NHS
University Hospitals of North Midlands
NHS Trust

Trust Board (Open)

Meeting held on Wednesday 7th June 2023 at 9.30 am to 12.15 pm
Via MS Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**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 3rd May 2023	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
10 mins	**6.**	Chief Executive's Report – May 2023	Information	Mrs T Bullock	Enclosure	
10:05		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (01-06-23)	Assurance	Prof A Hassell	Enclosure	1
10 mins	**8.**	Quality Account	Approval	Mrs AM Riley	Enclosure	1
5 mins	**9.**	Q4 Infection Prevention Board Assurance Framework	Assurance	Mrs AM Riley	Enclosure	1
5 mins	**10.**	Maternity Quality Governance Committee Assurance Report (23-05-23)	Assurance	Prof A Hassell	Enclosure	1
10 mins	**11.**	Maternity Serious Incident Report	Assurance	Mrs AM Riley	Enclosure	1
10:40		**PEOPLE**				
5 mins	**12.**	Transformation and People Committee Assurance Report (31-05-23)	Assurance	Prof G Crowe	Enclosure	2, 3, 4, 6, 9
10:45		**RESOURCES**				
5 mins	**13.**	Performance & Finance Committee Assurance Report (30-05-23)	Assurance	Dr L Griffin	Enclosure	5, 7, 8
10:50 – 11:05 COMFORT BREAK						
11:05		**RESPONSIVE**				
10 mins	**14.**	Independent Review of Waiting List Management	Assurance	Mrs T Bullock Ms K Thorpe	Enclosure	5
40 mins	**15.**	Integrated Performance Report – Month 1	Assurance	Mrs AM Riley Ms K Thorpe Mrs J Haire Mr M Oldham	Enclosure	1, 2, 3, 5, 8
11:55	**GOVERNANCE**					
10 mins	**16.**	G6 & FT4 Self-Certification	Approval	Mrs C Cotton	Enclosure	
12:05	**CLOSING MATTERS**					
10 mins	**17.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
	18.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 5th June to** Nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:15	**DATE AND TIME OF NEXT MEETING**					
	19.	**Wednesday 5th July 2023, 9.30 am, via MS Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 3rd May 2023 at 9.30 am to 12.30 pm
Held in the Trust Boardroom, Third Floor, Springfield, RSUH

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												
Mrs T Bullock	TB	Chief Executive												
Mr P Bytheway	PB	Chief Operating Officer												
Prof G Crowe	GC	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Dr M Lewis	ML	Medical Director												
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	Associate Director of Corporate Governance	NH											
Mrs A Freeman	AF	Director of Digital Transformation												
Mrs J Haire	JH	Chief People Officer												
Prof A Hassell	AH	Associate Non-Executive Director												
Mrs L Thomson	LT	Director of Communications												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI												

In Attendance:	
Mr S Badjie	Radiographer (item 1)
Mrs N Hassall	Deputy Associate Director of Corporate Governance (minutes)

Members of Staff and Public: 4

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Staff Story**	
062/2023	Mrs Haire introduced Mr Badjie to members of the board. Mr Badjie explained that he came to the UK from Gambia in 2012 when he commenced work at UHNM as a Porter, providing him with a good overview of the different areas of the Trust. He explained that he found the CT Department interesting and was invited to accompany the patients into the room and made to feel part of the team. He explained how he was encouraged by a member of staff, Mr Vince Marsden, to do an Access course which he completed while continuing with his portering duties, before applying for an Imaging Department Assistant (IDA) role which he was successful in gaining. He described his career journey which included working in ultrasound, before going to University to study for a	

	degree although he continued to work in the CT Department on a zero hours contract at weekends. Once he had finished his degree he was encouraged to apply for a vacancy in CT which he commenced as a Band 5. He described the sense of belonging and the way in which he was encouraged and supported throughout his career by members of the team and added that he treated patients like he would his family members and therefore had an ethos of providing them with the best quality service. Mr Badjie explained that he was subsequently successful in gaining a Band 6 position which included being shift lead and after two years he was asked to apply for a Band 7 role, although he felt comfortable in his own role and did not initially apply as he felt the change in role would have a reduction in patient contact. He described the support he had from staff throughout the service who continued to encourage him to move into a Band 7 role and after a discussion with management he agreed to apply as an aspiring position, which he found he liked particularly training new starters. Mr Badjie explained that other staff in the Department had been supported with their development and were progressing onto a similar career journey. Mrs Bullock thanked Mr Badjie for sharing his story and inspirational journey and suggested that this be shared as widely as possible. She welcomed the support and encouragement Mr Badjie had received and in particular from Mr Marsden. Mr Bytheway thanked Mr Badjie for his story and welcomed the references made on the teamwork, encouragement, feeling like a family and work ethic which should be encouraged. Professor Toor highlighted the difference one person could make in an individual's life and the way in which Mr Marsden had shaped and nurtured Mr Badjie's career which demonstrated the positive impact others could emulate. Ms Bowen queried the advice Mr Badjie would give to people starting their journey to which he commented that they should not limit themselves, always be open and try. Mrs Freeman thanked Mr Badjie for his story and queried who he was supporting and he explained that he was supporting the development of a current porter who was moving into an IDA role through an apprenticeship, as well as supporting another couple of IDAs. Mr Wakefield thanked Mr Badjie for his story and the way in which he had demonstrated his resilience and hard work. He added that the inspirational nature of his story would help to encourage others at UHNM and the thanked him for joining the Board to share his story. **The Trust Board noted the story.** Mr Badjie left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
063/2023	Mr Wakefield welcomed Board members to the meeting. Apologies were received as recorded above, and the meeting was confirmed as quorate. Mr Wakefield highlighted that Professor Toor had agreed to take on the role of Non-Executive Director Maternity Champion.	

3.	**Declarations of Interest**	
064/2023	There were no declarations of interest raised.	
4.	**Minutes of the Previous Meeting held 4th April 2023**	
065/2023	Professor Hassell requested an amendment to the sentence on page 3 to read as follows: "the Committee received the Organ Donation report which highlighted that UHNM was *the* top donating hospital in the Midlands and second in the country". In addition, it was agreed to amend the sentence on page 4 to read "…80 graduates were planned to join the Trust, which *kept* the Trust at a steady state". Dr Lewis requested an amendment to the sentence on page 4 to read "the West Midlands was an outlier for neonatal mortality when considering the benchmarked data for 2020, which was published in 2021". **With the exception of the above amendments, the minutes of the meeting held 4th April 2023 were approved as a true and accurate record.**	
5.	**Matters Arising from the Post Meeting Action Log**	
066/2023	PTB/569 – Mrs Cotton highlighted that the action had been completed, although work to complete the assurance map remained ongoing. PTB/571 – Mrs Cotton Well highlighted that the action had been completed.	
6.	**Chief Executive's Report – April 2023**	
067/2023	Mrs Bullock highlighted that no update was provided by the Trust Executive Committee, due to having met on 2nd May, although the majority of items would be covered by the papers on the agenda. She highlighted a number of other items from her report. Mr Wakefield referred to the strike action and requested an update on how the Trust had coped with the last nursing strike. Mrs Bullock stated that whilst UHNM nurses did not strike, others in the region did this had minimal impact on the Trust. Ms Bowen welcomed the collaborative working with North Staffordshire Combined Healthcare. **The Trust Board received and noted the report and approved eREAF 10554.**	
HIGH QUALITY		
7.	**Quality Governance Committee Assurance Report (27-04-23)**	
068/2023	Professor Toor highlighted the following from the report: • The Committee considered the training demands in relation to resuscitation whereby capacity needed to increase and work was ongoing in this area • 18 Care Excellence Framework (CEF) visits had been undertaken during quarter 4, whereby 5 areas saw a reduction in the rating and action plans were in place to address the issues raised. The aim to strengthen the validation process in the next quarter was also highlighted. • Written duty of candour compliance remained below target and remains an area of focus	

	• The Committee welcomed the improved response rate for friends and family test in maternity services and welcomed there being no reported cases of MRSA in the past quarter • It was noted that Ward 8 had maintained a platinum CEF award for a fifth year and the Committee discussed how it could replicate the success of this in other areas, in terms of sharing knowledge and approaches Mrs Riley highlighted that due to the CEF process using a new set of more rigorous standards the changes in ratings did not necessarily relate to a decline in performance. Mr Wakefield referred to the recruitment of a c-difficile nurse and queried the impact of this. Mrs Riley stated that the nurse had not been in post for long but training and education was a key area for the nurse, which was taking place and therefore it was anticipated that improvements in performance would be demonstrated in Quarter 1. **The Trust Board received and noted the assurance report.**	
8.	**Care Quality Commission (CQC) Action Plan**	
069/2023	Mrs Riley highlighted the following from the report: • A monthly digital audit process was being put in place, which included auditing elements associated with the CQC action plan to provide assurance on the outcomes of the actions taken, and the roll out across both sites was due to be completed in summer • The action plan had been revised to incorporate actions from all inspections • For any area identified as bronze in the CEF process, in any domain, a monthly meeting was held to enable a supportive conversation to take place • The action plan would continue to be reviewed and in particular strengthened to identify the evidence demonstrating completion and outcome of the action taken Mrs Freeman queried the reason for the change in number of actions and it was noted that due to the action plan being a live document, additional actions were added as required. Mr Wakefield queried if the actions which had not yet been completed were on track and Mrs Riley stated that the roll out of Tendable was not yet complete, in addition some of the actions in relation to mandatory training were problematic but these continued to be considered and discussed with Divisional teams. Mrs Riley referred to the Section 29A notice which had been received following the inspection of maternity, and stated that the Trust was disappointed to receive the notice, although the Trust was already aware of the two areas raised and action had already been taken to address these prior to the inspection. She stated that the metric regarding triage times and induction of labour had been the subject of an improvement project with the Local Maternity and Neonatal Systems (LMNS) and NHS England since October 2022, and as such the Trust had confirmed with the CQC that there were no new actions to be taken, but rather the focus would be on sustaining improvement which the Trust was required to demonstrate by the end of June 2023. Mr Wakefield referred to the delays which had previously been reported and queried the cause of these. Mrs Riley stated that this was due to demand, availability of workforce but also difficulties in getting mutual support due to	

	regional colleagues having the same struggles with activity. She added that the Trust had consequently worked with regional NHS England in improving the regional escalation processes and monitoring. Mr Wakefield queried if patients and children were safe to which Mrs Riley confirmed and added that no untoward incidents had been reported. She stated that in terms of the delays in triage, she was not aware of any incidents which had resulted in a negative outcome. Mr Wakefield queried when it was anticipated that the Trust could request to remove the notice and Mrs Riley stated that the Trust could ask the team to revisit the Trust, and the timing of this would be discussed with the Quality Governance Committee (QGC). Professor Hassell welcomed the use of reporting on outcome data and referred to the triage assessment being a watch metric and queried if this should be a driver metric. Mrs Riley stated that this was monitored regularly and the usual business rules would be followed and if these were triggered, the metric would be considered being moved to a driver metric. Ms Bowen queried how the Trust had learned from this, in terms of taking forward audits of other standards across the Trust. Mrs Riley stated that triage times and induction of labour data was reported at the Maternity QGC and Mrs Bullock added that the revised CEF framework and monthly audits provided an additional level of assurance regarding adherence with standards. **The Trust Board noted the revised CQC action plan and the Section 29A Warning Notice relating to maternity services.**	
9.	**Nurse Staffing Establishment Review**	
070/2023	Mrs Riley highlighted the following from the report: • The paper had been discussed at both the Transformation and People (TAP) Committee and QGC, which highlighted the methodology used and triangulation of metrics • Internal audit had been asked to assess the process in 2023/24 to provide third line assurance of the processes undertaken • No approval for funding was being sought as Divisions were to work through the findings via the usual prioritisation process • No immediate concerns had been identified regarding patient safety and patient acuity was continually monitored Mr Wakefield referred to the requirement for 179 posts, although 84 were required for escalation wards and 30 were required to improve services from 5 to 7 days, therefore leaving a shortfall of 65 posts. Mr Wakefield asked for confirmation that the real term deficit was 65 posts and Mrs Riley agreed. Professor Hassell referred to uplift and vacancy rates and Mrs Riley stated that 21.5% uplift was applied to some areas although the Royal College of Nursing recommendation was 25% uplift. She confirmed that the shortfall was small in percentage terms and agreed to clarify this in future iterations. Mrs Bullock stated that the 21% versus 25% uplift did not relate to vacancies, but was put in place to provide cover for training, maternity and sick leave. Mr Oldham stated that the winter funding which had not been allocated was available recurrently and was therefore expected to fund the escalation wards.	

	Based on the discussion, Mr Wakefield summarised that the gap was small when considering the total workforce, which reflected the previous investments made in staffing. **The Trust Board:** **1. Noted the progress made to ensure compliance with national guidance in relation to determining safe nursing and midwifery staffing levels.** **2. Noted that Divisional leadership teams would be responsible for prioritising requests and developing business cases in line with the recommendations from the establishment review and that no changes to establishments would be made before a business case is approved.**	
10.	**PLACE Inspection Findings and Action Plan**	
071/2023	Mrs Whitehead highlighted the following from the report: • The report and action plan had been discussed at the QGC • The Trust achieved above the national average in 7 / 8 assessments • The results were testament to the hard work and commitment of staff continuing to focus their attention on the environment Mr Wakefield thanked Mrs Whitehead for the successful results. Professor Crowe commented that PFIs often struggle with such reviews so the outcome should particularly be congratulated and was a positive reflection of the good collaborative relationships in place. **The Trust Board received and noted the contents of the report and its findings following PLACE inspections undertaken during October and November 2022. The Trust Board noted the actions identified to improve the patient environment and experience which had also been provided to QGC.**	
PEOPLE		
11.	**Transformation and People Committee Assurance Report (26-04-23)**	
072/2023	Professor Crowe highlighted the following from the report: • The Committee considered the establishment review which confirmed the process was effective and had been enhanced with further improvements planned • The latest update in relation to Improving Together was provided and the continued progress was welcomed, in particular how this aligned to the NHS continuous improvement approach • The action plan following the staff survey was considered and a similar discussion was held as per the CQC action plan, in terms of the need for outcome monitoring to ensure the actions were having the desired impact • A risk was highlighted in respect of the data security and protection toolkit and the ability to achieve the mandatory training target of 95% by June 2023 • A verbal update was provided on the recent network outage and a review was ongoing to consider causes and identify lessons learned **The Trust Board received and noted the assurance report.**	
RESOURCES		
12.	**Performance & Finance Committee Assurance Report (25-04-23)**	
073/2023		

	Ms Bowen highlighted the following from the report: • UHNM was to be classed as tier 1 for elective care and despite the good performance in cancer this is routinely part of tier 1 for electives. • Urgent care performance had improved although trolley waits remained an area of concern • An independent review was underway on elective data and the full outcome was to be presented in May 2023 • The financial plan for 2023/24 highlighted a particular risk associated with cost improvement savings, elective recovery fund, recurrent investments and capital • The Trust delivered its 2022/23 financial plan break even position • An update was requested from the Surgical Division in relation to theatre delays Mr Akid thanked Mr Oldham and the team for delivering the breakeven position and catching up on the capital spend. He also welcomed the sustained reduction in ambulance holds. **The Trust Board received and noted the assurance report.**	
13.	**Annual Plan 2023/24**	
074/2023	Ms Ashley highlighted the following from the report: • The annual plan brought together Trust priorities and the workplan for 2023/24 • A number of elements had previously been discussed with Board members • The plan sought to align annual objectives to delivery of the Trust's priorities in addition to how the divisional priorities sought to support the priorities • Key sets of metrics had been identified • It was intended to revise and refresh the Integrated Performance Report (IPR) to include the metrics in the annual plan Mr Wakefield commented that the plan had been built on the people promise although queried the achievability of rewarding people appropriately given the ongoing strikes. Mr Wakefield queried whether it was reasonable to expect 1 m more GP appointments per week and Ms Ashley stated that the specifics had been reviewed in the operating plan, and this was dependent on workforce although this had been built into the GP primary care strategy. She stated that by working together with other system providers the Trust needed to support colleagues in enabling the workforce to be in place to deliver expectations. **The Trust Board approved the Annual Plan and noted that assurance of its delivery would be provided through the Transformation and People Committee, over the course of 2023/24.**	
RESPONSIVE		
14.	**Integrated Performance Report – Month 12**	
075/2023	Mrs Riley highlighted the following in relation to quality and safety: • The incident reported in relation to Your Next Patient (YNP), where pressure damage had been noted to have occurred in the community was being reviewed and considered with the ICB in order to identify the collaborative actions which could be taken to reduce harm going forwards • The number of moderate harms per 1000 bed days had reduced	

- A never event was under investigation but no harm to the patient had been identified

Mr Wakefield referred to the patient safety incidents in relation to YNP and queried if anything was being done differently in relation to the improvements seen. Mrs Riley stated that the reduction in incidents reflected the reducing winter pressures and processes becoming more embedded. Mrs Bullock added that YNP improved patient flow from the Emergency Department to wards, therefore reducing pressures in addition to improvements in sickness absence and recruitment to vacancies.

Mr Wakefield referred to the reduction in nosocomial infections whilst there continued to be a sizable number of patients with covid, and queried the reason for the reduction. Mrs Riley stated that she expected this to be related to the reductions in testing which had not been reflected in the way in which numbers continued to be reported. Mr Bytheway stated that between 20 to 25 beds continued to be restricted due to covid.

Mr Bytheway highlighted the following in relation to urgent care:

- Ambulance handovers had improved to 150 hours lost and improved performance had been sustained for 3 weeks
- The environment was due to be 'stress tested' to establish whether the improvements could be sustained
- Corridor care was being used infrequently
- In April the Trust achieved above 70% for 4 hour performance as opposed to the trajectory for 64%, although there continued to be challenges with long waits

Professor Crowe queried the progress with the Same Day Emergency Care (SDEC) modular development and Mr Bytheway stated that the short form business case was due to be submitted by 4th May. Mr Oldham stated that the financial assessment was to be provided to the Performance and Finance (PAF) Committee, although there was an assumption that it would be funded from national monies. Ms Ashley stated that the activity and impact on bed occupancy had been built into the plan.

Mr Wakefield queried when the Trust would stop using YNP and Mr Bytheway stated that as this was based on risk and whether the Trust was holding ambulances it would be used as required. He confirmed that the process was not to be undertaken as business as usual and expected it to be used infrequently.

Mrs Bullock reiterated that corridor care and YNP was not business as usual, but would be part of the formal escalation process to be used in times of extremis.

Mr Bytheway highlighted the following in relation to cancer performance:

- It was disappointing to have been placed in tier 1 despite the work undertaken to improve cancer performance but noted the tier 1 was not in relation to cancer care but as part of the elective tier 1.
- 2 week wait had been maintained and the faster diagnosis standard was nearly achieving the target
- There had been a reduction in the 104 and 62 day backlogs
- A deterioration in performance was expected, due to a reduction in activity in April although this was expected to improve during May

Mr Wakefield queried whether if the Trust was not in tier 1 for planned care, it would not have been placed in tier 1 for cancer. Mrs Bullock agreed and clarified

that as cancer performance had been very good and ahead of trajectory, the Trust had been placed in tier 1 due to elective performance. She stated that this was disappointing but the Trust had been provided with additional funding which would be used to support improvements in cancer as well as improvements in elective care.

Professor Hassell congratulated the team on the improved cancer performance in particular cancer two week wait which was positive for patients.

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

- The Trust ended April with 583 78 week wait breaches and 50 104 week breaches as expected
- The NHS England visit had taken place to review the plan and the positive work undertaken had been noted.
- A second theatre improvement event was to be held
- The governance review was expected to report to PAF in May

Ms Bowen queried the productivity improvements being made and Mr Bytheway stated that a dashboard had been developed to measure performance and further information was to be taken to PAF on the work undertaken and progress to date. Mrs Bullock highlighted that there were multiple reasons as to why theatres started late and this continued to be reviewed as part of theatre transformation.

Mr Wakefield queried why there was a reliance on the Independent Sector rather than mutual aid and Mr Bytheway stated that the focus on specialist work such as ophthalmology was to utilise the Independent Sector, but for orthopaedics mutual aid was being agreed with the Royal Orthopaedic in Birmingham, given they could not be treated by the Independent Sector. It was noted that due to the difficulties of moving people across the system, the focus was on utilising the Independent Sector.

Mr Wakefield referred to the financial plan assuming elective recovery monies and queried the level of confidence in the ability to meet the targets. Mr Bytheway stated that if insourcing and Independent Sector support was provided the targets should be delivered.

Professor Crowe referred to the challenges of mutual aid in an ICB with limited similar providers which required further debate given the reliance on the ICB to negotiate with the Independent Sector.

Ms Bowen referred to diagnostics and the 7 day reporting turnaround for urgent cases which was below target and she queried the barrier for performance. Mr Bytheway stated that workforce and demand were the limiting factors and added that a business case had previously been approved for additional radiology workforce.

Mrs Haire highlighted the following in terms of workforce performance:

- Slight improvements had been made in relation to PDR and statutory and mandatory training compliance, although there had been an increase in sickness absence
- In terms of vacancies and turnover, it had positively been reported that critical care were fully established
- Progress continued to be made in relation to the placement of newly qualified nurses
- Due to the investment in recruitment, a number of recruitment campaigns were underway, demonstrating high number of views via social media, and further information was to be obtained in terms of how these converted to

	applications • Compassionate and inclusive workforce was the focus for May. Large scale events focussing on Being Kind were being explored and a series of other events were taking place in May Mr Wakefield referred to the vacancy rate of 12.5% and sickness of 5.28% equating to 18% of the workforce not being in place, and he queried if staffing was uplifted to 21% why this was an issue. Mrs Haire explained that the vacancy rate related to substantive staff and this was supported by additional bank and agency staff. Mrs Riley stated that the uplift related to annual leave, study leave, sickness, maternity and paternity and which created the gaps. Professor Crowe requested that clarification be provided to Board members outlining the vacancy and sickness rates and how these linked to the uplift so that the nuances of understanding the figures could be provided. Mrs Haire and Mrs Riley agreed to provide this. Professor Crowe welcomed the staff engagement activity taking place and requested opportunities for Board members to be involved. Ms Bowen referred to the turnover target of 11% and given the workforce challenges queried whether this should be lower. She also queried how this compared to peers. Mrs Haire stated that 11% had been a long standing target and when benchmarking the Trust performed better than others whose performance was between 12% and 14%. She stated that once the gap on vacancies had been reduced, the turnover target could be reviewed. Mr Oldham highlighted the following in relation to financial performance: • The Trust delivered a break even position for 2022/23 despite the variances associated with cost improvement delivery • The position had absorbed covid costs in addition to the wage award shortfall and cost of the Junior Doctor strike • A review of the balance sheet and goods received notes had been undertaken which resulted in a number of funds being released which supported the break even position • External audit were undertaking their review which would be reported to the Board in due course Mr Wakefield welcomed the way in which the finances had been managed during the year. **The Trust Board received and noted the report.**	**JH/AMR**
GOVERNANCE		
15.	**Audit Committee Assurance Report (27-04-23)**	
076/2023	Professor Crowe highlighted the following from the report: • The draft annual opinion from internal audit had been considered which demonstrated an above the line opinion, with opportunities for further enhancements • The external audit was proceeding • An annual return on counter fraud regarding assessing the control standards had been undertaken demonstrating a green rating which was encouraging • The internal audit plan for 2023/24 had been agreed • Some salary overpayments had been identified as being related to job planning sign off and increased discipline was required to sign these off in	

	good time • Partial assurance had been received from internal audit into bank and agency with a number of improvements identified • Q4 stock write offs were £700,000 in year and when compared as a percentage of overall spend was modest • The Committee became inquorate during the meeting resulting in circulating some papers afterwards for approval **The Trust Board received and noted the assurance report.**	
16.	**Board Assurance Framework (BAF) Q4**	
077/2023	Mrs Cotton highlighted the following from the report: • The BAF had been considered by the relevant Committees, with the main movements relating to an increase in risk score for IT infrastructure due to network outages • Additional work had been undertaken in terms of identifying a System BAF and the system had been held up as a case study with the Good Governance Institute for the work undertaken • The draft internal audit into the BAF and risk management had concluded with a substantial / significant audit rating for the sixth consecutive year which had contributed to the Head of Internal Audit Opinion Mr Wakefield queried the lower risk for finance and given the financial outlook going forwards if that was valid. Mr Oldham stated that the rating reflected delivering the break even position and stated that the risk score for Quarter 1 would reflect the challenges in delivering the financial position for 2023/24. Professor Crowe drew attention to the look ahead to the strategic risks for 2023/24 and the top risks identified for the Annual Governance Statement which included a change in risk for 2023/24 regarding financial sustainability. **The Trust Board noted the key observations and confirmed the levels of risk identified and noted the approved strategic risks which would form the basis of the 2023/24 BAF and the Annual Governance Statement. The Trust Board noted the developments planned for the 2023/24 BAF.**	
17.	**Committee Effectiveness and Revised Rules of Procedure**	
078/2023	Mrs Hassall highlighted the following: • The documents summarised the outcomes of the Committee Effectiveness reviews which were presented to Committees in April and focussed on reviewing the processes for each Committee in addition to obtaining comments from members on effectiveness. • The reviews were positive in the main, although a number of improvement actions had been identified • Annual reports for each Committee had been prepared summarising the items of business considered during the year • Terms of Reference had been revised based on the outputs of the reviews with the main changes related to the business cycles which would continue to be reviewed as required throughout the year • It was clarified that the number of Non-Executive and Executive Directors referred to in the constitution, referred to the number of voting members only Professor Crowe and Mr Wakefield thanked Mrs Hassall for the work undertaken and the thorough process and undertaken.	

	The Trust Board: • **Noted the outcomes of the self-assessment process.** • **Noted that annual reports for each Committee had been considered by the respective Committees.** • **Noted that revised Committee Governance Packs had been approved by each Committee, and incorporated within the Rules of Procedure for 2023/24** • **Approved the revised Rules of Procedure for 2023/24, incorporating the Trust Board Business Cycle and Committee Governance Packs.**	
CLOSING MATTERS		
18.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
079/2023	Professor Crowe welcomed the proactive approach to circulating questions beforehand which helped with the discussion and smooth running of the meeting.	
19.	**Questions from the Public**	
080/2023	Mr Syme referred to the backlogs and delays in reporting paediatric scans and queried how the delays were being rectified to ensure timely reporting. Mr Bytheway stated that there were backlogs of 4 months and stated that within 6 months he expected performance to return to a 2 week turnaround. Mr Syme referred to the nursing establishment review and nursing and midwifery shortages and given the NHS workforce demographic was female for the majority in addition to an aging workforce, he suggested that UHNM would need to recruit to increasing numbers of young individuals. He referred to the cost of childcare and the closure of the hospital crèche, and given there were other Trusts nationally which provide crèche facilities for their staff he queried if the Trust had considered reopening a crèche for Trust employees. Mrs Riley stated that this had been looked at and ruled out as viable option. She explained that the Trust did not have enough space and did not have the staff trained to the standards required to run a crèche, and due to being subject to a different regulatory framework it was deemed unviable. She confirmed that there were 45 crèches in the local area including one at County Hospital and stated that the offers available for staff were being communicated. Mrs Riley added that the Trust was looking at what could be done for staff to make their childcare easier such as flexible working and different start and finish times. Mr Syme referred to UHNM having received two section 29 letters from the CQC within several months. He stated that whilst appreciating the considerable workforce constraints within Maternity services he queried why immediate actions were required after the visit and whether these should have been known to the Trust beforehand to avoid women receiving sub-optimal care. Mrs Riley reiterated that the Trust was aware of two issues raised, and therefore this was not a surprise. She stated that the triage processes was part of the Trust's Improving Together work, and a joint project with the LMNS and NHS England was taking place in relation to induction of labour, therefore the work was already underway. She stated that some minor changes were taken on the day of the visit and a lot of work was already in train. Mrs Riley stated that the Trust continued to be transparent in terms of maternity serious incidents, reporting these to QGC and the Board as well as involving the ICB and LMNS. She added that poor experience does not always equate to poor	

	outcomes but accepted there were some women where care could have been improved and these instances were investigated and actions taken to reduce recurrence. Mrs Riley stated that families were included in the investigation whereby the Trust acknowledged the issues as well as offering an apology. Mrs Riley stated that professional maternity advocates were in place to provide support to during investigations and Mr Wakefield stated that in reference to Mr Syme's comment of sub-optimal care, the good score from the maternity friends and family test and assurance that patients and babies were safe demonstrated that whilst improvements could be made, care was not sub-optimal. Mrs Bullock agreed and stated that given the number of births at the Trust, c 6000 in a year, the number of harm related incidents were minimal.	
DATE AND TIME OF NEXT MEETING		
20.	**Wednesday 7th June 2023, 9.30 am, via MS Teams**	

Trust Board (Open)

Post meeting action log as at 31 May 2023

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/569	09/11/2022	CQC Action Plan	To discuss the assurance map with Professor Crowe in order to highlight the work being undertaken to assess the adequacy of assurance.	Claire Cotton	~~31/01/2023~~ 31/05/2023	03/05/2023	It was agreed that the action had been completed, although work to complete the assurance map remained on-going.	B
PTB/571	07/12/2022	Well-Led Self-Assessment	To update the document to include additional narrative for the actions within Section 6, including target dates and to discuss at a future NED meeting.	Claire Cotton Nicola Hassall	~~31/01/2023~~ 31/05/2023	03/05/2023	Noted as complete.	B
PTB/579	03/05/2023	Integrated Performance Report - M1	To provide a summary to board members of the nuances associate with vacancy and sickness rates and links to the nursing uplift.	Jane Haire Ann Marie Riley	30/06/2023		Action not yet due.	GB

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

May 2023

Part 1: Contract Awards and Approvals

2.1 Contract Awards and Approvals

Since 14th April to 15th May, 2 contract awards over £500,000 were made, as follows:

- **Histopathology Outsourcing of Laboratory Specimens and Reporting** supplied by Source Bioscience, for the period 01.09.23 – 31.08.25, at a total cost of £3,202,500, approved on 23.03.23
- **Supply of Hearing Aids** supplied by Oticon and Phonak via NHS Supply Chain, for the duration 01.06.23 – 31.05.27, at a total cost of £890,150, providing Negated Inflation savings of £7,414.92, approved on 31/03/2023

In addition, the following eREAF was approved at the Performance and Finance Committee on 30th May, and also requires Trust Board approval due to the value:

Cytotoxic Dose Banded - Chemo, Immunotherapy and Monoclonal Medicines (eREAF 10811)

Contract Value £14,000,000 incl. VAT
Duration 01/07/23 – 30/06/24
Supplier Quantum Pharmaceutical / Sciensus Pharma / Qualasept Bath ASU / Baxter

The Trust Board is asked to approve the above eREAF.

2.2 Consultant Appointments – May 2023

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Clinical Oncologist - Urology & Colorectal (CRC)	New	Yes	TBC
Locum Consultant Body Radiologist interest in Oncological Imaging	New	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Locum Consultant Orthopaedic Surgeon	Extension	01/05/2023
Consultant Plastic Surgeon	Extension	02/05/2023
Locum Consultant Neonatologist	Vacancy	02/05/2023
Locum Consultant T&O / General Anaesthetist	New	02/05/2023
Consultant Orthopaedic Hand Surgeon	Vacancy	02/05/2023
Specialist Doctor in Breast Radiology	New	02/05/2023
Locum Consultant Neurosurgeon	Vacancy	09/05/2023
Consultant Gastroenterologist	Vacancy	15/05/2023
Locum Consultant Obstetrician and Gynaecologist	New	02/05/2023
Specialist Grade Doctor in ENT	Extension	16/05/2023
Specialist Doctor in Cellular Pathology	New	09/05/2023
Consultant Orthopaedic Surgeon	Extension	16/05/2023
Locum Consultant Ophthalmologist with an Interest in VR	Extension	09/05/2023

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

Post Title	Closing date	Note
Consultant Gastroenterologist	11/05/2023	No Applications
Consultant Hepatologist	11/05/2023	No Applications

2.3 Internal Medical Management Appointments – May 2023

The following table provides a summary of medical management interviews which have taken place during May 2023:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Women's, Children's and Clinical Support Services Medical Director	Vacancy	Yes	09/05/2023

The following provides a summary of medical management who have joined the Trust during May 2023:

Post Title	Reason for advertising	Start Date
Foundation Training Programme Director	New	01/05/2023
Women's, Children's and Clinical Support Services Medical Director	Vacancy	09/05/2023

There were no medical vacancies which closed without applications / candidates during May 2023.

Part 2: Highlight Report

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

National / Regional

3.1 Royal College of Nursing – Notice of Ballot and Voting

On 11th May, I received a letter from the Royal College of Nursing (RCN) in accordance with Section 226a of the Trade Union and Labour Relations (Consolidation) Act 1992 to notify us of the intention to hold an industrial action ballot, opening on 23rd May 2023.

The Ballot relates to a new strike mandate in respect of both the 2022/23 and 2023/24 pay years and the letter outlined the number of staff involved in the ballot, along with their department. The proposed closing date for the Ballot was set as 23rd June 2023.

I will continue to update the Board on this matter as further details become available.

3.2 NHS Response to Covid-19: Stepping down from NHS level 3 incident

On 18th May, I received a letter to confirm that NHS England would be stepping down the Covid-19 level 3 incident. The letter outlined the implications of moving away from the incident arrangements as follows:

- From 30 June, data will no longer be collected on deaths from Covid-19 via the patient notification system
- Standing down the acute Covid-19 data collection process with a subset of data incorporated into existing UEC data collection from June

In addition, National and Regional Operations Centre, responsible for national communications and the outbreak reporting process are being reviewed.

NHS England took the opportunity to thank everybody for the outstanding efforts to deal with the impact of such an extraordinary health emergency and acknowledged the tireless response from all parts of the NHS.

3.3 2023/24 Fellowship Expressions of Interest

On 2nd May, we received confirmation from NHS England that two of our applications expressing an interest in the 2023/24 Fellowship Project were successful and will therefore be hosted by UHNM:

- 40,000 Nurses Commitment Fellows
- Neonatal Fellowship

We were told that the panel were very impressed with our applications and the next steps will include beginning the recruitment process to place a fellow on the project, with Health Education England being keen to participate in this process.

This is excellent news for us and demonstrates the great work being undertaken by our Centre for Research Education Excellence (CenREE) which is really helping to build a positive research reputation for our organisation.

3.4 Elective Recovery

As reported previously, we are in Tier 1 nationally for elective care and cancer, as a result of the number of patients on our elective lists still waiting for their treatment and operations and this means that we are receiving the highest level of scrutiny.

Therefore, during the month a team from NHS England visited both our County and Royal Stoke sites to talk to our endoscopy team, who play a key role in the delivery of both elective and cancer services. The team were keen to understand the challenges we face and how we are addressing these and the feedback was exceptionally positive with the visiting team commenting on our team's commitment and the improvement work underway.

Whilst we recognise that there is much more to do, it was very positive to see the efforts of our team receiving this feedback.

3.5 Visit from NHS England Food and Cleaning Standards

We were also visited at County Hospital by NHS England Food and Cleaning Standards. The visiting lead was very impressed with what he saw and commented via social media that it had been a 'superb visit' with a 'team so focussed on partnership, working across planning, nursing, dietetics, catering and facilities management'.

My thanks go out to all involved as it is clear that the work they do leaves a lasting impression.

System Focus

3.6 Urgent and Emergency Care (UEC) – Tier 2 and Improvement Support

On 10th May, we received a letter regarding the delivery plan (published January 2023) for recovering urgent and emergency care. This highlighted the need to ensure that the very best integrated urgent and emergency care is being provided and in particular, the need to raise standards of quality and safety for the most vulnerable patients and their families, including older people with frailty, children and young people, people with disabilities and those with mental health needs. It outlined two key targets for 2023 / 24:

- **Patients being seen more quickly in emergency departments:** to improve to 76% patients being admitted, transferred or discharged within 4 hours by March 2024, with further improvement in 2024/25
- **Ambulances getting to patients quicker:** with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

NHS England are working with regions and systems to support these improvements and as part of their approach, each system has been allocated into three tiers which determine the level of oversight. As a 'Tier 2' system for UEC, we will receive regionally led oversight through an approach which is tailored to the specific challenges we face. The initial stage will be a system wide 'diagnostic' and below are some examples of support that may be offered:

- Self-assessment framework and maturity indices
- Best practice standards, guidance and case studies
- Support and oversight from the regional team including advice, expertise on operational and clinical leadership aimed at supporting system led improvement and providing clear accountability for the jointly agreed improvement plan

Discussions around the support offer more specifically are underway with NHSE, which are focussed on how we work together to deliver the UEC Recovery Plan.

3.7 Staffordshire and Stoke on Trent Integrated Care Board (ICB) Staff Forum

During the month I was asked to join the Staffordshire and Stoke on Trent ICB staff development forum. This was an interesting event where I was asked to present and facilitate a discussion on opportunities for provider collaboration and to help them understand their potential roles in this regard.

Collaboration is a key focus for all of us and I have discussed this at many forums at UHNM.

Organisational Focus

3.8 Administration and Clerical (A&C) Conference 2023

On 17th May we held our third annual Administration and Clerical Conference which was a huge success and was attended by over 140 colleagues. Speakers shared inspiring personal journeys and gratitude for the work of our A&C workforce, whilst opportunity was also taken to discuss financial wellbeing and our Performance Development Review (PDR) process.

A lot of work goes into organising these events and my special thanks go to Nicola Hassall, Deputy Associate Director of Corporate Governance for ensuring the event was a success on the day. My thanks also go to our Organisational Development Team for their presentations and engagement sessions and to all those involved in providing Market Stalls which provided an excellent opportunity for networking.

3.9 Culture Improvement Programme

As we continue to deliver our Cultural Improvement Programme, I'm delighted that we have launched our 'Being Kind in Action' events. These are aimed at all staff working at UHNM regardless of position. Delivered by Tim Keogh from A Kind Life, this investment has been made as a direct result of what staff have told us.

We have also developed a resource pack on 'micro-aggressions', explaining what they are and importantly how to challenge it if such behaviours are witnessed.

3.10 Freedom to Speak Up Guardian (FTSU)

Our new Freedom to Speak Up Guardian, Rob Irving commenced his role on 22nd May. As well as promoting our arrangements for Speaking Up and being available to listen and support staff with concerns, Rob will be looking at our Speaking Up infrastructure, our policy and our training and will be coming along to a Board Development Session later in the year where we will take the opportunity to complete the 'self-reflection tool'.

3.11 Leaders Network Event

During the month we held an online session in the first of our Leaders Network Events. Attended by more than 300 UHNM leaders, we had a great conversation about our collective behaviours and how through our Being Kind approach we can all play our part in making UHNM a great place to work for everyone.

3.12 Chief Operating Officer

I am sad to advise that due to personal health issues Paul Bytheway has resigned from his post as Chief Operating Officer (COO). I am sure you will all agree and join me in thanking Paul for the massive contribution he has made to UHNM over the last 4 years. Paul is a highly competent and experienced COO who safely guided UHNM through some of our most difficult challenges such as the Covid19 Pandemic, numerous winters and critical incidents, post Covid19 recovery of services and more latterly

through the rigours of national and regional scrutiny in respect of elective waits and ambulance handover delays.

The role of a COO is quite possibly one of the most critical and difficult executive roles so it is important to move forward with finding a substantive replacement. An interim COO has been secured and an announcement will be made in due course. The Nomination and Remuneration Committee will meet on the 7th June following which the substantive recruitment process will commence.

Quality Governance Committee Chair's Highlight Report to Board

1st June 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Medicines related supply chain risks remain ongoing due to pharmacy market instability and national contracting arrangements, this is a moving picture and therefore remains High 12 on the Risk Register • Number of trained staff in pharmacy technical services to deliver aseptic products; alternative options regarding the workforce are being considered and a paper is being taken to the System Quality Group to consider this matter further • The Mortality Review Group are looking into an increase in Standardised Hospital Mortality Ratio (SHMI), although this remains within the expected range for mortality, a more detailed review of diagnostic groups will be reported • There has been an increase in medicines related incidents which is being worked through to further understand • The NHS Oversight Framework report identified are 3 indicators which are in the lowest quartile and which will require improvements to be monitored by the Committee in line with the governance structure – this includes consistency of reporting incidents and a brief paper was requested	• Lots of work being undertaken in relation to Pharmacy workforce with the support of the Chief People Officer which will be taken through the Transformation and People Committee • Electronic Prescribing is subject to a delay due to a 'clinical narrative' incompatibility component which has transpired during the testing phase • An updated version of the Infection Prevention and Control Board Assurance Framework in line with national changes will be reported from July 2023 • Work remains ongoing to address a number of risks identified within the Infection Prevention and Control Board Assurance Framework, including in relation to mask fit testing, cleaning standards • Some of the timescales for completion of actions within the Board Assurance Framework need to be updated including where due dates have deferred • An annual mortality review will be developed in addition to the quarterly reports to provide a longer term view • Clarification will be sought as to whether the Bereavement Services team have completed their review of processes where relatives have raised concerns • A piece of work is being undertaken around timely observations and an update will be provided to the Committee in 2 months • A regular update on progress against the Exit Criteria will be reported to the Committee, with other indicators being highlighted as NOF indicators within the Performance Report • A HealthWatch visit had been undertaken and the report would be circulated • An action plan is underway in response to a Regulation 28 report from the Coroner
✓ Positive Assurances to Provide	**Decisions Made**
• Achieved the antimicrobial CQUIN for all 4 quarters of 2022/23 and the contractual requirements have all been achieved (subject to validation) • Exceptional support was provided by the Pharmacy team during the junior doctors strike action • A bid has been successful at system level by Health Education England to recruit additional Pharmacy Technician students • There has been an improvement in the rate of Serious Incidents, with the last 7 consecutive months all below the mean rate • Family and Friends Test for Emergency Department has improved again during April 2023	• Approval of the Quality Account 2022/24 subject to some minor changes being identified • Approval of the Quality Governance structure for the NHS Oversight Framework
Comments on the Effectiveness of the Meeting	

- The Medicines Optimisation and Safety Report and the NHS Oversight Report will be used as a model of best practice for Effective Reports
- Attendance was low although the meeting was quorate, there was some reflection on the level of scrutiny during the meeting and some differing views – consideration may be given to future scheduling of meetings
-

2. Summary Agenda ! ✓

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Medicines Optimisation and Safety Report Quarter 4 2022-23	BAF 1	ID25152 ID24181 ID23506 ID23500		Assurance	5.	Quality & Safety Report – Month 1 23/24	BAF 1	Ext 20		Assurance
2.	Infection Prevention Board Assurance Framework Q4	BAF 1	Ext 20		Assurance	6.	Quality Account 2022/23	BAF 1	Ext 20		Assurance
3.	Mortality Assurance Report Q4 2022/23	BAF 1	Ext 20		Assurance	7.	NHS Oversight Framework – Assessment Process, Governance, Exit Criteria & Indicators	Various			Assurance /Approval
4.	Serious Incident Highlight Report Q4 2022/23	BAF 1	Ext 20		Assurance	8.	Quality & Safety Oversight Group Assurance Report	BAF 1	Ext 20		Assurance

3. 2022 / 23 Attendance Matrix

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

Attended | Apologies & Deputy Sent | Apologies

Executive Summary

Meeting:	Trust Board	**Date:**	7th June 2023
Report Title:	UHNM Quality Account 2022/2023	**Agenda Item:**	8
Author:	Jamie Maxwell – Head of Quality, Safety & Compliance Department		
Executive Lead:	Mrs 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

BAF 1	Delivering Positive Patient Outcomes	**Ext 16**

Executive Summary

Situation

The attached is the latest draft of the Trust's annual Quality Account. The account summarises activity during 2022/2023. The content of the Quality Account is defined by the Quality Accounts letter issued by NHS Improvement and the NHS Quality Accounts Guidance which continues to apply. Noted NHS providers are no longer expected to obtain assurance from their external auditor on their Quality Account for 2020/21.

The Quality Account has been shared with external stakeholders for completion and return of the final Stakeholder comments from Integrated Care Board, Overview & Scrutiny Committees of both Stoke-on-Trent City Council and Staffordshire County Council and Healthwatch by 1st June 2023. The received stakeholder comments have been included and the Quality account approved at the Trust's Quality Governance Committee on 1st June 2023.

Background

Part A of the Quality Account provides summary of Strategic Objectives, Quality Priorities and Objectives for 2022/2023 and how these will be measured and monitored, participation in clinical audit programmes, clinical research participation, CQINS, PLACE Inspections data quality results and Data, Security and Protection (DSP) Toolkit attainment levels. There are also updates provided in relation to Care Quality Commission inspections and the Trust's own Clinical Excellence Framework visits.

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

The identified priorities for 2023/2024 are:

- To reduce patient harm and improve clinical effectiveness and outcomes for our patients
- To improve patient experience
- To further develop staff wellbeing and experience

Part B of the account reviews the Trust's Quality Performance for 2022/2023 against the priorities that were identified last year. These include both local and national results and how the indicators compare against the different targets that had been set.

Part C has been updated as of 1st June 2023 with received stakeholder comments which have provided positive feedback on the presentation and content of the Quality Account.

Assessment

The Quality Account for 2022/2023 meets the statutory and regulatory requirements and includes all the required information. There are some outstanding data that will require updating but at time of the final draft being published are not yet available via national sources.

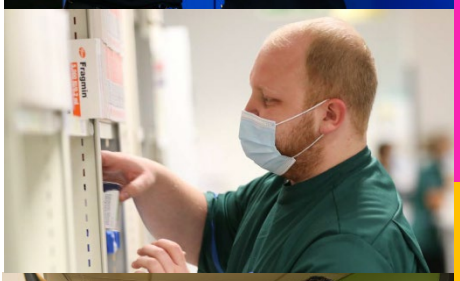
There has been good engagement in the completion of the variation sections from identified leads and has been shared for external stakeholder comment with received statements included.

Key Recommendations

The Trust Board are asked to:

- To approve the Final Draft version of the latest Quality Account 2022/2023 along with the quality priorities for 2023/2024 and links to existing Trust aims and objectives.

NHS
University Hospitals of North Midlands
NHS Trust



UHNM Quality Account 2022/2023

CONTENTS

Part A: Statement on quality

OVERVIEW

1. Introduction to UHNM

Welcome to the Quality Account for the University Hospitals of North Midlands NHS Trust (UHNM) for 2022/2023. As we review the last 12 months and consider our priorities for the year ahead, we reflect on the impact the continuing challenges and developments have had on our hospitals, our staff and our patients.

We are committed to providing safe, high quality care to our communities and we continue to focus on delivering quality improvement in all we do. Despite all of the pressures brought on by COVID, we have continued to demonstrate the commitment of our staff to improve the quality, safety and experience of patients in our care. We will continue to achieve this by developing our staff and empowering and equipping them to deliver excellence every day resulting in improved patient outcomes, staff morale, productivity and efficiency.

Our staff have continued to adapt and show resilience under extreme pressure and acted with compassion and professionalism. That care and compassion was acknowledged with an 'Outstanding' rating in the care domain during our most recent Care Quality Commission (CQC) inspection. This report aims to provide an open and honest account of where we have moved forward, both as a result of and despite the pandemic, and where we still have further improvements to make.

UHNM has two hospital sites, Royal Stoke University Hospital and County Hospital, and we are extremely proud of the services provided across both sites. We are a large, modern trust in Staffordshire, providing services in state-of-the-art facilities. We provide a full range of general hospital services for approximately 900,000 people locally in Staffordshire, South Cheshire and Shropshire.

We employ around 11,000 members of staff and we provide specialised services for a population of three million people, including neighbouring counties and North Wales.

We are one of the largest hospitals in the West Midlands and have one of the busiest emergency departments in the country, with an average of nearly 15,000 patients attending each month across both of our sites. Emergency patients are brought to us from a wide area, by both helicopter and land ambulance, due to our Major Trauma Centre status, as we are the specialist centre for the North Midlands and North Wales.
As a University Trust, we work very closely with our partners at Keele and Staffordshire Universities and we are particularly proud of our medical school

which has an excellent reputation. We also have strong links with local schools and colleges. We hold a large portfolio of commercial research, which provides us with a source of income, and our research profile also enables us to attract and retain high quality staff.

Working alongside our University Partners we have a newly developed Centre for Nursing, Midwifery and Allied Health Professions Research and Education Excellence (CeNREE). At CeNREE the focus is on increasing research that is led by nurses, midwives and AHPs to improve patient experience and outcomes by providing a clear structure of support and resource for research, academic and professional development and Clinical Academic Careers (CAC).

Royal Stoke University Hospital

The County Hospital (Stafford)

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

We are a key player in the Integrated Care System (ICS) and take an active part in the planning and discussions. The health economy plan remains focused on minimising admissions to and discharging as soon as possible from the major acute site at Royal Stoke University Hospital, with as much care as possible is being delivered in community settings or at County Hospital.

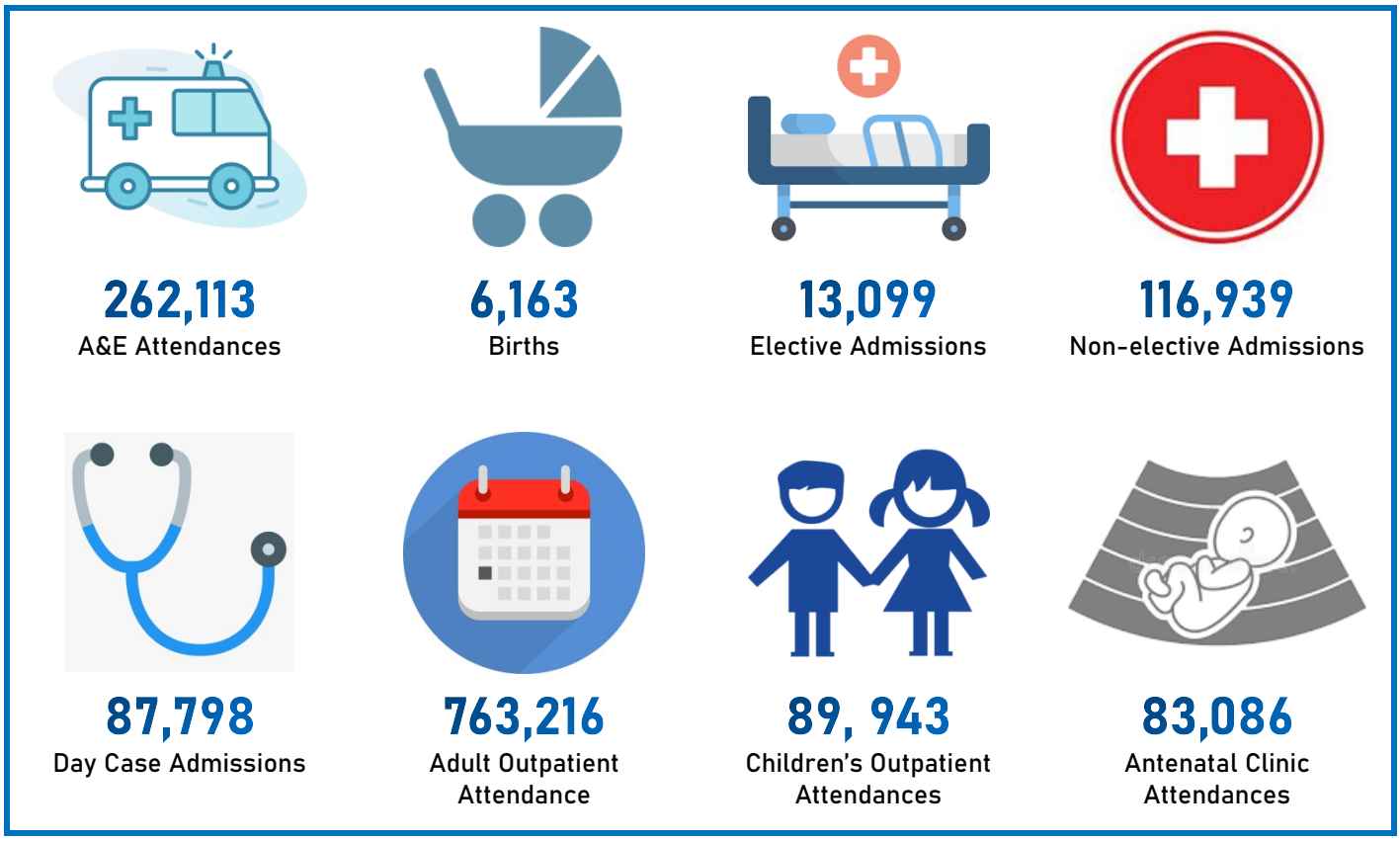
We benefit from being able to attract and retain high quality staff. In order to do this we need to continue to maintain and expand our tertiary capabilities to service the populations of North West Midlands, Derbyshire, Wales, South Manchester and the northern suburbs of Birmingham.

Postgraduate Medical Education has strong links with both Keele and Staffordshire Universities. All our trainees are allocated from Health Education England, West Midlands. We are looking at a possible expansion in our foundation doctors and are working with directorates to look at opportunities.

Nursing and midwifery continues to maintain strong links with Keele and Staffordshire Universities supporting the development of registered nurses in addition to nursing associates and the provision of a wide range of post registration courses. In-house developments have seen the development of a *'Skills Escalator'* enabling our staff to undertake career progression though apprenticeships both at unregistered and registered levels as part of our '*Grow Our Own Strategy'*. The Centre for Nursing, Midwifery and Allied Health Professions Research and Education Excellence (CeNREE) provides on-going staff development opportunities through initiatives such as the Chief Nurse

Fellow programme and Legacy Mentor Programme, in addition to application and on-going support for masters and doctoral degree programmes, enabling the highest levels of evidence-based practice.

2022/2023 Activity Data



2. Statement on quality

The period covered by this Quality Account is from 1 April 2022 through to 31 March 2023. Our teams here at UHNM continue to show their commitment to improve the quality, safety and experience of patients in our care.

We would like to express, on behalf of the Trust Board, our deep and sincere gratitude to colleagues working across our hospitals for their unwavering commitment and dedication throughout another challenging year. We have been overwhelmed by our teams continued professionalism, flexibility and positivity to transform and improve the way we deliver services.

So many staff have, and continue to, worked tirelessly under immense pressure and within the tightest of timescales and there is much to be proud of, including:

- Urgent elective and cancer services continued to be delivered;
- In 2022, 20,696 referrals were received by the 2hr Community Rapid Intervention Service (CRIS) service run by UHNM
- Some face to face Outpatient appointments were reintroduced in combination with virtual appointments – by telephone or video – enabling the Trust to keep people safe whilst continuing to deliver their essential care;
- Introduction of Tendable – our new real time electronic ward/department quality and safety audit system;
- Launch of the Safe Mobility Ambition and the Nutrition and Hydration Ambition – these form part of a suite of harm free care ambitions that support delivery of our Quality Strategy. The ambitions highlight key priorities over the next 3 years;
- Development of 30 Professional Nurse Advocates across the Trust with training planned for further 25 during 2023/24. These posts are supporting the retention of valued staff and supporting career development and progression;
- Investment in recruiting staff within maternity services, dietetic service for Oesophageal cancer and AMU;
- Appointed new Lead for Vulnerable People who is responsible for planning, development and implementation of an efficient, effective and high quality strategic approach to safeguarding children, adults at risk, the Mental Health Act, dementia, learning disabilities and autism.
- Appointed our first Patient Safety Partner as part of Patient Safety Incident Review Framework (PSIRF) implementation

Our people are our greatest asset and we have continued to provide packages of support and offers of wellbeing provision as well as develop our teams through our quality improvement programme 'Improving Together', to empower and support all colleagues and departments to make changes, no matter how small, to deliver better services and play a vital role in building healthier, happier, fairer lives for the people we serve – our patients, our people and our local communities.

On 1 July 2022, the 42 Integrated Care Systems in England evolved and created new structures, to deliver new national legislation. The relationships with all our partners across our system are highly valued and are seen as central to our collective success. In March 2023, Staffordshire and Stoke-on-Trent's first Integrated Care Strategy was published, that focused on long-term priorities to prevent ill health, reduce inequalities and deliver better health and care services for our population. Close partnerships across the NHS, local authorities, the volunatary community social enterprise sector, healthwatch, hospices, universities and wider public sector organisations are crucial in implementing this strategy. We are grateful to our partners within the Staffordshire and Stoke-on-Trent Integrated Care System and beyond for their support throughout the year and look forward to working closer with them throughout 2023/24.

Looking ahead to 2023/24 we will continue to address our biggest challenges around capacity and demand with focus on urgent and emergency care across both our sites and our recovery process so we can deliver safe quality care to those who need it the most. In doing so, we will build on partnerships, such as with the Midlands Partnership Foundation Trust (MPFT) and the West Midlands Ambulance Service (WMAS) to ensure our patients are supported at the right time and in the most appropriate place.

We made good progress against our quality and safety priorities during the year, including:

- 45% reduction in Category 3 Hospital Acquired Pressure Ulcers with 'lapses in care' in 2022/23 compared to 2021/22 totals
- Improvement in Sepsis screening for Inpatients
- Continuing to exceed the 95% National Target for Harm Free Care (New Harms)
- Continuing to compare well against our peers during and remaining within expected ranges for both HSMR and SHMI mortality indicators
- Sustained improvement in exceeding national VTE risk assessment compliance with average 99%
- Reduced rate of formal complaints received during 2022/23 from 2021/22
- Our Speaking Up Index score as part of Staff Survey has improved year on year
- Reduced number of Never Events compared to 2021/22

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

- Crowded Emergency Departments with long waits.
- Long waits for ambulances and delayed handovers.
- Continued improvement in Sepsis screening compliance and pathway
- Further reduce avoidable harm
- Elimination of long waits elective care, planned operations and cancer care.
- Responding to increased demand for our services which has been made worse by the COVID pandemic.

It has been a challenging year for all but also one that we are very proud of. Attendances across the Emergency Departments were in excess of 262,000 having an impact on the number of ambulance handovers transacting in a timely manner, patients seen within four hours and those waiting over 12 hours for admission into the hospital. To mitigate these delays and improve patient experience numerous initiatives have focused on improving flow through the hospital, the most significant of which include:

- Front Door Reconfiguration (to ensure sufficient physical space to appropriately handover and treat patients in the emergency department).
- the implementation of the Referral and Admission Policy (to ensure timely specialty input in the most appropriate environment where such expertise is required).

It is widely acknowledged that waiting lists across the NHScontinue to increase following COVID, with UHNM being no exception.

We have seen an increasing amount of open Referral to Treatment pathways throughout 2022/23, at the end of the year at 77, 000 open pathways. This has resulted in an increase in patients waiting over 52 weeks for treatment.
The number of patients waiting less than six weeks for a diagnostic test has improved to 78% compared to 69% in 2021/22. With waiting lists increasing, as part of the recovery, focus has been on improving DNA rates, theatre utilisation and reducing cancelled operations – all of which have improved during the year.

It has been an incredibly challenging year for all of us but it is also one that has made us very proud to be Chairman and Chief Executive of UHNM. Undoubtedly there will be further challenges ahead for us throughout 2023/24 and beyond but given we have seen what our UHNM teams can do we are confident that together, we will come through and we look forward to seeing how the 'new NHS' evolves. We hope you enjoy reading this Quality Account.

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

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

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

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

David Wakefield
Chairman

Tracy Bullock
Chief Executive Officer

2.2 Strategic objectives

'Our 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 patients receive the highest standard of care and the place in which the best people want to work.

"Delivering Exceptional Care with Exceptional People"

To achieve Our 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 need to think further than the 'here and now' and continue to look beyond the boundaries of our organisation for inspiration. Our involvement in the ICS is crucial in enabling us to move towards our vision and to become a sustainable provider of healthcare services for generations to come.

Our strategic objectives

Our vision is underpinned by six key strategic priorities:

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.

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

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

Priorities for improvement

3.1 Our quality priorities and objectives for 2022/23

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

We want everyone who works at UHNM to share this vision and place quality at the heart of everything we do by embracing and demonstrating the following Trust values of Compassion, Safety, Improving and Together. The Trust is supporting this vision through a number of initiatives.

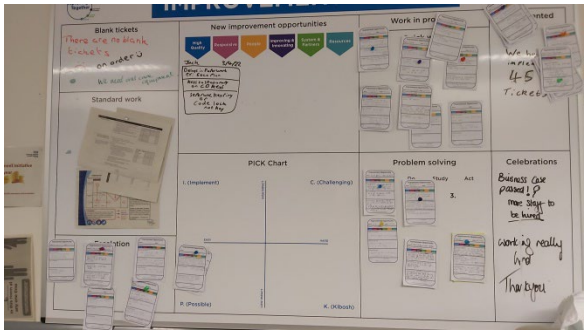
Improving Together

In 2021/22, through the implementation of the Improving Together programme, the Trust established its new strategic planning framework, with six strategic priority domains (a clear and certain direction for our work) being shared with teams across the Trust.

