalation of patients whose condition meeting the NEWS2 medium to high risk sepsis triggers.
- Working towards implementation of electronic screening

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

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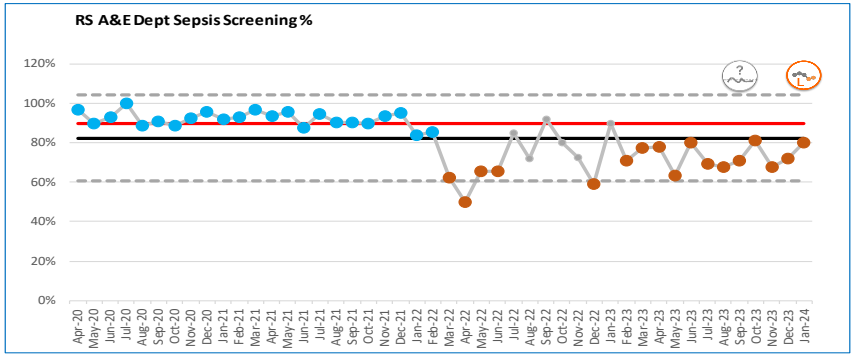

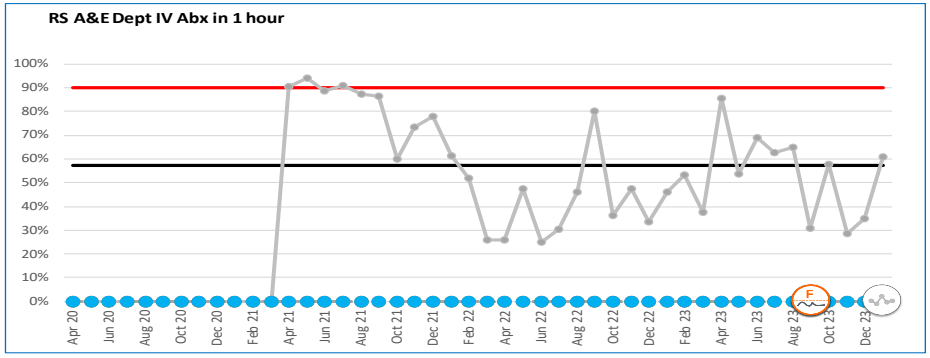

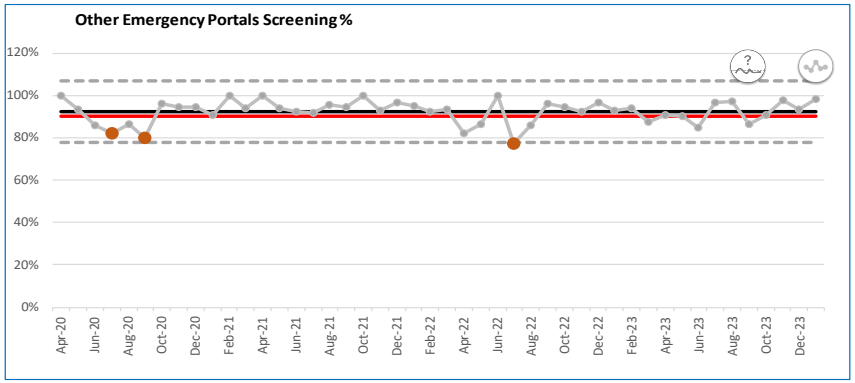

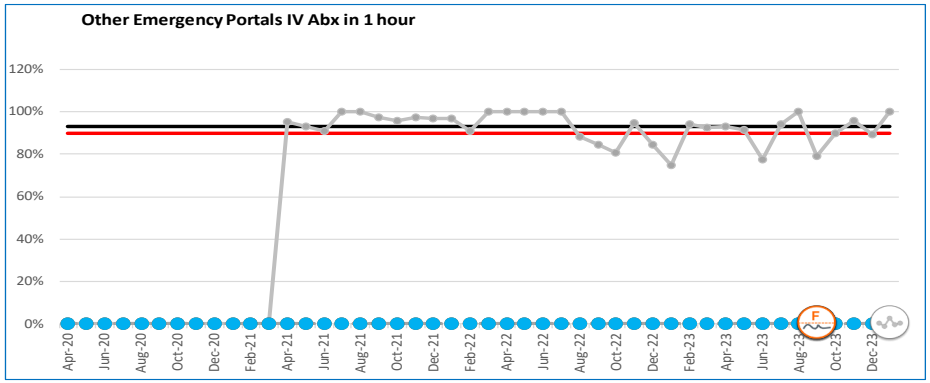

What is the data telling us:

The Emergency Department at RSUH remain below target rate for both screening and IVAB within the 1 hour for January 2024.

Actions:

- To provide short sessions in ED staff during the winter months 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.
- Colleagues from the ICS visited ED on 30th November 2023 to review practice in terms of sepsis screening and verbal feedback has been positive and the written report is awaited.

Sepsis Screening Compliance ALL Maternity

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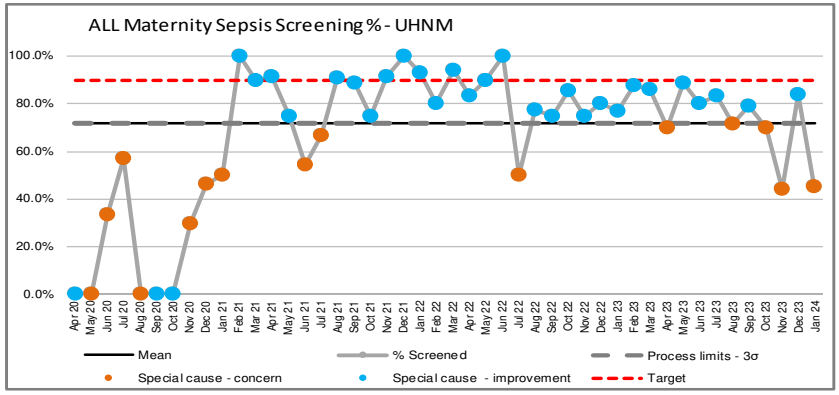

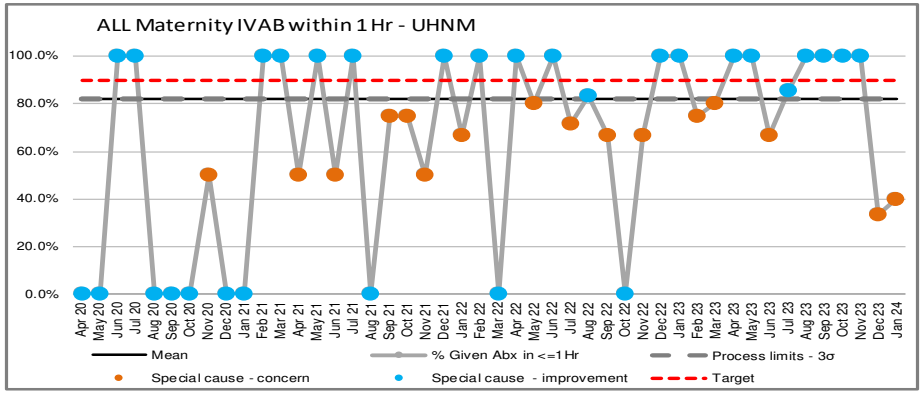

Variation	Assurance
L	F

Target	Nov 23	Dec 23	Jan 24
90%	44.4%	84.2%	45.5%

Background

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

Variation	Assurance
L	F

Target	Nov 23	Dec 23	Jan 24
90%	100%	33%	40%

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 for emergency portals. Inpatient areas are also well below target for screening. The compliance was also below target for IVAB within 1 hour. This compliance score is based on a very small number (cases).

There were 13 cases audited from emergency portal (MAU) and 9 cases from inpatients with total of 12 missed screening (has been escalated but no documentation in the screening tool).

Actions:

- Maternity antibiotic PGD has been drafted and is currently under review by the Pharmacy Team; still awaiting finalisation
- Monthly Maternity sepsis skills drill is now replaced with ad hoc sepsis sessions in each clinical areas; on-going
- Sepsis sessions will focus and highlight the importance of screening documentation
- The sepsis team will create further awareness and plan collaborative work with maternity educators and senior team

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Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

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Urgent and Emergency Care Performance (Non-Elective Care)

- Context
  - 12 Hour Trolley Waits deteriorated from 1059 in December to 1263 in January.
  - Type 1 A&E Attendances increased from 13491 in December to 13561 in January.
- Driver Metrics
  - Four Hour Performance broadly maintained from 64.5% in December to 64.2% in January.
  - 12+ Hours In ED deteriorated from 1968 in December to 2319 in January.
  - Ambulance Handovers <60 Minutes also deteriorated from 78.1% in December to 63.3% in January.

Planned Care, Cancer and Diagnostic Performance (Elective Care)

Diagnostics Summary

- DM01 activity in January was below 19/20 levels, however data is unvalidated.
- DM01 performance was 74.3% overall in January, a drop of 4.3% from December (78.6%).
- Endoscopy performance is the main contributor to this performance being below the national target of 99%

Endoscopy:

- Insourced weekend service continues alongside an additional locum in the service, following external funding from WMCA.
- Routine, urgent, surveillance and planned patients continue to wait longer than expected. Maximising in week sessions and use of CNS Tis, additional support from surgeons and 18 Weeks Insourcing to support these cohorts
- Long term trajectory and resource requirement submitted but funding not currently available to further drive non-cancer cohorts
- Request to Proceed being drafted to request funding for recovery and BAU activity.
- January saw an increase in the 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 admin and clinical validation)
- Sustained improved booking performance for lower cancer PTL patients – now 3-4wks notice (was 3 days)
- Improvement plan ongoing and workstream leads progressing actions
- Four Eyes Insight on to Week 5 of their Improving Efficiency Programme within the Endoscopy service

Spotlight Report from Chief Operating Officer

NHS
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Referral to treatment (RTT Planned Care and Elective Recovery)

- 104ww three patients were waiting in January – 2 of which were identified through validation of waiting lists, the other was offered an earlier date in Jan, but the patient chose to wait until TCI 6th Feb.
- 78ww January has increased to 147 as the final validated position
- 78ww February with IA prediction is 167 for UHNM. The overall Referral To Treatment (RTT) Waiting has increased this month to 81,352 (unvalidated), up from 80,987 in December.
- Day case as a % of all elective work is currently 88.8%.

Cancer

- From October, Cancer Waiting Times standards have been 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%
- Combined 62 Day Standard achieved 59.1% in December. The current provisional position for January is 50.8%.
- The combined 31 Day Standard achieved 89.3% in December. It is predicted to land at 81.3% in January.
- The combined Faster Diagnosis Standard achieved 69.7% in December. It is predicted to land at around 68% in January.
- The total GP referred suspected cancer PTL sits around 3200 in total currently; the same as last month.
- UHNM is within the 62 day backlog recovery trajectory to return the number of patients waiting over 62 days to pre-pandemic levels by March 24.
- UHNM continues to receive and see a high volume of GP suspected cancer referrals, more than usual seasonal demand plus the predicted growth, with some weeks exceeding 1000 referrals received.

Section 1: Non-Elective Care

Headline Metrics

Non-Elective Care – monthly *(context)*

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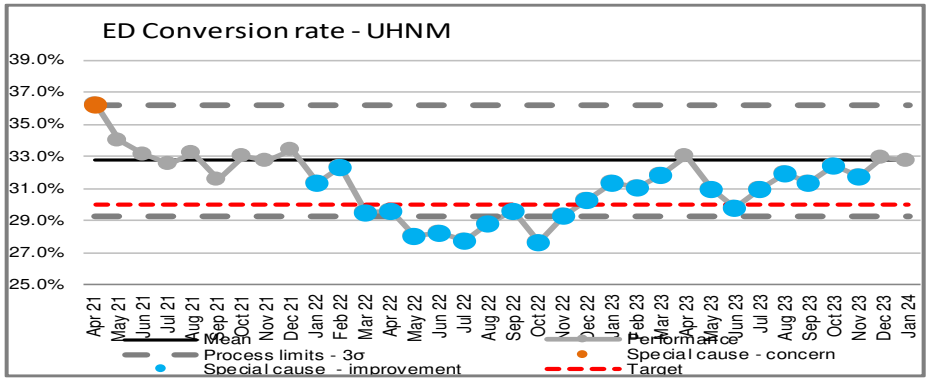
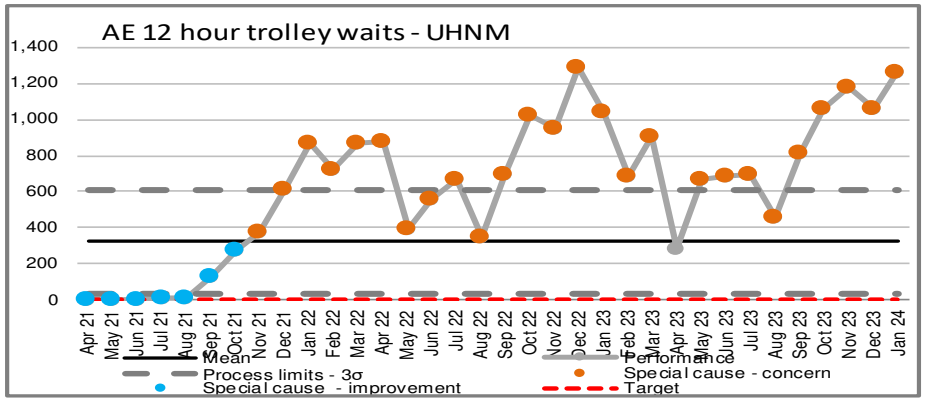


Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
30%	31.7%	33.0%	32.8%

Background

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

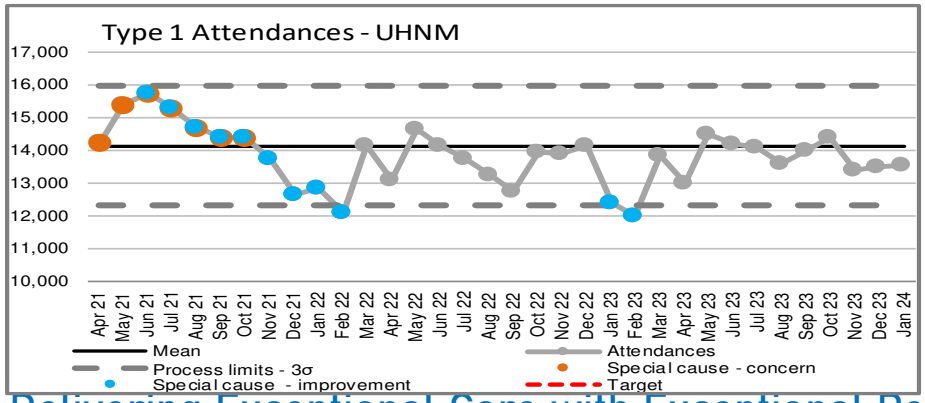


Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
0	1175	1059	1263

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

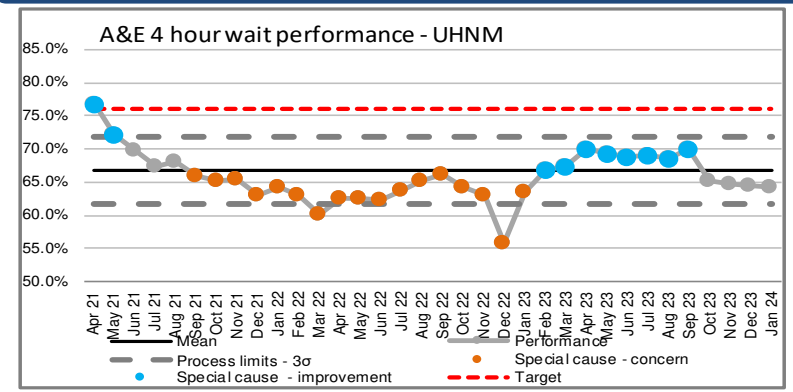
Target	Nov 23	Dec 23	Jan 24
N/A	13400	13491	13561

Background

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

Non-Elective Care – Headline Metrics

University Hospitals of North Midlands NHS Trust



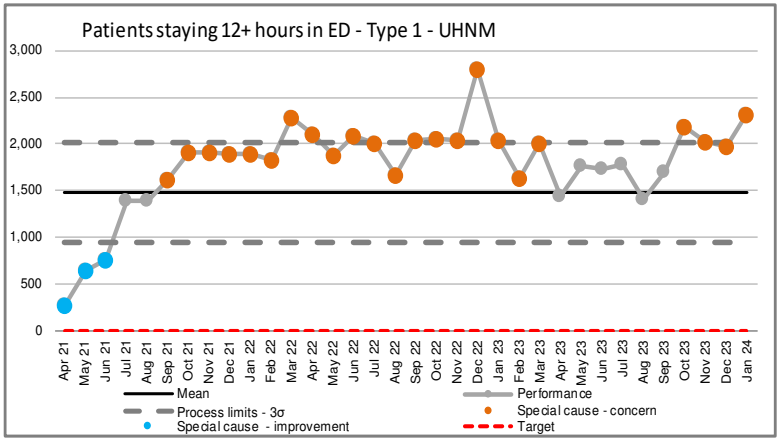
Variation	Assurance
	F

Target	Nov 23	Dec 23	Jan 24
76%	64.7%	64.5%	64.2%

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. Despite performance being below target, this has plateaued at 64%.



Variation	Assurance
H	F

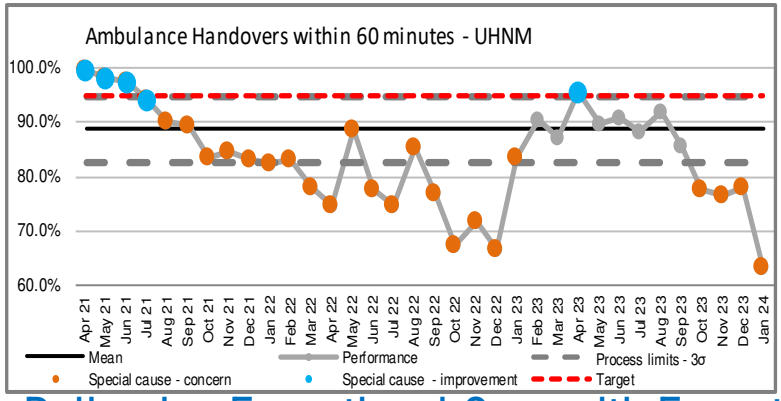
Target	Nov 23	Dec 23	Jan 24
0	2019	1968	2319

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 18% in January and exceeded normal variation limits.



Variation	Assurance
L	F

Target	Nov 23	Dec 23	Jan 24
95.0%	76.5%	78.1%	63.3%

Background

The percentage of ambulance handovers completed within 60 minutes.

Ambulance handovers within 60 minutes performance dropped considerably in January reaching levels last seen in December 2022.

Delivering Exceptional Care with Exceptional People

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

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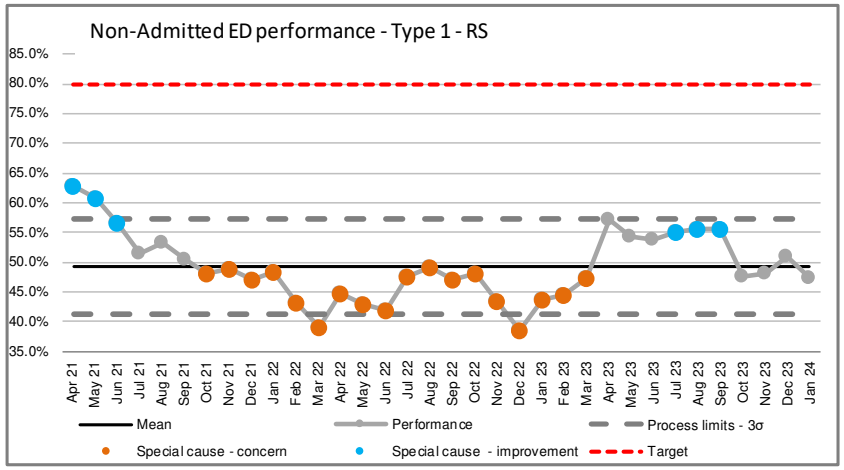


Variation	Assurance
	

Target	Nov 23	Dec 23	Jan 24
80%	48.1%	51.0%	47.4%

Actions

- Review of the data has been undertaken and expanded to review ambulatory performance by hour and demand profile looking at EhPC and portal deflections from ED.
- Reviewing staffing to support opening ambulatory CDU consistently.
- Once CDU is open to undertake a clinician led live audit of the CDU criteria to support maximising utilisation.
- Data review of deflections from the ED to support increase in SDEC utilisation.
- Data review of DTA's in ambulatory (over the last 12 months) to determine potential gains to support 4-hour performance.
- Expansion of the EhPC operating model is awaiting a go live date. This will lead to greater utilisation as a result of a single streaming model across the entire service.

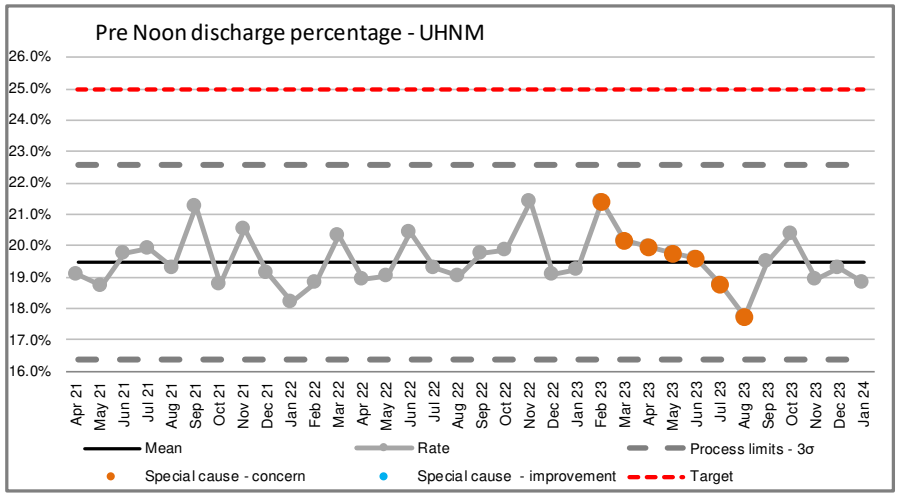
Summary

4-hour Non-Admitted (NAD) performance was 47.4%. Operational pressures have continued to affect performance against this measure.

Workstream 1 continue to focus on the 4-hour non-admitted performance as part of the non-elective refresh. A3 has been reviewed and the governance for the workstream has been revised, it has been agreed that each countermeasure will have leads assigned as a triumvirate approach to support delivery.

Workstream 2; Standard Work
Pre-Noon Discharges

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
25%	19.0%	19.3%	18.8%

Background

The percentage of discharges complete before 12 noon.

Summary

UHNM pre-noon discharges are 18.8% against a target of 25%.

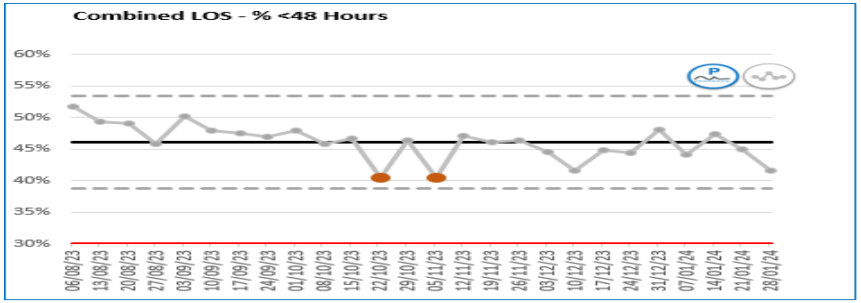
This is a new workstream and the A3 is currently in development; the problem statement, current situation and draft vision completed. The governance processes are in progress.

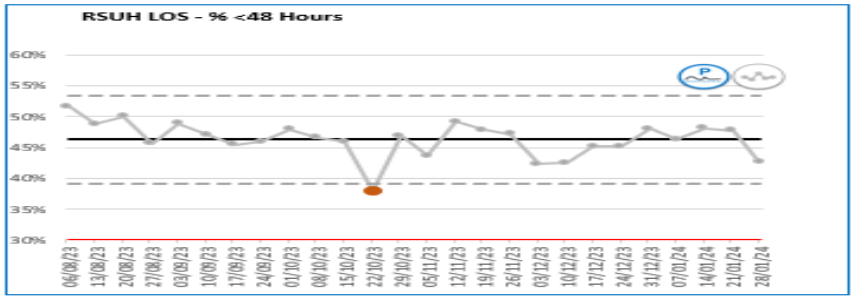
KPMG are currently undertaking a rapid improvement project to support simple & timely discharges with the aim to identify a process to ensure adherence to standard work.

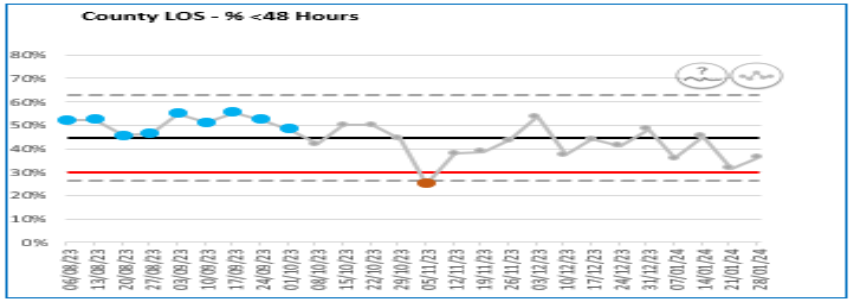
Actions

- Continue with the A3 – undertake the root cause analysis and identify the countermeasures.
- KPMG project: A key focus around developing Standard work detailing how to adhere to SAFER principles, which can be iterated and spread to different wards.
    - Agreed a focus on 4 wards in Medicine to understand the reason for delays in relation to simple & timely discharges.
    - Agreed targets around opportunity for improvement with these wards.
    - Agreed ops managers support with Test of Change week (w/c 26th February) on wards enabling sustainability.

Workstream 3; Frailty
75+ Patients with LOS <48 Hours







Actions

- The frailty subgroups (below) which have been developed from the countermeasures to identify key actions:

  Frailty subgroups:
  - Pre-hospital/front door
  - In-hospital
  - Discharge

A clinical lead for each of these subgroups is being assigned to support delivery who will support the development of the actions that will feed up to the main workstream.

The group have now incorporated County frailty group that will feed into these 3 subgroups.

- Actions to be defined that are both for both Royal and County sites i.e. CFS and CGA roll out (which County frailty group have developed).

Summary

As part of the non-elective refresh, the frailty subgroup has now evolved to be the main workstream. The group have agreed the driver metric of <48hour LoS for frail patients. The governance has been reviewed and the membership of the group is being extended to include wider parties to support the subgroups i.e. pre-hospital. The group are now focusing on developing actions against each of the countermeasures.

Workstream 4; County Hospital UEC
County Hospital Four Hour Performance

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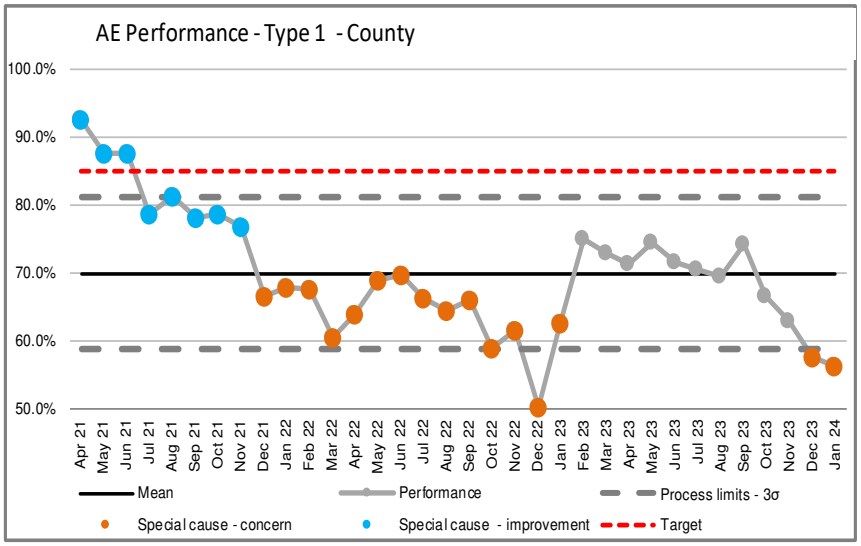


Variation	Assurance
L	F

Target	Nov 23	Dec 23	Jan 24
85%	62.8%	57.6%	56.4%

Summary

The 4-hour Standard for County Hospital in January was 56.4%, which has been impacted by operational pressures.

As part of the non-elective refresh the governance for this workstream have been reviewed and it has been agreed that each countermeasure will have leads assigned as a triumvirate approach to support delivery.

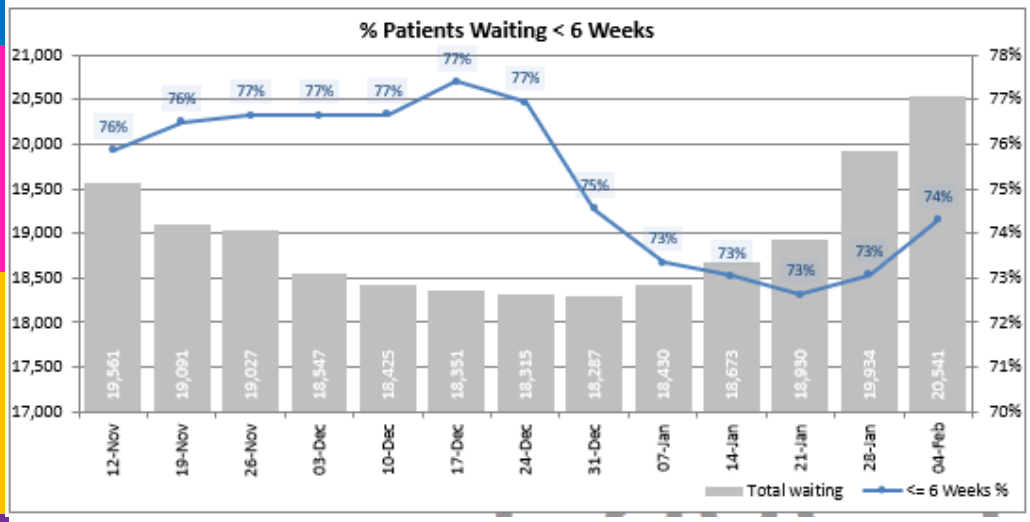
A review of the data has been undertaken and agreed and the A3 countermeasures have been updated and agreed.

Actions

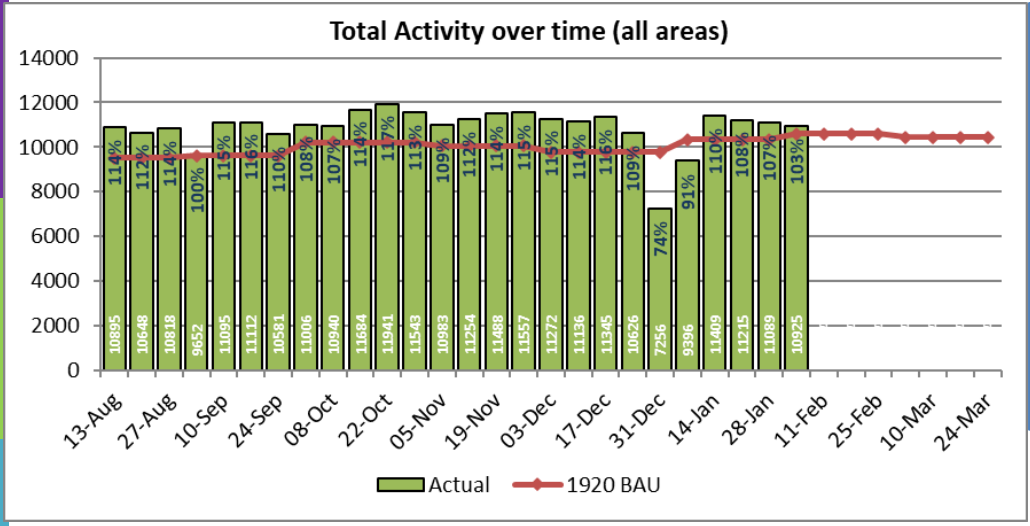
- Senior Management support to hold focus negotiations with ward areas to agree the driver metrics for improvement using the Teams learning and training in QI.
- Working with the leads of the countermeasures to produce a new set of actions ahead of the next meeting with a focus on immediate actions rather than a long list of actions to support improvement in performance.

Section 2: ELECTIVE CARE

Planned Care - *Diagnostics*



Test	<=6	6-9	10-12	13+ Wks	Total	% <6Wks
Magnetic Resonance Imaging	3,101	299	2	0	3,402	91.2%
Computed Tomography	3,868	36	5	2	3,911	98.9%
Non-obstetric Ultrasound	4,940	740	5	3	5,688	86.8%
DEXA Scan	0	0	0	0	0	
Cardiology - Echocardiography	1,181	510	71	45	1,807	65.4%
Cardiology - Electrophysiology	0	0	0	0	0	
Colonoscopy	494	191	163	1,170	2,018	24.5%
Flexible sigmoidoscopy	274	123	99	823	1,319	20.8%
Cystoscopy	134	35	13	45	227	59.0%
Gastroscopy	459	205	118	269	1,051	43.7%
Neurophysiology	373	145	34	0	552	67.6%
Respiratory physiology	435	49	18	64	566	76.9%
Urodynamics	0	0	0	0	0	
Total	**15,259**	**2,333**	**528**	**2,421**	**20,541**	**74%**



Pathology*:*

The following represents performance as at 22nd January 2024;

- Urgent (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day 18 (no change), with 80% of cases reported by Day 11 (Previously Day 12)
- Accelerated (include all Cancer Resections): 95% reported at Day 25 (Previously Day 27) with 80% of cases reported by Day 14 (Previously Day 18)
- Routine (all Specimens not in above categories): 95% Day reported at 27 (No Change) 80% of cases reported by Day 18 (Previously Day 19)

Our 7 day reporting turnaround time (TAT) for Urgent cases is at 55% against the Royal College of Pathologists' target of 80% within 7 days (No Change)

Planned care - *Diagnostics*

NHS University Hospitals of North Midlands NHS Trust

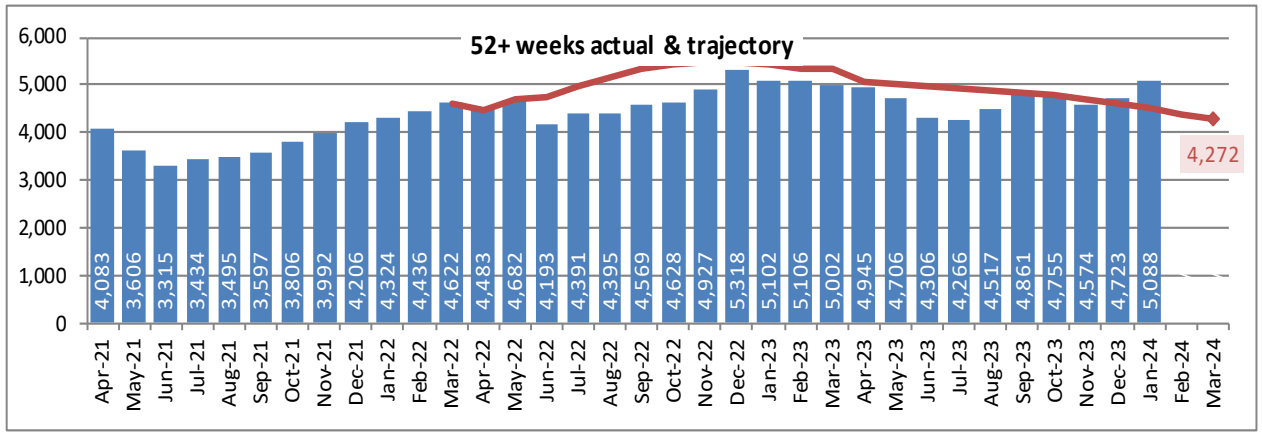
Diagnostics Summary

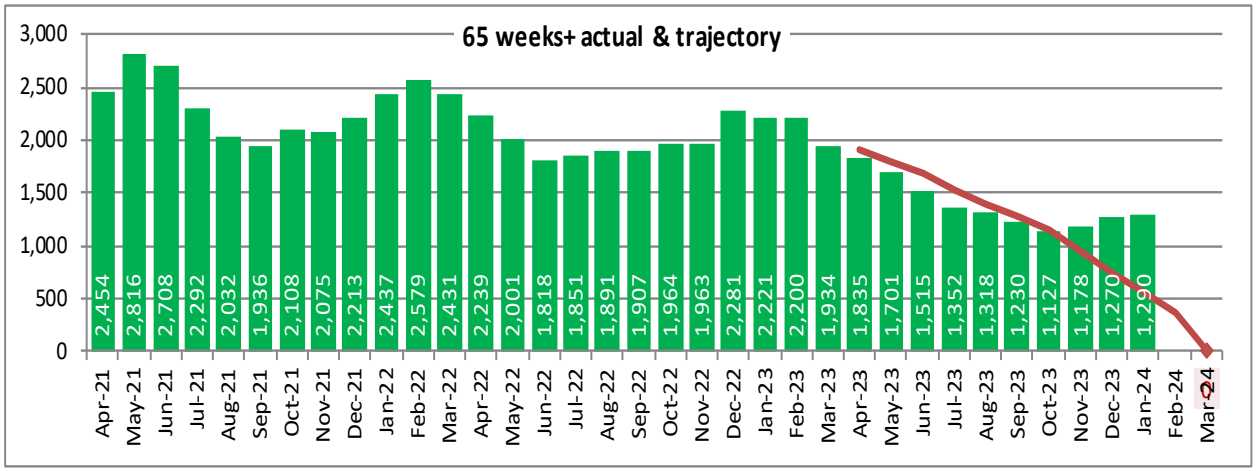
- DM01 activity in December was below 19/20 levels, however data is unvalidated.
- DM01 performance was 74.3% overall in January, a drop of 4.3% from December (78.6%). Endoscopy performance is the main contributor to this performance being below the national target of 99%
- In pathology 7 day reporting turnaround time (TAT) for Urgent cases is at 55% against the Royal College of Pathologists' target of 80% within 7 days (No Change)

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 March 2024 and from February extending into County site, following external funding from WMCA. This resource is specifically to support reducing cancer wait time but March capacity will support 78ww position
- Concerns raised by surgical/gastro pathways that delays are hindering their ability to deliver 65wks by end of March
- Routine, urgent, surveillance and planned patients continue to have wait more than their target date. Maximising in week sessions and use of CNS Tis, additional support from surgeons and 18 Weeks to support these cohorts
- Capacity and Demand model currently being reworked
- Long term trajectory and resource requirement submitted but funding not currently available to further drive non-cancer cohorts
- Request to Proceed being drafted to request funding for recovery and BAU activity.
- January saw an increase in the 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 admin and clinical validation)
- Sustained improved booking performance for lower cancer PTL patients – now 3-4wks notice (was 3 days)
- Improvement plan ongoing and workstream leads progressing actions
- Four Eyes Insight on to Week 5 of their Improving Efficiency Programme within the Endoscopy service

Planned Care – *RTT*





Patients waiting 52+ weeks saw a further increase in January and exceeded the trajectory.