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

These domains allow all members of UHNM staff to align their work with the priorities of the organisation. The metrics associated with these domains allow the Trust to understand if it is delivering the services to the required standard for its patients and help to identify where improvements can be made.

In the second year of this new way of working a further 13 teams were trained in the tools and routines to enable continuous improvement to become part of everyday work of the Trust. This brings the Trust total number of teams trained to 36. With the Quality Improvement Academy's focus being County Hospital site, the teams trained include: Wave2 - Elective Orthopaedic Unit and Ward 8, and in Wave 4 wards 1, 12, 14, 15, Pre-Admissions Clinic and County Theatres. In addition the two outstanding management teams have been trained – Imaging and Pathology. These teams have had five months of training and coaching in the new skills and are now embedding them into practice. This year has also seen the introduction of 3 e-learning packages for which staff can self-register, in addition to the section on Trust induction that all new starters complete. These packages along with stand-alone 'bootcamps' to upskill new team members means that in total 2,356 staff currently working at UHNM have Improving Together training at some level on their ESR.



Over the course of the 12 months the Divisions and Directorates progressed improvement work on their agreed priorities with most showing good progress and many meeting and sustaining their desired targets. For example WC&CSS Division delivered CO monitoring in pregnant women; Surgery Division achieved sustained delivery of the Cancer 2 week wait standard and Network Services delivered sustained reductions in the number of falls with harm. A refresh of these priorities for 23/24 has taken place, those not delivered last year continue with new opportunities to improve agreed with the Executive team. These will be cascaded to the Directorates and this year for the first time down to ward level, where teams have been trained in the methodology. This process creates a golden thread from ward to Board of aligned priorities for improvement.

Our frontline teams are now able to share their improvements on a monthly basis with their Chief Nurse, through the establishment of the Improving Together Team Leadership Council. A representative from each trained area is invited to present their work in this forum, sharing good practice across the teams, creating peer support and also an opportunity to escalate challenges where they exist. The highlight report from these meetings are published on the Trust intranet improving-together-team-leadership-council-meeting-highlight-report-febr.pdf

As we move into 2023/24, the Quality Improvement Academy continues is focus at County Hospital through Wave 5 & 6 of training. This will see completion of both elective surgical and acute medical patient pathways. In addition the summer months will see the training of the Royal Stoke Emergency Department team and Site Management team, preparing them to use these new tools and routines through the winter months.

Finally, in quarter 1 of 2023/24 a new Executive Improving Together Leadership Development Forum will commence. This forum will underline the Executive Team's commitment to Improving Together being the way we work at UHNM and support them in developing the senior leaders of our organization in the tools, routines and behaviours needed to develop a Learning Improvement Culture.

Centre for Nursing, Midwifery and Allied Health Professions (NMAHP) Research and Education Excellence (CeNREE)

CeNREE was launched on 25th April 2022 in response to a desire from UHNM to have a service where research remains highly integrated with clinical practice throughout a clinical career. The UHNM 2025 Strategic Vision includes a goal to be a world-class centre of achievement, where patients receive the highest standards of care and the best people come to learn, work and research. This has led to the development of CeNREE and their mission statement:

The mission of the Centre for NMAHP Research and Education Excellence (CeNREE) is to create the most supportive environment possible so that our researchers, practitioners, and learners can do what they do best: improve clinical outcomes and experience through access to clinical research for staff and patients. Excellence will be applicable across the wider NHS through leadership and excellence in nursing, midwifery and allied health professional education, research and practice.

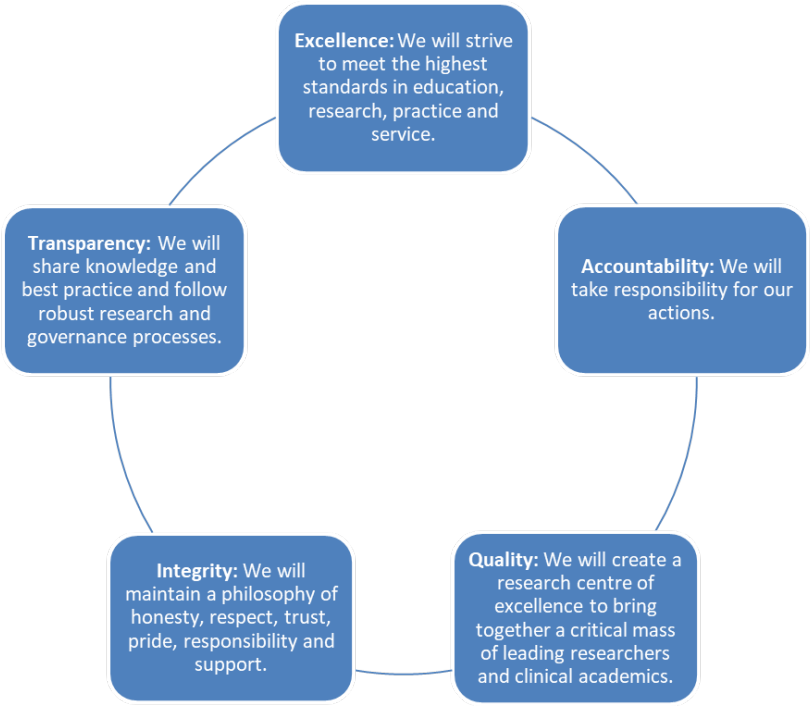
CeNREE Fellows and Chief Nurse Fellows attending their first day of teaching alongside Chief Nurse Ann-Marie Riley and Assistant Director of Nursing (NMAHP) Research & Academic Development and CeNREE Lead Dr. Alison Cooke

More recently CeNREE has extended its portfolio to internal fellowship opportunities which provide staff with access to professional development tailored to organisational needs and encourage and energise staff to then consider and pursue more advanced opportunities. The infrastructure created by CeNREE is focused on the talent management of UHNM NMAHPs, developing a culture of professional curiosity and advanced knowledge and skills.

In the first year CeNREE have:

- Provided support to over 70 NMAHPs
- The CeNREE Lead has achieved the NIHR Senior Research Leader award
- Two prestigious NIHR PCAF fellowships, one Cystic Fibrosis Trust fellowship, one North Staffs Medical Institute grant and one West Midlands Clinical Research Network Personal Development grant have been awarded
- CeNREE and the Improving Together Team hosted a successful symposium
- CeNREE hosted an internship programme for a PhD student
- The CeNREE Lead has been invited as a member of CNO Research Transformation Leaders Network and to represent UHNM as a member of the CoDH Clinical Academic Roles Implementation Network (CARIN)
- CeNREE provided a Stepping Stone pump priming opportunity for staff, after successful application of UHNM Charity support
- CeNREE have developed two internal fellowship opportunities for staff development, including in the first cohort three UHNM staff members on the CeNREE Fellowship Programme and eight UHNM staff members currently on the Chief Nurse Fellowship Programme

CeNREE Values:



Prioritising our quality improvement areas

We have continued our focus on quality aligned to our strategic objectives and 2025Vision.

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

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

The impact of the pandemic has been far reaching for all our communities and our staff. It has been a period of significant and fast paced change impacting on how we deliver our services and the ways our colleagues work. We recognise that compassionate and engaging leadership will be the critical component to how we move through and we will provide a full programme of support and development to all our leaders and their teams.

Our plan has our Trust values firmly at its core. We continue to promote a compassionate culture through our values, which identify the attitude and behavioural expectations of our staff with inclusivity at the heart of our values. These values are threaded through the People Plan priorities in response to the feedback received from our cultural review.

Our overall goal for 2023/24 is:

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

Aims

To reduce patient harm and improve clinical effectiveness and outcomes for our patients

How will we do this:

- To reduce our patient waiting lists and backlogs and maintain patient safety
- To reduce ambulance handover delays in conjunction with our partner providers
- To reduce avoidable harm
- To benchmark against national best practice and assess our outcomes and effectiveness
- Improve how we share learning
- Implement new national PSIRF
- Improve sepsis treatment and recognition of deteriorating patients;
- Evaluate and introduce new technologies and techniques for treating patients;
- Increase the visibility of research and the capability of staff to lead research and provide evidence-based practice; and
- Continued delivery of the Improving Together Programme.

We will measure this through:

- Quality Performance Report;
- Harm Free Care;
- Incident analysis and thematic reviews;
- Legal claims;
- Mortality reviews and outcomes;
- Getting It Right First Time (GIRFT) reviews and analysis;
- Clinical audits

To improve patient experience

How will we do this:

- Improve sharing of learning from patient feedback and involve patients in learning and improvement with a particular focus on ''seldom heard' patient groups
- To develop the role of Patient Safety Partners and PSIRF implementation
- Ensure that all research is aligned with Trust strategic priorities and includes outcomes that will benefit our patients
- Formalise patient engagement and coproduction in research, patient safety programmes and improvement initiatives

We will measure this through:

- Inpatient and Outpatient surveys;
- Complaints and PALS themes; and
- Patient stories.

To further develop staff wellbeing and experience

How will we do this:

- To further develop staff wellbeing and experience
- Supporting the Trust's wellbeing programme and activities that focus on staff wellbeing and empowerment including #BeingKind compact
- Ensuring that staff are working within COVID-19 secure environments and are provided with the support which meets their needs;
- Supporting staff and services in providing care in 'new ways' following COVID-19;
- Promoting mental health wellbeing and support;
- Delivering the Improving Together Programme; and
- Provide staff with research, professional and academic development opportunities through CeNREE.

We will measure this through:

- The nation NHS staff survey;
- Pulse Checks;
- Staff Voice;
- Chief Executive briefings; and
- Freedom to Speak Up report

3.2 How we have performed against quality key performance indicators

** Results published by NHS Digital Quality Accounts data sets for mandatory indicators. The most up to date data is included.*

Quality Indicator	Previous Period		Current Period / Latest Published
The value of the Summary Hospital level Mortality Indicator (SHMI)	**January 2021 – December 2021** 1.02 (Band2)		**January 2022 – December 2022** 1.05 (Band 2)
The percentage of deaths with palliative care coded at either diagnosis and/or specialty level	1.9%		1.8%
Patient Reported Outcome Measures scores* *(National Average)* Groin hernia surgery Varicose Vein Surgery Hip Replacement Primary Surgery Knee Replacement Primary Surgery **EQ-5D scores finalised data release*	**Participation Rate 2020/21** - - *- (66.5%)* *9.0% (66.5%)*	**Health Gain 2020/21** - - *0.830 (0.472)* *0.431 (0.315)*	Awaiting new data publication available from NHS Digital portal
Percentage of patients aged 0 to 15; and 16 and over Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital	2021/2022 17.1% 14.5%		Awaiting new data publication available from NHS Digital portal
The Trust's responsiveness to the personal needs of its patients	**2021/22 Survey** TBC		Awaiting new data publication available from NHS Digital portal
Percentage of staff employed by the Trust who would recommend the trust as a provider of care to their friends and family (Agree / Strongly Agree)	**2021** 69.7% *England Average Acute Trusts 66.9%)*		Awaiting new data publication available from NHS Digital portal
Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (Acute Trusts) *(National Average)*	**2019/20** Q1 93.79% (95.56%) Q2 93.99% (95.47%) Q3 93.29% (95.33%) Q4 TBC % (TBC%)		Awaiting new data publication available from NHS Digital portal
The rate per 100,000 bed days of Clostridium Difficile infection reported within the Trust amongst patients aged two or over (Trust apportioned)	**2020/21** 51.0		**2021/22** 46.7
The number and rate of patient safety incidents reported within the trust - Acute trusts (non specialist)	April 2020 – March 2021 16440 45.8 per 1000 bed days		No new data publication available from NHS Digital portal March 2023 - Indicators are under review for future NHS Outcome Framework
The number and rate of such patient safety incidents that resulted in severe harm or death— acute (non specialist)	April 2020 – March 2021 35 0.1		

Commissioning for Quality and Innovation (CQUIN) Indicators for 2022/23

The Commissioning for Quality and Innovation (CQUIN) financial incentive scheme was suspended for the entire period of the COVID-19 pandemic. To support the NHS to achieve its recovery priorities, CQUIN has been reintroduced from 2022/23.

NHS England and NHS Improvement identified a small number of core clinical priority areas, where improvement was expected across 2022/23. In general, these are short-term clinical improvements that were selected due to their ongoing importance in the context of COVID-19 recovery and where there was a clear need to support reductions in clinical variation between providers.

CCG/ICB scheme- There were 9 clinical priority areas highlighted for adoption in Acute Trusts and Trusts were instructed to choose five schemes. As UHNM agreed an Intelligent Fixed Payment Contract with local commissioners, there was no incentive CQUIN funding or need to negotiate the five most important indicators. Although UHNM was not required, from a contract perspective to adopt five CQUINS, there was a quarterly reporting requirement for all nine schemes.

It was decided that although UHNM was not contractually obliged to do so, we would adopt five schemes in order to implement clinical improvements.

The selected schemes are as follows:

- CCG1: Flu vaccinations for frontline healthcare workers
- CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+
- CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
- CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service
- CCG8: Supporting patients to drink, eat and mobilise after surgery

In conjunction with the Clinical Teams, the Clinical Audit Department have undertaken quarterly audits to demonstrate progress and provide assurance against the above.

Specialised Services (PSS) scheme – UHNM were required to adopt three PSS schemes as detailed below, which had been selected by the Specialised Commissioners:

- PSS1: Achievement of revascularisation standards for lower limb ischaemia
- PSS2: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery
- PSS5: Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines

Scheme leads were identified and audit/reporting arrangements agreed to demonstrate improvements in each scheme.

A similar model has been proposed for 2023/2024.

4. Patient stories

I started with migraine headaches in about 1996- I put down the cause of these as being an RTA- I certainly didn't suffer with migraines before I had the accident. I initially tried to self-medicate but over the years, the migraines have got progressively worse and more frequent. At the worst point, I was only having 2 or 3 migraine-free days a month. These migraines affected every part of my life- my work, my home, my social life. It felt like I had a screwdriver being driven behind my left eye. I tried every treatment available from reflexology and acupuncture to chiropractor and physiotherapy. I took more and more medications, starting on minimal dose and gradually increasing to the highest dose possible. At my lowest point, I would sit in bed, rocking, cradling my head. I genuinely contemplated suicide I was in so much pain. I couldn't see an end to them and it felt like no matter what I did, I was getting worse not better.

I was initially referred to see a neurology consultant at UHNM and a new type of treatment was started. It worked for a while but again, eventually became less effective. Out of desperation, I was referred to the National Migraine Centre. I was told I was overmedicating so had to go cold turkey for a month- withdraw from all medication completely, before I could start a new treatment. It was a month of hell but I did it. After the month, I was started on a new drug called Fremanezumab in the form of monthly injections which I had to pay for privately. The immediate relief was huge. After a couple of months, I was down to around 4 or 5 episodes a month instead of 25. However, continuing to pay for these injections was not sustainable, although the thought of not being able to continue with this treatment was unbearable.

Last October, I was referred back to UHNM under the Headache Team and saw Claire Winstanley. The team has been amazing. I am now having the injections on the NHS every month and the difference it has made to my life is miraculous. I am so grateful to UHNM that they provide this life-changing treatment.

I am writing to pay tribute to members of the team for the first-class care I received recently at UHNM.
In November, I severely injured my left wrist in an accident at home with an electric saw and was taken to the Emergency Department where I was seen immediately. My wonderful initial experience at the hands of hospital staff continued with treatment from a nurse called Leanne before I was transferred to Ward 225. It was while I was there that I was visited by one of the Anaesthetists, Dr Greenway, who was, quite simply, the epitome of kindness. His communication skills were second to none and he explained perfectly the procedure I was about to undergo in theatre. Unable to have a general anaesthetic, I had something I learned was called a "block". As well as being truly grateful that this technique could be used to operate on me, it was a real eye opener for how operations work.

Dr Greenway remained with me throughout the operation, talking to me for over 2 hours, which, for that alone, he deserves a medal!

I have visited many great theatres in the performing arts sector and seen some great performances but none that came close to the theatre at the Royal Stoke. Every member of the medical cast that day was a first-class act. My superb experience at the hospital continued with the after-care treatment from the Occupational Therapy Team led by Debbie Ferneyhough and Ujaala Yonnis. Both of these ladies are a real credit to the NHS with their impressive people skills and outstanding professional care.
I finished my treatment in January and will remain forever grateful to everyone involved in the wonderful care I received.

5. Statement of assurances

5.1 Review of services

Care Quality Commission

The Trust was last inspected on 24 and 25 August 2021 and the inspection followed the new regime for inspection. The CQC carried out a short notice announced inspection of the following acute services provided by the Trust and inspected two core services due to concerns about the quality and safety of services. These were:

- Urgent and emergency care at the Royal Stoke University Hospital; and
- Medicine at the Royal Stoke University Hospital.

The CQC also carried out two focused inspections as part of the continual checks on the safety and quality of healthcare services. These were:

- Medicine at County Hospital. This was a focused inspection on the safe, effective and well-led key questions: and
- Surgery at County Hospital. This was a focused inspection of safe and well-led key questions.

The final report was published on 21 December 2021. The overall rating for the Trust stayed the same. The CQC rated UHNM overall as **'Requires Improvement'**. The CQC rated the reviewed services as follows:

- Medicine at County Hospital – Requires Improvement
- Surgery at County Hospital – Good
- Urgent and Emergency Care at Royal Stoke University Hospital – Requires Improvement
- Medicine at Royal Stoke University Hospital – Good

Some services previously rated requires improvement were not inspected because the latest inspection was focused only on services where there were concerns or had not been inspected for some time. The CQC continue monitoring the progress of improvements to the services and will re-inspect them as appropriate. Services previously rated as Requires Improvement and not inspected this time include:

- Urgent and Emergency Care at County Hospital.
- Outpatients at County Hospital and the Royal Stoke University Hospital.

Whilst the CQC rated the Trust overall as Requires Improvement, we did see improvements in two of the domains

- Caring improved from Good to Outstanding
- Well Led improved from Requires Improvement to Good

The table below shows the rating by the five key domains and compares results to previous inspections:

Domain	June 2019 Ratings	August 2021 Ratings	
Are services safe?	Requires Improvement	Requires Improvement	●
Are services effective?	Requires Improvement	Requires Improvement	●
Are services caring?	Good	Outstanding	★
Are services responsive?	Requires Improvement	Requires Improvement	●
Are services well led?	Requires Improvement	Good	●
Overall	Requires Improvement	Requires Improvement	●

Section 29A Warning Notice

Following the inspection in 2021, the CQC served a Warning Notice under Section 29A of the Health and Social Care Act 2008. This warning notice served to notify 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 needs medicine at County Hospital required significant improvement. UHNM submitted a comprehensive response to the CQC, within the required timescale.

On Tuesday 4th 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 the Royal Stoke University Hospital they still had concerns about the assessment, recording and mitigation of risks associated with acute mental health concerns in medicine at County Hospital and subsequently issued a 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. At time of reporting, the Trust have not received any feedback about the outcome of the evidence review.

Although the CQC rated the safe and effective domains for medical care at County Hospital Inadequate, the overall ratings for both County Hospital and the Trust overall remains as 'Requires Improvement'.

The CQC also conducted a focused visit to Maternity Services on 7th March 2023. At the time of reporting, the full report is awaited. Concerns were raised in two areas:
1. Delays in maternity triage meaning some women waited longer than the 15 minute target.
2. Management of induction of labour delays.

This resulted in the issue of a Section 29A Warning Notice under the Health and Social Care Act 2008, on 28th March 2023. The Trust is required to provide evidence of significant improvement in relation to the Section 29A warning notice by 30th June 2023. All required actions were implemented during the inspection process.

Section 31 Notices

On 19th June 2019 the Trust was served notice under Section 31 of the Health and Social Care Act 2008, imposing specific conditions in relation to the Emergency Department at Royal Stoke and Medical Care (compliance with Mental Health Act Code of Practice) at Royal Stoke.

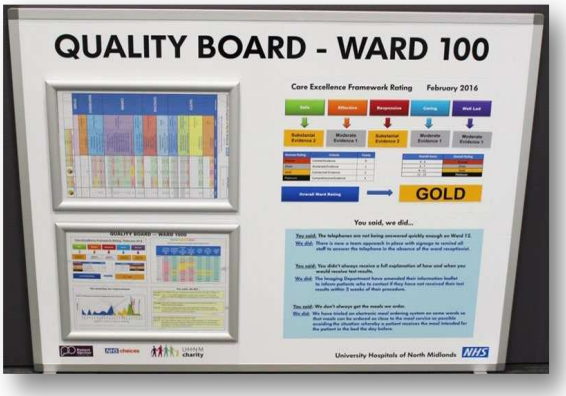
A weekly report was developed, which set out the specific detail of conditions imposed along with an Assurance Framework that detailed the immediate actions taken in response along with monitoring arrangements, ongoing assurance mechanisms and supporting evidence available.

In September 2020, the CQC removed the conditions in relation to the Mental Health Act code of practice but the conditions relating to the Emergency Department remained in place because:

- The Trust had not yet achieved 95% compliance with assessing patients within 15 minutes of arrival in emergency department at Royal Stoke University Hospital;
- Audits undertaken did not provide the CQC with full assurance of the systems in place to ensure that patients are assessed within 15 minutes of attending the department by suitably qualified and trained staff in line with national guidance; and

In response to the letter received, the weekly report was amended and enhanced in order to provide the CQC with additional assurance. Since January 2022, the CQC have accommodated monthly reporting. A further application has been submitted by the Trust, in April 2023, both to vary the condition and also to remove the conditions relating to the Emergency Department at Royal Stoke University Hospital.

Care Excellence Framework



The Care Excellence Framework (CEF), developed at University Hospitals of North Midlands NHS Trust, is a unique, integrated tool of measurement, clinical observations, patient and staff interviews/feedback, benchmarking and improvements.

- Safety
- Effectiveness
- Responsive
- Caring
- Well led

It is supported by data from clinical indicators and intelligence and is an internal accreditation system providing assurance from ward to board which is aligned to the National quality agenda, the Health and Social Act (2021), the National Outcomes Framework (2022), the CQC Quality Statements and UHNMs Strategic priority objectives. An overall award for each ward/department based on evidence collated is given, the awards range through bronze, silver, gold and platinum.

The CEF has been established at UHNM since 2016. It has been modified and adapted to enable its use in all areas of the organisation. Bespoke tool kits are available for inpatients, paediatrics, maternity, outpatients, theatres and the emergency department. The tool kits are regularly reviewed to reflect current issues and areas requiring focused improvement.

Each ward/department will have at least one Care Excellence visit per year reviewing all domains and will receive ad-hoc visits throughout the year to seek assurance with regards to individual domains. The CEF is delivered in a supportive style fostering a culture of learning, sharing and improving, as well as reward and recognition for achievement. We are able to demonstrate improvements and trends over time which help to benchmark and spread excellence across the organisation.

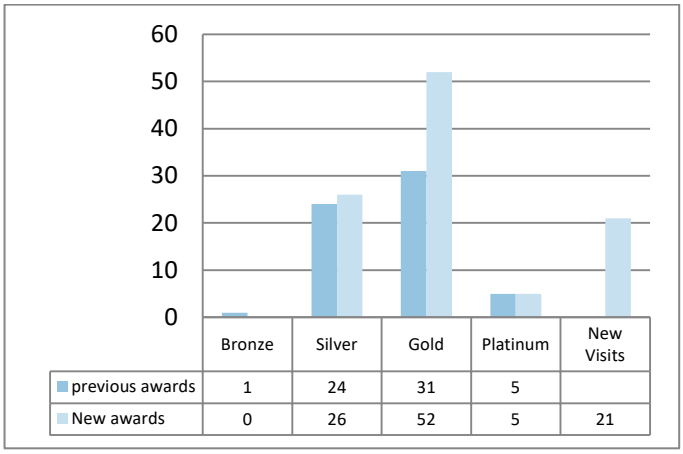
A review of the process was completed during 2022. Following consultation with staff groups, changes have been made to the CEF tool kits which include:

- The addition of anonymous staff comment collection boxes
- Opportunity for ward/department manager feedback
- Local sharing of reports for checking for factual accuracy before they are shared with wider divisional and executive teams in line with the CQC process
- Development of an award criteria to enable robust allocation of awards that are driven by quantitative as well as qualitative achievements.

- Allocation of MUST do actions and given any immediate positive feedback at the time of the visit.
- Appointment of a Senior Nursing Assistant to support areas with action plan assurance and engage staff in sharing successes and identifying improvements.

Below is a summary of the published reports from 2022-2023. 102 visits were completed including 21 new areas visited for the first time.

Published CEF Awards 2022/2023



	Bronze	Silver	Gold	Platinum	New Visits
previous awards	1	24	31	5	
New awards	0	26	52	5	21

Ward 8 – Platinum CEF Award January 2023

PLACE inspection

UHNM returned to a full PLACE inspection in Autumn 2022 following a two year pause introduced nationally due to COVID-19. UHNM achieved above the national average for all but one of the domains below which was ward food which marginally fell below the national average score. An action plan has been produced to support areas where improvements are required. The PLACE scores achieved in 2022 for UHNM and its sites Royal Stoke and County Hospitals demonstrate that the hospital environment for patients from a non-clinical perspective at UHNM continues to provide a positive experience for our patients. Good environments and services that respond to the needs of our patients really do matter and thanks go to all staff for their continued hard work and commitment in this area.

Special recognition goes to our Estates, Facilities and PFI Division for the vital part they play every day in continuing to maintain an excellent care environment and impacting positively on our patient and staff experience.

The table below outlines the site scores for Royal Stoke University Hospital and County Hospital plus the overall UHNM Trust organisation score alongside the national average for 2022.

Site Name	CLEANING Score %	FOOD Score %	Organisation Food %	Ward Food %	PRIVACY, DIGNITY & WELLBEING Score %	CONDITION & MAINTENANCE Score %	DEMENTIA Score %	DISABILITY Score %
THE ROYAL STOKE UNIVERSITY HOSPITAL	99.71	91.60	97.57	90.05	91.94	99.82	87.50	90.96
THE COUNTY HOSPITAL	99.75	97.06	94.79	98.59	94.33	97.54	93.17	92.64
UHNM TRUST SCORE	99.72	92.31	97.21	91.17	92.25	99.52	88.24	91.18
NATIONAL AVERAGE	98.05	91.27	91.15	91.94	87.94	95.99	83.21	84.32

Patient Representative Comments

In addition to completing score sheets on a pass, fail or qualified pass basis, patient assessors are encouraged to provide any supporting comments that the Trust may take on board. Below is a summary of some of the comments received for each site:-

County Hospital:-

"Despite their age buildings maintained to a very high standard, very clean in all areas inspected, standard of decoration high".

"Walking through the communal areas was a really pleasurable experience; they were all clean and well signposted".

Royal Stoke Hospital:-

"Allowing for the constraints place upon the Royal Stoke from the pandemic and staffing issues, the hospital has managed to maintain and improve on their level and standard of cleanliness and also in the maintenance of the fabric of the estate".

"We found no issues of substantial concern on the day of the inspection".

"The oral clinic deserve a special credit for maintaining standards and practices together with their helpful information boards".

"Overall all staff deserve credit for what they have achieved".

"Just want to say thanks for inviting and allowing myself to take part in this year's place inspections, I really appreciate it and feel privileged to take part in inspecting such a great hospital and all the work that goes into it by the staff".

5.2 Participation in clinical audit

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

- National audit where specialties/directorates are asked to be involved;
- Corporate and divisional audits; and
- Local audits which clinical teams and specialties determine and reflect their local priorities and interests.

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

The national clinical audits and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) enquiries that the Trust participated in, and for which data collection was completed during 2022/23 alongside the number of cases submitted, are referred to in the tables below:

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

National confidential enquiries

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

NCEPOD Study	UHNM Registered	Status
NCEPOD: Transition from Child Health Services to Adult Care	Yes	Awaiting Report
NCEPOD: Community acquired pneumonia	Yes	Awaiting Report
NCEPOD: Crohns disease	Yes	Awaiting Report
NCEPOD: Epileptic seizures	Yes	Data Collection
NCEPOD: Testicular Torsion	Yes	Data Collection
NCEPOD: Endometriosis	Yes	Planning

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

5.3 National Clinical Audits

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

National Clinical Audit National Audit	UHNM Registered	% of cases Submitted
Breast and Cosmetic Implant Registry	Yes	100%
Case Mix Programme - Intensive Care National Audit and Research Centre (ICNARC)	Yes	100%
Cleft Registry and Audit Network (CRANE) continuous data collection	Yes	100%[#]
Elective Surgery (National PROMs Programme)	Yes	100%
Emergency Medicine QIP: Pain in Children	Yes	100%
Emergency Medicine QIP: Assessing Cognitive Impairment in Older People	Yes	100%
Emergency Medicine QIP: Mental Health Self Harm	Yes	100%
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls	Yes	100%
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database	Yes	100%
Falls and Fragility Fracture Audit Programme: The Fracture Liaison Service Audit	Yes	100%
Gastro-Intestinal Cancer Audit Programme: National Bowel Cancer Audit	Yes	100%
Gastro-Intestinal Cancer Audit Programme: National Oesophago-gastric Cancer	Yes	100%
Inflammatory Bowel Disease Audit (IBD)	Yes	100%
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	100%
MBRRACE-UK: Maternal Mortality Surveillance	Yes	100%
MBRRACE-UK: Perinatal Confidential Enquiries	Yes	100%
MBRRACE-UK: Perinatal Mortality Surveillance	Yes	100%
Muscle Invasive Bladder Cancer Audit	Yes	100%
National Adult Diabetes Audit: National Diabetes Core Audit	Yes	100%
National Adult Diabetes Audit: National Pregnancy in Diabetes Audit	Yes	100%
National Adult Diabetes Audit: National Diabetes Footcare Audit	Yes	100%
National Adult Diabetes Audit: National Inpatient Diabetes Audit	Yes	100%
National Asthma and COPD Audit Programme: Adult Asthma Secondary Care	Yes	100%
National Asthma and COPD Audit Programme: COPD Secondary Care	Yes	100%
National Asthma and COPD Audit Programme: Paediatric Asthma	Yes	100%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%

National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia	Yes	100%
National Bariatric Surgery Registry	No	-
National Cardiac Arrest Audit	No	N/A **
National Cardiac Audit Programme: Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Cardiac Audit Programme: National Adult Cardiac Surgery Audit	Yes	100%
National Cardiac Audit Programme: National Audit of Cardiac Rhythm Management Devices and Ablation	Yes	100%
National Cardiac Audit Programme: National Audit of Percutaneous Coronary Interventions	Yes	100%
National Cardiac Audit Programme: National Congenital Heart Disease Audit (NCHDA)	Yes	100%
National Cardiac Audit Programme: National Heart Failure Audit (NHFA)	Yes	100%
National Child Mortality Database (NCMD)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Joint Registry	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme	Yes	100%
National Ophthalmology Audit Database	No	-
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Perinatal Mortality Review	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Vascular Registry	Yes	100%
Neurosurgical National Audit Programme	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Perioperative Quality Improvement Programme	Yes	100%
Renal Audits: National Acute Kidney Injury Audit	Yes	100%
Renal Audits: UK Renal Registry Chronic Kidney Disease Audit	Yes	100%
Respiratory Audits: Adult Respiratory Support Audit	Yes	100%
Respiratory Audits: Smoking Cessation Audit – Maternity and Mental Health Services	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine Benchmarking Audit	Yes	100%
Trauma Audit and Research Network (TARN)	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%

UK Parkinsons Audit	Yes	100%

[#] *UHNM only provide demographic data to the Cleft Registry, further patient care is provided at specialist centres.*

*** University Hospitals of North Midlands NHS Trust is currently not signed up to this national audit as the Resuscitation Team do not have the funding or the resource to complete the audit. The collection, submission and verification of information requires dedicated administrative support.*

Corporate and local clinical audits

A total of 106 clinical audit projects were completed by clinical audit staff and a further 412 clinician led audit projects were registered during 2022/23. These audits help us to ensure that we are using the most up-to-date practice and identify areas where we can make further improvements. An example of improvements made in response to the audit results is:

Re-Audit of the RESPECT document

Action	Co-ordinator	Status of Action
In order to ensure that all relevant staff are aware of the results of the clinical audit a summary of the results will be presented at the following: • The RESPECT Steering Groups – UHNM and ICS • The End of Life Steering Group • Divisional Governance Meetings • Quality and Safety Oversight Group	Consultant in Palliative Care / Chief Clinical Information Officer	In progress
In order to improve compliance with national mandate and local policy the following actions have been prioritised:		
The results of the audit will be included in the Medical Director's Communication Bulletin. The following areas will be highlighted for immediate action: • Completion of clinical recommendation section • Completion of the Mental Capacity Assessment form • Presence of the RESPECT document on the I-portal system	Chief Clinical Information Officer / Head of Communications	In progress
Work will be undertaken to digitalise the RESPECT Document as a system wide document on Graphnet /One Health and Care system. This will allow clinicians across different care settings to complete the document and improve visibility.	Chief Clinical Information Officer / Transformation Project Manager	In progress
The Working Group will submit a formal recommendation for Level 1 RESPECT awareness training to be included as part of the statutory and mandatory training for all patient facing roles	Chief Clinical Information Officer / Transformation Project Manager	In progress
The Trust will develop and introduce a RESPECT champion programme. Each Ward will allocate a member of staff who will receive bespoke training with a view to them promoting outstanding practice within their area.	Chief Clinical Information Officer / Transformation Project Manager	In progress
RESPECT Level 2 Training pack for authors will be finalised and published on ESR.	End of Life Care Facilitator	In progress
A re-audit will be undertaken to monitor the above actions and to ensure improvements in practice	Clinical Audit & Effectiveness Team	In progress

5.4 Participation in clinical research

UHNM participates in clinical trials across the healthcare sector from novel interventions and drugs to device innovations which aim to improve quality of life and outcomes for our patients. For some studies, research practitioners, midwives and paediatric nurses work alongside clinical teams and support services to identify and consent potential research participants, discussing trials with patients and providing care throughout the studies. UHNM also has research which is led by nurses, midwives and AHPs. During the past year UHNM have been involved in trials that have provided important information on the epidemiology of the virus as well as potential treatment options for those affected by COVID-19.

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

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

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

Strategic Aims

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

Research and innovation highlights from 2022/2023

The Trust has successfully recruited over 1,500 participants to research studies over the past 12 months.

- We are one of the top three recruiting sites in the country for REMAP-CA, this intensive care based study, looks at patients with Community Acquired Pneumonia and identifies the effect of a range of interventions to improve outcomes.
- We have concluded successful recruitment to the COVAR-MS study. An observational study to evaluate immune response to COVID-19 vaccines, infections and immune treatments in people with multiple sclerosis. A paper, reporting the results of this study, has been written and submitted for publication.
- We are recruiting patients to Research for Patient Benefit grant 'Comparison of Lower Airway Sampling Strategies In Children with Protracted Bacterial Bronchitis (CLASSIC PBB)'. This multi-center study has opened at Newcastle-upon-Tyne Children's Hospital, Sheffield Children's Hospital and Alder Hey Children's hospital. Physiotherapists from UHNM are supporting our Sheffield collaborators with patient recruitment, to better ensure the success of the study.
- We have begun recruitment to a medical device trial led by one of our UHNM paediatric consultants, in collaboration with an international company. The trial will look at performance and adherence in children and young people whilst using asthma devices.

- We supported, to conclusion, the management and evaluation of the £1.2m Innovate UK Heart Failure Test Bed project, which used digital technology to improve early detection of deteriorating health in heart failure.
- Following the success of this study, the Academic Team with Consultant lead have secured a further £200k of funding to replicate this work in the community.
- In the last 12 months, three Consultants have secured a research scholarship with the support of R&I.
- Two key researchers within the Trust were awarded Honorary Professorships for Keele University
- A small grant of £14,000 was awarded by the North Staffordshire Medical Institute (NSMI) to a UHNM dietician with support from the academic team. This pilot/feasibility study will look at whether using coloured crockery with older people improves their dietary intake.
- The Trust has also been awarded funding for three other NSMI grants which are in the fields of pathology, radiography and paediatrics.
- An ED Consultant secured £300k of funding from the army to support the Inhalant study with the support of the academic team.
- UHNM has implemented the use of RED-CAP, which is a system that enables better data management and also enables virtual consenting of patients taking part in research.
- We are one of the top 4 recruiting sites for OPTIMA (optimal personalised treatment of early breast cancer using multi-parameter analysis).
- REMAP CAP (Randomised, Embedded, Multi-Factorial, adaptive platform for community-acquired pneumonia): The Trust has recruited the 169th patient into the REMAP CAP trial in critical care; this put Royal Stoke as the second top recruiting site nationally.
- OPTIMAS – (OPtimal TIMing of Anticoagulation after acute ischaemic Stroke: a randomised controlled trial (OPTIMAS Trial): UHNM is one of the top recruiting sites in the country.
- UHNM recruited an Assistant Director of Nursing, Midwifery and Allied Health Professions (NMAHPs) Research and Academic Development to create and lead a Centre for NMAHP Research and Education Excellence (CeNREE) to increase the visibility of research, to support NMAHP-led research and academic development and to create a clinical academic career pathway for NMAHPs.
- Over 70 NMAHPs have been or are being supported by CeNREE to develop NMAHP-led research.
- The CeNREE Lead is working with the Corporate ACP Lead to finalise an ACP Strategy and job planning tool to protect ACP time for research. This will enable our ~200 ACPs to engage with research opportunities.
- CeNREE is collaborating with Keele University to develop four clinical academic roles at band 5, with research projects that are aligned to Trust priorities.
- The CeNREE Lead has achieved the NIHR Senior Research Leader award and CeNREE has supported two prestigious NIHR PCAF fellowships, one Cystic Fibrosis Trust fellowship, one North Staffs Medical Institute grant and one West Midlands Clinical Research Network Personal Development grant.

5.5 Data quality

The Data Quality Strategic Plans and Data Quality Assurance Group continued to provide strategic and operational assurance to the Executive Business Intelligence Group, led by the Chief Financial Officer, throughout 2022/23. The corporate Data Quality Team has continued to provide assurance throughout the last year to support the improvement of data quality and the provision of excellent services to patients and other customers.

- The Data Quality Team continued to support UHNM staff, answering and resolving thousands of queries. The DQ User Support Process has been re-implemented to provide support, training and assurance of user understanding.
- The Data Quality structure has been reviewed and additional facilitators recruited to meet service requirements.

- The Data Quality Team provided specialist knowledge to various validation projects to support the national targets for waiting Lists, amongst others.
- Support for IT projects was also continued with testing, validation and systems expertise provided by the team.
- The divisional data quality groups are well established, with representation from all directorates in attendance. These groups fulfill an important role in the 'Data Quality Assurance Framework'.
- The action plan supporting the Data Quality Strategy continues to be monitored and updated.
- The terms of reference for the Data Quality Assurance Group have been ratified for 23/24 ensuring they address data quality obligations to the Data Security and Protection Assurance Framework.

2022/23 has been another productive year for the data quality team and we aim to build on this throughout 2023/24, supporting the strategic aims of the Trust.

5.6 NHS Number and General Medical Practice (GMP) code validity

UHNM submitted records to the Secondary Uses System (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. This is a single source of comprehensive data which enables a range of reporting an analysis in the UK. The figures below are for the period April 2022 to January 2023. The percentage of UHNM records in the published data which included the patient's valid **NHS number** was:

- 99.8% for admitted patient care; national performance is 99.6%
- 99.9% for outpatient care; national performance is 99.8%
- 100 % for Maternity care; national performance is 99.9%

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

- 100% for admitted patient care; national performance is 99.7%
- 100% for outpatient care; national performance is 99.5%
- 100% for Maternity care;; national performance is 99.8%

Additional benchmarking is carried out using the NHSE Data Quality Maturity Index (DQMI) dashboard. Throughout 2022/23 UHNM has consistently reported above the national average on all Inpatient, Outpatient and Maternity metrics. These are reported to the Trust's Executive Business Intelligence Group for assurance purposes.

5.7 Clinical coding accuracy rate

The annual internal Data Security and Protection Toolkit (DSPT) clinical coding audit took place during 2022/23, achieving an overall '**mandatory**' rating in all areas of the audit: primary & secondary diagnoses and procedures. All recommendations from the 20201/22 audit have been actioned. The Trust's clinical coding auditors carried out this year's audit.

The internal Staff Audit Programme continued throughout 2021/22 for all coding staff. The audit process has been expanded to include a robust assurance process for the completion of recommendations.

The Trust has a qualified Clinical Coding Trainer who reviewed the two year training programme for trainee coders in 2022. Development of in-house workshops continues for existing staff. In addition, they provide all mandatory national training, ensuring all coders are compliant with training requirements.

5.8 Data, Security and Protection (DSP) Toolkit attainment levels

The Data, Security and Protection Toolkit is a self-assessment, seeking assurance all standards supporting the integrity, confidentially and availability of information have been achieved. The toolkit continues to evolve by incorporating best practice guidance; thereby ensuring continuous improvement in the Trust's DSP position.

The COVID-19 pandemic required a revision of the yearly submission dates such that the Trust's self-assessment deadline is now submitted 30th June. The Trust submitted its final assessment for the period July 2021 to June 2022 declaring all standards had been achieved except for one. An improvement plan was developed and approved by NHS England and the Trust has been awarded a rating of 'standards not fully met (plan agreed)' pending completion of the improvement plan (scheduled for June 2023). The internal audit review confirmed the overall risk assurance across all 10 National Data Guardian standards as Substantial and a High confidence level of the independent assessor in the veracity of the self-assessment.

To support the Trust with its assessment for July 2022 to June 2023 an internal audit is currently underway; the findings of which will be reported to the Executive Digital and Data, Security & Protection (DSP) Group. Areas for improvement will be monitored via an improvement plan with monthly reporting to the Executive Digital and DSP Group. As in previous years, if the Trust does not achieve all standards by the June submission, the Trust's rating will be classified as 'Standards not fully met (plan agreed)'. An improvement plan will be submitted to NHS England for their approval. The Executive Digital and DSP Group will continue to seek assurance on the Trust's DSP toolkit position, thereby providing assurance to the Trust Board via the Transformation and People Committee.

5.9 Seven day services

The seven day services standards were established to ensure that patients admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. Ten clinical standards for seven day services in hospitals were developed and four of these subsequently identified as priorities on the basis of their impact on patient outcomes. These are:

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

The importance of ensuring that patients receive the same level of high quality care every day is reflected in the inclusion of these standards in the NHS Standard Contract. The CQC current hospital inspection regime features seven day services under the effective key question.

In response to UHNM's consistent compliance with the standards, an assurance framework was developed which moved away from large scale audits to an overview of performance supported by a more focused review process. A further revision of guidance in February 2022 simplified the expectations around the Board Assurance Framework and gave additional examples of evidence that can be used to support this. Our existing framework is fully aligned to the new guidance. A clinical audit programme has been developed to continually monitor compliance, delegations of authority under Standard 8, and evidence of appropriate staffing levels. The clinical audit programme focuses on the following areas of practice;

- Consultant review
- Shared Decision Making
- Complex and on-going care needs

- Clinical handover process
- Provision of diagnostic services
- Provision of Consultant directed interventions

UHNM continues to meet the four high priority standards; improvement work is focused around process and clinical record keeping and assurance of agreed local practice in respect of further demonstration of compliance with Standard 8.

Part B: Review of quality performance

6. Quality priorities 2022/23

In 2022/23, in partnership with our stakeholders we identified three specific priorities to focus on:

- **To continue to improve safe care and treatment to patients;**
- **To improve staff engagement and wellbeing following COVID-19 pandemic; and**
- **To improve patient experience.**

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

We use statistical process control (SPC) methods to draw two main observations of our performance against our key performance indicators (KPI's) along with a series of icons to describe what our performance data is telling us.

Quality Performance

Key Performance Indicator	Target	2022/23 Performance	2021/22 Performance
Harm Free Care (new harms)	95%	96.0%	96.2%
Patient Falls (per 1000 bed days)	5.6	5.9	5.9
Patient Falls with harm (per 1000 bed days)	1.5	1.91	1.53
Medication Errors (per 1000 bed days)	6.0	5.2	4.9
Never Events	0	4	6
Duty of Candour (verbal / formal notification)	100%	92.9%	97.8%
Duty of Candour (written within 10 days)	100%	55.9%	89.2%
Pressure Ulcers (category 2 hospital acquired with lapses in care)	96	69	56
Pressure Ulcers (category 3 hospital acquired with lapses in care)	48	12	22
Pressure Ulcers (category 4 hospital acquired with lapses in care)	0	0	0
Friends and Family Test (% A&E recommendedations)	85%	62.9%	73.0%
Friends and Family Test (% inpatient recommendations)	95%	97.3%	98.5%
Friends and Family Test (% maternity recommendations)	95%	90.2%	96.0%
Written Complaints (rate per 10,000 spells)	35	22.57	27.51
Hospital Standardised Mortality Ratio (HSMR) (rolling 12 month)	100	97.27 (01/22 – 12/22)	96.60 (02/21 – 12/21)
Standardised Hospital Mortality Indicator (SHMI) (rolling 12 months)	100	1.04 (11/21 – 10/22)	1.01 (01/21 – 01/22)
Nosocomial 'definite' Covid 19 Deaths	N/A	70	20
VTE Risk Assessment Compliance	95%	99.0%	99.3%
Reported C-Difficile	96	144	112
Avoidable MRSA Bacteraemia Cases	0	1	2
Inpatient Sepsis Screening Compliance	90%	89.7%	87.9%
Inpatient IV Antibiotics (given within 1 hour)	90%	93.4%	99.1%
Children Sepsis Screening Compliance	90%	89.7%	89.7%
Children IV Antibiotics(given within 1 hour)	90%	66.7%	100%
Emergency Portals Sepsis Screening Compliance	90%	81.8%	92.4%
Emergency Portals IV Antibiotics (given within 1 hour)	90%	63.9%	84.7%
Maternity Sepsis Screening	90%	80.6%	83.5%
Maternity IV Antibiotics (given within 1 hour)	90%	83.9%	76.4%

Priority 1:
To continue to improve harm free care and treatment to patients

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

We said we would aim to achieve this by:

- Improve sepsis treatment and recognition of deteriorating patients;
- To evaluate and reduce long waiters following the COVID-19 pandemic;
- To support the recovery and restoration plan across the health economy;
- Ensure that services follow appropriate infection prevention guidance and continue to be COVID-19 secure;
- Aim to reduce patient falls resulting in low harm or above by a further 5% from 2020/2021 baseline;
- Aim to reduce total numbers of Category 2 to 4 Pressure Ulcers, unstageable pressure ulcers and deep tissue injuries developed under UHNM care by 10% from 2020/2021 baseline;
- Evaluate and introduce new technologies and techniques for treating patient;
- Improve the number of reported medication errors and associated training in medication safety; and
- Increase the visibility of research and the capability of staff to lead research and provide evidence-based practice through CeNREE; and
- Delivering the Improving Together Programme.

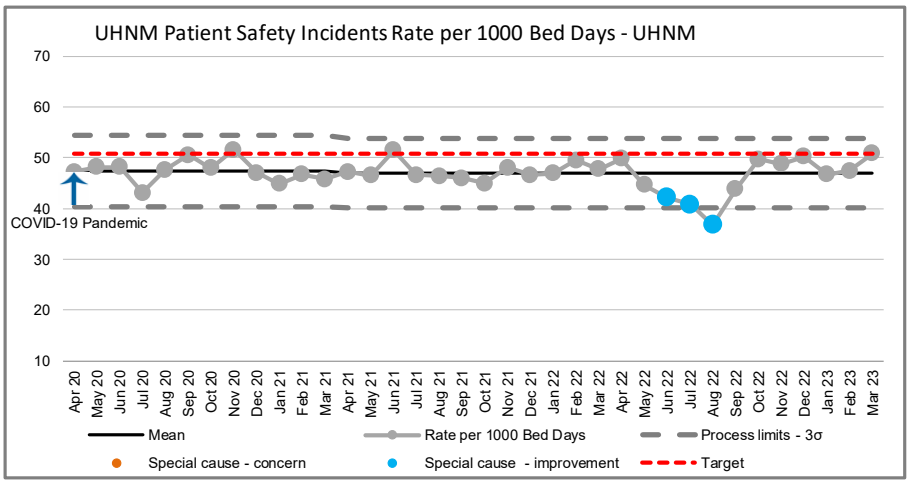
Performance against this priority and its aims has been monitored during 2022/23 using a range of key indicators which are reported monthly through the Trust and Divisional Quality & Safety Reports. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

Patient Safety Incidents

We continue to aim to reduce harm to our patients. A key indicator of this is the number of patient safety incidents* reported and the rate per 1,000 bed days and the number and rate of patient safety incidents with moderate harm or above.

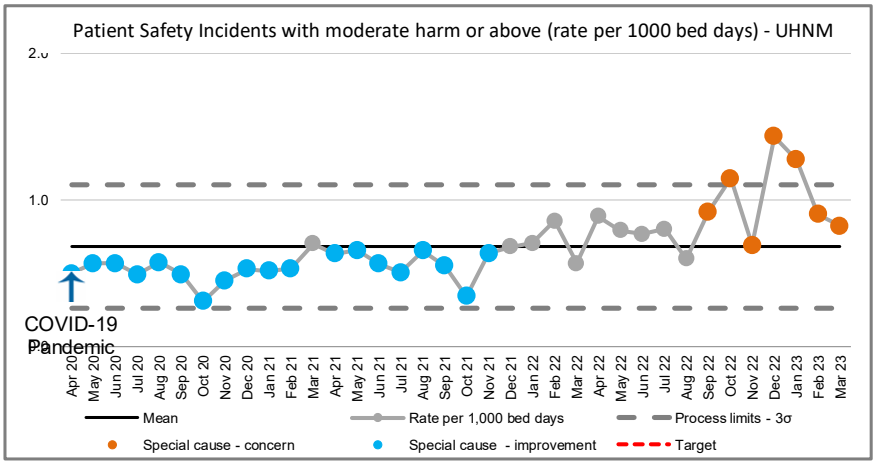
Total reported patient safety incidents have increased during 2022/2023 compared to 2021/2022 as the Trust has continued to promote positive reporting of adverse incidents. However, the rate of reported incidents has however remained relatively stable with a slight reduction in 2022/2023 with a rate of 45.5 patient safety incidents per 1,000 bed days compared to 47.3 in 2021/2022.

There has been an increase in the rate of patient safety incidents resulting in moderate harm or above. The increase in total numbers is partly explained by the increase in hospital activity during 2022/2023 compared to 2021/2022. In addition the largest increases were noted in the exceptionally challenging period during October 2022 to January 2023 when the local health economy and NHS in general were facing extreme operational pressures. New ways of working were implemented to support safe treatment and care of patients which started to improve the pressures and flow of patients, as demonstrated in the chart below by the reducing rate of moderate harm incidents in February and March 2023.



3.6% decrease in rate of reported patient safety incidents per 1,000 bed days from 2021/22 to 2022/2023.

Rate of reported patient safety incidents with moderate harm per 1,000 bed days in 2022/2023 has increased from 0.6 to 0.9. The increase noted during period of extreme operational pressures

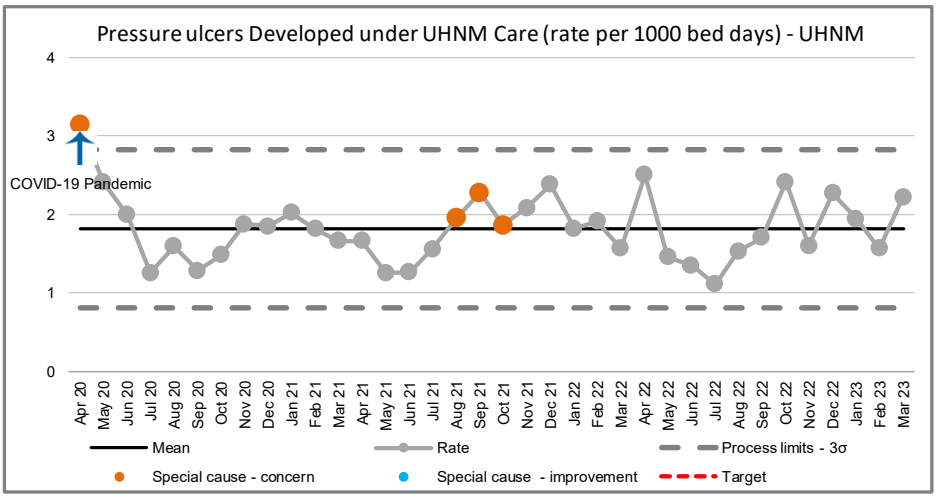


Pressure ulcers developed under UHNM Care

We have seen an increase in pressure ulcers developed whilst under the care of UHNM. During 2022/2023 there were 854 reported pressure ulcers developed at UHNM compared to 800 in 2021/2022. This equates to 6% rise in identified pressure ulcers. However, due to increased activity during 2022/2023, the rate of pressure ulcers developed under UHNM care has reduced by 6%

6% increase in reported pressure ulcers developed whilst under care of UHNM.

6% decrease in rate of reported pressure ulcers developed whilst under care of UHNM.



During 2022/2023, there have been changes in the number of pressure ulcers with identified lapses in care compared to 2021/2022. During 2022 the assessment and review process was changed within UHNM that has resulted in increased identification of Category 3 and Deep Tissue Injury. The new process allows for quicker identification and review of reported pressure damage by the Tissue Viability Team

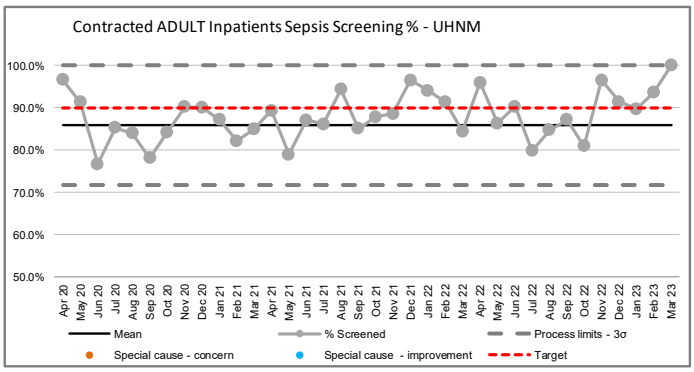
CATEGORY 2
25% increase in 2022/2023 compared to 2021/2022

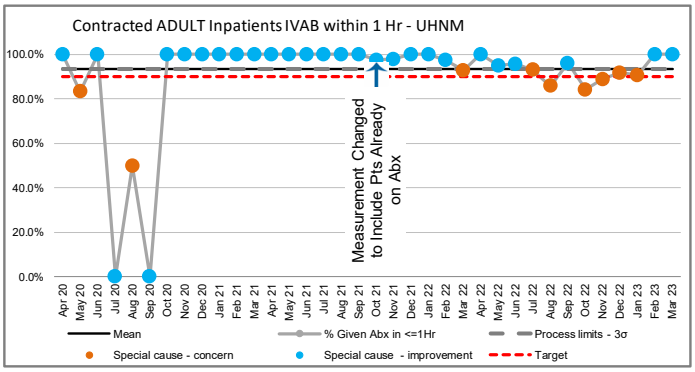
CATEGORY 3
43% reduction in 2022/2023 compared to 2021/2022

DEEP TISSUE INJURY
30% increase in 2022/2023 compared to 2021/2022

Sepsis recognition and treatment

Inpatient areas have seen improvements in sepsis screening but Intravenous Antibiotics (IVAB) in one hour reduced during 2022/2023. Sepsis screening improved from 87.9% to 89.7%. The IVAB in one hour has declined from 99.1% to 93.4%.





Emergency Portals have seen reduction in screening and IVAB in one hour during 2022/2023. Sepsis screening decreased from 92.4% to 81.8% and the IVAB in one hour from 84.7% to 63.9%.

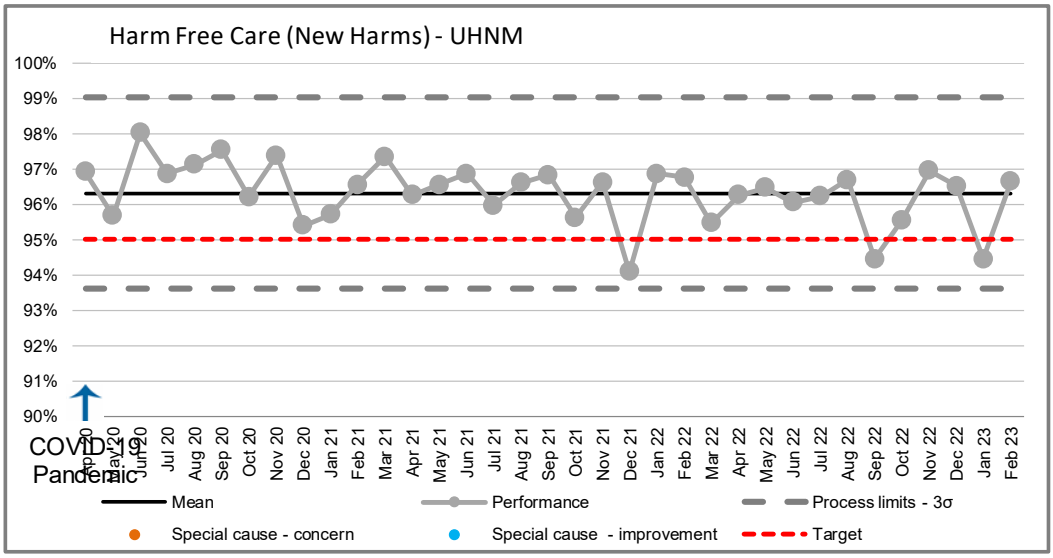
Actions and Next Steps

- The Sepsis team is working collaboratively with the A&E Quality nurses, sepsis champions, senior team and A&E sepsis clinical lead to provide support with late IVAB incidents and missed screens. Issue with holding ambulances remain a challenge.
- Face to face A&E sepsis induction for new nursing staff, nursing assistant and medical staff will recommence once capacity pressure/flow improve in the department.
- Regular meeting with A&E senior team reinstated to review current process and actions; on-going
- Monitoring impact of long ambulance waits on timely assessment and treatment of sepsis
- CAS card has been further updated to reflect the sepsis pathway and to ensure all staff are following the correct guidance (awaiting new printing from Harlow)
- Directorate devised a SOP for nursing staff to advise of agreed actions of Ambulance assessment nurse to escalate NEWS and sepsis trigger to the Resus Consultant between the hours of 8am-12midnight, EPIC 12midnight to 8am using the Vocera call system. This will enable accurate and safe assessment of the patients sepsis trigger and to ensure correct urgent antibiotic prescription and administration.
- Sepsis kiosks re-instated in ED focusing on the importance of sepsis screening documentation and urgent escalation for true red flag sepsis triggers

Harm free care (new harms)

The national target for harm free care (new harms) is 95% and UHNM has exceeded this target during 2022/2023 with average rate of 96.1% (refer to chart following). The results are gathered during the monthly Safety Thermometer Assessments where all UHNM Inpatients are reviewed on one day of the month to assess whether they have experienced harm from a fall, pressure ulcer, pulmonary embolism/deep vein thrombosis or catheter associated urinary tract infection during their current inpatient admission. These results are reported nationally on monthly basis.

The mean rate for 2022/2023 has varied and there have been decreases compared to 2021/22 (96.2%) but the Trust has continued to exceed the national target despite the continued challenges the organisation has faced during the past 12 months.



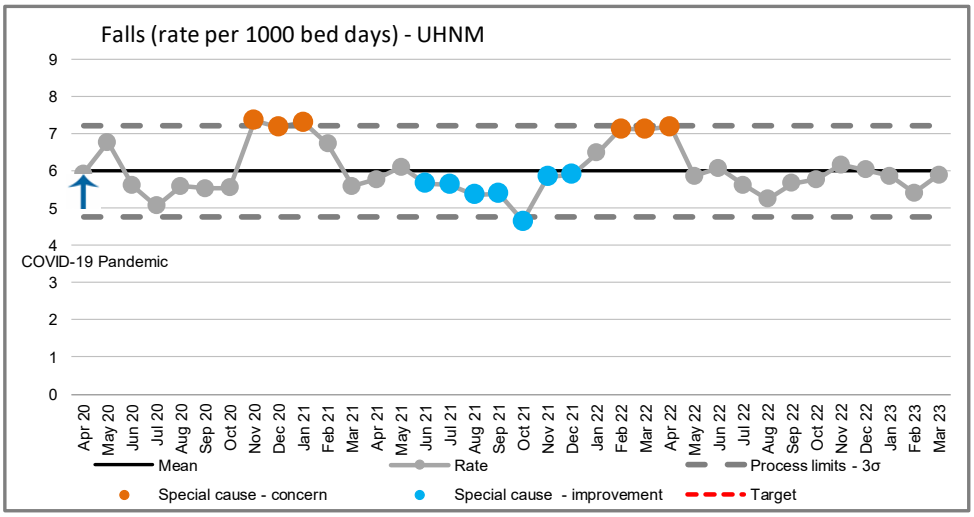
The Trust exceeded the 95% National Target for Harm Free Care (New Harms) throughout 2022/2023.