65+ week waiters increased further in January and continues to exceed the trajectory.

Planned Care – *RTT Long Waiters*

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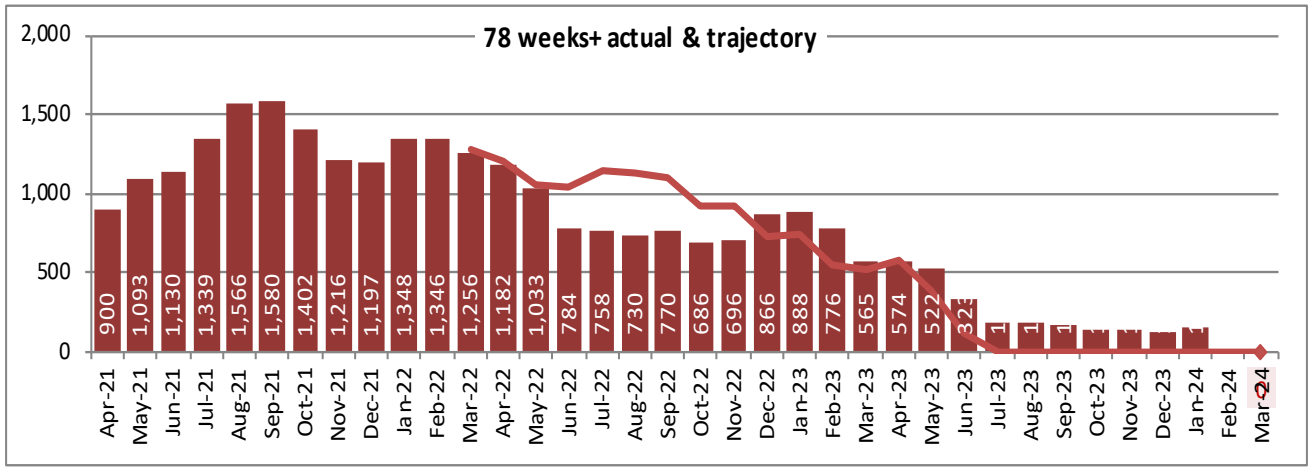
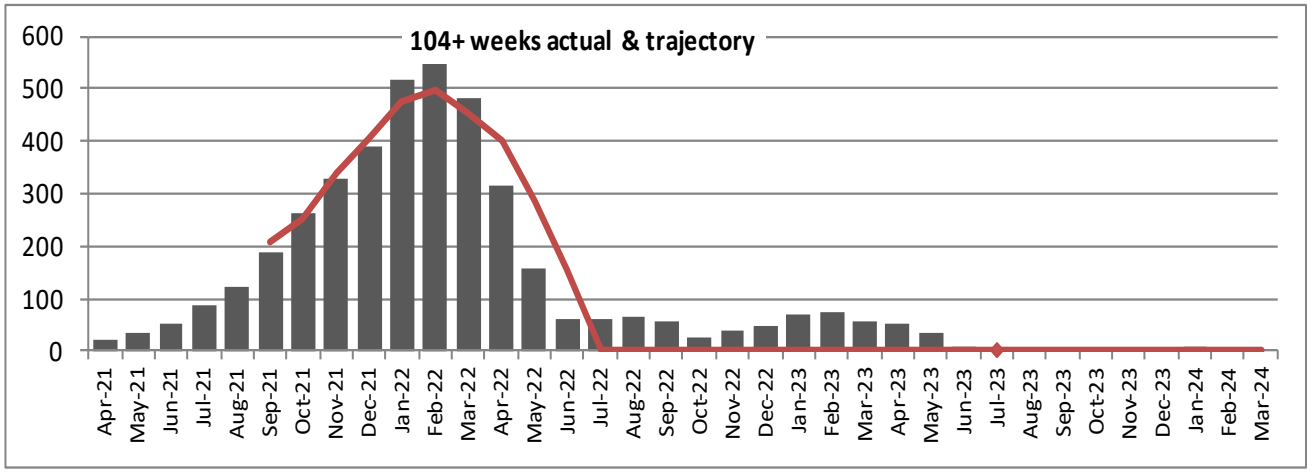


The number of patients waiting over 78 weeks increased by 29 in January, to 147.

January data is unvalidated and is likely to reduce marginally.



There are three patients who have been waiting 104+ weeks in January.

Planned care - *RTT*

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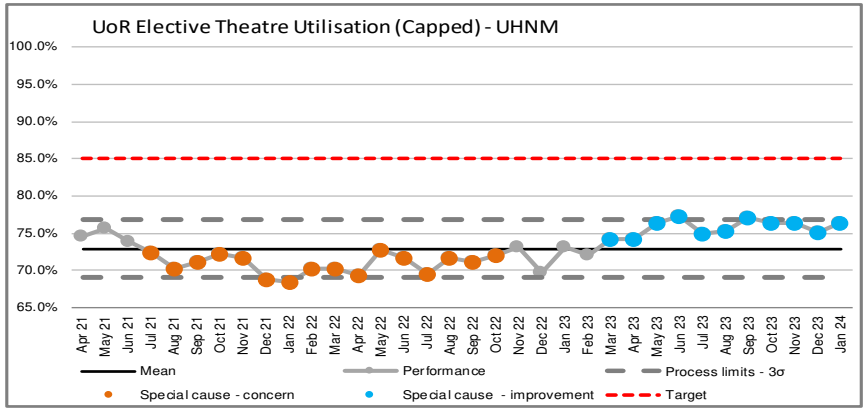
Summary

- 52+ week patients increased during January to 4,948 (unvalidated).
- 78+ patients have been gradually reducing, Dec was 117. However, due to winter pressures and IA the number has now increased to 145 (unvalidated)
- The overall Referral To Treatment (RTT) Waiting list now sits 82,007 end of January (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 January the number of > 104 weeks was 3.
- The IS have taken over 1000 patients from Orthopaedics & Spinal (out of over 1000 considered), with a further 60 patients being worked through to contact & transfer.

RTT

- Validation has increased with some additional resource in the short term. Temporary validation resource will cease by the end of the financial year, decreasing Corporate Validation capacity by 60%.
- RTT Performance sits at 50.0% , a decrease from 51.7% in December.
- 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 66% of all pathways over 52 weeks having been validated within the last 12 weeks. This is a deterioration on last month's 83%
- 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 still 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. Training programme complete – 525 people attended training.
- Work underway to develop new training courses and add on to Intranet, with courses bookable on ESR.
- 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, validation of NON-RTT outpatient referrals commenced 21st November.
- External validation support sought from MBI, commenced 4th October. Work completes 12th January, with final report received & disseminated.

Planned Care – *Theatres*

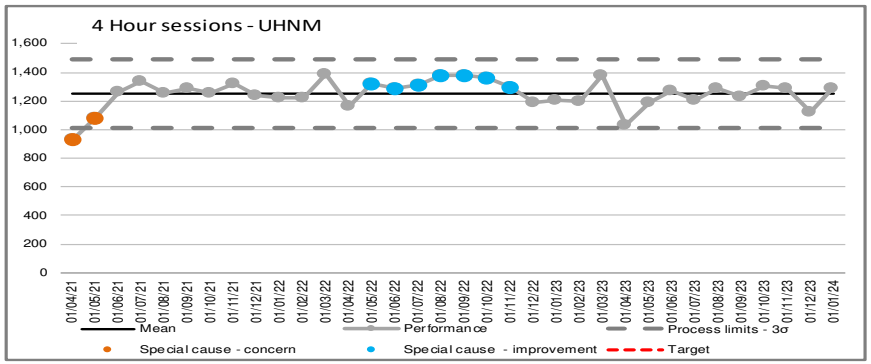


Variation	Assurance
H	F

Target	Nov 23	Dec 23	Jan 24
85%	76.4%	75.2%	76.3%

Background

The percentage of theatre time used (capped).

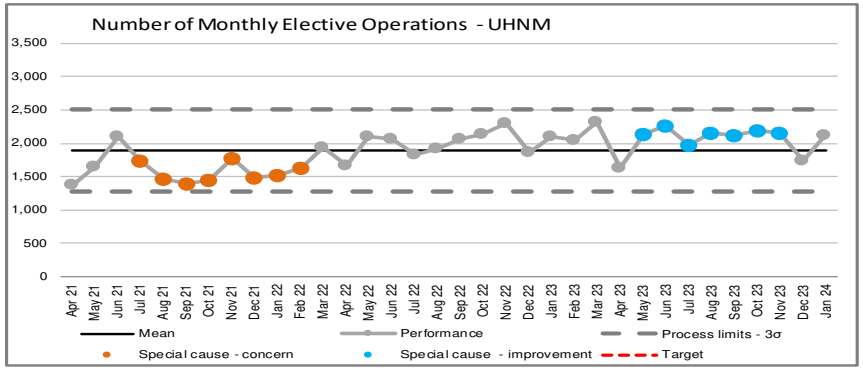


Variation	Assurance

Target	01/11/23	01/12/23	01/01/24
N/A	1285	1124	1287

Background

The number of 4 hour sessions during the month.



Variation	Assurance

Target	01/11/23	01/12/23	01/01/24
N/A	2152	1747	2112

Background

The total number of elective operations during the month.

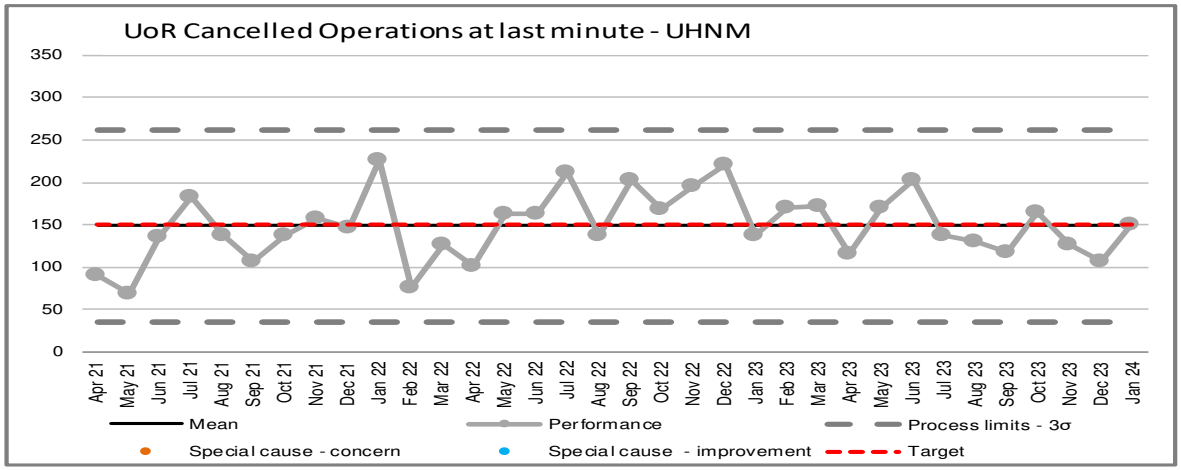
Capped Utilisation performance has seen normal fluctuation since Mary 2023.

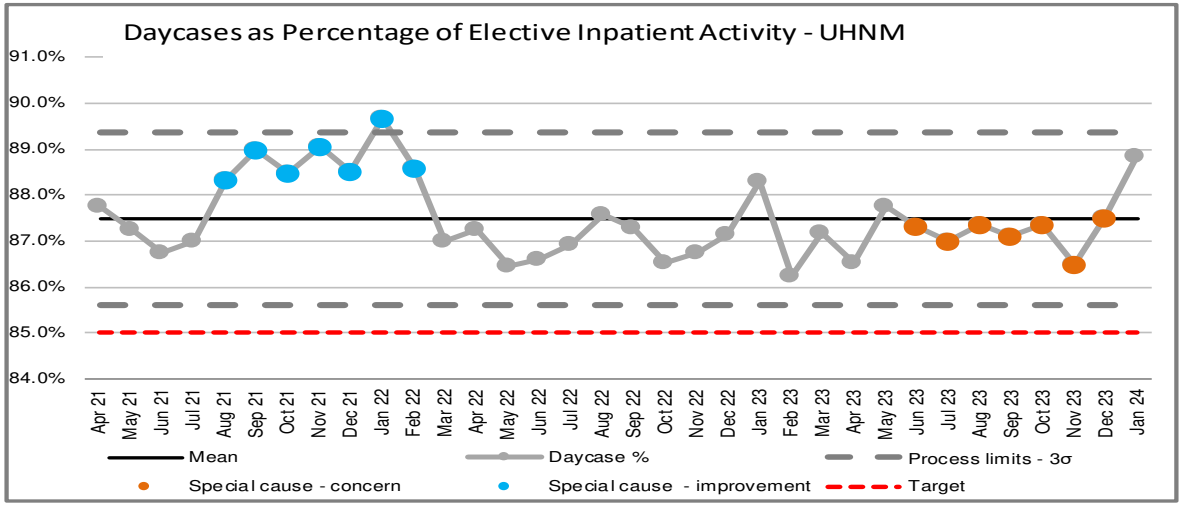
The number of 4 hour sessions continues to see normal variation.

Following a dip in December, Elective Operations are back to normal levels.

Delivering Exceptional Care with Exceptional People

Planned Care – *Theatres*





January saw an increase in Cancelled Operations, but remains within normal variation.

The proportion of Daycase activity increased in January, exceeding the 85% target.

Planned Care - *Theatres*

University Hospitals of North Midlands NHS Trust

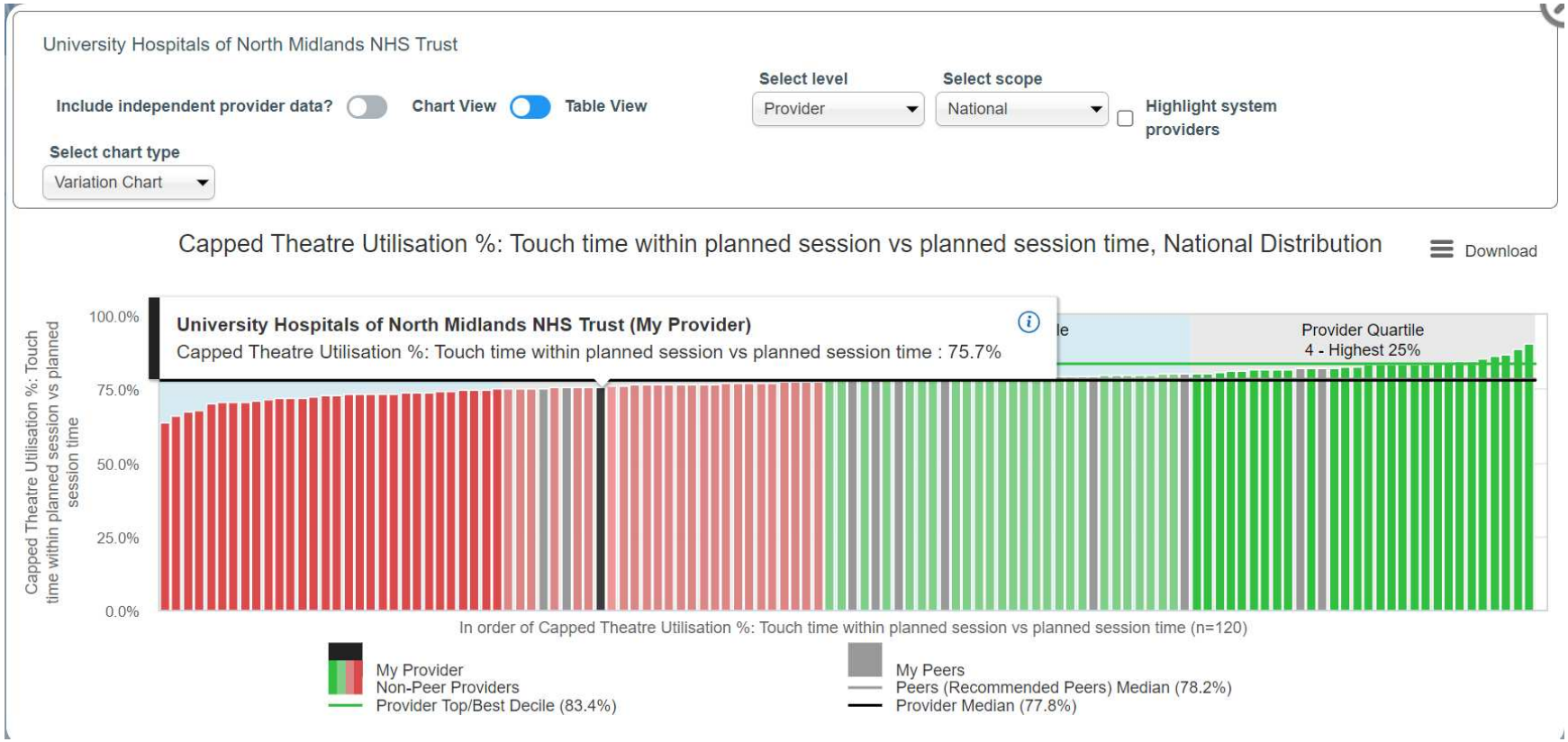
Elective inpatients Summary

- Capped utilisation remains reduced in month but above mean at 76.3%.
- Cancelled operations increased to 10% - increased focus planned in coming weeks with use of Nexalus and APOM pathway work
- Perioperative Pathway Working Group inaugural meeting 12th Feb, pathway transformation intended to positively impact Productivity and reduce cancellations, delays and LoS.
- Increased demand for Elective Obstetric capacity, currently adversely impacting on Gynae elective. Plan required to establish up to additional 3 x Pm LSCSC sessions to meet demand

Actions

- Regional Early Screening and Optimisation workshop attended by Pre-Ams and IT, helped inform next steps and strategy for APOM and Perioperative working group.
- Further advancements with approval to integrate Remcare as digital platform for early Screening
- Due to the very sad loss of Theatre data analyst a validation report of existing Theatre dashboard has been created. Now undertaking a rebuild of the reporting Dashboard in order to advance the accessibility and functionality of the reporting function and to establish cloud-based reporting.
- Ongoing support of ERF activity via Day Webster framework agency rather than off –framework
- Anaesthetic workforce review meetings with finance to establish agreed benefits of next investment from Business Case and impact on Pay run rate, reduction in agency spend
- Robotic Assisted Surgery strategy continues to develop through workshops
- Model Health reporting raised with NHSE as reported data appears to significantly differ from internal reported data – appears to be linked with new "County Elective Hub" data set.

Theatres - Benchmarked



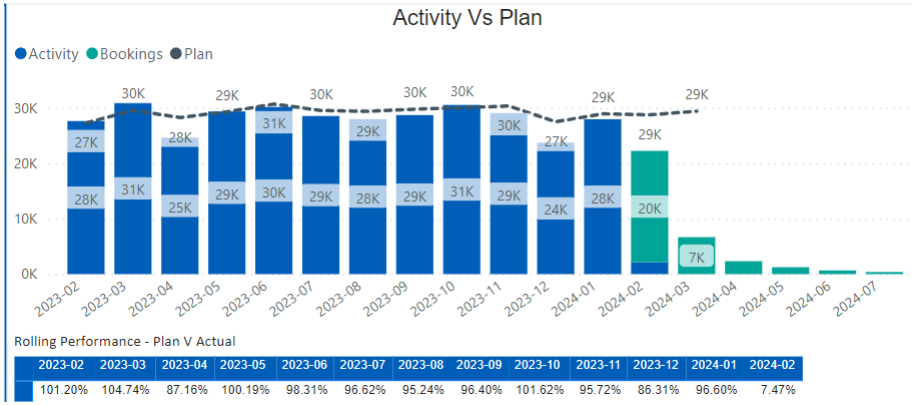
- UHNM have seen an improvement since the last report from 71% to 75.7% and remain in the bottom quartile.

Source data: Model Hospital 28/01/2024

Planned Care – *Outpatients*

University Hospitals of North Midlands NHS Trust

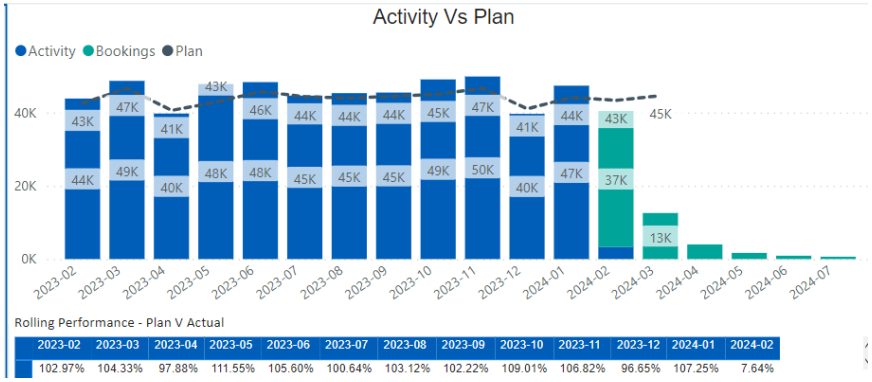
New Outpatient Performance to Plan



Rolling Performance - Plan V Actual

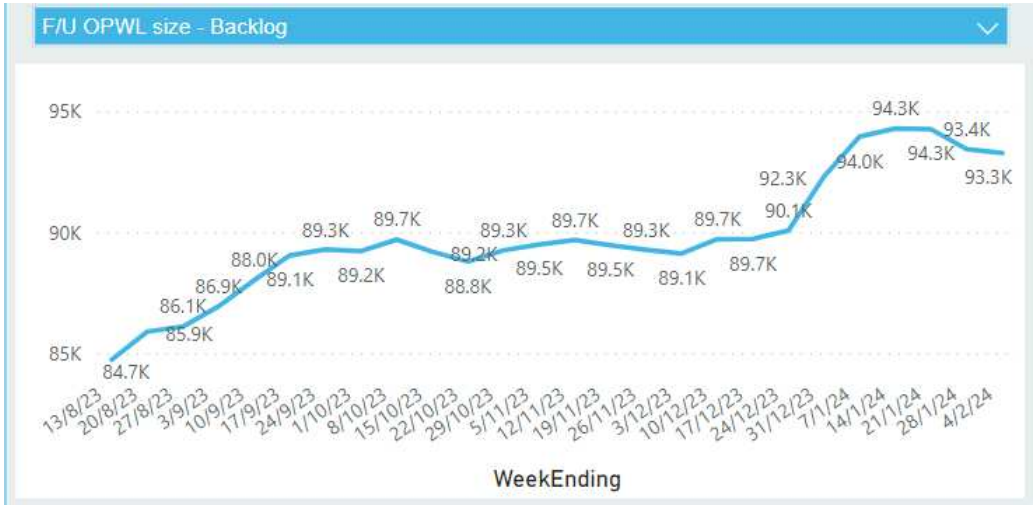
2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2024-01	2024-02
101.20%	104.74%	87.16%	100.19%	98.31%	96.62%	95.24%	96.40%	101.62%	95.72%	86.31%	96.60%	7.47%

Follow Up Outpatient Performance to Plan



Rolling Performance - Plan V Actual

2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2024-01	2024-02
102.97%	104.33%	97.88%	111.55%	105.60%	100.64%	103.12%	102.22%	109.01%	106.82%	96.65%	107.25%	7.64%



New Outpatient activity performance was 97% of plan in January and 95% YTD. Outpatient Follow Up performance was 107% in January with YTD at 104%.

The Follow Up Backlog waiting list increased c.1% in January.

Planned care – *Outpatients*

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Actions

- **OP Cell Programme Structure** - reframed on reducing follow ups without a procedure by 25%, reflecting the 23/24 Elective Recovery Guidance ambition. Regular meetings with NHSE have confirmed alignment of approach and 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 the Elective Steering group. Awaiting 24/25 Planning Guidance.

  Risks: - Business plans signed off for 23/24 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, previously escalated at Planned Care Improvement Board
  - PKB functionality to support waiting list validation & 2way SMS: timeline risk, (revisiting 2-way SMS targeting DNAs)
  - Impact of further Industrial Action (IA) on cancelled OP sessions / attendances, impact on improvement work
  - CIP impact on admin vacancies process – admin resource remains critical for transformation & sustained performance

- **Referral Management / Variation**

  Advice & Guidance - Advice & refer 'triage by default': scoping internal /external support. Presentation shared at OP Cell and Planned Care, plan to present to System Groups for review & discussion ahead of decision on pilot. Also reviewing usage variation Trust-wide / by GPs.

  E-referral worklist reports - Reports revised to reflect workflow, with filters to support oversight of urgent & 2ww triage position.

- **Activity Management / Variation**

  PIFU - Position Jan 2024: 5.1% Benchmarking vs national median December – UHNM: 24th of 142 providers (5.0% vs 3.0%).

  'PIFU by Default' initiative – with NHSE support; clinical workshop Nov 7th with Medical Director & Clinical Leads, well attended, updated UHNM comms. Plan for specific clinical discussion with 4 initial priority specialties (with NHSE clinical support), proving difficult to schedule regular contact with clinical teams due to competing priorities. Helpful clinician to clinician meeting held for one specialty with next steps, two other specialty meetings scheduled. Detailed template to feed back on progress submitted to NHSE. Due to present at Midlands OP Board (as PIFU by Default pilot site).

  Outcomes – Tail broadly cleared, continuing progress on backlog (cohorts not high risk). Following iportal directive, new report views to target improvement actions effectively (eg unoutcomed where iportal outcome captured and/or letter completed). >45% of outcomes initially recorded on Careflow. Review of reporting and associated operational processes underway with DQ and specialty input.

  RPA OP Outcomes - Scoping specialty pilot with UHNM BI, agreement in principle for pilot in a specialty using available robot capacity.

  OP Productivity; Utilisation – Position Jan 2024: Clinic Utilisation: 88.8% vs 90.0% (plan); Booking rate: 95.2% (vs 96.3%) DNA rate: 6.7% (vs 6.5%), detailed review of bookings by TFC to understand under-utilised slots. **Missed Appointments -** overbooking to compensate, **2-way messaging –** paper approved in principle at IM&T SMT, meeting with supplier. **Health inequalities Audits -** HED DNA benchmarking specialties vs national position identifies outliers. Linking with NHSE & Public Health consultant around approaches. Initial analysis complete, scoping meetings with specialty.

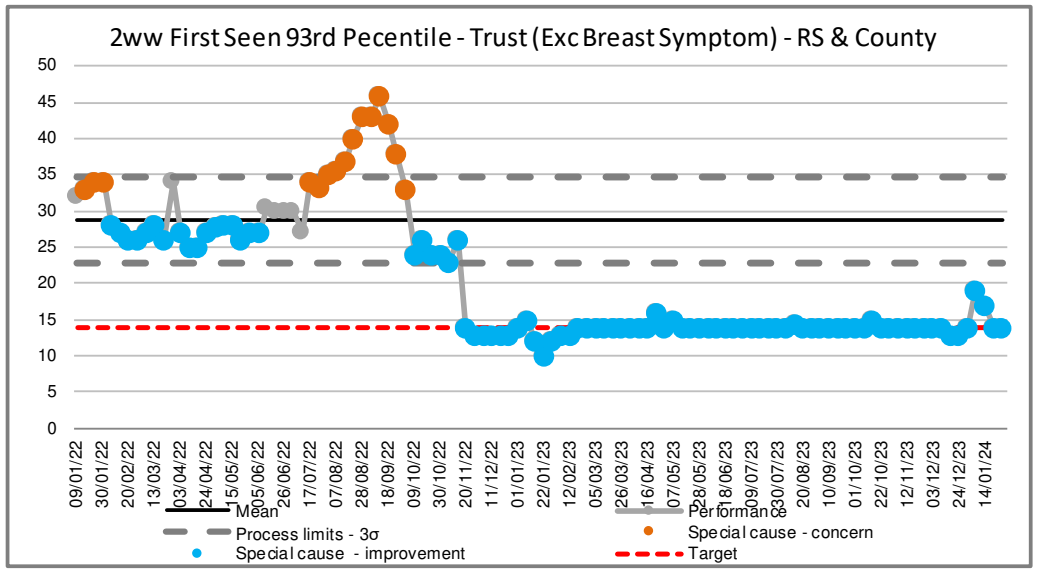
- **Key Enablers**

  GIRFT Further, Faster – key programme, UHNM a cohort 2 Trust. Handbooks shared; monitoring onboarding (14/17) & follow on meetings with clinical & mgt specialty teams. Many outpatient actions similar to OP GIRFT Guidance. Specialty Checklists being reviewed with clinicians (59.5% updated). February Midlands Monthly OP Transformation Network dedicated to Further Faster.

  PIFU RPA – Discharge Letters (at Review Date),with UHNM BI; Urology live, rolling out vs plan for other specialties. Paediatrics going live February 2024.

Cancer – Headline metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

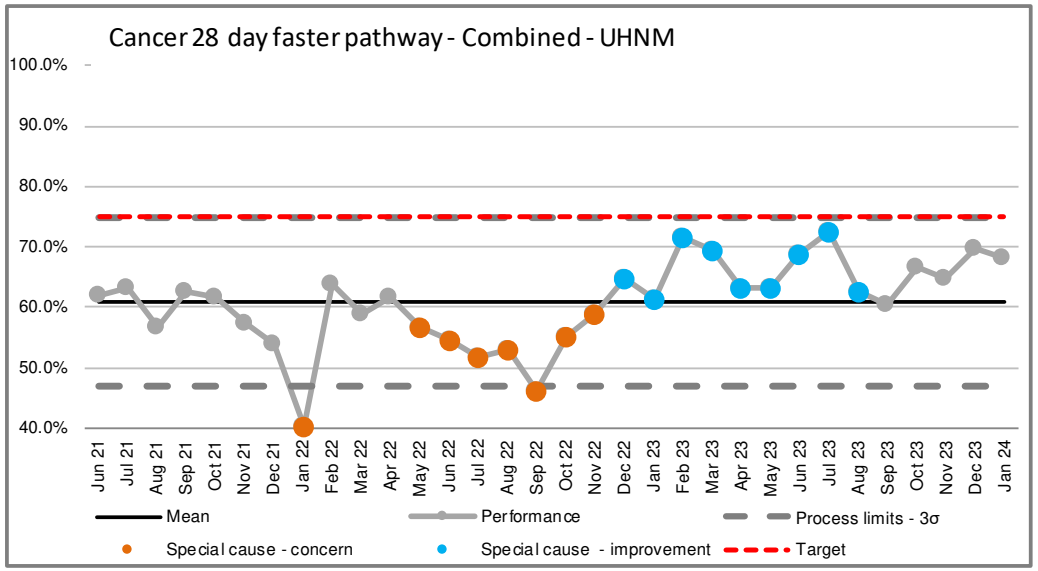
Target	14/01/2024	21/01/2024	28/01/2024
14	17	14	14

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 December had a 14 day clock stop within day 14 of the pathway.



Variation	Assurance
	

Target	Nov 23	Dec 23	Jan 24
75%	64.9%	69.7%	68.3%

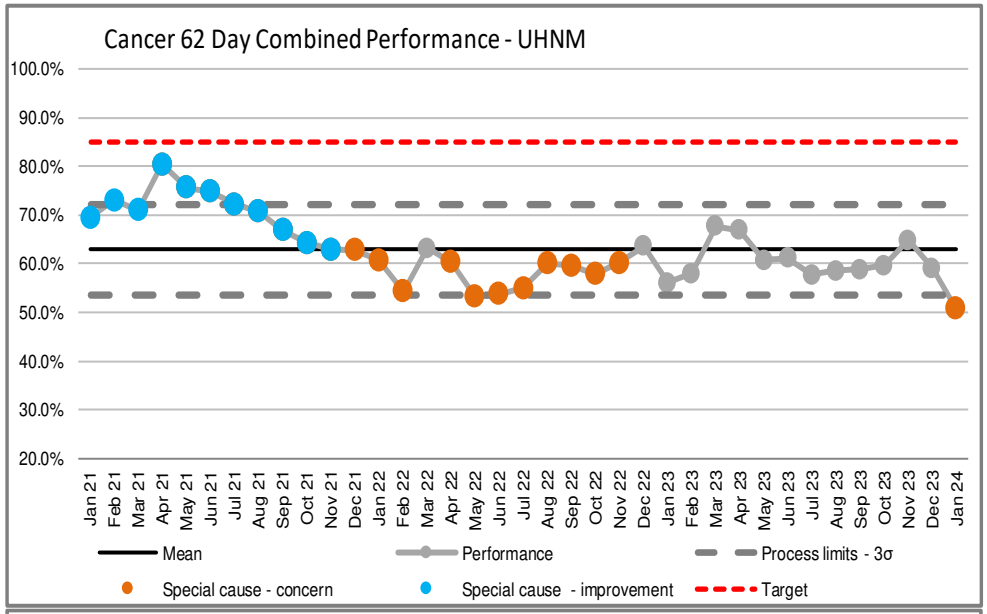
Background

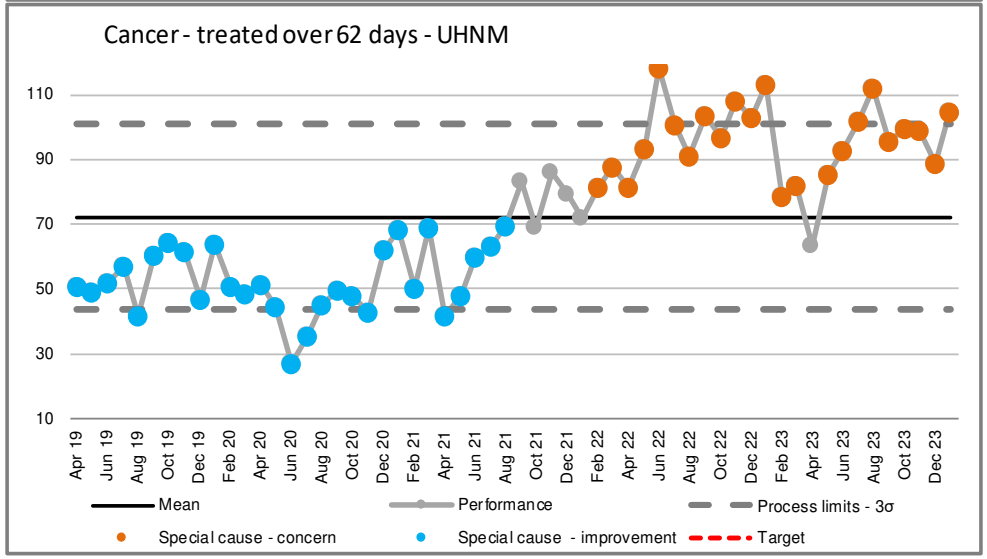
Performance of confirmation or exclusion of cancer communicated with patients within the 28 day timeframe.

What is the data telling us?

The FDS performance is continuing to improve, with pockets of good practice. E.g. Breast, Lung and Upper GI all achieve the standard . The combined Faster Diagnosis Standard achieved 69.7% in December. It is predicted to land at around 68% in January, however validation is ongoing.

Cancer – Headline metrics





Target	Nov 23	Dec 23	Jan 24
85%	64.9%	59.1%	50.8%

Background

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

What is the data telling us?

Performance significantly challenged and below standard for the past 2 years. Performance remains between 50 – 60% for Oct, Nov & Dec. The January 24 position is incomplete and still being validated.

Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
N/A	99.0	89.0	105.0

Background

The number of patients treated over 62 days

What is the data telling us?

Demonstrates total volume of GP referred patients who have been treated beyond day 62 is a cause for concern and has been rising over the past 2 years.

Cancer Actions

NHS University Hospitals of North Midlands NHS Trust

- The Faster Diagnosis Standard has improved over the past few months for most challenged tumour sites Gynae, Urol, LGI and Skin.
- The 62 day and 104 day backlogs have reduced in line with trajectory for the past 4 months, with Colorectal and Skin ahead of trajectory.
- 25% of referrals received on the lower GI suspected cancer 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.
- During a regional audit of 3 months worth of data, UHNM completed colonoscopies for just 0.3% of FIT negative patients who were on a suspected cancer LGI pathway – this is the lowest in the region when benchmarked against providers within the West Midlands.

Most Challenged Areas

LGI:

- Surgical capacity has been released through additional activity delivered by SHS supporting recovery of the LGI cancer pathway backlog of patients waiting for diagnosis and treatment. This is enabled by using a mixture of OPAs and, Day Case capacity and has resulted in an improvement of the 62+ backlog position in LGI. In addition, the LGI FDS performance has improved over the past 3 months and is expected to continue to recover.

Skin:

- Extra minor ops and OPA capacity is being provided through weekend activity. TIs are also supporting the position including insourcing.
  An increase in activity in January 24 is built into the trajectory, reported each week through the cancer governance structure.
  The 62+ day backlog position was expected to plateau over the Christmas period but is within trajectory and continues to recover.

UROL:

- An escalation for support has been submitted to the system, to explore expansion of referral optimisation hub to include all suspected cancer referrals. This is expected to improve FDS performance due to improved quality of referrals. Timescales for the completed review of the Choice and Referral centre which began last year are still TBC. The UROL Expert Advisory Group of the west midlands is focusing on targeted case finding in primary care.

Pathology:

- Pathologists are prioritising reporting into Urgent and Accelerated streams, particularly for high volume pathways such as Skin and Colorectal. One locum consultant, 2 fixed term Band 4's and one locum BMS were recruited using recovery funds in November 23. TATs for Cancer specimens: 95% are reported at Day 18 – a deterioration since last month.

Endoscopy:

- Recovery plans are being enacted to increase internal capacity using a combination of clinical Endoscopists, consultants/middle grades to improve utilisation. Locums are supporting diagnostic and surveillance waits. Insourced management support has been commissioned.

Radiology:

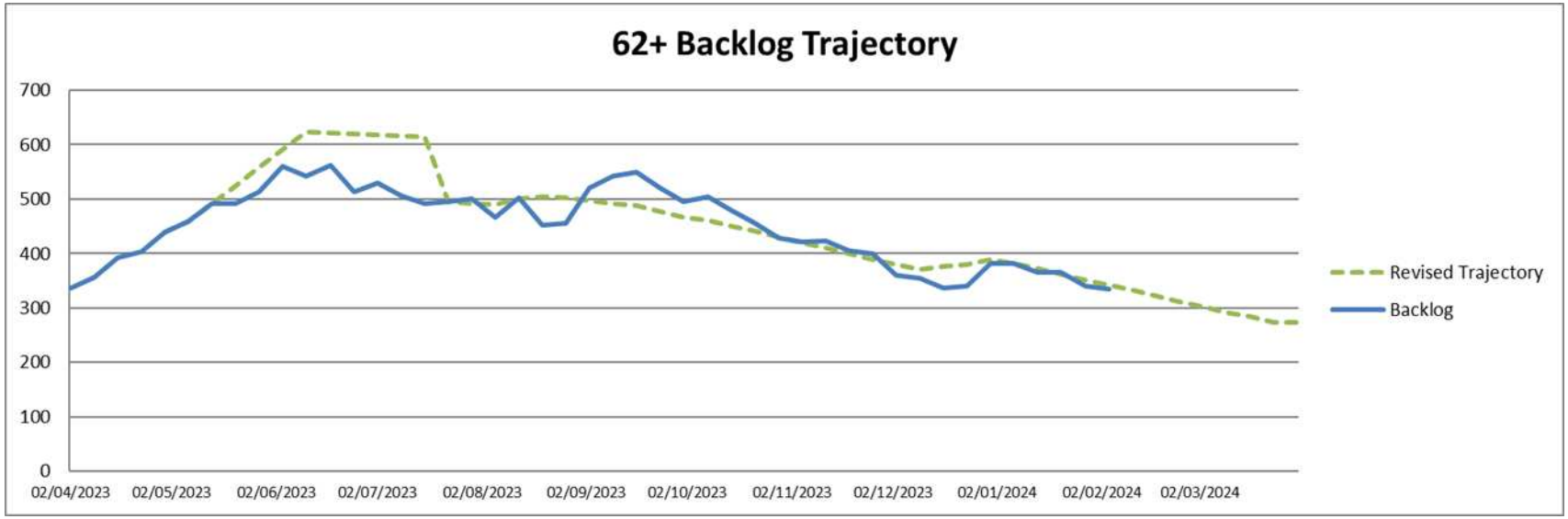
- For increased Radiology reporting capacity to support cancer pathways, TIs are being offered, in addition recruitment is underway for an additional fellow, plus a review of outstanding reports and allocation / escalation is continuous.

Escalations:

- 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.
- An audit of referral quality will commence in February, making note of errors and omissions on GP cancer referrals. This will be shared with ICS colleagues to highlight themes of sub-optimal referrals and to support targeted improvement actions, such as an expansion of the referral optimisation hub.

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, with UHNM target being 273. 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 patients 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 04.02.24.
- 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 by 47 patients since last month to a current position of 335.
    - The number of days waited for 1st OPA (93rd Percentile) has reduced to within target of 14 days.
    - The total PTL has reduced to a current position of around 3200.
    - The number of patients waiting over 104+ has reduced by 28 patients since last month to a current position of 84.
    - The combined Faster Diagnosis Standard was submitted at a final December 23 position of 69.7% - demonstrating a 5% increase since last month.



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	11.21%	9.79%	8.96%	7.78%	7.76%	11.32%	11.74%	10.30%	13.40%	7.17%	0.56%
Weeks Waited- 78-104	12.59%	10.30%	10.30%	10.44%	8.00%	12.07%	9.85%	10.15%	10.15%	4.74%	1.41%
Weeks Waited- 52-77	14.25%	12.12%	10.89%	9.10%	8.14%	10.30%	9.62%	9.00%	10.71%	4.95%	0.93%
Weeks Waited- Under 5	13.73%	11.30%	10.14%	9.08%	7.47%	10.59%	10.60%	8.89%	11.08%	5.62%	1.50%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	10.41%	9.60%	9.33%	8.57%	7.87%	11.19%	11.73%	10.07%	13.23%	6.86%	1.14%
Weeks Waited- 78-104	11.18%	10.45%	9.76%	8.71%	7.72%	10.46%	11.05%	10.22%	12.25%	6.80%	1.40%
Weeks Waited- 52-77	12.91%	11.47%	10.10%	9.20%	7.52%	10.91%	10.50%	8.97%	11.12%	6.04%	1.27%
Weeks Waited- Under 5	13.42%	11.42%	10.06%	8.86%	7.50%	10.46%	10.47%	9.11%	11.28%	5.89%	1.52%

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	0.13%	0.45%	0.08%	0.45%	0.37%	0.59%	0.03%	0.11%	0.27%	0.40%	0.45%	0.16%	0.03%	92.96%	0.37%	1.07%	1.74%	0.29%	
Weeks Waited- 78-104	0.30%	0.37%	0.22%	0.89%	0.44%	1.26%	#N/A	#N/A	0.07%	0.52%	0.81%	0.22%		89.93%	0.37%	1.85%	1.33%	1.11%	
Weeks Waited- 52-77	0.58%	0.69%	0.31%	0.82%	0.79%	1.41%	0.07%	0.21%	0.14%	0.62%	1.37%	0.38%	0.14%	85.75%	0.45%	2.23%	1.58%		
Weeks Waited- Under 5	0.49%	0.70%	0.25%	0.69%	0.51%	1.69%	0.17%	0.19%	0.12%	0.55%	1.55%	0.33%	0.20%	83.58%	0.38%	2.72%	2.31%	3.33%	

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	0.35%	0.39%	0.18%	0.53%	0.48%	0.94%	0.06%	0.15%	0.18%	0.53%	1.41%	0.30%	0.15%	0.21%	88.00%	0.37%	2.52%	1.91%	1.32%
Weeks Waited- 78-104	0.37%	0.71%	0.14%	0.62%	0.54%	1.12%	0.19%	0.11%	0.21%	0.68%	1.54%	0.29%	0.13%	0.20%	84.97%	0.31%	2.83%	2.26%	2.77%
Weeks Waited- 52-77	0.35%	0.72%	0.23%	0.59%	0.60%	1.13%	0.17%	0.21%	0.13%	0.64%	1.53%	0.29%	0.14%	0.20%	83.35%	0.30%	3.21%	2.41%	#N/A
Weeks Waited- Under 5	0.70%	0.74%	0.24%	0.66%	0.61%	1.34%	0.17%	0.17%	0.16%	0.72%	1.90%	0.35%	0.19%	0.24%	82.18%	0.31%	3.15%	2.54%	

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APPENDIX 1

Operational Performance

Constitutional standards

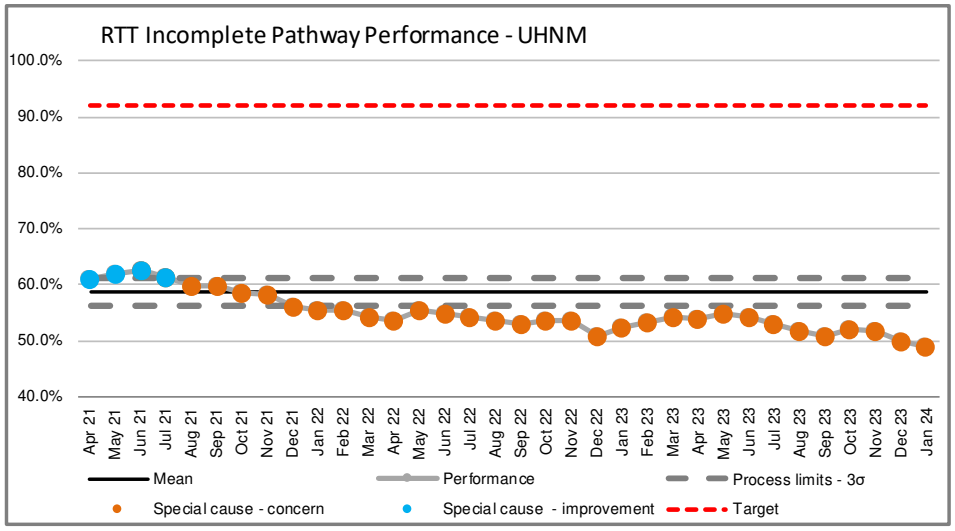
NHS University Hospitals of North Midlands NHS Trust

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	Percentage of Ambulance Handovers within 15 minutes	0%	21.05%	L		
	Ambulance handovers greater than 60 minutes	1	1	L	F	
	Time to Initial Assessment - percentage within 15 minutes	85%	55.89%		F	
	Average (mean) time in Department - non-admitted patients	180	303	H	F	
	Average (mean) time in Department - admitted patients	180	465	H	F	
	Clinically Ready to Proceed	90	640	H	F	
	12 Hour Trolley Waits	0	1263	H	F	
	Patients spending more than 12 hours in A&E	0	2319	H	F	
	Median Wait to be seen - Type 1	60	109		F	
	Bed Occupancy	92%	88.28%			
Cancer Care	Cancer 28 day faster pathway	75%	68.28%		F	
	Cancer 31 Day Combined	96%	81.27%	L	F	
	Cancer 62 Day Combined	85%	50.78%	L	F	
	2WW First Seen (exc Breast Symptom)	93%	92.69%	H	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	6.7%	L	?	
	Cancelled Ops	150	150		?	
	Theatre Utilisation	85%	80.8%			
Inpatient / Discharge	Same Day Emergency Care	30%	40%	H	?	
	Super Stranded	183	186		?	
	MFFD	100	91	L	?	
	Discharges before Midday	25%	18.8%		F	
	Emergency Readmission rate	8%	14.4%	H	F	
Elective waits	RTT incomplete performance	92%	48.96%	L	F	
	RTT 52+ week waits	0	5088	H	F	
	Diagnostics	99%	74.34%		F	

Referral To Treatment

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

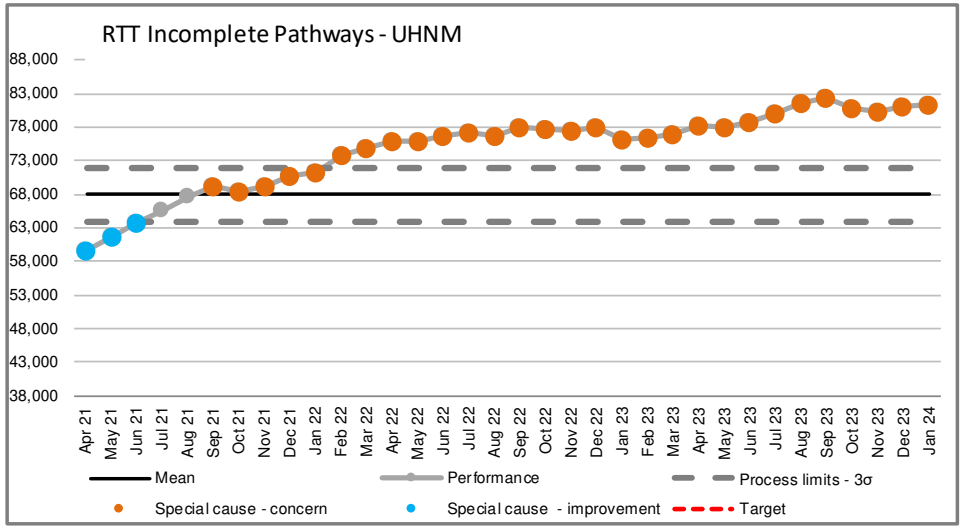
Target	Nov 23	Dec 23	Jan 24
92%	51.8%	49.8%	49.0%

Background

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

What is the data telling us?

RTT performance reduced further in January and continues to see a declining trend.



Variation	Assurance
H	

Target	Nov 23	Dec 23	Jan 24
N/A	80366	80987	81352

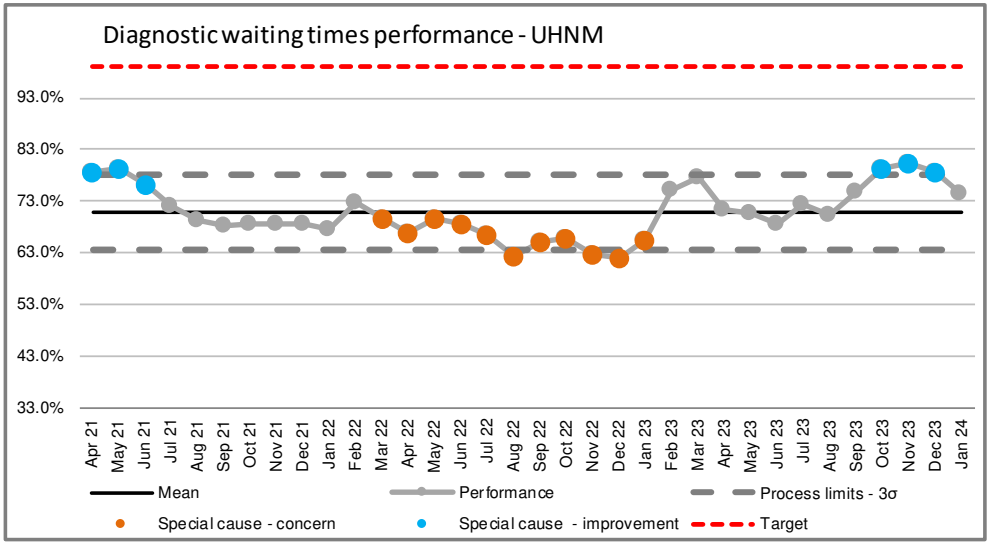
Background

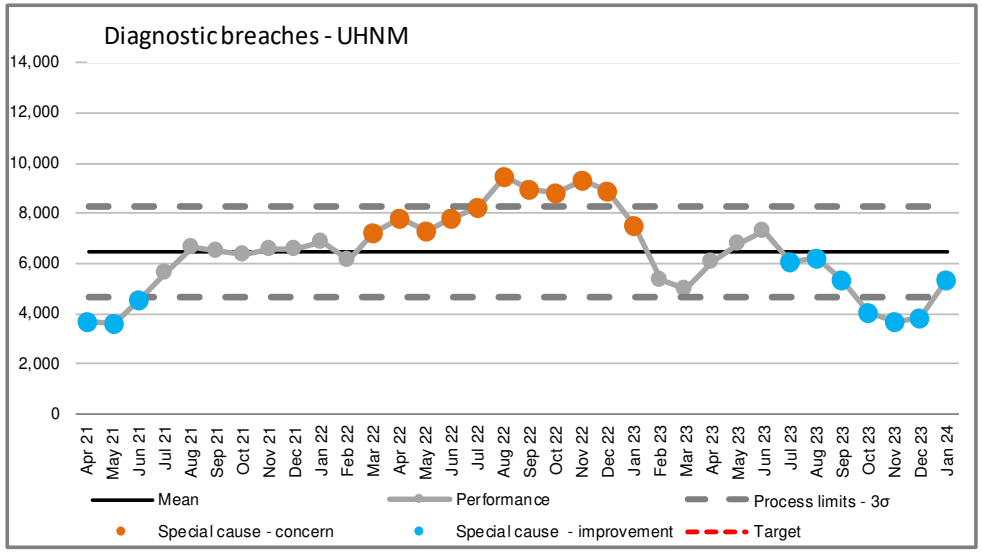
The number of patients waiting over 18 weeks for treatment since their referral.

What is the data telling us?

Total number of RTT pathways has plateaued since September 2023, despite performance against the 18 week target deteriorating.

Diagnostic Standards





Variation	Assurance
	

Target	Nov 23	Dec 23	Jan 24
99%	80.5%	78.6%	74.3%

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 deterioration in January of 74% against the 99% target.

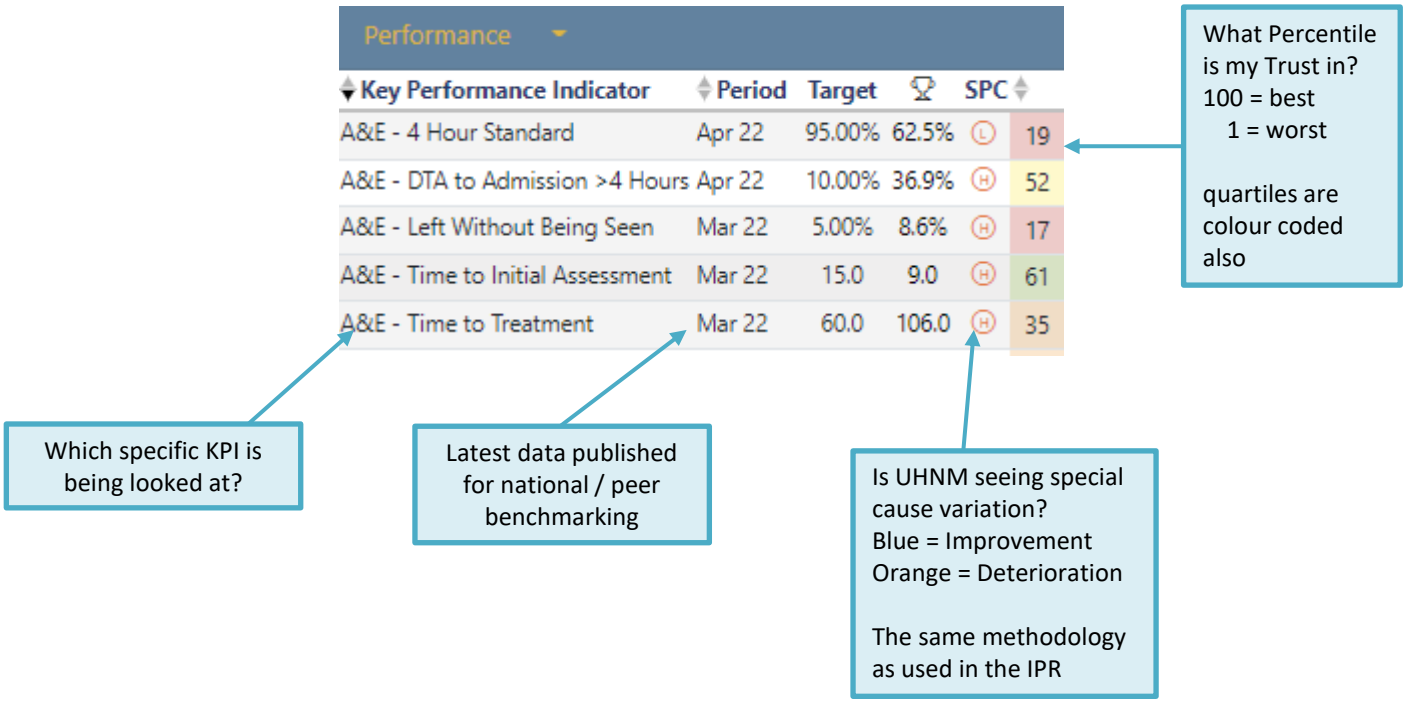
Overall waiting list increased by 3000, where breaches increased by over 1500 in January comparing to December.

NHS
University Hospitals of North Midlands
NHS Trust

UHNM Benchmarked Performance

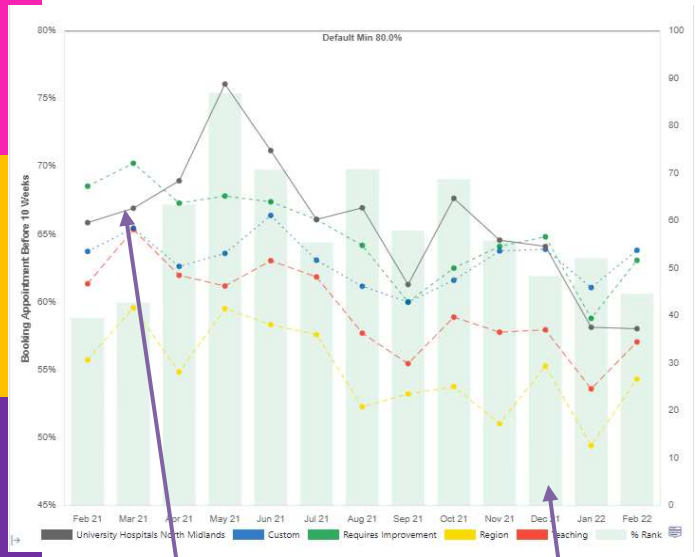
Contents

UHNM Benchmarked Performance – understanding the Tables



UHNM Benchmarked Performance – understanding the Charts

University Hospitals of North Midlands NHS Trust



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

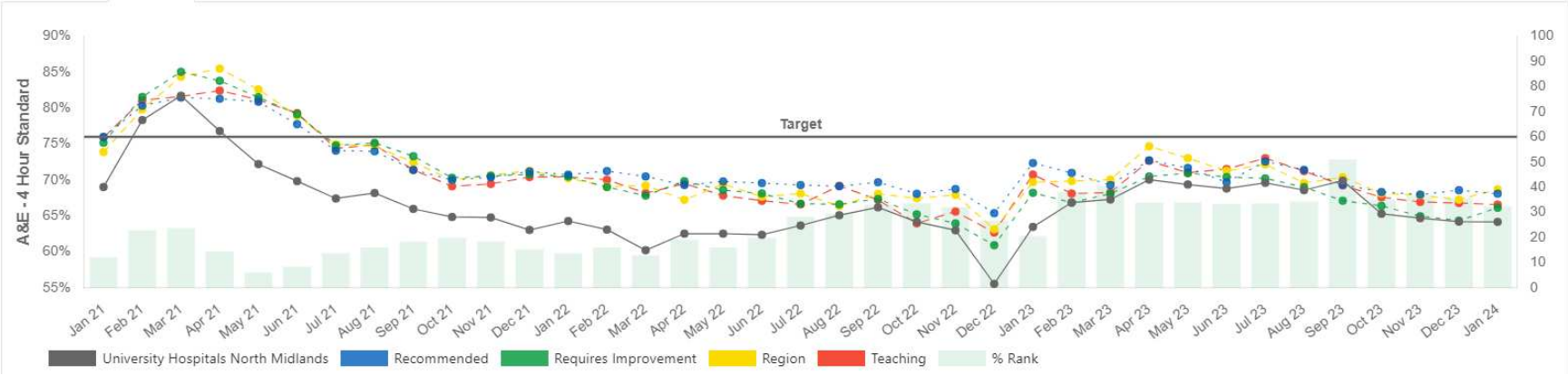
Urgent Care - 4 hour standard

NHS University Hospitals of North Midlands NHS Trust

A&E - 4 Hour Standard

Jan 24 Performance: 64.17% | Rank: 97th of 143

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



- 4 hour performance over the latest three months has plateaued.
- UHNM have been consistently below all peers during this period.
- UHNM remain in the third quartile.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Jan 24	1.0%	**17.1%**	
A&E - 4 Hour Standard	Jan 24	76.00%	**64.2%**	
A&E - 4 Hour Standard (Type 1)	Jan 24	76.0%	**42.9%**	
A&E - 4 Hour Standard (Type 2 or 3)	Jan 24	95.0%	97.2%	
A&E - Conversion Rate	Jan 24	25.0%	**27.6%**	
A&E - DTA to Admission >12 Hours	Jan 24	0.0%	**19.6%**	
A&E - DTA to Admission >12 Hours#	Jan 24	0.0	**1,209.0**	
A&E - DTA to Admission >4 Hours	Jan 24	10.00%	**32.7%**	
A&E - Left Without Being Seen	Dec 23	5.00%	**6.3%**	
A&E - Reattendance Rate	Dec 23	5.0%	**9.0%**	
A&E - Time to Initial Assessment	Dec 23	15.0	8.0	
A&E - Time to Treatment	Dec 23	60.0	**85.0**	
A&E - Total Time in A&E	Dec 23	160.0	**188.0**	
A&E - Total Time in A&E (Admitted)	Dec 23	180.0	**406.0**	
A&E - Total Time in A&E (Non-Admitted)	Dec 23	140.0	**164.0**	

Urgent Care - 12 hour standard

NHS University Hospitals of North Midlands NHS Trust

- All peer groups have followed a similar trend since February.
- UHNM have continued to have the highest % of 12 hour breaches compared to peer groups.
- UHNM have dropped to the lowest quartile since the last report.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Jan 24	1.0%	17.1%	
A&E - 4 Hour Standard	Jan 24	76.00%	64.2%	
A&E - 4 Hour Standard (Type 1)	Jan 24	76.0%	42.9%	
A&E - 4 Hour Standard (Type 2 or 3)	Jan 24	95.0%	97.2%	
A&E - Conversion Rate	Jan 24	25.0%	27.6%	
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A&E - DTA to Admission >4 Hours	Jan 24	10.00%	32.7%	
A&E - Left Without Being Seen	Dec 23	5.00%	6.3%	
A&E - Reattendance Rate	Dec 23	5.0%	9.0%	
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A&E - Total Time in A&E	Dec 23	160.0	188.0	
A&E - Total Time in A&E (Admitted)	Dec 23	180.0	406.0	
A&E - Total Time in A&E (Non-Admitted)	Dec 23	140.0	164.0	

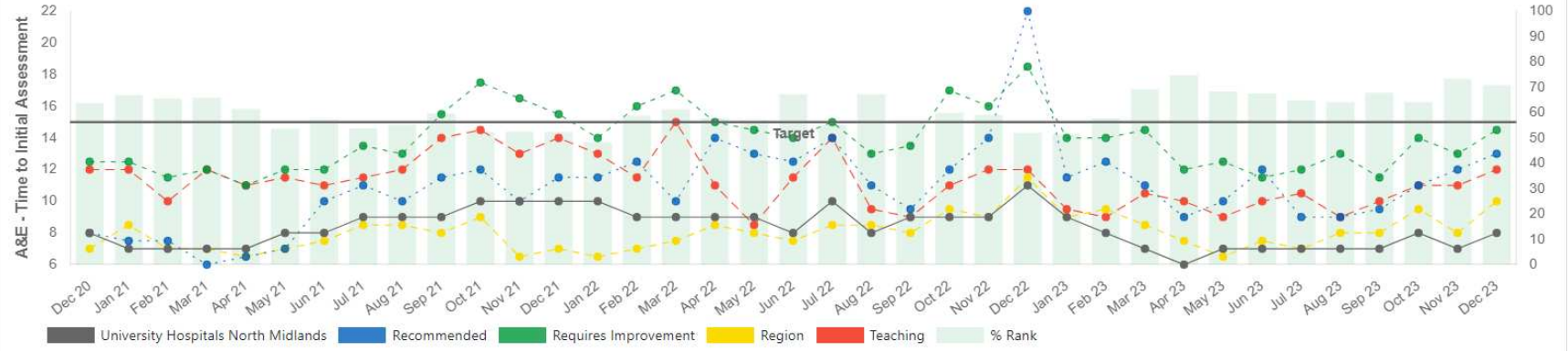
Urgent Care – Initial Assessment

NHS University Hospitals of North Midlands NHS Trust

A&E - Time to Initial Assessment

Dec 23 Performance: 8.0 | Rank: 36th of 121

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



- UHNM average time to initial assessment (ambulance cases only) remains better than all other peer groups.
- UHNM performance deteriorated marginally in December 2023, but significantly better than December 2022.
- UHNM remain in the second quartile.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Jan 24	1.0%	17.1%	
A&E - 4 Hour Standard	Jan 24	76.00%	64.2%	
A&E - 4 Hour Standard (Type 1)	Jan 24	76.0%	42.9%	
A&E - 4 Hour Standard (Type 2 or 3)	Jan 24	95.0%	97.2%	
A&E - Conversion Rate	Jan 24	25.0%	27.6%	
A&E - DTA to Admission >12 Hours	Jan 24	0.0%	19.6%	
A&E - DTA to Admission >12 Hours#	Jan 24	0.0	1,209.0	
A&E - DTA to Admission >4 Hours	Jan 24	10.00%	32.7%	
A&E - Left Without Being Seen	Dec 23	5.00%	6.3%	
A&E - Reattendance Rate	Dec 23	5.0%	9.0%	
A&E - Time to Initial Assessment	Dec 23	15.0	8.0	
A&E - Time to Treatment	Dec 23	60.0	85.0	
A&E - Total Time in A&E	Dec 23	160.0	188.0	
A&E - Total Time in A&E (Admitted)	Dec 23	180.0	406.0	
A&E - Total Time in A&E (Non-Admitted)	Dec 23	140.0	164.0	

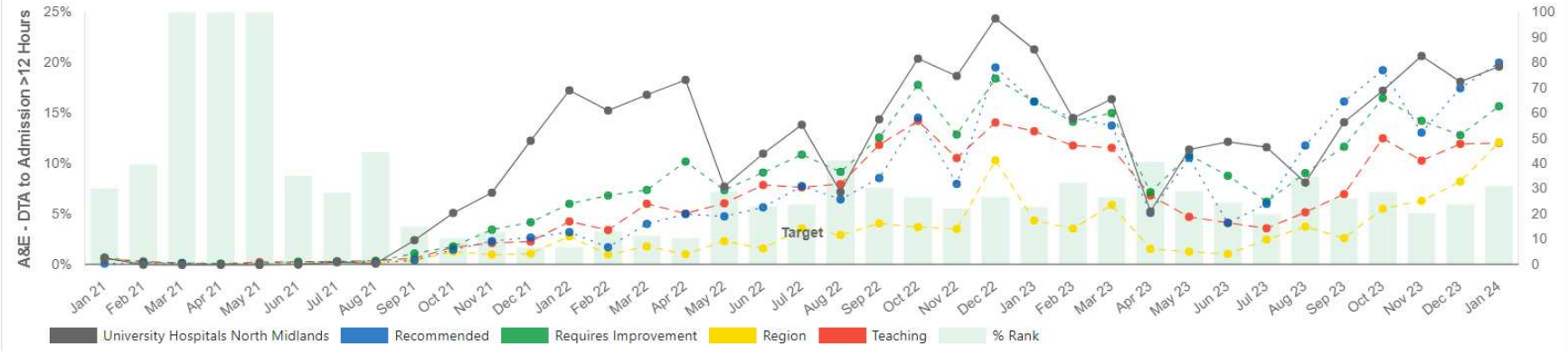
Urgent Care – DTA waits over 12 hours

NHS University Hospitals of North Midlands NHS Trust

A&E - DTA to Admission >12 Hours

Jan 24 Performance: 19.6% | Rank: 89th of 129

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



- All peer groups have seen an increase in the proportion of patients waiting over 12 hours to be admitted since August and have followed a similar trend.
- UHNM are seeing similar rates as their Recommended peer group.
- UHNM have sustained their position in quartile 3.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Jan 24	1.0%	**17.1%**	
A&E - 4 Hour Standard	Jan 24	76.00%	**64.2%**	
A&E - 4 Hour Standard (Type 1)	Jan 24	76.0%	**42.9%**	
A&E - 4 Hour Standard (Type 2 or 3)	Jan 24	95.0%	97.2%	
A&E - Conversion Rate	Jan 24	25.0%	**27.6%**	
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A&E - DTA to Admission >12 Hours#	Jan 24	0.0	**1,209.0**	
A&E - DTA to Admission >4 Hours	Jan 24	10.00%	**32.7%**	
A&E - Left Without Being Seen	Dec 23	5.00%	**6.3%**	
A&E - Reattendance Rate	Dec 23	5.0%	**9.0%**	
A&E - Time to Initial Assessment	Dec 23	15.0	8.0	
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A&E - Total Time in A&E	Dec 23	160.0	**188.0**	
A&E - Total Time in A&E (Admitted)	Dec 23	180.0	**406.0**	
A&E - Total Time in A&E (Non-Admitted)	Dec 23	140.0	**164.0**	

Urgent Care – Re-attendance Rate within 7 days

- Since June 2023, UHNM's reattendance rate has been aligned to most peer groups, although remains slightly higher.
- UHNM remain in the 3rd quartile.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Jan 24	1.0%	**17.1%**	
A&E - 4 Hour Standard	Jan 24	76.00%	**64.2%**	
A&E - 4 Hour Standard (Type 1)	Jan 24	76.0%	**42.9%**	
A&E - 4 Hour Standard (Type 2 or 3)	Jan 24	95.0%	97.2%	
A&E - Conversion Rate	Jan 24	25.0%	**27.6%**	
A&E - DTA to Admission >12 Hours	Jan 24	0.0%	**19.6%**	
A&E - DTA to Admission >12 Hours#	Jan 24	0.0	**1,209.0**	
A&E - DTA to Admission >4 Hours	Jan 24	10.00%	**32.7%**	
A&E - Left Without Being Seen	Dec 23	5.00%	**6.3%**	
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A&E - Total Time in A&E	Dec 23	160.0	**188.0**	
A&E - Total Time in A&E (Admitted)	Dec 23	180.0	**406.0**	
A&E - Total Time in A&E (Non-Admitted)	Dec 23	140.0	**164.0**	

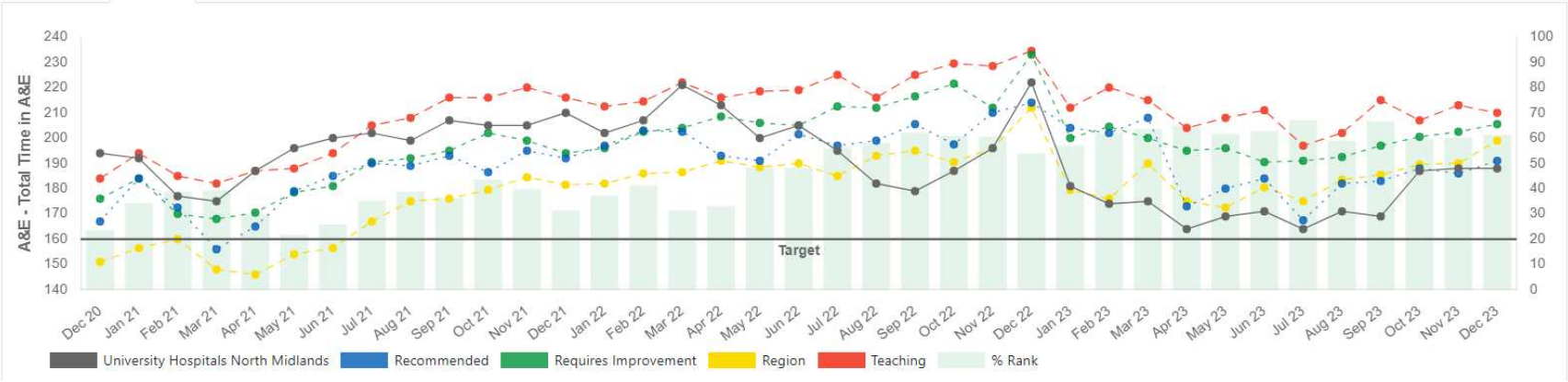
Urgent Care – Total time in ED

NHS University Hospitals of North Midlands NHS Trust

A&E - Total Time in A&E

Dec 23 Performance: 188.0 | Rank: 53rd of 135

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



	Key Performance Indicator	Period	Target		SPC
1200	A&E - 12 Hour Standard	Jan 24	1.0%	17.1%	
14	A&E - 4 Hour Standard	Jan 24	76.00%	64.2%	
60	A&E - 4 Hour Standard (Type 1)	Jan 24	76.0%	42.9%	
61	A&E - 4 Hour Standard (Type 2 or 3)	Jan 24	95.0%	97.2%	
62	A&E - Conversion Rate	Jan 24	25.0%	27.6%	
63	A&E - DTA to Admission >12 Hours	Jan 24	0.0%	19.6%	
64	A&E - DTA to Admission >12 Hours#	Jan 24	0.0	1,209.0	
34	A&E - DTA to Admission >4 Hours	Jan 24	10.00%	32.7%	
33	A&E - Left Without Being Seen	Dec 23	5.00%	6.3%	
65	A&E - Reattendance Rate	Dec 23	5.0%	9.0%	
52	A&E - Time to Initial Assessment	Dec 23	15.0	8.0	
53	A&E - Time to Treatment	Dec 23	60.0	85.0	
54	A&E - Total Time in A&E	Dec 23	160.0	188.0	
66	A&E - Total Time in A&E (Admitted)	Dec 23	180.0	406.0	
67	A&E - Total Time in A&E (Non-Admitted)	Dec 23	140.0	164.0	

- UHNM have consistently performed better than peer groups during 2023.
- Although from October 2023, this has deteriorated to levels seen in other peer groups.
- For UHNM this deterioration is due to Admitted patients spending more time in ED.
- UHNM remain in the 2nd quartile.