Mean rate 96.1%.

Patient falls

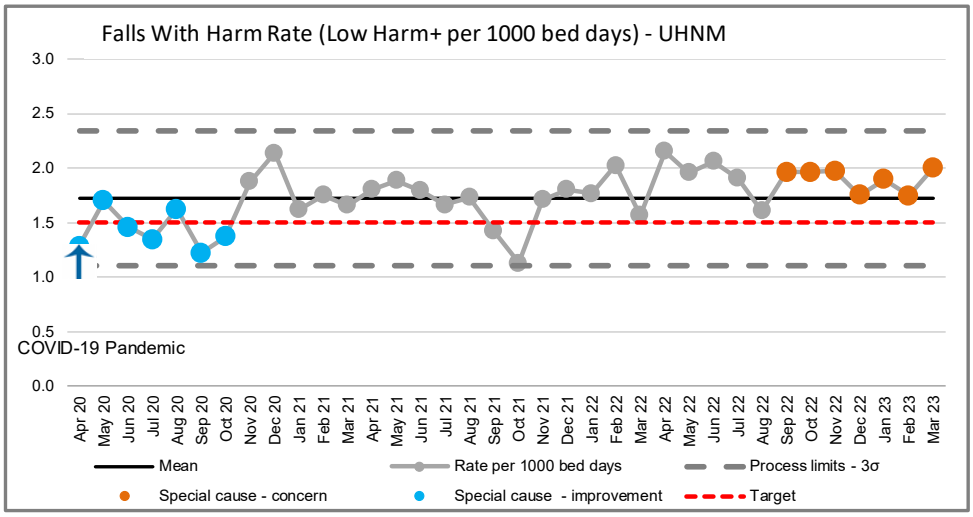
Patient falls have increased in total numbers in 2021/22 compared to 2020/21 with 2637 and 2388 respectively. In order to be able to account for changes in activity the Trust uses the patient falls rate per 1,000 bed days. During 2022/2023 the overall rate was 5.9 which was the same as 2021/2022 and 6.2 in 2020/2021.

UHNM uses the previously published Royal College of Physicians national average for acute NHS trusts of 5.6 falls per 1,000 bed days as an internal benchmark for improvement.



The 2022/2023 mean Falls rate has remained same as 2021/2022 at 5.9.

11% increase in rate of harm to patients as result of falls per 1,000 bed days in 2022/23 with 1.9 compared to 1.7 in 2021/22.



There have been increases in rate of patient falls that have resulted in harm. This is important as the aim was to reduce harm from falls by 10% whilst encouraging incidents to be reported.

Actions and Next steps:

- Audits have been undertaken in all of these TOP 5 reporting areas. Results have been fed back to the ward managers and their teams. Time is given for the wards to action the findings and then there is a re-audit undertaken. Support is given to the areas where no improvement is made and communication is made with the matron of the area.

Never events

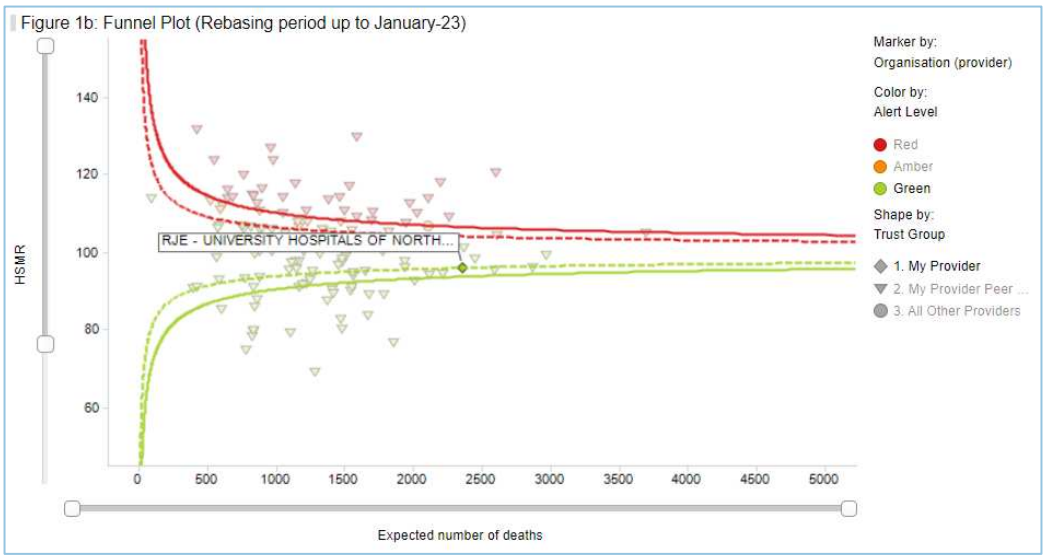
UHNM has introduced strong systems to allow for the reporting of adverse incidents to ensure lessons are learnt whenever possible. During 2022/23, we reported four never events compared to six reported in 2021/22.

There were 4 reported never events during 2022/2023.

2022/17264 Wrong site Surgery (August 2022)
2022/13571 Retained foreign object post procedure (September 2022)
2022/23091 Misplaced Nasogastric Tube (October 2022)
2023/6299 Incorrect Implant/Prosthesis (March 2023)

Mortality

The Trust's mortality rate with the current 12 month rolling Hospital Standardised Mortality Ratio (HSMR) score (February 2022 – January 2023) is 95.89. This means that UHNM's number of in hospital deaths is significantly less than the expected range based on the type of patients that have been treated. This compares to 93.45 for February 2021 to January 2022.



UHNM continues to compare well against peers during 2022/23 and is better than expected based on standardised case mix.

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

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

Like HSMR the prediction takes into account factors such as age and gender of patients and their diagnosis. The current SHMI value for the Trust is 107.18 (as expected). This is a rolling 12 month measure and covers the period January 2022 – December 2022. The value for January 2021 to December 2021 was 104.11.

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

Learning from deaths - mortality reviews

During 2022/2023, the Trust continued to use its online Mortality Review Proforma to allow in hospital deaths to be electronically reported following review of the patient death. The outcomes of these reviews were included within Mortality Summary Report presented at the Trust's Quality Governance Committee and reported to the Trust Board.

Of 3,786 inpatient deaths during 2022/23 (Apr 22 to Mar 23) 2170 patients have been reviewed (57%).

Overall number of reviews submitted during 2022/23 to date is 3,347.

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

The Trust has completed 2,170 online proformas for hospital deaths recorded during 2022/2023 (57%). Each one of these deaths is assessed to classify the level of care the patient received (some reviews completed by the Nosocomial COVID-19 panel require the scoring to be confirmed by the parent specialty). The overall number of mortality reviews submitted during 2022/23 is 3,347. Completion of the reviews has been impacted by the COVID-19 pandemic.

It should be noted that the mortality reviews are currently ongoing and these figures relate to deaths in 2022/2023 that have also had completed reviews submitted by 6th April 2023. There are deaths that are still being reviewed as part of the Trust's local Mortality and Morbidity Review Meetings but, whilst the deaths may have occurred in 2022/2023, the reviews will be completed in 2023/2024.

	2022/23 Total		Q1		Q2		Q3		Q4[1]	
Total number of deaths in reporting period	3786		862		879		1018		1027	
Total number of deaths in reporting period reviewed (% of total deaths)	2170	57%	672	78%	619	70%	640	63%	239	23%
Total number of reviewed deaths with suboptimal care identified – NCEPOD grade E (% of reviews)	3	0.1%	0	-	0	-	2	0.3%	1	0.4

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

[1] As at time of updating the list of inpatient deaths ran up to March 2023 deaths

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

The following provides a summary of issues identified during the Structured Judgment Review process that could be improved for SJRs submitted during 2022/2023:

- Delays in CT scans;
- Issues with patient flow affecting patient care (especially in the Emergency Department)
- Inappropriate patient transfers;
- Importance of communication with families around DNAR and End of Life Care; including timely discussion of these with the patient when it is recognised that they are approaching end of life, timely uploading of these into medical records and ensuring relatives are given time to make decisions and establishing ceilings of care for patients;
- Importance of completing key documentation in timely and accurate way, including updating and signing of care records, medication charts and scoring tools, fluid balance charts, cause of death and discharge summaries, RESPECT and DNAR documentation
- Importance of consulting senior colleagues if unsure regarding appropriate treatment of patient;
- Importance of timely monitoring and review of patients manner and for escalation to senior clinicians for review where appropriate especially re fluid balance, hypoglycemia and during dialysis;
- Medication issues including accuracy of prescriptions, timeliness of administration and review of medication (especially antibiotics and anticoagulants) and the timeliness of prescribing;
- Should always ensure full history is checked when clerking patients to inform care;
- Importance of access to imaging to inform care and timeliness of reviewing imaging reports;
- Timeliness of carrying out investigative tests to inform care e.g. bloods

Hospital acquired infections

The Trust continues to strive to reduce the number of avoidable hospital associated infections. Two of the key infection associated indicators that are used are Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Diff). During 2022/2023, the Trust has seen increase in like for like numbers compared to 2021/2022 for Clostridium Difficile.

Indicator	2022/23 Target	2020/21	2021/22	2022/23
To reduce C Difficile infections	96	107	112	144
To reduce MRSA infections (Trust apportioned)	0	4	2	1

Actions and Next Steps

- Routine ribotyping of samples continues
- Recruitment to the C Diff Nurse role has been successful and commenced 20th February 2023. This role is 50% patient reviews/50% staff training.
- The bi-weekly Cdiff MDT meeting has been re-commenced
- Review of the RCAs demonstrate a theme where patients have been admitted with documented diarrhoea, yet a sample is not submitted until day 3 or later – this then becomes hospital apportioned. At the clinical group meeting

all clinicians were reminded of the importance of early sampling, and the Alert Group is exploring any options for an electronic alert for early sampling

- RCAs continue to be reviewed by ICB in relation to avoidability

Priority 2:
To improve staff engagement and wellbeing following COVID-19 pandemic

We said we would do this by:

- To support the introduction of the Trust's Wellbeing Programme and activities that focus on staff wellbeing and empowerment;
- Ensure that staff are working within COVID-19 secure environments and support provided to staff;
- Support staff and services in providing care in 'new ways' following COVID-19;
- Promote mental health wellbeing and support;
- Providing staff with research, professional and academic development opportunities through CeNREE
- Delivering the Improving Together Programme

Performance against this priority and its aims has been monitored during 2020/21. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

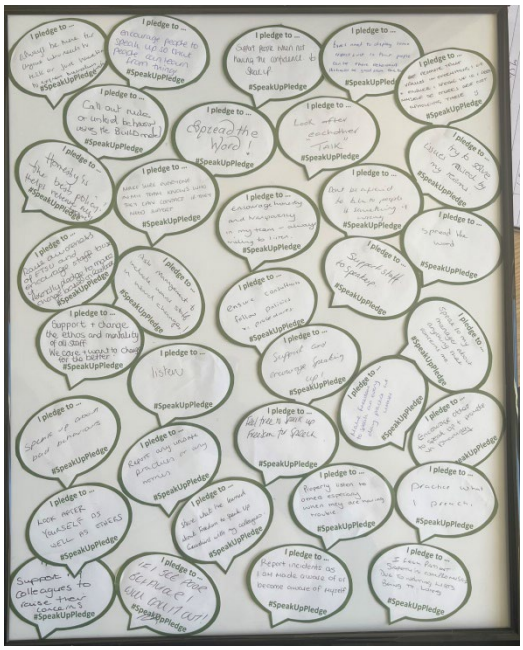
Freedom to Speak Up 2022/23

Freedom to Speak Up
Your voice matters at UHNM

At the start of 2022/23, following a review into Speaking Up arrangements at Blackpool Teaching Hospitals NHS Trust, responsibility for the Speaking Up services was transferred from the People Directorate over to our Corporate Governance Office. At the same time, we appointed a new Lead Freedom to Speak Up Guardian and increased the time allocated to this role from part time to a full time position, allowing the Lead Guardian to take a more proactive approach to engaging with and listening to our staff. To support the Lead Guardian in this role, we sought expressions of interest to increase our Speaking Up capacity and through a successful stakeholder engagement process, we were able to secure five Associate Freedom to Speak Up Guardians, from a range of backgrounds who have undertaken the role on a voluntary basis throughout the course of the year.

With the increased capacity within the team, we have been pleased to report an increase in concerns being raised which we believe correlates with the work we have undertaken to establish a positive Speaking Up Culture within the organisation. Some key developments include:

- Development of a new Quarterly Report to our Transformation and People Committee along with a new summary 'Board Brief'
- Regular promotion of the Speaking Up service through our corporate communication channels (Monday Message, Facebook Live) with a particular campaign held during Speaking Up Month where staff were asked to make pledges
- Development of branding 'Your Voice Matters at UHNM' to support our promotional materials including posters, screen savers and an animated video
- Support and visibility at staff briefings following the publication of our Culture Review
- Publication of a Speaking Up Calendar including drop in sessions across both of our sites
- Development and introduction of a digital feedback system to gauge feedback on the Speaking Up process and also capture information on gender, ethnicity and disabilities to ensure that our processes are both inclusive and effective
- Reviewed our Policy in line with the National Policy



Pledges made by our staff during Speak Up Month

- Introduced the training packages available from the National Guardian's Office – Speak Up, Listen Up and Follow Up
- Development of a 'Heat Map' for Speaking Up concerns
- Engagement in Speaking Up Networks at a system, region and national level

Key Developments for 2023/24:

- A review of the Associate Freedom to Speak Up Guardian role and service provision
- Exploration of digital options for Speaking Up
- Finalisation and launch of our Speaking Up Policy in line with the national deadline of January 2024
- Review and consolidation of Speaking Up Training
- Development of our Speaking Up Strategy
- Board Development Session including completion of the National Self Reflection Tool

2022 NHS Staff Survey – The National Context and Trust Outcomes

The 2022 NHS Staff Survey was carried out between September and December 2022 and the Trust response rate was 33% (43% in 2021).

The Annual NHS Staff Survey was open to all staff and 3,685 took part (4,749 in 2021). The national average for the benchmark group (acute and acute and community trusts) is 44%. It should be noted data in the national results is weighted to reflect the distribution of staff according to staff group.

The key focus of actions will be to address behaviours, possibly targeted as specific groups or hotspots. The Trust has developed a resolution policy on how to address issues via an informal footing, but within a specific framework. Issues around behaviours are linked to the two corporate risks and also impact on recruitment and retention.

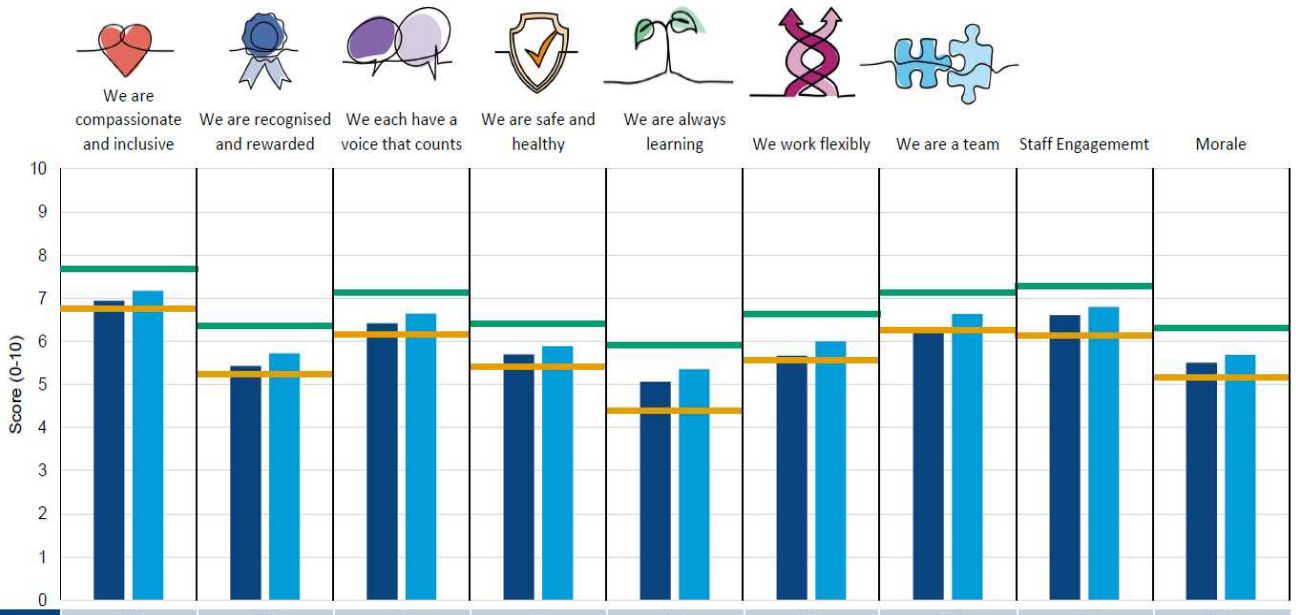
The results of the NHS Staff Survey are now measured against seven People Promise elements and against the two themes 'Staff Engagement' and 'Morale' which have been reported in previous years. However, this does mean that historic trend data is not available for many of the questions asked in the Survey.

- Against the seven People Promise themes, this Trust scored lower than national average on each theme.
- At 6.6, the staff engagement score reduced slightly. The score for the benchmark group overall stayed stable at 6.8. The Trust continues to remain just below the acute trust average score.
- Overall, the benchmark group results remained stable at 5.7 compared to 2021 and the Trust's score experienced a slight reduction of 0.1. At 5.5, the Trust's score remains just below the Acute Trust average of 5.7, as it did in 2021. Although the results are below average, the trajectory has followed the benchmark group.

The following table presents an overview of the seven themes, staff engagement and morale scores and compares this Trust's results to the national average for our benchmarking groups, and indicating the scores of the best and worst performing acute trusts.

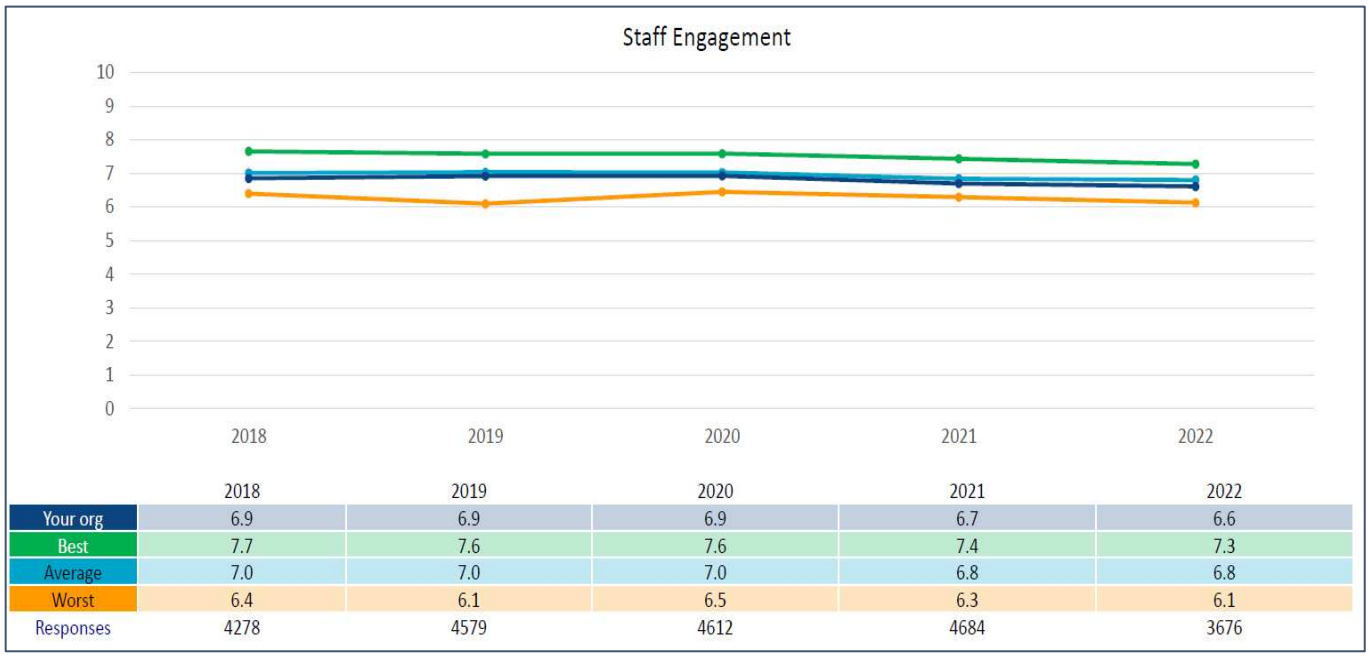
This Trust scored lower than national average against all seven themes, as well as staff engagement and morale.

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**



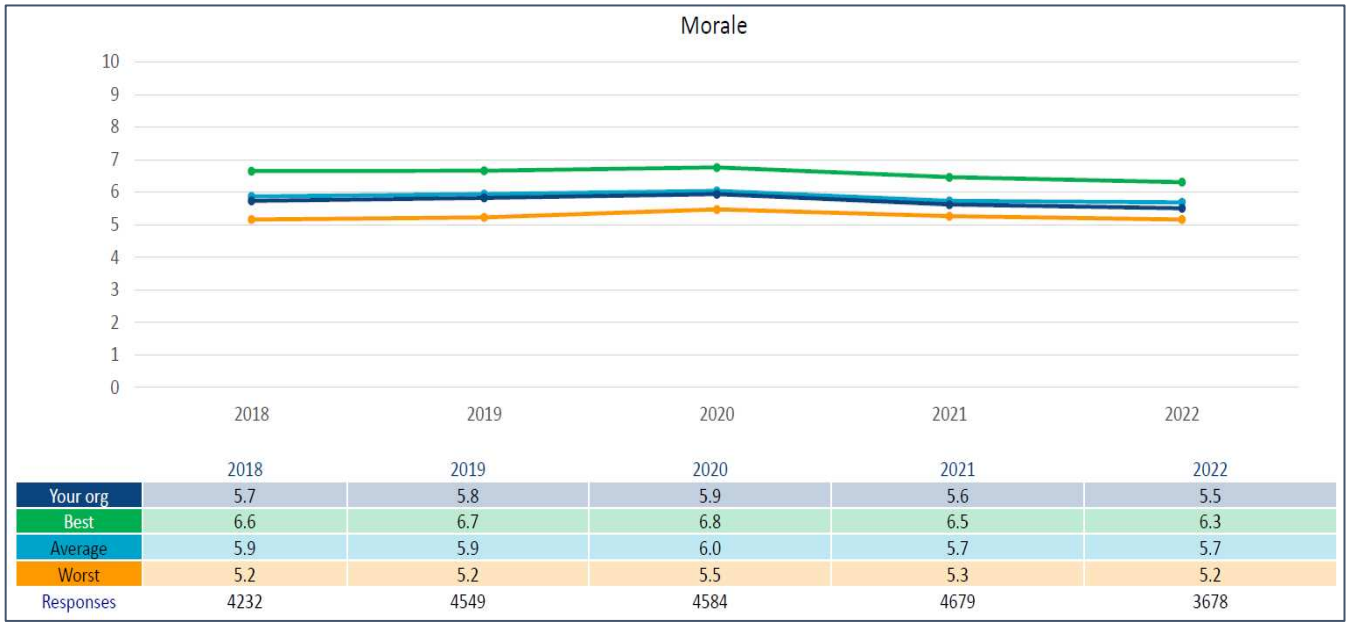
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	6.9	5.4	6.4	5.7	5.1	5.7	6.3	6.6	5.5
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	3675	3676	3650	3655	3548	3663	3671	3676	3678

Staff engagement – At 6.6, the staff engagement score reduced slightly. The score for the benchmark group overall stayed stable at 6.8. The Trust continues to remain just below the acute trust average score.



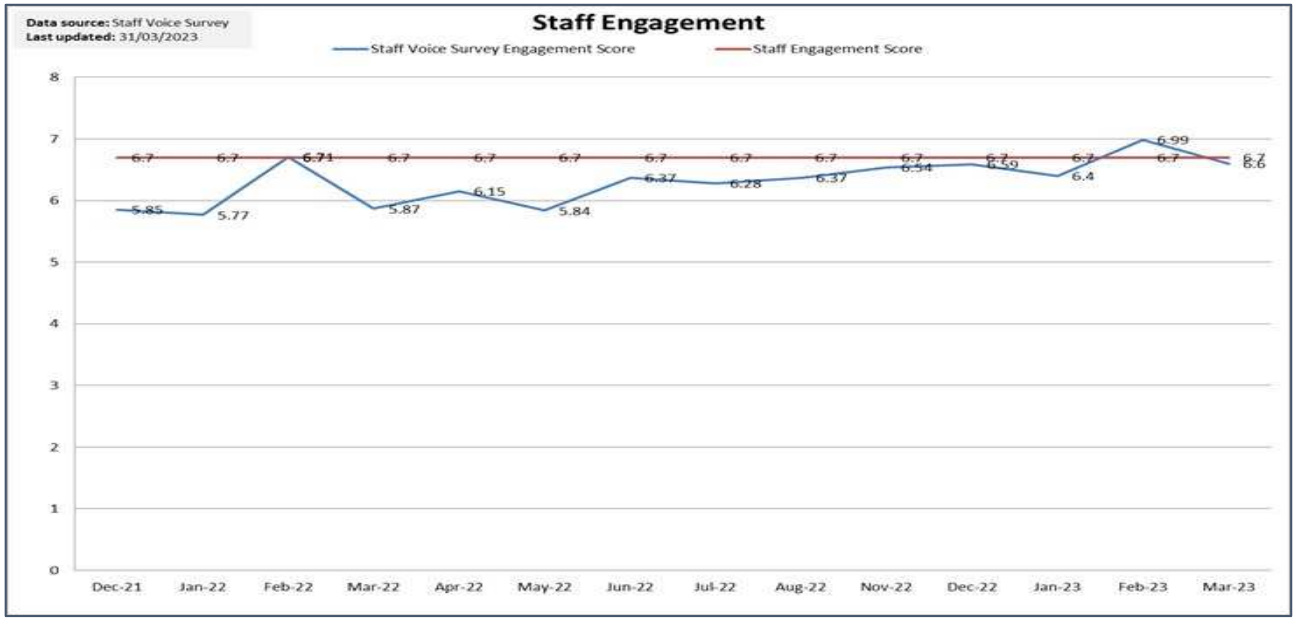
	2018	2019	2020	2021	2022
Your org	6.9	6.9	6.9	6.7	6.6
Best	7.7	7.6	7.6	7.4	7.3
Average	7.0	7.0	7.0	6.8	6.8
Worst	6.4	6.1	6.5	6.3	6.1
Responses	4278	4579	4612	4684	3676

Staff morale – Overall, the benchmark group results remained stable at 5.7 compared to 2021 and the Trust's score experienced a slight reduction of 0.1. At 5.5, the Trust's score remains just below the Acute Trust average of 5.7, as it did in 2021. There is one item within this element that UHNM scores worst on and this is unrealistic time pressures. The benchmark score has remained stable (22%) but UHNM's score has now fallen below average (20%).

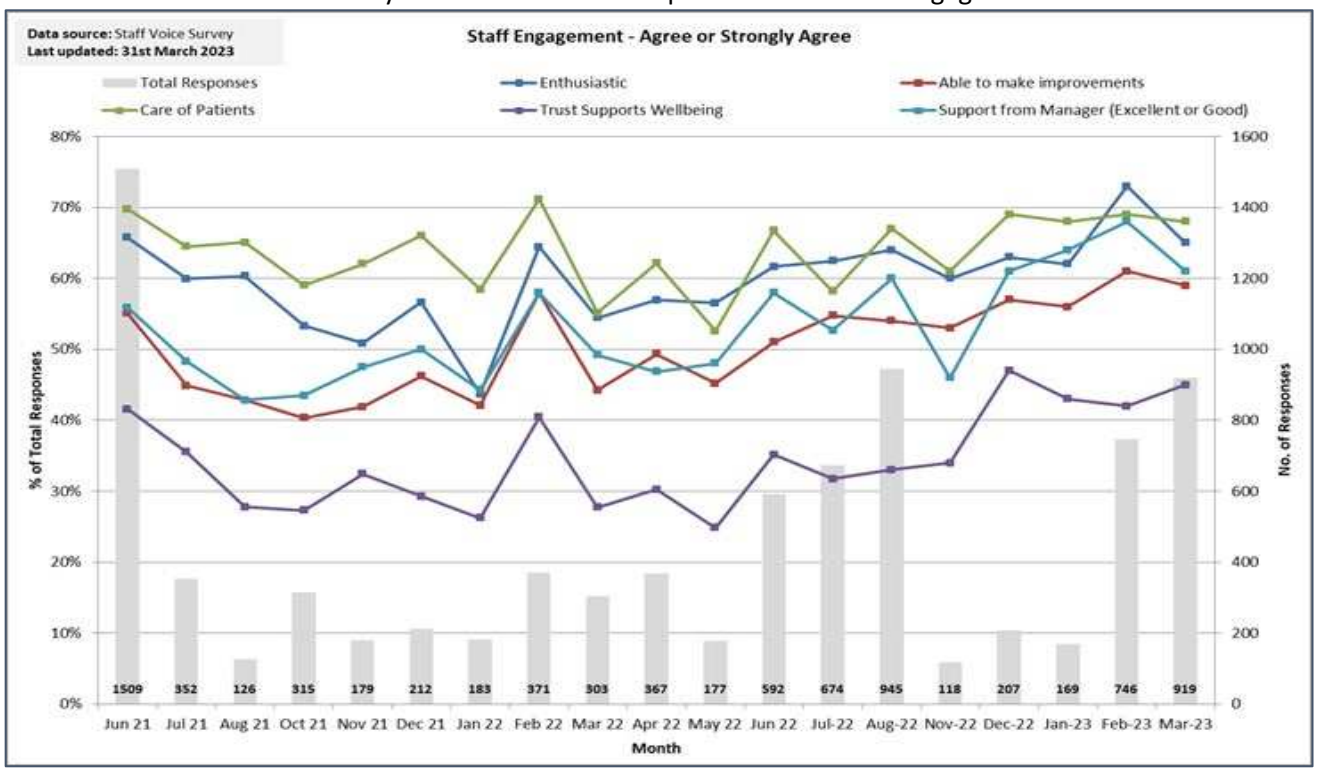


	2018	2019	2020	2021	2022
Your org	5.7	5.8	5.9	5.6	5.5
Best	6.6	6.7	6.8	6.5	6.3
Average	5.9	5.9	6.0	5.7	5.7
Worst	5.2	5.2	5.5	5.3	5.2
Responses	4232	4549	4584	4679	3678

The local Staff Voice survey indicates that, since the national survey, there may have been a more recent upturn in factors affecting staff engagement. There is a notable spike in February of both 2022 and 2023. Once factor which may have caused this in 2022 was the announcement of the Wellbeing Day, however this would not account for the spike in 2023. It would be helpful to identify any factors that may have led to the spike so that we can learn from them and implement any improvements or initiatives Trust -wide.



This is demonstrated in more detail by the factors which comprise the local staff engagement rate.



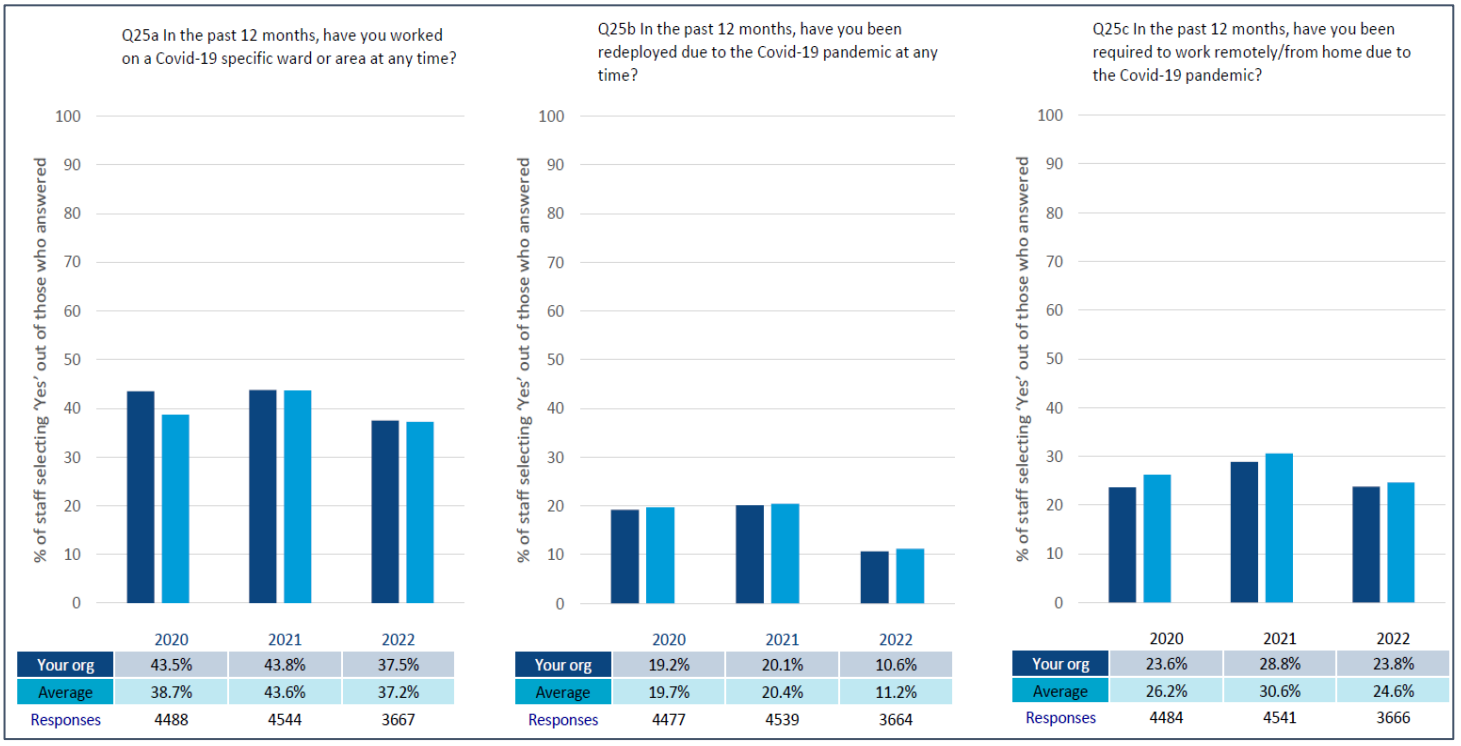
Adverse staff behaviours increase the risk to the Trust's culture, values and aspirations, impacting on patient care, increasing staff disengagement and affecting performance as well as having an adverse effect on our ability to recruit and retain staff.

Staff experience during COVID-19

In the 2022 Staff Survey, staff were asked three questions relating to their experience during the COVID-19 pandemic:

a) In the past 12 months, have you worked on a COVID-19 specific ward or area at any time?
b) In the past 12 months, have you been redeployed due to the COVID-19 pandemic at any time?
c) In the past 12 months, have you been required to work remotely/from home due to the COVID-19 pandemic?

Compared to 2021, there was a significant reduction both nationally and locally in the number of staff that reported being redeployed. This reflects how the nation is recovering from the impact of the pandemic.



	2020	2021	2022
Your org	43.5%	43.8%	37.5%
Average	38.7%	43.6%	37.2%
Responses	4488	4544	3667

	2020	2021	2022
Your org	19.2%	20.1%	10.6%
Average	19.7%	20.4%	11.2%
Responses	4477	4539	3664

	2020	2021	2022
Your org	23.6%	28.8%	23.8%
Average	26.2%	30.6%	24.6%
Responses	4484	4541	3666

Next Steps

The improvement activities follow on from the 2019 and 2020 Staff Surveys, when the Trust set out the key areas of corporate focus planned for 2020/21. The pace at which change has been delivered in many areas has been impacted by the COVID-19 pandemic and the need for staff to work clinically and in patient facing areas. Key developments such as the Enable Programme and other important leadership activities are still being fully embedded and the focus has understandably been on supporting the operational delivery of services and patient care and staff wellbeing.

The Trust did not achieve the goal of being above average in terms of Staff Engagement by the 2021 Survey, although the aspiration to be in the top 20% of trusts by 2023 remains.

A comprehensive and clear Staff Survey Action Plan is under development to address the key issues highlighted in the National Staff Survey and other engagement feedback from staff. In addition to this, each Division reviews, takes action and communicates back to staff in relation to the qualitative feedback which colleagues give on a monthly basis via the Staff Voice Survey. Staff Engagement is also now a metric which is reviewed at regular Divisional performance panels.

Promoting mental health wellbeing and support
The ICS online psychological support service was implemented as part of COVID support and has continued to be a resource accessible for all Trust staff. It provides fast track psychological and mental wellbeing support and advice for colleagues. 93 UHNM staff accessed the service.

Additionally, during 2022/23 a total number of 453 colleagues accessed the Staff Counselling and Support Service. 79% of service users were extremely satisfied with the service and 85% would highly recommend to a colleague.
Internally alongside the 'wellbeing wagon' where all colleagues can 'drop in' and discuss wellbeing and seek a range of support materials; webinars and online support seminars took place to support staff financial wellbeing which is a major factor in supporting employee mental health. Resources are available on the intranet accessible 24/7. A total of 186 staff have attended RESPOND, our 7 step model to having a wellbeing conversation.

Priority 3: To improve patient experience

We said we would do this by:

- Utilise patient and visitor feedback;
- Seek wider engagement with 'seldom heard' patient groups;
- Review patients experiences during COVID-19 and identify positive changes to adapt service provisions; and
- Review the different ways that patient experience and views are gathered and acted upon within UHNM.

Performance against this priority and its aims has been monitored during 2022/23. The following section provides a summary of the performance for these indicators and what these results mean for our patients

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

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

- Hospital User Group (HUG) – has continued their monthly meetings, using a mixture of face to face and virtual meetings to maximise attendance. We have also actively sought out more diverse representation from "seldom heard" groups and have representatives from young people, people with disabilities and include representatives from our LGBTQ+ community.
- Raising the profile of our Patient Leaders to increase involvement in projects across the Trust including CEF audits, obtaining feedback around specific initiatives and working with the Quality and Safety team to support improvements.
- Healthwatch – our close relationship with Healthwatch is maintained through their membership of the HUG. Healthwatch has been invaluable for collecting and sharing feedback from our and they continue to work with us undertaking their Enter & View visits;
- Patient Information Ratification Group has continued to meet virtually to ensure a robust process for the production of Trust patient information leaflets;
- Assist, dDeaflinks and Capita have continued to provide interpretation services. The majority of foreign language interpretation now takes place via video or telephone with good effect; and the Trust is trialing the launch of a new "on-demand" video interpretation service.
- UHNM membership of the CCG Community and Engagement Group to provide consistent messaging to the general public and seldom heard groups throughout Staffordshire;

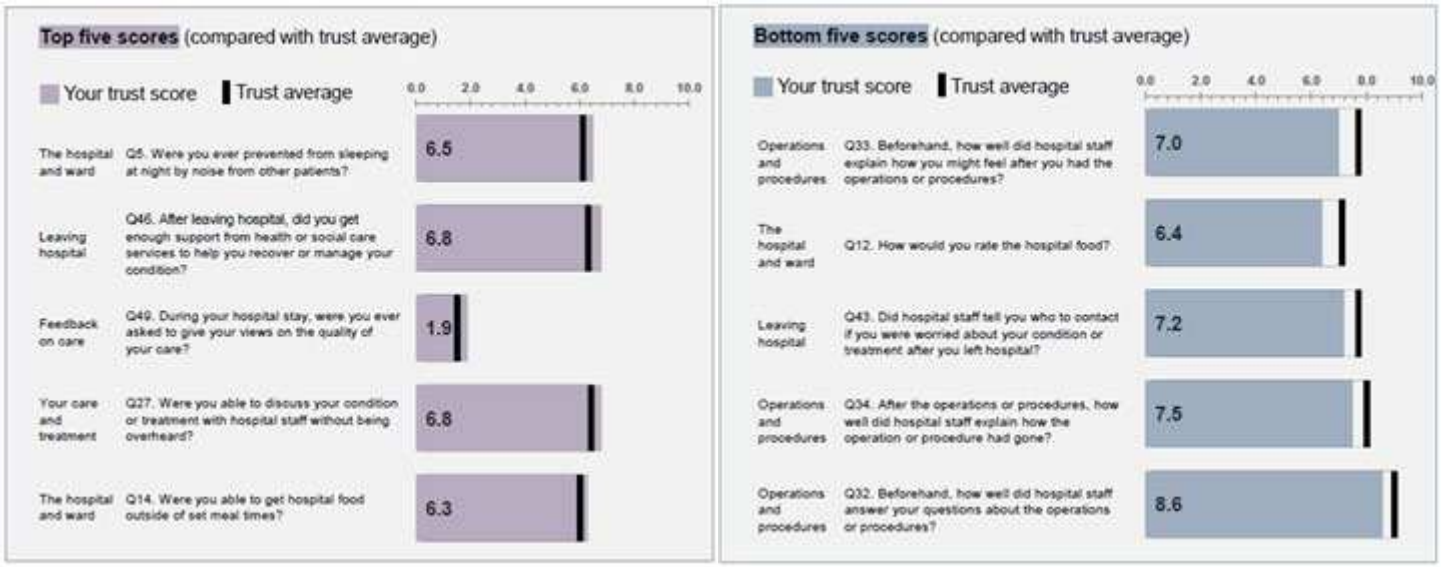
- Membership of the Carers Partnership Board to support delivery of the Stoke-on-Trent Carer's Strategy 2021-25 and the development of the UHNM Carer's strategy; and
- Working with MPFT, Combined Health and the CCG to agree a consistent approach and peer review of local Equality Delivery System objectives.

Annual Inpatient Survey

The 2021 Inpatient Survey results were published by the CQC in October 2022. 1,249 patients who were in hospital in November 2021 were invited to participate in the survey and the Trust had a 34% response rate. The Trust did not score better than expected in comparison to all other trusts in any questions and scored about the same as expected in 46 questions. There was 1 question where we performed worse than expected compared to all other trusts:

"Before hand, how well did hospital staff explain how you might feel after you had the operation or procedure?"

UHNM top and bottom five scores compared with trust average.



The way we communicate with our patients continues to have a significant effect on overall patient experience. The Trust continues to work towards improving the way we provide information and support to our patients to ensure they are able to be more involved in decisions that affect their care and treatment.

Improvement initiatives include:

- Working with our Spiritual, Pastoral and Religious Care (SPaRC) team to reach a more diverse population and ensure wider inclusivity in our Patient Representatives.
- Health literacy training continues and the Patient Experience Team are working collaboratively with NHS Libraries of North Staffordshire to provide this to a wider range of staff across the Trust;
- Patient Experience Team have been working with the Trust's Improving Together Team to incorporate Health Literacy Awareness as part of the program.

- A redesign of the Trusts Complaints Leaflet and website page incorporating FAQ's to make it easier for patients, relatives and visitors to understand the complaints process and provide feedback.
- A review of the "Accessible Communication Alerts" with a view to expanding these in line with feedback from our d/Deaf community.
- A review of the Friends & Family questionnaires to incorporate specific areas of improvement identified in the National Inpatient Survey results to ensure real-time feedback is obtained and meaningful improvements can be made.
- Triangulation of quality and safety data to identify themes;
- Proactive recruitment of volunteers to assist with the improvement of service delivery and the patient experience; and
- The Trust was given an "Initial Stage" award for the Rainbow Badge accreditation to demonstrate our commitment to improving our LGBTQ+ inclusivity. An Action plan is in plan to work towards improving this award during the next assessment.
- Re-launch of our Patient Experience Group with new membership and a more structured approach for accountability and sharing of Patient Experience initiatives and improvements as a result of feedback, FFT and CQC National surveys.

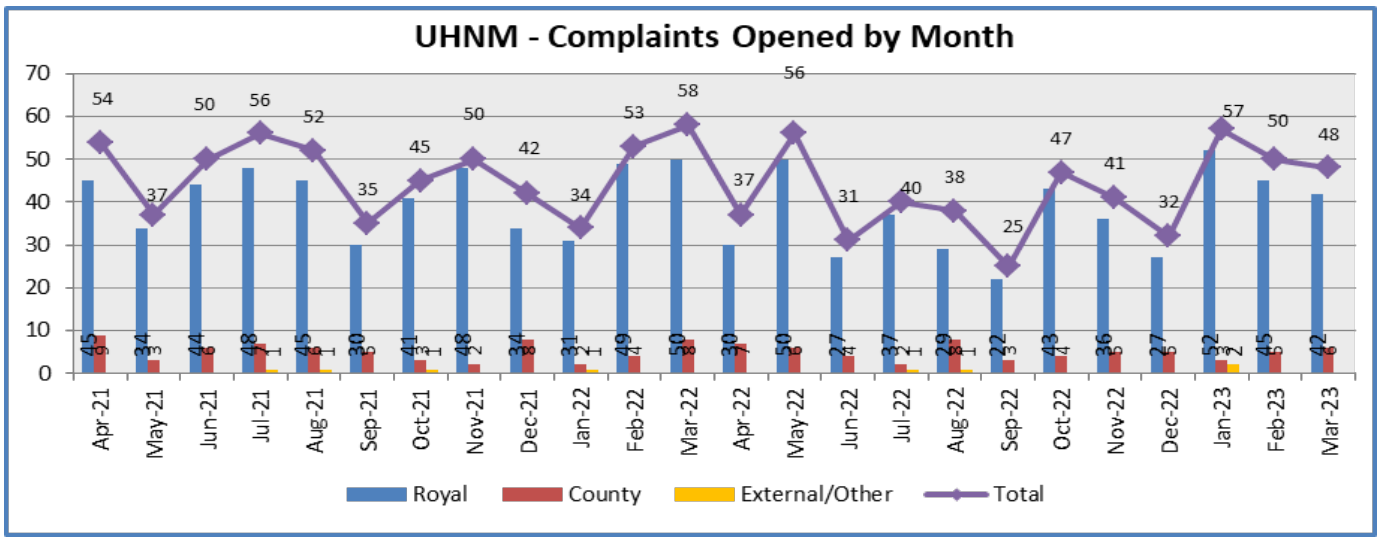
Complaints

The total number of complaints opened at Royal Stoke University Hospital during 2022/23 is 440 which is 29% lower than the pre COVID-19 three year average of 616.

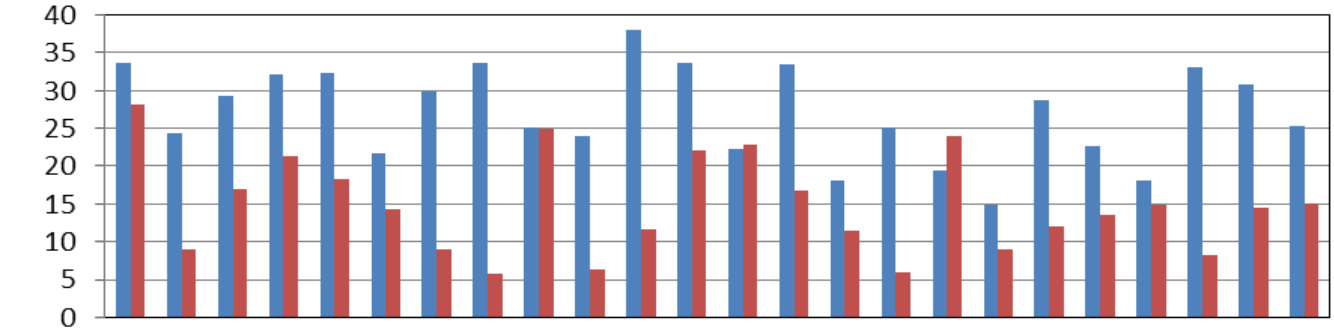
The total number of complaints opened at County Hospital 58 in 2022/23, which is 48% lower than the pre-COVID 3 year average of 112.

During 2022/23, the Complaints Team has achieved the following:

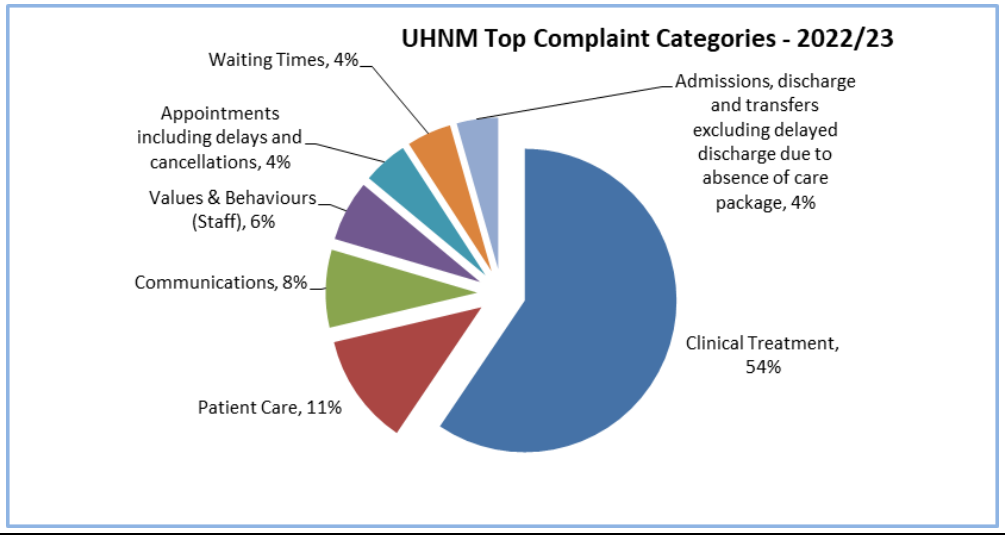
- Continued effective working with the PALS Team to resolve complaints informally where possible;
- On-going review of the current process to facilitate an improvement in the timeliness of responses from receipt of complaint to final response;
- A new triage process has been implemented to ensure complaints and concerns are addressed in the most effective and efficient manner.



UHNM Complaints Rates per 10,000 Episodes



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Royal	33.7	24.3	29.2	32.1	32.4	21.6	29.9	33.7	25.2	23.9	38.0	33.6	22.3	33.5	18.2	25.1	19.5	14.8	28.6	22.7	18.1	33.0	30.8	25.2
County	28.2	9.0	17.0	21.3	18.2	14.3	9.0	5.7	24.9	6.3	11.7	22.1	22.9	16.8	11.5	6.1	24.0	8.9	12.0	13.5	14.9	8.2	14.5	15.0



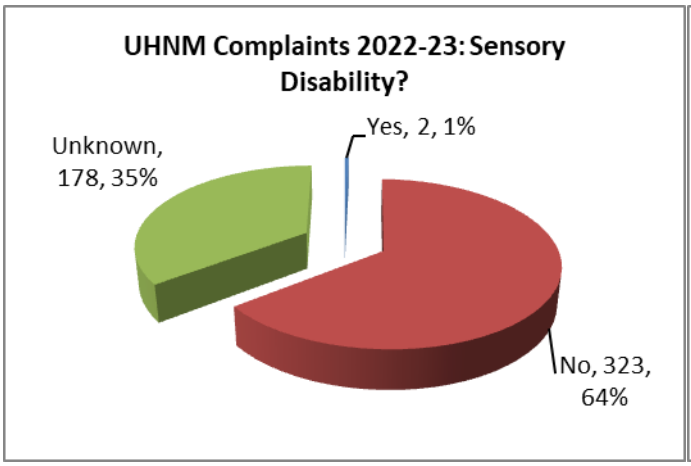
Ethnicity of complaint subject	No of complaints	% of complaints	% All patients discharged
White British	414	82%	84.5%
Not Stated	53	11%	5.7%
Any other White background	5	1.0%	1.9%
Any Other Mixed Background	5	1.0%	0.8%
Indian	5	1.0%	0.6%
Any other ethnic group	4	0.8%	0.9%
Pakistani	5	1.0%	2.0%
Any Other Black Background	2	0.4%	0.3%
White & Black African	2	0.4%	0.3%
Chinese	1	0.2%	0.2%
Bangladeshi	2	0.4%	0.2%
White Irish	-	-	0.4%
White & Asian	1	0.2%	0.4%
White & Black Caribbean	1	0.2%	0.3%
Caribbean	1	0.2%	0.2%
Black African	1	0.2%	-
Any Other Asian Background	1	0.2%	0.8%
African	-	-	0.6%

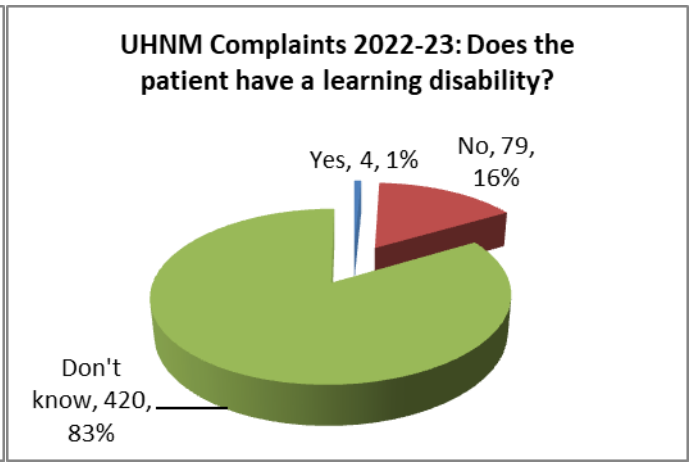
Ethnicity of Complainant	No of complaints	% of complaints
White - British	265	53%
Not stated	215	43%
Indian	5	1%
Pakistani	4	1%
White - other white	3	1%
Other ethnic category	2	0.4%
Bangladeshi	2	0.4%
Other mixed	2	0.4%
Mixed white and black African	1	0.2%
Black Carribean	1	0.2%
Mixed white and Asian	1	0.2%
Black African	1	0.2%
Chinese	1	0.2%

The tables above show complaints numbers according to ethnicity of the person/patient who was the subject of the complaints, and also by the ethnicity of the complainant, where recorded. The first table also shows ethnicity percentages for all inpatients discharged from UHNM in 2022-23, plus those discharged from the emergency department.

7% in total of complaints opened in 2022-23 have been recorded as relating to a person whose ethnicity was not White – British. This compares to 10% of all patients discharged recorded as having an ethnicity other than White – British. 5% of complainants in total were recorded as having an ethnicity other than White – British.

No single ethnic group appears to be over represented in these numbers. Those recorded as Pakistani may be under represented as they account for just 1% of complaints, but 2% of discharges.





The charts above show the numbers of complaints where the person/patient who was the subject of the complaint has been recorded as having a sensory or learning disability. As a significant proportion are 'unknown/don't know', it is hard to draw firm conclusions from these numbers. For context, of inpatients discharged in 2022-23, 0.04% (93) were known to have a sensory disability, and 0.6% (1433) to have a learning disability. The degree of uncertainty in these numbers is unknown.

Learning from Complaints

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

You said: You were admitted to ED following a night out where, although you had been drinking alcohol, this was not to excess. You suffered a fainting episode and banged your head as you fainted. You were unconscious for about 15-20 minutes and were bleeding from a head wound. You were reviewed in ED and then discharged without being scanned and without any discharge advice for your wife who was caring for you. When you woke the following day, you were uncharacteristically angry and remained disorientated and confused. You were subsequently readmitted to ED.

We Did: Your case was discussed at the Morbidity and Mortality meeting where it was identified that, in line with NICE guidelines, you should have had a CT scan, even if the clinicians suspected intoxication, as you presented with a head injury and decreased level of consciousness.

You said: You were admitted to ED as you were concerned you were developing sepsis. You know the signs as you have had sepsis twice before. You were initially seen quickly and administered IV paracetamol however had no ID wristband provided before these were administered and you were then left for 6 hours without being checked on. You were transferred to AMU and then to SSU even though there was no bed available on SSU.

We Did: Learning alerts have been circulated to all staff in ED reiterating the policy for medicine administration and the need for an ID wristband. A second learning alert has been circulated regarding the need for timely observations in line with NEWS score.

You said: Patient had a chest x-ray completed at the Royal A&E Department. It showed a likely lung cancer; advice was given for a CT scan. Nil action was taken and patient sent home; the discharge letter states CXR - Nil acute. Patient deteriorated and was discussed in lung fast track meeting following a 2 week wait referral, the patient was seen in the lung cancer clinic with the results of the CT. The patient now has stage 4 lung cancer and the Family have questioned why the CXR was not acted upon.

We Did: A full RCA was completed and the outcome shared with the family. Actions identified:
Introduce a new electronic reporting system which will eliminate paper based reports and highlights critical, urgent and unexpected findings.
Learning alert:

- Staff to be made aware of the Careflow – ordercomm referrals for 2ww pathway - to refer patients with suspected cancer to 2-week wait clinic.
- Introduce a new imaging discrepancy meeting for the ED department where all imaging where abnormalities were missed / not actioned.
- Weekly training sessions for junior trainees to include CXRs.
- Doctor who reviewed the CXR to reflect on the case in the electronic training portfolio and discussed with the clinical supervisor.

Part C: Statements from our key stakeholders

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Staffordshire & Stoke-on-Trent Integrated Care Board (ICB) are pleased to comment on this Quality Account 2022/2023.

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

The ICB acknowledge that the Trust have had a challenging year following the impact of the pandemic and the requirement for different ways of working and fast-paced change. We echo the Trusts Board's thanks and appreciation to all the Trust's staff for their continued hard work, commitment, and dedication.

The ICB would like to recognise the Trust's commitment to making progress improving the following quality and safety priorities during 2022/23:

- Reduced rate of formal complaints received during 2022/23 from that reported in 2021/22
- Continuing to compare well against peers during and remaining within expected ranges for both HSMR and SHMI mortality indicators
- Improvement in Sepsis screening for Inpatients
- Reduced number of Never Events compared to 2021/22
- 45% reduction in Category 3 Hospital Acquired Pressure Ulcers with 'lapses in care' in 2022/23 compared to 2021/22 totals
- Development of 30 Professional Nurse Advocates across the Trust with training planned for further 25 during 2023/24.

However, 2022/23 has been continued to be a challenging time for all following the pandemic and a difficult winter. We look forward to continuing collaborative working with the Trust and other system partners to see further quality improvements in the following areas over the coming year:

- To reduce ambulance handover delays in conjunction with system partners and improve Emergency 4-hour target performance
- Improve sepsis treatment and recognition of deteriorating patients
- To reduce patient waiting lists and backlogs and maintain patient safety

Priorities for 2023/24

The Integrated Care System will continue to support and collaborate in respect of the Trust's Quality priorities for 2023/24 and have recognised the following areas as requiring further focused work to ensure that required standards are consistently achieved:

- To reduce patient harm and improve clinical effectiveness and outcomes for our patients by reducing waiting lists and backlogs and maintain patient safety
- To improve patient experience by improving sharing of learning from patient feedback and involve patients in learning and improvement with a particular focus on ''seldom heard' patient groups
- To further develop staff wellbeing and experience
- To continue to manage Inductions of Labour ensuring backlogs are minimised and that appropriate escalation continues to be routine practice when issues do occur.
- To work with system partners to continue to improve the prompt discharge of patients who are medically fit to return to their normal place of residence, and
- To continue ongoing work to ensure CQC improvement notices are addressed and where appropriate closed down, supporting a move towards achieving an improved overall CQC rating in the future.

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

Heather Johnstone
Chief Nursing & Therapies Officer
NHS Staffordshire and Stoke-on-Trent ICB

Peter Axon
ICS/ICB Interim Chief Executive Officer
NHS Staffordshire and Stoke-on-Trent ICB

City of
Stoke-on-Trent

Quality Account – Adult Social Care, Health Integration and Wellbeing Overview and Scrutiny Committee

Not received statement/comments to circulated Quality Account

Quality Account – Staffordshire County Council Overview and Scrutiny Committee

Staffordshire County Council Overview and Scrutiny Committee welcomes the positive UHNM 2022-23 Quality Account. The report recognises the national requirements and the complexity of the UHNM organisation, the geography, and the resident base. Members felt that future reports may benefit if the QA reflected the outcomes as well as the inputs measures. It recognised the positive contribution of staff in challenging circumstances, although an ambition should be to increase the participation in staff engagement surveys so that they were more representative of overall number of staff, with only 33% participating, representing a drop of 21% year on year.'

Statement regarding the UHNM Quality Account 2022/2023

Not t received statement/comments to circulated Quality Account

healthwatch Stoke-on-Trent

Statement regarding the UHNM Quality Account 2022/2023

Not received statement/comments to circulated Quality Account

Executive Summary

Meeting:	Public Trust Board	**Date:**	7th June 2023
Report Title:	Q4 Infection Prevention Board Assurance Framework	**Agenda Item:**	9.
Author:	Helen Bucior, Infection Prevention Lead Nurse		
Executive Lead:	Mrs Ann-Marie Riley, Chief Nurse/DIPC		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Executive Summary:

Situation

To update the Trust Board on the self-assessment compliance with NHS England Infection Prevention and Control Board Assurance Framework version (BAF) Version 1.0 for quarter 4 22/23

The new IP BAF has now been published (17th April 2023) and will replace the current 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.

Background

The UKHSA guidance was archived at the end of April 2022. The proposal is that the National Infection Prevention Manual combined with this version of the Board Assurance Framework will support this transition

Each criteria had been risk scored and target risk level identified with date for completed. Although work is in progress, the self-assessment sets out what actions, processes and monitoring the Trust has in place and action and interventions required.

Assessment/risks

- FFP3 resilience principles
- Cleaning standards work continues
- Assurance for isolation of clinically immunocompromised in ED and general wards
- Mask fit staff to two or more models of UK made FFP3 masks
- Transfer of FFP3 mask fit testing document from Health roster to ESR
- UHNM has a IP Q+A manual which is available on Trust desk top for easy access
- Patients moved on occasions to manage operational pressures and release available capacity

Progress

- Central funding for external company mask fit support ended in March 2023 this service will occur a cost if the Trust decide to continue . A number of options are being considered
- Paper submitted to request to proceed with business case for mask fit testers

Key Recommendations:

The Trust Board are asked to note the document for information, and note the on-going work to strengthen the assurance framework going forward.

NHS
University Hospitals of North Midlands
NHS Trust

Infection Prevention and Control Board Assurance Framework

March 2023

Delivering Exceptional Care with Exceptional People

Summary Board Assurance Framework

Ref / Page	Requirement / Objective	Risk Score					
		Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Change
BAF 1 Page 4	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.	High 9	Mod 6	Low 3	Low 3	Low 3	→
BAF 2 Page 8	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Mod 6	Mod 6	Mod 6	Mod 6	→
BAF 3 Page 14	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Mod 6	Mod 6	Low 3	Low 3	Low 3	→
BAF 4 Page 17	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care, in a timely fashion.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 5 Page 20	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 6 Page 25	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 7 Page 27	Provide or secure adequate isolation facilities.	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 8 Page 29	Secure adequate access to laboratory support as appropriate	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 9 Page 32	Have and adhere to policies for the individual's care and provider organisations that will help to prevent and control infections	Low 3	Low 3	Low 3	Low 3	Low 3	→
BAF 10 Page 34	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Low 3	Low	Mod 6	Mod 6	Mod 6	→

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	2	1	1	1	There are a number of controls in place. UHNM Risk assessment are in place where deviation from regional COVID guidelines and testing recommendations	Likelihood:	1	End of Quarter 4 22/23
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	9	6	3	3	3		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	Systems and processes are in place to ensure that: • A respiratory plan incorporating respiratory seasonal viruses that includes: ○ Point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services ○ Segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g. clinically	• UHNM use PCR testing for patients suspected to have respiratory infection - Laboratory24 hour service • A number of rapid PCR is result is available when required • Triage system in place in ED , use of single rooms with doors for those suspected or confirmed respiratory infection • On arrival to ED patients are immediately identified either asymptomatic for COVID -19 symptoms and infection prevention precautions applied. • ED navigator in place • Aerosol generating procedures in single rooms with doors closed • Major's resuscitation area for all patients	• COVID outbreak • DATIX • Monitoring COVID patient numbers at UHNM for any increase in cases • Monitoring the number of COVID outbreaks for any increase • Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision making and escalation • Tactical, Operational Delivery Group - The delivery of the objectives	• Although rapid PCT testing option in place for situations where a rapid results would benefit , trust re visit POCT options • Assurance from Emergency portal and wards re isolation of the clinically vulnerable

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	immunocompromised.	requiring this level of medical care. This area consists of single rooms with sliding doors and neutral pressure ventilation. Signage in place to set out level of PPE required for each room depending on infectious status of patient. • Patients are asked to wear face covering/mask • Extremely vulnerable patient placement in COVID ward round guidance and IP Q+A manual • COVID screening guidance includes COVID screening for the immunocompromised	and benefits, and programme communications COVID 19 response and R&R. Co - ordination of resources. Escalation forum for linked Groups and Cells ensuring that the interdependencies are effectively managed, including system. Makes recommendations to Gold Command for key decisions. • Clinical steering Group – Coordinate clinical decision – making to underpin continual service delivery and COVID 19 related care • Workforce Group – Lead the plan and priorities for our people recovery. Health and Wellbeing. Agree significant pipeline changes in working practices. Agree the impact if change made during COVID and priorities to support recovery • Divisional Groups – Agree infection Prevention	
	○ A surge/escalation plan to manage increasing patient/staff infections.	• Incident Control Centre (ICC) • Major incident plan • Surge plan • Weekly clinical Group • Tactical group structure in place, meetings currently paused. COO stands up group when required. • COVID Gold command , decisions /assurance report to Trust Board via CEO/COO • Daily COVID report , inpatient status, COVID related staff absences • Demographic and Health responsive staff risk assessment -COVID risk assessments • Isolation of suspected or Confirmed	 COVID19RRGOVERNANCE NOV20v1.pptx measures	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	○ A multidisciplinary team approach is adopted with hospital leadership, operational teams, estates & facilities, IP teams and clinical and non-clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan. • Organisational /employers risk assessments in the context of managing infectious agents are: ○ Based on the measures as prioritised in the hierarchy of controls. ○ Applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ Communicated to staff. ○ Further reassessed where there is a change or new risk identified e.g. changes to local prevalence.	infectious patients • Advised window opening for a minimum of 10 minutes per hour • Cleaning of work station remains/cleaning of the environment • Down time for areas undertaking AGP's  ventilation-air-changes-per-hour-2021-06 • COVID 19 prevalence rates discussed at weekly clinical group although difficult due to no community testing and screening as per low prevalence guidelines. • Updates are via UKHSA • Maintain routine wearing of face masks in all clinical areas and corridors. • FFP3 masks when caring for confirmed or highly suspected COVID 19 patients and AGP's with patients with infection transmitted by the respiratory route or unknown infectious status • Patient mask wearing where tolerated by patient • Corporate and local risk assessments • Risk assessment policy and template • Risk assessment through COVID governance • COVID care plan	• Audit programme • Datix /inappropriate transfers • Monitoring COVID patient numbers at UHNM for any increase in cases • Monitoring the number of COVID outbreaks for any increase	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
• The completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems. • Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents. • Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons. • Resources are in place to monitor and measure adherence to the NIPCM (national infection prevention and control manual). This must include all care areas and all staff (permanent, flexible, agency and external contractors). • The application of IP practices within the NIPCM is monitored. • The IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level. • The Trust Board has oversight of incidents/outbreaks and associated action plans	• Transfer policy • IP Q+A manual • Audit programme • Matrons walk round • Agenda item Trust Board • National definition of outbreak in place • Outbreak meetings • Outbreak areas included in daily tactical information • Definite Nosocomial COVID 19 numbers are included in Quality performance report • Nosocomial Death review process		• Patients moved on occasions to manage operational pressures and release available capacity

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
1.2	• The Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	• A number of mask models are available, however, further work is required to ensure staff are fitted on 2 models of FFP3 masks – see criteria 10	• Staff training records • Procurement – mask usage	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1	1.1	Segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g. clinically immunocompromised	Matrons/IP	March 2023	November 2022 – to explore gaining assurance around segregation of clinically immunocompromised from emergency portals and wards March 2023 – no issues raised related to segregation	
2	1.1	To revisit POCT testing options	Laboratory	April 2023	November 2022 – Although rapid PCR option in place for situations where rapid response is required, to revisit PCOT options and reliability. It is vital that the tests are POCT are accurate. System in place in place, fast track PCR. To review after April 2023. April 2023 – no change in current process remains in place for fast track PCR	
3	1.1	Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons.	DIPC	March 2023	Patients moved on occasions to manage operational pressures and release available capacity. Cases discussed with DIPC /IP Team. Risk assessment in place to mix COVID contacts with Similar dates.  Risk Assessment COVID IPC reducing	

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	2	2	2	Whilst cleaning procedures are in place to ensure the appropriate management of premises further work is in progress re cleaning standards and role and responsibilities	Likelihood:	1	End of Quarter 2 2023/24
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	6	6	6	6	6		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
2.1	Systems and processes are in place to ensure that: • The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. • The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room • Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment. • Enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained. • Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant	• Currently The Royal PFI Operating to 2002 standards • Currently Royal retained and county Operating to 2007 standards • A multi-disciplinary Cleaning Standards Group established to work through the implications of the new standards and identify the actions needed to achieve compliance and any resource requirements • SOP and cleaning method statements for cleaning teams • High level disinfectant , Virusolve and Tristel in place and used for all decontamination cleans • Increased cleaning process (	• CEF audits • C4C audits • Audits and assurance visits by IP • Ward audits • Spot check assurance audits completed by cleaning supervisors/managers • Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / domestic supervisors • Patient survey feedback is reviewed by joint CPM /	• Implementation of National Standards of cleanliness 2021

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	solutions/products. • For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: o patient isolation rooms o cohort areas o donning & doffing areas – if applicable o 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails.	barrier clean) included in Infection Prevention Questions and Answers manual available on all Trust desk top • Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans • Cleaning schedules in place • Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points • Process and designated staff for ED to ensure cleans are completed timely • Responsibility framework • Who cleans what posters • IP Q+A manual - bed cleaning posters • IP Q+A manual - decontamination • Use of Medical Device/equipment policy MDM02 • Terminal clean process • Audit process • IP Q+A manual -	Sodexo/EFP group and action plan completed if needed. • Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %. • C4C report presented at IPCC • GREAT training record cards are held centrally by Sodexo for all individual domestics • Key trainers record • Notes from Sodexo Performance Monthly meeting , Sodexo Operational meeting , Divisional IP Meeting and facilities/estates meeting • Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %. • IP unannounced checks	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea and/or vomiting. • The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness • A terminal clean of inpatient rooms is carried out: ○ when the patient is no longer considered infectious ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). ○ following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • Reusable non-invasive care equipment is decontaminated: ○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care	decontamination • Use of Medical Device/equipment policy MDM02	• Barrier clean request log • Terminal clean request log • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled / barrier cleans. • Non-clinical areas are cleaned at regular frequencies through the day especially sanitary ware, and if additional cleans are required between scheduled cleaning, these can be requested via the helpdesk. • IP audits held locally by divisions • Datix reports/adverse incident reports • IP Audits • Clinical cleaning schedule records	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	equipment.			
2.2	• Ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/ • Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible. • where possible air is diluted by natural ventilation by opening windows and doors where appropriate	• UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and reduction in risk of infection transmission through ventilation systems. TOR written • The Trust also appointed external authoring Engineers. This is in line with the NHS estates best practise and guidance from Health Technical Memorandum (HTM) namely 03/01 Specialised Ventilation for Healthcare Premises. • Trust Estates Ventilation Aps attended week long Specialized ventilation in health care at Leeds University – Much of this content contact relates to airborne respiratory infections • Lessons learnt poster which encourage regular opening of windows to allow fresh air  ventilation-air-changes-per-hour-2021-06 •	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for system compliance.	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• IP and estates have worked with areas know to be undertaking aerosol generating procedures and completed the fallow times • IP have nominated point of contact re ventilation advise • Most wards have mechanical ventilation in core areas and natural ventilation in bays e.g. window opening • Estates and IP continue to explore air scrubber technology • IP and Estates have compiled a list of high risk area and current air changes. This work will then extend to other general inpatient areas.		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
2	2.1	Review of cleaning standards	Divisions Facilities/DDN	12/11/2021 31/12/2021 End of quarter 1 2022	<u>July 2022</u> Discussion and agreement with NHSEI the dismantling of beds to the level undertaken during the CPE would be considered during planned deep cleans/ ward refurbishments and continue with standard and terminal clean process as usual.	
	2.1	Review of bed /trolley. Refresh Roles and responsibilities for bed /trolley space cleaning	Divisional Directors of Nursing /IP	June 2023	<u>March 2023</u> On occasions bed/trolley frames have been identified during IP audits that have not met the cleanliness standard. A number of these beds were labelled as ready to use. Meeting to be organised to discuss with Divisional Directors of Nursing/ Heads of Nursing and A3 meeting for bed process meeting	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
	2.1	Plan for implementation of National Standards of cleanliness 2021	Facilities/Estates PFI	Quarter 1 23/24	A multi-disciplinary Cleaning Standards Group established earlier this year, including representatives from retained estate, CPM, Sodexo and Infection Prevention to work through the implications of the new standards and identify the actions needed to achieve compliance and any resource requirements. Options analysis paper submitted against the 2021 standards. The Trust are pursuing option 2 which is the implementation of the National Standards of Cleanliness 2021 and the business case is awaiting formal approval On review of all options it has been noted that Option 2 will align all operational processes to allow us to achieve full compliance with the 2021 standards and comparison of cleaning standards will be easy to track via the prescribed star rating system. There will be defined responsibility for cleaning across all disciplines with consistency of approach across the Royal and County sites. There is a need for further work to conclude in respect of quantifying the Nursing elements <u>April 2023</u> National Standard for cleanliness due for roll out Quarter 1 23/23	
	2.2	To explore alternative technologies to enhance ventilation in bays that have natural ventilation	Infection Prevention Team/Estates	July 2023	IP and Estates compiled a list of high risk areas and current air changes for these areas and other general inpatient areas and current air changes. Areas such as critical care, theatres, ED resus, and endoscopy have mechanical. Most general ward bays are natural ventilation e.g. window opening. March 2023 To be discussed at next ventilation group July	

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	1	1	1	Antimicrobial prescribing is reviewed by ward pharmacy teams on each drug chart review. The AMS team also undertakes targeted ward rounds in clinical areas where the monitoring of antimicrobial consumption indicates areas may need additional support. The AMS team are contactable by clinicians requesting advice re: optimising antimicrobial therapy and this may include escalation to duty Consultant microbiologist if necessary	Likelihood:	1	End of Quarter 1 2023
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	6	6	3	3	3		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				

3.1	• arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated
	• NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use
	• the use of antimicrobials is managed and monitored:
	  • to optimise patient outcomes
	  • to minimise inappropriate prescribing
	  • to ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed
	• contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including:
	  • total antimicrobial prescribing;
		• Regular, planned Antimicrobial stewardship (AMS) ward rounds
		• Formal lead is the Lead Consultant Microbiologist supported by the Advanced Pharmacist Practitioner- ID & Antimicrobials
		• Trust antimicrobial guidelines available 24/7 via intranet and mobile device App
		• Antimicrobial action plan in place
		• Clostridium-*difficile* Period of increased incidence and outbreaks are reviewed by member of AMS team and
			• Same day escalation to microbiologist, if concerns. Outcome recorded on I portal
			• Metric available around the number of times App accessed by UHNM staff
			• Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC)
			• Meeting minutes reviewed and actions followed up
			• Real time discussions /	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
• broad-spectrum prescribing; • intravenous route prescribing; adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources • • Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors).	actions generated cascaded to ward teams • Regional and National networking to ensure AMS activities are optimal • Formal regional meetings and informal national network activities • AMS CQUIN further mandates key AMS principles to be adhered to • Regular meetings held between commissioners, Trust leads and AMS team to monitor compliance with contractual reporting requirements. CQUIN compliance reported to IPCC • Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM • Reintroduction of point prevalence audits as the Trust comes out of pandemic pressures. Results will be made available to divisional teams and support provided by AMS team to optimise prescribing of antimicrobials.	requests for support / advice enabled via regional and national networks for challenging cases where additional expert advice around optimal choice of antimicrobials is needed • Trust and commissioners require timely reporting on compliance with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 3 Progress Report	BRAG
1						

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
4.1	Systems and processes are in place to ensure that: • IP advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use • Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • National principles on inpatient hospital	• Posters and signage in place • Mask available at hospital entrance • Information available on Trust internet site • 30th May visiting updated .The majority of inpatients are permitted to have two visitors, between 2pm and 4pm and again between 6pm and 8pm. In the majority of cases these do not have to be the same two	• Monitored by clinical areas • PALS complaints/feedback from service users • Outbreak meetings	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	visiting and maternity/neonatal services will remain in place as an absolute minimum standard. national guidance on visiting patients in a care setting is implemented. • Patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice. • Restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives.	visitors. • UHNM visiting information public internet site  Visiting at UHNM internet site.docx • Outbreak management • Discussed at outbreak meeting		
4.2	• There is clearly displayed, written information available to prompt patients' visitors and staff to comply with hand washing, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment.	• Posters and signage in place • Mask available at hospital entrance • Refreshed mask wearing communication sent out 21st January 2023 • At UHNM FFP3 is recommended for all contact with COVID or high suspected COVID patient	• Monitored by clinical areas • PALS complaints/feedback from service users • Outbreak meetings	
4.3	• If visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate	• PPE available • Clinical area to advise visitor	• Monitored by clinical areas • PALS complaints/feedback from service users	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	PPE. • Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting. • Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	• Support from IP Team and Consultant Microbiologist when required • Information available on COVID intranet page • Advice from IP Team and Consultant Microbiologist Infection Prevention triage desk which provides advice and support to clinical areas	• Outbreak meetings • Datix	
4.4	• Implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	• Resources reviewed • Implementation of a number of controls e.g. staff well being	• Audits • Staff feedback • PAL/complaints - feedback	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 3 Progress Report	BRAG

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	1	Arrangements are in place to ensure the screening of patients in line for National guidance. – COVID testing in periods of low prevalence. To continue to reinforce COVID screening protocol.	Likelihood:	1	
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3	3		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
5.1	Systems and processes are in place to ensure that: • all patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients). • Signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM).	• **COVID Testing** C1662_covid-testing -in-periods-of-low-pre • Routine asymptomatic testing in a number of setting will pause 31st August 2022 • High – risk patient identified for COVID19 MAB and antiviral treatment - PCR • Admission to high risk area at UHNM(Haematology, oncology, real wards Critical care, ward 222, SSCU and PICU) • Symptomatic patients for clinical diagnostic pathway	• COVID 19 -Themes report to IPCC • COVID screening spot check audits • Datix • Outbreak investigation	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Symptomatic or immunocompromised patients who are admitted as an emergency or maternity care • Symptomatic or immunocompromised elective care patients prior to acute day case/overnight pre-admission • Transfer into or within hospital for immunocompromised patients • Discharge patients to care home/hospices • Outbreak testing in healthcare settings  uhnm-guidance-on-testing-and-re-testing  Elective and Planned Admission Covid-19 F  emergency-and-non-elective-admissions-c		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Signage in place - instruction for patients if they have symptoms of infection • Screening questions ED		
5.2	• The infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement • Triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated. • Patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated. • Patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite). • Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and	• Transfer policy • COVID screening for patients discharged to Nursing /Care homes • Process in place for screening and cohorting COVID contacts exposed during inpatient stay • COVID contact areas reviewed daily by the IP team • COVID contacts are cohorted with similar isolation periods to reduce risk • Where possible cohort nursing staff to provide care for the contact and the negative or positive patients separately • PPE changed when moving between cohorts • Clinical equipment where possible designed to cohort and decontaminated after use • ED triage	• COVID 19 -Themes report to IPCC • COVID screening spot check audits • Datix • Outbreak investigation • Inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary • COVID electronic Contact tag to electronic records applied by IP Team • COVID electronic record tag on place • Electronic tag/alert for other infections e.g. Cdiff/MRSA in place	• Assurance that transfer policy is followed and hand over received

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	tolerated only required if single room accommodation is not available.	• IP Q-A manual – isolation of patient if infection is suspected or confirmed • COVID 19 screening and step down guidance • Screening for other resistant organisms is included in the IP Q+A manual • Facemasks available for patients and encourage if appropriate and tolerated		
5.3	• Patients at risk of severe outcomes of infection receive protective IP measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation	• Single rooms recommended for patients who are at severe risk from COVID 19 - included in IP Q+A manual • COVID 19 care plan	• Outbreak investigation • COVID themes report • Complaints • Datix	
5.4	• The use of facemasks/face coverings should be determined following a local risk assessment. • Patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy.	• Patient are encourage to wear mask – leaflet in place • Mask stations in place • OPD process for patients who display symptoms	• Spot check audits	
5.5	• Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection	• Staff Covid /flu vaccination hub in place • Vaccination information available on the Trust intranet • Team Prevent have system in place staff vaccination	• Staff vaccination uptake reported	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		programme other than flu and COVID		
5.6	• Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	• Outbreak process in place	• Outbreak investigation • COVID 19 -Themes report to IPCC	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1	5.2	Assurance that transfer policy is followed and hand over received	DIPC/Quality Lead	February 2023	To gain assurance that transfer policy is followed and hand over received. Datix process already in place which allows the receiving ward to log any incidents	

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	1	Information and communication/controls are in place to ensure staff are aware of their responsibilities spot audits continue.	Likelihood:	1	
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3	3		Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
6.1	Systems and processes are in place to ensure that: • IP education is provided in line with national guidance/recommendations for all staff commensurate with their duties. • Training in IPC measures is provided to all staff, including: the correct use of PPE	• Trust induction and mandatory training • IP Q+A manual • COVID 19 intranet page • PPE posters • Donning and Doffing posters, videos and PHE available on Covid-19 section of Trust intranet • Matron walk rounds	• Audits • Unannounced IP checks	
6.2	• All staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM); • Adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to	• Trust induction and mandatory training • IP Q+A manual • PPE posters • IP assurance visits • Matrons visits to clinical areas • UHNM recommend staff use of for highly suspected or confirmed COVID 19 patients	• Audits • Unannounced IP checks • Mandatory training compliance records	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	mitigate any identified risk • Gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. • Hand hygiene is performed: ○ before touching a patient. ○ before clean or aseptic procedures. ○ after body fluid exposure risk. ○ after touching a patient; and ○ after touching a patient's immediate surroundings. ○ The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM	• FFP3 mask /hood • Eye protection • Gloves • Apron(gown for AGP • IP Q+A manual – five moments for hand hygiene posters and education • Hand washing technique depicted on soap dispensers • Social distance posters displayed throughout the Trust Alcohol gel availability at the point of care • Hand dryers are not available within clinical areas	• Audits • Datix • Hand hygiene audits • Unannounced visits • Audits • Building/clinical space design guidance	
6.3	• Staff understand the requirements for uniform laundering where this is not provided for onsite.	• Laundering of own uniform - information available on Trust Intranet page	• Monitor for any updates in National guideline • Datix/adverse incident	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
6						

7. Provide or secure adequate isolation facilities

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	1	Single rooms are available throughout the Trust , however there is a need to explore increasing single room availability (pods).	Likelihood:	1	
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3	3		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
7.1	Systems and processes are in place to ensure: • That clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	• IP Q+A manual • COVID poster • Mask stations	• IP Spot checks • Assurance obtained for monitoring of inpatient compliance with wearing face masks via Matrons daily walk round	• To gain further assurance re patient mask wearing and documentation if unable to wear a mask
7.2	• Patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM. • Patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent.	• IP Q+A manual • PPE chapter • Infection Prevention triage desk which provides advice and support to clinical areas	• Audit • Spot checks • Datix • Outbreak/incidents	• Work in progress to assess the need for more single room availability to facilitate patient flow and surgical pathway

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
7.3	• Standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings • Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	• IP Q+A manual • PPE chapter	• Audit • Spot checks • Datix • Outbreak/incidents	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
7	7.1	The compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	DIPC/Heads of Nursing	End of January 2023	To gain further assurance re patient mask wearing and documentation if unable to wear a mask	
7	7.2	To assess the need for further single room isolation facilities (PODS) to facilitate COVID patients remaining on their original ward, facilitate flow and surgical pathway	DIPC	Quarter 2 2023	May 2022 Request made to analyst to map/predict isolation need. August 2022 single room capacity modelling being added to the acute patient flow work stream' Surgical Division are exploring the use of PODS in a number of wards March 2023 Pods remain on the winter plan agenda	

8. Secure adequate access to laboratory support as appropriate.

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	1	Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited.	Likelihood:	1	
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3	3		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
8.1	There are systems and processes in place to ensure: • Laboratory testing for infectious illnesses is undertaken by competent and trained individuals.	• Testing takes place in the pathology Laboratory • How to take a COVID screen information available on Trust intranet. This has been updated in November 2020 • Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited.	• Laboratory accreditation	
8.2	• Patient testing for infectious agents is undertaken promptly and in line with national guidance.	• IP Q+A Manual • COVID screening information Trust intranet • COVID Testing and step down guidance • Occupational Health Service in place	• Occupational Health monitoring • Report to IPCC	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	• Staff testing protocols are in place for the required health checks, immunisations and clearance • There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise	• Turnaround times included in tactical slides • Screening guidelines • IP Q+A Manual	• Outbreak investigation • Datix	
8.3	COVID-19 Specific • Patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk) • For testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	• High – risk patient identified for COVID19 MAB and antiviral treatment - PCR • Admission to high risk area at UHNM(Haematology, oncology, real wards Critical care, ward 222, SSCU and PICU) • Symptomatic patients for clinical diagnostic pathway • Symptomatic or immunocompromised patients who are admitted as an emergency or maternity care • Symptomatic or immunocompromised elective care patients prior to acute day case/overnight pre-	• Reviewed as part of outbreak investigation • Spot checks/audits	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		admission • Transfer into or within hospital for immunocompromised patients • Discharge patients to care home/hospices • Outbreak testing in healthcare settings  uhnm-guidance-on-t esting-and-re-testing  Elective and Planned Admission Covid-19 F  emergency-and-non-elective-admissions-c • Process in place for staff COVID testing screening via Empactis system		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	1	There is a range of information, procedures, and pathways available along with mechanism to monitor.	Likelihood:	1	
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3	3		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
9.1	Systems and processes are in place to ensure that • Resources are in place to implement, measure and monitor adherence to good IP and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • staff are supported in adhering to all IPC and AMS policies.	• IP included in mandatory update • Infection Prevention Questions and Answers manual with ICON on every desk top for ease of use • Infection Prevention triage desk which provides advice and support to clinical areas	• IP audit programme • Audits undertaken by clinical areas • CEF audits • Proud to care booklet audits • AMS audits	
	• Policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	• Included in IP Q+A manual	• Outbreak investigation • Datix	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
9.2	• All clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM	• Waste policy in place • Waste and stream included in IP mandatory training • Waste and Linen included in IP Q+A Manual	• Audits and spot checks • The Trust has a Duty of Care to ensure the safe and proper management of waste materials from the point of generation to their final disposal • This includes: • Ensuring the waste is stored safely. • Ensuring the waste is only transferred to an authorised carrier and disposer of the waste. • Transferring a written description of the waste • Using the permitted site code on all documentation. • Ensuring that the waste is disposed of correctly by the disposer. • Carry out external waste audits of waste contractors used by the Trust.	
9.3	• PPE stock is appropriately stored and accessible to staff when required as per NIPCM	• Procurement and stores hold supplies of PPE • PPE at clinical level stores in store rooms • Donning and doffing stations at entrance to wards	• PPE availability agenda item on Tactical Group meeting • Audits • Datix	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 3 Progress Report	BRAG

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	2	2	2	There are clear control in place for management of occupational needs of staff through team prevent to date Monitoring of adhere to PPE requirements continues. Work in progress to further improve develop a long term, sustainable fit testing to ensure staff are fit tested to at least two masks and records entered onto ESR	Likelihood:	1	Q2 23/24
Consequence:	3	3	3	3	3		Consequence:	3	
Risk Level:	3	3	6	6	6		Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	Systems and processes are in place to ensure that: • Staff seek advice when required from their occupational health • bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff	• Occupational Health Provision in place at UHNM		
10.2	• Staff understand and are adequately trained in safe systems of working commensurate with their duties.	• Induction and Mandatory Training • At UHNM FFP3 recommended for all contact with COVID19 confirmed or suspected	• Induction and Mandatory Training compliance records • Audits	
10.3	• A fit testing programme is in place for those who may need to wear respiratory protection.	• Mask fit strategy in place • List of mask fit testers within a clinical areas available on the intranet. • Ashfields external mask fitters assisting currently with testing	• Mask fit training records • List of mask fit testers	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		programme. The support from external trained tester via supply chain is until March 2023 which would leave a gap in support provision after this date if support is not extended or internal team appointed		
10.4	• Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: • lead on the implementation of systems to monitor for illness and absence. • facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice. • lead on the implementation of systems to monitor staff illness, absence and vaccination. • encourage staff vaccine uptake.	• Team Prevent contract and service in place	• Outbreak • Datix /adverse incident review	
10.5	• Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM.	• COVID 19 advice available on Trust intranet • Team Prevent Service/advice and follow up • Advice from Consultant Microbiologist	• Audit	
10.6	• A risk assessment is carried out for health and social care staff including	• All managers carry our risk assessment	• Risk assessment and temporary risk mitigation	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications. ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. A risk assessment is required for health and social care staff at high	• Process available on the COVID 19 Trust intranet page • Linked to Empactis	will be reported to the workforce bureau. To protect confidentiality individual risk assessments will not be requested as these should be kept in the employees personal file • Managers required to complete , review and update risk via Empactis	
10.7	• Testing policies are in place locally as advised by occupational health/public health.	• Staff testing as per National guidance • Information available on Trust intranet • COVID communications	• Outbreak investigation	
10.8	• NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	• Process in place • Information available on Trust intranet	• Outbreak investigation • Datix	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
10.9	• staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records. • Staff who carry out fit test training are trained and competent to do so. • Fit testing is repeated each time a different FFP3 model is used. • All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood.	• Certificate of testing issued to staff Member • Electronic record currently held locally and on Health Roster • In house train the tester/cascade trainers programme place • Support from external mask fit testers in place Ashfields until end of March 2023 • A number of mask fit testers have been trained to use the portacount machine using an external company/trainer and results uploaded onto ESR • Air powered hoods and reusable P3 mask available for those that have failed on FFP3 mask • IP Q+A Manual details mask fitting • SOP's in place • Initial priority to ensure staff that are required to wear are FFP3 masks are fit tested. • Further work is required to ensure staff are fitted to use at least two different models of masks	• Mask fitting is currently recorded Health Roster records • Test certificate also retained in staff personal folders	• Further work is required to record training on ESR. Currently FFP3 mask fit is recorded on Health roster and ESR for some staff • Further work is required to ensure staff are fitted to use at least two different models of masks to ensure FFP3 resilience

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	• That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions • Members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. • Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	• Air powered system hoods and SOP • In situations when staff member fails FFP3 mask fitting. Alternative models available and air powered system. • Discussion should be held in personal folders • Mask fitting certificate to be held in personal folder • Currently added to health roster but further work required to transfer to ESR		
10.10	• Staff who have symptoms of infection or test positive for an infectious agent should	• All managers carry our risk assessment	• Via Empactis • Staff queries' through	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
have adequate information and support to aid their recovery and return to work.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms • Flow charts or staff returning to work available on COVID 19 section of intranet	workforce bureau or team prevent	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
10	10.9	**FFP3 resilience principles**. Currently Health roster is used to record mask fit testing. Capturing the data on ESR will allow the information to transfer with the staff member if they transfer between Trusts.	**IP**	June 2023	October 2022 Delivery Manager – National FFP3 Fit Test Team has made contact with UHNM to arrange meeting/support to discuss FFP3 resilience principles and transfer of mask fit data to the ESR system February 2023 Various meetings held regarding ESR and recording of mask fit testing. ESR aligned with National system/criteria on ESR. Progress has been made, however, further discussion required regarding the uploading of data process	
10	10.9	**FFP3 Resilience principles** FFP3 users should be tested on two different models of masks (ideally 3)	**IP**	**Quarter 2 2023**	October 2022 - The focus has been to ensure all staff that require FFP3 masks are fitted. Work to ensure staff are fitted to 2 models of FFP3 masks will required working through to establish resources required. IP have appointed a band 3 for a 6 month period to help with fit testing. FFP3 resilience principles paper submitted to IPCC November 2022 February 2023 Paper submitted to request to proceed with business case for internal mask fit tester team. During the Pandemic the model of using the external company to manage the fit testing has worked exceptionally well, with staff being fit tested when required and also relieved the pressure from the ward and departmental teams. The free external fit testing team service ended in March 2023. Further support form external mask fit will be at a cost	

					The approach of having permanent face fit testers employed directly to carry out the fit testing needs of all staff across the Trust is more resilient as these persons are responsible for scheduling in re-testing and new tests with staff and attending the wards / departments to complete the testing, the team maintain the training records in accordance with HSE. Options to be considered by Divisional Directors of Nursing to take forward if there is no investment	

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

Maternity Quality Governance Committee Chair's Highlight Report to Board

23rd May 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • Maternity services survey highlighted areas for improvement in terms of partner support to mothers during their stay, receiving help during pregnancy and being provided with a choice of where to have their baby • The quarter 4 maternity dashboard highlighted areas of performance below target in respect of the freestanding midwifery birth unit, smoking at time of delivery, midwifery red flags and induction of labour with ongoing improvement actions identified • In terms of induction of labour rates, it was noted that rates were remaining static due to an increasing prevalence of mothers with diabetes, promotion of early birth to avoid stillbirth and changes in guidance as to overdue pregnancies • Areas of concern highlighted within the quarter 4 Ockenden update related to external review of perinatal mortality cases, compliance with saving babies lives care bundle and review of communications for inclusion and diversity	• To expand upon the serious incident report to include neonatal serious incidents in addition to maternity • Maternity workforce retention and recruitment plan to be presented regionally and nationally. In addition, work remaining ongoing with regards to Preceptorship and retention of mid career and late career midwives • A trajectory for the reinstatement of the home birth service continued to be identified and worked towards, which was dependent upon further recruitment • To provide an update at future meetings with regards to challenges and risks associated with the medical workforce within maternity and neonatology • Response to the Care Quality Commission factual accuracy submitted and awaiting response
✓ Positive Assurances to Provide	**Decisions Made**
• A staff story was provided by a bereavement midwife which highlighted the way in which the role had evolved to include neonatology, with ongoing work being undertaken with parents and families included establishing a memorial • Maternity services survey highlighted positive experiences in terms of provision of information, cleanliness, discharge and aftercare • Maternity family experience report highlighted ongoing actions to increase response rates such as use of QR codes, direct links to complete the test, text messaging reminders and ongoing engagement with maternity and neonatal voices partnership • The saving babies lives care bundle highlighted improved performance in respect of CO monitoring, and good progress with assessing fetal growth restriction and raising awareness of reduced fetal movements • Quarter 4 perinatal mortality report highlighted 100% compliance with CNST safety action 1 • The outcome of the maternity rapid quality review undertaken by the Integrated Care Board was received which highlighted improvements with no further review planned	• No decisions were required to be made

Comments on the Effectiveness of the Meeting

• The Committee welcomed the wide ranging attendance which included Divisional representatives and representatives from neonatology

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Staff Story	BAF 2		✓	Assurance	7.	Saving Babies Lives Care Bundle, (SBLCB) Version 2: Q4 Update	BAF 1	ID24037	✓	Assurance
2.	NHS Maternity Services Survey Improvement Plan 2022	BAF 1		! ✓	Assurance	8.	Q4 Perinatal Mortality Report	BAF 1		✓	Assurance
3.	Maternity Dashboard – Q4 2022/23	BAF 1	ID13419 ID15993	!	Assurance	9.	Maternity Retention Report 2022/23	BAF 3	ID13419	-	Assurance
4.	Maternity and Neonatal New Serious Incident Report Q4 2022/23	BAF 1	ID15593 ID13419 ID23361	-	Assurance	10.	Maternity Rapid Quality Review	BAF 1	ID13419	✓	Assurance
5.	Maternity Family Experience Report	BAF 1	ID13419 ID15993	✓	Assurance	11.	Update on the Suspension of the Home Birth Service	BAF 1	ID13419 ID15993	-	Assurance
6.	Ockenden Update Q4	BAF 1	ID13419	!	Assurance	12.	Maternity & Neonatal Quality & Safety Oversight Group Assurance Report	BAF 1		-	Assurance

3. 2022 / 23 Attendance Matrix

Attended	Deputy Sent	Apologies Received

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Public Trust Board	**Date:**	7th June 2023
Report Title:	Maternity and Neonatal New Serious Incident (SI) Report Quarter 4	**Agenda Item:**	11.
Author:	Donna Brayford, Deputy Director of Midwifery - Governance		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

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

Executive Summary

Situation

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

No of open Maternity and Neonatal Serious Incidents	**15**
Investigation in progress: - Healthcare Safety Investigation Branch Investigations - Perinatal Mortality Review Tools	**6, of which:** 3 3
Investigations completed/awaiting to be presented and closed by Risk Management Panel and ICB SI Group:	**9**
No of overdue open serious incidents:	**9**

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 Q4 - 4 new serious incidents were reported; 1 in January, 1 in February and 2 in March 2023. Of these, 1 is a Healthcare Safety Investigation Branch (HSIB) investigation and 3 new incidents investigated by the Perinatal Mortality Review Tool (PMRT).

Key Recommendations

The Trust Board is asked to note the report.

Introduction

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

Maternity New Serious Incident Reporting Process – for information

The Maternity Team strive to declare Serious Incidents as soon as possible. The Quality and Risk Team are informed of the incident by Datix, a clinician or mother's concern or on completion of an investigation such as a Perinatal Mortality Review Tool (PMRT). The Clinical Director (CD) and Head of Midwifery (HOM) are immediately informed. The incident is discussed at the weekly Multi-disciplinary Obstetric Risk meeting to establish facts and ensure all immediate actions are implemented. A 72 hour brief is prepared and once approved by the HOM and CD is then escalated to the Divisional Team for approval by the Director of Midwifery/Divisional Director of Nursing and Divisional Governance Lead. The Serious Incident will be disclosed as soon as possible to the woman and her family.

HSIB Investigations and SI Reporting

There has been recent discussions regarding reporting all maternity cases that are reported to Health Safety Investigation Bureau (HSIB) for investigation as Serious Incidents. There does appear to be some variation in practice across the country. Some Trusts are reporting all cases as Serious Incidents and some are reporting retrospectively following the HSIB investigation and patient safety recommendations. At UHNM we initially Serious Incident report and then de-escalate afterwards if appropriate.

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

Number of open Maternity and Neonatal Serious Incidents:15
Investigation in progress: 6 (3 with HSIB and 3 Perinatal Mortality Review Tools).

Investigations completed/awaiting to be presented and closed by Risk Management Panel and ICB Serious Incident Group: 9
No of overdue open serious incidents: 9

Assessment

In Q4 - 4 new serious incidents were reported:

January	2023	1 incident
February	2023	1 incidents
March	2023	2 incidents

Category of Incidents:

1 Healthcare Safety Investigation Branch (HSIB) investigation.
3 new incident investigated by the Perinatal Mortality Review Tool (PMRT).

Future reports will include a trajectory for closure of Serious Incidents within 6 months.

Transformation and People Committee Chair's Highlight Report to Board

31st May 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • An increase in physical assaults was highlighted within the violence prevention and reduction standards report, mainly due to the patients' medical conditions although the majority were low or no harm • A review of statutory and mandatory essential to role training identified that when compared to peers, the Trust had a higher number of essential to role subjects and higher target completion rates which required review. Resuscitation training remained to be an area of challenge although additional space had been identified to hold the training and additional trainers were being recruited • Agency pay spend ceiling had been set at no more an 3.7% of total pay spend which was challenging and ongoing actions were being undertaken to reduce expenditure	• Non-Executive Directors to visit areas who are successfully sustaining the use of the Improving Together tools and techniques • To provide a further update on the investigation of network outages and actions being taken at the next meeting • To consider how updates on the Provider Collaborative could be provided in future ICS updates, including consideration of risk • Chief People Officer report to be established and provided to future meetings • Further clarity required in terms of the attendance rates for ENABLE • Further review and removal of subjects within essential to role training to be undertaken and proposal to be considered by the Executive • Divisions undertaking targeted intervention on any hotspots to address sickness absence • Freedom to Speak Up Report to be provided in July focussing on Quarter 4 and Quarter 1
✓ Positive Assurances to Provide	**Decisions Made**
• Improving together training delivery remained on target but sustainability of the programme remained the main challenge • An update was provided on the six main strategic transformation and service change programmes and suggestions were made in terms of strengthening future reports • The Committee welcomed sight of the NHS Oversight Framework (NOF) Exit Criteria and suggested Board oversight of the indicator summary on a regular basis • The Committee noted the proposed actions to receive additional assurance in relation to postgraduate medical education in terms of feedback from induction, evidence of six weekly local junior doctors' forum meetings and annual appraisal of educational supervisors • Fewer exception reports in the quarter were highlighted by the guardian of safe working with the main themes associated relating to workload and these not being reported / escalated at the time • UHNM demonstrated compliance with 38 / 42 violence prevention and reduction standards • A comprehensive update was provided in relation to the commitments which had been delivered in the first year of the People Strategy, against each of the four domains. The Committee endorsed the continued focus and momentum on engagement and equality, diversity and inclusion • Month 1 workforce performance demonstrated the majority of metrics having slightly improved • Highlights from the Executive Workforce Assurance Group included updates on the development of Professional Nurse Advocates and receipt of the Gold Pastoral Award • A new Freedom to Speak Up Guardian commenced in post on 22nd May who was focussing on the infrastructure associated with Freedom to Speak Up Associates, Trust Policy and training	• The Committee approved the Health Library Service Strategy for 2023-2028 • The Committee approved the governance structure associated with the NOF Exit Criteria although requested clarification of oversight of the theme associated with preventing ill health and reducing health inequalities

Comments on the Effectiveness of the Meeting

Committee members welcomed the focussed discussion on the people delivery plan and essential to role training

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Health Library Service Strategy 2023-2028	BAF 9	Ext 15	-	Approval	8.	People Delivery Plan 2022-23/People Strategy Launch Update	BAF 2/3	12 16	✓	Assurance
2.	Improving Together Countermeasure Summary	-		✓	Assurance	9.	Statutory & Mandatory Training – Essential To Role Update	BAF 2/3	12 16	!	Assurance
3.	Executive Digital and Data Security and Protection Group Assurance Report	BAF 6	Ext 16	-	Assurance	10.	Workforce Report – M1 2023/24	BAF 2/3	12 16	✓ !	Assurance
4.	ICS Transformation Update	BAF 4	Mod 6	✓	Assurance	11.	Violence Prevention & Reduction 6 month report October 2022 – March 2023	-		✓ !	Assurance
5.	NHS Oversight Framework – Assessment Process, Governance, Exit Criteria & Indicators	Various		✓	Assurance / Approval	12.	Executive Health & Safety Group Assurance Report	-		-	Assurance
6.	Postgraduate Medical Education Governance and Structure	BAF 3	ID16652	✓	Assurance	13.	Speaking Up – Verbal Update	BAF 2	High 12	✓	Assurance
7.	Q4 Guardian of Safe Working Report	BAF 3	Ext 16	✓	Assurance	14.	Executive Workforce Assurance Group Assurance Report	BAF 2/3	12 16	✓	Assurance

3. 2022 / 23 Attendance Matrix

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

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

Performance and Finance Committee Chair's Highlight Report to Board

30th May 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • The review of the colorectal cancer business case demonstrated partial improvements in 2 week wait and 28 day performance whilst noting that since the FIT negative strategy had been deployed this had reduced referrals as anticipated. However, a number of performance metrics had not been achieved and it was agreed to receive a further update on progress in October 2023 • The independent review of waiting list management, data and reporting highlighted the requirement to minimise future errors by focussing on training, improved pathway administration and monitoring data quality via a defined set of measures. It was noted that the report would be considered by the Trust Board in June • Updates on the predicted number of 78 and 104 week wait patients for May were provided which remained challenged • The growth in medication spend was highlighted which had largely been driven by commissioner spend associated with Specialised Commissioning and the highest risks associated with medicines related to the supply and procurement of medicines • The Trust delivered a £0.1 m surplus for month 1 against the planned surplus of £1.1 m driven by cost improvement programme (CIP) underperformance whereby £3 m CIP savings had been validated against a plan of £4.6 m and the costs of the previous junior doctor strike action at £1.1 m	• To review the colorectal cancer business case revenue costs for 2021/22 compared to the initial business case • CIP tracker to be included in future finance updates • Formal SDEC business case to be provided to the Committee in due course • Update in relation to the community diagnostic hub business case to be provided at the next meeting
✓ Positive Assurances to Provide	**Decisions Made**
• A bi-annual update on sustainability was provided which highlighted positive progress made with the Trust's green plan and the ongoing work towards reducing Trust emissions to the net zero target • A presentation was provided in relation to theatre productivity which had utilised Improving Together methodology to review current processes and identify actions for further improvement. It was suggested to receive further updates on progress on a 6 monthly basis • Improvements in urgent and emergency care performance during April were highlighted, in particular 12 hour trolley waits, ambulance handovers and 4 hour performance • 2 week wait cancer performance in April stood at 93.6% despite high volumes of referrals although the colorectal pathway remained a challenge in respect of 62 day performance • The pharmacy financial savings which had been realised were highlighted alongside positive year end stock take position. • Confirmation received from NHS England that £13.4 m capital monies will be provided for the Same Day Emergency Care (SDEC) Business Case in addition to part year revenue funding	• The Committee approved the governance structure associated with the NHS Oversight Framework (NOF) and noted the work undertaken and exit criteria • The Committee approved the following eREAFs 10811 - Cytotoxic Dose Banded Chemo, Immunotherapy and Monoclonal Medicines, 10824 - Supply of X-Ray Contrast Media (Extension) and 11003 - Theatres Staffing Contract

Comments on the Effectiveness of the Meeting

- The Committee welcomed the discussions held particularly in relation to the items associated with theatre productivity and independent review of waiting list management

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Sustainability Bi-Annual Report	BAF 7	High 12	✓	Assurance	7.	Medicines Finance, Procurement and Supplies Report Quarter 3&4	BAF 8	ID24181 ID25152	! ✓	Assurance
2.	BC-0398: Colorectal Cancer Pathway Redesign Business Case Review (12 months)	BAF 5	Ext 20	!	Assurance	8.	Finance Report – Month 1 2023/24	BAF 8	Mod 4	!	Assurance
3.	Theatre Productivity Plan 2023-2025	BAF 5	Ext 20	✓	Assurance	9.	SDEC Business Case	BAF 5	Ext 20	✓	Information
4.	Independent Review of Waiting List Management, Data & Reporting	BAF 5	Ext 20	!	Assurance	10.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-		-	Approval
5.	Performance Report – Month 1 2023/24 • UEC Tier 2 and Improvement Support Letter	BAF 5	Ext 20	! ✓	Assurance	11.	Executive Business Intelligence Group Assurance Report	-		-	Assurance
6.	NHS Oversight Framework – Assessment Process, Governance, Exit Criteria & Indicators	BAF 5	Ext 20	-	Assurance/ Approval						

3. 2022 / 23 Attendance Matrix

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

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th June 2023
Report Title:	Independent Review of Waiting List Management	**Agenda Item:**	14.
Author:	Wendy Baines		
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	✓		

Executive Summary

Situation

This report details the findings from an independent review of waiting list management at UHNM which was commissioned as part of a diligence exercise to provide assurance that waiting times within University Hospital North Midlands (UHNM) are being managed and reported appropriately, and in accordance with national guidelines following an increase in the number of 78 week waiters being reported.

Background

The impact of the COVID-19 pandemic has caused national backlogs across patients waiting for treatment and has placed significant strain on planned care delivery. Nationally, the latest figures show a total of 20,101 patients were waiting over 18 months for elective treatment as of 19 March 2023, down from 123,969 in September 2021. In UHNM, as at 11th May 2023 there are 46 patients that had waited 104 weeks or more, and 539 patients that were waiting between 78 and 103 weeks.

The below considerations were factored into the assessment of the position:

1. The sources and flow of waiting time information and reporting
2. Systems/mechanisms used to administer pathways
3. Roles and responsibilities of staff involved in waiting list management and reporting
4. Approaches taken to maintain oversight and manage waiting times
5. Governance framework in situ to manage and report waiting times

Assessment

The review found no evidence of deliberate irregularities in the management of waiting times, but as with all NHS organisations, the capacity for human error when administering patient pathways is constant. The review found that UHNM did not differ in this respect to any other NHS acute Trust. Importantly, the review also noted that the data within the reports produced by the Trust was correct and represented the intended purpose of the report. The key findings of the report are outlined in the accompanying document.

Key Recommendations

The Board is asked to note the findings detailed in the report and support initiation of a programme of work to take forward the actions contained within the report, including the below immediate priorities that need to be addressed:

- Mass validation of all patients in Careflow (including legacy patients) with a clinical harm review performed in parallel. Consider software to support.
- Mass training of workforce (RTT and general waiting time principles).
- Restriction where possible of access to RTT status impacting interventions including a review of failsafes in place to capture ALL errors where possible.
- Related to above – ensure that resources are aligned to failsafes to enable timely identification and rectification of errors.
- Rationalisation of waiting time reports to ensure relevancy, increase literacy around use of reports and align to operational validation schedules. Process to include amnesty of all internal and external reporting.

Independent Review of Waiting List Management, Data & Reporting

Summary Version 2.0

BAINEW201
5/17/2023

Waiting Management Information Review

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Executive Summary

The impact of the COVID-19 pandemic has caused national backlogs across patients waiting for treatment and has placed significant strain on planned care delivery. Nationally, the latest figures show a total of 20,101 patients were waiting over 18 months for elective treatment as of 19 March, down from 123,969 in September 2021. In UHNM, as at 11th May 2023 there are 46 patients that had waited 104 weeks or more, and 539 patients that were waiting between 78 and 103 weeks. As the Trust has not met the targets set by the regional NHSE Team to eliminate waits of over 18 months by April 2023 the Trust has been designated as a Tier 1 provider.

In March 2023 an independent review was commissioned as part of a diligence exercise to provide assurance that waiting times within University Hospital North Midlands (UHNM) are being managed and reported appropriately and in accordance with national guidelines. This followed increases in the number of 78 week waiters being reported.

The below considerations were factored into the assessment of the position:

1. The sources and flow of waiting time information and reporting
2. Systems/mechanisms used to administer pathways
3. Roles and responsibilities of staff involved in waiting list management and reporting
4. Approaches taken to maintain oversight and manage waiting times
5. Governance framework in situ to manage and report waiting times

As with all NHS organisations, the capacity for human error when administering patient pathways is constant and the review found that UHNM did not differ in this respect.

The key findings of the full report are:

- The risk of patients suddenly appearing on the reports as a long waiter, or what is known as a 'pop-up' is high. These pop-ups will be a mixture of errors or 'true' long waiters which have been corrected by the corporate validation team, or by the divisional teams. The root causes of the pop-ups were found to be multi-faceted and could be attributed to breakdown in communication, user error, training and governance issues, and a lack of resource around validation of waiting times. Pop-ups tend to occur when changes to the pathway are made either correctly or incorrectly.
- The Trust Access Policy is consistent with national guidance; however local implementation can be open to different interpretation and management.
- The combination of having a centralised and decentralised outpatient access model contributes to the variance from the Trust Access Policy and resultant long waiters.
- Silo working and communication issues between the corporate and operational functions with evidence of disagreement regarding length of wait/pathway status.
- Management of referrals and waiters differed across the Royal Stoke and County Hospital sites and also within the specialties.
- Inconsistency of waiting time information is reported within the organisation; there are a total of 163 reports and 38 dashboards relating to RTT and diagnostic waiting times alone and whilst these reflected what had been entered into the patient administration system, these reports were not always synchronised to operation validation cycles.
- Users reported that inflexibility in the patient administration system and radiology system meant that 'workarounds' in MS Excel have to be used to collate key information.
- Access to the key patient administration system (Careflow), whilst 'according to role' has the potential for staff to inadvertently alter patient events connected to waiting times and therefore create pop-ups.
- Corporate training supported by data quality, IM&T and divisional management are not always aligned leading to inconsistency in message.
- Whilst there are failsafes and processes in place to pick up and monitor administrative pathway errors, the current governance mechanisms don't cover all risks, and not all of the failsafes are 'manned'.

- Validation demand exceeds capacity with the corporate validation team and divisional teams not meeting in the middle to ensure all patients are regularly validated. Unable to meet NHSE introduce targets around validation.

The review found no evidence of deliberate irregularities in the management of waiting times. Although as the case for most NHS Trusts, the capacity to misrepresent the 'true' volume of waiters at a certain point in time is significant. Managing this risk by minimising the capacity for errors through training, the right pathway administration systems and tools, and the ability to monitor data quality through a defined set of process assurance measures is key. Whilst UHNM possesses these components, they are not necessarily working in cohesion to provide the assurance and oversight needed to manage patient waiting times.

Whilst the remit of the review did not cover inspection of the algorithms used to both extract the raw data and populate the reports and dashboards; reconciliation exercises were performed to understand whether there were differences. From an RTT reporting perspective all differences in the number of patients waiting could be accounted for and affiliated to errors, 'pop ups' and reporting timescale differences. However, there were differences in the number of waiters when cross referencing other information sources such as the inpatient and outpatient waiting lists against some of the dashboards although this could be attributed to reporting multiple events in the patient pathway. It is understood that the algorithm behind all statutory returns are shortly to be reviewed and it is recommended that this is extended to the many internal reports that are in situ.

The full report contains a detailed action plan which is separated into fifteen themes that were felt to cause potential long waits or delays in the patient pathway, or could contribute to inaccuracy of information representing the patient true status/waiting time. The fifteenth theme is an outlier in that it covers the patient harm process as opposed to being a contributor to delays or reporting issues. Recommendations are aligned with assessment of the timeliness of response estimated.

1. Introduction

University Hospitals North Midlands (UHNM) is committed to ensuring that patients receive diagnosis and treatment in accordance with the constitutional targets. The combination of on-going pressure on services, the backlog of patients waiting for elective treatment post COVID, and workforce shortages mean that waiting times have increased to record highs across the NHS.

There have been recent deteriorations in the 78 week and 104 week position with challenges around the utilisation of buffer capacity provided by the independent sector (IS) and in accessing mutual aid due to a combination of patient suitability and patient choice and facility considerations. UHNM currently rank poorly in terms of long waiters (78 & 104 weeks) nationally and as a result have been designated as a Tier 1 provider Trust.

As part of the scrutiny around waiting times provided by NHSE, all Trusts are required to complete a weekly CCC return covering patients waiting 78+ weeks and 104+ weeks. The process for reporting these cohorts has recently become more complicated due to NHSE initiated changes in the methodology used to produce the return, the subjective nature of the return i.e. what 'might' happen, resulting in the requirement to manual input status in MS Excel, and the use of calculated logic as opposed to pure data extraction.

A significant contributor to the inconsistency in reporting is the potential for the volumes within these cohorts to change minute by minute by what us known locally as 'pop-ups. The capacity for the numbers to change, compounded by the propensity for the NHSE team to attempt to triangulate the contents of the return with other information sources, (often unvalidated sources or snapshots taken at different time periods), result in the impression that there is a lack of grip on waiting times due to the changes in numbers presented.

It was therefore considered necessary to review the process surrounding production of the CCC return and on a wider scale, review the factors contributing to patients becoming a long waiter, and to assess whether there is adequate oversight of patient waiting time status across the pathway.

2. Purpose

The purpose of this report is to provide a summary overview of the functions, processes and systems involved in providing oversight and assurance surrounding waiting time performance. It also seeks to provide a list of recommended actions to strengthen the ability of the Trust/system to plan and deliver elective care that meets the NHS constitutional standards around waiting times.

The findings from the review are divided into five sections:

- Component Issues Waiting List information, processes and reporting (section 1)
- Waiting Time/Reporting Governance (section 2)
- Waiting Time Assurance & Oversight (section 3)
- Transfer to external providers (section 4)
- Future strategic developments (section 5)
- Summary & Recommendations

It must be noted that productivity and efficiency were excluded as part of this review.

3. Methodology

In order to assess the efficiency of waiting list management processes, information flows and reporting it was agreed that the approach would be qualitative and involve a combination of interviews with key stakeholders using a semi structured questionnaire. The questionnaire was designed to understand the entirety of the patient waits from the arrangements for processing referrals, placing patients on the waiting lists, application of national rules surrounding waiting times, clock stops etc., monitoring of lists and how they are kept accurate and up to date. The interviews were conducted over Microsoft Teams late March to mid April 2023, and also via a series of 'virtual' focus groups with the secretaries and operational service managers. Consultant views were also sought as part of the process including a review of the preliminary findings with the Deputy Medical Director and plans to hold clinical focus groups to discuss waiting list data and management to be chaired by the Deputy Medical Director.

Overall, there was good engagement with the process with a total of 51 stakeholders participating in the interviews and focus groups. Staff groups include representatives from:

- Divisional Management Teams (including Radiology, Endoscopy)
- Data Quality
- Information Teams
- Patient Administration System
- Performance Management
- Programme Management Office
- Outpatients
- ICB

The review also included a quantitative element via interrogation of the reports used by the divisional teams to monitor waiters, and the processes, governance frameworks and data sources used to both highlight and produce the internal reports used in performance management, and also the external reports to NHSE (CCC return/flash report). National and cross region benchmarking, and desktop research was also performed to support the process and to confirm strategy, targets, governance, and performance frameworks etc.

The review was performed over a five week period, and whilst endeavours were made to understand the intricacies of all processes undertaken around waiting list management, the timeframe was too short to be confident that full coverage was achieved.

4. Section 1- Component Issues

The root causes of the pop-ups was found to multi-faceted and could be attributed to the breakdown in communication, user error, training and governance issues, and a lack of resource around validation of waiting times. Pop-ups tend to occur when changes to the pathway are made either correctly or incorrectly. As a result of these pop-ups, the Executive Team cannot be totally confident with what is being reported. The below areas were identified as enablers of patient pathway delays, or providing the potential for waiting times and reporting to be distorted.

4.1 Outpatient Access

- Prior to COVID the Trust had successfully implemented NHS the electronic referral system (e-RS) and meeting the 48 hour turnaround targets. However, during COVID the Trust switched off e-RS and has not yet returned to pre-pandemic utilisation levels. Patients that are referred to the Trust immediately appear on an Appointment Slot Issue work list (ASI). In general, it takes on average 3 days for a patient to be actioned on the ASI and added to the OP waiting list, although it can take much longer in cases of high referral volumes. This presents significant risk as there is a time where all patients will be absent from either list whilst being removed from ASI and being added to a waiting list. It is currently being discussed as to whether the Trust fully reopen e-RS or whether it continues with the current manual approach. If the decision is to retain current practice then in order to minimise the associated risk with this way of working, a technical solution is needed to support the interaction between Careflow and e-RS.
- There was evidence of significant variation in how a patient can be referred to the Trust, with many referral routes such as e-RS, paper, e-mails, referral centres and internal consultant to consultant forms thus increasing the risk of the referral not being processed.
- Feedback suggested a perceived disconnect between the outpatient booking team and the divisions. Furthermore it was felt that the Trust's Access Policy was not being followed where appointments were booked by the central team, as patients were being rebooked after multiple DNA's or cancellations, and without consultation with the divisions. It was also reported that some clinicians are reluctant to discharge patients according to these rules.
- The Trust regularly cancels clinics with less than six weeks' notice and even less than 24 hours' notice. Examination of the number of appointments cancelled by the hospital with less than six weeks' notice over the period January 29th 2023 to 23rd April 2023, shown that on average **2824 patients are cancelled every week** with less than six weeks' notice.
- The range of staff that are able to book appointments (new and follow up) include medical secretaries, waiting list officers, clinic and ward staff. It is felt that the current way of working needs to be reset to ensure that the ability to deviate from national guidance and local access policy is minimised, and that there are clear communication structures and standard operating procedures to ensure that the patient is seamlessly pushed through the non-admitted pathway.
- It was reported during the interviews that it is difficult to measure effectiveness of the Patient Initiated Follow Up pathway (PIFU), and also identify PIFU-related activity when a patient activates from a PIFU pathway. It was also found that the PIFU process in situ is currently artificially increasing referral rates where new referrals are added to start the PIFU pathway.

4.2 RTT Training

- RTT training is provided by the corporate training team and includes theoretical RTT and IT training. A formal programme is in situ, and staff are called for training on an annual basis. The ability to request ad-hoc training or RTT advice is also available. It was clear from the interviews that the training provided by the corporate validation team wasn't always fully utilised, with examples for training being provided by the Data Quality Team, IT Training Team or internally within the divisions. It was also stated that staff had not attended training when offered.