Urgent Care – Conversion Rate

NHS University Hospitals of North Midlands NHS Trust

A&E - Conversion Rate

Jan 24 Performance: 27.6% | Rank: 122nd of 143

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

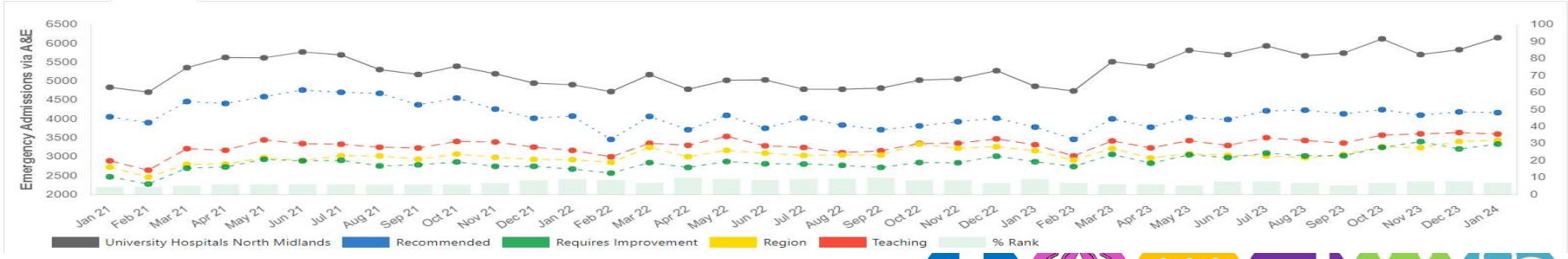
- The proportion of patients attending ED who are admitted at UHNM continues to remain significantly higher than most peer groups.
- UHNM have been on an upward trend over the last 12 months.
- UHNM remain in the bottom quartile.
- UHNM admit significantly more emergency patients than other peer groups.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Jan 24	1.0%	17.1%	
A&E - 4 Hour Standard	Jan 24	76.00%	64.2%	
A&E - 4 Hour Standard (Type 1)	Jan 24	76.0%	42.9%	
A&E - 4 Hour Standard (Type 2 or 3)	Jan 24	95.0%	97.2%	
A&E - Conversion Rate	Jan 24	25.0%	27.6%	
A&E - DTA to Admission >12 Hours	Jan 24	0.0%	19.6%	
A&E - DTA to Admission >12 Hours#	Jan 24	0.0	1,209.0	
A&E - DTA to Admission >4 Hours	Jan 24	10.00%	32.7%	
A&E - Left Without Being Seen	Dec 23	5.00%	6.3%	
A&E - Reattendance Rate	Dec 23	5.0%	9.0%	
A&E - Time to Initial Assessment	Dec 23	15.0	8.0	

Emergency Admissions via A&E

Jan 24 Performance: 6,153 | Rank: 120th of 129

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

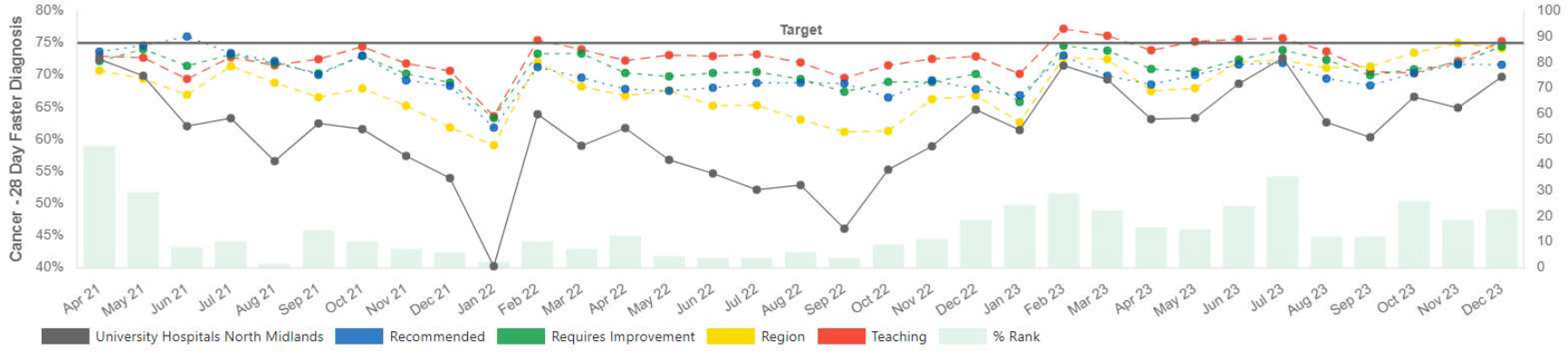


Cancer

Cancer - 28 Day Faster Diagnosis

Dec 23 Performance: 69.7% | Rank: 107th of 138

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



	Key Performance Indicator	Period	Target		SPC
403	Cancer - 28 Day Faster Diagnosis	Dec 23	75.0%	69.7%	
406	FDS Acute Leukaemia	Dec 23	75.0%	-	
407	FDS Brain Tumours	Dec 23	75.0%	0.0%	
408	FDS Breast Cancer	Dec 23	75.0%	89.7%	
404	FDS Breast Symptoms	Dec 23	75.0%	95.8%	
409	FDS Children's Cancer	Dec 23	75.0%	78.9%	
410	FDS Gynaecological Cancer	Dec 23	75.0%	57.5%	
411	FDS Haematological Malignancies	Dec 23	75.0%	64.7%	
412	FDS Head & Neck Cancer	Dec 23	75.0%	77.5%	
413	FDS Lower Gastrointestinal Cancer	Dec 23	75.0%	39.4%	
414	FDS Lung Cancer	Dec 23	75.0%	84.6%	
405	FDS Missing or Invalid	Dec 23	75.0%	-	
415	FDS Other Cancer	Dec 23	75.0%	-	
416	FDS Sarcoma	Dec 23	75.0%	50.0%	
417	FDS Skin Cancer	Dec 23	75.0%	79.9%	
418	FDS Testicular Cancer	Dec 23	75.0%	81.3%	
419	FDS Upper Gastrointestinal Cancer	Dec 23	75.0%	85.4%	
420	FDS Urological Malignancies	Dec 23	75.0%	52.6%	

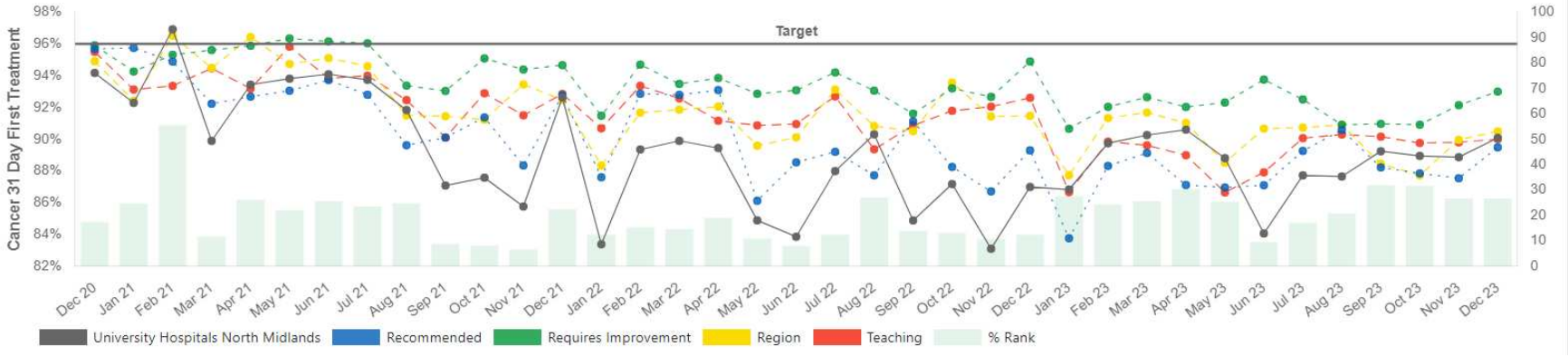
- All peer groups including UHNM remain below target, except the Teaching group.
- UHNM have seen the greatest improvement since September 2023, but continue to remain below target.
- UHNM remain in the bottom quartile.

Cancer

Cancer 31 Day First Treatment

Dec 23 Performance: 90.08% | Rank: 100th of 136

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



- Since June 2023, UHNM performance has seen an improving trend, whilst not all peer groups are seeing this same improvement.
- UHNM continue to remain midpoint between peers.
- UHNM remain in the third quartile.

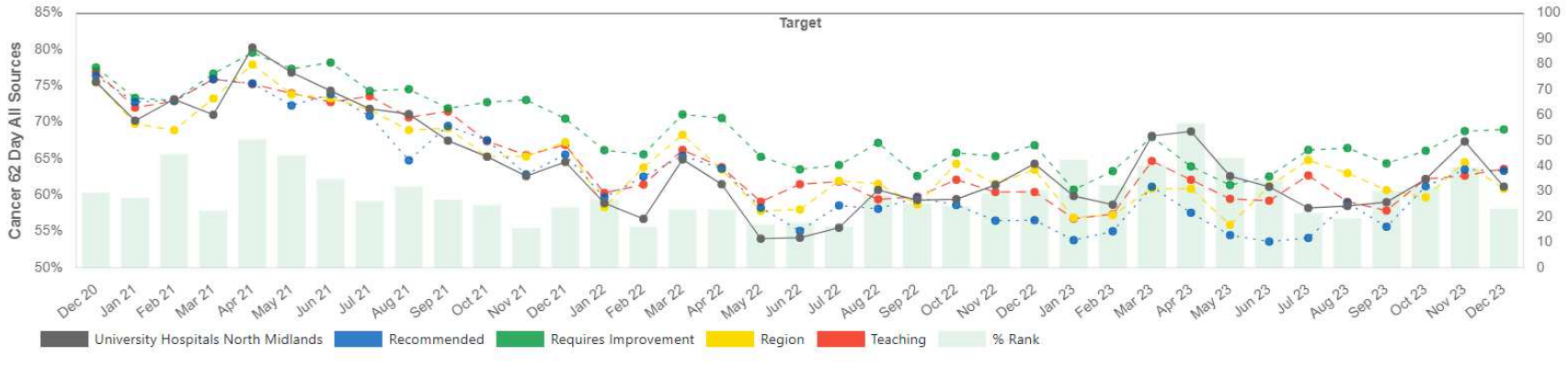
	Key Performance Indicator	Period	Target		SPC
45	Cancer 2 Week Wait	Dec 23	93.00%	96.5%	
99	Cancer 2 Week Wait Breast Symptomatic	Dec 23	93.0%	94.4%	
46	Cancer 31 Day First Treatment	Dec 23	96.00%	**90.1%**	
120	Cancer 31 Day Subsequent Treatment	Dec 23	96.0%	**88.2%**	
51	Cancer 62 Day All Sources	Dec 23	85.00%	**61.1%**	
100	Cancer 62 Day Consultant Upgrade	Dec 23	85.0%	**66.7%**	
35	Cancer 62 Day Screening	Dec 23	90.0%	**63.6%**	
118	Cancer Sub Treat Drugs	Dec 23	96.0%	98.8%	
119	Cancer Sub Treat Radiotherapy	Dec 23	96.0%	97.5%	

Cancer

Cancer 62 Day All Sources

Dec 23 Performance: 61.14% | Rank: 107th of 139

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



- All peer groups are currently performing at similar levels.
- UHNM saw the greatest improvement since September, however December saw a sharp deterioration which wasn't seen in other peer groups.
- UHNM have moved to the bottom quartile.

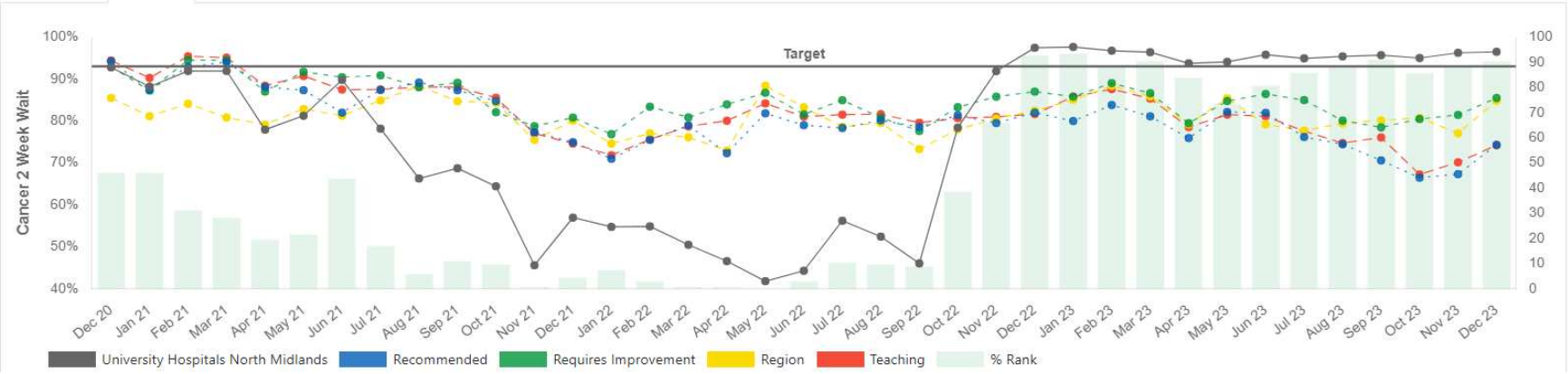
	Key Performance Indicator	Period	Target		SPC
45	Cancer 2 Week Wait	Dec 23	93.00%	96.5%	
99	Cancer 2 Week Wait Breast Symptomatic	Dec 23	93.0%	94.4%	
46	Cancer 31 Day First Treatment	Dec 23	96.00%	**90.1%**	
120	Cancer 31 Day Subsequent Treatment	Dec 23	96.0%	**88.2%**	
51	Cancer 62 Day All Sources	Dec 23	85.00%	**61.1%**	
100	Cancer 62 Day Consultant Upgrade	Dec 23	85.0%	**66.7%**	
35	Cancer 62 Day Screening	Dec 23	90.0%	**63.6%**	
118	Cancer Sub Treat Drugs	Dec 23	96.0%	98.8%	
119	Cancer Sub Treat Radiotherapy	Dec 23	96.0%	97.5%	

Cancer

Cancer 2 Week Wait

Dec 23 Performance: 96.47% | Rank: 14th of 134

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



- UHNM continue to perform well in this area and have remained above target since December 2022.
- All peer groups are consistently below target but have seen an improvement since October 2023.
- UHNM have are currently ranked 14th out of 134 and remain in the top quartile.

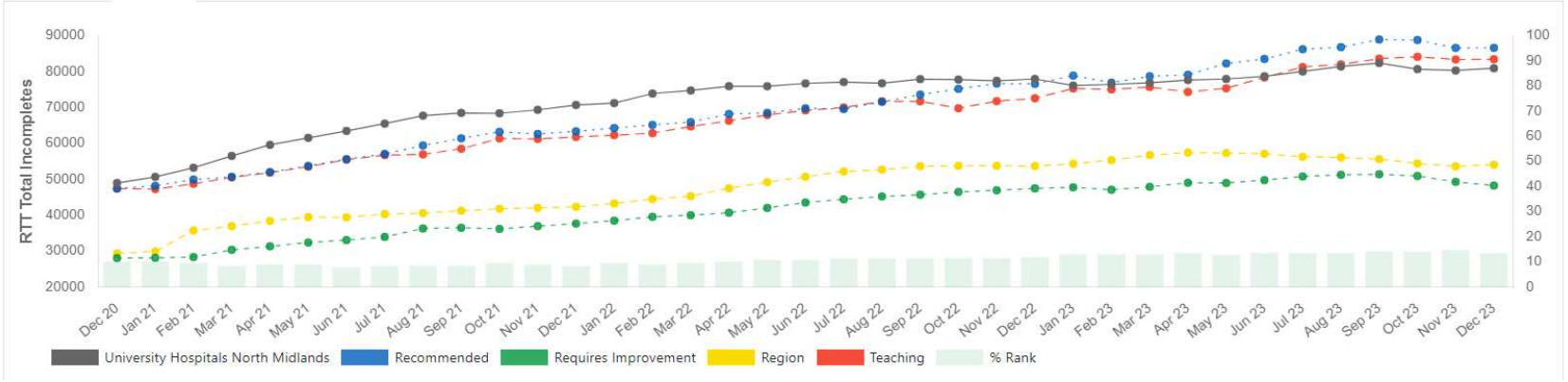
Key Performance Indicator	Period	Target		SPC
Cancer 2 Week Wait	Dec 23	93.00%	96.5%	
Cancer 2 Week Wait Breast Symptomatic	Dec 23	93.0%	94.4%	
Cancer 31 Day First Treatment	Dec 23	96.00%	**90.1%**	
Cancer 31 Day Subsequent Treatment	Dec 23	96.0%	**88.2%**	
Cancer 62 Day All Sources	Dec 23	85.00%	**61.1%**	
Cancer 62 Day Consultant Upgrade	Dec 23	85.0%	**66.7%**	
Cancer 62 Day Screening	Dec 23	90.0%	**63.6%**	
Cancer Sub Treat Drugs	Dec 23	96.0%	98.8%	
Cancer Sub Treat Radiotherapy	Dec 23	96.0%	97.5%	

RTT

RTT Total Incompletes

Dec 23 Performance: 80,868 | Rank: 149th of 172

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



- UHNM have plateaued at c. 81,000 open RTT pathways since September 2023.
- Recommended and Teaching peer groups continue to have more open pathways than UHNM.
- UHNM remain in the bottom quartile.

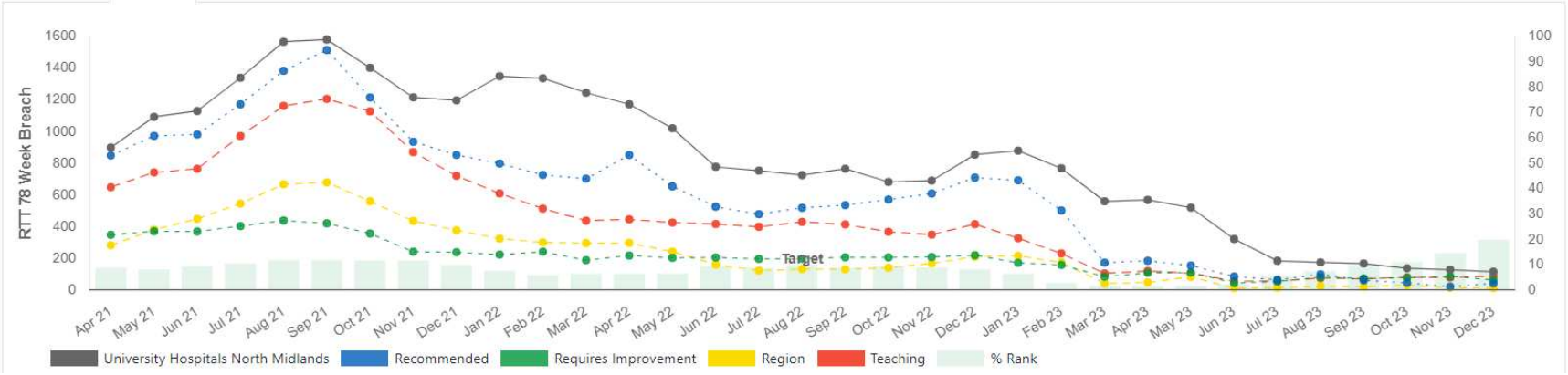
Key Performance Indicator	Period	Target		SPC
RTT 104 Week Breach	Dec 23	0	**3**	
RTT 52 Week Breach	Dec 23	0	**4,717**	
RTT 65 Week Breach	Dec 23	-	1,266	
RTT 78 Week Breach	Dec 23	0	**117**	
RTT 95th Percentile Admitted Waiting Time	Dec 23	18.0	**69.2**	
RTT 95th Percentile Non-Admitted Waiting Time	Dec 23	18.0	**61.1**	
RTT Admitted Treatment Within 18 Weeks	Dec 23	90.0%	**53.7%**	
RTT Average (Median) Admitted Waiting Time	Dec 23	9.0	**14.8**	
RTT Average (Median) Non-Admitted Waiting Time	Dec 23	5.0	**8.3**	
RTT Average Wait for Incomplete	Dec 23	7.00	**18.1**	
RTT Incomplete 92nd Percentile	Dec 23	-	48.7	
RTT Incomplete Pathways With a DTA	Dec 23	25.0%	15.2%	
RTT Non-Admitted Treatment Within 18 Weeks	Dec 23	95.0%	**67.6%**	
RTT Total Clock Starts	Dec 23	-	13,424	
RTT Total Clock Stops	Dec 23	-	12,487	
RTT Total Incompletes	Dec 23	-	80,868	

RTT

RTT 78 Week Breach

Dec 23 Performance: 117 | Rank: 138th of 172

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



	Key Performance Indicator	Period	Target		SPC
950	RTT 104 Week Breach	Dec 23	0	**3**	
56	RTT 52 Week Breach	Dec 23	0	**4,717**	
1202	RTT 65 Week Breach	Dec 23	-	1,266	
949	RTT 78 Week Breach	Dec 23	0	**117**	
142	RTT 95th Percentile Admitted Waiting Time	Dec 23	18.0	**69.2**	
144	RTT 95th Percentile Non-Admitted Waiting Time	Dec 23	18.0	**61.1**	
135	RTT Admitted Treatment Within 18 Weeks	Dec 23	90.0%	**53.7%**	
141	RTT Average (Median) Admitted Waiting Time	Dec 23	9.0	**14.8**	
143	RTT Average (Median) Non-Admitted Waiting Time	Dec 23	5.0	**8.3**	
55	RTT Average Wait for Incomplete	Dec 23	7.00	**18.1**	
133	RTT Incomplete 92nd Percentile	Dec 23	-	48.7	
134	RTT Incomplete Pathways With a DTA	Dec 23	25.0%	15.2%	
136	RTT Non-Admitted Treatment Within 18 Weeks	Dec 23	95.0%	**67.6%**	
138	RTT Total Clock Starts	Dec 23	-	13,424	
137	RTT Total Clock Stops	Dec 23	-	12,487	
132	RTT Total Incompletes	Dec 23	-	80,868	

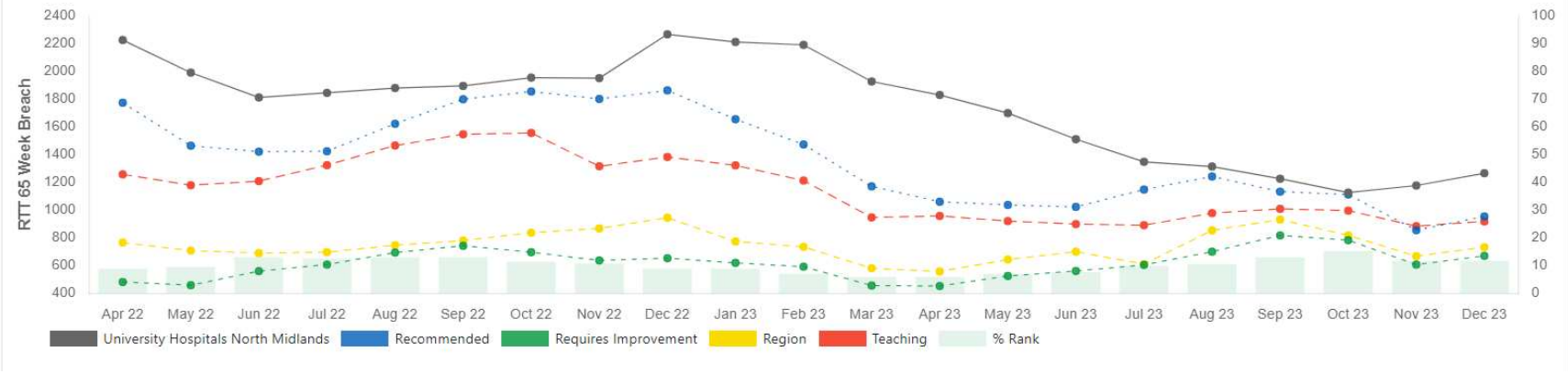
- UHNM remain above all peer groups and have plateaued at c.120 for the last three months.
- UHNM remain in the bottom quartile.

RTT

RTT 65 Week Breach

Dec 23 Performance: 1,266 | Rank: 152nd of 172

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



Key Performance Indicator	Period	Target		SPC
RTT 104 Week Breach	Dec 23	0	**3**	
RTT 52 Week Breach	Dec 23	0	**4,717**	
RTT 65 Week Breach	Dec 23	-	1,266	
RTT 78 Week Breach	Dec 23	0	**117**	
RTT 95th Percentile Admitted Waiting Time	Dec 23	18.0	**69.2**	
RTT 95th Percentile Non-Admitted Waiting Time	Dec 23	18.0	**61.1**	
RTT Admitted Treatment Within 18 Weeks	Dec 23	90.0%	**53.7%**	
RTT Average (Median) Admitted Waiting Time	Dec 23	9.0	**14.8**	
RTT Average (Median) Non-Admitted Waiting Time	Dec 23	5.0	**8.3**	
RTT Average Wait for Incomplete	Dec 23	7.00	**18.1**	
RTT Incomplete 92nd Percentile	Dec 23	-	48.7	
RTT Incomplete Pathways With a DTA	Dec 23	25.0%	15.2%	
RTT Non-Admitted Treatment Within 18 Weeks	Dec 23	95.0%	**67.6%**	
RTT Total Clock Starts	Dec 23	-	13,424	
RTT Total Clock Stops	Dec 23	-	12,487	
RTT Total Incompletes	Dec 23	-	80,868	

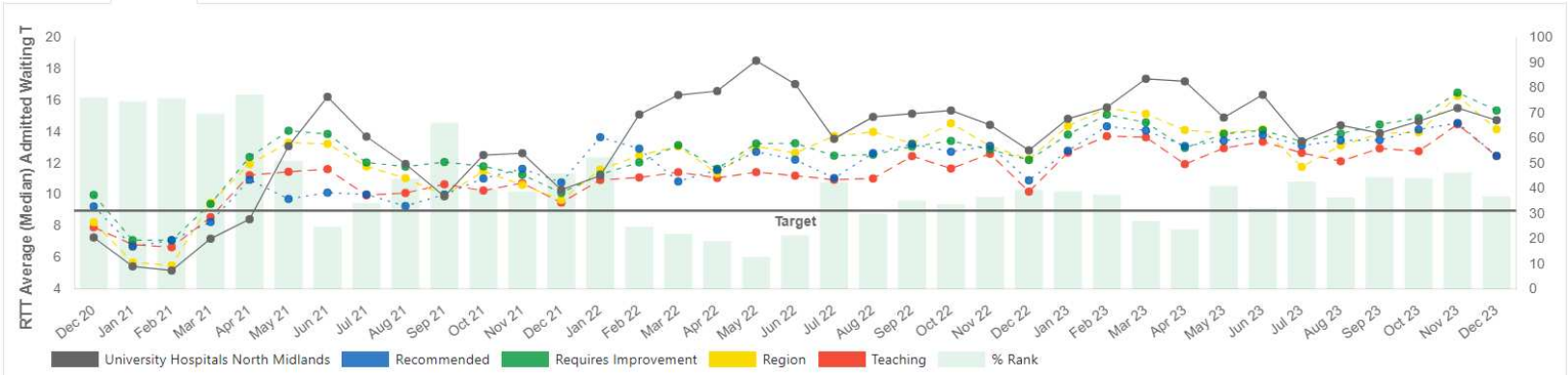
- All peer groups have followed a similar trend over recent months and all saw an increase in December.
- UHNM remain above all peer groups.
- UHNM remain in the bottom quartile.

RTT

RTT Average (Median) Admitted Waiting Time

Dec 23 Performance: 14.8 | Rank: 88th of 139

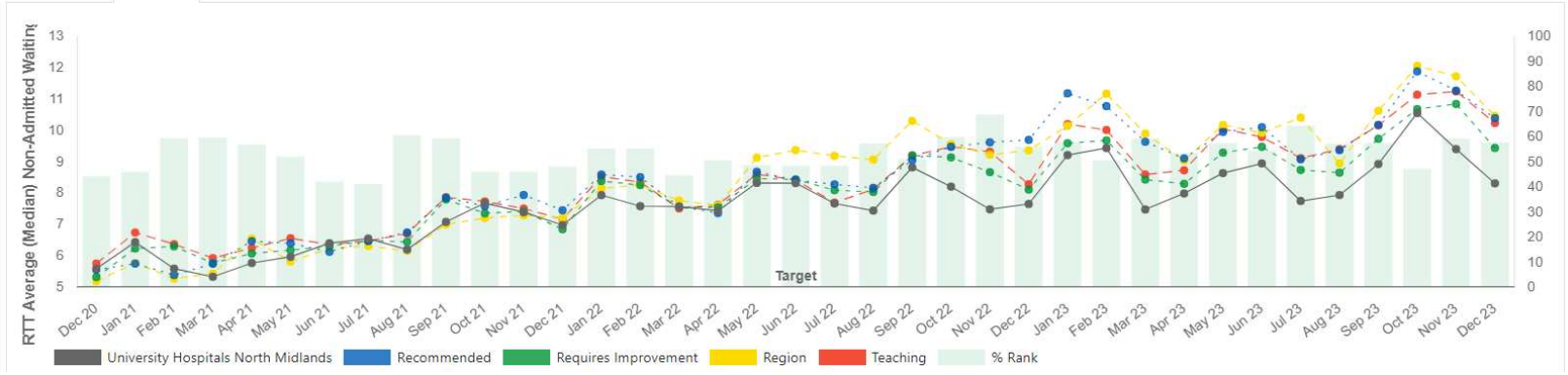
Ranking | Trend | Delta | SPC | ICS | Siblings | Data | Detail



RTT Average (Median) Non-Admitted Waiting Time

Dec 23 Performance: 8.3 | Rank: 71st of 167

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



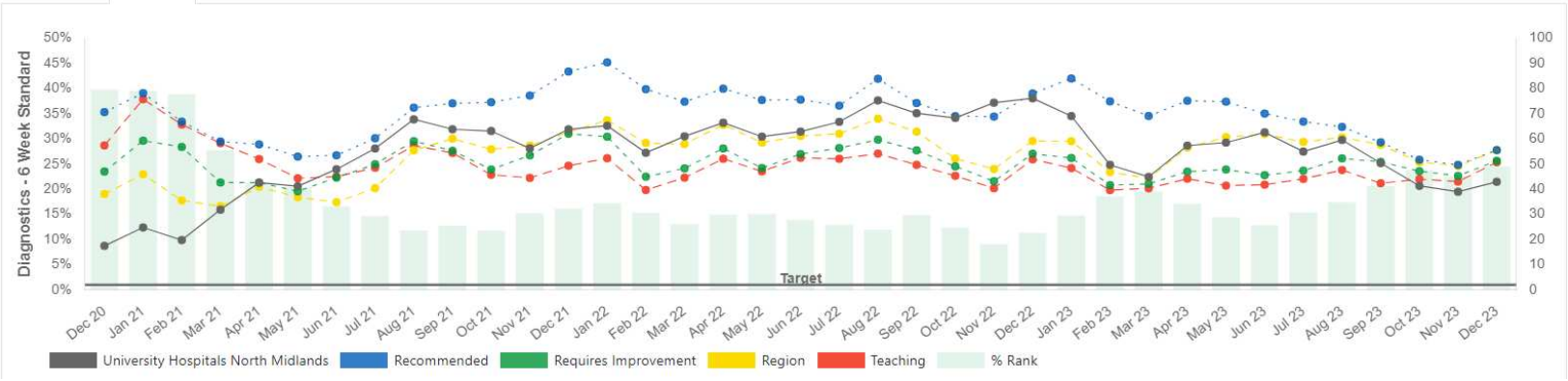
- The average wait (median) for patients at UHNM on an RTT admitted pathway has been at mid point between peers since September 2023, with all peers following a similar trend.
- All peer groups for those patients on a non admitted RTT pathway have improved since November 2023, with UHNM seeing the biggest improvement.

Diagnostics

Diagnostics - 6 Week Standard

Dec 23 Performance: 21.46% | Rank: 80th of 156

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



Key Performance Indicator	Period	Target		SPC
Audiology	Dec 23	1.00%	6.5%	
Colonoscopy	Dec 23	1.00%	68.3%	
Computed Tomography	Dec 23	1.00%	1.5%	
Cystoscopy	Dec 23	1.00%	6.2%	
DM01 Waiting <13 Weeks	Dec 23	100.00%	89.2%	
Diagnostics - 6 Week Standard	Dec 23	1.00%	21.5%	
Diagnostics - 6 Week Standard Reversed	Dec 23	99.00%	78.5%	
Echocardiography	Dec 23	1.00%	34.3%	
Electrophysiology	Dec 23	1.00%	-	
Flexi Sigmoidoscopy	Dec 23	1.00%	75.0%	
Gastroscopy	Dec 23	1.00%	46.8%	
Magnetic Resonance Imaging	Dec 23	1.00%	3.3%	
Neurophysiology	Dec 23	1.00%	16.1%	
Non-obstetric Ultrasound	Dec 23	1.00%	3.2%	
Sleep Studies	Dec 23	1.00%	21.2%	
Urodynamics	Dec 23	1.00%	0.0%	

- All peer groups are performing at a similar level.
- UHNM continue to perform better than all peer groups, despite a slight deterioration in December.
- 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.

Workforce

University Hospitals of North Midlands NHS Trust

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

Delivering Exceptional Care with Exceptional People

Workforce Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key messages

- The 12m Turnover rate in January 2024 improved slightly to 8.2% (8.3% in December 2023) which remains below the trust target of 11%.
- M10 vacancies improved to 8.46% (8.94% in December), influenced by a total increase of 70.32 FTE in post, across all staff groups, offset by a 12.99 FTE increase in the budgeted establishment, reducing the vacancy FTE by 57.33 FTE overall.
- For M10, the in-month sickness rate fractionally improved by 0.09% to 5.84% (5.93% in December 2023). The 12-month cumulative rate increased fractionally to 5.22% (5.20% in December 2023).
- Stress and anxiety continues to be the top reason for sickness in January 2024, but decreased by 1.1% in the last month to 23.2% (24.3% in December). Chest & Respiratory remains the second most common reason, at 13.7%, followed by Cold, Cough & Flu at 10.4%, which reflects the high numbers of reported Covid-19 cases.
- Employees may report covid-like symptoms on Empactis, but Managers are then recording this as either chest & respiratory, or cold & flu, on ESR, in the absence of a formal lateral flow test, following the cessation of symptomatic covid testing, since May 2023. During January 2024, the overall number of employees who reported Covid-19 slightly decreased to 329 episodes, on Empactis, from 391 cases in December 2023. However, managers reported 198 covid-related absences on ESR for January 2024, which is an increase on the 185 episodes reported in December 2023.
- January 2024's PDR Rate declined to 82.1% (82.8% in December 2023). The refreshed PDR paperwork, to support colleagues in achieving their potential, was published in January 2024, with twelve drop-in sessions taking place, to complement the new guides and electronic training materials which have been made available on the Intranet.
- The Statutory and Mandatory training rate on 31st January 2024 declined by 0.89% to 93.5% (94.4% on 31st December 2023). This compliance rate is for the 7 'Core for All' subjects only

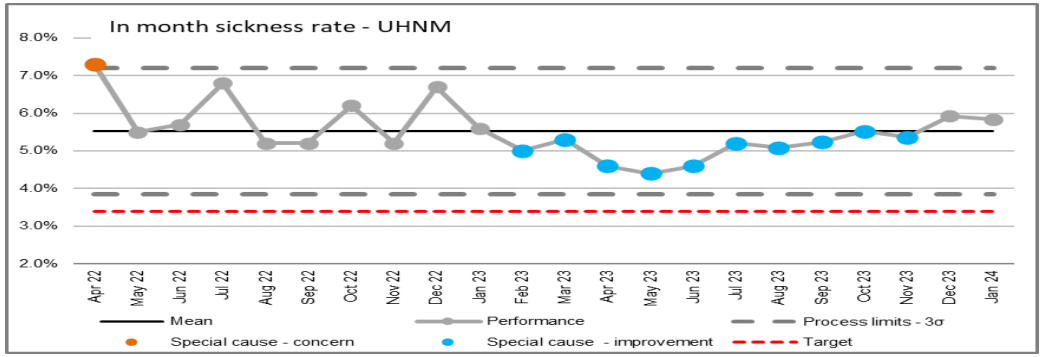
Workforce Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.84%		F
Staff Turnover	11%	8.19%	L	P
Statutory and Mandatory Training rate	95%	93.54%		F
Appraisal rate	95%	82.12%	H	F
Agency Cost	N/A	4.04%		P

Sickness Absence

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Nov 23	Dec 23	Jan 24
3.4%	5.4%	5.9%	5.8%

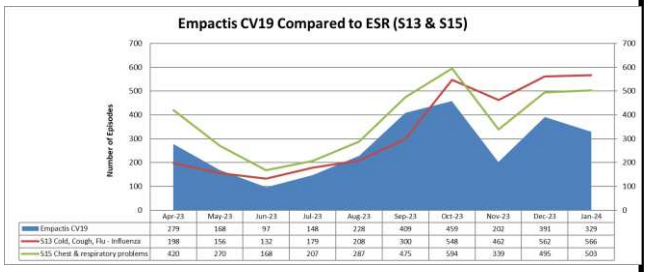
Background

Percentage of days lost to staff sickness

Summary

Org L2	Divisional Trajectory - March 2024	2023 / 02	2023 / 03	2023 / 04	2023 / 05	2023 / 06	2023 / 07	2023 / 08	2023 / 09	2023 / 10	2023 / 11	2023 / 12	2024 / 01	Trajectory
205 Central Functions	3.39%	4.03%	3.61%	2.80%	2.37%	2.81%	3.54%	3.46%	3.44%	3.82%	3.78%	3.92%	4.22%	↑
205 Division of Network Services	5.25%	4.51%	4.64%	3.91%	3.80%	4.00%	4.35%	4.82%	4.51%	5.30%	5.09%	5.58%	5.44%	↓
205 Division of Surgery, Theatres and Critical Care	5.25%	5.93%	6.47%	5.47%	4.90%	5.24%	6.62%	6.14%	6.11%	6.14%	6.14%	6.86%	7.33%	↑
205 Estates, Facilities and PFI Division	5.25%	5.65%	6.30%	6.00%	5.32%	5.09%	4.69%	5.11%	4.87%	6.13%	5.19%	4.35%	3.98%	↓
205 Medicine and Urgent Care	5.25%	5.05%	5.25%	5.10%	4.88%	4.78%	5.67%	5.35%	6.12%	6.26%	5.79%	6.45%	5.96%	↓
205 North Midlands & Cheshire Pathology Service (NMCPS)	4.50%	5.49%	5.61%	4.71%	4.68%	5.38%	4.71%	4.37%	4.82%	5.65%	5.00%	5.01%	5.64%	↑
205 Women's, Children's & Clinical Support Services	5.25%	5.00%	5.11%	4.63%	4.62%	5.09%	5.08%	5.01%	4.90%	4.92%	5.18%	5.92%	5.57%	↓

- For M10, the in-month sickness rate fractionally improved to 5.84% (5.93% in Dec-23).
- The 12-month cumulative rate increased fractionally to 5.22% (5.20% in Dec-23).
- Stress and Anxiety continues to be the top reason for sickness in January but decreased by 1.1% to 23.2% in Jan-24 (24.3% in Dec-23). Chest & Respiratory remains the second most common reason, at 13.7%, followed by Cold, Cough & Flu at 10.4%, which reflects the high numbers of reported Covid-19 cases.
- 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.



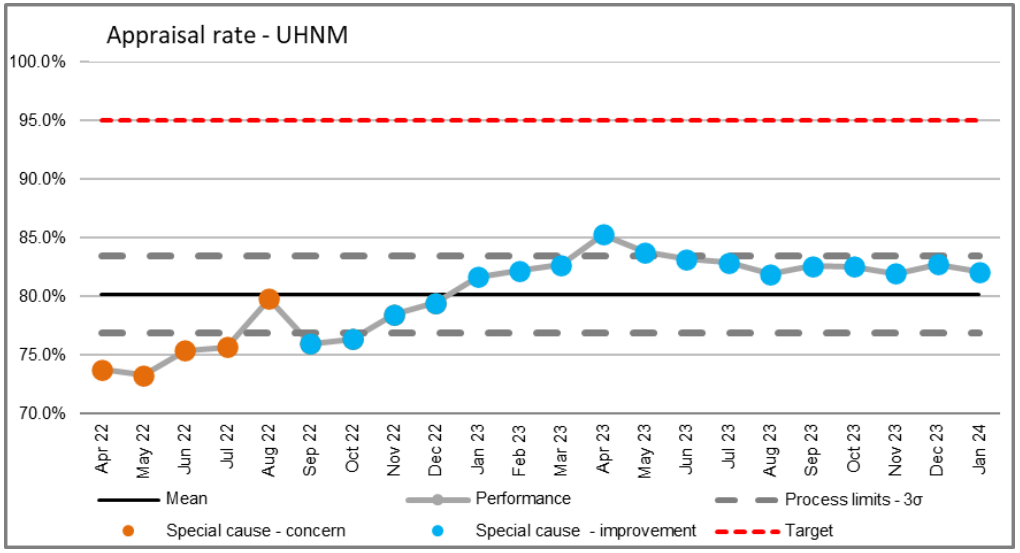
Sickness rate is consistently above the target of 3.4%.

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
H	F

Target	Nov 23	Dec 23	Jan 24
95%	82.0%	82.8%	82.1%

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 January 2024, the PDR Rate declined by 0.64% to 82.1%, compared to 82.8% for December 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.
- The new PDR documentation was published in January 2024, with twelve drop-in sessions taking place, to complement the new guides and electronic training materials which have been made available on the Intranet.

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.

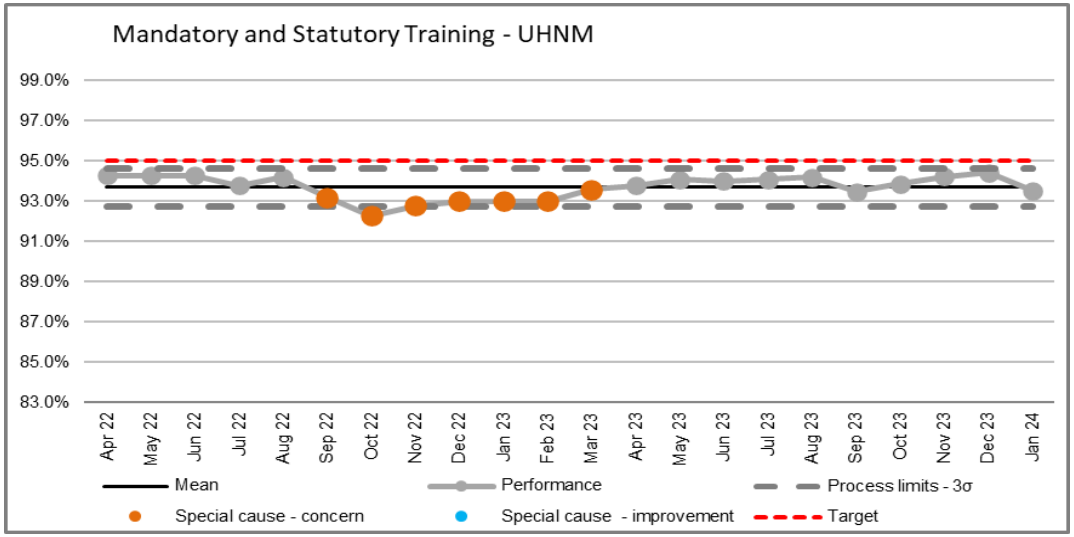
Network Division - Hold a dedicated weekly PDR compliance hotspot and assurance meetings

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

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
	F

Target	Nov 23	Dec 23	Jan 24
95%	94.2%	94.4%	93.5%

Background

Training compliance.

What is the data telling us?

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 January 2024 declined by 0.89% to 93.5% (94.4% on 31st December 2023). This compliance rate is for the 7 'Core for All' subjects only.

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|LOCAL|Security Awareness - 3 Years|	11580	11580	10884	93.99%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	11580	11580	11011	95.09%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	11580	11580	10942	94.49%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	11580	11580	11011	95.09%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	11580	11580	11074	95.63%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years	11580	11580	10905	94.17%
NHS|MAND|The Oliver McGowan Mandatory Training on Learr	11580	11580	10000	86.36%

Compliance rates for the Annual competence requirements were as follows:

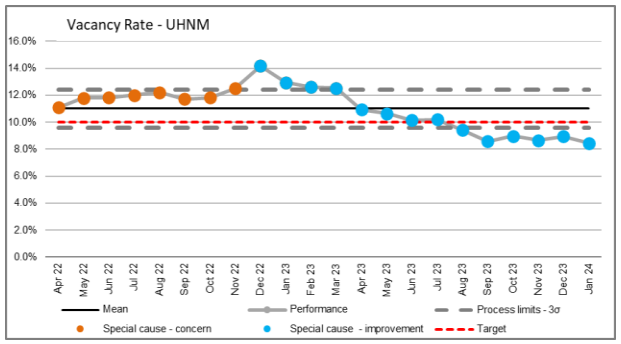
Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	11580	11580	8721	75.31%
NHS|CSTF|Information Governance and Data Security - 1 Year|	11580	11580	10420	89.98%

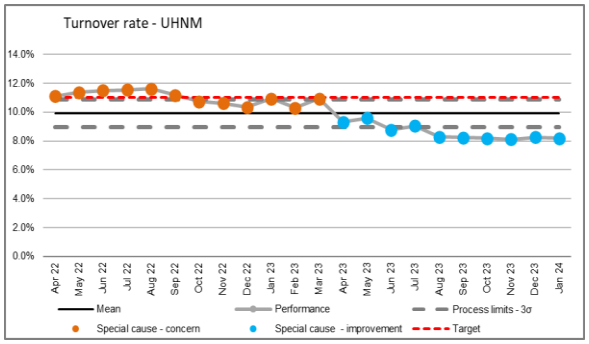
Actions

- 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 and Oliver McGowan Training are now reported as part of 'Core for All' subjects.

Workforce Vacancies and Turnover

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Nov 23	Dec 23	Jan 24
11.0%	8.1%	8.3%	8.2%

Background

Turnover rate

What is the data telling us?

The turnover rate for January 2024 remains below the trust target of 11%.

Turnover rate when measured against total staff in post improved slightly to 8.2% from 8.3% last month.

Low vacancies and turnover rates signify on-going successes in recruitment and retention processes.

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 January 2024 improved slightly to 8.2% (8.3% in December 2023) which remains below the trust target of 11%.
- The summary of vacancies by staff groupings highlights a 0.48% improvement in the vacancy rate over the previous month.
- M10 vacancies improved to 8.46% (8.94% in December). Colleagues in post increased in January 2024 by 70.32 fte, budgeted establishment increased by 12.99 fte, which reduced the vacancy fte by 57.33 FTE overall [*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 31/01/24]

Vacancies at 31-01-24	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,688.62	1,459.38	229.24	13.58%	15.19%
Registered Nursing	3694.75	3310.25	384.50	10.41%	10.77%
All other Staff Groups	6710.92	6302.09	408.83	6.09%	6.34%
Total	12,094.29	11,071.71	1,022.58	8.46%	8.94%

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"

Finance Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key elements of the financial performance year to date are:

- For Month 10 the Trust has delivered a year-to-date deficit of £2.1m against a planned surplus of £0.8m; this adverse variance of £2.9m is primarily driven by underperformance against the Trust's in year CIP target and unfunded additional winter escalation capacity that remained open through the year.
- The Trust has received £9.0m additional funding towards the cost of industrial action and other cost pressures for Month 1 to 7; this additional income was recognised in the Month 8 position. No additional funding has been received to cover industrial action costs incurred in December although for Performance Management purposes the Trust's yearend target has been adjusted to breakeven plus the impact of Industrial Action in December and January.
- The Trust has incurred £5.0m of costs relating to winter escalation capacity remaining open to Month 7 partially funded by £2.1m of additional funding from the local ICB. Winter and escalation costs from Month 8 are funded as part of the Trust's winter plan.
- To date the Trust has validated £37.0m of CIP savings to Month 10 against a plan of £45.8m. The Trust has recognised £4.3m of CIP due to an assumed reduction in the annual leave provision delivering 50% of the NR ICB stretch CIP target; the balance is expected to be delivered from a further reduction in the provision. 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.
- The Month 10 actual performance of a £0.9m surplus is in line with the Trust's Month 8 breakeven forecast for the year presented to the Committee in November.
- There has been £53.1m of Capital expenditure which is £4.8m below plan.
- The cash balance at Month 10 is £68.2m which is £3.8m lower than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	96.4		
	Expenditure - Pay	variable	57.5		
	Expenditure - Non Pay	variable	37.3		
Activity	Daycase/Elective Activity	variable	10,076		
	Non Elective Activity	variable	11,523		
	Outpatients 1st	variable	27,741		
	Outpatients Follow Up	variable	44,998		

Income & Expenditure

Income & Expenditure Summary Month 10 2023/24	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,014.4	84.7	87.8	3.1	845.5	852.1	6.5
Other Operating Income	87.8	7.3	8.6	1.2	73.4	74.7	1.3
Total Income	1,102.2	92.0	96.4	4.3	918.9	926.8	7.9
Pay Expenditure	(672.5)	(56.7)	(57.5)	(0.8)	(558.8)	(551.6)	7.2
Non Pay Expenditure	(403.4)	(34.1)	(37.3)	(3.2)	(337.4)	(357.9)	(20.5)
Total Operational Costs	(1,075.9)	(90.8)	(94.8)	(3.9)	(896.2)	(909.5)	(13.3)
EBITDA	26.3	1.2	1.6	0.4	22.8	17.4	(5.4)
Interest Receivable	2.9	0.2	0.4	0.2	2.4	4.8	2.4
PDC	(10.3)	(0.9)	(1.5)	(0.6)	(8.5)	(8.5)	0.0
Finance Cost	(19.0)	(1.6)	(1.6)	0.0	(15.8)	(15.8)	0.0
Other Gains or Losses	0.0	0.0	(0.0)	(0.0)	0.0	0.0	0.0
Total	0.0	(1.0)	(1.0)	(0.0)	0.8	(2.1)	(2.9)

The overspend of £2.9m is mainly driven by.

- an under delivery of CIP by £8.8m. The main CIP schemes behind plan at Month 10 are the ICB non-recurrent stretch of £4.3m and the divisional target of £6.6m.
- 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. Additional winter and escalation costs from Month 8 are funded as part of the Trust winter plan.
- The additional £9m funding received to cover the costs of Industrial Action and other pressures has been allocated to cover the additional pay costs incurred due to industrial action of £4.1m with the remaining £4.9m allocated against non-pay pressures.

Capital Spend

NHS University Hospitals of North Midlands NHS Trust

UHNM Capital Plan	2023/24 Plan/forecast £000	Movement £000	2023/24 Revised Plan/forecast £000	YTD Plan M10 £000	YTD Actual M10 £000	Variance M09 £000
Capital funding						
PFI & Loan Commitments	19.6	-	19.6	15.8	15.8	-
Base STP allocation	22.1	-	22.1	18.5	18.5	-
Share of ICB 2022/23 surplus re-distribution	0.7	5.9	6.6	5.5	5.5	-
Public Dividend Capital funding	19.3	8.2	27.4	-	-	-
Donated, granted other capital funding	5.0	1.0	6.0	2.9	2.9	-
Internal funding source (including capital receipts	2.7	(1.4)	1.3	-	-	-
Total Capital funding	69.5	13.7	83.1	42.7	42.7	-
Capital expenditure						
PFI & Loan Commitments	(19.6)	-	(19.6)	(15.8)	(15.8)	-
Pre-committed investment items (ICB						
Project Star	(20.7)	-	(20.7)	(18.8)	(17.9)	0.9
Other	(9.2)	1.8	(7.5)	(3.9)	(3.0)	0.9
Total Pre committed Investment items	(30.0)	1.8	(28.2)	(22.7)	(20.9)	1.8
IMT Sub Group Total Funding	(2.3)	-	(2.3)	(1.9)	(0.8)	1.1
Medical Devices Sub Group Total Funding	(2.4)	-	(2.4)	(2.3)	(2.2)	0.1
Estates Sub Group Total Funding	(3.6)	-	(3.6)	(1.9)	(2.0)	(0.1)
Sub-group brought forward from 2024/25	-	(1.5)	(1.5)	-	-	-
Health & Safety compliance	(0.2)	-	(0.2)	(0.1)	(0.1)	0.0
Net zero carbon initiatives	(0.1)	-	(0.1)	(0.1)	-	0.1
Central funding beds, mattresses, hoists	(0.1)	-	(0.1)	(0.1)	(0.1)	(0.0)
Total Sub Groups	(8.7)	(1.5)	(10.2)	(6.3)	(5.1)	1.2
New IFRS16 leases (previously classified as operating leases and charged to revenue)						
Lease liability re-measurement	(0.2)	(0.1)	(0.4)	(0.5)	(0.5)	-
IFRS 16 leases	(0.9)	(1.5)	(2.4)	(1.5)	(1.5)	-
Community Diagnostic Centre lease	-	-	-	-	-	-
IFRS16 funding offset	1.1	1.6	2.7	2.0	2.0	-
Total Internal Capital Expenditure programme	(58.2)	0.3	(58.0)	(44.8)	(41.7)	3.0
Additional CRL / Externally Funded PDC						
Wave 4b Funding - Lower Trent Wards	(1.6)	0.3	(1.3)	(0.5)	(0.4)	0.0
TIF 2 PDC CTS phase 1 - enabling slippage	(0.4)	-	(0.4)	(0.4)	(0.4)	-
TIF 2 PDC (Day Case Unit)	(2.7)	1.2	(1.5)	(0.6)	(0.6)	0.0
TIF 2 PDC (Women's Hospital)	(1.2)	0.6	(0.7)	(0.2)	(0.2)	(0.0)
PDC - additional General & Acute beds	(13.4)	2.0	(11.4)	(7.2)	(5.4)	1.8
PDC - Community diagnostic centre phase 1	-	(1.1)	(1.1)	(0.6)	(0.6)	-
PDC - Pathology LIMS	-	(1.3)	(1.3)	(0.8)	(0.8)	-
PDC - Frontline digitalisation EPR	-	(1.5)	(1.5)	-	-	-
Required NHSE plan re-phasing adjustment	7.2	(7.2)	-	-	-	-
Equipment - endoscopy CDEL (transfer from NCA)	-	(1.0)	(1.0)	-	-	-
Air heat boiler replacement PSDS Grant BC 510	(2.9)	-	(2.9)	(1.1)	(1.1)	-
Charitable funded expenditure	(2.1)	-	(2.1)	(1.8)	(1.8)	-
Total Additional CRL / PDC Funded expenditure	(17.1)	(8.1)	(25.2)	(13.1)	(11.4)	1.8
Total Capital Expenditure	(75.3)	(7.8)	(83.1)	(57.9)	(53.1)	4.8
Planned under/(over) spend	(5.9)	5.9	(0.0)			

At Month 10 capital expenditure was £53.1m against a revised plan of £57.9m, an underspend of £4.8m. Of the £43.3m expenditure, £15.8m is related to pre-committed items for the repayment of PFI and IFRS16 lease liabilities and PFI lifecycle expenditure. The main reasons for the underspend of £4.8m relate to the following schemes:

- Project Star is £0.9m behind plan based on costs from the latest statement of works, which showed an underspend in Month 10. A review of the forecast for the remainder of the financial year has been undertaken and as part of changes to the capital plan it is anticipated that expenditure will increase by £0.5m in 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.
- ED ambulance drop-off - enabling ward moves is £0.5m behind plan due to delays in finalising costs and the scope of work within the available funding. As part of the changes to the capital plan this scheme will be completed in 2024/25.

The IM&T sub-group is showing an underspend of £1.1m at Month 10, which is mainly due to delays in the radiation oncology equipment scheme (£0.75m) forecast with expenditure expected to be in line with plan at the year end.

The PDC funded scheme for general and acute beds is £1.8m behind plan at Month 10 and reflects the latest certified value of expenditure, the current underspend has been rephased over the remaining months of the financial year. Work is being undertaken to bring forward the equipment relating to the scheme from 2024/25 to reduce the level of overall slippage and impact of the additional costs in 2024/25.

The overall forecast for the 2023/24 capital plan is that capital funding and expenditure will be in line with plan at the year-end.

Balance sheet

Balance sheet as at Month 10	31/03/2023	31/01/2024			
	Actual £m	Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment *	627.6	647.3	644.3	(3.0)	Note 1
Right of Use Assets	18.8	15.8	16.0	0.3	
Intangible Assets	18.4	14.3	13.8	(0.5)	
Trade and other Receivables	1.4	1.4	1.4	0.0	
Total Non Current Assets	666.1	678.7	675.4	(3.3)	
Inventories	16.8	16.8	17.7	0.8	
Trade and other Receivables **	57.9	39.5	40.4	0.9	
Cash and Cash Equivalents **	84.0	72.0	68.2	(3.8)	Note 2
Total Current Assets	158.7	128.3	126.2	(2.1)	
Trade and other payables **	(134.0)	(123.2)	(122.9)	0.3	
Borrowings	(14.0)	(14.0)	(13.6)	0.3	
Provisions	(5.6)	(5.6)	(5.6)	0.0	
Total Current Liabilities	(153.5)	(142.8)	(142.1)	0.6	
Borrowings	(256.8)	(245.6)	(246.1)	(0.5)	
Provisions	(2.7)	(2.7)	(2.5)	0.1	
Total Non Current Liabilities	(259.5)	(248.3)	(248.6)	(0.4)	
Total Assets Employed	411.7	416.0	410.9	(5.1)	
Financed By:				-	
Public Dividend Capital	665.0	665.0	665.0	-	
Retained Earnings *	(427.5)	(423.2)	(428.0)	(4.8)	Note 3
Revaluation Reserve *	174.2	174.2	173.9	(0.3)	
Total Taxpayers Equity	411.7	416.0	410.9	(5.1)	

Variances to the plan at Month 10 are explained below:

Note 1. Property, plant and equipment is £3m lower than plan and reflects the slippage in the capital programme at Month 10. The main variances relate to lower than planned expenditure on a number of projects including the multi-storey car park, the PDC funded general and acute beds scheme, and lower than forecast spend by capital sub-groups. Expenditure is expected to be in line with plan at the year-end.

Note 2. At Month 10 our cash balance was £68.2m, which is £3.8m lower than the revised plan of £72m. Cash received is £12.8m higher than plan overall, of which £11m relates to the ICB block mandate including cash to cover the additional cost of industrial action.

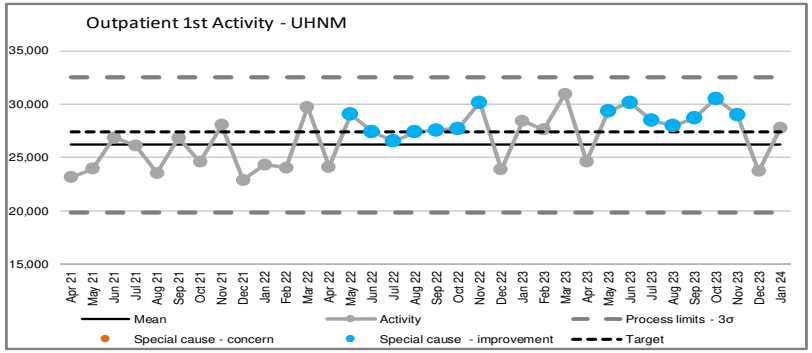
- Other income and VAT reimbursements are £7m and £2.5m ahead of plan and include higher than expected interest received and higher than planned cash received from ICBs that is not reflected in the block mandate. Capital funding (PDC Capital) is £8m behind plan as no requests for cash drawdowns in January had been submitted.
- Payments are £16.6m ahead of plan at Month 10. General and payroll related payments are £11m and £2.4m ahead of plan respectively and reflects the revenue deficit reported in previous months and the cost of covering industrial action.
- Capital payments are £1.9m ahead of plan and reflect the cash impact of the progress on the capital program and in particular the construction of the multi-storey car park.

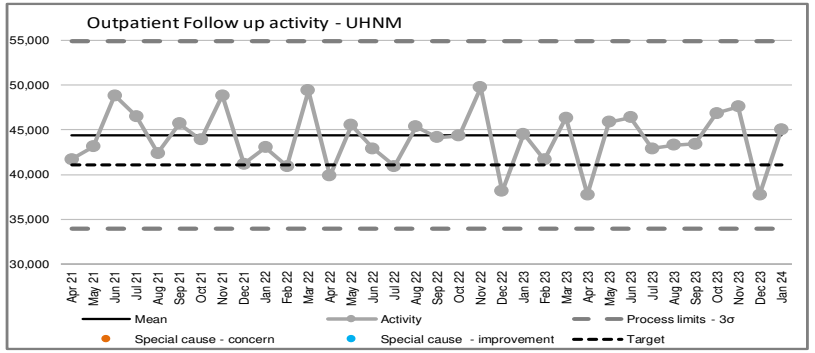
Note 3. Retained earnings are showing a £4.8m variance from plan which reflects the revenue variance from plan of £2.9m at Month 10. The remaining variance is due to lower than planned capital donated income (relating to donated capital expenditure) and higher than planned donated depreciation.

Activity

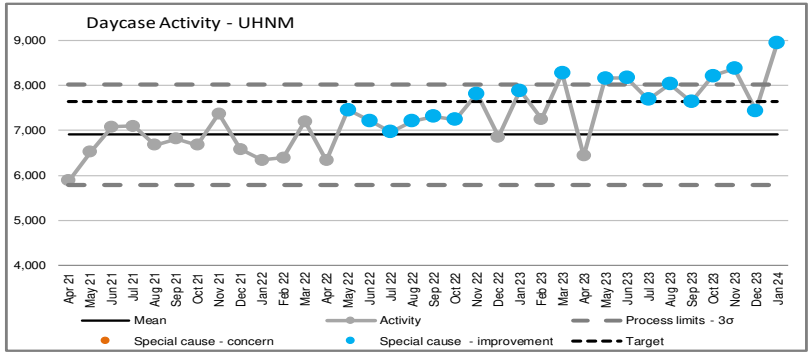
NHS
University Hospitals of North Midlands
NHS Trust

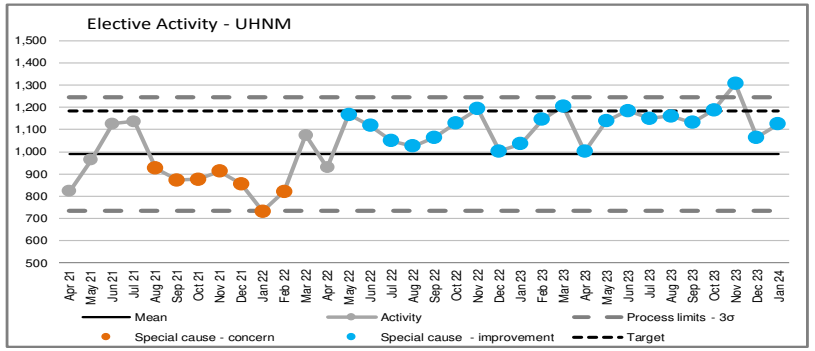
Planned care Outpatient



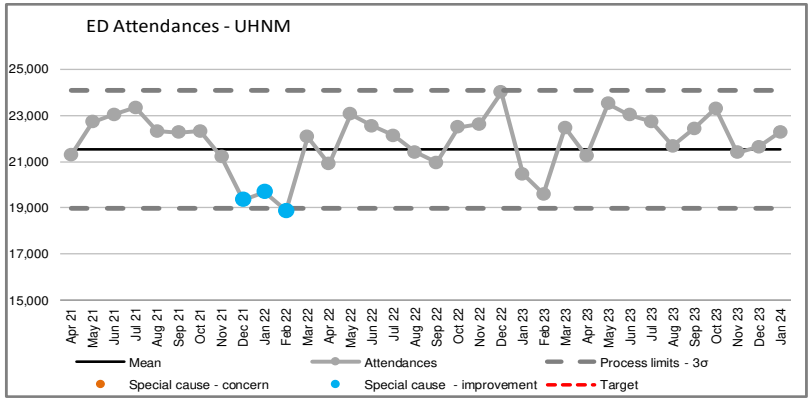


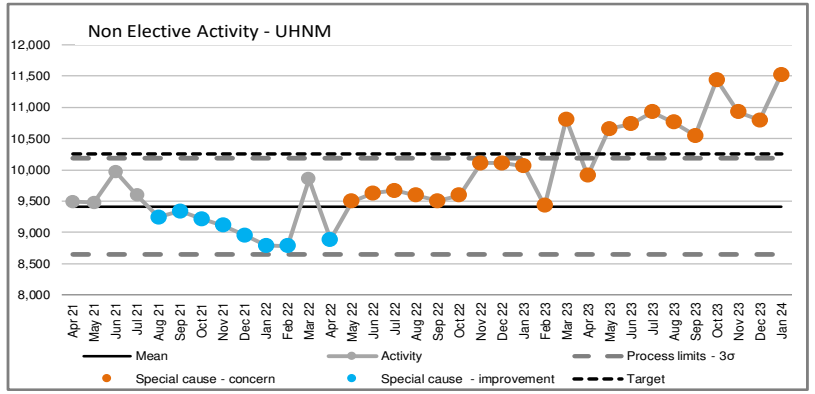
Planned care Inpatient





Urgent Care





Delivering Exceptional Care with Exceptional People

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th March 2024
Report Title:	Population Health and Wellbeing Strategy	**Agenda Item:**	16.
Author:	Matthew Missen & Elaine Andrews		
Executive Lead:	Helen Ashley, Executive Director of Strategy and Transformation		

Purpose of Report

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

Alignment with our Strategic Priorities

High Quality	x	People	x	Systems & Partners	X		
Responsive	x	Improving & Innovating	x	Resources	X		

Executive Summary

Situation

This paper sets out, the UHNM Population Health and Wellbeing Strategy 2024-27. The Strategy was considered and approved by the Transformation and People Committee in December 2023 and is being presented to the Trust Board for final approval.

Background

As part of the UHNM strategic planning framework, the population health and wellbeing strategy is the last of our Trust enabling strategies.

Assessment

There has been extensive engagement in developing this strategy, both internally and with our partners through dedicated workshops. The strategy shows our response to tackling health inequalities, preventing ill health and our wider role as a major local employer (an Anchor Institution). There is a clear link between this strategy and our people strategy through improving the health of our staff.

Overall responsibility for this strategy sits with Strategy and Transformation. Over the last year there has been considerable work undertaken, using our quality improvement methodology, to ensure there is robust delivery in place to support the implementation of this strategy, with a reconfigured health and wellbeing group and supporting workstreams for health inequalities (led by Strategy and Transformation), Prevention (led by corporate nursing) and Anchor (led by communications). With the support of dedicated public health resource, we have strengthened our links with local partners who are crucial in implementing this strategy (health, local authority and voluntary sector).

Key Recommendations

The Trust Board is asked to approve the population health and wellbeing strategy.

NHS
University Hospitals of North Midlands
NHS Trust

UHNM Population Health and Wellbeing Strategy

2024-2027

****draft and under design

Foreword

University Hospitals of North Midlands NHS Trust (UHNM) is proud of its role as a key organisation supporting local communities over many years as both a major employer of local people and a provider of NHS services. We are embedded in our local communities and influence the social, demographic and healthcare factors that determine the health of many local people.

We are pleased to welcome you to our Population Health and Wellbeing Strategy, outlining the actions we will take to improve the health and wellbeing of patients, staff and our local population.

We recognise that not everyone experiences equal opportunities to improve or maintain their health and some have poorer access, experiences, and outcomes from healthcare. We also know that a significant amount of illness and disability in our population can be prevented if behaviours and life experiences harmful to health can be avoided or stopped earlier in life.

Through partnership with other organisations and communities in our Integrated Care System (ICS), we aim to ensure that everyone has equal opportunity to access and benefit from the care we provide and contribute to collective efforts to address health inequalities in our population.

Helen Ashley
Director of Strategy and Transformation

Matthew Lewis
Medical Director

1. Introduction

The NHS Constitution explicitly states the NHS exists to improve health and wellbeing of the population, supporting people to keep mentally and physically well, to get better when ill and, when people cannot fully recover, to stay as well as they can to the end of our lives.

Over the past decade we have seen significant changes to the social and demographic profile of our local population. Our population has a shorter life expectancy compared to other areas in England and spends longer living with poor health. Stoke-on-Trent is the 13th most deprived unitary authority, and we know a growing number of local people are now living with chronic illnesses and disabilities which require increasing levels of care. We are faced with the challenge of how we support our population to remain active in their local communities through action on maintaining good health and wellbeing across their lifetime.

Many illnesses we are seeing in our clinics and services are preventable. Physical inactivity and excess weight, smoking and excess alcohol consumption are significant contributors to ill health. The impact of this results in increasing numbers of people living with cardiovascular disease, respiratory disease, musculoskeletal conditions, mental health, and cancer, many of whom become UHNM patients.

The Covid-19 pandemic highlighted the significant impact social and health inequalities have on the health of local people and communities. Population groups who are marginalised, live in deprived communities, and have other protected characteristics are at increased risk of preventable disease and premature death.

We see the impact of these inequalities. More patients from our deprived communities need a greater amount of care for long term conditions and experience increased emergency hospital attendances and admissions across their life course.

To address health inequalities and increase the prevention of illness there is a need to adapt our approach; providing high quality healthcare to all but offering targeted interventions to those who we know experience inequalities in access, experience, and outcomes.

There is an increasing recognition of the role we can play as a major employer to improve the wider determinants of health, influencing as much as 80 per cent of local people's long-term health status.

We need to work in partnership to address the needs of our local population. We are committed to playing our part as a member of the Integrated Care System (ICS) and will work to strengthen and develop our partnership approach with health and care organisations, as well as our local communities.

With the NHS Long Term Plan, the UHNM Vision and the Integrated Care Partnership Strategy all prioritising a focus for action to improve population health and wellbeing, this Strategy sets out how we will deliver our role in improving the health and wellbeing of our local population.

2. Our population

The Trust provides care for a catchment population of three million people across Mid and North Staffordshire, Stoke-on-Trent and parts of Cheshire, Shropshire and Derbyshire. With a workforce of more than 12,000 people, many employees are residents in local communities around the Trust.

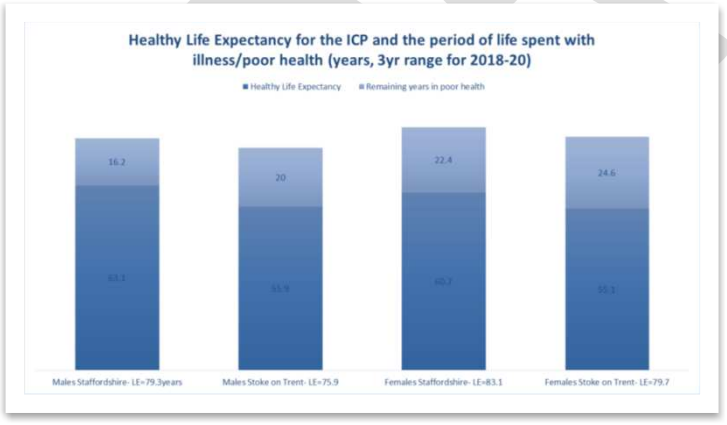
As part of this Strategy, we are undertaking a population health needs assessment to fully understand the health and wellbeing of the Trust's catchment population and the distribution of factors that influence health and wellbeing.

Demographic Profile of the Staffordshire and Stoke-on-Trent population

- In Staffordshire and Stoke-on-Trent the population is growing and demand for health and care services is increasing. Population growth from 2022-2032 is anticipated to be 4% in Staffordshire and 2% in Stoke-on-Trent, with much of this growth in the older population aged >65 years.
- Social and economic deprivation has a strong influence on health, with people living in more deprived communities more likely to experience social and health inequality. This has a stark impact in Stoke-on-Trent where 53% of the local population lives in the 20% of the most deprived communities in England.
- The 2021 census identified increasing ethnic diversity within the local population. In 2021, 13% of the Stoke-on-Trent population was born outside of the UK, with 16% of the population identifying as belonging to minority ethnic groups with Asian or Asian British being the largest.

Population Health Measures

- At a population level, improvements in population health have stalled. In some of the most deprived communities, measures of population health have worsened.
- Healthy life expectancy is the number of years people can expect to live in good health. Our local population can expect to live 56-63 years in good health but then between 16 and 22 years living in poor health. These measures are not equal. There is a difference of 18.6 years in healthy life expectancy between males living in the most and least deprived communities.