- The Corporate Training Team are receptive to any change in training needs and have plans to ensure that training delivery is more specialty specific, and for training to be provided to clinical staff which will hopefully minimise the errors being made by the clinicians. A one month audit of pop-ups to understand trends and root causes to inform future training is currently being performed (due to be concluded mid-June).
- Many of the root causes of pop-ups can be related to training and therefore training is a cross cutting theme across many of the component issues contained within this section. The NHSE team are currently looking at the provision of mass training across the NHS in response to the issue.
- It is imperative that training should be delivered in a structured and co-ordinated manner so that it is consistent and compliant with the national rules. Work should be done around the culture to deviate from central team delivery, and the fact that this can be seen as optional.

4.3 Careflow Administration

- During the course of the interviews, and during the exercise to reconcile the reporting volumes, it became apparent that some of the pop-ups were inadvertently being created by ward staff. Upon discussion with the PAS Lead, and Data Quality Team it was apparent that some checks were in place to make sure that staff were trained in all functions or access restricted, however there were still some gaps. Further discussions are currently taking place around PAS access to establish whether any mechanisms can be instilled to restrict the ability to reopen pathways for instance, and prevent staff from inadvertently altering records when inputting to PAS for a non RTT reason. To date the capacity to reopen referrals has been reviewed and this will be followed by the review of all high risk functionality.

4.4 Outcome Forms/RTT Codes

- Issues were reported around the outcome form, and also around the collection and actioning of clinic outcomes. Some specialties reported that the RTT outcome form did not cater for the intricacy of their specialty; with others reporting that RTT codes in the system did not cover planned next steps. There was variance in the staff type actioning the outcome form and on many occasions the secretaries were correcting the RTT codes used when typing the clinic letter.
- In addition to the above, and in line with other Trusts, there are high volumes of unoutcomed clinics and attendances. Whilst this is highlighted and disseminated via the Data Quality Team, the governance around this needs to be revisited to ensure that outcomes are updated near real time.
- It is understood that there is also a review of the outcome form currently taking place. It is important that any revision is signed off by all clinical leads to provide assurance around appropriateness.

4.5 RTT Policy Application

- Due to a combination of the components included in this report it was felt that there is inconsistency in compliance with the Trust Access Policy, RTT and planned waiter guidance. However it must be stated that this was not systemic or deliberate, more that non standardisation and variances had evolved over time due to changes in personnel, specialty intricacies, and the centralised/de-centralised nature of the access model.
- One of the key areas of focus and checks was on how the divisions both interpreted RTT guidance and distinguished between patients that are on an RTT pathway and those that should be placed on a Non RTT/planned waiting list, and also whether patients were being booked in order of priority. It was apparent that patients weren't always being correctly classified as Non RTT/planned and booked in order of priority
- Analysis was performed on the RTT reports, data quality reports and inpatient and outpatient waiting lists in order to attempt to reconcile volumes. Unfortunately this was not possible as

the granularity of reporting mean that as a patient could be waiting for multiple events such as a follow up appointment, and also a diagnostic test, they will be reported in multiple buckets. This is why divisional feedback on occasions stated that the reports were showing 'more' patients. A more simplistic way of reporting would be if patients were cohorted as RTT, NON RTT with a diagnostic or planned flag assigned. This would show true volumes of waiters, with attached status and would enable reconciliation of numbers.

- During the course of the review and examination of data it became apparent that there are what was referred to as' legacy' patients which were described as patients with long term conditions or historic referrals. It is imperative that these patients are highlighted and validated to establish whether any clinical harm as ensued and whether they should be entered onto an active waiting list
- On occasions, it was clear that the Trust systems prevented recording and reporting of accurate waiting list information. Some specialties reported that Careflow did not recognise injections as a clock stop. A process has commenced to collate known examples so that this can be updated in Careflow. On an on-going basis these will be picked up by the validation team.
- Members of the information and performance team felt that reporting from the back- end of Careflow was difficult, making it harder to extract the information that they needed.

4.6 Information Systems, Sources & Flow

- Although the algorithms behind each report were not assessed during the review due to the technical /developer skills required and the imminent nature of the planned agenda around this, as previously stated, reconciliation exercises were performed of the reports used by the divisional teams to monitor long waiters (and therefore some of the rules applied), and the methodology behind the CCC return also.
- Over time, the required oversight of waiting times has led to a large plethora of datasets, reports and dashboards. However, the creators and developers of these information sources have not necessarily been consistent and during the review there was no evidence of a governance mechanism around their production to ensure that they contain the same rules and methodologies as described above. It has since been confirmed that there are plans to do this as part of the newly created Operational Intelligence Group.
- It was confirmed during the review that there are 163 (automated) internal and external reports relating to RTT and diagnostic waiting times, and there are a further 38 dashboards. This in itself creates the propensity for information to differ in terms of volumes across the reports due to the date stamp of the extractions and the validation schedules. However it is important to state that it was found that the 'data' within the reports was correct and represented the intended purpose of each report.
- As a result, the information used to monitor, manage and report waiting times can be inconsistent and it was apparent during some performance meetings that the divisions were being performance managed using figures that didn't align to the live and validated information causing lack of confidence in the data, and therefore an impression could be given that there was no grip on waiting times due to the inconsistency in reports.
- It was also evident that information was being sent to external parties outside of the information team, and that information was also being reported externally without being signed off by the specialty. An amnesty of reports that are produced internally along with external submissions is recommended and a decision made around future governance to ensure all information is controlled and verified as accurate.
- Confusion on how to interpret the information was reported on several occasions and this in itself led to inaccuracies in presenting the information. A 'how to' guide was found alongside the RTT dashboard but there did not appear to be any supportive documents for the other reports. On more than one occasion the divisions stated that they were 'data rich information poor'.

- There were several reports i.e. the Long Waiter report (source for CCC return), DM01 (imaging and endoscopy) that involved using MS Excel to collate validated information on waiting times and patient status as this could not be extracted from the source system. The inflexibility to accommodate rules, i.e. patient choice in RIS meant that workarounds had been developed in order to report accordingly. Aligned to the above, the divisions stated that they were duplicating input due to having to validate Excel reports then update Careflow. The impression given was that Excel was given priority over Careflow on occasions.
- The current ways of working have developed over time and no doubt provided a solution to be able to comply with statutory reporting where additional manipulation of the information is required over and above what can be extracted as previously stated. However the current method poses risk and wherever possible all information should be both entered and extracted from the core systems.
- It is understood that Careflow as the Trust patient information system is shortly to be reviewed (although the process will only complete during 2027), and this presents the ideal opportunity to ensure that front and back end functionality is aligned to needs.
- Also related to this category, feedback was given around the structure of the information/performance and IM&T teams in that it wasn't always clear who was responsible for what and therefore who to approach.

5. Section 2 – Waiting Time/Reporting Governance

As the case for most NHS Trusts, the potential to misrepresent the 'true' volume of waiters is a constant battle. Managing this risk by minimising the capacity for errors through training, the right pathway administration systems and tools, and the ability to monitor data quality through a robust governance framework with a defined set of process assurance measures is key. This section looks at the mechanisms and failsafes in place to highlight and rectify administration errors.

5.1 Data Quality Team

- The Data Quality Team monitors a set of data quality key performance indicators on a regular basis. Information is made available via a dashboard and this shows an historical trend around errors. In addition to the dashboards there is a robust process to highlight key data errors with the individual and an escalation process to ensure that the error is fixed or escalated to the individual's manager should this not be the case. The team also take a proactive stance around PAS access and training with linkage to the corporate training team.
- Complementing the dashboard is a suite of reports that have been developed, and also currently in development and being tested. However, it was found that a high volume of the reports are not proactively monitored by the team although they are reported.
- This means that whilst there are failsafes in place, there are many cohorts of errors not being monitored unless they are over 52 weeks by the corporate validation team (aspiration to meet NHSE target of 12 weeks+ waiters and unvalidated for 12 weeks+) but currently validating at 52 weeks along with the month end completed pathways. There are further cohorts where the pathway is closed and therefore not monitored by the corporate validation team. This has led to an immediate sample validation of some of the waiting lists according to the data quality KPI's to understand what is behind the volumes i.e. legacy patients and to inform next steps. It has since been confirmed that long waiters/breaches have been found as a result of the sample validation.
- It is important that a mass validation is performed as soon as is practical alongside a clinical harm review to provide a 'clean' waiting list and to provide assurance around patient safety whilst waiting. There is an abundance of software available to assist with this process.

5.2 Clinical Harm Reviews

- Whilst there is a current governance mechanism in place to monitor potential clinical harm for patients, it was felt that this needed a refresh as it was not high on the elective agenda. As described above, this is recommended to run in parallel to the mass validation exercise.

5.3 Validation

- The Trust currently have 5 substantive full time equivalent posts and a substantive team leader in the Corporate Validation Team, as well as 4 on secondment funded by ERF (two of whom are backfilling other members of the corporate team on secondment). It is important to state at the outset that the affiliation of staff to patient records (incompletes only) compared to other Trusts is low.
- Currently the team are validating patients that have been waiting 52 weeks in addition to month end completes and patients reported in the 78 and 104 week waiter cohorts which falls short of the NHSE target of all patients that have been waiting for over 12 weeks or who have not been validated within 12 weeks, by the end of April 23.
- Each of the operational divisions has some validation resource in terms of Junior Operational Service Managers and dedicated trackers. Other members of staff within the divisions undertake validation work when required. This can be sporadic and difficult to track and manage, and maintaining high standards of validation work is challenging where competing priorities exist. It was clear from the interviews and attended meetings that there are gaps in validation and that the corporate team and divisional teams are not quite meeting in the middle.
- There was evidence of conflict over the validation of pathways and the assertion of local rules. Requests for local rules have been made to the divisions by the corporate team on many occasions but they confirm that have not yet been provided with any documents to explain the rules and to prove that they have been signed off by the lead clinician (best practice).
- It is clear that much work needs to be done to clarify who has the overall say in pathway status and to be clear of the role of the corporate validation team, and the validators and those within the divisions. Furthermore, consideration to how this resource can be better co-ordinated.

6. Section 3 – Waiting Time Assurance & Oversight

There were five main tiers of waiting time performance management evident at UHNM (below). RTT is further monitored as part of the monthly formal divisional performance meetings as either driver or watch metrics as agreed between the divisional leadership team and the Executive Team. This is reported through the Trusts governance processes such as Performance and Finance Committee and Trust Boards via the operational report and integrated balanced scorecard:

1. Operational Service Managers reporting to Senior Operational Manager/Divisional Directors - **Divisional PTL Meetings**
2. Senior Operational Managers reporting to Chief Operating Officer/Deputy Chief Operating Officer – **Elective Oversight Management Group & Planned Care Improvement Board (strategic)**
3. Chief Operating Officer/Deputy Chief Operating reporting to NHSE – **78 & 104 Week NHSE Call**
4. Chief Operating Officer reporting to Executive Team – **Performance & Finance Committee**
5. Executive Team to Board – **Trust Board**

- The information provided at each of these meetings originates from either the information or performance team (details in full report).
- Each Division has adopted various structures and processes to monitor waiting time performance, as deemed appropriate to each directorate, although this appeared to vary across the divisions in terms of intensity. These include interventions such as:

    - ❖ Regular validation and tracking of waiting lists
    - ❖ Utilising the Patient Tracking Lists (PTLs), including adding additional fields to enhance the information i.e. trends etc.
    - ❖ Holding weekly Patient Tracker List meetings covering elective specialties with a review of the factors that are influencing longer RTT waits.

- ❖ Operating trigger mechanisms where capacity does not support achieving of RTT waiting times (although these didn't appear to be documented)

- In addition to using the RTT dashboards, long waiter report and OP and IP waiting lists downloaded from Report Centre, the surgical division are sent e-mail from their Divisional Business Advisor (DBA) detailing the latest long waiter position and details of any pop-ups that have occurred since the last e-mail. However, this wasn't done by the other DBA's and there is an unfilled DBA vacancy in Medicine.
- Several meetings were observed as part of the review and it was felt that there was adequate challenge at senior divisional management level and forums for the divisional management teams to escalate any issues of particular concern which cannot be resolved within the specialty, or need to be considered within the wider strategic context.
- During the course of the interviews a common theme from JOSM/SOSM and Directorate Manager level was that they didn't feel that 'they' received the same amount of challenge that they had received in historical PTL meetings pre COVID. This could be attributed to the previous meeting structure and exposure to the challenge that is now provided at a more senior level in the weekly Elective Oversight Group meetings.

6.1 78 & 104 Week Waiter Call – NHSE

- As stated in the introduction, there has been frustration around the declaration of breach and non-breach volumes that can change on a day to day basis. These issues have been compounded by the propensity for the NHSE team to attempt to triangulate the contents of the return with other information sources, often unvalidated sources or snapshots taken at different time periods, and as they admit, personal preference regarding report source by members of the NHSE team.
- Considerable work has gone into stabilising this process to provide a more robust picture and to include predictive performance based on historical activity (closures) adjusted by the divisions based on capacity (negative or positive adjustment) alongside actual TCI bookings. This therefore provides the Trust with the ability to take additional actions should the trajectory be off course.

7. Section 4 - Transfer to External Providers

- Enquiries were made around the processes employed to transfer patients outside of the Trust for treatment. It became clear that overall the process was felt to be problematic from many aspects in that it was reported that:

  - ❖ Patients were reluctant to have their care transferred (even with transport provided)
  - ❖ Consultants aren't always supportive of having their patients transferred
  - ❖ Operational teams reported that the process was elongated and often created a further delay in the pathway
  - ❖ Patients are removed from the PTL when accepted by the provider only to be subsequently rejected (for clinical reasons)
  - ❖ There is a residual lack of trust on behalf of the independent sector (IS) due to previous attempts to treat UHNM patients (see below)
  - ❖ Processes have had to be revised on many occasions in order to manage communications and reduce the capacity to send duplicate patients
  - ❖ Issues surrounding ownership of the process and lack of communication around changes resulting in lengthy delays
  - ❖ Dissemination of patients identified with the operational teams unclear resulting in TCI's being allocated by other members of the team
  - ❖ Late notification of capacity provider by independent sector

- Patient willingness to transfer to the IS presents a huge problem to UHNM, and prevents utilisation of this capacity buffer. The divisional and corporate teams state that patients are even often unwilling to transfer to the County site. It is difficult to address the assertion of the constitutional right to patient choice, especially where the patient has an established

relationship with their consultant. Whilst the corporate team are using a script to ensure consistency of message, this is not having the desired effect.

- It appeared that there had been many changes made to the IS process that had not been effectively communicated between the triumvirate parties; UHNM, Independent Sector and the ICB (previously CCG). Responsibility and oversight of the process appears to have historically sat with the ICB but passed to UHNM at one point (reportedly without adequate communication). Whilst there are some joint meetings in place to discuss the process and transfer of patients, the ways of working at a system level feel disconnected, and as a result the impression given is that accountability ultimately lies with UHNM as opposed to a joint approach.
- ICB representatives stated that block booked capacity had been made available previously but had not been utilised leading to the Independent Sector being unhappy with UHNM, however this is not isolated to UHNM and reported nationally. Within the Trust it was reported that communication of available slots was done without affording the Trust with the relevant amount of time to arrange suitable patients.
- Patients are only updated in Careflow as being transferred to the IS once both the patient and IS have agreed/been accepted. At this point the patient is removed from the PTL but will remain on the tracker (Excel spreadsheet) until the IS have confirmed that treatment has been provided. There are clear issues with this process in that on occasions patients have been subsequently rejected upon admission (despite being previously accepted) which then relies on the corporate team sending the patient to the data quality team to be reinstated.
- The corporate team report that the tracker is not always returned/updated in a timely manner from the IS. An alternative mechanism is needed to be able to track patients through this journey and to ensure that they only 'leave' the PTL and IP waiting list once they have HAD treatment. One solution would be a joint IT system to make the system more seamless and timely.
- There were similar issues reported in influencing patients to transfer to one of the Mutual Aid Providers, and consultant reluctance as with the independent sector. As with the IS process it was unclear as to the roles and responsibilities at system level and who was acting as the broker of local resources for the requesting and other provider organisations.

7.1 Section 5 - Strategic Developments

- The "Choice and Referral Centre" is a legacy of the North Staffs and Stoke-on-Trent CCGs and provides a service across the former North locality. The service was initially established to demonstrate that meaningful choice was being offered to patients, and there is a modest referral management function whereby GP referrals into some specialties are triaged by a GP for appropriateness. The ICB feel that the role of the Choice and referral centre is largely a provider function and should not be core business of the ICB. It is the aspiration of the ICB to transfer responsibility and accountability to either "place" or via a provider collaborative (below) and therefore the preferred ICB option is that the current function and team are transferred to UHNM.
- Discussions are at an early stage between UHNM and the ICB regarding UHNM becoming a Lead provider within a Provider Collaborative Model. The aim is that UHNM would hold the primary contract with the ICB and would be responsible for sub-contracting with other providers within the collaborative, i.e. the independent sector to coordinate service delivery and improvement.
- A 'system' demand and capacity exercise would need to be performed on the collective capacity using current access times to be able to strategically inform what services should be provided in what location in future to be able to provide timely planned care.
- Both the IS and Mutual Aid processes are overseen by the Corporate Access Team, and consideration needs to be given to the Team's future role in the positioning of the Choice & Referral Centre and Provider Collaborative. These strategic developments are currently at early stage discussion between UHNM and the ICB and will likely change the contractual relationships with the independent sector and the roles and responsibilities of the Corporate Access Team.

8. Summary & recommendations

This document outlines the findings from the review of waiting list management process, governance and information review. The recommendations and actions are described in both the full report and improvement plan, and have been RAG rated in terms of the component issue having the potential to either change the number of long waiters declared to NHSE via the CCC return, or in contributing to the patient becoming a long waiter. The improvement plan proposes the short, medium and long term actions required to address current gaps and to minimise the potential for misinterpretation of waiting time principles and inaccurate administration and misreporting of patient waiting times.

It is recommended that the programme of work is taken forward and co-ordinated by the Programme Management Office over a 12 to 18 month period. However, there are some immediate priorities that need to be addressed including:

- Mass validation of all patients in Careflow (including legacy patients) with a clinical harm review performed in parallel
- Mass training of workforce (RTT and general waiting time principles)
- Restriction where possible of access to RTT status impacting interventions including a review of failsafes in place to capture ALL errors where possible
- Related to above – ensure that resources are aligned to failsafes to enable timely identification and rectification of errors
- Rationalisation of waiting time reports to ensure relevancy, increase literacy around use of reports and align to operational validation schedules. Process to include amnesty of all internal and external reports

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th June 2023
Report Title:	Integrated Performance Report, Month 01 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: Paul Williams, Assistant Director of Human Resources; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Chief Nurse / Chief Operating Officer /Chief People Officer / 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

Assessment

- Friends & Family Test for A&E has improved again during April 2023 but remains slightly below the 85% target of patients recommending the service. Whilst there has been improvement in the results it is important to note that there has been continued further increases in the response rate with 15% response rate response rate (previously 10.5%) and over 1200 responses received during April 2023. These improvements are following the continued work by the Patient Experience Team with the ED Teams to promote the FFT surveys and improve feedback. UHNM is now 31st out of 125 Trusts for number of responses completed.

- Inpatient FFT results are still above the 95% target. There was a 20% response rate for Inpatient related FFT with over 2000 responses received which is 700 lower than March. There are key improvement initiatives identified previously are continuing and focus on key priorities identified within the FFT returns – timely medications, better pain management and improving the involvement of patients and/or family in care and decision making

- Following improvement last month, Maternity FFT has again achieved the 100% target and following the launch of the text messaging service in February 2023 the number of responses continue to increase. During March, 100% of the completed responses recommended the service and 100 (March 2023 returned 79) completed responses and 51 (previously 39) from the Birth touchpoint.

- Complaints rate remains below the target/benchmark rate of 35 and has remained below this target and long term mean rate for 13 months.

- The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers continue to be Patient Falls, Medication, Patient Flow and then Clinical Assessment related incidents. Within these incidents 117 of the incidents identified as related to 'Your Next Patient' which accounted for 6.2% of total patient safety incidents. 53% were Tissue viability related. However, 72.5% of these were NOT hospital acquired but recording pressure damage on admission/attendance at UHNM. As the extreme operational and capacity pressures were reduced in April as result of the ongoing work across the Trust, admission portals and local health system, the number of incidents reported relating to Your Next Patients has also reduced.

- Moderate harm or above incidents, both raw numbers and rate per 1000 bed days have reduced again in April and are within normal variation following previous increases reported in December 2022 and January 2023. It is key to note that during April 2023 there have again been zero patient flow related incidents following 1 in February and 8 in January at the peak of the operational pressures. As noted the different working practices and patient flow pathways continue to show positive impacts with further reductions noted during April 2023 compared to previous months.

- Serious incident numbers and rates continue to show longer term reduction trend which supports the noted reductions in incidents with moderate harm of above and overall patient safety incident reporting. Falls continue to be the main reason for serious incidents being reported.

- There was 1 new Never Event reported during March 2023 in relation to an incorrect screw being used in an orthopaedic procedure. The incident has been reported on STEIS and is under ongoing investigation to identify learning and improvement. It should be noted that the incident has been reviewed internally following initial reporting and 72 Hour report and identified that the use of the screw will have no long term impact on the patient and that there was no risk of severe harm or death to the patient. When the investigation is completed and learning identified, the Never event categorisation will be reviewed formally with the ICB so de-escalation can be considered.

- Duty of Candour compliance for evidence in written notification has improved to 60.9% and is the best performance for 5 months since September 2022. The dedicated sessions with various Directorates and clinical teams appear to have had positive impacts along with the increased support and escalations from the Divisional Quality & Safety Managers.

- Timely Observations are continuing to improve across the Trust although still below target. Medicine, Surgery and Network Services have all now included Timely Observations as Driver Metrics and focussing as priority to improve compliance. No patient harm has been reported within any Division in relation to delay in timely observations. A new task and finish group will consider any additional countermeasures required to improve performance.

- Nosocomial COVID infections have seen further reduction in April 2023, and there has also been a reduction in the number of definite nosocomial deaths reported.

- Hospital Associated Thrombosis rate has reduced further in April 2023 with 15 cases.

- The QPR now includes information on new Patient Safety alerts received each month via the national Central Alert System (CAS), numbers closed and those overdue closure with updates on current positions. The current position shows that there were no new Patient Safety Alerts issued during April 2023 but there remain 1 overdue Nat/PSA 2021 005 MHRA - Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particles and volatile organic compounds

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

Operational Performance

Emergency Care

- April saw significant improvements across Non-Elective Care which continues the post October, November, and December trend against baseline. The most notable improved KPI were 12 Hour Trolley Waits, One Hour Ambulance Handovers, and System Four Hour performance, all of which performed at their highest levels since the summer of 2021. These improvements have been enabled by relatively static attendances, continuing

reduction of IP restrictions, and the temporary cessation of industrial actions.

- The new National Oversight Framework reporting structure for UEC has now been confirmed and established with UHNM entering Tier 2. While this is a reflection that further improvements across the NEL pathway need to be transacted, recent performance has been positively received as demonstrated by commitments to commence discussions to exit Tier 2 should current trends be maintained. This is in the context of achieving the regional median of 70.1% against the System Four Hour Standard and an approximate 80% reduction in lost ambulance hours against October to December baseline in April.

- Following confirmation of UHNM UEC Tier 2 placement and subsequent clarification of UEC Tier 2 Exit Criteria driver metrics across the Non-Elective Improvement Programme were again adjusted to reflect the significance of these targets. The Exit Criteria are System 4 Hour Performance, Patients 12+ Hours In ED, WMAS Category 2 Mean Response Time (with Hour Ambulance Holds as an acute proxy measure), G&A Occupancy, and % LOS =<14 Days with exact targets still to be agreed. Performance against these 5 KPI will be highlighted directly in a standalone performance table from next month to ensure appropriate oversight.

- Final written confirmation is still awaited for the £12.7m capital and £8.1m revenue monies bid for in the Additional Capacity Targeted Investment Fund Short Form Business Case but verbal feedback has been positive with written confirmation expected in May. This investment would release 50 G&A beds for the Medical Division with work not requiring financial expenditure already commencing in order to support achievement of a December opening deadline.

Cancer

- Two week wait performance continues to book within standard at 14 days, currently at 93.6%. This has been maintained in the face of high referral volumes.
- The 28 Day Faster Diagnosis position is currently 64.9% for April; this is showing signs of improvement towards the 75%target. This standard is the focus of an Improving together project covering all pathways.
- In February the backlog of patients has seen a significant reduction from 1041 at the end of August to 313 at the end of March.
- The incremental decrease of the Skin and Colorectal backlogs have been modelled to continue past March 2023, this has been taken forward into the annual plan for the coming year. Colorectal is a pathway of concern feeling the impacts in the endoscopy delays.
- Most recent submitted Cancer Waiting Times position is March which was 62.2% for 62 day performance. April is currently predicted to be 54.8% although this will improve post validation, this is due to the number of treatments for our longest waiting patients increasing.
- The 62 day target has slipped its improvement trajectory due to the impact o endoscopy delays on the colorectal pathway, however capacity has been sourced to managing the backlog.
- Cancer will form a workstream as part of the Planned Care governance structure – this will initially focus on our challenged pathways of Skin and Colorectal, alongside 2WW and FDS more generally.
- The Trust has been escalated to Tier 1 for for elective care and cancer will be included within weekly meetings with the Regional NHSE team, however due to the significant improvement in the cancer position this will be at summary level.

Planned Care

- Day case as a % of all elective work is currently 86.5%.
- There is a real focus on 104w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 78week+ patients however and number of 104 remain and the April 104 position ended at 52.
- Theatre transformation has been added as an additional workstream under Planned Care and begins with a focus on moving from a 6-5-4 to a 6-4-2 booking process with support from the regional theatres team. This is now a driver for the surgical Improving together programme
- The focus is also with 78 week waiters and the National ask was to achieve 0 patients waiting over 78 weeks by the end of March 2023. This was not achieved and April ended with 572 78 breaches. Current modelling with additional capacity schemes sees elimination of 78 weeks mid July.

RTT

- The overall Referral To Treatment (RTT) Waiting list currently sits at 78094, this has been relatively stable over the past few months, although significantly higher than were we would want it to be .
- The number of patients > 52 weeks continues to increase – from 4377 in August to now 5052 in April.
- At the end of March the numbers of > 104 weeks was 52. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness

for treatment.
- The Trust has been escalated to Tier 1 for 104> & 78> performance with weekly meetings with the National NHSE team and considerable scrutiny and on site presence.

Diagnostics
- Overall DM01 performance was 69%, a decrease in performance on last month's 78%.
- Within DM01, the greatest proportions of > 6 week waits are within endoscopy. Non-obstetric ultrasound while still not meeting target have shown considerable improvements, however Endoscopy remains a concern.
- Full DM01 recovery plan agreed which sees a plan for the Trust achieving 6ww, the timeline on this is dependant on the modality. This will be monitored through the planned care group. Key risk has been identified in endoscopy with weekly performance meetings instigated for the specialty. They will now be receiving some on site support from the NHSE diagnostic team for support recovery.
- Radiology backlog of reporting risk remains.
- Activity has remained largely consistent against previous months. Incentive schemes starting to improve activity (non-obs ultrasound notably)

Workforce

Key messages

- Our two main areas of focus continue to be on addressing staff availability in relation to absence rates and turnover.
- The 12m Turnover rate in April 2023 sat at 9.79% figure sitting below the trust target of 11%.
- The M1 figure of 10.95% highlights a decrease in the overall vacancy rate over the previous month.
- For M1, the in-month sickness rate decreased by 0.67% to 4.61% (5.28% in March 2023). The 12 month cumulative rate decreased to 5.65% (5.86% in March 2023).
- Stress and Anxiety has moved into the top reason for sickness in April, which saw an increase of 1.12% in the last month to 20.6% (19.58% in March 2023). Chest & respiratory problems saw a decrease of 5.8% in the last month to 13.7% (19.5% in March 2023).
- On 30 April 2023 covid-related absences stood at 30, which was 5.84% of the 514 open absences. This is 11.84% decrease on same time the previous month.
- At 30 April 2023, the PDR Rate increased by 2.6% to 85.3% (82.7% at 31 March 2023). This continues the small upward trend; however, this figure still sits below the overall target.
- Statutory and Mandatory training rate on 30 April 2023 was 93.8% (93.6% at 30 April 2023) showing a slight increase. This compliance rate is for the 6 'Core for All' subjects only.
- The Being Kind e-learning is now mandated from 1 April 2023 and face-to face sessions will be starting in June and July.
- The Staff Voice trust survey for April 2023 received a total of 652 submissions providing an overall colleague engagement score of 6.31.

Finance

Key elements of the financial performance year to date are:
- For Month 1 Trust has delivered a small actual surplus of £0.1m against a planned surplus of £1.1m; this adverse variance is primarily driven by underperformance against the Trust's in year CIP target.
- The Trust incurred £0.8m of costs relating to winter capacity remaining open in April. The Month 1 position assumed this additional cost will be funded by the local ICB.
- To date the Trust has validated £3.0m CIP savings to Month 1 against a plan of £4.6m. The £1.6m under delivery of CIP is driving the in month overspend against plan. Schemes of £47m have been identified for delivery in 2023/24. The PMO is currently working with scheme leads to develop robust plan to deliver these savings. The £8.0m divisional schemes remain unidentified.
- There has been £0.75m of Capital spend in Month 1 and the paper sets out the revised plan which has been adjusted to reflect conversations with NHSE.
- The cash balance at Month 1 is £77.9m, which is £8.0m lower than plan. Cash holdings are below plan mainly due to additional accounts payable payments in April.

Key Recommendations

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

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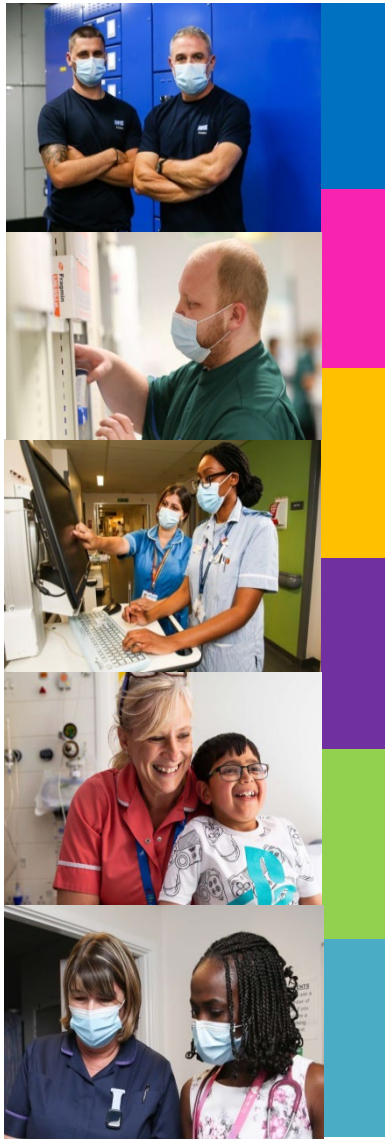


Integrated Performance Report

Month 01 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

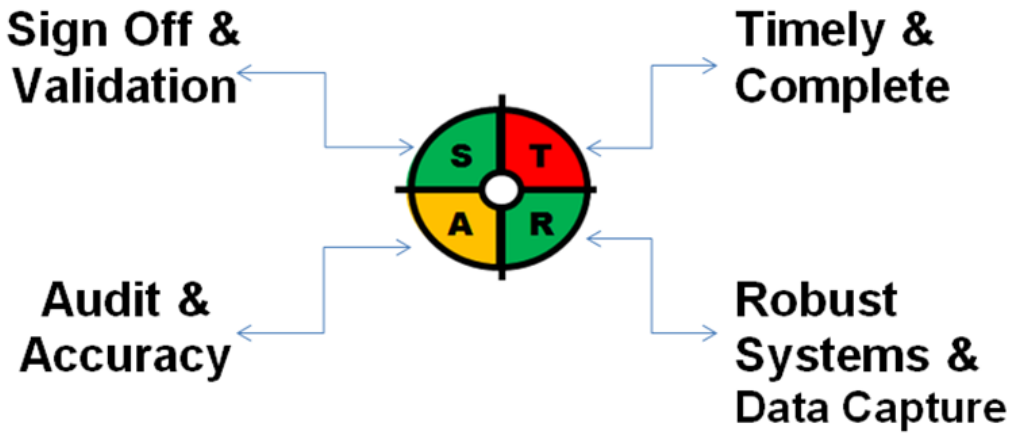
Assurance - how assured of consistently meeting the target can we be?

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**

Quality

Caring and Safety

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

Quality Spotlight Report

NHS
University Hospitals of North Midlands

The Trust achieved the following standards in April 2023:

- Friend & Family (Inpatients) 95.4% and exceeds 95% target.
- Friend & Family (Maternity) 100%.
- Harm Free Care improved and continues to exceed 95% target rate with 97.8%
- Falls rate was 5.4 per 1000 bed days for April 2023
- 0 Never Events
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 98.0% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- Inpatient Sepsis IVAB within 1 hour achieved 97.1% and above 90% target rate
- Maternity IVAB compliance 100% and above the 90% target for audited patients

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E has improved but remains below 85% target at 82.4%
- There were 27 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 87.0% verbal Duty of Candour compliance recorded in Datix
- 47% 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
- Timely Observations remain below the 90% target but has seen improvement during recent months with 68.6%
- E. Coli Bacteraemia cases above trajectory with 23 in April compared to target of 16.
- C Diff YTD figures above trajectory with 13 against a target of 8.
- Inpatients Sepsis Screening below 90% target rate at 86%.
- Sepsis Screening compliance in Emergency Portals declined to 81.8% below the target 90%.
- Children's Sepsis Screening compliance 83.3% and below the 90% target
- Emergency Portals Sepsis IVAB in 1 hour improved to 56.8% but remains below the 90% target for audited patients
- Maternity Sepsis Screening compliance 70% against 90% target
- 1 overdue and open Patient Safety Alert in relation to replacement of Phillips ventilator, CPAP/BiPAP machines. Issue of risk register and manage through MDSC

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

- The rate of complaints per 10,000 spells is 25.42 and is below the target of 35 and within normal variation. Majority of complaints in April 2023 continue to relate to clinical treatment.
- Total number of Patient Safety Incidents decreased in month (1882) and the rate per 1000 bed days has also decreased at 47.84 but is within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents remain in control limits and normal variation levels. Rate of incidents continue to reduce following peak in December 2022.
- Rate of falls reported that have resulted in harm to patients currently at 1.5per 1000 bed days in April 2023. The rate of patient falls with harm continues to be within the control limits and normal variation.
- Medication related incidents rate per 1000 bed days is 5.3 and patient related 4.3 which are lower than previous month and mean rates. The monthly variation is within the normal expected variation and consistent with Trust mean rates.
- Pressure Ulcers per 1000 bed days developed under UHNM care is now 0.69 in April 2023 and above the target rate 0.5
- Hospital Associated Thrombosis has decreased and is within normal variation and cases are under review.
- Decreased numbers of Definite Hospital Onset / Nosocomial COVID-19 cases reported with 38 in total.
- 3 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 8 Serious Incidents reported during with 5 falls related.
- SHMI has seen increases and under review for diagnosis groups but is within expected range (see funnel plot chart)

Quality Dashboard

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Metric	Benchmark	Previous	Latest	Variation	Assurance
Patient Safety Incidents	N/A	2171	1882	H	
Patient Safety Incidents per 1000 bed days	50.70	52.45	47.84	H	?
Patient Safety Incidents per 1000 bed days with no harm	N/A	33.08	29.82		
Patient Safety Incidents per 1000 bed days with low harm	N/A	16.45	15.51	H	
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	2.08	1.65		
Patient Safety Incidents with moderate harm +	N/A	33	32	H	
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.80	0.81	H	
Harm Free Care (New Harms)	95%	95.7%	97.8%		?
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		?
Patient Falls per 1000 bed days	5.6	5.9	5.4		
Patient Falls with harm per 1000 bed days	1.5	2.0	1.5		?
Medication Incidents per 1000 bed days	6	5.5	5.3		?
Medication Incidents % with moderate harm or above	0.50%	0.00%	2.90%		?
Patient Medication Incidents per 1000 bed days	6	4.8	4.3		F
Patient Medication Incidents % with moderate harm or above	0.50%	1.67%	0.00%		?

Metric	Benchmark	Previous	Latest	Variation	Assurance
Serious Incidents reported per month	0	10	8		F
Serious Incidents Rate per 1000 bed days	0	0.24	0.00		?
Never Events reported per month	0	1	0		?
Duty of Candour - Verbal/Formal Notification	100%	87.0%	87.0%	L	?
Duty of Candour - Written	100%	61%	47.0%	L	?
All Pressure ulcers developed under UHNM Care	TBC	89	84	H	
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	2.15	2.10		
All Pressure ulcers developed under UHNM Care lapses in care	12	27	27	H	?
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.65	0.69	H	?
Category 2 Pressure Ulcers with lapses in Care	8	5	7		?
Category 3 Pressure Ulcers with lapse in care	4	0	1		?
Deep Tissue Injury with lapses in care	0	18	15	H	
Unstageable Pressure Ulcers with lapses in care	0	4	4		?

Delivering Exceptional Care with Exceptional People

Quality Dashboard

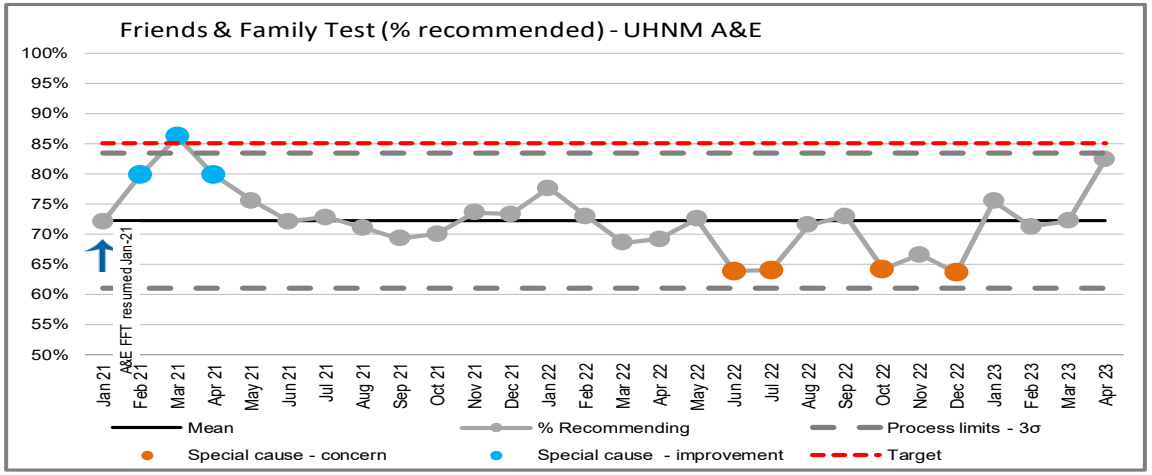
NHS
University Hospitals of North Midlands
NHS Trust

Metric	Benchmark	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	72.1%	0.0%	L	F
Friends & Family Test - Inpatient	95%	97.1%	0.0%	L	?
Friends & Family Test - Maternity	95%	95%	100.0%		
Written Complaints per 10,000 spells	35	23.67	25.42	L	?
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	95.99	95.55	H	P
Rolling 12 Month SHMI (4 month time lag)	100	105.71	105.55	H	F
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	8	3		
VTE Risk Assessment Compliance	95%	98.7%	98.0%		P
Timely Observations	90%	67.8%	68.6%	H	F
Reported C Diff Cases per month	8	13	17	H	?
Avoidable MRSA Bacteraemia Cases per month	0	0	0	L	?
HAI E. Coli Bacteraemia Cases per month	16	21	23	H	?
Nosocomial "Definite" HAI COVID Cases - UHNM	0	50	38	H	

Metric	Benchmark	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	100.0%	86.0%		?
Inpatient IVAB within 1hr (Contracted)	90%	100%	97.1%	H	P
Children Sepsis Screening Compliance (All)	90%	91%	83.3%	L	?
Children IVAB within 1hr (All)	90%	100%	N/A	H	P
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	82%	85.3%	L	?
Emergency Portals IVAB within 1 hr (Contracted)	90%	57%	89.8%		?
Maternity Sepsis Screening (All)	90%	86%	70.0%	L	F
Maternity IVAB within 1 hr (All)	90%	80%	100.0%	H	F

Delivering Exceptional Care with Exceptional People

Friends & Family Test (FFT) – A&E



Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
85%	71.2%	72.1%	82.4%

Background

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

What do the results tell us?

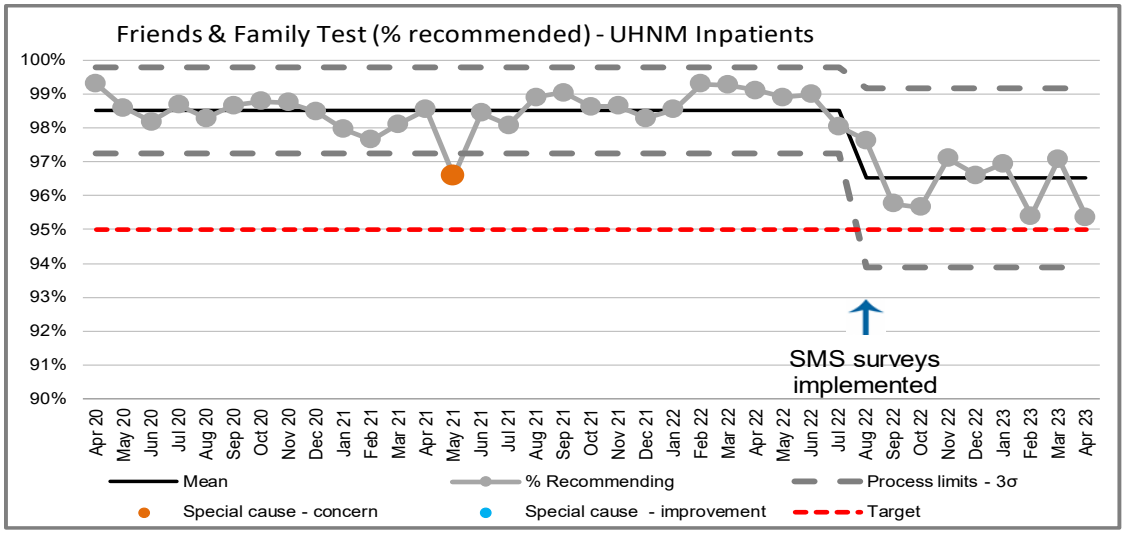
- The overall satisfaction rate for our EDs remains below our internal target at 82.4% for April 2023 despite improvements over the past 4 months .
- The Trust received 1278 responses which is an increase on the previous month with a 15% response rate for overall. The Trust's overall satisfaction rate is slightly lower than the national average of 80% (NHS England February 2023 latest figure). UHNM is 31st out of 125 Trusts for number of responses in ED (NHS England February 2023).
- Feedback from patient experience of using 111First and the kiosks is being monitored. 23% of respondents in April 23 reported to have used 111First prior to attending ED, which is a very slight increase on March 23. Key themes from April 2023 remain the same: poor communication, long waits, especially related to Royal Stoke; lack of compassion and patient's feeling dismissed. And these are similar across RSUH and County Hospital.

Actions :

- Work streams have been re-established to look at individual processes
- Patient Experience Team to meet with Senior Operational Services Manager regarding a plan to increase FFT response and satisfaction rates.

Friends & Family Test (FFT) - Inpatient

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
95%	95.4%	97.1%	95.4%

Background

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

What do the results tell us?

- The monthly satisfaction rate for inpatient areas continue to exceed both the internal target rate of 95% and the national average of 94% (February 2023 NHS England) at 95.4% for April 2023.
- In April 2023 a total of 2031 responses were collected from 65 inpatient and day case areas (10308 discharges) equating to a 20% return rate which is a decrease on the previous month and remains lower than the internal target of 30%. UHNM remain the 14th highest response rate for all reporting Trusts in the country (154) NHS England February 2023 (most recent data available).

Actions:

- Continue to ensure that FFT surveys are available in other formats to ensure accessibility for all patients.

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

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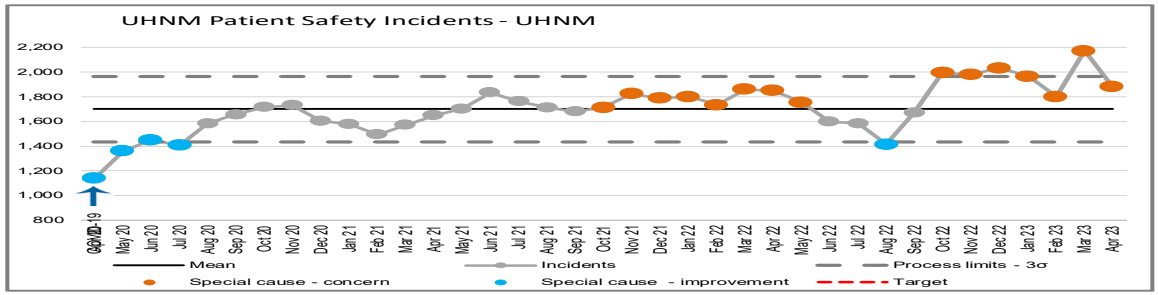
Reported Patient Safety Incidents

NHS
University Hospitals of North Midlands
NHS Trust

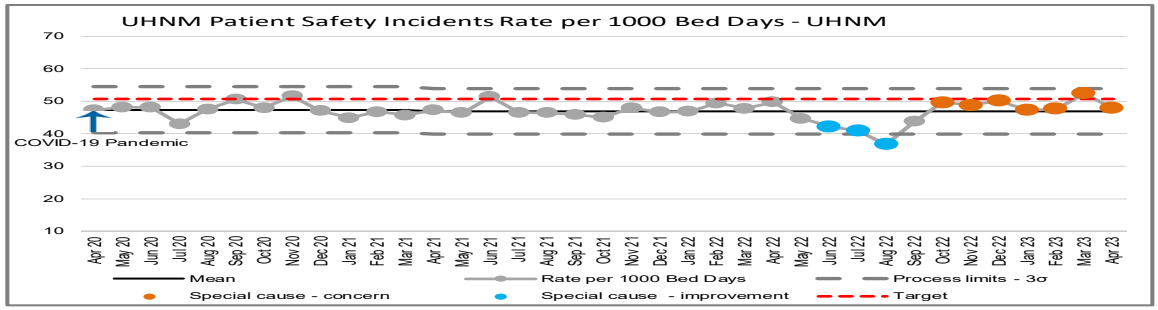


Variation	Assurance
H	

Target	Feb 23	Mar 23	Apr 23
N/A	1801	2171	1882

Background

Total Reported patient safety incidents



Variation	Assurance
H	?

NRLS Mean	Feb 23	Mar 23	Apr 23
50.70	47.62	52.45	47.84

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The April 2023 total is above the mean total since COVID-19 started but this may be due to increased activity throughout the Trust. The rate per 1000 bed days has, despite increases in total numbers remain relatively stable and is at mean rate.

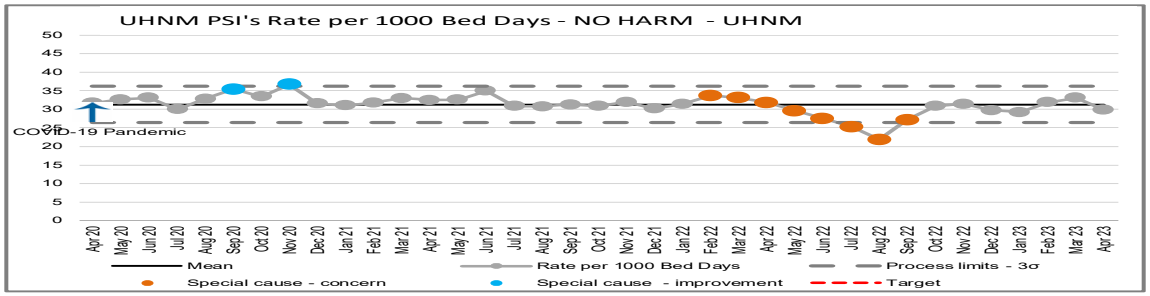
However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers are Patient Falls, Patient Flow, Medication, Patient Flow and Treatment related incidents. There has been no significant changes in these categories compared to previous months. There have been 117 (reduction from 157 in March, 170 in February and 228 in January 2023) of the incidents identified as related to 'Your Next Patient' which accounts for 6.21% (7.4%in March, 9.8% in February and 12% in(January 2023) of total patient safety incidents. 52.99% (61.8% previously) were Tissue viability. However, 72.5% of these were **NOT** hospital acquired but recording pressure damage on admission/attendance at UHNM.

The rate of reported PSIs per 1000 bed days remains similar to the long term mean rate and well within control limits and normal variation.

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

University Hospitals of North Midlands NHS Trust

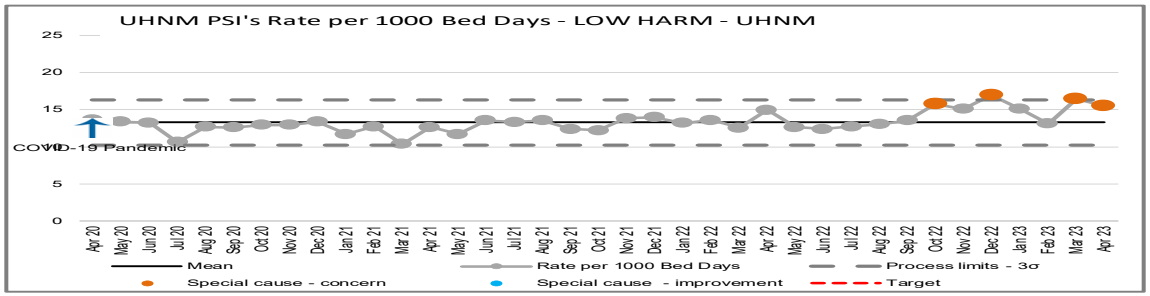


Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
N/A	31.89	33.08	29.82

Background

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

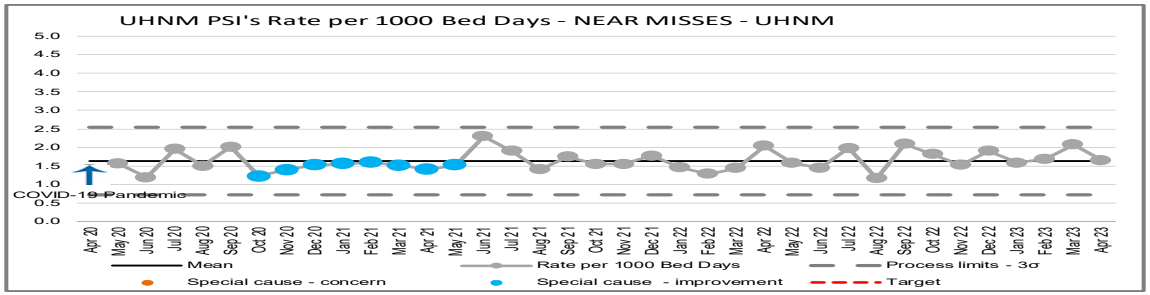


Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
N/A	13.14	16.45	15.51

Background

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



Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
N/A	1.69	2.08	1.65

Background

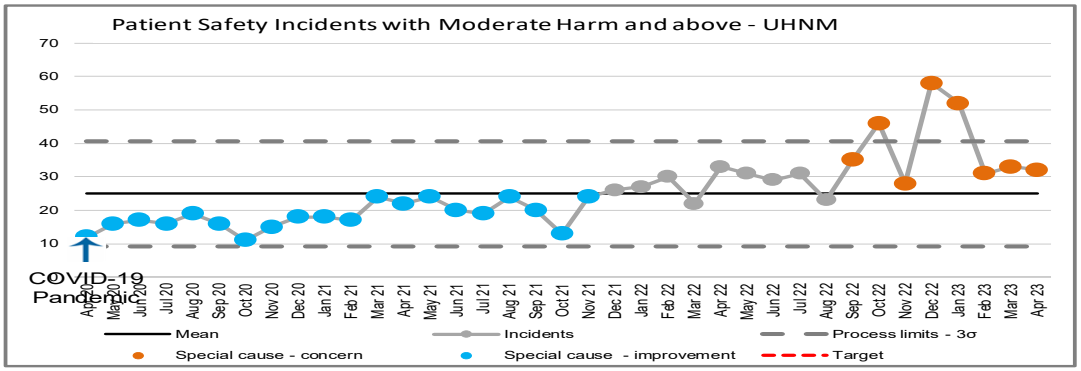
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with low harm or near misses are showing more consistent trends. The no harm incidents have seen rates back to the mean rate in recent months. With slight increase in low harm and near misses.

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

Reported Patient Safety Incidents with Moderate Harm or above

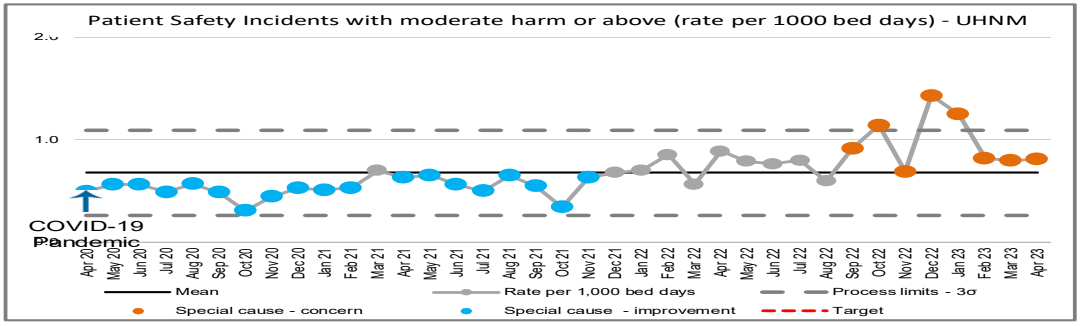


Variation	Assurance
	

Target	Feb 23	Mar 23	Apr 23
N/A	31	33	32

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance
	

Target	Feb 23	Mar 23	Apr 23
N/A	0.82	0.80	0.81

What is the data telling us:

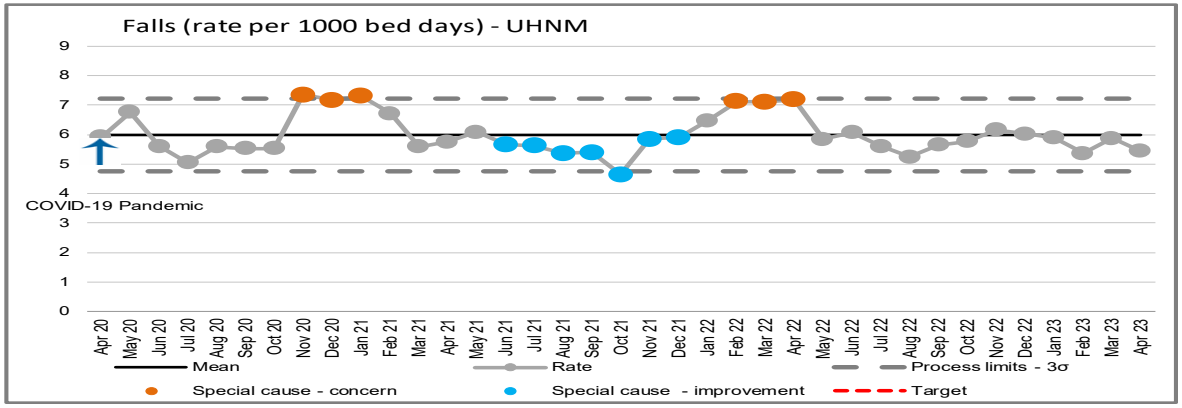
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is above the upper process control limit and has shown increasing total numbers since August 2022. The rate of moderate harm and above has also reduced in February so is not just a result of less days per month but is reduction based on standardised activity rates too.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 7 treatment related, 6 Medication 5 Falls, 5 Pressure Ulcer (Hospital acquired), 3 Care and ongoing monitoring

None of these moderate harm and above incidents were noted as relating to **'Your Next Patient'**

Patient Falls Rate per 1000 bed days

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
N/A	5.4	5.9	5.4

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 the normal range in April.

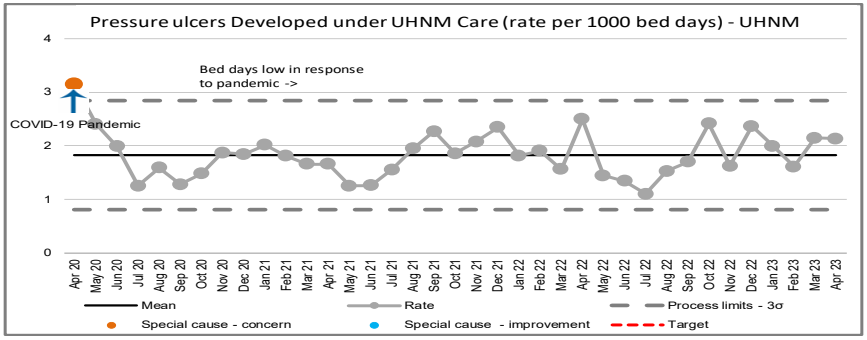
The areas reporting the highest numbers of falls in April 2023 were:
Royal Stoke ECC – 20 falls, Royal Stoke AMU – 11 falls, Ward 113 – 11 falls, Ward 228 – 9 falls
ED falls numbers per month have doubled since Autumn 2020, however, the rate per 1000 attendances has also been 77% higher since Autumn 2020 indicating that increased activity may not be the only factor behind increased falls.

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

- Audits have been undertaken in all of these TOP 5 reporting areas. Results have been fed back to the ward managers and their teams. Time is given for the wards to action the findings and then there is a re-audit undertaken. Support is given to the areas where no improvement is made and communication is made with the matron of the area.
- Discussion has taken place with the ECC team regarding all aspects of falls including risk assessment, documentation, prevention of falls, reconditioning and learning from recent SI's. The team are holding a falls awareness week on the 16.5.23 and this is including the front of house team and they will be discussing with the staff how they can support the prevention of falls in hospital.
- A discussion has been held between ECC and AMU in order to identify the patient that has falls factors on transfer. ECC are trialling yellow wristbands for these patients. On arrival to AMU the escort nurse will immediately hand over a falls alert symbol to be placed at the bed side. For those patients that have had a fall in the department, exceptionally confused or are a 1:1, then the NIC in ECC will contact the AMU NIC through vocera to alert them of this fact so that the most appropriate bed space can be provided.
- AMU are in the process of updating the current risk assessment booklet so that this includes the multifactorial risk assessment. Currently they are using loose sheets to complete if the falls core questions have been positive.
- Discussion has taken place with the heads of nursing in medicine, they have been updated regarding the work that is going on in the division regarding falls. They will be included in all the audit feedback that is going out to the wards in the future for their awareness and they have agreed to provide any support that is required by the quality and safety team.

Pressure Ulcers developed under care of UHNM per 1000 bed days

University Hospitals of North Midlands NHS Trust

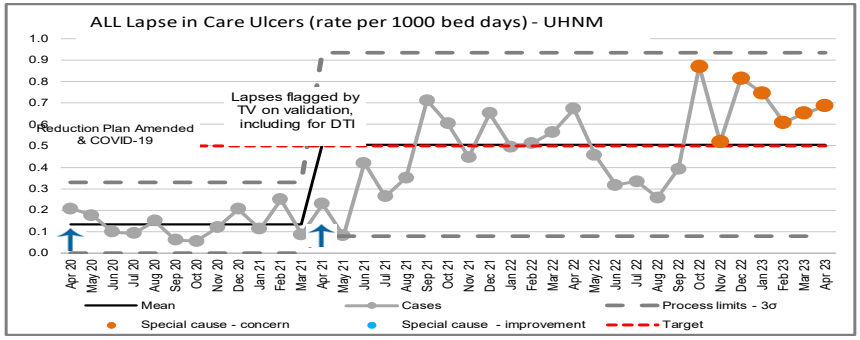


Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
N/A	1.61	2.15	2.14

Background

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



Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
0.5	0.61	0.65	0.69

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 April. The rate of cases with lapses in care identified has been above average for 7 consecutive months which may indicate significant change.

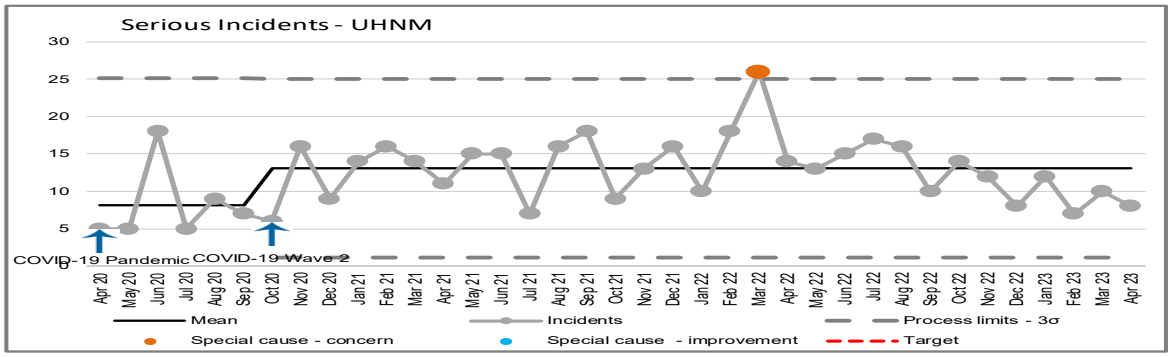
Acuity for ward areas is taken into account in line with lapses in care.