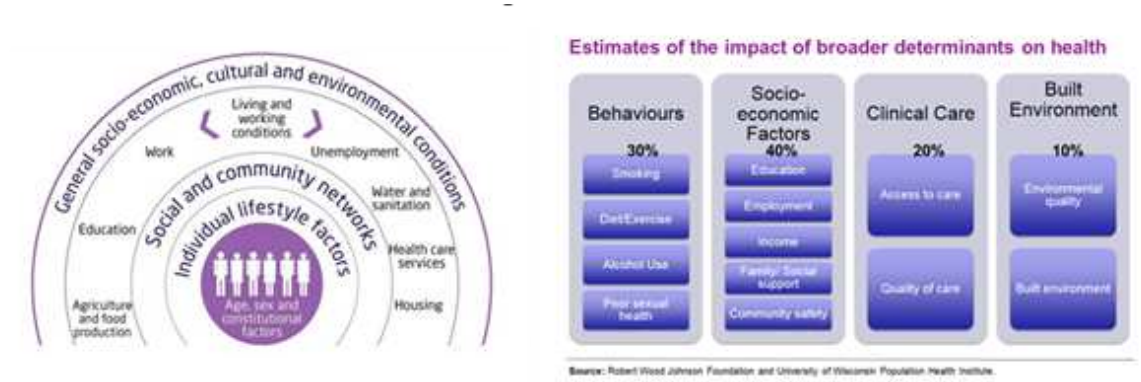


Wider Determinants of Health

- Evidence confirms around 80% of people's health is determined by their environment, social networks, culture, employment, income, and factors which influence behaviours and choices relating to health.
- In our area an estimated 27,200 children under 16 years are living in relative poverty, with 20,090 older people aged over 65 years living in income deprivation. In the current cost of living context these figures are expected to increase, with evidence that these population groups are at increased risk of poor health outcomes and emergency hospital admission due to the health impacts of poverty.
- Unemployment is also a risk factor for poorer health outcomes. An estimated 14,240 local people aged 16 to 64 years are claiming welfare entitlements due to being unemployed (February 2023). National evidence highlights that people who are unemployed are at increased risk of worse health outcomes.

Those people that have physical and learning disability or long-term conditions experience barriers to employment, despite evidence that good employment can benefit health and wellbeing.

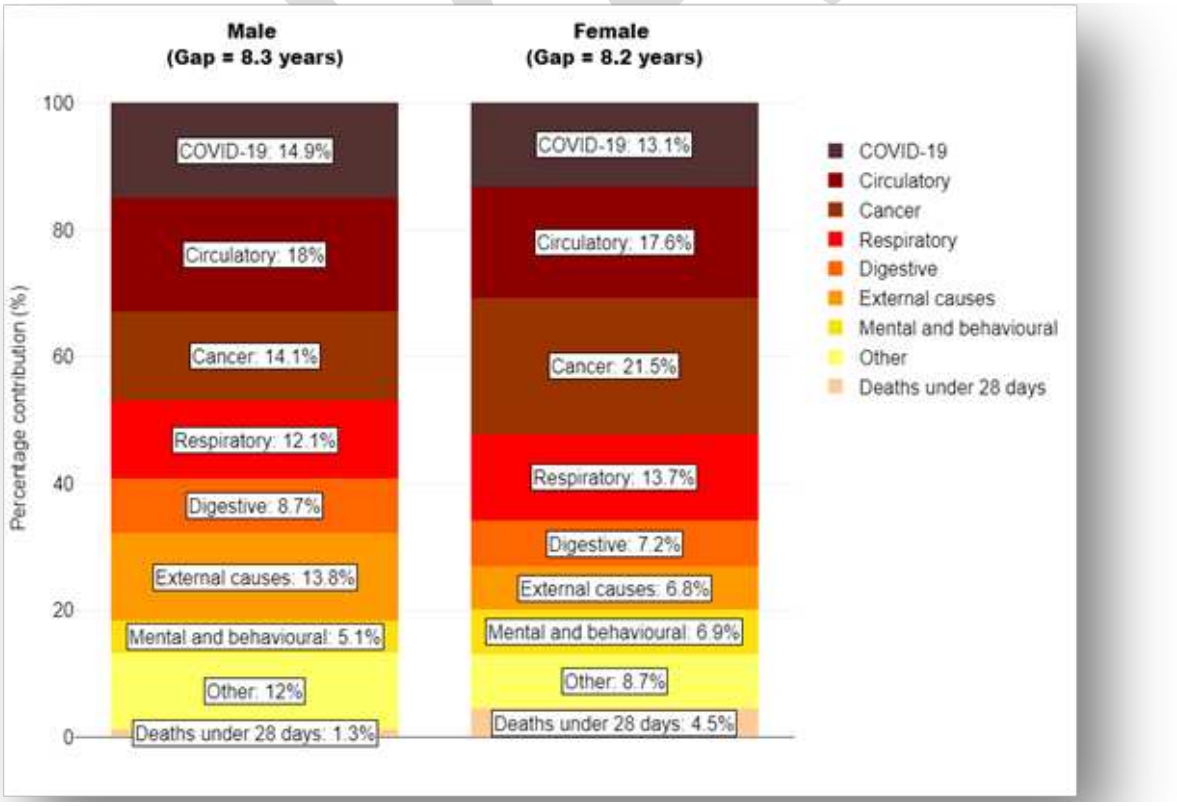
- Recent years have seen decreasing smoking prevalence, but work needs to be done until the harm from smoking has stopped. Smoking prevalence is strongly associated with deprivation. Locally the prevalence of smoking varies from 8.5% of the population identified as currently smoking in Staffordshire Moorlands compared to 16.5% in Stoke-on-Trent.
- Inclusion health groups and those living in the most deprived communities experience a greater number of social barriers and inequality that make it much harder to access a healthy balanced diet, opportunity for physical activity, attend routine or preventative healthcare appointments like screening.



Source: Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?

Healthcare

Population health data shows that that more deprived communities and inclusion health groups experience more preventable illnesses. They are more likely to see their illness progress to become more severe or develop multimorbidity. Circulatory disease, cancer, respiratory disease, health impacts of alcohol, suicide and infant mortality are priority population health outcomes where increased prevention could help reduce inequalities in health and mortality.



3. How have we developed this strategy?

This strategy is driven by our population's health and wellbeing needs. We have used existing Joint Strategic Needs Assessments along with Health and Wellbeing Strategies, Integrated Care Partnership Strategy, and the NHS Long Term Plan to understand national and local priorities to improve the health and wellbeing of our population.

The views and expertise of our clinical teams provide valuable insight into the health and wellbeing needs of our local population. Importantly many employees are part of the local population, so linking employee health and wellbeing initiatives forms an important element of this strategy.

To support the development and implementation of the strategy we have formed a Health Inequalities and Prevention Steering Group. Leads have engaged widely to seek views, through meetings with those that work in services supporting prevention, inclusion health groups, and those groups that have taken action to address identified health inequalities in patient groups and the population.

4. Alignment to our Trust Strategy

To help us to achieve the UHNM Strategy, we have developed supporting strategies that underpin our vision, values and strategic priorities. This Population Health and Wellbeing Strategy has been identified as a core supporting strategy.
There is a key link between this strategy and our People strategy. Supporting our people to be healthy and well, both physically and psychologically, will also have a wider population benefit.

We have an established strategic planning framework, with six strategic priority domains. This strategy is directly linked to our strategic priority objective of working together to improve the health of our population.

5. Where do we want to get to?

Vision: We will work in partnership to deliver exceptional care that is inclusive and enables patients, people and communities to have ownership of their health and wellbeing.

Priority 1: Health Inequalities

UHNM Health Inequalities and Prevention group	Health Inequalities as Core Business	Data Collection	Population Health Management	ICS Health Inequalities Programmes
Establish a multi-disciplinary Trust Health Inequalities and Prevention Group which will deliver action on health inequalities and prevention agenda within the trust and implement the Strategy	Develop an approach that places health inequalities within core business of the Trust, systematically considering and addressing health inequalities in decision making, planning and delivery	Consistently collect the data needed to identify and understand health inequalities, meeting equality requirements and inform equality, diversity and inclusion priorities across the Trust.	Develop a systematic approach to using population health management programme to identify and address health inequalities through evidence based service improvement and development	Work with system partners to develop an approach to meet national requirements focused on health inequalities including Core20Plus5 programme framework

Priority 2: Prevention

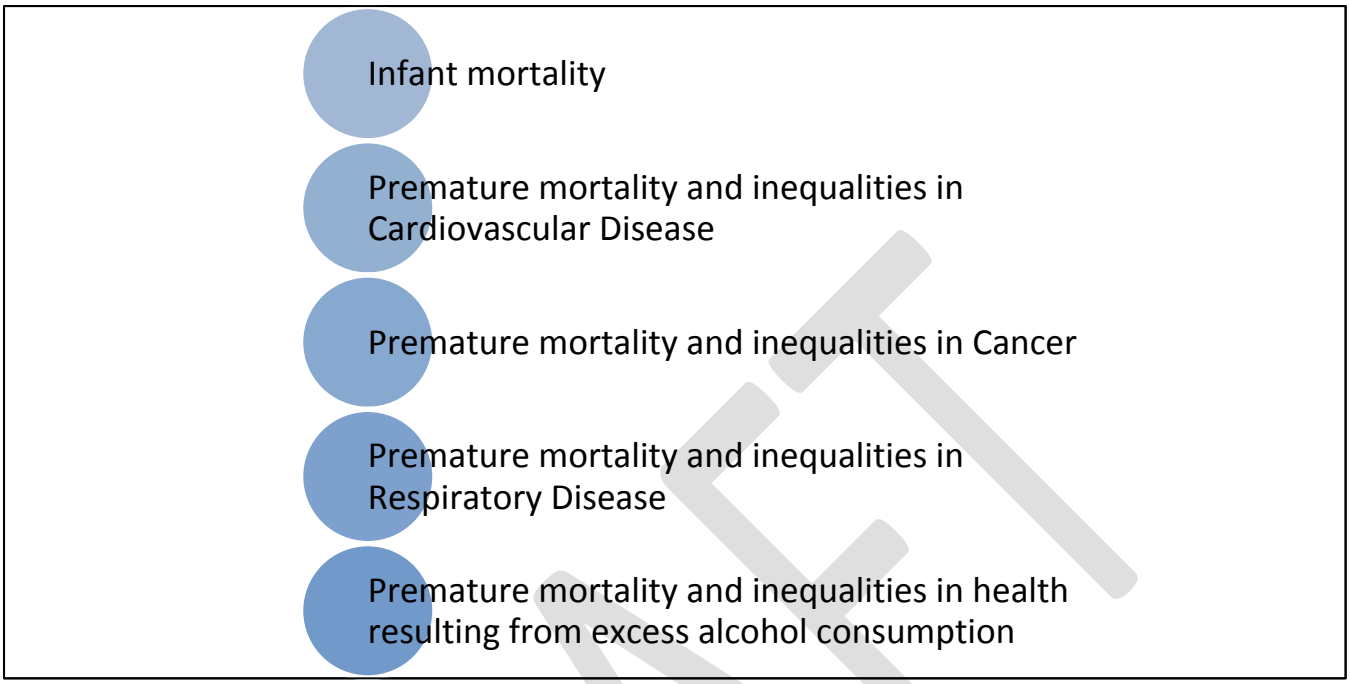
Prevention as Core Business	Targeted Health Promotion	Partner on prevention	Patient Centred Care	Digital Solutions
Offer opportunistic evidence based preventative interventions to patients in the hospital setting Ensure staff delivering direct patient care are enabled to deliver MECC approach and brief interventions Promote positive behaviour change in patients whilst attending or admitted to hospital	Understand and prioritise care for those with greatest capacity to benefit. Target anticipatory care to prevent complications from illness and emergency admissions in patients with frailty and/or long term conditions.	Support the local delivery of Prevention programmes with ICS partners Identify opportunities to integrate care pathways to provide enhanced prevention offer for patients, reflective of local needs.	Utilise personalised care approach to prevent complications and adverse health events in those living with long term conditions. Identify opportunities to integrate care pathways to provide enhanced prevention	Make use of digital solutions to improve health and wellbeing, independence and self-manage long term conditions. Utilise digital tools and media to improve health literacy, encourage behaviour change and direct them to resources and services that can support them.

Priority 3: UHNM as an Anchor Institution

UHNM as an Anchor Institution	Community Involvement	Patient Centred Care	Our People Strategy	Health Promoting Workforce
We will strengthen our communities through creation of pathways into employment for local people, making best use of our estate, resources and procurement to improve local social networks, economy and environment	We will partner with communities and inform the development of services through engagement, increasing involvement from communities in decisions and learning from those exposed to social and health inequality	Work in partnership with communities and ICS partners to inform integrated models of care to integrate health improvement services into health and care pathways, developing person centred models of care	The Trust will continue to deliver the People Plan and acknowledge the contribution of good health and wellbeing in staff to the quality of care for patients We will continue to develop the heath and wellbeing offer to staff to improve and protect their physical and mental health	We will enable our staff to promote healthy choices to patients, family and friends, developing a culture that promotes optimal health and wellbeing for all people

6. How will we measure our success?

To measure our progress, an outcomes framework (Appendix 1) that reflects a focus to reduce health inequalities and prevent ill health is under development with input from partners. This encompasses:

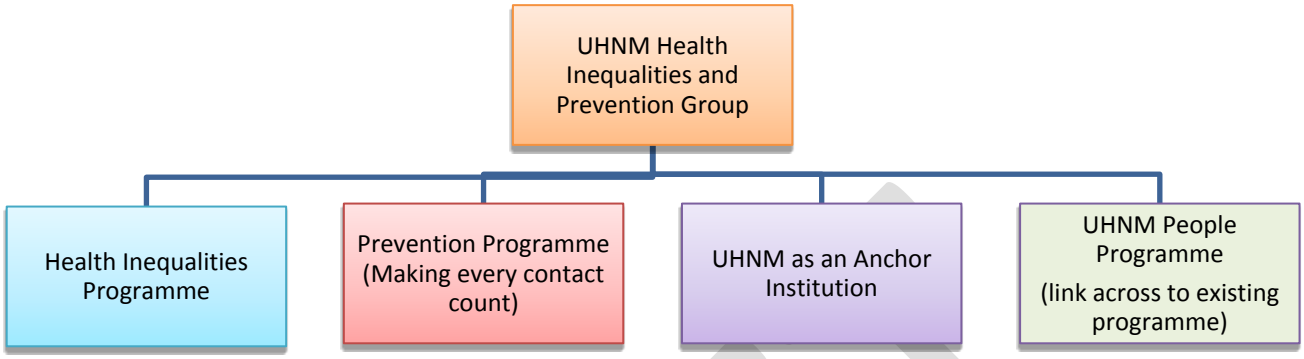


The Trust Anchor Institution Programme will measure progress using the following proposed outcomes:

When aiming to improve population health and wellbeing outcomes it is important to acknowledge that whilst UHNM can make a significant contribution to improvements in outcomes, overall success is heavily dependent on broader plans and action across the Integrated Care Partnership, Integrated Care System, and society.

7. How will we get there?

A Health Inequalities and Prevention Steering Group has been established. This will report through to the Trust's Transformation and People Committee and has oversight delivery of the strategy's objectives and delivery plans. The steering group will be supported by working groups supporting the delivery programmes.

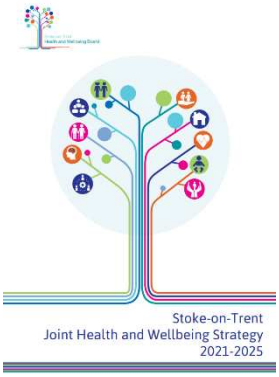


As we move forward, we will continue to engage with our employees, ICS partners and communities to understand opportunities to increase the positive impact of existing services and initiatives supporting the strategy's objectives. This will include identifying and developing integrated approaches with ICS partners to innovate and expand existing good practice.

8. Alignment to System Plans

Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy outlines how the Integrated Care Partnership plans to improve population health and wellbeing, address inequalities in access, experience and outcomes from health and social care services. It seeks to work in partnership with communities to achieve social, economic, and environmental development in local communities. This overarching strategy reflects existing Health and Wellbeing Strategy and priorities which were identified in Joint Strategic Needs Assessment and from engagement with local communities.

Staffordshire Health and Wellbeing Strategy 2022-27 outlines the key priorities and actions the Board will take to improve health and wellbeing in the Staffordshire population. It is based on data Staffordshire County Council has gathered on local issues, health need, and feedback from local people. The strategy promotes a system-wide ambition to improve health and wellbeing outcomes for local people and complements the approach of organisations in Staffordshire. It also forms a key part of the wider vison for the ICS.



Stoke-on-Trent Joint Health and Wellbeing Strategy 2021-25 outlines the Stoke-on-Trent plan for reducing health inequalities and improving health and wellbeing for residents of all ages. It is based on the Joint Strategic Needs Assessment for the city and engagement with stakeholders and the public to understand local priorities for action. The strategy has defined objectives for each priority and indicated outcomes and measures for partners to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing. It recognises the need to work better together on wider services such as housing, transport, the environment, and the local economy.

9. Alignment to National Policy

NHS Long Term Plan (2019): Defines how the NHS will increase its use of population health management to improve the prevention of ill health and adverse experience. In addition, addresses health inequalities as an integral part of its activities and the need to work in partnership with the ICS.

NHS People Plan 2023: The NHS People Plan reflects how employee health and wellbeing will benefit those working in the NHS, their families, patients, and the local population.

Implementing phase 3 of the NHS response to the Covid-19 pandemic (2020): Specifies how we will take action to address inequalities in NHS provision and outcomes from the Covid-19 pandemic and support equitable recovery of NHS Services.

Core20Plus5 framework for Adults and Core20Plus5 framework for Children and Young People are the national NHS England approach to inform action to reduce healthcare inequalities at both national and system level.

The approach defines a target population – the 'Core20PLUS' – and identifies five clinical areas requiring accelerated improvement. Core20 is defined as the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). PLUS population groups are identified in the Integrated Care Partnership Strategy. These are recognised population groups with particular characteristics that experience health inequality. These include people from ethnic minority communities; people with a learning disability and autism; people with multiple long-term health conditions; and other groups that share protected characteristics as defined by the Equality Act 2010.

10. Resources Required

This strategy is led through the Strategy and Transformation Team, using public health expertise, which forms as essential component of our strategic plan. There is already expertise within our specialities which is providing essential capacity to deliver this strategy. Implementing this strategy will involve people from all areas in the Trust as well as people from our communities.

Population Health Management (PHM) capability is essential in informing the intelligence needed on health inequalities and the target prevention intervention needed for those with greatest capacity to benefit. To develop this, we will seek Population Health Management support from the ICS.

Financial investment from NHS England, Staffordshire and Stoke-on-Trent Integrated Care Board and other funding organisations will be key in enabling us to innovate and expand good practice that achieves an impact on patient or population health and wellbeing outcomes. Where available we intend to apply for grant funding and seek recurring investment as part of an 'invest to save' approach.

11. How will we communicate this strategy?

We are building an engagement programme across the organisation. To progress our partnership approach, an engagement workshop has taken place to seek the views, feedback and perspective of key partners in the Staffordshire and Stoke-on-Trent ICS.

As we further develop our work programmes, we will put the views and experiences of our workforce, patients and people living in local communities at the centre of developments and improvements. We will work with engagement leads, partner organisation and local communities to understand lived experience and what people need to live healthier and more fulfilling lives. Importantly we will focus on engaging with those who are socially marginalised and experience health inequalities.

12. How we will ensure equality, diversity and inclusion?

This strategy advocates for a systematic Trust-wide approach to improving health equity and address health inequalities in our population, both internally and in partnership with others. In working towards achieving health equity in our workforce and population and ensuring that every person has a fair opportunity to achieve their best health, we support the advancement of equality and diversity as central to how we deliver care and conduct business.

We are proud to be an employer of a diverse local workforce and we are committed to championing equality, diversity and inclusion. We will champion equity of opportunity to realise the health and wellbeing benefits from employment. Inequalities in our local population will be reflected in our workforce, many of who are local residents. How we employ our people and offer them support with maintaining or improving their health and wellbeing we can realise a positive impact on the health and wellbeing of not just our workforce but also their families and the wider community.

We know health inequalities exist in our local population. The Trust recognises that each patient is a unique individual and that some people will need different treatments to achieve fair and inclusive access, experience, and outcome from care. In taking a more systematic and focused approach to identifying, understanding, and taking action on health inequalities, we will advance equity of opportunity for local people to maximise their health and wellbeing. In doing so, we aim to provide more inclusive services that are reflective of our diverse population's needs and contribute to ICS's efforts to address health inequalities.

By doing this, we will support meeting our statutory duties outlined in the Trust's Equality, Diversity and Inclusion Policy encompassing the Equality Act (2010), Public Sector Equality Duty (PSED) and the Human Rights Act (1998), as both an employer and service provider.

Reflecting our strategic commitment to health inequalities and how this supports equality, diversity and inclusion, we will strengthen consideration of equity and impact on health inequalities in all decisions through impact assessments and other processes using Health Inequality and Equity Impact Assessments.

13. Strategic Delivery Plan

Year 1	Year 2	Year 3
Health inequalities		
• Promote opportunities for service-based response for CORE20PLUS5. • Use data and engagement to increase understanding of where health inequalities may exist within our elective backlog. • Work with ICS partners to understand Core20Plus5 needs in our population using PHM. • Develop new ways of working to systematically identify and address health inequalities. • Scope and develop the Trust's contribution to partnership strategy and actions on specified outcomes with capability to collect necessary data on Trust outcomes framework.	• Develop evidence-based framework to initiate action on health inequalities. • Further develop the Core20PLUS5 approach. • Link service teams with academic networks and institutions to identify areas to research new ways for tackling inequalities. • Embed approaches to reduce waiting list inequalities. • Develop a Trust approach to use of population health management to identify, understand and address health inequalities.	• Build on the implementation of an evidence-based framework to embed action on health inequalities. • Be undertaking a higher proportion of interventions with partners. • Routinely undertaking and sharing our experiences, best practice, and research.
Prevention		
• Embed tobacco dependency treatment for our inpatients. • Secure ongoing resource for the Trust's alcohol care team. • Develop approach for prehabilitation. • Recommend how to progress tier 3 and 4 weight management services. • Complete pilots to understand how the skills and confidence for our people to make every contact count.	• Develop new ways to tackle obesity. • Expand our approach for prehabilitation, as a key component in pre-operative care. • Roll out the skills and confidence for our people to make every contact count.	• Seek to embed tobacco dependency treatment and lifestyle support at every point of contact with our services. • Embed approach for prehabilitation. • Embed the skills and confidence for our people to make every contact count.
Anchor organisation		
• Scope actions undertaken by us and partners against our anchor institution framework. • Develop specific programmes to improve the wider determinants of health with a focus on employment and sustainability. • Develop community programmes establishing and strengthening partnership with other organisations and local community networks to put people and communities at the centre of our work.	• Identify opportunities to expand good practice. • Instigate new initiatives to address priority gaps within our framework for action. • Continue to support system and partner initiatives in developing our anchor institution (e.g., Marmot ICS approach).	• Refine and expand the actions being undertaken. • Evaluate the impact of our interventions.

Appendix 1: Health inequalities, prevention and Anchor institution outcomes framework

Reduce infant mortality

- Reduce inequalities in early booking for antenatal care (% booked at 10 weeks gestation)
- Reduce DNA to antenatal appointment
- To offer personalised and continuous care, prioritising high risk groups for continuity of care.
- Reduce the rate of low birthweight at delivery
- Reduce the rate of premature birth
- Improve management of obesity and complications from excess weight durng pregnancy
- Improve maintainence of healthy weight during pregnancy
- Improve uptake of maternal vaccinations (flu, pertussis and covid-19)
- Reduce the rate of smoking at time of delivery
- Reduce the rate of maternal alcohol consumption during pregnancy
- Improve self-reported mental health in mothers and families.
- Improve self-reported health literacy on safe sleeping, preventing accidents in the home and managing disease.
- Improve breastfeeding rates at 6-8 weeks

Reduce premature mortality and inequalities in Cardiovascular Disease

- Improve rates of diagnosed hypertension, familial hypercholesterolaemia, CKD and atrial fibrillation in the population
- Improve and reduce inequalities in early diagnosis and treatment of angina, heart failure, heart attacks
- Improve initiation of treatment for stroke within 4.5 hours
- Improve and address inequalities in coverage of AAA screening programme
- Reduce inequalities in emergency admissions in those living with diagnosed CVD
- Increase documented delivery of personalised care approach in diagnosed CVD patients under Trust management
- Improve self-reported quality of life measures in diagnosed CVD patients under Trust management
- Increase coverage of smoking cessation in current smokers attending or inpatient in UHNM
- Improve delivery of alcohol screening and brief interventions in all adults attending the Trust
- Improve opportunistic identification and referral of eligible patients to weight management using MECC approach

Reduce premature mortality and inequalities in Cancer

- Improve stage of diagnosis to achieve 75% of cancer diagnosed at stage 1 or 2 by 2028
- Reduced inequality in waiting times from referral to diagnosis and diagnosis to treatment
- Reduce DNA and loss to follow up during diagnosis and treatment
- Reduce unwarranted variation in use of rapid diagnostics to improve access to Cancer Diagnosis
- Improve NHS cancer screening programme coverage and address inequalities in uptake for programmes delivered by UHNM
- Reduce and address inequalities in the proportion of cancers diagnosed through emergency portals
- Increase documented delivery of personalised care approach in diagnosed Cancer patients under Trust management
- Improve patient reported measures of self-management and quality of life in Cancer patients under Trust management
- Improve self-reported health literacy on cancer symptoms and appropriate healthcare seeking behaviours.
- Increase coverage of smoking cessation in current smokers attending or inpatient in UHNM
- Improve delivery of alcohol screening and brief interventions in all adults attending the Trust
- Improve opportunistic identification and referral of eligible patients to weight management using MECC approach

Reduce premature mortality and inequalities in Respiratory Disease

- Improve early diagnosis of asthma and COPD
- Improve management of asthma in children and young people aged <18 years to address inequalities in rate of emergency inhaler use (salbutamol)
- Increase uptake of flu and covid-19 vaccinations in those eligible living with respiratory disease
- Improve uptake of Lung Health Screening
- Increase coverage of smoking cessation in current smokers attending or inpatient in UHNM
- Improve patient reported confidence in self-management of asthma and COPD
- Address inequalities in emergency admissions in those living with diagnosed asthma to reduce overall rate
- Address inequalities emergency admissions in those living with COPD to reduce overall rate
- Increase documented delivery of personalised care approach in patients diagnosed with respiratory disease under Trust management
- Improve patient reported measures of self-management and quality of life in patients diagnosed with respiratory disease under Trust management

Reduce premature mortality and inequalities in health resulting from excess alcohol consumption

- Reduce rates of hospital admission for alcoholic liver disease
- Reduce rates of hospital admission due to alcohol specific conditions
- Reduce rates of hospital admission due to alcohol related conditions (narrow and broad definitions)
- Reduce incidence of alcohol related cancer
- Improve detection of early stage alcoholic liver disease
- Increased delivery of alcohol screening and brief intervention by Alcohol Care Team
- Increased referrals from UHNM Alcohol Care Team to local Alcohol Treatment Services
- Reduce loss to follow up in referrals to local Alcohol Treatment Services
- Contribute to increased delivery of integrated care for people living with co-occuring mental health, drug and alcohol misuse
- Reduce episodes of alcohol related violence in Trust care settings.

Reduce unemployment locally in target populations	• More young people entering healthcare education, career or apprenticeships • Trust workforce is diverse and more representative of the communities it serves (at all staffing levels) • Trust workforce report feeling supported to stay in employment with the trust • Reduce in-work poverty and increase financial support among those employed by the trust
Increase investment of wealth in local areas through NHS capital development to deliver social value	• Trust supply chain increases investement for social value through weighting in procurement • Increased proportion of suppliers in Trust supply chain who explicitly contribute to local employment and sustainability goals • The Trust is an active partner in local communities through investment into community assets
Minimise the negative impact of Trust Services and Estate on the local environment to progress towards NHS net zero	• Reduce carbon emissions and waste from healthcare • Reduce carbon emissions from fleet services • Invest in active and sustainable travel for staff and patients • Minimise negative impacts on the environment from hospital food supply
Maximise staff health and wellbeing	• *Outcomes and domains for delivery for this component of the Trust Anchor Instituion Approach are delivered through UHNM People Strategy*

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th March 2024
Report Title:	Performance & Accountability Framework 2024-2026	**Agenda Item:**	17.
Author:	Claire Cotton, Director of Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

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

n/a	*There are no specific risks relating to this framework although reference to the BAF is made within*

Executive Summary

Situation

The Performance and Accountability Framework sets out our arrangements for holding the organisation to account including corporate and divisional governance and performance management. Whilst the review period is on a two-year cycle, it has undergone a refresh and is being presented to the Board for approval. The key changes are summarised below.

Background

The Framework was initially developed and approved by the Board in August 2020. It was revised in October 2022 where our revised performance management arrangements were incorporated, aligned with the approach used as part of our Improving Together programme.

Assessment

The Performance and Accountability Framework sets out how it supports achievement of the Well Led Framework although there are two specific Key Lines of Enquiry (KLOE) that it underpins. The framework has been developed with an aspiration to become 'Outstanding' in these domains and the characteristics of those two specific KLOEs are as follows:

KLOE		Characteristics of Outstanding
W4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?	Governance arrangements are proactively reviewed and reflect best practice. A systematic approach is taken to working with other organisations to improve care outcomes.
W5	Are there clear and effective processes for managing risks, issues and performance?	There is a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviews how they function and ensures that staff at all levels have the skills and knowledge to use those systems and processes effectively. Problems are identified and addressed quickly and openly

The most significant change to the Framework following this review has been the revised **Corporate Governance Structure**, which now features the following:

- The separation of the Transformation & People Committee into the 'People, Culture & Inclusion Committee' and the 'Strategy & Transformation Committee' which have operated in shadow form during quarter 4 2023/2024

- The introduction of an 'Executive, Finance, Operations and Activity Group' which will be led by the Chief Operating Officer and the Chief Finance Officer and will be accountable to the Performance and Finance Committee
- A direct line from the Professional Standards and Conduct Group into the People, Culture & Inclusion Committee (previously sat beneath Executive Workforce Assurance Group) which will be a report included on the Annual Business Cycle
- Greater clarify on divisional governance expectations in terms of formal meetings / reporting expectations aligned to the Divisional Governance Framework

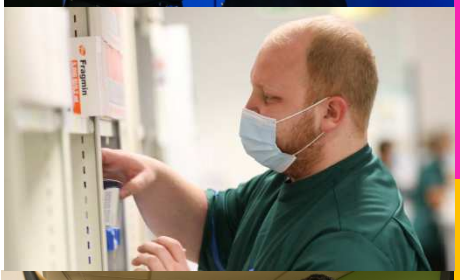
Other key changes include:

- Clarifications to the responsibilities and accountability for the Chief Nurse, aligned with the annual review of Executive Portfolios
- Reference to midwifery within the divisional leadership arrangements
- Inclusion of the requirement to include Clinical Effectiveness and Divisional Shadow IT within divisional governance requirements
- Review of Divisional Governance framework following a review of divisional governance
- Updated Performance Management Framework (KPI's) including reference to NHS Oversight Framework, Undertakings and Strategic Priority metrics

Key Recommendations

The Board is asked to approve the revised Framework

NHS
University Hospitals of North Midlands
NHS Trust



Accountability & Performance Framework

2024 - 2026

Delivering Exceptional Care with Exceptional People

Contents

Part A: Overview

1. Introduction

Good governance is essential to the provision of safe, sustainable, and high-quality care for patients. Accountability and performance management are core components of our governance framework and enable the Board to fulfil our obligations in the effective management of the organisation.

This Accountability Framework sets out the key enabling structures and processes to support the delivery and achievement of our Vision and strategic objectives, our Annual Plan and our key enabling strategies.

"Accountability typically refers to a relationship involving answerability, an obligation to report, to give an account of actions and 'non-actions'.

This indicates that there is an assumed expectation of the need to report and explain, either in person or in writing."

Kings Fund, 2011

2. Accountability and Responsibility

The main difference between responsibility and accountability is that responsibility can be shared while accountability cannot. Being accountable not only means being responsible for something also ultimately being answerable for your actions.

Individuals are held to account only after a task is done or not done whereas individuals can be responsible before and / or after a task.

- The **accountable person** is the individual who is ultimately answerable for the activity or decision. This includes 'yes' or 'no' authority and 'veto' power. Only one accountable person can be assigned to an action.
- The **responsible person** is the individual/s who actually complete the task. The responsible person is responsible for action / implementation and this responsibility can be shared. The degree of responsibility is determined by the individual with accountability.

3. Well Led Framework

The table below describes how this Accountability Framework will support us to monitor, assure and improve performance against the Well Led Framework:

No.	Well Led Domain	Impact of Accountability Framework
1.	**Is there the leadership capacity and capability to deliver high quality, sustainable care?**	• Accountabilities and responsibilities are clearly defined for individuals and enable effective delegation • Leaders understand the challenges to quality and sustainability • Clear priorities for ensuring sustainable, compassionate, inclusive, and effective leadership are understood
2.	**Is there a clear vision and credible strategy to deliver high quality, sustainable care to people and robust plans to deliver?**	• Progress against delivery of the strategy and local plans is monitored and reviewed and there is evidence to show this • The Vision, Values and Strategy has been developed using a structured planning process in collaboration with staff, people who use services and external partners
3.	**Is there a culture of high quality, sustainable care?**	• Action is taken to address behaviour and performance that is inconsistent with the Vision and Values, regardless of seniority • Staff and teams work collaboratively, share responsibility, and resolve conflict quickly and constructively

No.	Well Led Domain	Impact of Accountability Framework
4.	**Are there clear responsibilities, roles, and system of accountability to support good governance and financial management?**	• Effective structures, processes and systems of accountability are in place to support the delivery of the strategy, and these are regularly reviewed and improved • Staff at all levels are clear about their roles and they understand what they are accountable for and to whom
5.	**Are there clear and effective processes for managing risks, issues, and performance?**	• There are comprehensive assurance systems and performance issues are escalated appropriately through clear structures and processes • There are processes to manage current and future performance. These are reviewed and improved
6.	**Is appropriate and accurate information being effectively processed, challenged, and acted upon?**	• There is a holistic understanding of performance, which covers and integrates people's views with information on quality, operations, and finances • There are clear and robust service performance measures which are reported and monitored
7.	**Are the people who use services, the public, staff, and external partners engaged and involved to support high quality sustainable services?**	• There are positive and collaborative relationships with external partners which build a shared understanding of challenges within the system and the needs of the relevant population and to deliver services to meet those needs • There is transparency and openness with all stakeholders about performance
8.	**Are there robust systems and processes for learning, continuous improvement, and innovation?**	• Participation in and learning from internal and external reviews – learning is shared effectively and used to make improvements • All staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes, and performance – this leads to improvements and innovation

4. Culture of High Performance

As illustrated below, a culture of high performance is defined by continued improvement, leadership development, and empowerment to act, providing clear direction through a credible strategy, objectives / values and ensuring effective systems for appraisal and feedback. There is a strong and established evidence base demonstrating the link between cultures of compassionate and inclusive leadership and stronger organisational performance in terms of patient experience, innovation, finances, staff retention and staff engagement. Our Cultural Improvement Programme focuses on a number of these areas.

Achieving a culture of high performance is dependent upon performance management being an integral part of our organisational environment and is recognised as a positive, not punitive activity. The implementation of this Accountability Framework will support us in delivering our objectives and our strategies and will provide clarity on our expectations.

5. Vision, Values & Strategic Priorities

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

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

Our Vision – 'Delivering Exceptional Care with Exceptional People'

Through our organisation wide 'Improving Together' programme, which involves a Trust wide approach to continuous quality improvement, we have reviewed our organisation wide strategic vision and priorities.

Whilst the ambitions outlined within our 2025 Vision remain true, we have simplified our vision statement to provide greater clarity and our refreshed strategic priorities and objectives are aligned to our Improving Together programme.

Our Strategic Priorities and Objectives

High Quality	Responsive	People	Improving & Innovating	System & Partners	Resources
Providing safe, effective, and caring services	Providing efficient and responsive services	Creating a great place to work	Achieving excellence in development and research	Working together to improve the health of our population	Ensuring we get the most from the resources we have, including staff, assets, and money

Our Values

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

6. Equality, Diversity and Inclusion

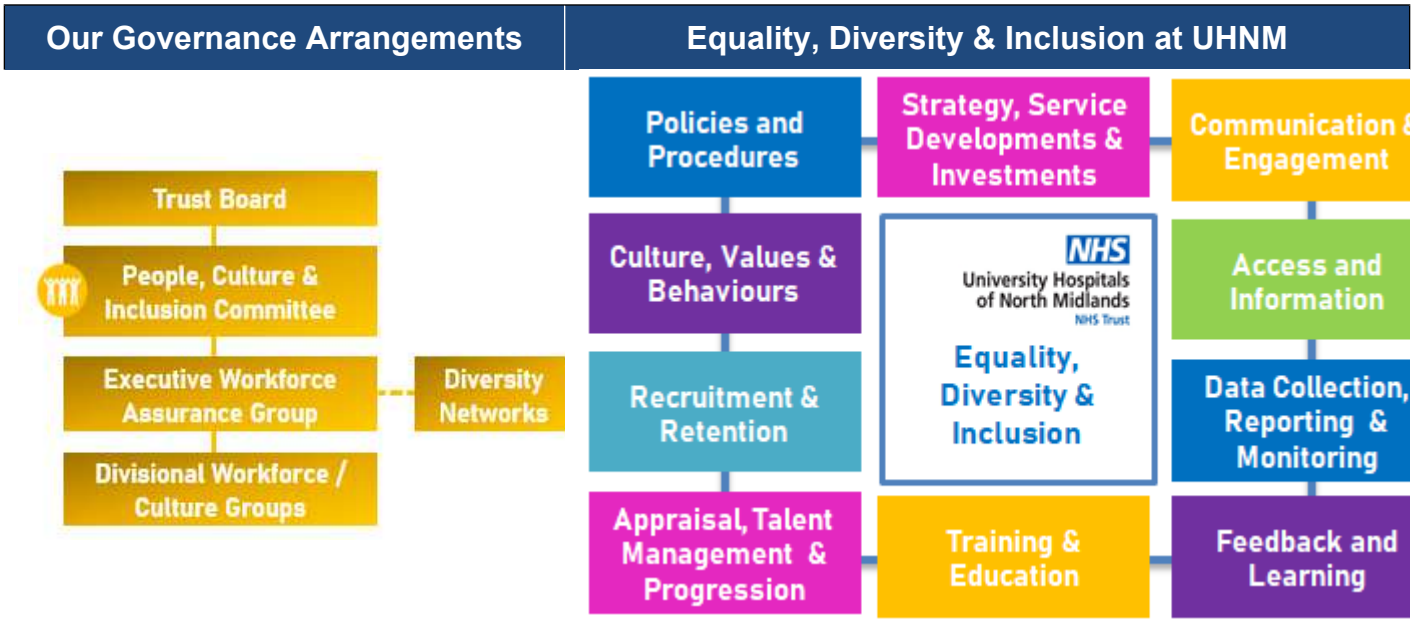
As a major employer and health service provider, we are committed to building an inclusive workforce which is valued and whose diversity reflects the community we serve, enabling us to deliver the best possible health and care services to our patients, carers and communities.

We have a clear policy and a strategy in place which set out our Equality, Diversity and Inclusion expectations for all of our staff, ensuring that equality, diversity and inclusion is integral, not additional, to the way we work.

Equality	Diversity	Inclusion
At its core, equality means fairness or equity. We must ensure that individuals or groups of individuals are not treated less favourably or do not have the same opportunities because of their protected characteristics.	Is recognising, respecting, celebrating, and valuing each other's differences. A diverse environment is one with a wide range of backgrounds and mind sets, which allows for an empowered culture of creativity and innovation.	Means creating an environment where everyone feels welcome and valued and confident to be themselves. When all three of these elements are working together, greater impact and change can be achieved.

Accountability for the delivery of our **policy and strategy** rests with the unitary Board. However, our Chief People Officer and our Chief Nurse have specific responsibilities for equality, diversity and inclusion and they are held to account for this. Whilst not mandated, we also have a nominated non-executive champion for Equality, Diversity and Inclusion to provide focussed support and challenge. We have also nominated Executive Sponsors for each of our diversity networks, to support them in delivering their objectives.

Whilst we expect that equality, diversity, and inclusion features in everything that we do, and we expect oversight, scrutiny and monitoring to take place throughout our governance structure, we do have a defined governance framework for specific elements of this, i.e. scrutiny of our Workforce Race Equality Standard / Workforce Disability Equality Standard / RACE Equality Code compliance.



Part B: Corporate Governance

7. Policies and Procedures

There are a number of core governance policies and procedures which have been set by the Board, defining how we operate at an organisational level, in accordance with the regulatory framework. These policies are:

- Standing Orders
- Scheme of Matters Reserved to the Board / Scheme of Delegation
- Standards of Business Conduct
- Standing Financial Instructions
- Risk Management Policy

8. Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) provides a structure and process which enables the Board to focus on the key strategic risks which might compromise the achievement of our Strategic Objectives. We have adopted a '3 lines of defence' approach which highlights the levels of control in place and assurance obtained, both internally and externally, along with clear identification of those accountable for further actions to be taken to reduce risk. The Board Assurance Framework is scrutinised by the Board and our Committees on a quarterly basis.

9. Corporate Governance Structure

Our Corporate Governance Structure is reviewed and refreshed on an annual basis. The structure defines the arrangements through which we monitor and seek assurance, from an operational level through to the Board.

Committees of the Board are chaired by our Non-Executive Directors, who play a key role in holding Executive Directors to account. The chairs of our committees provide assurance to the Board through a report which identifies:

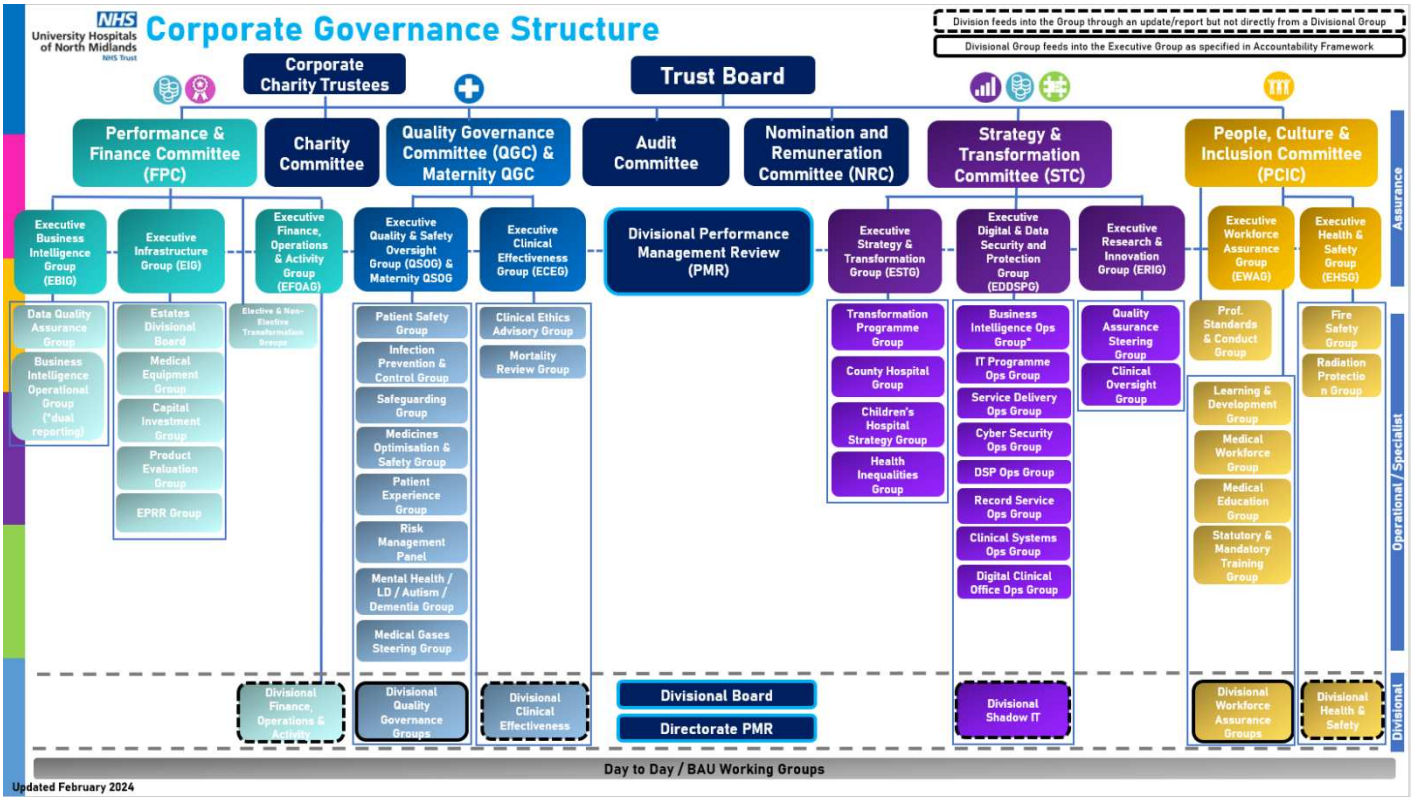
- Areas of concern / matters to escalate
- Areas of good practice
- Key actions agreed / work underway
- Decisions made

Reporting into our Committees are a series of 'Executive Groups'. These are how the Executive Team seek action and assurance and report to Committees of the Board in the same way as described above. They have a core set of responsibilities as defined within their Terms of Reference which are focussed on Performance, Risk, Strategy and Governance.

Reporting into our Executive Groups are a series of 'Operational Groups'. These provide operational oversight and ensure delivery against specific priorities and objectives, for example Patient Safety, Data Quality, Learning and Education.

Terms of Reference and Membership are in place for all meetings identified within our structure, which define their objectives and responsibilities. An annual cycle of effectiveness reviews is undertaken to provide opportunity to reflect, learn and continuously improve our governance arrangements and these are also subject to independent scrutiny through our regulators and internal auditors.

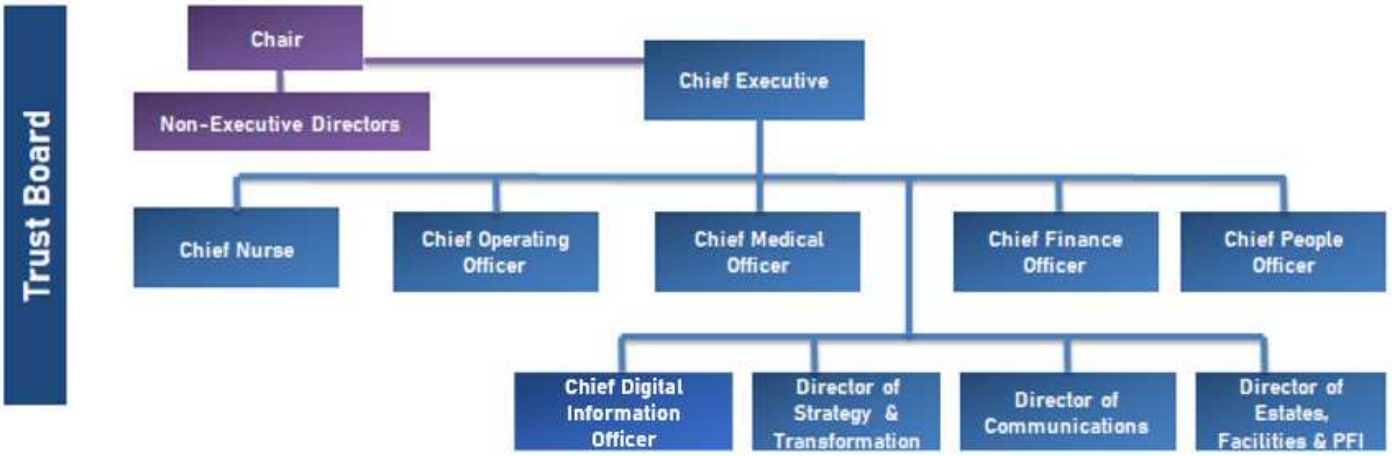
The Corporate Governance Structure (updated February 2024) is illustrated below:



Part C: Accountability

10. Board Accountability

Effective governance requires defined accountabilities, roles and responsibilities and clear ownership. The Board plays a key role in shaping the strategy, vision, and purpose of the organisation. They hold the Chief Executive and the Executive Team to account for the delivery of the strategy and ensure value for money. They are also responsible for assuring that risks to the organisation and the public are managed and mitigated effectively. The Board is led by an independent chair and composed of a mixture of both executive and non-executive directors; the Board is a unitary Board who make decisions as a single group, sharing responsibility and liability for all Board decisions, with collective responsibility for the performance of the organisation.



The table below outlines the distinction between Executive and Non-Executive roles of the Board:

	Chair	Chief executive	Non-executive director	Executive director
Formulate Strategy	Ensures board develops vision, strategies and clear objectives to deliver organisational purpose	Leads strategy development process	Brings independence, external skills and perspectives, and challenge to strategy development	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant)
Ensure Accountability	Holds CE to account for delivery of strategy Ensures board committees that support accountability are properly constituted	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Acts as Accountable Officer	Holds the executive to account for the delivery of strategy Offers purposeful, constructive scrutiny and challenge Chairs or participates as member of key committees that support accountability	Leads implementation of strategy within functional areas
Shape Culture	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected and modelled in their own and in the board's behaviour and decision making Board culture: Leads and supports a constructive dynamic within the board, enabling contributions from all directors	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected in their own and the executive's behaviour and decision making	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour Provides a safe point of access to the board for whistle-blowers	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour
Context	Ensures all board members are well briefed on external context	Ensures all board members are well briefed on external context		
Intelligence	Ensures requirements for accurate, timely & clear information to board/ directors (and governors for FTs) are clear to executive	Ensures provision of accurate, timely & clear information to board/ directors (and governors for FTs)	Satisfies themselves of the integrity of financial and quality intelligence	Takes principal responsibility for providing accurate, timely and clear information to the board
Engagement	Plays key role as an ambassador, and in building strong partnerships with: • Patients and public • Members and governors (FT) • Clinicians and Staff • Key institutional stakeholders • Regulators	Plays key leadership role in effective communication and building strong partnerships with: • Patients and public • Member and governors (FT) • Clinicians and Staff • Key institutional stakeholders • Regulators	Ensures board acts in best interests of the public Senior independent director is available to members and governors if there are unresolved concerns (FTs)	Leads on engagement with specific internal or external stakeholder groups

10.1 Trust Chair

The Chair is accountable for leading the Board and is responsible for its overall effectiveness in directing the Trust. The Chair is accountable to the Secretary of State, through NHS England, for giving leadership to the Board, ensuring the Trust provides high quality, safe services, and value for money within NHS resources. This includes:

- Promoting the highest standards of integrity, probity, and corporate governance throughout the organisation and particularly the Board
- Promoting a healthy culture for the organisation so that staff have a safe point of access to the Board for raising concerns
- Demonstrating visible and ethical personal leadership by modelling the highest standards of personal behaviour and ensuring that the Board follows this example
- Leading the Board in establishing effective decision-making processes and acting as the guardian of due process
- Making sure the Board understands its own accountability for governing the organisation
- Ensuring the Board Committees that support accountability are properly constituted
- Leading the Board in being accountable

10.2 Non-Executive Directors

Non-Executive Directors have a duty to ensure that the Trust has sufficient control measures in place to be able to effectively manage risk and ensure the governance structure is fit for purpose.

- The Audit Committee, which is a Non-Executive Director Committee, has the delegated responsibility from the Board for ensuring an effective system of integrated governance, risk management and internal control is in place.
- Non-Executive Directors are members of and Chair the Quality Assurance Committee which is a Board sub-committee with overarching responsibility for all aspects of quality governance; the Performance and Finance Committee which is the Board sub-committee with overarching responsibility for financial and operational performance, governance and risk and the Transformation and People Committee which is the Board sub-committee with overarching responsibility for our People and Transformation strategies, performance and risk.

10.3 Chief Executive Officer

The Chief Executive Officer is accountable for:

- Maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding public funds and departmental assets
- Ensuring that the Trust is administered prudently and economically, that resources are applied efficiently and effectively and that there are adequate arrangements in place for the discharge of statutory functions
- Ensuring that there is robust risk management across all organisational, financial, and clinical activities

The Chief Executive is accountable to the Board for meeting their objectives and as Accountable Officer, to the Chief Executive of the NHS for the performance of the organisation. The Chief Executive helps create the strategy and vision for the Board and the organisation to modernise and improve services and is responsible for ensuring that the Board's plans and objectives are implemented and that progress towards implementation is regularly reported to the Board using accurate systems of measurement and data management. The Chief Executive also agrees the objectives of the senior executive team and reviews their performance.

10.3 Tier 1 Executive Leadership

Executive Directors are the executive 'arm' of the Board. They meet as a group weekly and have oversight of the efficient and effective management of the Trust by ensuring that there is robust strategic development

and operational plans in place to facilitate the achievement of the Trust's objectives and Board decisions. Executive Directors lead the Central Functions / Estates, Facilities & PFI Divisions which comprise a range of centralised services to support the strategic leadership of our clinical divisions.

This includes providing direction and support, monitoring delivery, and considering and ensuring action upon risks and mitigations. Specific responsibilities are outlined below:

Executive Director	Responsibility and Accountability
Director of Strategy & Transformation / Deputy CEO	• Leading the development and delivery of the organisation wide strategy, incorporating the Clinical Services Strategy and a coherence annual planning and business development strategy • Co-ordination, production, and oversight of the delivery of enabling strategies, business cases and annual plans • Lead executive for system wide working
Chief Nurse	• Quality, safety, and compliance including the systems, and behaviours by which quality is governed • SRO and executive sponsor / lead across a range of initiatives within the organisation (including Quality Improvement, Ethnic Diversity and Hospital Food Review) and system / regional initiatives • Contributes to the development and implementation of key objectives to deliver safe and efficient services and effective, high quality patient care and ensure equality, diversity, and inclusion • Professional leadership of nurses / midwives and AHPs (including accountability for the Director of Midwifery), provision of professional advice and assurance to the Board, infection prevention and control, public and patient experience, CQC registration and liaison and compliance with Care Quality Commission standards, Executive Maternity Safety Champion, Baby Friendly Guardian, Mental Health, Learning Disabilities, Demetia and Autism, Adult and Children Safeguarding, Centre for Nursing, Midwifery and Allied Health Professionals Research and Education Excellence, End of Life and Palliative Care • Driving professional standards and accountability in delivering key performance indicators and engendering effective clinical leadership, education, training and continued professional development for Nursing, Midwifery and Allied Health Professionals including advanced clinical practice
Chief Finance Officer	• Financial strategy and ensuring effective financial management and control • Providing financial leadership by setting, evaluating, and developing organisation wide service and financial frameworks within which operational services can be delivered • Effective operation of the financial performance, performance reporting and accountability framework
Chief Operating Officer	• Development and implementation of key objectives to deliver services that provide optimum patient care, efficient use of resources and promotion of a culture that is progressive, inclusive and values driven • Providing operational leadership through setting, evaluating, and developing effective systems and processes which ensure the smooth running of the organisation and achievement of NHS constitutional targets • Accountability for the management and performance of clinical divisions
Medical Director	• Quality, including the systems, processes, and behaviours by which quality is governed • Contributes to the development and implementation of key objectives to deliver efficient services and effective, high quality patient care and ensure equality, diversity, and inclusion • Professional leadership of the medical workforce and for medicines optimisation, including accountability for the Clinical Director of Pharmacy • Driving professional accountability in delivering key performance indicators and engendering effective medical leadership
Chief People Officer	• Leading the development and delivery of strategies relating to all aspects of employment, workforce, and organisational development, ensuring links into other strategies, and are aimed at enhancing clinical care and outcomes and ensure equality, diversity and inclusion • Provide workforce advice to the Board, ensuring compliance with all legal and social obligations to employees • Shape and implement the strategic direction of the Trust through the introduction, development, and maintenance of human resource practices
Director of Estates, Facilities & PFI	• Leading strategic and operational estate management including development of the estate strategy, management of property, land, building maintenance, space management, energy, utility management, facilities management and the PFI • Leading the PFI, ensuring services are delivered consistent with the contract and collaborative working with PFI partners to optimise value for money • Providing professional advice to the Board on estates, facilities and PFI issues, ensuring compliance with all statutory responsibilities associated with the estate and the PFI
Chief Digital Information Officer	• Leading the development of the Digital Transformation strategy and service, providing innovative solutions to improving the efficiency and effectiveness of the Trust's operation • Developing the infrastructure to support the delivery of ICT systems across the Trust • Influence and support the delivery of ICT systems across the Staffordshire STP / ICP • Senior Information Responsible Officer (SIRO) with responsibility for the provision of information
Director of Communications & Charity	• Development and implementation of strategic communications and engagement with all internal and external stakeholders • Development and delivery of a strategy to increase charitable income, aligned to the Clinical Services Strategy, ensuring optimum benefit to patients and staff

11. Divisional Accountability

11.1 Tier 2 Divisional Leadership (Triumvirate):
Divisional Medical Director, Divisional Operations Director and Divisional Nurse / Midwifery Director

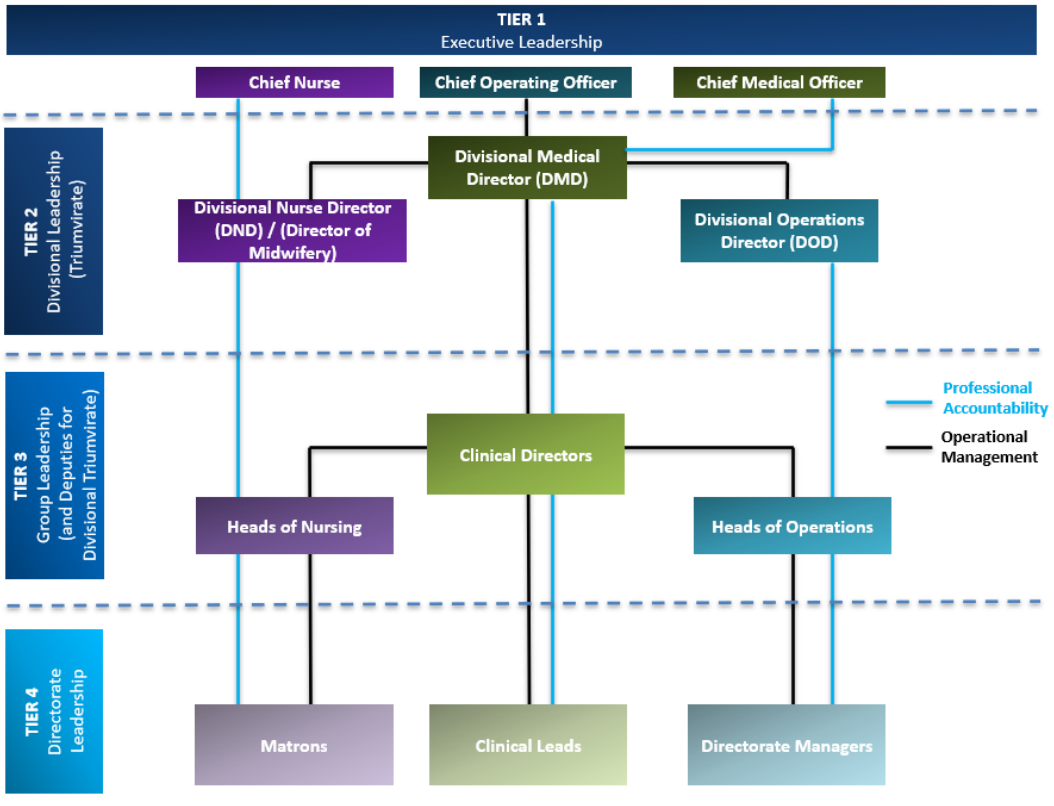
Our Clinical Divisions are managed by clinically led triumvirates comprised of a Divisional Medical Director, Divisional Operations Director, and Divisional Nurse Director / Director of Midwifery. These individuals have responsibility and accountability for specific aspects of the Divisional portfolio. The triumvirates are directly accountable to the Chief Operating Officer (through the Divisional Medical Director except for the Director of Midwifery who is directly accountable to the Chief Nurse through the divisional Medical Director) although have professional lines of accountability as follows:

- The Divisional Medical Directors are professionally accountable to the Medical Director
- The Director of Midwifery and Divisional Nurse Directors are professionally accountable to the Chief Nurse

Divisions are held accountable through Performance Management Review Meetings, which are led by the Executive Team. The triumvirate have responsibility for ensuring delivery of agreed organisational policies, objectives and key performance metrics and the governance, oversight, and co-ordination of performance within and across all Groups / Directorates. In addition, they are responsible for the development and implementation of robust remedial plans for areas of underperformance and escalating to the Executive Team key areas of risk that may affect delivery of organisational objectives and strategy.

The Divisional Management Team comprises a wider team who are accountable to the Divisional Triumvirate, however, there are individual members of the team who also have professional / managerial accountability to the relevant members of the Executive team as follows:

- Divisional Business Advisor: professionally accountable to the Chief Finance Officer
- People Business Partner: professionally and managerially accountable to the Chief People Officer
- Divisional Informatics Advisor: professionally and managerially accountable to the Chief Finance Officer



[NB: this structure is a broad illustration of accountabilities although there are some differences between each of the Divisions which are set out in their individual structures]

11.2 Tier 3 Group Leadership:
Clinical Directors, Heads of Nursing / Midwifery, Deputy Nurse Directors and Heads of Operations / Deputy Directors of Operations

Supporting our Divisional Triumvirate and overseeing our Directorate Teams is our Group Leadership comprising Clinical Directors, Heads of Nursing / Midwifery and Heads of Operations. These individuals have responsibility and accountability for specific aspects / services within the Divisional portfolio (as well as deputising for Tier 2). They are directly accountable to the Divisional Triumvirate.

- Clinical Directors are operationally and professionally accountable to the Divisional Medical Director
- Heads of Nursing are operationally and professionally accountable to the Divisional Nurse Directors
- Heads of Operations are accountable to the Divisional Operations Director

11.3 Tier 4 Directorate Leadership:
Clinical Leads, Matrons and Directorate Managers

Each of our Directorates is led by a Clinical Lead, Matron and Directorate Manager. They have responsibility for ensuring delivery of agreed organisational policies, objectives and key performance metrics and the governance, oversight, and co-ordination of performance within and across their Directorate. In addition, they are responsible for the development and implementation of robust remedial plans for areas of underperformance and escalating to the Divisional Leadership Team key areas of risk that may affect delivery of organisational objectives and strategy.

Clinical Leads and Matrons have designated leadership roles in relation to health and care professionals at a speciality level. They have key responsibilities and accountability for ensuring effective clinical and quality governance and that the values and professional standards are instilled within their workforce. They ensure that their teams are aware of and contribute to the organisation wide ambitions and promote essential standards to be delivered.

Directorates are held accountable through Directorate Performance Management Review Meetings, which are led by the Divisional Triumvirate. The Directorate Leadership Team is accountable for supporting managers / leaders within individual wards and departments, who manage and lead our frontline staff on a day to day basis.

11.4 All Staff

All staff have a responsibility for performance management and improvement, relevant to their role and are supported to identify improvement opportunities and to take action required. Specific and generic roles and responsibilities are outlined within all job descriptions.

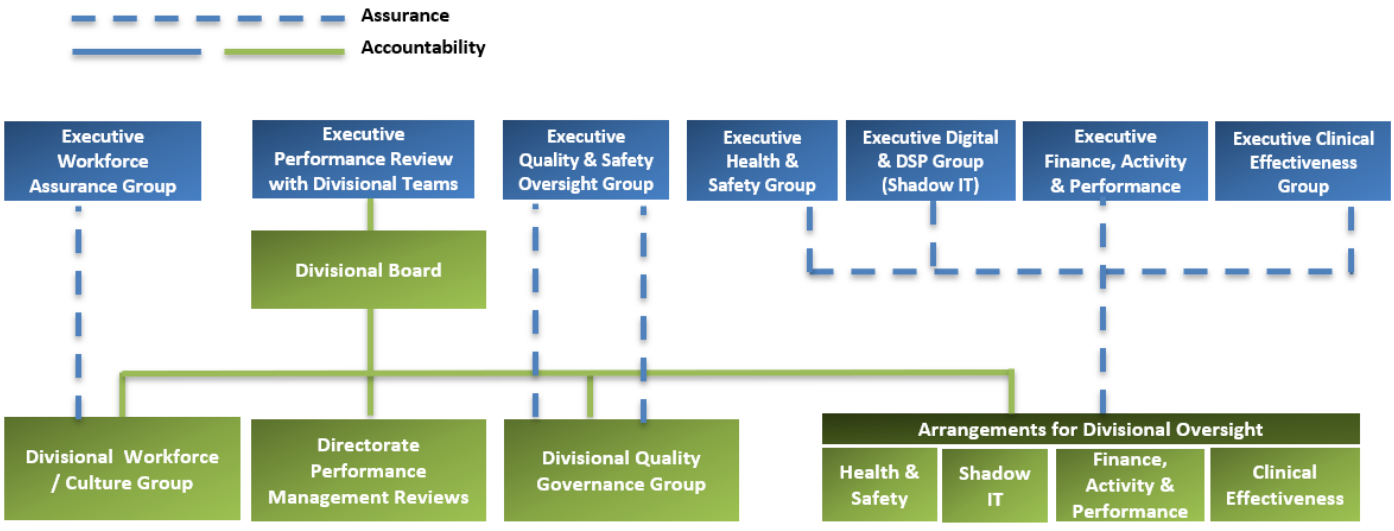
Part D: Divisional Governance

12 Divisional Governance Structure

Divisions are expected to have a clear and cohesive structure in place which sets out the framework within which the performance of the division is governed. Whilst it is recognised that divisional structures need to be tailored to meet the governance needs of each division, as a minimum they must have:

- A clear line of accountability into the Corporate Governance Structure through the Divisional Performance Management Reviews and Executive Groups as appropriate
- A fully constituted Divisional Board comprising the Divisional Management Team, with documented and approved Terms of Reference and Membership, with meetings being held monthly covering all aspects of divisional strategy, performance, risk and governance, aligned with our Strategic Priorities (a template can be found at appendix 1)
- A Divisional Quality Governance Group, with documented and agreed Terms of Reference and Membership, directly accountable to the Divisional Board and providing assurance through the Executive Quality and Safety Oversight Group
- A Divisional Workforce / Culture Group, with documented and agreed Terms of Reference and Membership, directly accountable to the Divisional Board and providing assurance through the Executive Workforce Assurance Group
- A forum within which Health & Safety matters are governed, with assurance being provided through to the Executive Health & Safety Group
- A forum within which Clinical Effectiveness is governed, with assurance being provided through to the Executive Clinical Effectiveness Group
- A forum within which Divisional Shadow IT is governed, with assurance being provided through the Executive Digital & Data Security and Protection Group
- A forum within which Finance, Activity and Operations are governed with assurance being provided through the Executive Finance, Performance & Activity Group
- A documented and approved process for the management, escalation, and oversight of risk, in accordance with the Risk Management Policy
- Directorate Performance Management Reviews, which align with the Performance Management Framework set out within this document
- Arrangements to ensure consideration of Highlight Reports from relevant Executive Groups to ensure effective flows of information

The minimum structure required is illustrated below:



13 Divisional Board – Core Responsibilities

To ensure consistency across the organisation, each Divisional Board should have a core set of responsibilities which enable the effective oversight and scrutiny of their division. These are outlined below and are covered within the template Terms of Reference at appendix 1.

Strategy

- Oversee development and implementation of strategy and operational plans at a Divisional level and associated Key Performance Indicators (KPIs), ensuring the adoption of best practice where available
- Develop and oversee implementation of an Annual Plan, aligned with priorities agreed through our Improving Together Programme
- Consult upon and agree any relevant policies, procedures, guidelines, standard operating procedures, and protocols and monitor their implementation, where relevant, at a Divisional level

Performance

- Receive assurance on the delivery of strategy and relevant key performance metrics (including driver / watch), ensuring the appropriate allocation of resource
- Monitor the operational systems and processes which ensure competent management within the Division
- Identify, delegate, and review relevant actions to improve performance
- Report any exceptions to the Annual Plan, delivery of strategy or areas of underperformance to the Executive Team via the Performance Management Review process

Risk Management

- Where relevant, monitor Root Cause Analysis / trends relating to adverse incidents, ensuring that appropriate action is taken, and lessons are learned (this may be delegated to the Divisional Governance Group although the Divisional Board will retain responsibility for oversight)
- Ensure that any risks are managed and reviewed via the Risk Register and in accordance with the Risk Management Policy

Governance

- To review national legislation, guidance and best practice and address local implications of such guidance as appropriate
- Oversee / monitor implementation of actions plans arising from internal / external review, audit, assessment or accreditation
- Undertake an annual self-assessment of effectiveness to inform any changes to Terms of Reference and Membership

Part E: Performance Management Framework

14 Performance Management

Performance management is a process of setting goals, monitoring of progress towards delivery and ensuring goals are consistently met in an efficient and effective manner. The goal of performance management is to ensure that all parts of the organisation are optimally working together and taking action in response to actual performance to improve the outcomes for our patients and users.

Performance management requires both good management systems and processes, and an organisational culture that supports and integrates them into the daily work of frontline staff and managers to promote the continuous improvement of services.

14.1 Key Performance Indicators

Performance management is integral to our Corporate Governance Structure. We have agreed a broad range of Key Performance Indicators (KPI's) which form the basis of our performance management framework. These KPI's are aligned to our Strategic Priorities and consider all NHS constitutional patient access targets and statutory obligations, along with targets we have agreed locally to support the delivery of our overarching 2025 Vision, enabling strategies and to address key areas of risk.

14.2 Statistical Process Control (SPC)

Statistical Process Control (SPC) is an analytical technique that plots data over time, helping us to understand variation in performance, in order to inform decision making and appropriate action planning. We use SPC in our performance reporting to:

- Alert us to a situation that may be deteriorating
- Show if a situation is improving
- Demonstrate how capable a system is of delivering a standard or target
- Show if a process that we depend upon is reliable and in control

We have adopted a model of SPC reporting within our Integrated Performance Report which enables us to draw two main observations of our performance data:

- **Variation:** Are we seeing significant improvement, 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 our 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

14.3 Board / Committee / Executive Oversight, Scrutiny and Accountability

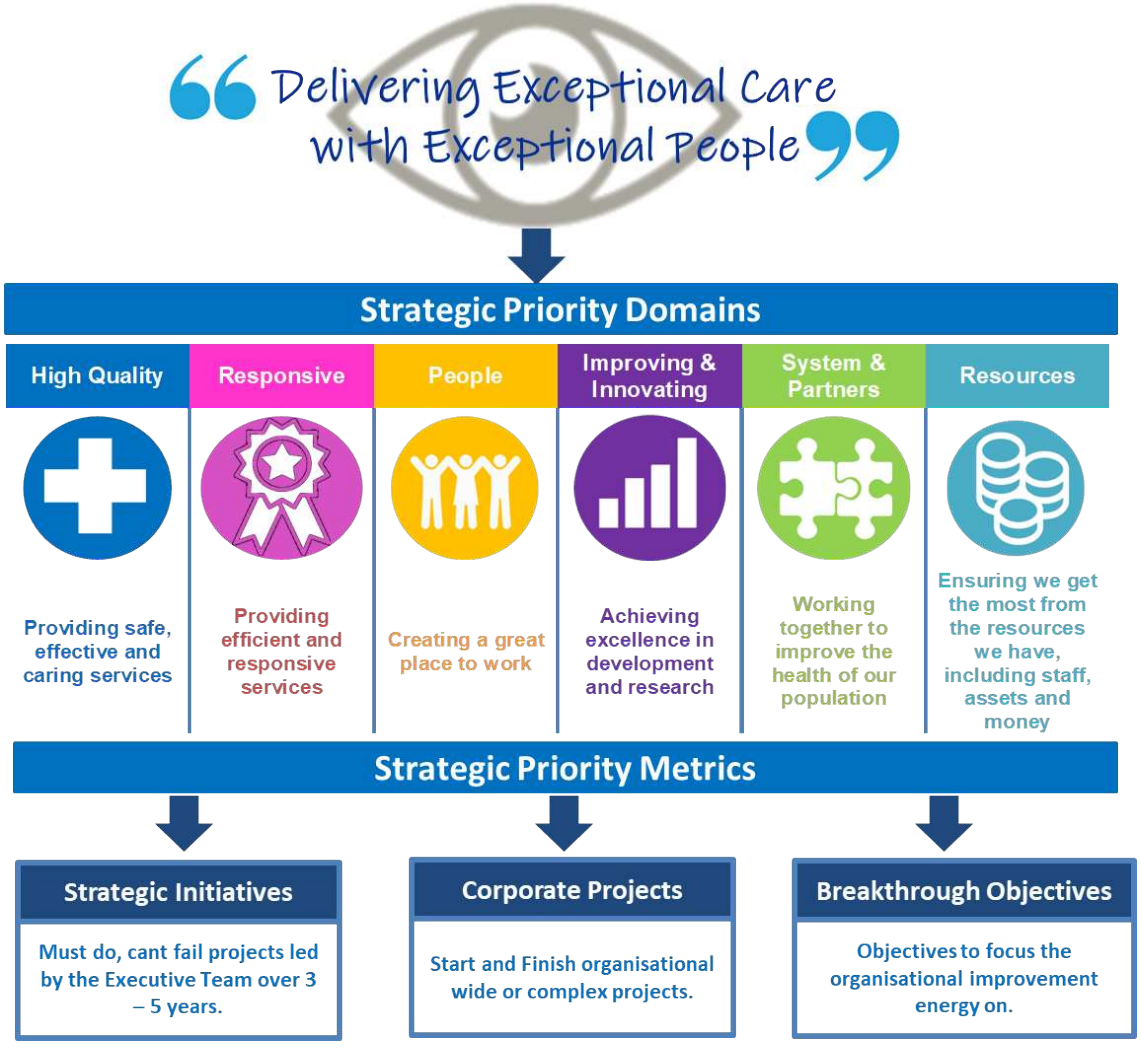
As the **Board** has ultimate responsibility for performance of the organisation, our 'core set' of KPI's are scrutinised and monitored by the Board through the Integrated Performance Report. The Integrated Performance Report is owned by the Executive Directors and is presented to the Board each month. This, along with a selection of other assurance reports agreed by the Board as part of their annual Business Cycle, form the basis upon which Executive Directors are held to account. **The full selection of KPI's included within our Integrated Performance Report to the Board can be found at appendix 2.**

For **Committees** reporting to the Board, we have determined a more granular detail of KPI's which are specific to each element of our strategy (i.e. High Quality, People, Resources, Responsiveness). These are monitored by each of our core Committees and are owned by the lead Executive Director/s and again presented each month for oversight and scrutiny, along with a selection of additional 'assurance reports' which have been agreed by the Board as part of the annual Business Cycle. These reports are scrutinised in the first instance through our **Executive Groups**, according to their Terms of Reference.