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 nursing assistants induction, ED mandatory training, Preceptorship days, and overseas nurses
- Pressure prevention days are arranged for all trust staff to attend
- The trialing of Respose proning overlay mattresses is continuing within Surgery Division
- Stakeholder group created for patient seating. To increase the completion of chair and mattress audits
- CQUIN to be implemented 23/24 for PURA and management
- Clinical Audit underway to cover period of October – December 23

Serious Incidents per month

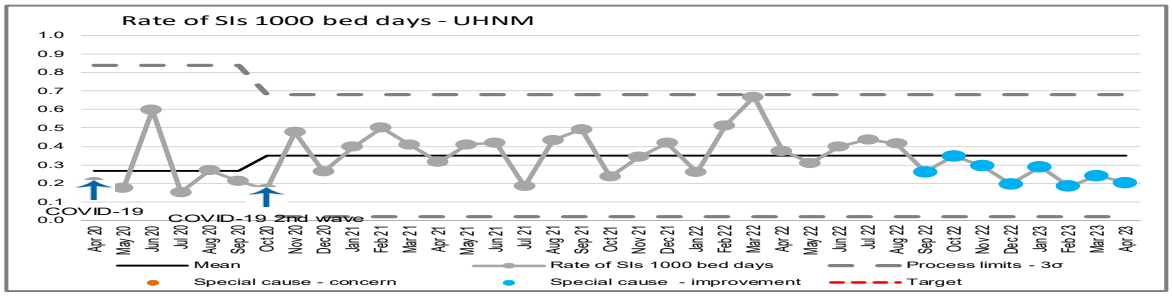


Variation	Assurance

Threshold	Feb 23	Mar 23	Apr 23
0	7	10	8

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
0	0.19	0.24	0.20

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

Monthly variation is within normal limits but has been consistently below the average rate for the past 8 consecutive months. Target has been set at 0 for serious incidents but this remains under review to develop trajectory for reducing serious incidents across UHNM. April 2023* saw 8 incidents reported:

5 Falls related incidents

2 Maternity related

1 Potential adverse Media related

The rate of SIs per 1000 bed days has varied consistently within confidence limits indicating normal variation and there has not been any significant trends. The current rate of SIs per 1000 bed days is 0.20 and is lower than the long term mean of 0.4 since COVID-19 started in December 2020. The previous 7 months have seen reporting rate lower than log term mean.

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

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

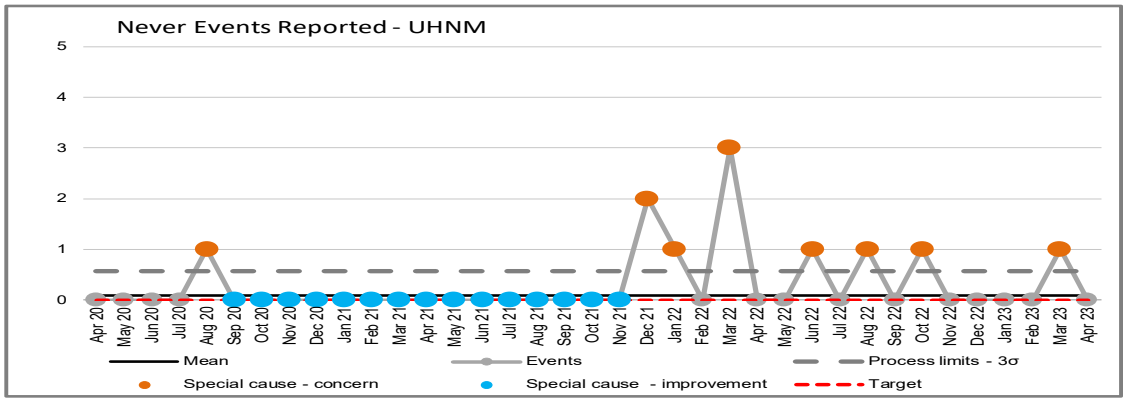
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during March 2023. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

There was 1 Maternity related Serious Incidents reported on STEIS during April 2023

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2023/7043	Other Ethnic - other	Maternity/Obstetric incident (baby only)	27/06/2023	Intra-uterine death confirmed by USS.

Never Events



Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
0	0	1	0

Background

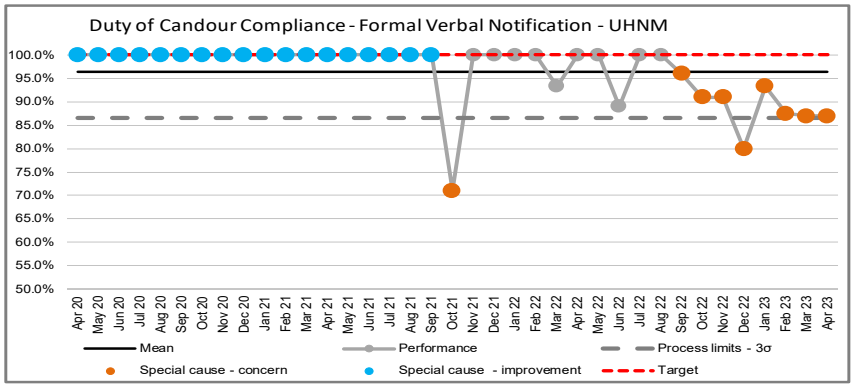
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

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

Log No.	STEIS Category	Never Event Category	Description	Target Completion date

Duty of Candour Compliance

NHS University Hospitals of North Midlands NHS Trust

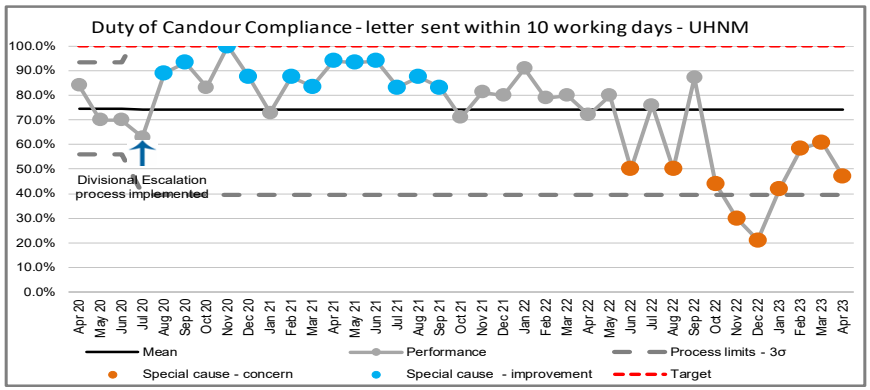


Variation	Assurance
	

Target	Feb 23	Mar 23	Apr 23
100%	87.5%	87.0%	87.0%

Background

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



Variation	Assurance
	

Target	Feb 23	Mar 23	Apr 23
100%	58.3%	60.9%	47.0%

Background

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

What is the data telling us:

During April there were 30 incidents reported and identified that have formally triggered the Duty of Candour. 87% have recorded that the patient/relatives been formally notified of the incident in Datix and within normal variation although remains below target rate.

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 April 2023 was 47% as at 6th May 2023 including those letters that are still within timescale. Outstanding letters / information uploaded to Datix has been escalated with individual wards/departments and via Directorate/Divisional structures. Medicine Division, in particular Emergency Medicine, have lowest compliance for written evidence of completion.

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.

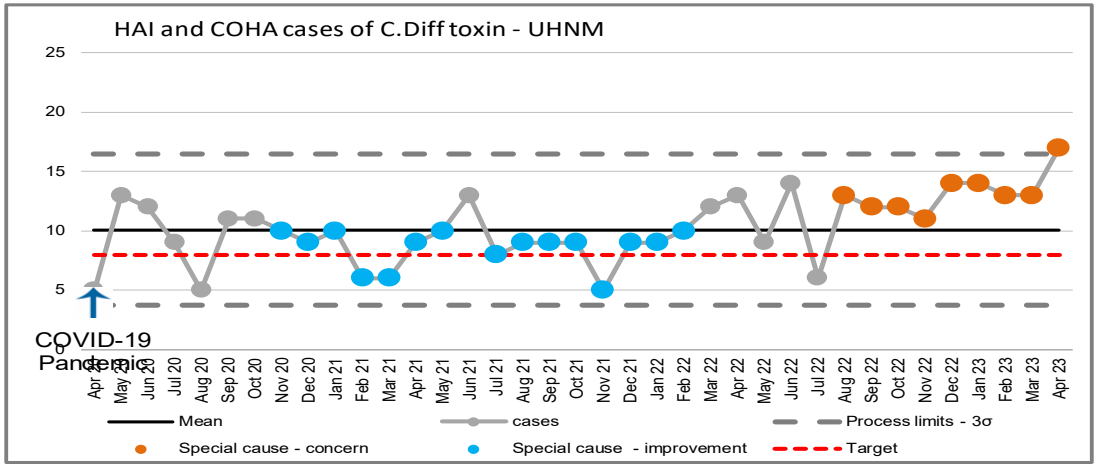
The initial actions taken within Emergency Medicine to support the clinicians with uploading and updating on Datix to evidence Duty of Candour completed especially during the continued increased extraordinary operational pressures have seen improvements locally.

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

Review of performance measure underway and will be reported at Quality Governance Committee

Reported C Diff Cases per month

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
	

Target	Feb 23	Mar 23	Apr 23
8	13	13	17

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

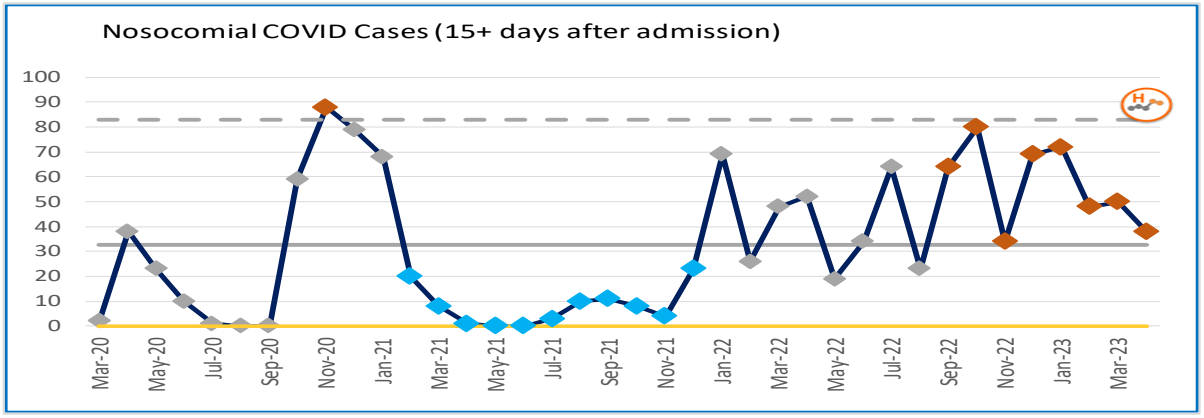
Number of C Diff cases cases are within SPC limits and normal variation .

There have been 17 reported C diff cases in April 2023 with 9 being Hospital Associated Infection (HAI) cases and 8 COHA cases.
HAI: cases that are detected in the hospital three or more days after admission (day 1 is the day of admission)
COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
There has been three clinical areas that has had more than one Clostridium *difficile* case in a 28 day period. FEAU 2x toxin and ward 78 2x toxin COHA. Awaiting ribotyping results and ward 81 2 x COHA ribotypes were different therefore person to person transmission is unlikely
The top 3 areas for C Diff during April 2023 were Ward FEAU, Ward 78 and ward 81 during April 2023

Actions:

- Routine ribotyping of samples continues
- Recruitment to the C Diff Nurse role has been successful and commenced 20th February 2023. This role is 50% patient reviews/50% staff training.
- The bi-weekly Cdiff MDT meeting has been re-commenced
- Review of the RCAs demonstrate a theme where patients have been admitted with documented diarrhoea, yet a sample is not submitted until day 3 or later – this then becomes hospital apportioned. At the clinical group meeting all clinicians were reminded of the importance of early sampling, and the Alert Group is exploring any options for an electronic alert for early sampling
- RCAs continue to be reviewed by ICB in relation to avoidability

HAI Nosocomial COVID Cases per Month



What do these results tell us?

- Decrease in cases throughout April 2023 with 38 definite Healthcare Acquired COVID-19 cases.
- Monthly total is within normal variation
- Follows national profile for increasing cases within the community
- COVID screening guidance changed 14/09/2022. Patients only swabbed on admission if being admitted to high risk area, immunocompromised or symptomatic for COVID. Otherwise patients are now not routinely screened. Asymptomatic cases are being identified when screening patients as part of an outbreak but currently

Actions :

- UHNM COVID screening changed in line with National guidance 14th September.
- No routine asymptomatic admission screening for COVID
- Screening for symptomatic, admission to high risk areas and immunocompromised patients
- In addition close patient contacts of a COVID case are also screened and patients who develop symptoms during their hospital stay
- COVID 19 themes report provided to IPCC
- UHNM Guidance on Testing and re-testing for COVID 19 plus step down of suspected/positive cases
- Isolate suspected patients on identification of symptoms
- Process for patients identified as a contact with positive patients
- Process in place for outbreak management and reporting

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	UHNM		
	Total Admissions	COVID cases	
		Prob	Def
Apr 21	16554	3	1
May-21	17273	0	0
Jun-21	18527	0	0
Jul-21	18168	4	3
Aug-21	17160	14	10
Sep-21	17327	11	10
Oct-21	17055	8	8
Nov-21	17700	4	4
Dec-21	16688	13	23
Jan-22	16109	67	69
Feb-22	16278	39	26
Mar-22	18518	71	48
Apr-22	16538	72	52
May-22	18484	14	19
Jun-22	18380	34	34
Jul-22	17983	45	64
Aug-22	18247	16	24
Sep-22	18279	58	64
Oct-22	18351	81	80
Nov-22	19607	29	34
Dec-22	18240	78	69
Jan-23	19466	81	72
Feb-23	18036	65	46
Mar-23	20695	87	50
Apr-23	17663	55	38

Nosocomial COVID-19 Deaths per month (with 1st positive result 15 days or more after admission)

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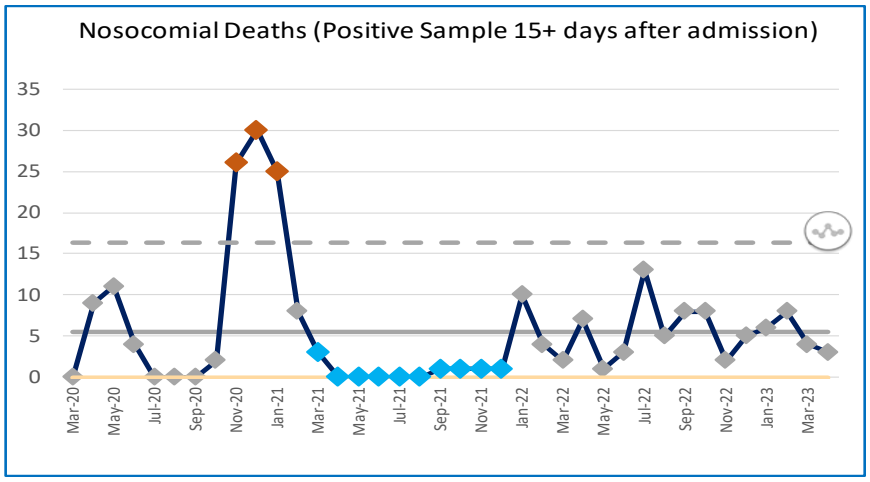

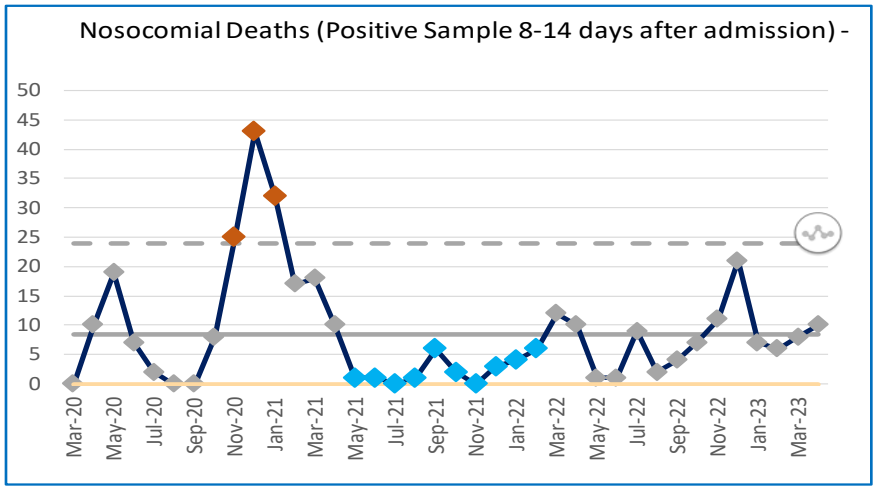

What do these results tell us?

Increase in monthly total but within normal variation limits

The criteria for the Definite Hospital acquired/Nosocomial COVID-19 is that the patient had **first positive** COVID-19 swab result 15 days or more following admission to UHNM.

- 3 recorded definite hospital onset COVID-19 deaths in April 2023
- 73 Definite Hospital acquired COVID-19 deaths during 2022/23 YTD
- The mean number of deaths per month since March 2020 is 6.

Actions :

Nosocomial COVID-19 deaths are continuing to be reviewed as part of Trust mortality review processes.

Sepsis Screening Compliance (Inpatients Contract)

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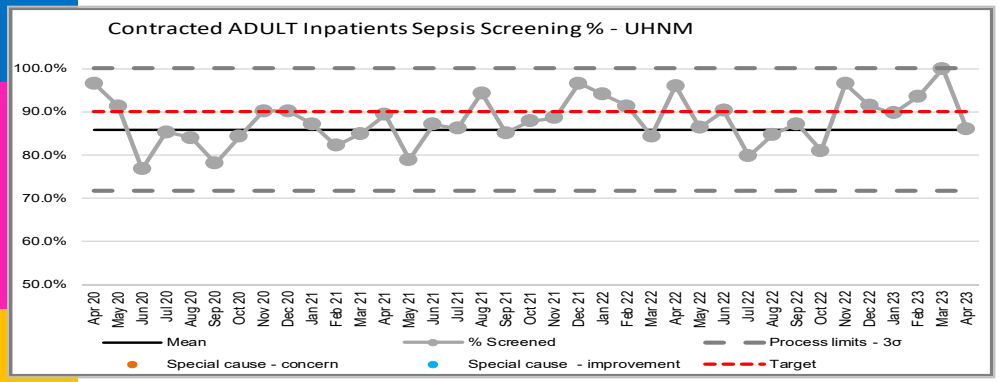

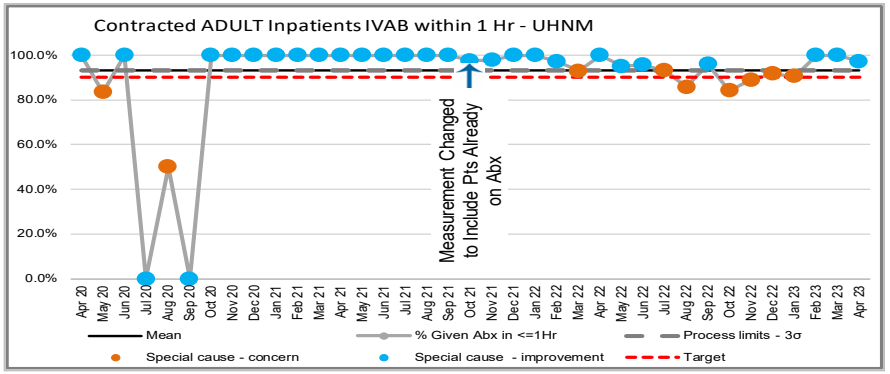

Variation	Assurance
	

Target	Feb 23	Mar 23	Apr 23
90%	93.6%	100.0%	86.0%

Background

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

Variation	Assurance
	

Target	Feb 23	Mar 23	Apr 23
90%	100.0%	100.0%	97.1%

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 in April 2023. There were 93 cases audited with 13 missed screening from different ward areas or divisions. Out of 93 cases audited, 35 cases were identified as red flags sepsis with 26 cases having alternative diagnosis and 35 cases were true red flags. Out of 35 true red flag cases, 31 were already on IVAB treatment and 3 were given IVAB treatment within 1 hour target. However 1 screening identified 1 IVAB was given over the 1 hour target.

Actions:

- To commence departmental/ divisional sepsis presentation to all level of clinicians from April 2023
- Collaborative work continued with the Vitalpac team to further improve the sepsis modules and new enhancement work for new IVAB guidelines; 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 will continue to promote sepsis awareness in both sites and will prioritise areas to visit with the clinical lead consultant; on-going
- Sepsis Champion training (5 hours CPD) will be available to all level of clinical and medical staff soon (spring-summer 2023)

Sepsis Screening Compliance (Emergency Portals Contract)

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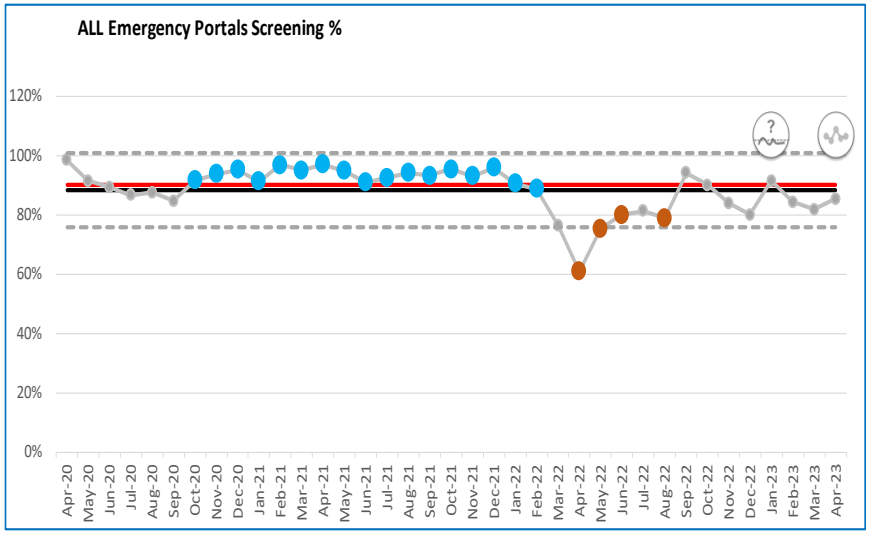

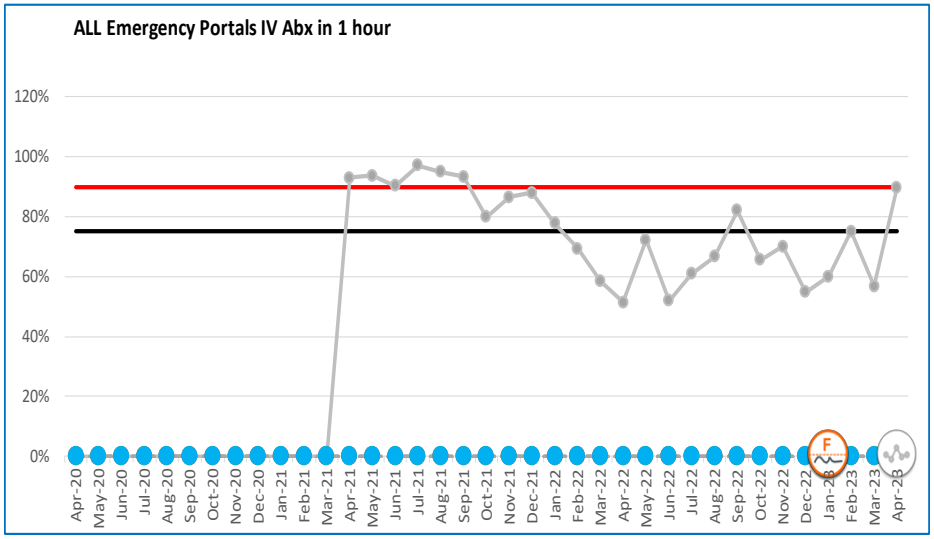

What is the data telling us:

Adult Emergency Portals screening did not meet the target rate for April 2023. There were 74 cases audited with 11 missed screening in total from the emergency portals. The performance for IVAB within 1 hour achieved 89.8%. Out of 74 cases, there were only 64 red flags sepsis in which the 20 cases already on IVAB, 29 cases were newly identified sepsis and 15 cases have alternative diagnosis. There were 5 delayed IVAB within 1 hour, this is mainly contributed by both ED sites and SAU. Missed screening contributed by both ED sites, AMU County and SAU.

Actions:

- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E regularly. Provide sepsis session when staffing and acuity allows.
- The Sepsis team is working collaboratively with the A&E Quality nurses, sepsis champions, senior team and A&E sepsis clinical lead to provide support with late IVAB incidents and missed screens. Issue with holding ambulances remain a challenge.
- Face to face A&E sepsis induction for new nursing staff, nursing assistant and medical staff will recommence once capacity pressure/flow improve in the department. Sepsis kiosks/ sessions recommence from April 2023 by the sepsis team.
- Regular meeting with A&E senior team reinstated to review current process and actions; on-going
- Monitoring impact of long ambulance waits on timely assessment and treatment of sepsis

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

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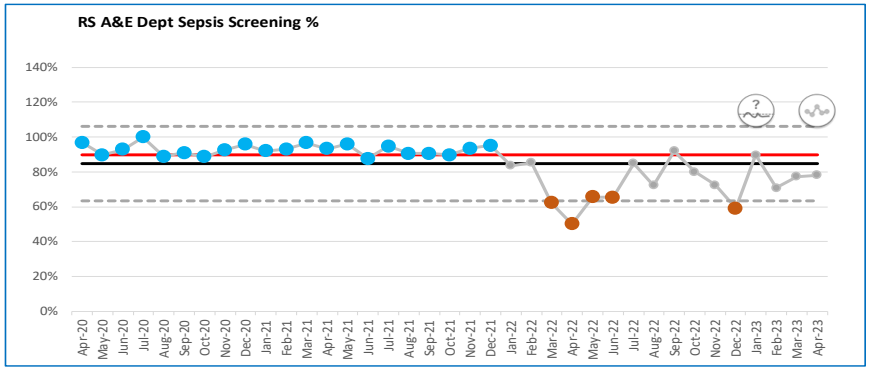

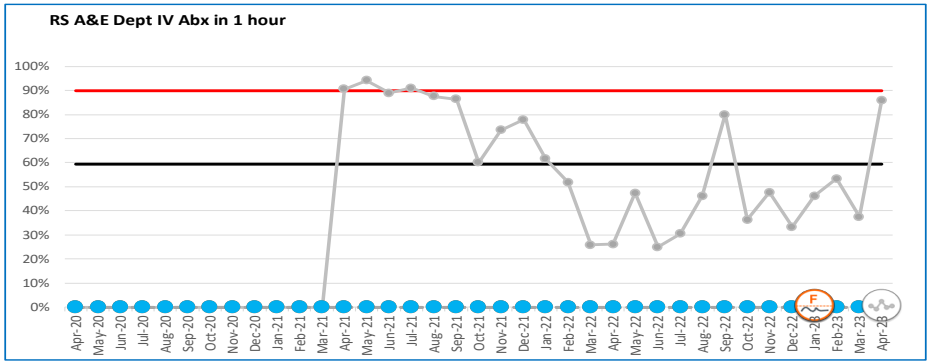

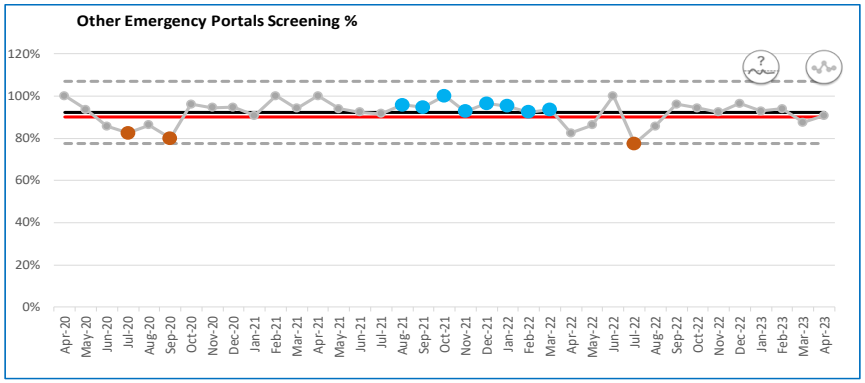

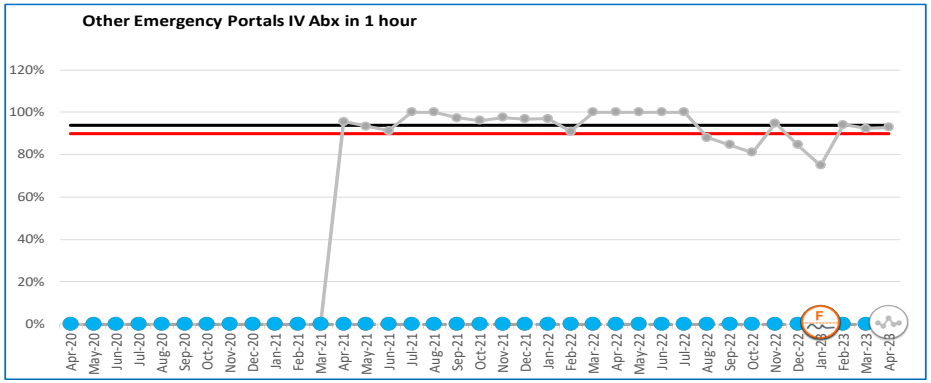

What is the data telling us:

RSUH Emergency Department performance in April 2023 remains below target rate, however we have noted some good improvement for IVAB within 1 hour. The RSUH ED is driving the overall Emergency Portals performance as other emergency portals are achieving Screening compliance and IVAB within 1 hour. However, this month it is slightly below target for screening (ED County, AMU County and SAU) and IVAB within 1 hour for ED County and SAU.

Actions:

- CAS card has been further updated to reflect the sepsis pathway and to ensure all staff are following the correct guidance (awaiting new printing from Harlow)
- Directorate devised a SOP for nursing staff to advise of agreed actions of Ambulance assessment nurse to escalate NEWS and sepsis trigger to the Resus Consultant between the hours of 8am-12midnight, EPIC 12midnight to 8am using the Vocera call system. This will enable accurate and safe assessment of the patients sepsis trigger and to ensure correct urgent antibiotic prescription and administration.
- Sepsis kiosks re-instate in ED focusing the importance of sepsis screening documentation and urgent escalation for true red flag sepsis triggers

Sepsis Screening Compliance ALL Maternity

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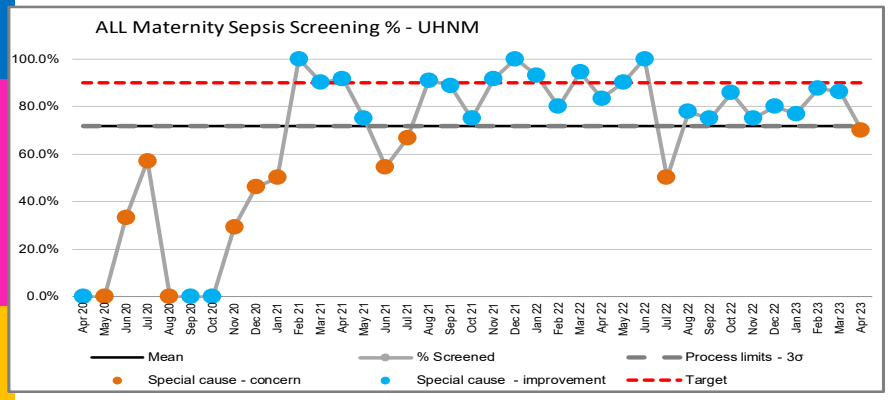

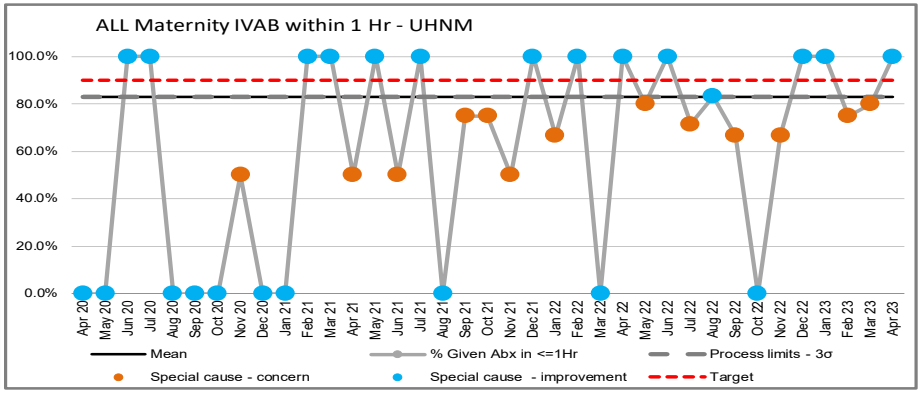

Variation	Assurance
L	F

Target	Feb 23	Mar 23	Apr 23
90%	87.5%	86.2%	70.0%

Background

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

Variation	Assurance
H	F

Target	Feb 23	Mar 23	Apr 23
90%	75%	80%	100%

Background

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

What is the data telling us:

Maternity audits in screening compliance is below the target at 70% however IVAB within 1 hour has improved to 100% during April 2023. This compliance score is based on a small number, however a regular spot checks audit is being conducted monthly.

There were 20 cases audited from emergency portal (MAU) and inpatients with 6 missed screening. There were 7 true red flags identified from the randomise audits, 0 alternative diagnosis and 7 cases received IVAB within 1 hour.

Actions:

- Maternity antibiotic PGD has been drafted and is currently under review by the Pharmacy Team; awaiting update
- Maternity educator is supporting the sepsis team by conducting independent / in-depth sepsis audits in the whole Maternity department , staff who had missed the screening documentation will be given constructive feedback and offered support/ training: on-going
- Monthly Maternity sepsis skills drill will be provided and delivered by the sepsis team and maternity clinical educator; on-going
- Sepsis awareness in the clinical areas will commence in spring-summer 2023

Sepsis Screening Compliance ALL Children

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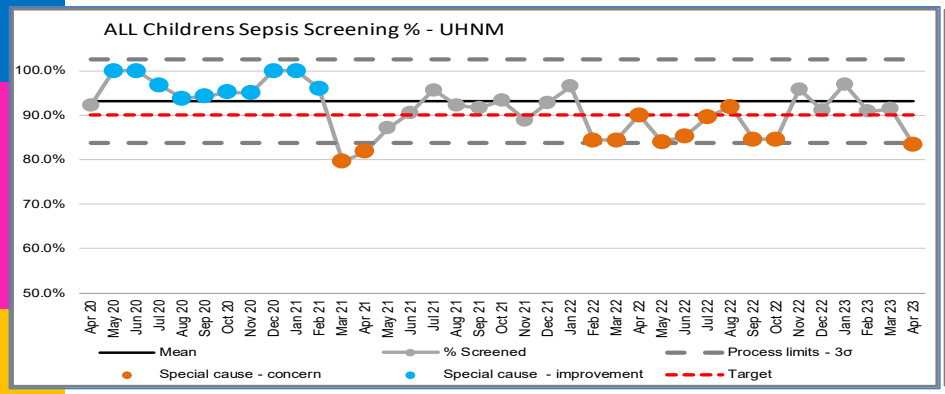

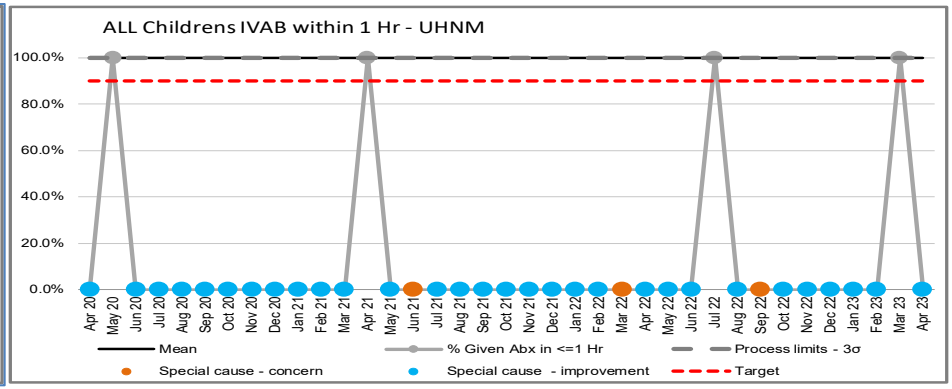

Variation	Assurance
L	?

Target	Feb 23	Mar 23	Apr 23
90%	90.9%	91.4%	83.3%

Background

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

Variation	Assurance
H	P

Target	Feb 23	Mar 23	Apr 23
90%	N/A	100.0%	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 show normal variation in the previous months, however target rate of > 90% was not achieved for April. Still seen 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 42 cases audited for emergency portals and inpatients areas with 7 missed screening (from CAU, 217 & Children's ED). No true red flags were identified from the randomise audits (both emergency & inpatients).

Actions:

- The Sepsis Team will continue to deliver sepsis drop in session (ward base training) as well as providing sepsis Induction session for newly qualified staff
- 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 3-5 hour Sepsis CPD champion training and ward based sessions: on- hold but plan to reinstate in the next few months

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Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS
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Non-Elective Care

- Context
  - ED Conversion increased from 31.8% to 33.0%
  - 12 Hour Trolley Waits decreased significantly from 906 to 286
  - Type 1 A&E Attendances reduced from 13868 to 13024
- Driver Metrics
  - 12+ Hours In ED improved from 2010 to 1437
  - Ambulance Handovers <60 Minutes improved from 87.0% to 95.8%
  - Four Hour performance increased again 67.4% to 70.1%

Cancer

- Trust overall 2WW Performance achieved 96.38% in March23 – a sustained achievement since last month.
- The Trust also predicted to achieve the 2WW in April. This sustained improvement is as a result of schemes such as the Lower GI Community Referral hub and Community Teledermatology pathways being successfully implemented.
- Breast symptomatic (where cancer is not suspected) achieved at 92.86% in February, just shy of the 93% target.
- The 62 Day Standard achieved better than predicted in March at 62.21%. The current provisional position for April is 54%. This is an un-validated and incomplete position that is expected to change as pathology confirms or excludes cancer for treated patients. Contributing factors include treatment and diagnostic capacity, with robust plans in place to tackle the most challenged specialties (LGI) over the next quarter.
- The 31 Day Standard improved since last month and achieved 90.53% for March. It is predicted to land at 88% in April.
- The 31 day Subsequent Radiotherapy achieved 93.89% in March, just shy of the 94% target, and is expected to achieve 91% in April.
- The 28 Day Faster Diagnosis Standard achieved 69.3% for all referral routes combined in March. The April position is currently incomplete and will be validated once Pathology confirms cancer or non cancer on high volume pathways such as Skin. Areas of best practice consistently achieving the standard are Breast and Upper GI.
- Suspected Breast Cancer, Skin and Lower GI continue to book 2WW referrals within 7 days, for first appointments.
- In August the PTL was over 6000 – this has now **reduced by around 2500** patients to around 3500 in total.

Spotlight Report from Chief Operating Officer

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Planned Care

The focus of activities for Planned Care has been as follows:

- Day Case activity and Elective Activity have moved from delivering 95% and 107% in February to 73% and 83% respectively for April., due to combination of IA and the Easter holiday periods. There is a real focus on the reintroduction of 6-5-4 with support from the regional theatres team. Day case as a % of all elective work is currently 86.5%.
- The focus has moved to 78 week waiters with an Annual Plan to reduce them to below 300 patients by March 2023. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge as soon as possible so any treatment can be carried out to meet the 78 week standard. The unvalidated number of 78 week breaches for end of April is 572.

RTT

- The overall Referral To Treatment (RTT) Waiting has increased from 77,487 March to 78,094 (unvalidated) in April. This is within the normal monthly variation.
- The number of patients > 52 weeks has started to decrease again, currently standing at 5,135 (unvalidated) decreased for the first time since summer 2022 4377 in August, 4,569 in September, 4,628 in October, 4,979 in November, 5,318 in December, 5,389 in January , 5,122 in February, and 5,425 in March.
- At the end of April the numbers of >104 patients was 52, a decrease of 6 from 58 at the end of February. The Trust has continued to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment. The Trust remains challenged in the delivery treating all patients waiting over 104 weeks, and the current unmitigated risk for the end of May is 37. This is predicted to be 16 with mitigating actions.

Diagnostics Summary

- During April the reported activity for Diagnostics was on plan when compared with 19/20 BAU.
- DM01 performance was 69 %. Non-obstetric ultrasound while still not meeting target have shown considerable improvements, however Endoscopy remains a concern.

Histology position – as at 1st May 2023:

- **Urgent:** 95% reported at Day 19 (previously Day 27), with 80% of cases reported by Day **13** (previously Day 19)
- **Accelerated:** 95% reported at Day **42** (previously Day 45)**,** with 80% of cases reported by Day **21** (previously Day 35)
- **Routine:** 95% reported at Day **44 (previously 46),** 80% of cases reported by Day **31** (Previously Day 31)

Radiology reporting backlog:

- High risk relating to 'routine / non cancer reporting' due to reporting capacity and delays in diagnosis. The Risk register has been updated with separate risks relating to each reporting group 25512 highest scores 12 – paediatric and MSK.

Endoscopy:

- NHSE visit 15th 16th May. Recovery trajectory in progress with additional capacity in scoping and booking administration teams.

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Section 1: Non-Elective Care

Headline Metrics

Non-Elective Care – monthly *(context)*

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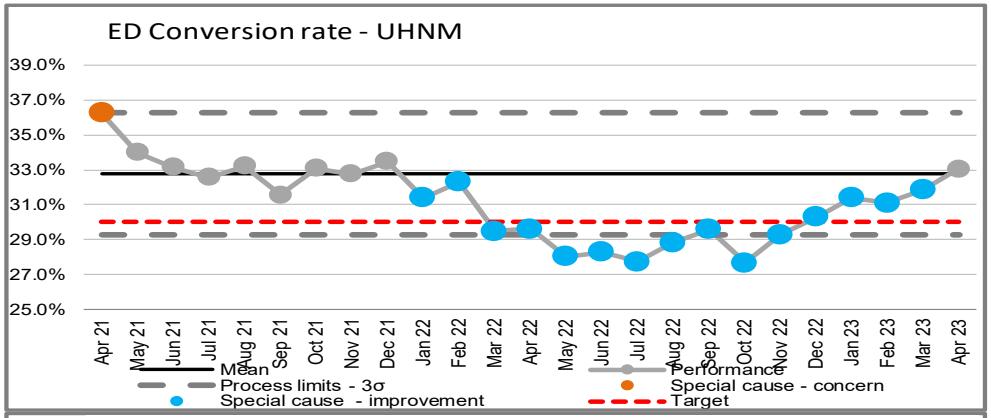
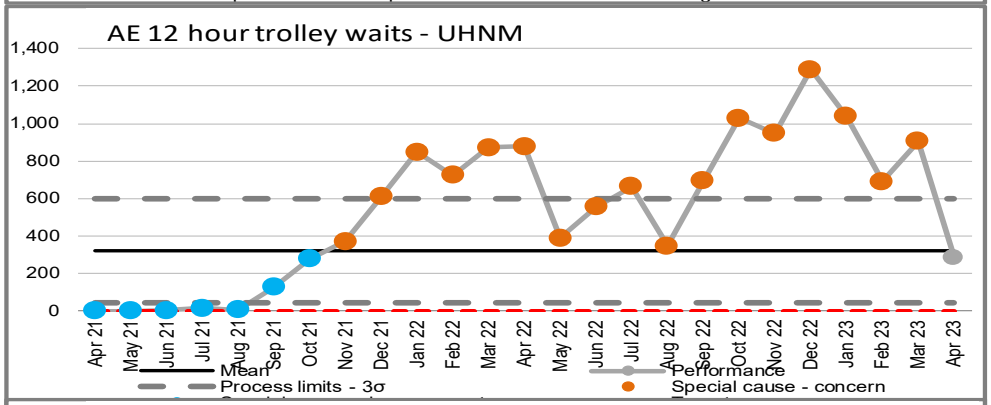


Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
30%	31.1%	31.8%	33.0%

Background

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

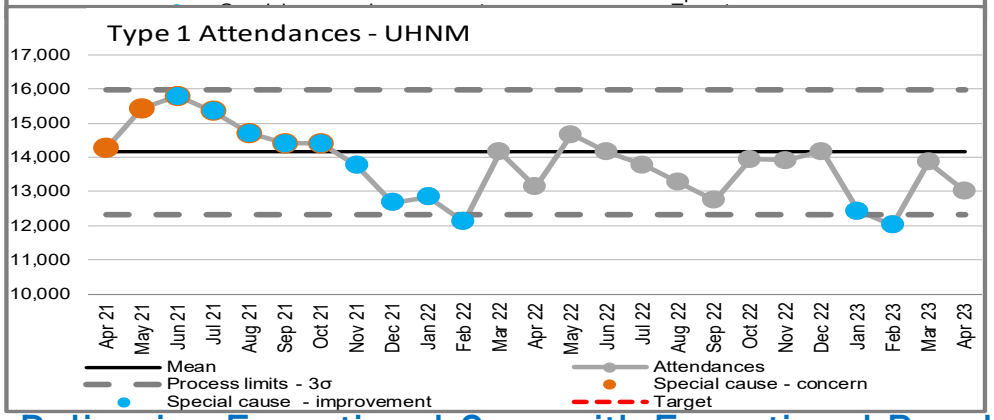


Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
0	690	906	286

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	Feb 23	Mar 23	Apr 23
N/A	12024	13868	13024

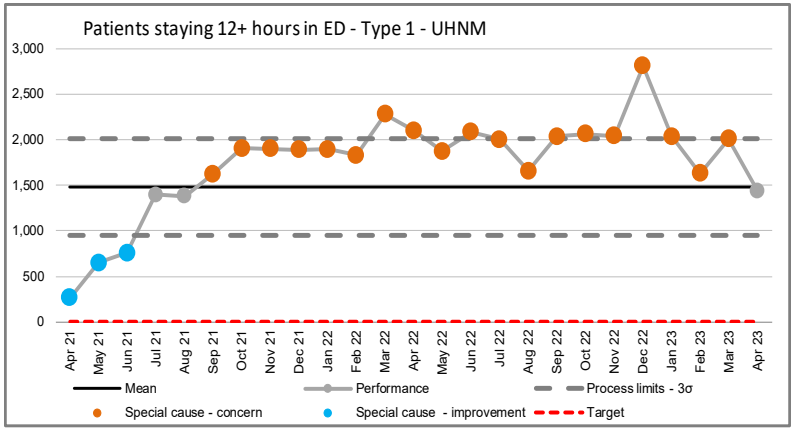
Background

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

Delivering Exceptional Care with Exceptional People

Non-Elective Care – Headline Metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

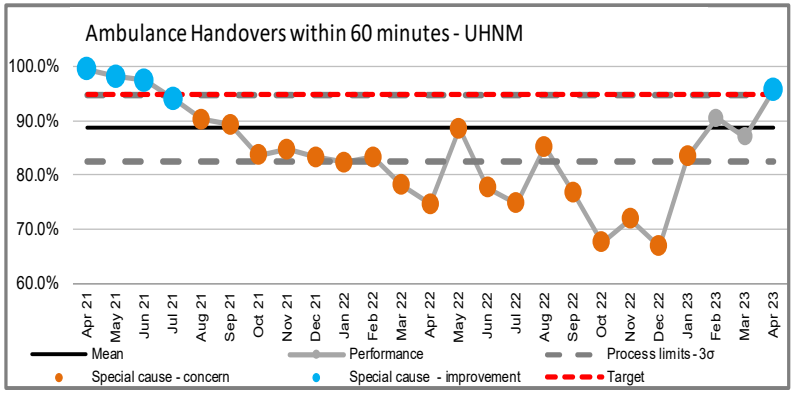
Target	Feb 23	Mar 23	Apr 23
0	1631	2010	1437

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 significantly improved during April, with volumes below the 2 year average.



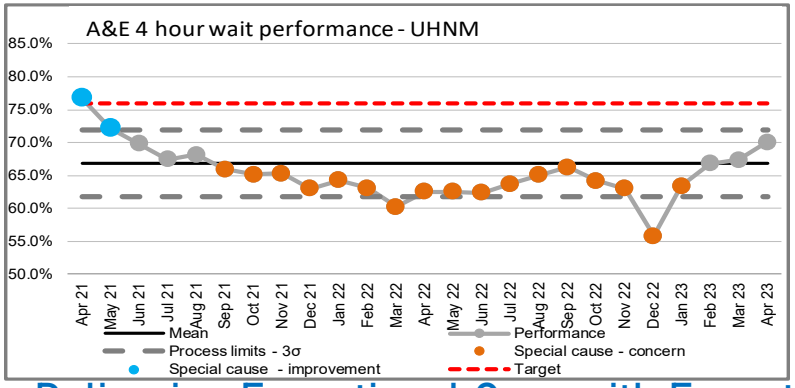
Variation	Assurance
H	F

Target	Feb 23	Mar 23	Apr 23
95.0%	90.5%	87.0%	95.8%

Background

The percentage of ambulance handovers completed within 60 minutes.

Ambulance handovers within 60 minutes exceeded the 95% target for the first time since June 2021.



Variation	Assurance
	F

Target	Feb 23	Mar 23	Apr 23
76%	66.8%	67.4%	70.1%

Background

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

4 hour performance has seen an improving trend since December 2022, reaching levels seen two years ago.

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

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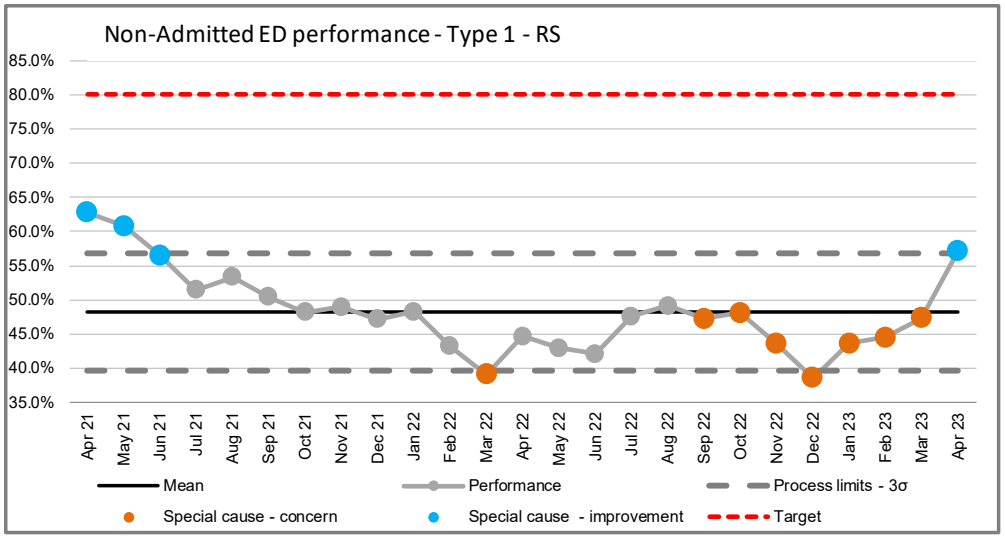

Variation	Assurance
H	F

Target	Feb 23	Mar 23	Apr 23
80%	44.5%	47.3%	57.2%

Actions

- Standard Work for Senior Decision Makers in the Ambulatory and CED areas has now been agreed and is embedding. It has been identified that non-clinical administrative support in these areas would support further improved productivity of clinicians. The trialling of such support is currently being scoped.
- The maintenance of performance between midnight and the morning shift commencing, when fewer Senior Decision Makers have greater demands on their capacity, has been identified as a critical area for improvement. Options are currently being appraised by the ED Leadership Team to extend additional senior cover into the night (or to commence earlier in the morning) with a focus on ambulatory performance.
- There has been continued refinement to the Escalation SOP with the final version now in production which will pull together multiple elements including the ED Corridor, AMU Corridor, and Your Next Patient to ensure a cohesive, consistent, and hospital wide response to ED pressures.

Summary

- RSUH ED Non Admitted 4 Hour Performance has been chosen as the single driver metric for Workstream 1 as it is both a critical component for achievement of 76% against the Four Hour Standard in March 2024, and largely within the gift of the ED to deliver. In order to support achievement a month by month trajectory was submitted for this metric detailing, based on previous activity data, performance required for this KPI in order to ensure achievement of the System Four Hour Standard. It is positive to note that the target was 50% for April with performance at 57.2%. This will need to be at least maintained for May to achieve the target of 55%.

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

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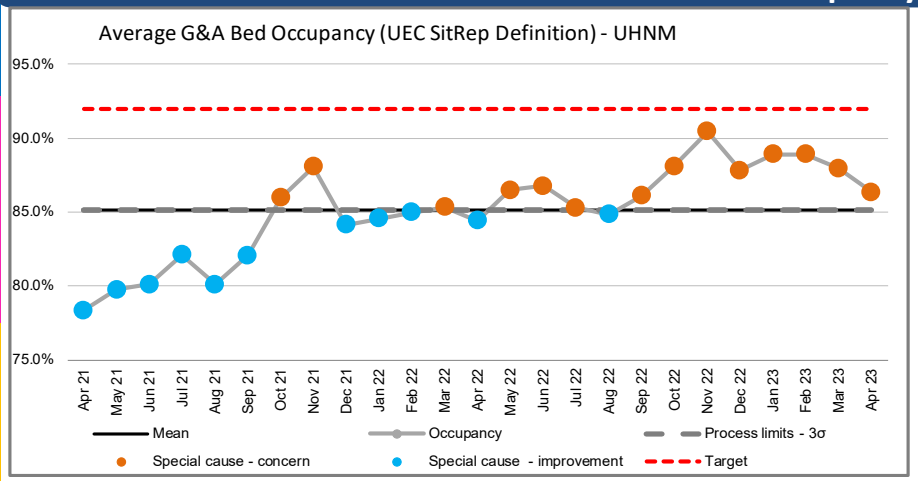
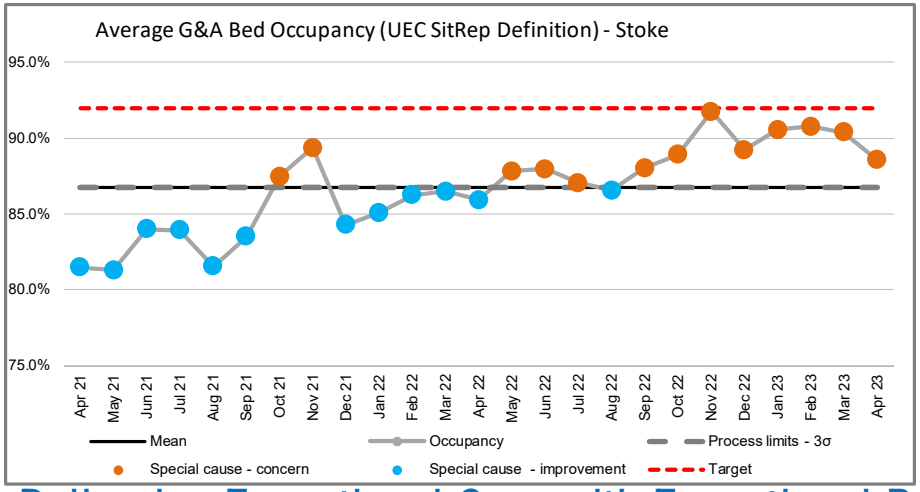


Variation	Assurance
H	P

Target	Feb 23	Mar 23	Apr 23
92%	88.9%	88.0%	86.3%



Actions

- Workstream 2 constituent Working Groups have now been confirmed as LOS Improvement (now combining Specialty LOS, Ward Standard Work, and Long LOS), Digital Tools, Reverse Bed Chaining, and Capacity & Demand. Each of these will have single KPI and be reported on from next month as per the NELIP POAP.
- Confirmation of funding for the proposed additional modular capacity is still pending following confirmation of placing in the highest priority group for funding allocation. Verbal feedback has been received and indicates a probable positive outcome. This investment will provide 50 G&A beds to Medicine which will both improve overall performance, and specific improvement direct to the area of greatest occupancy challenge.

Summary

- G&A Bed Occupancy has been chosen as the single driver metric for Workstream 2 as it is both a key metric submitted as part of the Annual Operational Plan and a NOF Tier 2 Exit KPI.
- G&A Bed Occupancy continues to perform at above target levels as reported. However, work is ongoing to refine the underlying data to ensure recent reconfigurations and the exact bed types are accurately reflected. This work will conclude in May is likely to increase reported occupancy levels although the difference is not expected to be significant.
- It should also be considered that while Trust G&A Bed Occupancy seems to be positive, the reported figure is not entirely representative of patient flow challenges throughout the Trust. This is because Divisional G&A Bed Occupancy varies significantly, with WC&CSS operating at a 60% - 70% occupancy and RSUH Medicine frequently exceeding 95%.

Workstream 3; Acute Portals & Navigation
CRTP+1

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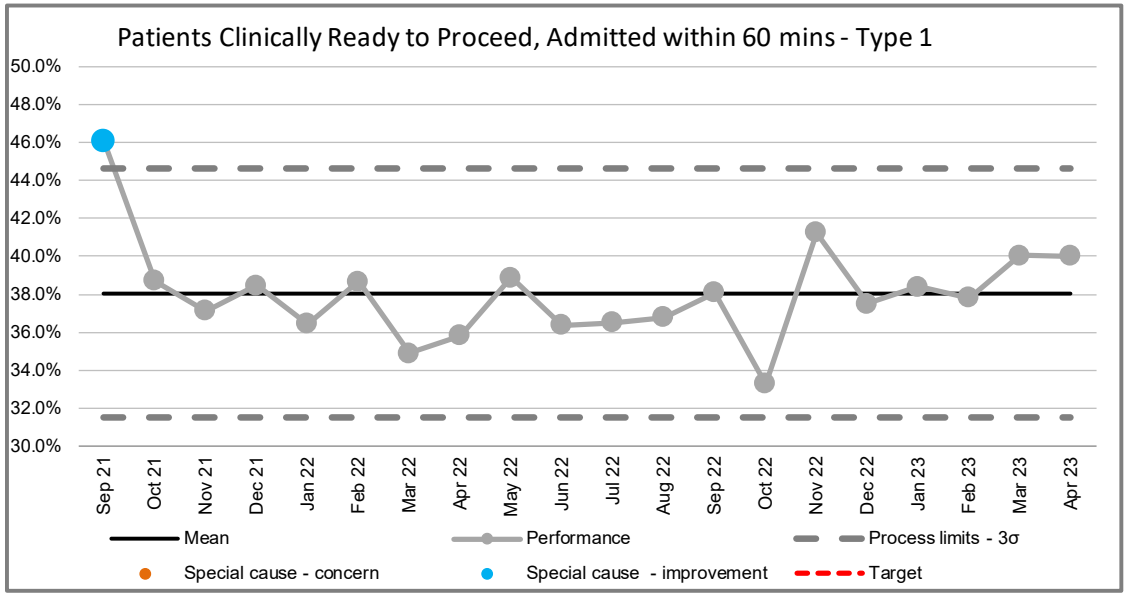

Variation	Assurance
	

Target	Feb 23	Mar 23	Apr 23
90%	37.8%	40.1%	40.0%

Actions

- Workstream 3 constituent Working Groups have now been confirmed as Alternative Pathways, Portal Preparedness, Portal Standard Work, and Frailty. Each of these will have single KPI and be reported on from next month as per the NELIP POAP.
- Given the significant shift from implementation of outputs from the NHSE Clinical Standards Review to the new scope of Acute Portals & Navigation, Workstream 3 requires the most support and development. To support this Surgery and Network have been tasked with commencing work to assess improvement opportunities in their respective portals.
- The Frailty Working Group has now also been established and will focus on outputs from the Regional Productivity Team benchmarking exercise. This will focus on SDEC type patients and turning around elderly and frail patients at the point of entry to the Trust.

Summary

- While CRTP+1 is no longer considered as significant a metric nationally as previously impressed as part of the NHSE Clinical Standards Review, the work done, and clinical engagement, has supported the retention of this a the driver metric for Workstream 3 as a key indicator of performance and flow through acute portals.
- CRTP+1 represents the KPI requiring the greatest improvement across all NELIP and Workstream KPI. While performance is above mean for the second month in a row, this demonstrates the scale of significant improvement still required. Following on from comments with regards to G&A Bed Occupancy data, CRPT+1 will likewise require significant scrutiny applied to Divisional specific performance given the variation of quantity and performance.

Section 2: ELECTIVE CARE

Planned Care - *Diagnostics*

NHS
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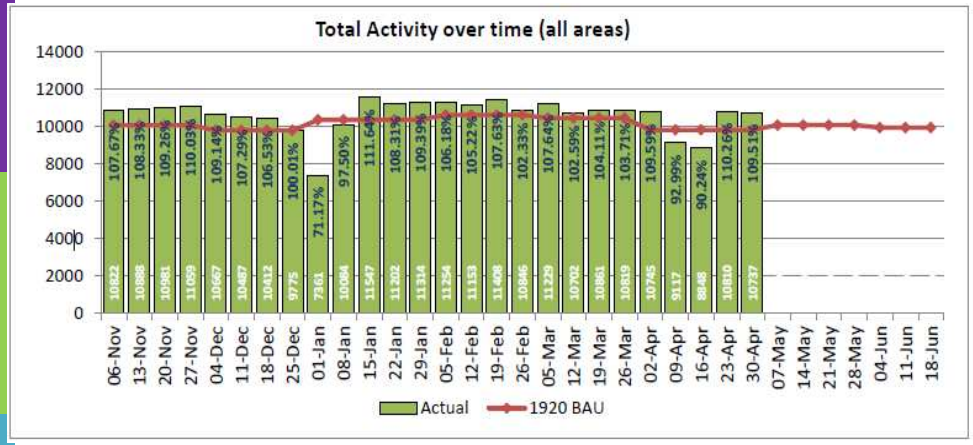
		2019 Method For Imaging Activity				2019 Method For Imaging Activity				Part Validated Data			
		Feb-23				Mar-23				Apr-23			
Area	DM01 Test	Total WL	6+	%	Activity	Total WL	6+	%	Activity	Total WL	6+	%	Activity
Imaging	Magnetic Resonance Imaging	3,886	504	87.0%	6,417	3,674	24	99.3%	7,583	3,005	27	99.1%	
	Computed Tomography	4,122	23	99.4%	12,892	3,948	84	97.9%	14,120	3,351	41	98.8%	
	Non-obstetric ultrasound	7,513	2,512	66.6%	6,535	7,436	2,315	68.9%	6,688	7,032	2,567	63.5%	
	Barium Enema	0	0		0	0	0		0				
	DEXA Scan												
Physiological Measurement	Audiology - Audiology Assessments	429	9	97.9%	296	352	14	96.0%	395	467	41	91.2%	
	Cardiology - echocardiography	2,476	987	60.1%	1,038	2,929	1,091	62.8%	1,362	3,123	1,525	51.2%	
	Cardiology - electrophysiology	0	0		0	0	0		2	0	0		
	Neurophysiology - peripheral neurophys	298	0	100.0%	233	316	0	100.0%	250	301	16	94.7%	
	Respiratory physiology - sleep studies	481	43	91.1%	294	493	58	88.2%	351	502	73	85.5%	
	Urodynamics - pressures & flows	1	0	100.0%	0	0	0		0	0	0		
Endoscopy	Colonoscopy	959	617	35.7%	140	1,326	661	50.2%	253	1,534	993	35.3%	
	Flexi sigmoidoscopy	558	357	36.0%	20	812	355	56.3%	49	1,085	695	35.9%	
	Cystoscopy	120	15	87.5%	230	146	4	97.3%	236	187	57	69.5%	
	Gastroscopy	797	300	62.4%	287	818	379	53.7%	545	1,276	679	46.8%	
	Totals	21,640	5,367	75%	28,382	22,250	4,985	78%	31,834	21,863	6,714	69%	0

>> Sunday Snapshot - Unvalidated Waiting List

Area	DM01 Modality	13+	% 13+
Imaging	Magnetic Resonance Imaging	1	0.0%
	Computed Tomography	5	0.1%
	Non-obstetric ultrasound	111	1.6%
	Barium Enema	0	
	DEXA Scan		
Physiological Measurement	Audiology - Audiology Assessments	26	5.3%
	Cardiology - echocardiography	153	4.9%
	Cardiology - electrophysiology	0	
	Neurophysiology - peripheral neurophysiology	0	0.0%
	Respiratory physiology - sleep studies	21	3.9%
	Urodynamics - pressures & flows	0	
Endoscopy	Colonoscopy	681	44.4%
	Flexi sigmoidoscopy	383	35.3%
	Cystoscopy	38	20.3%
	Gastroscopy	354	27.7%
	Total	1,773	8.1%



Pathology TAT chart will be added for June 23 report. While this is awaited the pathology performance currently is:

The following represents performance as at 1st May 2023;

- **Urgent** (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day 19 (previously Day 27), with 80% of cases reported by Day **13** (previously Day 19)
- **Accelerated** (include all Cancer Resections): 95% reported at Day **42** (previously Day 45), with 80% of cases reported by Day **21** (previously Day 35)
- **Routine** (all Specimens not in above categories): 95% reported at Day **44 (previously 46),** 80% of cases reported by Day **31** (Previously Day 31)

Our 7 day reporting turnaround time (TAT) for Urgent cases is at 44% against the Royal College of Pathologists' target of 80% within 7 days.

Diagnostics - benchmarked

	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
16	**Diagnostics - 6 Week Standard**	**Feb 23**	**1.00%**	**24.8%**			**37**
89	Audiology	Feb 23	1.00%	2.1%			67
85	Colonoscopy	Feb 23	1.00%	64.3%			9
83	Computed Tomography	Feb 23	1.00%	0.6%			67
87	Cystoscopy	Feb 23	1.00%	12.5%			65
83	DM01 Waiting <13 Weeks	Feb 23	100.00%	94.3%			52
16	Diagnostics - 6 Week Standard	Feb 23	1.00%	24.8%			37
999	Diagnostics - 6 Week Standard Reversed	Feb 23	99.00%	75.2%			37
90	Echocardiography	Feb 23	1.00%	39.8%			25
91	Electrophysiology	Feb 23	1.00%	-			-
86	Flexi Sigmoidoscopy	Feb 23	1.00%	64.0%			7
88	Gastroscopy	Feb 23	1.00%	37.7%			23
84	Magnetic Resonance Imaging	Feb 23	1.00%	13.0%			36
92	Neurophysiology	Feb 23	1.00%	0.0%			100
86	Non-obstetric Ultrasound	Feb 23	1.00%	33.5%			16
93	Sleep Studies	Feb 23	1.00%	8.9%			62
94	Urodynamics	Feb 23	1.00%	0.0%			100

- Despite UHNM seeing a greater improvement in performance over the last two months than peers, they are still behind most peers.
- UHNM are currently in the third quartile.

Planned care - *Diagnostics*

NHS University Hospitals of North Midlands NHS Trust

Diagnostics Summary

- During April the Diagnostic activity remained consistent with the March position.
- DM01 performance was 69% un-validated overall which was a decrease on March's 78%. Endoscopy performance is the main contributor to this performance

Top 6 contributors for DM01 performance have developed recovery plans, and have been requested to refresh these plans in line with National timescales for recovery, this was March 23 and while some have met this trajectory action plans have been extended for others. To be monitored once complete by Planned Care Group.

DM01 performance 69%: 6714 patients waiting 6 weeks+;

Top Contributors – in order of highest breach %

1.	Colonoscopy (35.3%)	993 breaches of 1534 patients
2.	Flexi Sigmoidoscopy (35.9%)	695 breaches of 1085 patients
3.	Gastroscopy (46.8%)	679 breaches of 1276 patients
4.	Non-Obstetric Ultrasound (63.5%)	2567 breaches of 7032 patients
5.	Echo (51.2%)	1525 breaches of 3123 patients

Actions - Imaging

Radiology reporting backlogs;

- Radiology workforce business case part approved – approval to recruit to 10wte radiology consultants; 2 Locum radiologists have been recruited and started in post.
- Weekly Radiology backlog risk management meetings are now in place with the speciality clinical leads, divisional and directorate management representatives with specialty specific action plans and individual risk register entries
- Price per scan TI payment model approved until Dec 2023 to support an increase in reporting and outsourcing remains in place
- Risk Scores are currently between 10 and 12 dependent on reporting group. Paediatrics and MSK have the longest waits (scored 12 currently)

Non – obs Ultrasound capacity for routine patients:

Approval on 11.05.23 to procure outsourced capacity – progressing procurement process

Approval to utilise bank rate until March 24. Plan to achieve DM01 trajectory by November 2023.

Actions - Endoscopy

Endoscopy; Weekend capacity reinstated and recovery trajectory in progress. Booking administration team capacity also increased to allow for dates to be provided for all >52week waits in colorectal and the cancer backlog. NHSE have undertaken a deep dive visit but will return to conclude the review of demand and capacity

Actions – Pathology

Histology Position – as at 1st May 2023:

- **Urgent** (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day 19 (previously Day 27), with 80% of cases reported by Day **13** (previously Day 19)
- **Accelerated** (include all Cancer Resections): 95% reported at Day **42** (previously Day 45)**,** with 80% of cases reported by Day **21** (previously Day 35)
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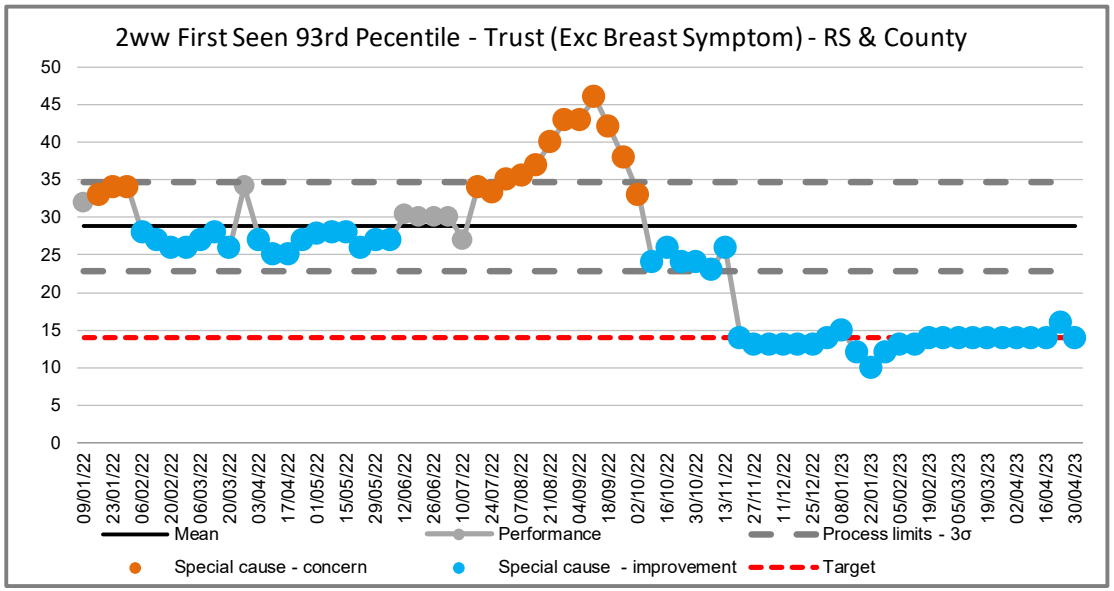
Our 7 day reporting turnaround time (TAT) for Urgent cases is at 44% against the Royal College of Pathologists' target of 80% within 7 days.

Cancer – Headline metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

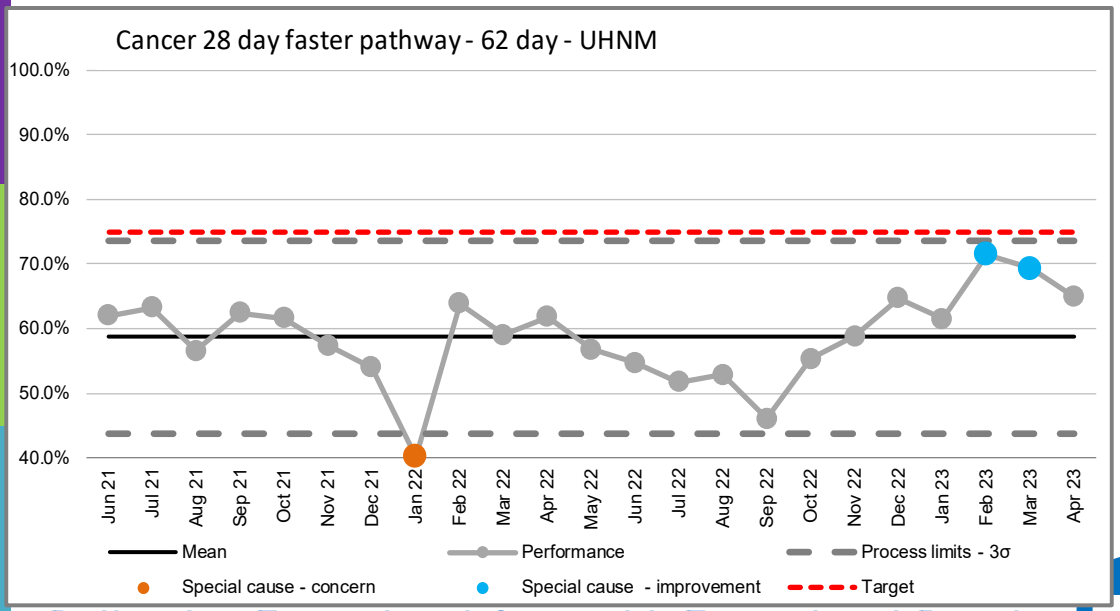
Target	16/04/2023	23/04/2023	30/04/2023
14	14	16	14

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



Variation	Assurance
	F

Target	Feb 23	Mar 23	Apr 23
75%	71.5%	69.3%	64.9%

Background

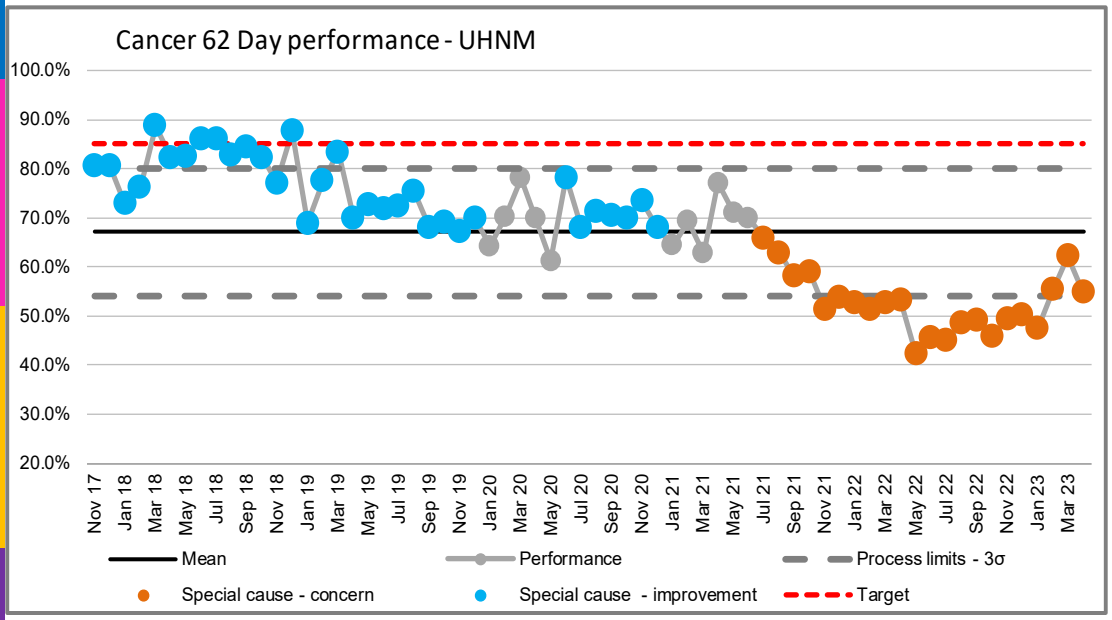
Performance of confirmation or exclusion of cancer communicated with patients within the 28 day timeframe.

What is the data telling us?

The FDS performance remains stable with pockets of good practice. E.g. Breast, Lung and Upper GI all achieve the standard . The March position landed at 69.3% - a special cause improvement on the SPC chart. April is currently incomplete but continued improvement is expected.

Cancer – Headline metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

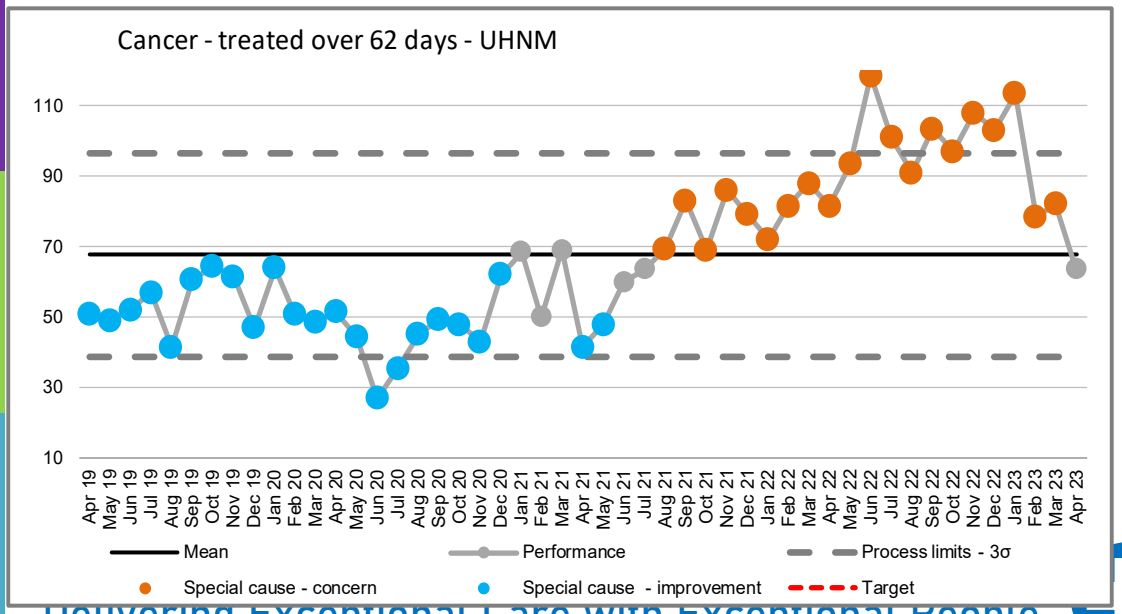
Target	Feb 23	Mar 23	Apr 23
85%	55.5%	62.2%	54.8%

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 12 months with a steep decline in May21 and landed at 62.2% in March23, the April23 position is still being validated.



Variation	Assurance
	

Target	Feb 23	Mar 23	Apr 23
N/A	78.5	82.0	63.5

Background

The number of patients treated over 62 days

What is the data telling us?

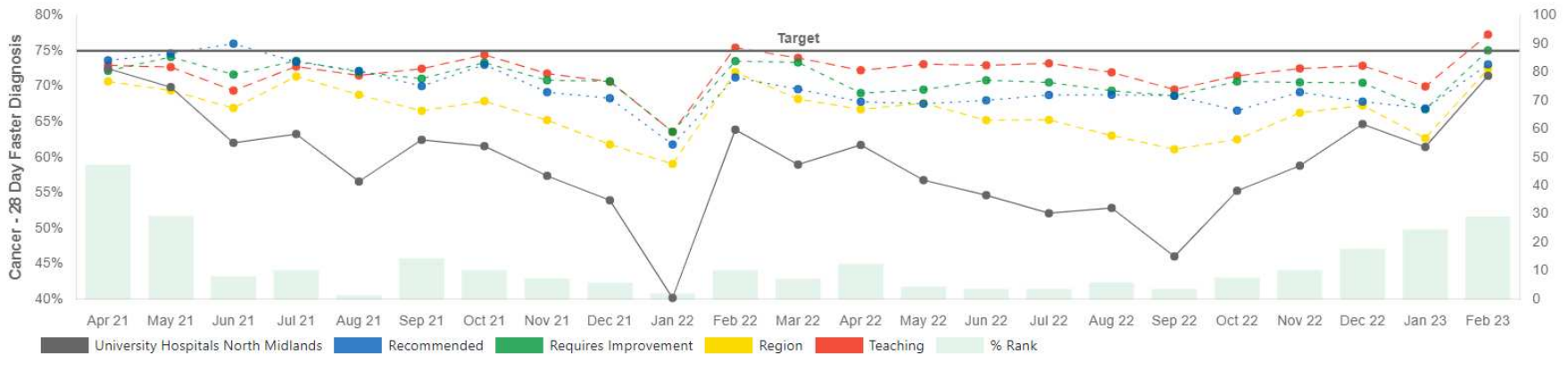
Demonstrates total volume of patients who have been treated beyond day 62 is a cause for concern and has been rising over the past 12 months. As the trust has significantly reduced the backlog of patients waiting, we've seen an improvement in Feb , March and April23 position.

Cancer – benchmarked

Cancer - 28 Day Faster Diagnosis

Feb 23 Performance: 71.5% | Rank: 96th of 135

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



	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
403	**Cancer - 28 Day Faster Diagnosis**	**Feb 23**	**75.0%**	**71.5%**			**29**
403	Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	**71.5%**			29
406	FDS Acute Leukaemia	Feb 23	75.0%	-			-
407	FDS Brain Tumours	Feb 23	75.0%	**0.0%**			0
408	FDS Breast Cancer	Feb 23	75.0%	95.6%			59
404	FDS Breast Symptoms	Feb 23	75.0%	97.4%			60
409	FDS Children's Cancer	Feb 23	75.0%	76.5%			22
410	FDS Gynaecological Cancer	Feb 23	75.0%	**59.9%**			34
411	FDS Haematological Malignancies	Feb 23	75.0%	**45.7%**			30
412	FDS Head & Neck Cancer	Feb 23	75.0%	**69.8%**			17
413	FDS Lower Gastrointestinal Cancer	Feb 23	75.0%	**56.9%**			43
414	FDS Lung Cancer	Feb 23	75.0%	78.6%			34
405	FDS Missing or Invalid	Feb 23	75.0%	-			-
415	FDS Other Cancer	Feb 23	75.0%	-			-
416	FDS Sarcoma	Feb 23	75.0%	**50.0%**			34
417	FDS Skin Cancer	Feb 23	75.0%	**71.7%**			11
418	FDS Testicular Cancer	Feb 23	75.0%	92.9%			59
419	FDS Upper Gastrointestinal Cancer	Feb 23	75.0%	88.8%			87
420	FDS Urological Malignancies	Feb 23	75.0%	**56.3%**			43

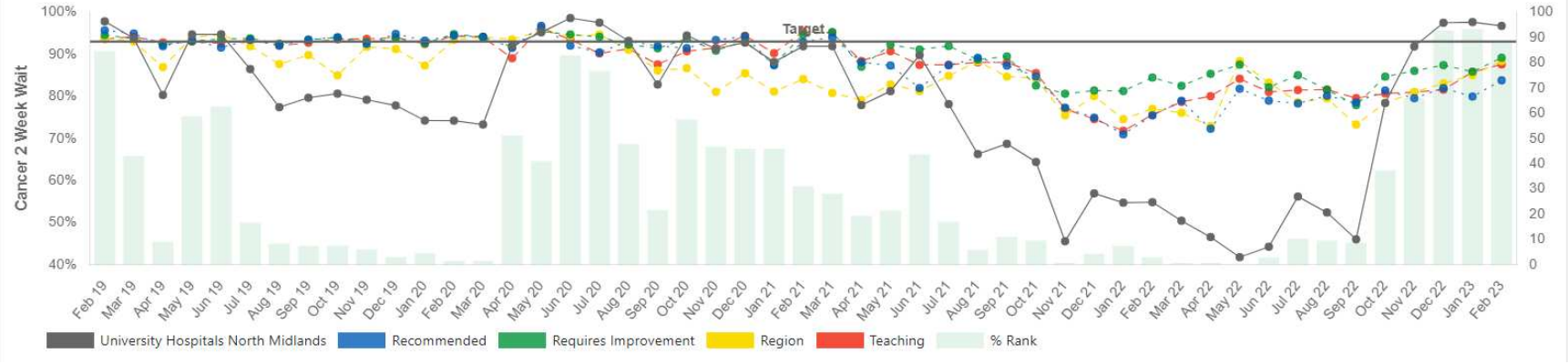
- The 28 Day Faster Diagnosis position for UHNM has been lower than all peer groups since June 2021.
- During 2023, UHNM are now aligned to other peers.

Cancer – benchmarked

Cancer 2 Week Wait

Feb 23 Performance: 96.73% | Rank: 17th of 135

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



	Key Performance Indicator	Period	Target		SPC Last 12 Months	Centile
45	**Cancer 2 Week Wait**	**Feb 23**	**93.00%**	**96.7%**		**88**
45	Cancer 2 Week Wait	Feb 23	93.00%	96.7%		88
99	Cancer 2 Week Wait Breast Symptomatic	Feb 23	93.0%	96.3%		71
46	Cancer 31 Day First Treatment	Feb 23	96.00%	90.5%		27
120	Cancer 31 Day Subsequent Treatment	Feb 23	96.0%	86.9%		21
51	Cancer 62 Day All Sources	Feb 23	85.00%	58.2%		33
100	Cancer 62 Day Consultant Upgrade	Feb 23	85.0%	69.6%		34
35	Cancer 62 Day Screening	Feb 23	90.0%	33.3%		12
118	Cancer Sub Treat Drugs	Feb 23	96.0%	91.4%		4
119	Cancer Sub Treat Radiotherapy	Feb 23	96.0%	97.5%		65

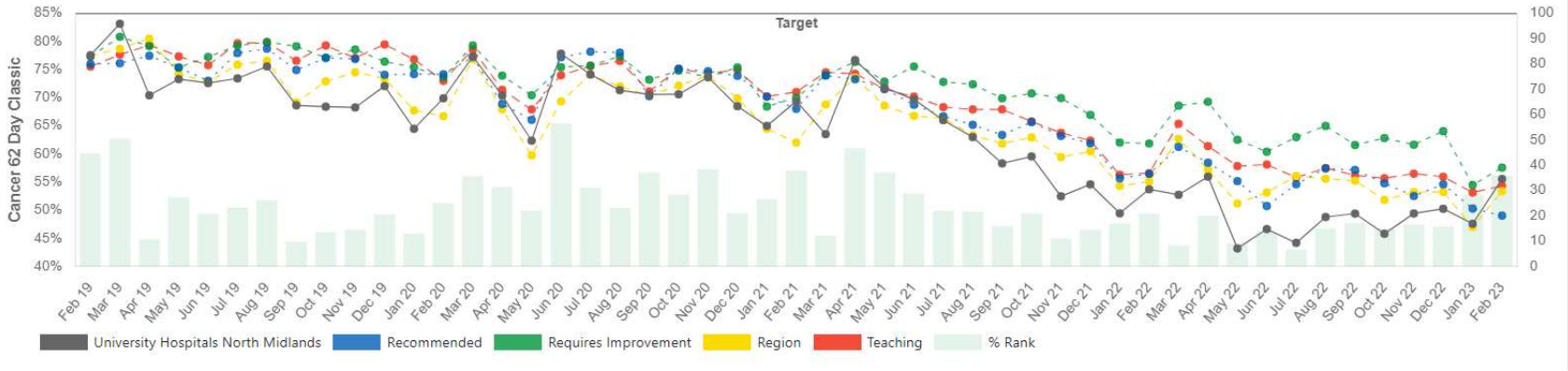
- Since September UHNM have seen a significant improvement.
- Exceeding all other peers and the national target of 93% since December 2022.

Cancer - Benchmarked

Cancer 62 Day Classic

Feb 23 Performance: 55.52% | Rank: 87th of 135

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



15	**Cancer 62 Day Classic**	**Feb 23**	**85.00%**	**55.5%**		**36**
	Key Performance Indicator	Period	Target		SPC Last 12 Months	Centile
161	Breast Cancer	Feb 23	85.00%	**61.5%**		21
15	Cancer 62 Day Classic	Feb 23	85.00%	**55.5%**		36
162	Lower Gastrointestinal Cancer	Feb 23	85.00%	**23.8%**		23
163	Lung Cancer	Feb 23	85.00%	**32.0%**		25
164	Other Cancer	Feb 23	85.00%	**54.5%**		56
165	Skin Cancer	Feb 23	85.00%	**83.3%**		37
166	Urological Cancer	Feb 23	85.00%	**55.8%**		58

- UHNM have seen an improvement since May 22, where other peer groups have either seen no improvement or seen a deterioration.

Cancer Trajectories

University Hospitals of North Midlands NHS Trust

Provider Level					April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	E.B.32	Count	The number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site specific symptoms	462	440	420	400	380	360	340	320	300	280	250	191
				UHNM snap-shot PTL position	579	632	639	815	1041	894	887	730	558	477	346	313

National planning guidance 22/ 23 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. The PTL Backlog trajectory for UHNM is set out above; the actuals shown above are a snap shot in time of the PTL position. This is for the week ending last full week of the month per PAF report.

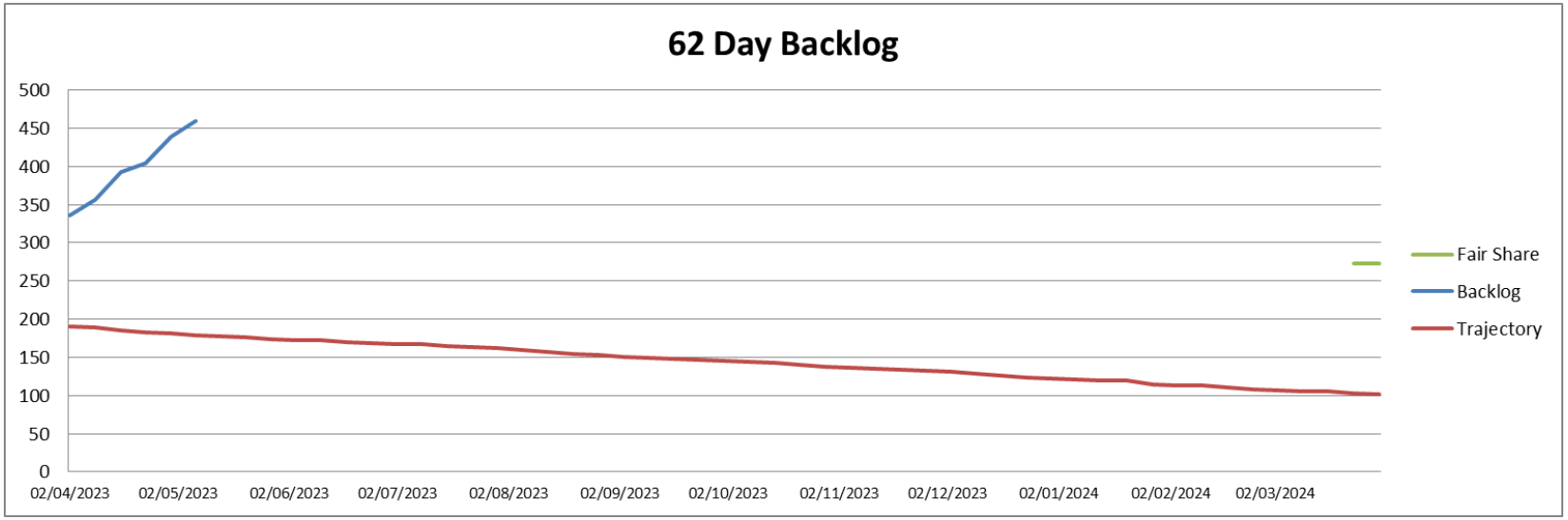
For the month of March 2023, the backlog position was 313 – a reduction of over 700 patients since August. This position includes patients with a decision to treat and a future treatment date scheduled. The majority of the backlog is attributable to Skin and Colorectal. High proportion of patients waiting over 62 days in both tumour sites have future scheduled treatment dates. The April 23 position is challenged by increasing turn around times in diagnostic services, and additional capacity schemes being sustained. Business cases have been worked up to describe activity that will sustain the improvements in Skin, awaiting sign off.

There are multiple contributing factors to the backlog, including delays to diagnostic reporting in pathology and imaging, urology robotic surgery capacity, oncology capacity, complex pathways, and an increasing element of patient choice and outstanding clinical reviews.

All divisions are focusing on the backlog and discharge patients where appropriate. There is a concentration on the first appointments and encouraging patients to attend as soon as possible, plus a focus on diagnostics and treatments including Surgical and Oncology. All diagnostic modalities have submitted plans for a reduction in waiting times which includes additional staffing, insourcing and outsourcing and building additional capacity through CDC's.

Cancer

- 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. It also allocated a fair shares total shown in green below. The internal PTL Backlog trajectory for UHNM is shown in red below; and the actuals, shown in blue, are a snap shot in time of the PTL position. This is for the week ending last full week of the month per PAF report.
- UHNM provide assurance to the regional NHSEI team, with detailed plans on a weekly basis. Tier 2 Progress to date:
  - The 62 day backlog has reduced by over 700 patients since August.
  - The number of days waited for 1st OPA (93rd Percentile) has reduced by 35 days since August.
  - The total PTL has reduced by around 2300 since August.
  - The number of patients waiting over 104+ has halved.
  - The Faster Diagnosis Standard has improved from 46% in September to a final March position of 69%



- Impacting the position in 23/24 are new challenges such as strike action, additional capacity scheme continuity, and diagnostic capacity in Endoscopy and Pathology.
- The West Midlands Cancer Alliance have been approached to continue to fund the additional capacity which contributed to the significant recovery of the Cancer position.

Planned Care – *RTT*

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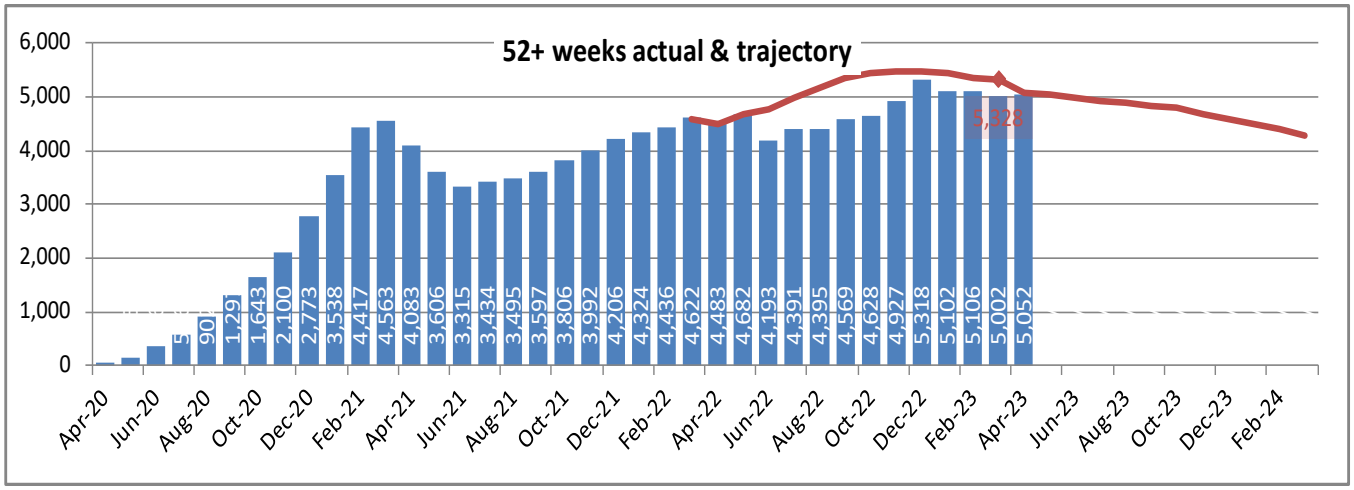

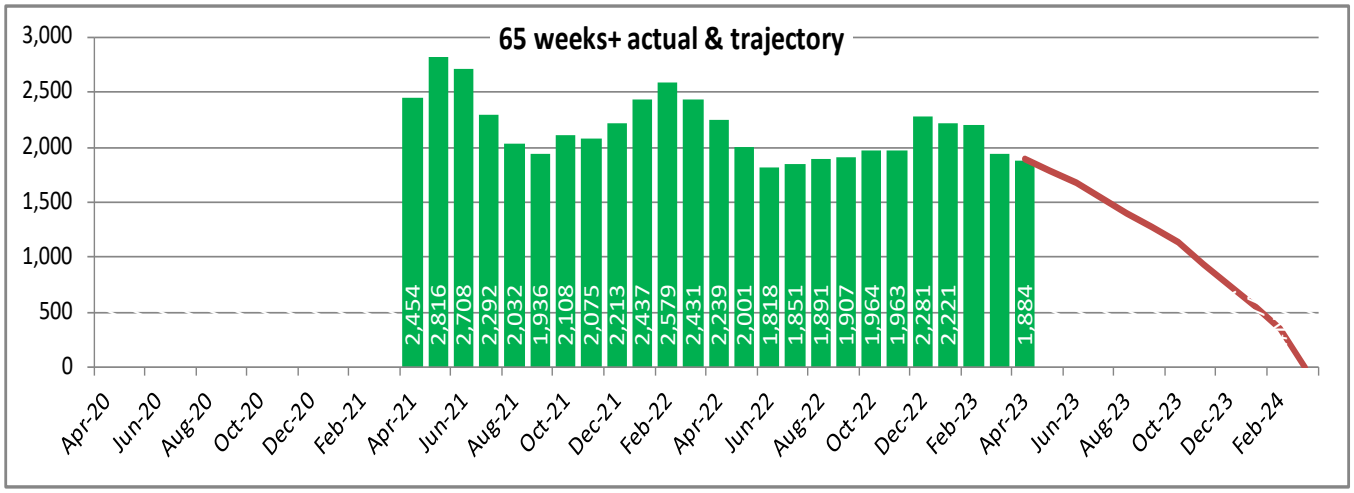

52+ week waiters have reduced marginally over recent months and continue to be within trajectory.

65+ week waiters continue to reduce and are within trajectory volumes.

Planned Care – *RTT Long Waiters*

NHS
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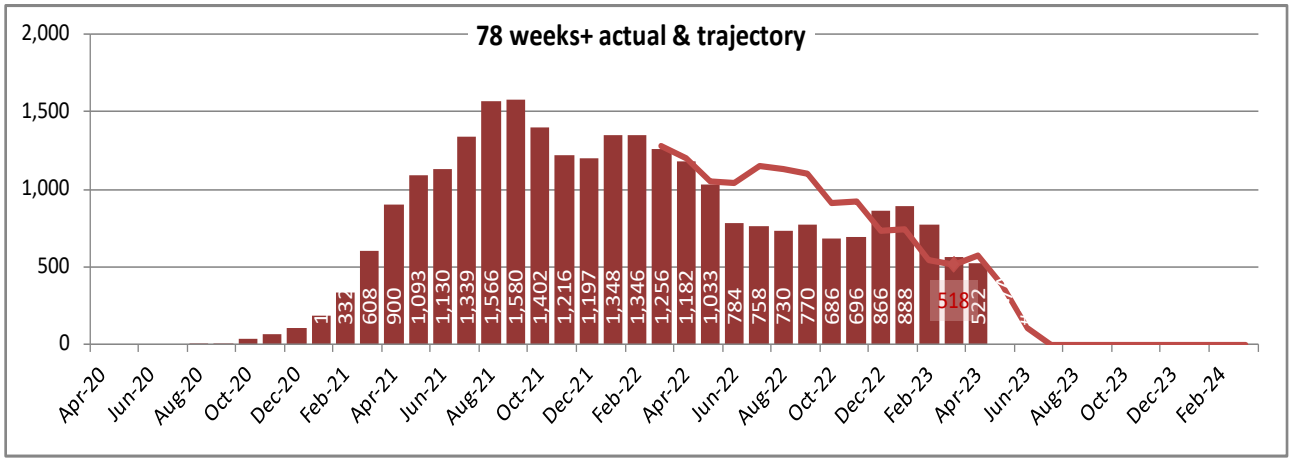
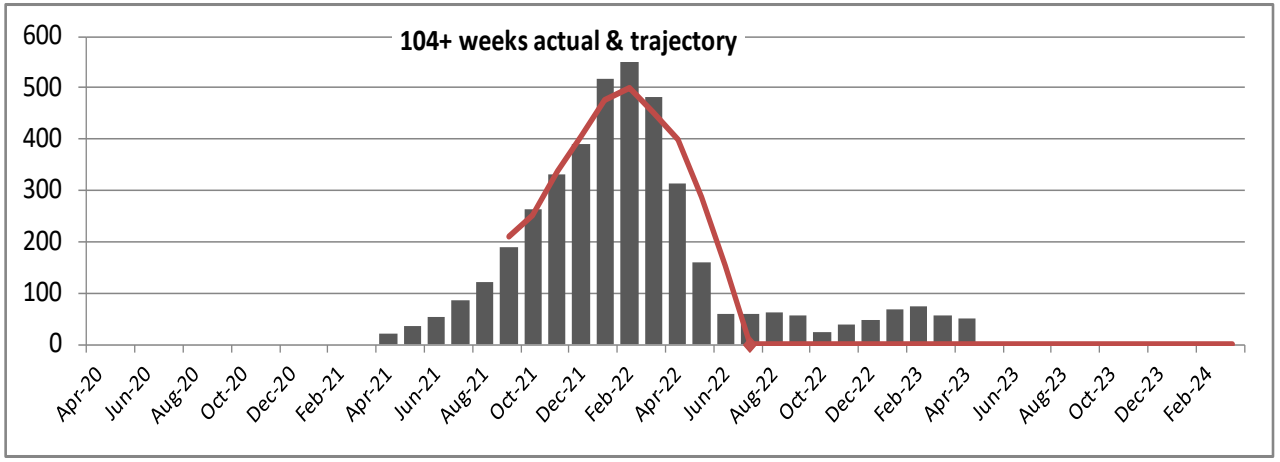
NHS Trust



Between February and March the number of patients waiting more than 78 weeks reduced considerably. From March to April there has been a marginal reduction. April data is unvalidated.



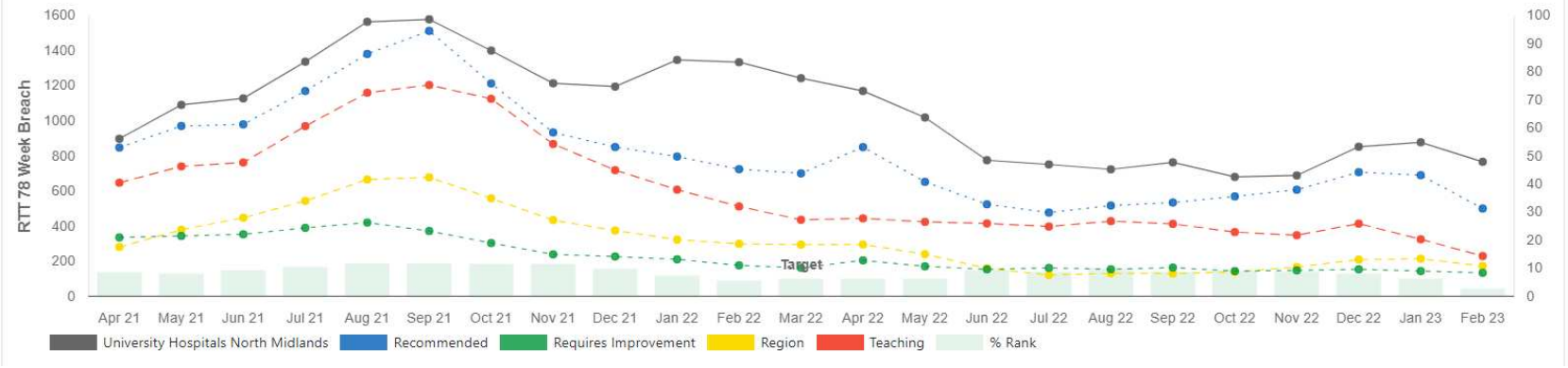
The number of patients waiting over 104 weeks increased during the winter period, with March and April seeing a reduction. This is made up of patient choice, patients presenting unwell or complex pathways. April data is unvalidated.

RTT - Benchmarked

RTT 78 Week Breach

Feb 23 Performance: 769 | Rank: 166th of 171

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



	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
949	**RTT 78 Week Breach**	**Feb 23**	**0**	**769**			**3**
950	RTT 104 Week Breach	Feb 23	0	**73**			2
56	RTT 52 Week Breach	Feb 23	0	**5,092**			9
949	RTT 78 Week Breach	Feb 23	0	**769**			3
142	RTT 95th Percentile Admitted Waiting Time	Feb 23	18.0	**80.4**			19
144	RTT 95th Percentile Non-Admitted Waiting Time	Feb 23	18.0	**58.2**			28
135	RTT Admitted Treatment Within 18 Weeks	Feb 23	90.0%	**53.4%**			36
141	RTT Average (Median) Admitted Waiting Time	Feb 23	9.0	**15.6**			38
143	RTT Average (Median) Non-Admitted Waiting Time	Feb 23	5.0	**9.4**			51
55	RTT Average Wait for Incomplete	Feb 23	7.00	**16.4**			21
133	RTT Incomplete 92nd Percentile	Feb 23	-	48.9			20
134	RTT Incomplete Pathways With a DTA	Feb 23	25.0%	15.3%			44
136	RTT Non-Admitted Treatment Within 18 Weeks	Feb 23	95.0%	**64.6%**			35
138	RTT Total Clock Starts	Feb 23	-	16,322			85
137	RTT Total Clock Stops	Feb 23	-	13,906			86
132	RTT Total Incompletes	Feb 23	-	76,374			13

- Although December saw an increase in the number of patients waiting >78 weeks, volumes have reduced in February.
- UHNM remain higher than all other peer groups and are ranked 166th out of 171.

Planned care - *RTT*

NHS
University Hospitals of North Midlands
NHS Trust

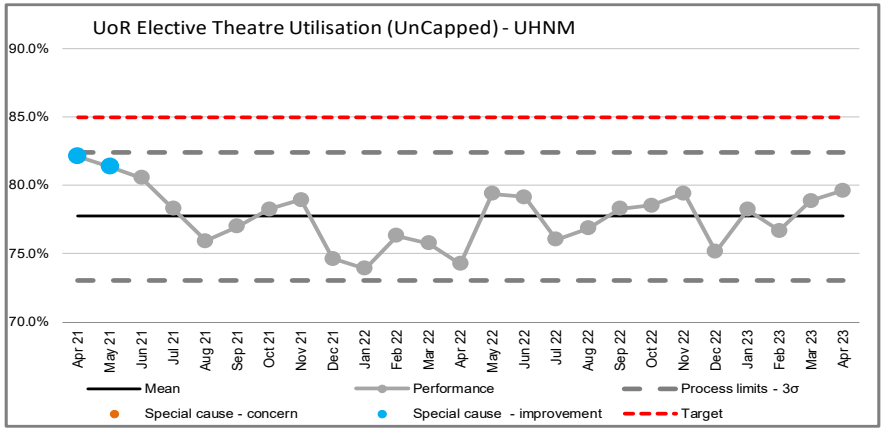
Summary

- 52+ week patients decreased April to 5,135 (un-validated)
- 78+ patients have been gradually reducing, but had reached a plateau in November at 725. This has increased in December to 863, due to winter pressures in combination with industrial action and in January rose to at 936. The number has decreased throughout since February, achieving 565 at March month end, and projected to be around 572 for April (as yet un-validated)
- The trust is did not achieve the national ask of eliminating 78 weeks waits by end of March 2023. Plans are in place to minimise the number of breaches, so that only patients who choose not to be treated before end of March or who have a highly complex case are still waiting at 78+ weeks. Current trajectories see this happening mid-June
- The overall Referral To Treatment (RTT) Waiting list now sits 78,094 end of March (un-validated).
- There is a real focus on 104w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 78week+ patients with the introduction of a weekly elective management oversight group.
- At the end of April the number of > 104 weeks was 52. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity. This has decreased by 6 on March. There is a challenge for some specific directorates in treating some of our long waiting complex patients within timeframe due to the size of the backlog.
- The IS have agreed to take T&O patients at risk of breaching 78 weeks by end of June who are clinically suitable. This is currently being worked through with the orthopaedic directorate.

RTT

- Validation has increased with extra resource. This will provide an accurate picture of the resource required in the medium term to reduce the list.
- Performance sits at 53.7%, a slight deterioration from 54.1% for February.
- 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 99.7% of all pathways over 52 weeks having ben validated within the last 12 weeks. The next national ask is to have all patients waiting longer than 12 weeks validated by 28th April 2023. The number currently not validated in the last 12 weeks is 37,545, down from 43,594 two months ago.
- Trust wide revamp of validation & training underway, focusing on tracking long waiters, exposing and addressing bottlenecks in pathways. Phase 1 to deep dive training needs analysis complete. Phase 2 underway – RTT Bitesize training now available to divisions., focused on key areas requiring improvement.
- RTT Training now available on 'Articulate' eLearning software.
- 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 as 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. This will be supported by the IST RTT training programme which takes place in Spring
- Roll-out of Palantir's Foundry platform underway, with working group to be up and running.

Planned Care – *Theatres*

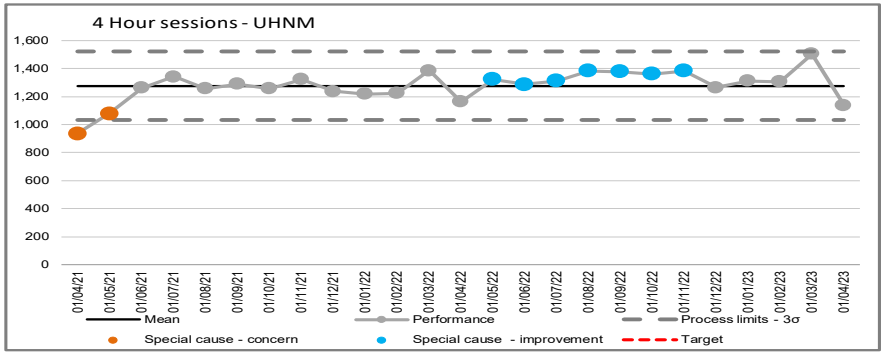


Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
85%	76.7%	78.9%	79.6%

Background

The percentage of theatre time used (capped).

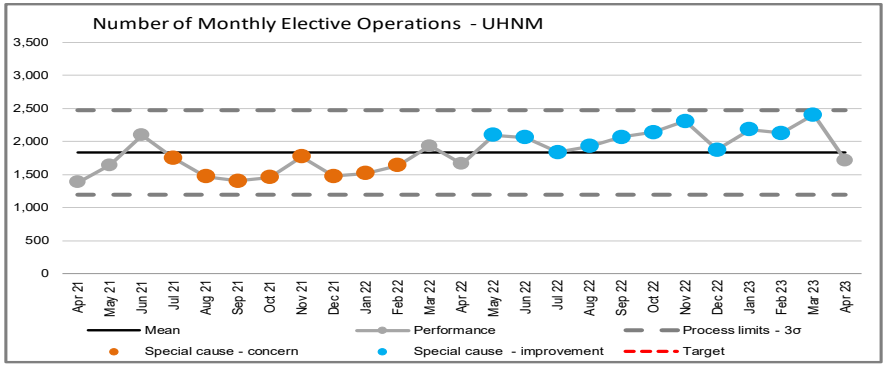


Variation	Assurance

Target	01/02/23	01/03/23	01/04/23
N/A	1307	1505	1138

Background

The number of 4 hour sessions during the month.



Variation	Assurance

Target	01/02/23	01/03/23	01/04/23
N/A	2123	2404	1709

Background

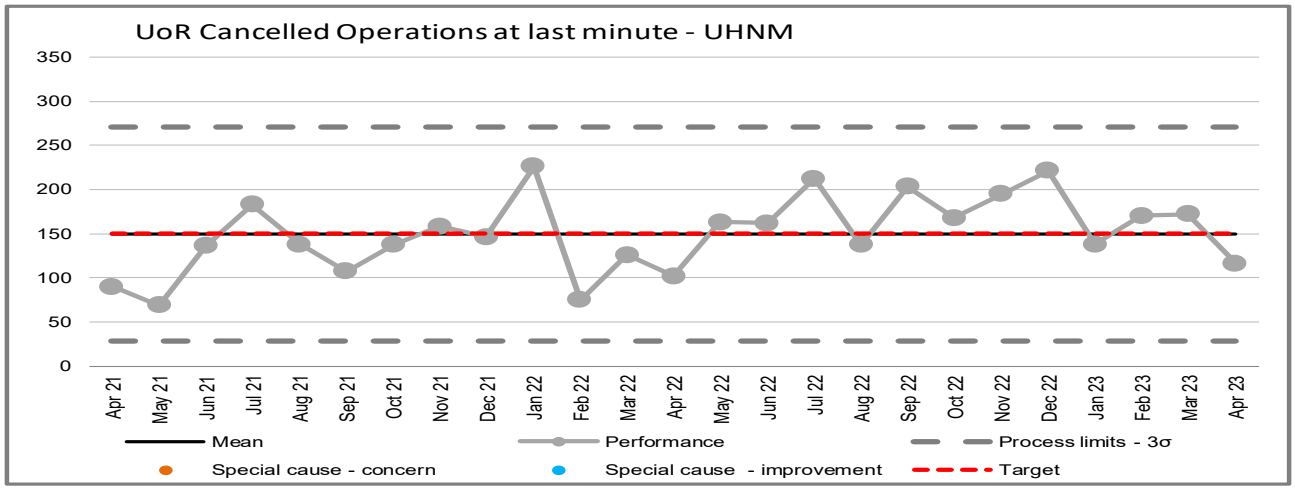
The total number of elective operations during the month.

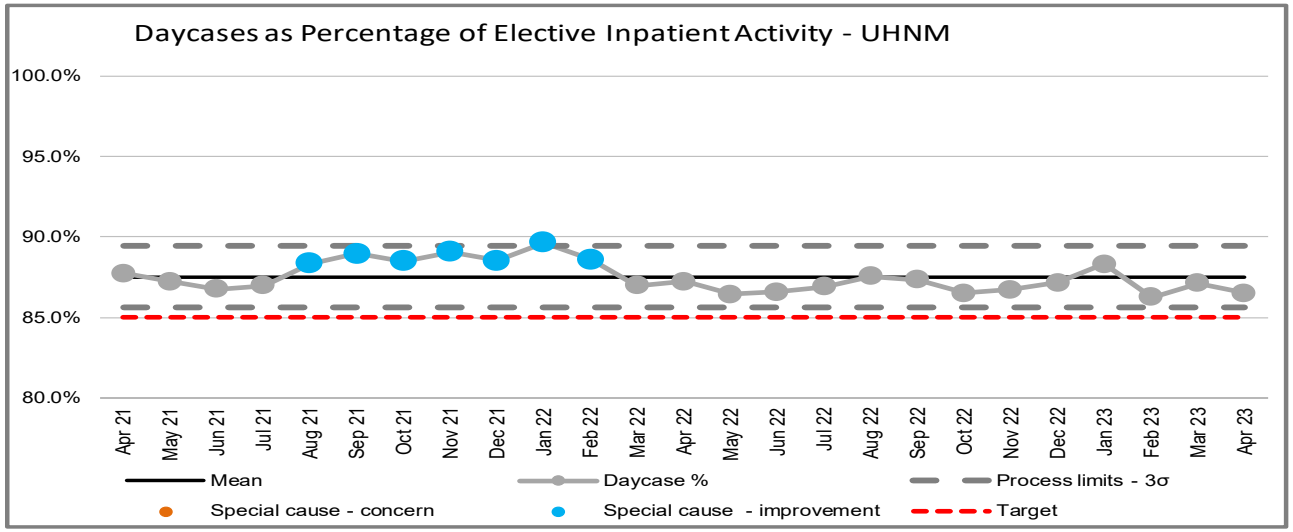
Theatre Utilisation performance has seen an improving trend since December 2022.

The number of 4 hour sessions has been relatively stable during 2022, with April seeing a drop to below the two year average.

Since December 2022, the volume of elective operations had been gradually increasing, however April saw a drop to below the two year average.

Planned Care – *Theatres*





The numbers of patients cancelled has seen a reduction since December 2022, with april at it's lowest since July 2022.

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

Theatres - Benchmarked

University Hospitals of North Midlands NHS Trust

Include independent provider data? Chart View Table View

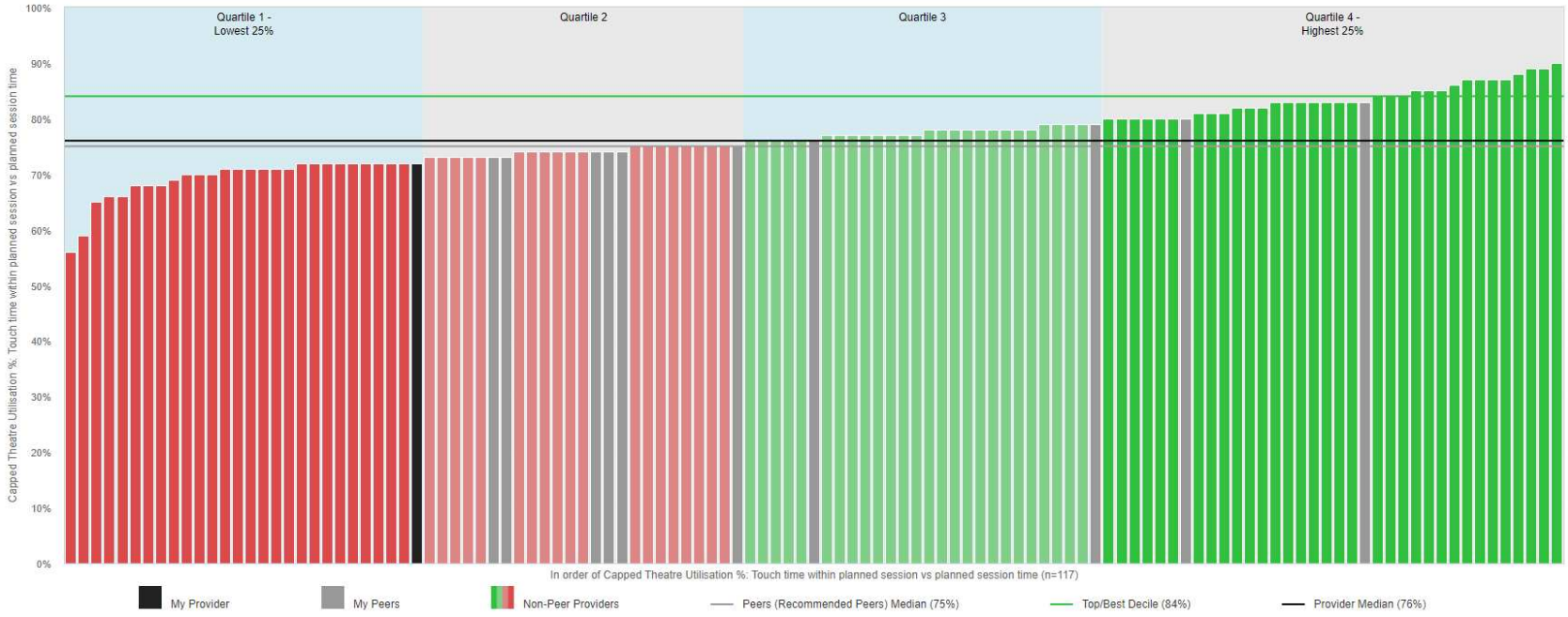
Select level: Provider | Highlight system providers

Providers in Midlands All providers (national)

Select chart type: Variation Chart

Capped Theatre Utilisation %: Touch time within planned session vs planned session time, National Distribution

Download



Planned Care - *Theatres*

University Hospitals of North Midlands NHS Trust

Elective inpatients Summary

- Day case as a % of all elective work is currently 86.5%.
- Contracts have been issued to secure additional weekend capacity through "Off Framework Agency provider of theatre staff" as well continued exploration of insourcing support
- All Performance metrics for Theatre Productivity showed improvement in April, driving increased activity of sessions that ran although total number of 4 hr sessions dropped due to Industrial Action & Bank Holiday's
- Uncapped Utilisation 80%, Capped Utilisation 73.5%, Start times 59% (within 15mins), OTD cancellations <10%.