14.4 Strategy Deployment Framework

Our Strategy Deployment Framework is how the Board identifies and communicates a focussed set of priorities to ensure that all staff can align with our organisation wide strategy and can understand their contribution to achieving the strategy. The Strategy Deployment Framework focuses on improvement activity and key priorities, identified from data on Trust performance and we have reset our Strategic Priorities and our Objectives as part of this programme.

Aligned to achieving our Vision and Strategic Priorities, a series of Strategic Priority Metrics are identified, performance against which is monitored and delivered through targeted Strategic Initiatives, Breakthrough Objectives, and a series of Corporate Projects; this is illustrated below and is set out within our Annual Plan:



14.5 Performance Management Reviews – Divisions / Directorates

Performance Management Reviews between the Divisional Management Team and the Executive Directors are the formal checkpoint at which Divisions are held to account for delivery of the annual plan. The reviews seek to ensure that each Division is balancing patient safety and staff wellbeing with the pressure of financial and operational delivery and the overall sustained health of the Division.

An annual 'focus negotiation' is held between Executive Directors and Divisional Management Team. The purpose of the focus negotiation is to agree 'Driver' and 'Watch' metrics (defined below), which will form the basis of Divisional Performance Management Reviews / Divisional Performance Management Reports, along with a summary of risks being managed by the Division.

Driver Metrics	Areas of performance to be actively worked on to improve, achieve and sustain an identified target.
Watch Metrics	Areas of performance which still require monitoring and reporting and will continue to be addressed through 'Business as Usual (BAU)' but not actively 'problem solved' as a team unless the business rules dictate a change.

The principle of having focus on specific metrics is on recognition of limits to our resource and therefore this ensures that by identifying a smaller number of priorities we can ensure sufficient focus on addressing root causes and implementation of sustainable solutions.

The Divisional Performance Management Reports are a compilation of A3's or 'Countermeasure Summaries' (see section 9.8), aligned to the agreed Driver Metrics. We have agreed 'Business Rules' which are used during the Performance Management Reviews, and these determine our expectations in terms of performance management. Using these business rules, a 'mini focus negotiation' takes place to determine whether any Driver Metrics can become Watch Metrics or vice versa.

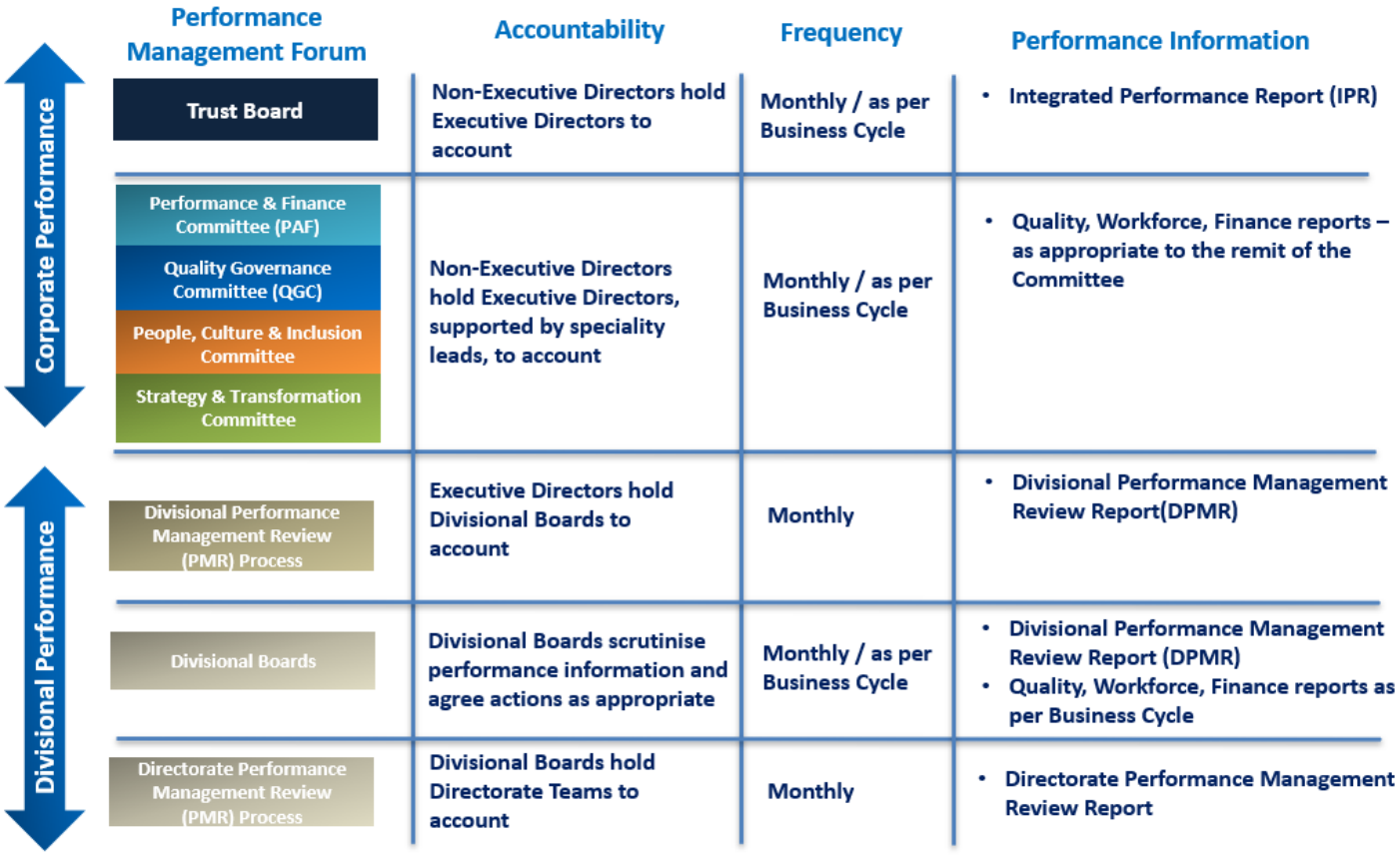
These business rules are described below:

	Rule	Business Rule	In meeting divisional expectation	Rationale	SPC alignment
Driver	Driver is **green** for one reporting period	D1	Celebrate success and move on	Starting to achieve our stretch target (not yet sustained).	Not applicable. Red/ Green classification based on Targets agreed in Focus Negotiation locally for each division. This is because the statistical model will not factor constraints in performance that apply to the situation and so might give "unattainable" targets.
	Driver is **green** for six reporting periods	D6	Standard verbal update and discussion: •Present Countermeasure and lessons learned / insights to share with relevant Divisions •Switch Driver to Watch or keep as Driver with increase target	Achieving our stretch target. Sustained improvement, not a result of natural variation	
	Driver is **red** for 1 reporting periods	D1	Standard verbal update and share top contributing reason, and the amount this contributor impacts the metric	Red means we are not achieving our stretch target. It is therefore the alert which is expected on the Driver metric. We are working to actively improve it in line with our strategic focus	
	Driver is **red** for 2 reporting periods	D2	Produce Countermeasure summary performance report		
	6 drivers are red	D6	Discuss with Exec which countermeasure summary should be prioritised		
Watch	Watch is **green** for reporting period	W1	No action required	Performance is within expected variation or threshold.	SPC chart shows a grey or blue dot
	Watch is **out of control limit** for 1 month	W1	Standard Verbal structure and share top contributing reason and move on (eg. special / significant event)	Red means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event	SPC chart shows an orange dot Where an SPC chart does not exist red would be where the threshold set is breached for the reporting period
	Watch is **red** for 4 months	W4	Standard verbal update and discussion: 1.Switch to driver metric (replace driver metric into watch) 2.Review thresholds	Four reds mean special cause variation causing adverse performance.	

This arrangement is repeated at a Directorate level, with Divisional Boards holding their Directorates to account for the performance of their Directorate.

The arrangements outlined above are illustrated below.

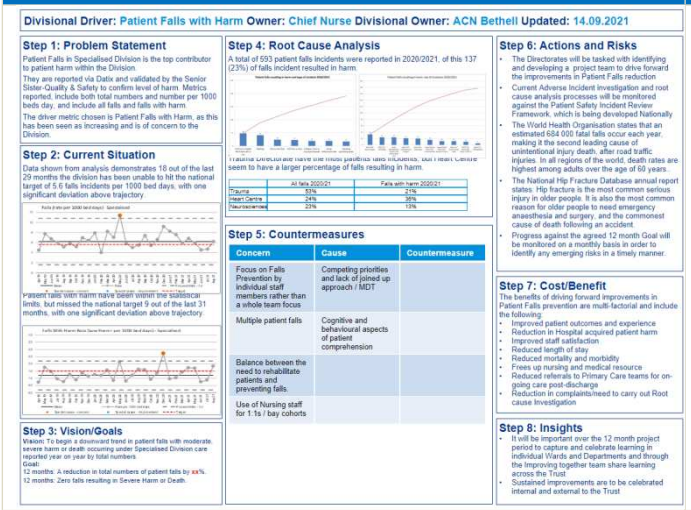
14.6 Overview of Performance Management Framework



14.7 Performance Management from Board to Ward

We use the same tools through from Board to Ward that we have introduced through our Improving Together Programme:

A3
A structured problem solving tool


Divisional Driver: Patient Falls with Harm Owner: Chief Nurse Divisional Owner: ACN Bethell Updated: 14.09.2021

Step 1: Problem Statement

Patient Falls in Specialised Division is the top contributor to patient harm within the Division.

They are reported via Datix and validated by the Senior Sister-Quality & Safety to confirm level of harm. Metrics reported include both total numbers and number per 1000 beds day, and include all falls and falls with harm.

The driver metric chosen is Patient Falls with Harm, as this has been seen as increasing and is of concern to the Division.

Step 2: Current Situation

Data shown from analysis demonstrates 18 out of the last 29 months the division has been unable to hit the national target of 5.6 falls incidents per 1000 bed days, with one significant deviation above trajectory.

Patient falls with harm have been within the statistical limits, but missed the national target 9 out of the last 31 months, with one significant deviation above trajectory.

Step 3: Vision/Goals

Vision: To begin a downward trend in patient falls with moderate, severe harm or death occurring under Specialised Division care reported year on year by total numbers.

Goal:

12 months: A reduction in total numbers of patient falls by xx%.

12 months: Zero falls resulting in Severe Harm or Death.

Step 4: Root Cause Analysis

A total of 593 patient falls incidents were reported in 2020/2021, of this 137 (23%) of falls incident resulted in harm.

	All falls 2020/21	Falls with harm 2020/21
Trauma	53%	21%
Heart Centre	24%	36%
Neurosciences	23%	13%

Step 5: Countermeasures

Concern	Cause	Countermeasure
Focus on Falls Prevention by individual staff members rather than a whole team focus	Competing priorities and lack of joined up approach / MDT	
Multiple patient falls	Cognitive and behavioural aspects of patient comprehension	
Balance between the need to rehabilitate patients and preventing falls.		
Use of Nursing staff for 1:1s / bay cohorts		

Step 6: Actions and Risks

- The Directorates will be tasked with identifying and developing a project team to drive forward the improvements in Patient Falls reduction
- Current Adverse Incident investigation and root cause analysis processes will be monitored against the Patient Safety Incident Review Framework, which is being developed Nationally
- The World Health Organisation states that an estimated 684 000 fatal falls occur each year, making it the second leading cause of unintentional injury death, after road traffic injuries. In all regions of the world, death rates are highest among adults over the age of 60 years.
- The National Hip Fracture Database annual report states: Hip fracture is the most common serious injury in older people. It is also the most common reason for older people to need emergency anaesthesia and surgery, and the commonest cause of death following an accident.
- Progress against the agreed 12 month Goal will be monitored on a monthly basis in order to identify any emerging risks in a timely manner.

Step 7: Cost/Benefit

The benefits of driving forward improvements in Patient Falls prevention are multi-factorial and include the following:

- Improved patient outcomes and experience
- Reduction in Hospital acquired patient harm
- Improved staff satisfaction
- Reduced length of stay
- Reduced mortality and morbidity
- Frees up nursing and medical resource
- Reduced referrals to Primary Care teams for on-going care post-discharge
- Reduction in complaints/need to carry out Root cause Investigation

Step 8: Insights

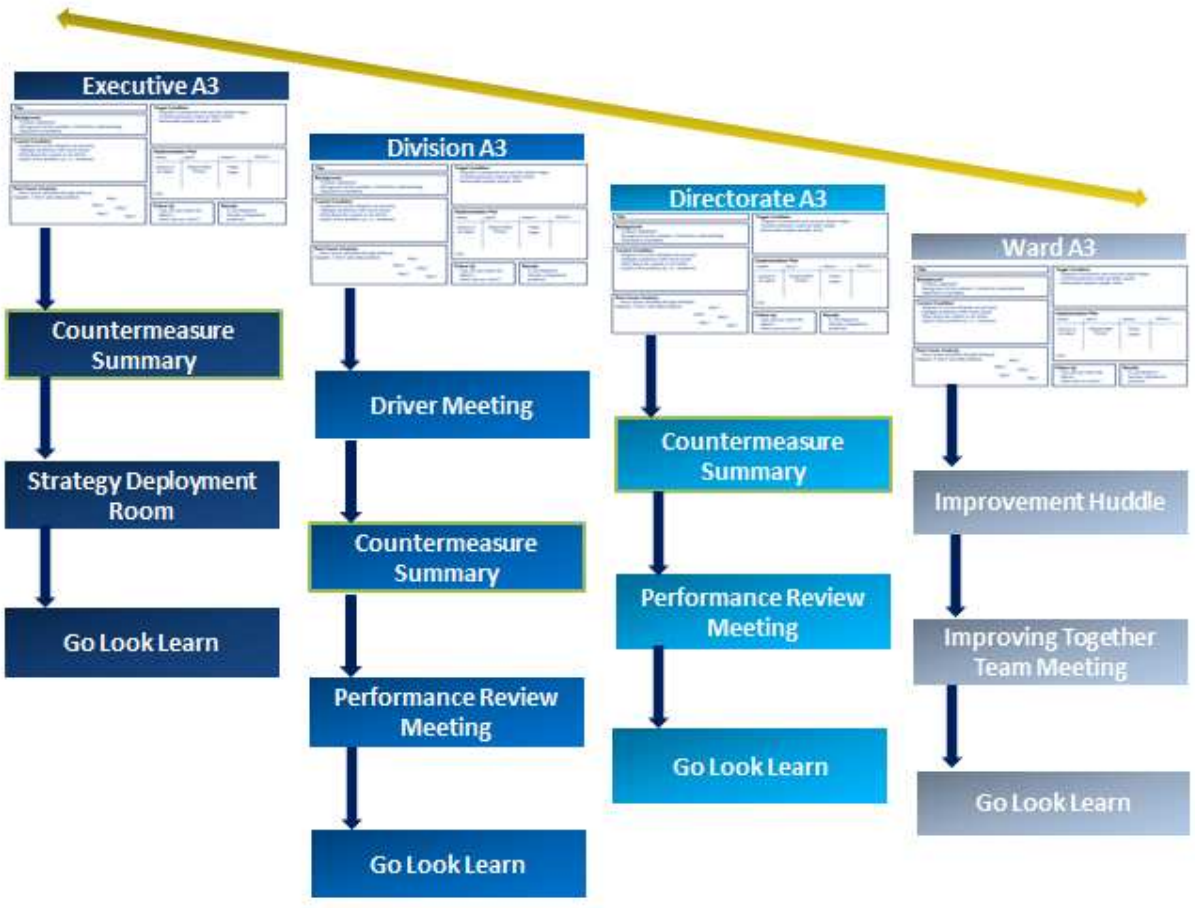
- It will be important over the 12 month project period to capture and celebrate learning in individual Wards and Departments and through the Improving together team share learning across the Trust
- Sustained improvements are to be celebrated internal and external to the Trust

Scorecard
A summary of Driver and Watch Metrics each team has agreed

Driver Metrics

Key Priority Domain	Annual Objective ?	Metric	Target	Jun	Jul	Aug	Sept	Business Rule	Business rule outcome
High Quality		Patient Falls with harm per 1000 bed days	1.5	0.8	0.9	1.8	1.9		
High Quality		Inpatient Sepsis Screening Compliance (contracted)	90.0	81.8	90.9	91.3	80.8		
Responsive		ED 90min referral	50%	44%	49%	51%			
Responsive		RTT >52 Weeks	TBC	1018	1226	1365	1475		
Responsive		Follow Up Backlog over 52 weeks	0	1706	1660	1687	1723		
Responsive		P2 waiting list	TBC	185	250	288	344		
People		Appraisal (PDR)	95%	81.5%	79.3%	82.2%			
People		Staff Vacancies	9% - Oct 21 8.5% - Mar 22	12%	10%	11%			

The nature of these tools means that we can have a golden thread through the organisation that lets everyone in the organisation understand the priorities and how at all levels we are working together to address them. The A3 problem solving tool drives and informs the various activities within teams, at all levels, to deliver collective problem solving (e.g. Improvement Huddles, Driver Meetings and Strategy Deployment Room) and Performance Reporting (Counter measure summaries, Performance Review and Improving Together team meetings) whilst identifying the opportunities to 'go look learn' from the people doing the work.



14.8 Escalation, Oversight, Intervention and Support

The table below sets out the framework that we are working towards to ensure a consistent approach to escalation, oversight, intervention and support. This requires corporate teams to ensure the timeliness and accuracy of information to support Divisional Performance Management Reviews. This is aligned to our model of SPC and should be replicated at a Directorate level, by Divisional Boards.

Performance Level	Characteristics of a Division / Directorate at this Level	Oversight Frequency	Intervention to Support Recovery	Support Provided
Low Intensity Support	• Consistent delivery of KPI's across all domains of Quality, Workforce, Operations and Finance • No 'special causes of concerning nature' (variation) or 'variation indicating consistent failing of targets' identified in SPC performance monitoring • Executive Team have confidence in the capacity to respond to and deliver any improvements required	• Executive Performance Management Review Meetings	• Earned autonomy • No interventions likely at this level, standard governance / performance management arrangements will apply.	• Support if required, focussed on development opportunities
Medium Intensity Support	• Delivery issues identified against some KPI's across the domains of Quality, Workforce, Operations and Finance • Variation indicates 'inconsistent passing of targets'	• Executive Performance Management Review Meetings • Oversight of individual performance areas by relevant Executive Lead via monthly Executive Groups.	• Interventions likely to be focussed on supporting improvement in particular areas • Broader intervention may be deployed as deemed appropriate by the Executive Director / Division	• Support focussed on specific improvement issues • Support ***may*** involve any of the points below – dependent upon the nature and level of risk
High Intensity Support	• Consistent indications of 'special causes of concerning nature' or 'consistent falling short of targets' • Likely to require significant support to achieve recovery • Executive team have limited confidence in the capacity/ability to deliver improvement without additional support and challenge	• Executive Performance Management Review Meetings • Oversight of individual performance areas by relevant Executive Lead via monthly Executive Groups with escalation to the relevant Committee as appropriate. • Weekly meetings with the relevant Executive Lead/s as appropriate.	• Development of comprehensive improvement plan, for approval of Executive Team • Intensive oversight arrangements (as deemed appropriate / proportionate) • Potential loss of autonomy • Potential service / capability review	• Support focussed on rapid quality / operational improvement • Lead Executive Director working with the team • Divisional triumvirate coached by Executive counterpart • Partnering with another high performer • Support from corporate functions, i.e. Transformation, Performance, Quality Teams where appropriate • External support / coaching where appropriate

15. Review of this Framework

This Accountability and Performance Framework will be reviewed every two years by the Director of Governance and will be submitted to the Board for approval and implementation.

Appendix 1:
Divisional Board Template Governance Pack

A) Divisional Board Terms of Reference and Membership Template

X Divisional Board
Terms of Reference and Membership
Date

University Hospitals of North Midlands NHS Trust

Constitution and Authority

The Trust Executive Team hereby resolves to establish a Divisional Board within each of the Clinical Divisions, to support oversight, scrutiny, and assurance at a divisional level in accordance with the Trust's Performance and Accountability Framework.

Membership

[names to be added as required for Division and Directorates]

- Divisional Medical Director (Chair)
- Divisional Operations Director (Vice Chair)
- Divisional Nurse Director / Director of Midwifery
- Head of Operations / Deputy Operations Director
- Head of Nursing / Midwifery / Deputy Nurse / Midwifery Director
- Clinical Directors
- Directorate Managers
- Matrons
- Divisional Governance and Quality Manager
- Divisional Business Advisor
- People Business Partner

Attendance at Meetings

Other staff members or external experts may be asked to attend by the Chair for all or part of any meeting, as and when appropriate / necessary, particularly when the Group is discussing an issue that is the responsibility of that person.

Substantive members are expected to attend 75% of meetings on an annual basis. This will be monitored through the inclusion of an Attendance Matrix within the minutes of each meeting.

Quorum

A quorum for the Board will be the chair (or vice chair), 50% of Clinical Directors, 50% Matrons and 50% Directorate Managers, from the above list of membership (or their nominated deputies).

Frequency of Meetings

The Board will meet monthly. However, the Chair may at any time convene additional meetings of the group to consider business that requires urgent attention.

Reporting

The Divisional Board will report to the Executive Team through Performance Management Review meetings and Executive Groups on how it discharges its responsibilities. This will include any matters requiring escalation for information or requiring executive support.

The Board will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Executive Team. This process will be supported by the Corporate Governance Team as required.

The Divisional Board will receive reports from the committees and groups reporting to it, by means of escalation and assurance.

Administrative Support

The Board shall be supported administratively by the Divisional PA, whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair in line with the Business Cycle and preparation, collation, and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend, or provide apologies / nominate a deputy in advance
- Taking the minutes for approval at the next meeting
- Keeping a record of matters arising and action points to be carried forward between meetings through use of the Post Meeting Action Log

Duties

The primary aim of the Divisional Board is to ensure scrutiny, assurance, and delivery of all objectives / targets, to monitor, control and escalate risks as appropriate and develop and oversee implementation of strategies and plans for all services within the Division.

The Divisional Board will consider all items in accordance with the Business Cycle, which will inform the monthly agenda.

Strategy

- Oversee development and implementation of strategy and plans at a Divisional level and associated Key Performance Indicators (KPIs), ensuring the adoption of best practice where available
- Develop and oversee implementation of an Annual Plan, aligned with priorities agreed through our Improving Together Programme
- Consider and approve business cases prior to Executive sign off
- Consult upon and agree any relevant policies, procedures, guidelines, standard operating procedures, and protocols and monitor their implementation, where relevant, at a Divisional level

Performance

- Receive assurance on the delivery of strategy and relevant key performance metrics (i.e. driver / watch), ensuring the appropriate allocation of resource
- Monitor the systems and processes which ensure competent management within the Division
- Identify, delegate, and review relevant actions to improve performance
- Report any exceptions to the Annual Plan, delivery of strategy or areas of underperformance to the Executive Team via the Performance Management Review process

Risk Management

- Where relevant, monitor Root Cause Analysis / trends relating to adverse incidents, ensuring that appropriate action is taken, and lessons are learned (this may be delegated to the Divisional Governance Group although the Divisional Board will retain responsibility for oversight)
- Ensure that any risks are managed and reviewed via the Risk Register and in accordance with the Risk Management Policy

Governance

- To review national legislation, guidance and best practice and address local implications of such guidance as appropriate
- Oversee / monitor implementation of actions plans arising from internal / external review, audit, assessment, or accreditation
- Undertake an annual self-assessment of effectiveness to inform any changes to Terms of Reference and Membership

Relationship with Executive Groups

The Group has a key relationship with all Executive Groups as defined within the approved Corporate Governance Structure.

Approval and Review

These Terms of Reference were approved on xx and will be reviewed on xx.

Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
To be completed			

Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Governance												
Directorate Highlight Reports	●	●	●	●	●	●	●	●	●	●	●	●
Risk Register (risks above 8, including annual risk management audit findings as required)	●	●	●	●	●	●	●	●	●	●	●	●
Annual Plan	●											
Annual Effectiveness Review						●						
Terms of Reference and Membership						●						
6 Monthly Fraud Update						●						
High Quality												
Divisional Quality Group Highlight Report (including reference to external accreditations / inspections)	●	●	●	●	●	●	●	●	●	●	●	●
Divisional Quality Report (including driver / watch metrics)	●	●	●	●	●	●	●	●	●	●	●	●
People												
Divisional Workforce / Culture Group Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Divisional Workforce Report (including driver / watch metrics)	●	●	●	●	●	●	●	●	●	●	●	●
6 Monthly Equality, Diversity and Inclusion Report						●						●
Resources												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Divisional Finance Report (including SFI breaches & salary overpayments)	●	●	●	●	●	●	●	●	●	●	●	●
Locally Managed Digital Systems Update	●	●	●	●	●	●	●	●	●	●	●	●
Business Cases / Reviews	As necessary											
Responsive												
Operational Performance Report (including driver / watch metrics)	●	●	●	●	●	●	●	●	●	●	●	●
Improving and Innovating												
Improving and Innovating												

Papers to be circulated on a regular basis for information / comment via email:

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Recently Approved Policies (policies online update to be circulated)	●	●	●	●	●	●	●	●	●	●	●	●
Committee/ Executive Highlight Reports (pack provided by Corporate Governance):												
Performance & Finance Committee Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Audit Committee Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Quality Governance Committee Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Maternity Quality Governance Committee Highlight Report		●			●			●			●	
Transformation and People Committee Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Executive Quality & Safety Oversight Group Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Executive Clinical Effectiveness Group Highlight Report	●			●			●			●		
Executive Workforce Assurance Group Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Executive Health & Safety Oversight Group Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Executive Business Intelligence Group Highlight Report			●			●			●			●
Executive Digital Data Security and Protection Group Highlight Report	●	●	●	●	●	●	●	●	●	●	●	●
Executive Research & Innovation Group Highlight Report		●			●			●			●	
Executive Strategy & Transformation Group Highlight Report		●			●			●			●	

AGENDA

Xx Divisional Board

Meeting held on xx 20xx at xx am to xx pm
Venue, Site or via Microsoft Teams

Time	No.	Agenda Item	Purpose	Lead	Format
	PROCEDURAL ITEMS				
	1.	Chair's Welcome, Apologies, Quoracy and Agreement of Meeting Roles	Information		Verbal
	2.	Declarations of Interest	Assurance		Verbal
	3.	Minutes of the Meeting held xx xx	Approval		Enclosure
	4.	Matters Arising via the Post Meeting Action Log	Assurance		Enclosure
	GOVERNANCE				
	5.	Xx Directorate Highlight Report (date)			
	6.	Xx Directorate Highlight Report (date)			
	7.	Risk Register – including risks scoring 8 and above			
		HIGH QUALITY			
	x.	Divisional Quality Group Highlight Report (date)	Assurance		Enclosure
	x.	Divisional Quality Report (including driver / watch metrics)	Assurance		Enclosure
		PEOPLE			
	x.	Divisional Workforce & Culture Group Highlight Report (date)	Assurance		Enclosure
	x.	Divisional Workforce Report	Assurance		Enclosure
		RESOURCES			
	x.	Divisional Finance Report	Assurance		Enclosure
	x.	Locally Managed Digital Systems Update	Assurance		Enclosure
	x.	Business Cases (ad hoc)	Approval		Enclosure
		RESPONSIVE			
	x.	Divisional Operational Performance Report	Assurance		Enclosure
		IMPROVING AND INNOVATING			
		SYSTEMS AND PARTNERS			
	CLOSING MATTERS				
		Review of Meeting Effectiveness			Verbal
		Agreement of Items for Escalation to Executive Groups			Verbal
		Any Other Business			Verbal
	DATE AND TIME OF NEXT MEETING				

B) Divisional Board Minutes Template

University Hospitals of North Midlands NHS Trust

Xx Divisional Board

Meeting held on xx 2024 at xx to xx
Venue, Site or via Microsoft Teams

MINUTES OF MEETING

Members:	A	M	J	J	A	S	O	N	D	J	F	M
xxx												
xxx												
xxx												
xxx												
xxx												
xxx												

In Attendance:		
xxx	xx	Personal Assistant (minutes)
xxx	xx	xxx
xxx	xx	xxx

No.	Agenda Item	Action
1.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
2.	**Title**	
	xx	
3.	**Title**	
	xx	
4.	**Title**	
	xx	
5.	**Date and Time of Next Meeting**	
	Date / Date / Time / Venue	

C) Divisional Board Annual Effectiveness Evaluation Template

Annual Effectiveness Evaluation

Divisional Board:	
Chair:	
Accountable to:	**Executive Team**
Date of Effectiveness Review:	

Processes

To be completed by the Chair on an annual basis (with the assistance of the Corporate Governance Team if required), and presented to Executive Team.

Area / Question	Yes	No	Comments/Action
Composition, establishment and duties			
Are items for escalation agreed at each meeting and escalated accordingly?			
Are meeting papers distributed in sufficient time for members to give them due consideration?			
Has the Divisional Board been quorate for each meeting this year?			

Committee Effectiveness

To be completed by each member of the Divisional Board for to submission to the Chair.

What works well?
What doesn't work well?
Suggestions for Improvement:

Appendix 2:
Performance Management Framework (KPI's)

High Quality

No.	Proposed Metric	SPC	NOF	Undertakings	UHNM Priorities	Benchmarking	Board IPR	Committee
Q1	Induction of Labour	●					●	●
Q2	Maternity Triage	●					●	●
Q3	Stillbirths per 1000 births		●					●
Q4	Patient Safety Incidents per 1000 bed days	●					●	●
Q6	Patient safety incidents with moderate harm and above per 1000 bed days	●					●	●
Q7	Patient falls with harm per 1000 bed days	●					●	●
Q8	Medication incidents per 1000 bed days	●						●
Q9	Medication incidents % with moderate harm or above	●					●	●
Q10	Patient Safety Incident Investigation (PSII's) instigated	●					●	●
Q11	Never Events per month	●					●	●
Q12	Duty of Candour –verbal/formal notification	●						●
Q13	Duty of Candour written	●						●
Q14	Pressure ulcers developed under UHNM per 1000 bed days	●						●
Q15	Pressure ulcers developed under UHNM with lapses in care per 1000 bed days	●					●	●
Q16	E Coli Bloodstream Infection Rate	●	●					●
Q17	Avoidable MRSA Bacteraemia	●	●					●
Q18	Reported C Difficle cases (hospital and community acquired)	●	●					●
Q19	Stillbirths per 1000 births	●	●					●
Q20	NPSA alerts not declared by deadline		●					●
Q21	Neonatal deaths per 1000 total live births	●	●					●
Q22	Family and Friends Test – Inpatient, ED and Maternity	●					●	●
Q23	Complaints response time	●						●
Q24	*Timely clinical observations (TBC)*	●						●
Q25	VTE risk assessment completion	●						●
Q26	HSMR / SHMI		●			●		●
Q27	Hospital Associated Thrombosis per 10000 admissions	●						●
Q28	**Sepsis indicators being revised** All children's IVAB in 1 hour							●
Q29	Contracted adult inpatient sepsis screening							●
Q30	All Maternity IVAB in 1 hour							●
Q31	All Emergency Portals IV Abx in 1 hour							●

Q32	RS ED IV Abx in 1 hour							●
Q33	Other Emergency Portals IV Abx in 1 hour							●
Q34	All children sepsis screening							●
Q35	All maternity sepsis screening							●
Q36	Contracted Adult Inpatient IVAB in 1 hour							●

Responsive

No.	Proposed Metric	SPC	NOF	Undertakings	UHNM Priorities	Benchmarking	Board IPR	Committee
O1	Cancer: 62 Day Backlog (#)	●	●	●	●	●	●	●
O2	Cancer: 31 Day Performance (%)	●			●	●	●	●
O3	Cancer: 28 Faster Diagnosis Performance (%)	●	●		●	●	●	●
O4	Diagnostics: DM01 (%)	●			●	●	●	●
O5	UEC: 4 Hour Target (%)	●	●	●	●	●	●	●
O5	UEC: 12 Hour Trolley Wait (% TBC)	●	●	●	●	●	●	●
O6	UEC: Cat Handover Average Time	●	●	●		●	●	●
O7	Electives: 52 week % incomplete RTT	●	●	●	●	●	●	●
O8	Adult general and acute type 1 bed occupancy		●			●		●
O9	Percentage of beds occupied by patients who no longer meet the criteria to reside		●			●		●
O10	Total patients waiting more than 65 weeks to start consultant led treatment		●			●	●	●
O11	Maintain zero 104 week waiters across the Trust's PTL in line with trajectories (agreed by NHS England) and this is maintained in line with plan.			●		●	●	●
O12	Achieve zero 78-week waiters and maintain this across the Trust's (PTL) and this is maintained in line with plan.			●		●	●	●
O13	Treating patients in a timely manner (hospital combined performance score)				●	●	●	●

People

No.	Proposed Metric	SPC	NOF	Undertakings	UHNM Priorities	Benchmarking	Board IPR	Committee
P1	Staff Engagement Sick			●	●	●	●	●
P2	Sickness Absence	●	●	●		●	●	●
P3	Vacancy Rate	●			●	●	●	●
P4	Turnover Rate (Leaver Rate)	●	●			●	●	●
P5	Performance Development Review (PDR)	●				●		●
P6	Statutory and Mandatory Training	●				●		●
P7	Agency Cost	●				●	●	●
P8	Apprenticeship Levy uptake	●			●			●

System & Partners

No.	Proposed Metric	SPC	NOF	Undertakings	UHNM Priorities	Benchmarking	Board IPR	Committee
S1	Increased partnership working				●		●	●
S2	Improve the health of our population				●		●	●

Improving and Innovating

No.	Proposed Metric	SPC	NOF	Undertakings	UHNM Priorities	Benchmarking	Board IPR	Committee
I1	Increase clinical trial participation	●			●	●	●	●
I2	Increase clinical academic posts and honorary contracts	●			●	●	●	●
I3	Increase research active employees	●			●	●	●	●

Resources

No.	Proposed Metric	SPC	NOF	Undertakings	UHNM Priorities	Benchmarking	Board IPR	Committee
R1	Total income	●			●		●	●
R2	Expenditure – Pay	●			●		●	●
R3	Expenditure – Non-Pay	●			●		●	●
R4	Daycase / Elective Activity	●			●		●	●
R5	Non-Elective Activity	●			●		●	●
R6	Outpatients 1st	●			●		●	●
R7	Outpatients Follow Up	●			●		●	●
R8	Agency spend against target	●			●		●	●
R9	CIP				●			●
R10	Freedom of Information performance	●	●		●		●	●
R11	Subject Access Request performance	●	●		●		●	●
R12	Carecert Cyber Security performance	●			●			●
R13	Data Security Breaches	●	●		●		●	●
R14	No. open Data Security / Protection incidents	●			●			●
R15	No. P1 Incidents	●			●			●
R16	Digital Project Delivery Lifecycle				●		●	

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	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		5	3	7	5	2	6	4	8	6	3	7	6	
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse		Staff		Staff				Staff			Staff		
Quality Governance Committee Assurance Report	Director of Governance											N/A		
Quality Strategy Update	Chief Nurse													Considered at the Trust Board Time Out - November 2023
Clinical Strategy	Director of Strategy													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			Q3	
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											N/A		
Gender Pay Gap Report	Chief People Officer													To be considered at the Trust Board in April 2024
People Strategy Update	Chief People Officer													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		Delay in obtaining Q3 data and therefore to be provided to March's meeting.
IMPROVING AND INNOVATING														
Research Strategy	Medical Director													Considered at the Trust Board Time Out - November 2023
SYSTEM AND PARTNERS														
System Working Update	Chief Executive / Director of Strategy													
Population Health and Wellbeing Strategy	Director of Strategy													
RESOURCES														
Performance and Finance Committee Assurance Report	Director of Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above	Director of Strategy	N/A	N/A			N/A			N/A		N/A	N/A		

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		5	3	7	5	2	6	4	8	6	3	7	6	
Digital Strategy Update	Chief Digital Information Officer													
Going Concern	Chief Finance Officer													
Estates Strategy Update	Director of Estates, Facilities & PFI													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													Not due for formal review until Q3 2024/2025. Interim refresh taking place January 2024
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- review to be undertaken April 2024
Risk Management Policy	Director of Governance													
Complaints Policy	Chief Nurse													Next due for review June 2024