Actions

- SHS weekend Plastics lists x 8/weekend to commence 13th May
- SHS weekend Gen Surg / Colorectal seeking to commence 27th May
- Theatre Transformation Programme being driven through Improving Together framework. A3's focused on delivery of Driver Metric include Theatre Utilisation, Theatre Start times and OTD cancellations.
- Governance of programme enhanced with TCSG (Theatre Clinical Strategy Group)reporting to Planned Care board chaired by Deputy Medical Director.
- Countermeasures informed through engagement sessions - 2 x Theatre Supported Performance weeks successfully completed. 2nd Week has identified delay discharge from PACU as significant constraint to productivity – actions developed
- Improvements from change to Default patient sending time of 08:15 have been sustained.
- Engagement session with Anaesthetists organised for 17th May to explore remaining constraints to prompt start times
- Portering service delays identified and meeting set with exec support 22nd May to review
- Workforce plan submitted following review identifying key areas adversely impacting productivity
- Weekly Forward loading meeting jointly between speciality and theatres focusing on maximising and increased bookings
- Opportunity for additional cases reviewed at weekly TPG by speciality to inform actions moving forward
- Start times for Paediatric lists changed to 09:00

Planned Care – *Outpatients*

OP First Year to date:

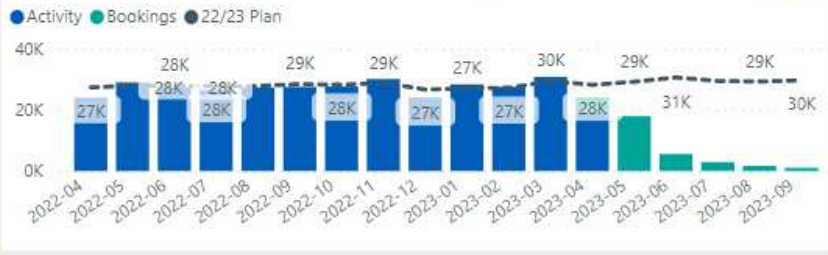
Plan	Actual(s)	% Plan Vs Actual	19/20 Actuals	Actual VS 19/20
28266	19478	68.91%	28351	68.70%

OP First Current Month:

85.70%

Plan V Potential %

Activity Vs Plan



OP Follow Up Year to date:

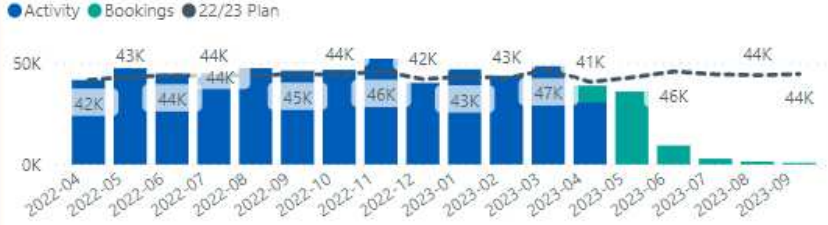
Plan	Actual(s)	% Plan Vs Actual	19/20 Actuals	Actual VS 19/20
40603	30553	75.25%	42175	72.44%

OP Follow Up Current Month:

95.60%

Plan V Potential %

Activity Vs Plan



Planned care – *Outpatients*

NHS
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NHS Trust

Actions

- **OP Cell Programme Structure** revising to reflect latest Elective Recovery Guidance (reducing follow ups). Meeting with NHSE confirmed main elements all covered from Reducing FUps focus slide. Linking with Business Planning re 23/24 plans. A3 being drafted by task & finish group with input from OP Cell.
- **Work stream 1 Outpatient Service Delivery & Performance**

  Utilisation; OP Cell Dashboard revised to support focus, booking & DNA Divisional / UHNM target & trajectories, utilisation Apr 86.1% vs 86.7% plan. Corporate action: link with 'Action on DNAs' NHSE initiative (see 2 Way Messaging below), plus Divisions have identified specialty-specific actions.

  Unoutcomed; DQ leading remedial actions, escalating to Divisions. Tail cleared, maintaining prior to previous month at circa 200 (12/05), focus.
- **Work stream 2 Outpatient Transformation**

  OP GIRFT: issued Nov/Dec, aimed at clinicians & operational teams in 15 specialties. UHNM baseline assessment complete vs customised maturity model. Met with general surgery, gynaecology & cardiology to review actions & comments. On track vs timeline for Specialty Meetings & Reviews.

  PIFU; 5% April 2023. Benchmarking vs national median - UHNM: 23rd of 143 providers (vs 2.2%). Clarifying requirements for new CDS from June 2023. Additional PIFU pathway opportunities from OP GIRFT guidance. Divisional PIFU targets 23/24 drafted in line with UHNM plan.

  Enhanced Advice & Guidance ICS Referral Optimisation Steering Group re-launched in April.

  Virtual Care >25%; SUS submission 'fix' implemented from Nov 2021 (with BI); longer term, alignment of clinic booking and media type outcomes. NHS Remote Monitoring Toolkit issued early December, baseline assessment submitted. One Consultation now live, IM&T updated at OP Cell April.

  Digital Enablers

  - **Waiting List Validation (OP/IP) –** As an alternative to proposed interim Netcall module solution, IM&T instead advising to scope bringing forward PKB functionality (via ERF monies bid) in order to support the waiting list validation approach. Risk around timelines vs waiting list pressures.
  - **2 Way Messaging; DNA reduction / Short Notice Booking** - Extension of current Netcall reminder functionality to 2 way messaging; confirm / cancel appointments, and worklist for short notice booking. 4K quote; WC&CSS have included in list of developments, plus posts to for further patient engagement to identify key reasons for missed appointments and to support short notice bookings, subject to approval.
  - **Robotic Process Automation (RPA); Outpatient Outcomes -** All OP outcomes captured by a clinician on iportal / paper forms need completing on Careflow. Circa 200K attendances annually with 'simple' outcomes eg discharge, could be completed via RPA. UHNM BI progressing.
  - **RPA; PIFU Discharge Letters (at Review Date) -** Scoping with UHNM BI (where pre-agreed by specialties), to pilot with Neuro & Urology May/June.
  - **Patient Portal**; IM&T regular monthly slot at OP Cell for updates. Director of Digital Transformation attended OP Cell in October to share Digital Vision. Patient Portal live from January, able to view appts & test results initially, digital letters planned for June plus invite comms.

Risks

- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, on Divisional Risk Registers.
- Clinical Validation requirement; risk of achieving vs resources available. PKB functionality to support waiting list validation: timeline risk.
- Lack of pace on schemes linked to System Partners, escalated at Planned Care Improvement Board.

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	10.45%	9.18%	9.18%	7.41%	7.52%	11.24%	12.99%	10.31%	13.89%	7.18%	0.65%
Weeks Waited- 78-104	13.66%	12.73%	8.26%	7.76%	8.26%	10.03%	10.96%	9.36%	11.89%	5.90%	1.18%
Weeks Waited- 52-77	14.63%	11.94%	9.25%	9.25%	7.10%	11.59%	9.79%	8.90%	12.16%	4.56%	0.82%
Weeks Waited- Under 52	13.80%	11.62%	10.44%	9.09%	7.53%	10.46%	10.21%	8.85%	11.41%	5.20%	1.39%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.45%	10.50%	9.40%	8.74%	7.95%	10.93%	11.58%	10.03%	12.28%	6.04%	1.11%
Weeks Waited- 78-104	12.43%	11.02%	9.83%	9.12%	7.68%	10.73%	10.68%	8.65%	12.01%	6.68%	1.18%
Weeks Waited- 52-77	12.82%	10.72%	9.91%	8.90%	7.58%	10.79%	10.70%	9.25%	11.68%	6.37%	1.28%
Weeks Waited- Under 52	13.28%	11.32%	10.07%	8.94%	7.54%	10.64%	10.50%	9.10%	11.37%	5.99%	1.25%

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 & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.17%	0.39%	0.08%	0.39%	0.31%	0.62%	0.06%	0.11%	0.20%	0.39%	0.51%	0.23%	0.06%	#N/A	93.32%	0.37%	0.73%	1.75%	0.31%
Weeks Waited- 78-104	0.17%	0.51%	0.17%	0.42%	0.51%	1.26%	0.08%	#N/A	0.25%	0.34%	0.76%	0.34%	0.08%	#N/A	89.80%	0.34%	2.53%	1.60%	0.84%
Weeks Waited- 52-77	0.44%	0.57%	0.41%	0.60%	0.67%	1.17%	0.10%	0.10%	0.25%	0.60%	2.03%	0.19%	0.22%	0.29%	87.27%	0.25%	1.74%	1.65%	#N/A
Weeks Waited- Under 52	0.43%	0.69%	0.29%	0.71%	0.63%	1.22%	0.17%	0.16%	0.15%	0.54%	1.47%	0.30%	0.16%	0.19%	84.23%	0.27%	2.87%	2.49%	3.03%

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	0.30%	0.50%	0.21%	0.48%	0.46%	0.85%	0.11%	0.19%	0.09%	0.41%	1.63%	0.27%	0.16%	0.12%	88.03%	0.33%	2.44%	2.10%	1.31%
Weeks Waited- 78-104	0.35%	0.53%	0.24%	0.62%	0.50%	0.98%	0.19%	0.14%	0.15%	0.61%	1.61%	0.37%	0.12%	0.19%	86.82%	0.20%	2.33%	2.13%	1.95%
Weeks Waited- 52-77	0.42%	0.69%	0.19%	0.63%	0.61%	1.10%	0.11%	0.12%	0.20%	0.63%	1.57%	0.27%	0.20%	0.21%	84.26%	0.29%	3.06%	2.56%	2.89%
Weeks Waited- Under 52	0.47%	0.67%	0.20%	0.64%	0.59%	1.30%	0.15%	0.17%	0.14%	0.61%	1.81%	0.33%	0.17%	0.24%	82.61%	0.30%	3.25%	2.77%	#N/A

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%	77.46%	H		
	Ambulance handovers greater than 60 minutes	1	1	H	F	
	Time to Initial Assessment - percentage within 15 minutes	85%	72.64%	H	F	
	Average (mean) time in Department - non-admitted patients	180	253		F	
	Average (mean) time in Department - admitted patients	180	339		F	
	Clinically Ready to Proceed	90	376	H	F	
	12 Hour Trolley Waits	0	286		F	
	Patients spending more than 12 hours in A&E	0	1437		F	
	Median Wait to be seen - Type 1	60	82		F	
	Bed Occupancy	92%	86.33%			
Cancer Care	Cancer 28 day faster pathway	75%	64.90%		F	
	Cancer 62 GP ref	85%	54.80%	L	F	
	Cancer 62 day Screening	90%	80.95%		?	
	31 day First Treatment	96%	90.16%	L	?	
	2WW First Seen (exc Breast Symptom)	93%	93.60%	H	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	6.9%	L	?	
	Cancelled Ops	150	116		?	
	Theatre Utilisation	85%	79.6%			
Inpatient / Discharge	Same Day Emergency Care	30%	35%	H	?	
	Super Stranded	183	186		?	
	MFFD	100	87		?	
	Discharges before Midday	25%	20.2%		F	
	Emergency Readmission rate	8%	6.1%	L	F	
Elective waits	RTT incomplete performance	92%	53.00%	L	F	
	RTT 52+ week waits	0	5052	H	F	
	Diagnostics	99%	69.00%		F	

Delivering Exceptional Care with Exceptional People

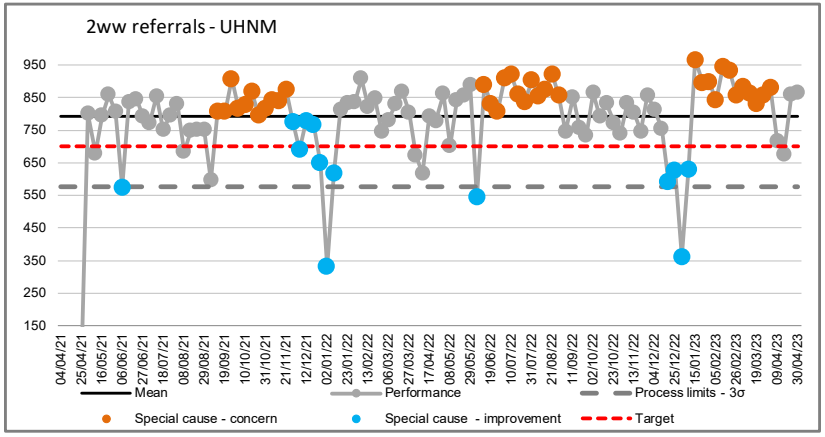
Cancer – 62 Day

NHS University Hospitals of North Midlands NHS Trust

Target	Feb 23	Mar 23	Apr 23
700	677	859	864

Background

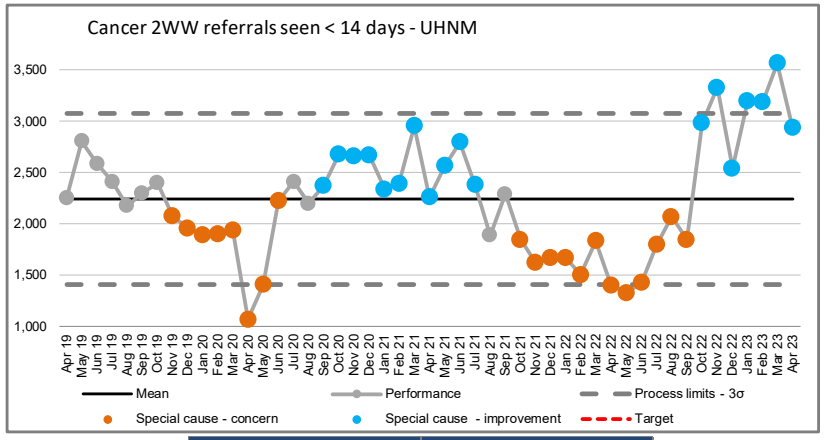
The number of patients referred on a cancer 2ww pathway.



Target	Feb 23	Mar 23	Apr 23
N/A	3192.0	3567.0	2941.0

Background

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



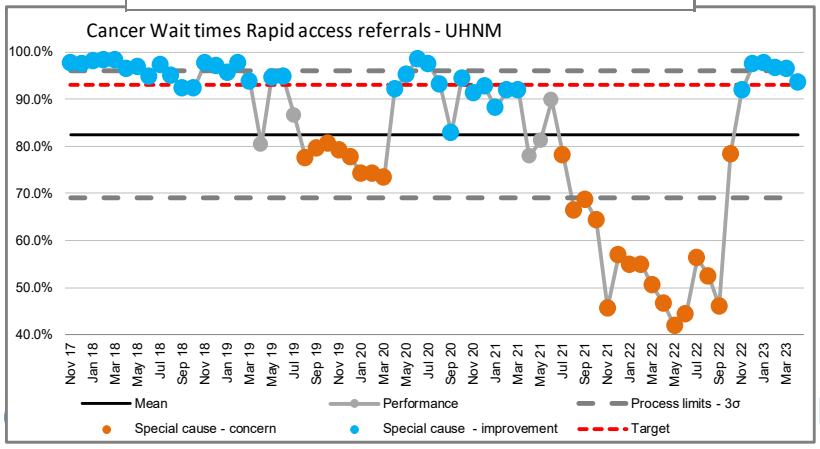
Target	Feb 23	Mar 23	Apr 23
93%	96.7%	96.4%	93.6%

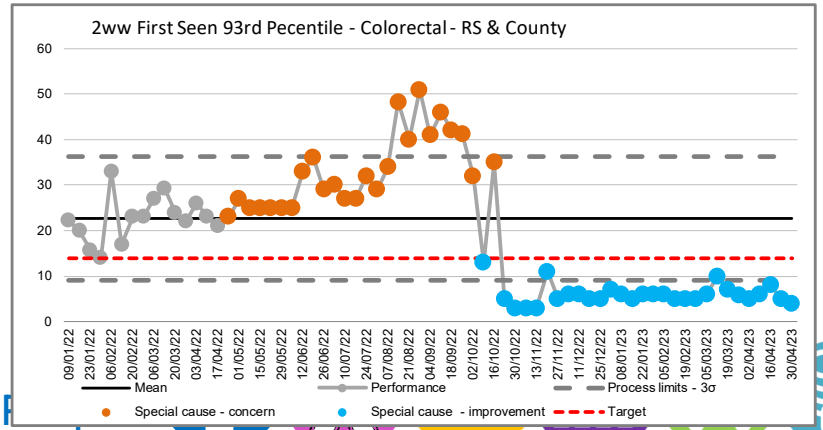
Background

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

Variation	Assurance
	

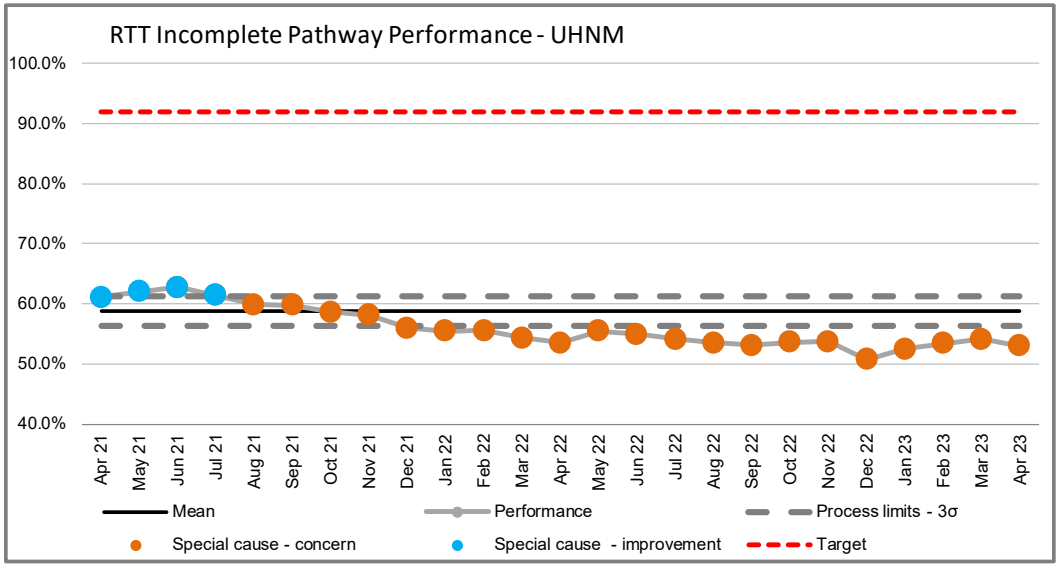
Target	Apr 23	Apr 23	Apr 23
14	8	5	4





Referral To Treatment

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

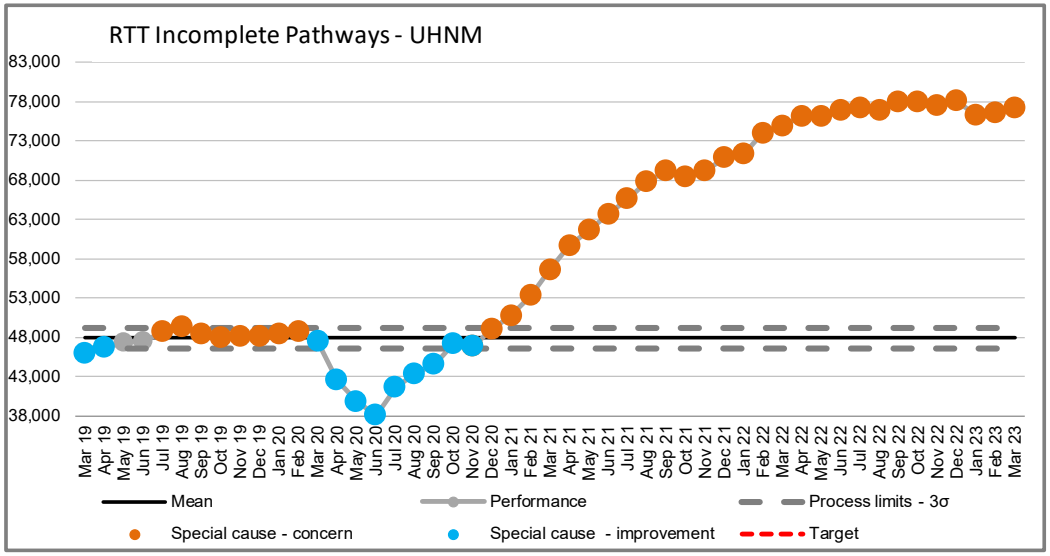
Target	Feb 23	Mar 23	Apr 23
92%	53.4%	54.1%	53.0%

Background

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

What is the data telling us?

RTT performance has stabilised at c. 53% during 2023.



Variation	Assurance
H	

Target	Feb 23	Mar 23	Apr 23
N/A	76502	76961	78219

Background

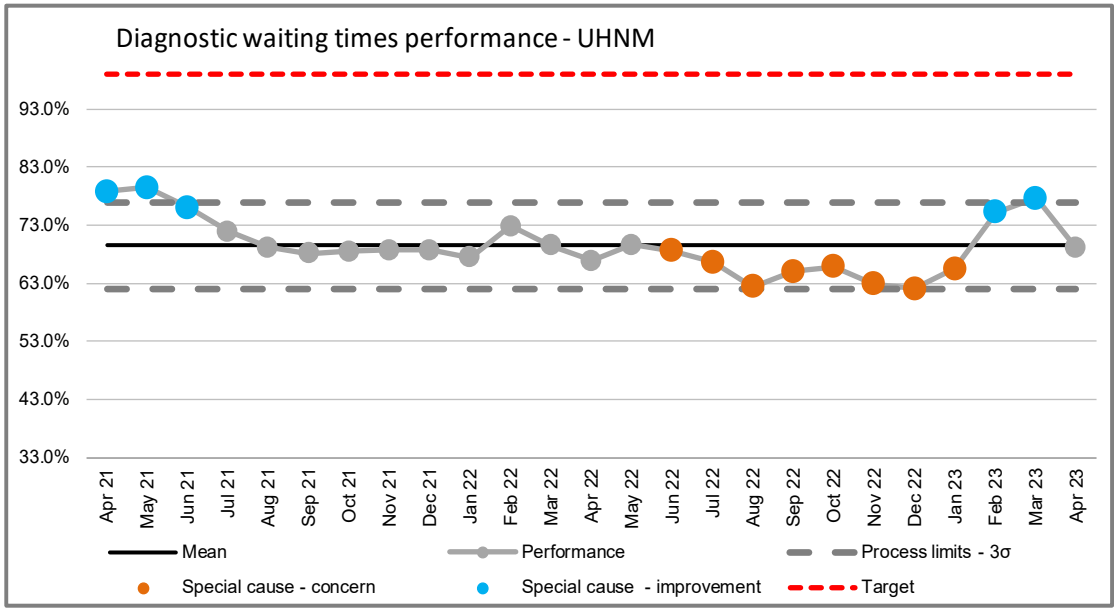
The number of patients waiting over 18 weeks for treatment since their referral.

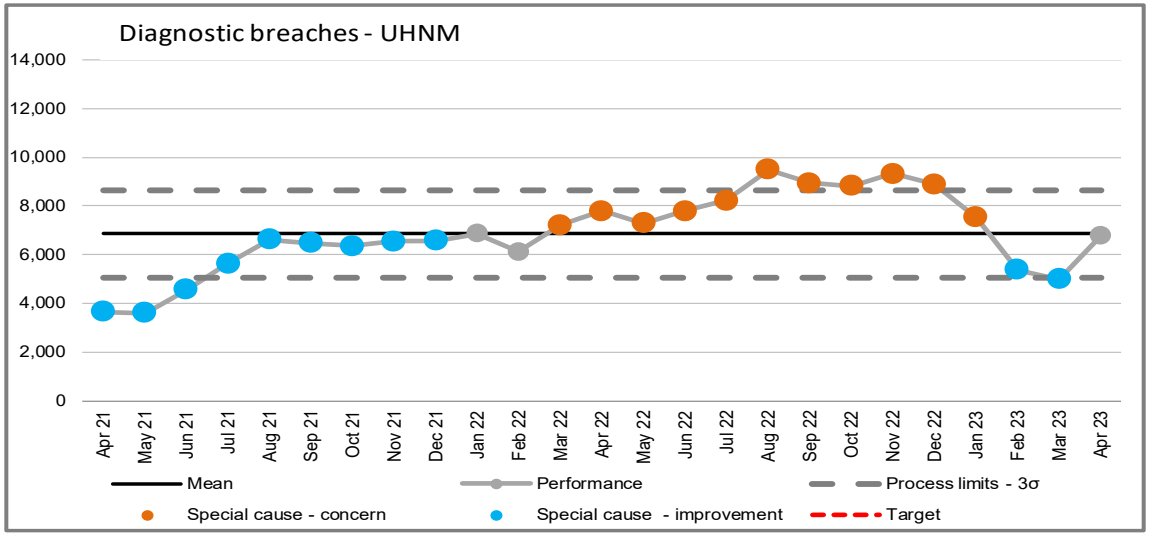
What is the data telling us?

The number of RTT Open pathways continues to increase.

Diagnostic Standards

NHS
University Hospitals of North Midlands
NHS Trust





Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
99%	75.2%	77.6%	69.0%

Background

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

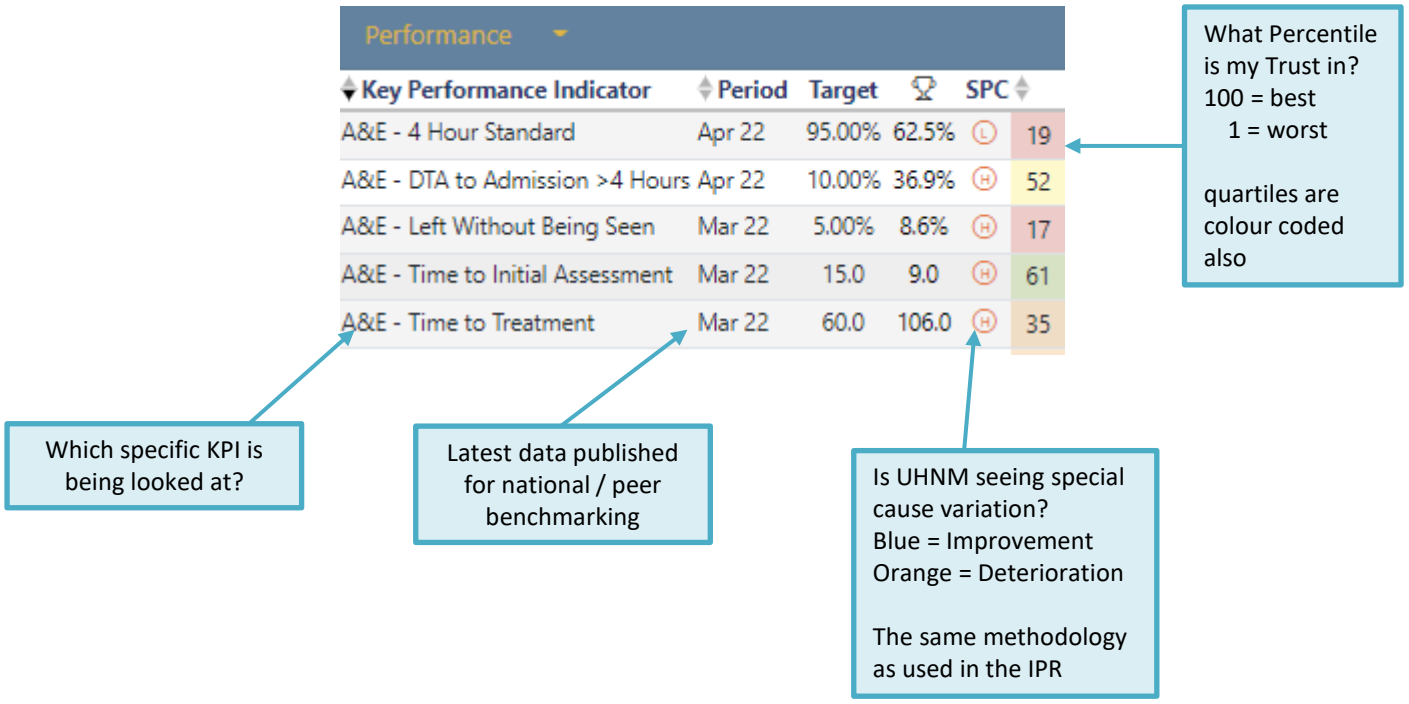
What is the data telling us?

Waiting times performance saw a sharp improvement during early 2023, in April this deteriorated to the two year average of 69%.
The volume of breaches increased in April, predominantly due to Endoscopy modalities.

UHNM Benchmarked Performance

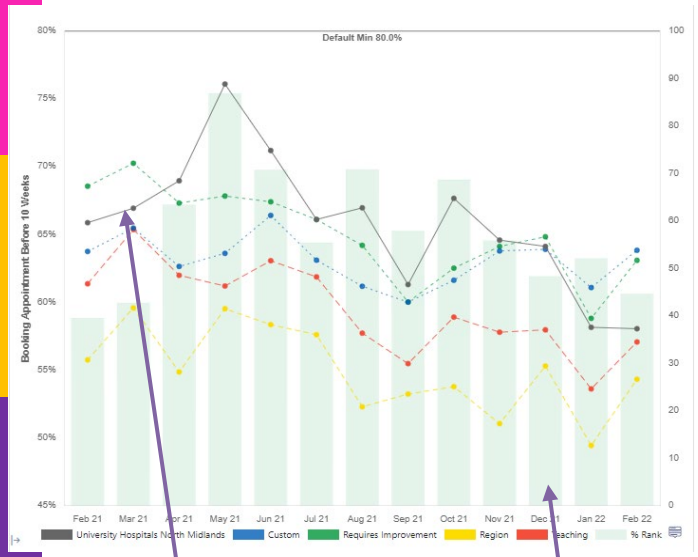
Contents

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

Non-Elective Care - 4 hour standard

University Hospitals of North Midlands NHS Trust

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	**Mar 23**	**76.00%**	**67.3%**			**40**
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Mar 23	76.00%	**67.3%**			40
A&E - 4 Hour Standard (Type 1)	Mar 23	76.0%	**48.2%**			18
A&E - 4 Hour Standard (Type 2 or 3)	Mar 23	95.0%	98.1%			56
A&E - Conversion Rate	Mar 23	25.0%	24.5%			25
A&E - DTA to Admission >12 Hours	Mar 23	0.0%	**16.4%**			27
A&E - DTA to Admission >12 Hours#	Mar 23	0.0	**906.0**			6
A&E - DTA to Admission >4 Hours	Mar 23	10.00%	**33.2%**			61
A&E - Left Without Being Seen	Feb 23	5.00%	**5.1%**			43
A&E - Reattendance Rate	Feb 23	5.0%	**9.1%**			23
A&E - Time to Initial Assessment	Feb 23	15.0	8.0			58
A&E - Time to Treatment	Feb 23	60.0	**73.0**			51
A&E - Total Time in A&E	Feb 23	160.0	**174.0**			63
A&E - Total Time in A&E (Admitted)	Feb 23	180.0	**361.0**			55
A&E - Total Time in A&E (Non-Admitted)	Feb 23	140.0	**149.0**			68

- UHNM 4 hour performance is below the three peer groups selected and ranked in the third quartile.
- Although UHNM is below peers, since September 2022, UHNM are following the same trend.
- Since December 2022 UHNM have seen improvement in the 4 hour performance.

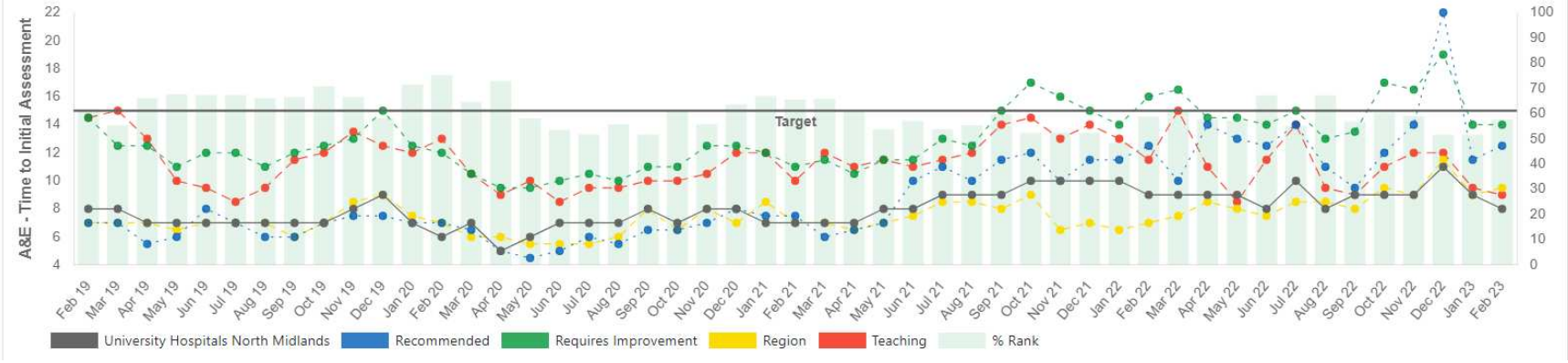
Non-Elective Care – Initial Assessment

NHS University Hospitals of North Midlands NHS Trust

A&E - Time to Initial Assessment

Feb 23 Performance: 8.0 | Rank: 53rd of 124

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



	A&E - Time to Initial Assessment	Feb 23	15.0	8.0		58
	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
14	A&E - 4 Hour Standard	Mar 23	76.00%	67.3%		40
60	A&E - 4 Hour Standard (Type 1)	Mar 23	76.0%	48.2%		18
61	A&E - 4 Hour Standard (Type 2 or 3)	Mar 23	95.0%	98.1%		56
62	A&E - Conversion Rate	Mar 23	25.0%	24.5%		25
63	A&E - DTA to Admission >12 Hours	Mar 23	0.0%	16.4%		27
64	A&E - DTA to Admission >12 Hours#	Mar 23	0.0	906.0		6
34	A&E - DTA to Admission >4 Hours	Mar 23	10.00%	33.2%		61
33	A&E - Left Without Being Seen	Feb 23	5.00%	5.1%		43
65	A&E - Reattendance Rate	Feb 23	5.0%	9.1%		23
52	A&E - Time to Initial Assessment	Feb 23	15.0	8.0		58
53	A&E - Time to Treatment	Feb 23	60.0	73.0		51
54	A&E - Total Time in A&E	Feb 23	160.0	174.0		63
66	A&E - Total Time in A&E (Admitted)	Feb 23	180.0	361.0		55
67	A&E - Total Time in A&E (Non-Admitted)	Feb 23	140.0	149.0		68

- Since October UHNM have performed better than all other peer groups.
- UHNM currently rank in the second quartile.

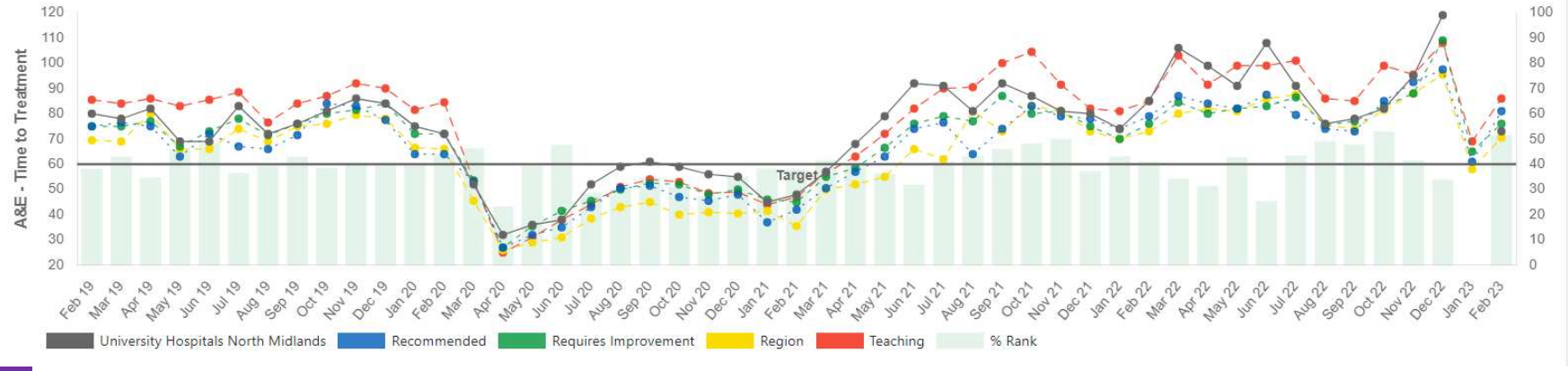
Non-Elective Care – Time to Treatment

NHS
University Hospitals of North Midlands
NHS Trust

A&E - Time to Treatment

Feb 23 Performance: 73.0 | Rank: 67th of 137

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



	A&E - Time to Treatment	Feb 23	60.0	73.0			51
	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
14	A&E - 4 Hour Standard	Mar 23	76.00%	67.3%			40
60	A&E - 4 Hour Standard (Type 1)	Mar 23	76.0%	48.2%			18
61	A&E - 4 Hour Standard (Type 2 or 3)	Mar 23	95.0%	98.1%			56
62	A&E - Conversion Rate	Mar 23	25.0%	24.5%			25
63	A&E - DTA to Admission >12 Hours	Mar 23	0.0%	16.4%			27
64	A&E - DTA to Admission >12 Hours#	Mar 23	0.0	906.0			6
34	A&E - DTA to Admission >4 Hours	Mar 23	10.00%	33.2%			61
33	A&E - Left Without Being Seen	Feb 23	5.00%	5.1%			43
65	A&E - Reattendance Rate	Feb 23	5.0%	9.1%			23
52	A&E - Time to Initial Assessment	Feb 23	15.0	8.0			58
53	A&E - Time to Treatment	Feb 23	60.0	73.0			51
54	A&E - Total Time in A&E	Feb 23	160.0	174.0			63
66	A&E - Total Time in A&E (Admitted)	Feb 23	180.0	361.0			55
67	A&E - Total Time in A&E (Non-Admitted)	Feb 23	140.0	149.0			68

- UHNM are aligned to all peer groups.
- UHNM have moved into the second quartile in recent months.
- Ranked 67th compared to 81st in November 2022.

Delivering Exceptional Care with Exceptional People

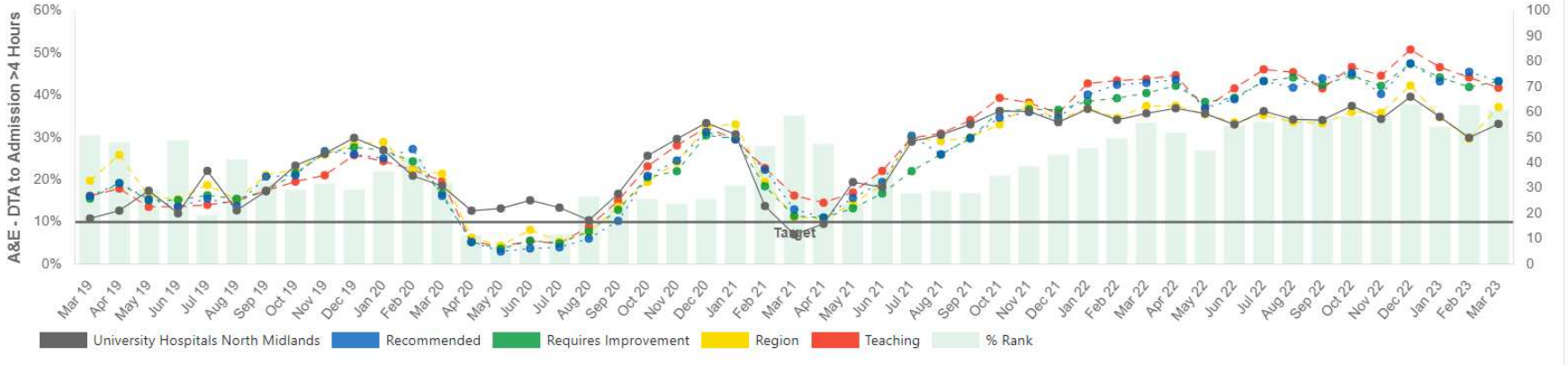
Non-Elective Care – DTA waits over 4 hours

NHS University Hospitals of North Midlands NHS Trust

A&E - DTA to Admission >4 Hours

Mar 23 Performance: 33.21% | Rank: 52nd of 132

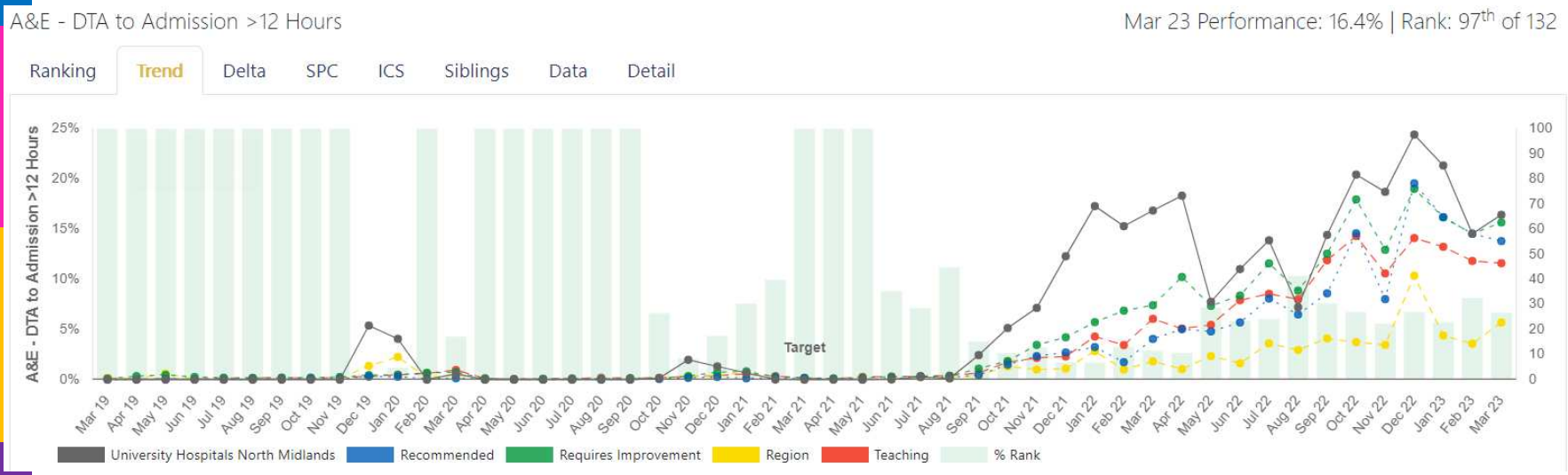
Ranking | Trend | Delta | SPC | ICS | Siblings | Data | Detail



	A&E - DTA to Admission >4 Hours	Mar 23	10.00%	33.2%			61
	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
14	A&E - 4 Hour Standard	Mar 23	76.00%	67.3%			40
49	A&E - 4 Hour Standard (Type 1)	Mar 23	76.0%	48.2%			18
61	A&E - 4 Hour Standard (Type 2 or 3)	Mar 23	95.0%	98.1%			56
62	A&E - Conversion Rate	Mar 23	25.0%	24.5%			25
63	A&E - DTA to Admission >12 Hours	Mar 23	0.0%	16.4%			27
64	A&E - DTA to Admission >12 Hours#	Mar 23	0.0	906.0			6
34	A&E - DTA to Admission >4 Hours	Mar 23	10.00%	33.2%			61
33	A&E - Left Without Being Seen	Feb 23	5.00%	5.1%			43
65	A&E - Reattendance Rate	Feb 23	5.0%	9.1%			23
52	A&E - Time to Initial Assessment	Feb 23	15.0	8.0			58
53	A&E - Time to Treatment	Feb 23	60.0	73.0			51
54	A&E - Total Time in A&E	Feb 23	160.0	174.0			63
66	A&E - Total Time in A&E (Admitted)	Feb 23	180.0	361.0			55
67	A&E - Total Time in A&E (Non-Admitted)	Feb 23	140.0	149.0			68

- The percentage of patients waiting over 4 hours from the point of decision to admit remains in line with the Region peer and below all other peer groups.
- Whilst Peers continue to see a higher number of patients waiting over 4 hours for a bed, UHNM and the Region have remained static since November 2021 around 33%.

Non-Elective Care – DTA waits over 12 hours

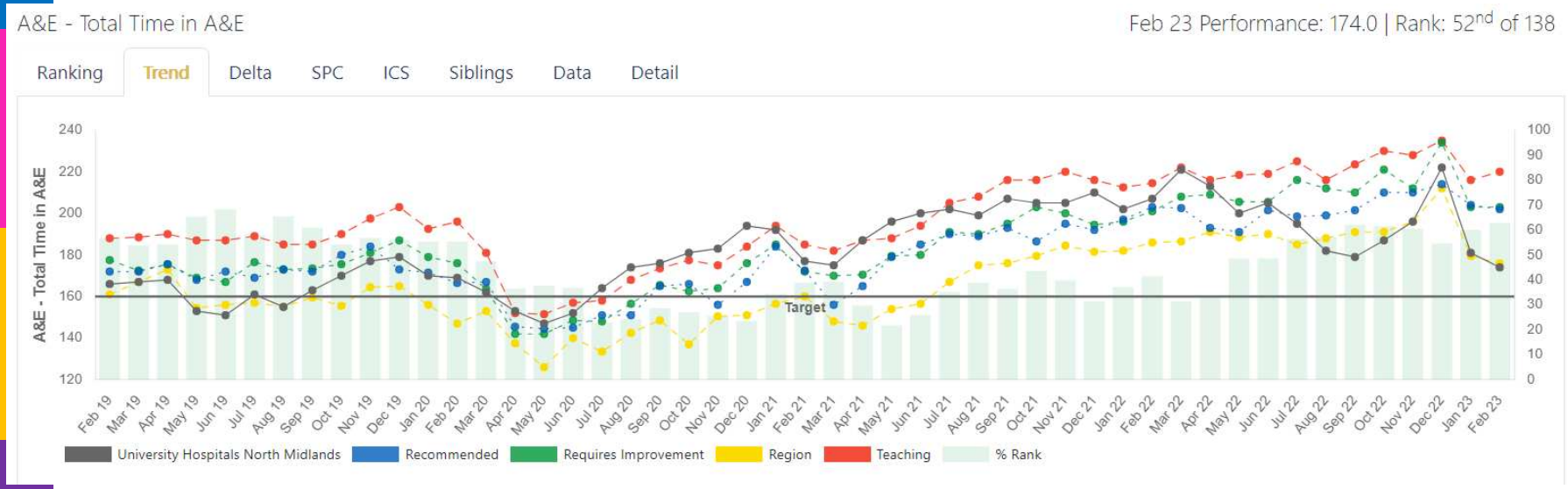


	A&E - DTA to Admission >12 Hours	Mar 23	0.0%	16.4%		27
	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
14	A&E - 4 Hour Standard	Mar 23	76.00%	67.3%		40
60	A&E - 4 Hour Standard (Type 1)	Mar 23	76.0%	48.2%		18
61	A&E - 4 Hour Standard (Type 2 or 3)	Mar 23	95.0%	98.1%		56
62	A&E - Conversion Rate	Mar 23	25.0%	24.5%		25
63	A&E - DTA to Admission >12 Hours	Mar 23	0.0%	16.4%		27
64	A&E - DTA to Admission >12 Hours#	Mar 23	0.0	906.0		6
34	A&E - DTA to Admission >4 Hours	Mar 23	10.00%	33.2%		61
33	A&E - Left Without Being Seen	Feb 23	5.00%	5.1%		43
65	A&E - Reattendance Rate	Feb 23	5.0%	9.1%		23
52	A&E - Time to Initial Assessment	Feb 23	15.0	8.0		58
53	A&E - Time to Treatment	Feb 23	60.0	73.0		51
54	A&E - Total Time in A&E	Feb 23	160.0	174.0		63
66	A&E - Total Time in A&E (Admitted)	Feb 23	180.0	361.0		55
67	A&E - Total Time in A&E (Non-Admitted)	Feb 23	140.0	149.0		68

- Following the peak in the percentage of patients waiting over 12 hours from the point of DTA early 2022, performance during the middle of the year dropped to the same levels as peer groups.
- Over the last two months this has increased again and UHNM remains higher than all peers.
- UHNM remain in the bottom quartile.

Non-Elective Care – Total Time in ED

NHS University Hospitals of North Midlands NHS Trust



	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
54	**A&E - Total Time in A&E**	**Feb 23**	**160.0**	**174.0**			**63**
14	A&E - 4 Hour Standard	Mar 23	76.00%	**67.3%**			40
60	A&E - 4 Hour Standard (Type 1)	Mar 23	76.0%	**48.2%**			18
61	A&E - 4 Hour Standard (Type 2 or 3)	Mar 23	95.0%	98.1%			56
62	A&E - Conversion Rate	Mar 23	25.0%	24.5%			25
63	A&E - DTA to Admission >12 Hours	Mar 23	0.0%	**16.4%**			27
64	A&E - DTA to Admission >12 Hours#	Mar 23	0.0	**906.0**			6
34	A&E - DTA to Admission >4 Hours	Mar 23	10.00%	**33.2%**			61
33	A&E - Left Without Being Seen	Feb 23	5.00%	**5.1%**			43
65	A&E - Reattendance Rate	Feb 23	5.0%	**9.1%**			23
52	A&E - Time to Initial Assessment	Feb 23	15.0	8.0			58
53	A&E - Time to Treatment	Feb 23	60.0	**73.0**			51
54	A&E - Total Time in A&E	Feb 23	160.0	**174.0**			63
66	A&E - Total Time in A&E (Admitted)	Feb 23	180.0	**361.0**			55
67	A&E - Total Time in A&E (Non-Admitted)	Feb 23	140.0	**149.0**			68

- During 2022 UHNM have improved to below peer levels which was seen pre pandemic.
- UHNM saw a greater spike in December 2022 compared to peers.
- UHNM continue to remain in the second quartile.

Non-Elective Care - Conclusion

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	**Mar 23**	**76.00%**	**67.3%**			**40**

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Mar 23	76.00%	**67.3%**			40
A&E - 4 Hour Standard (Type 1)	Mar 23	76.0%	**48.2%**			18
A&E - 4 Hour Standard (Type 2 or 3)	Mar 23	95.0%	98.1%			56
A&E - Conversion Rate	Mar 23	25.0%	24.5%			25
A&E - DTA to Admission >12 Hours	Mar 23	0.0%	**16.4%**			27
A&E - DTA to Admission >12 Hours#	Mar 23	0.0	**906.0**			6
A&E - DTA to Admission >4 Hours	Mar 23	10.00%	**33.2%**			61
A&E - Left Without Being Seen	Feb 23	5.00%	**5.1%**			43
A&E - Reattendance Rate	Feb 23	5.0%	**9.1%**			23
A&E - Time to Initial Assessment	Feb 23	15.0	8.0			58
A&E - Time to Treatment	Feb 23	60.0	**73.0**			51
A&E - Total Time in A&E	Feb 23	160.0	**174.0**			63
A&E - Total Time in A&E (Admitted)	Feb 23	180.0	**361.0**			55
A&E - Total Time in A&E (Non-Admitted)	Feb 23	140.0	**149.0**			68

Since the last benchmarking pack UHNM have improved in most ED pathway metrics, whilst there are some that require further improvement.
Metrics with the greatest improvement:

- 4 hour standard – ranking improved from 33 to 40 in November 2022. Since December 2022 UHNM have seen the greatest improvement compared to peers.
- Time to initial assessment – ranking has improved from 63 in October 2022 to 58 in February 2023. UHNM have consistently been better than most peers.
- Total time in A&E – ranking has improved marginally from 62 in October to 63 in February. UHNM remain better than all peers. Improvements seen for both admitted and non admitted patients.

Area that requires the greatest improvement:

- 4 hour performance (Type 1) – although UHNM have improved performance from 43% in November to 48% in March, UHNM are ranked in the bottom quartile, at 18th. All other peers are better than UHNM.

Additional suggested focus areas:

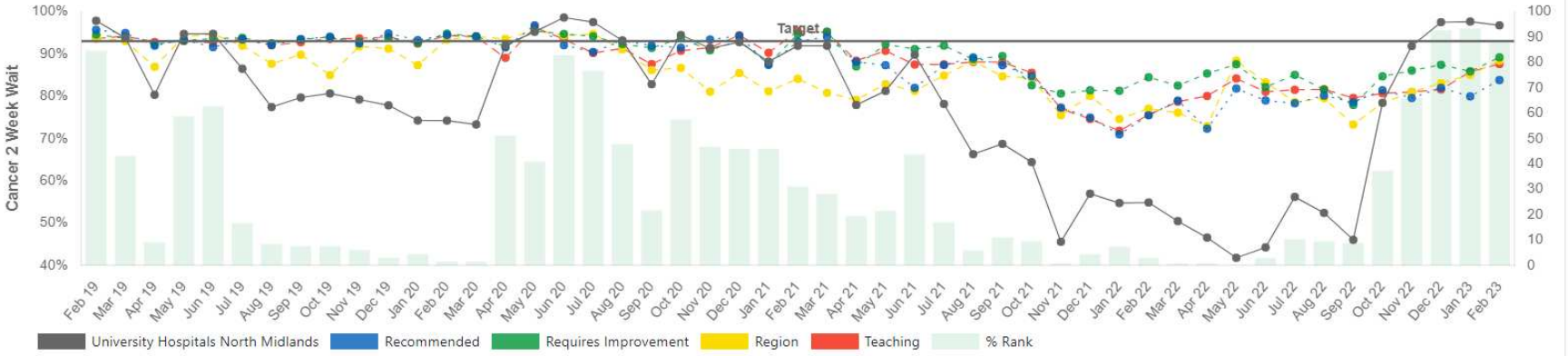
- A&E Re-attendance Rate – Since June 2022, UHNM have had a higher re-attendance rate than all peers. Although this has reduced in recent months, UHNM remain in the bottom quartile.

Elective Care - Cancer

Cancer 2 Week Wait

Feb 23 Performance: 96.73% | Rank: 17th of 135

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



	Cancer 2 Week Wait	Feb 23	93.00%	96.7%			88
	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
45	Cancer 2 Week Wait	Feb 23	93.00%	96.7%			88
90	Cancer 2 Week Wait Breast Symptomatic	Feb 23	93.0%	96.3%			71
46	Cancer 31 Day First Treatment	Feb 23	96.00%	**90.5%**			27
128	Cancer 31 Day Subsequent Treatment	Feb 23	96.0%	**86.9%**			21
51	Cancer 62 Day All Sources	Feb 23	85.00%	**58.2%**			33
100	Cancer 62 Day Consultant Upgrade	Feb 23	85.0%	**69.6%**			34
35	Cancer 62 Day Screening	Feb 23	90.0%	**33.3%**			12
118	Cancer Sub Treat Drugs	Feb 23	96.0%	**91.4%**			4
119	Cancer Sub Treat Radiotherapy	Feb 23	96.0%	97.5%			65

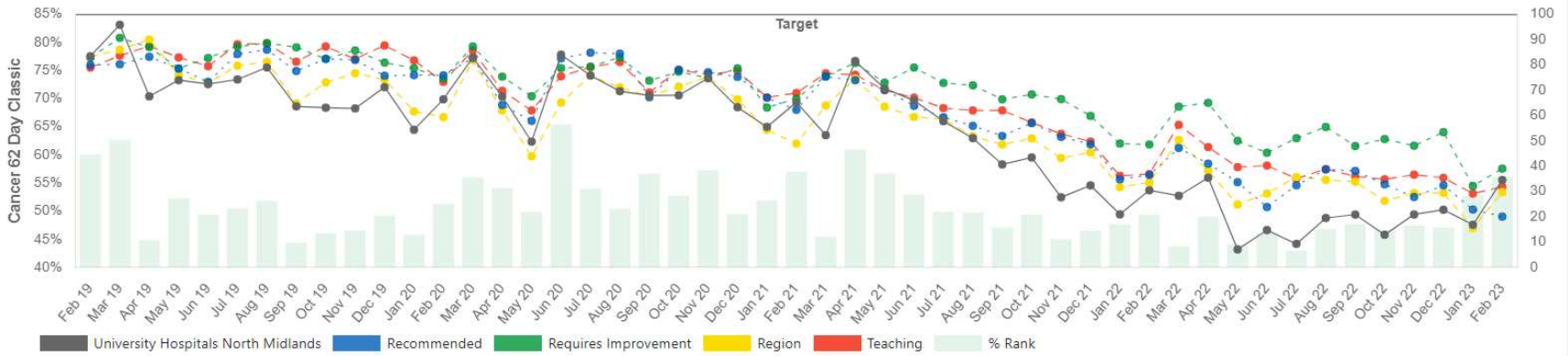
- UHNM have seen a significant improvement since September 2022 in it's 14 day performance from 46% to 97%.
- This improvement is not seen across all other peer groups.
- UHNM are ranked in the top quartile.

Elective Care - Cancer

Cancer 62 Day Classic

Feb 23 Performance: 55.52% | Rank: 87th of 135

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



	Cancer 62 Day Classic	Feb 23	85.00%	55.5%		36
	Key Performance Indicator	Period	Target		SPC Last 12 Months	Centile
161	Breast Cancer	Feb 23	85.00%	61.5%		21
15	Cancer 62 Day Classic	Feb 23	85.00%	55.5%		36
162	Lower Gastrointestinal Cancer	Feb 23	85.00%	23.8%		23
163	Lung Cancer	Feb 23	85.00%	32.0%		25
164	Other Cancer	Feb 23	85.00%	54.5%		56
165	Skin Cancer	Feb 23	85.00%	83.3%		37
166	Urological Cancer	Feb 23	85.00%	55.8%		58

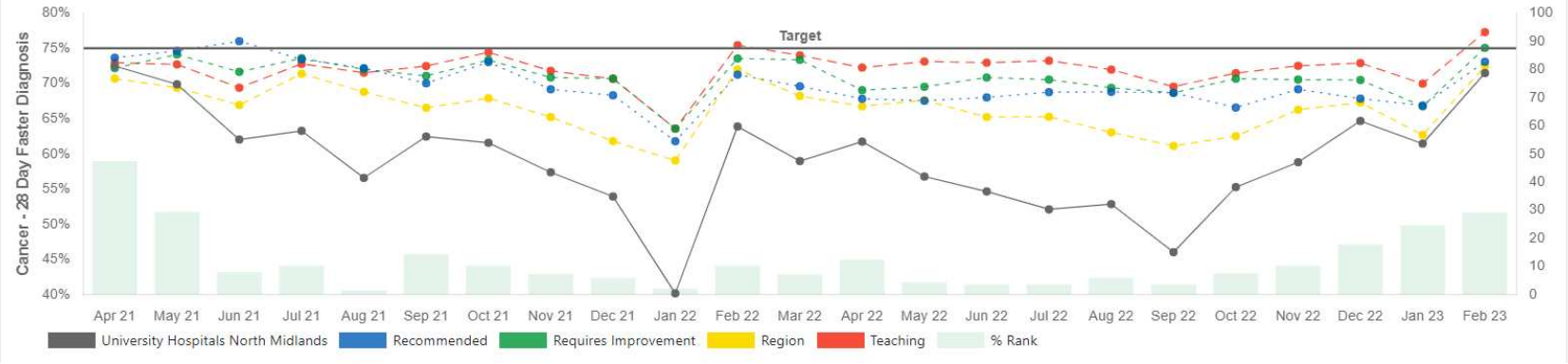
- Deterioration has been seen across all peer groups since April 2021, with UHNM seeing this more dramatically.
- Since May 2022, UHNM have seen a slow improvement with February 2023 performance higher than most peers.

Elective Care - Cancer

Cancer - 28 Day Faster Diagnosis

Feb 23 Performance: 71.5% | Rank: 96th of 135

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



	Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	71.5%			29
	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
403	Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	71.5%			29
406	FDS Acute Leukaemia	Feb 23	75.0%	-			-
407	FDS Brain Tumours	Feb 23	75.0%	0.0%			0
408	FDS Breast Cancer	Feb 23	75.0%	95.6%			59
404	FDS Breast Symptoms	Feb 23	75.0%	97.4%			60
409	FDS Children's Cancer	Feb 23	75.0%	76.5%			22
410	FDS Gynaecological Cancer	Feb 23	75.0%	59.9%			34
411	FDS Haematological Malignancies	Feb 23	75.0%	45.7%			30
412	FDS Head & Neck Cancer	Feb 23	75.0%	69.8%			17
413	FDS Lower Gastrointestinal Cancer	Feb 23	75.0%	56.9%			43
414	FDS Lung Cancer	Feb 23	75.0%	78.6%			34
405	FDS Missing or Invalid	Feb 23	75.0%	-			-
415	FDS Other Cancer	Feb 23	75.0%	-			-
416	FDS Sarcoma	Feb 23	75.0%	50.0%			34
417	FDS Skin Cancer	Feb 23	75.0%	71.7%			11
418	FDS Testicular Cancer	Feb 23	75.0%	92.9%			59
419	FDS Upper Gastrointestinal Cancer	Feb 23	75.0%	88.8%			87
420	FDS Urological Malignancies	Feb 23	75.0%	56.3%			43

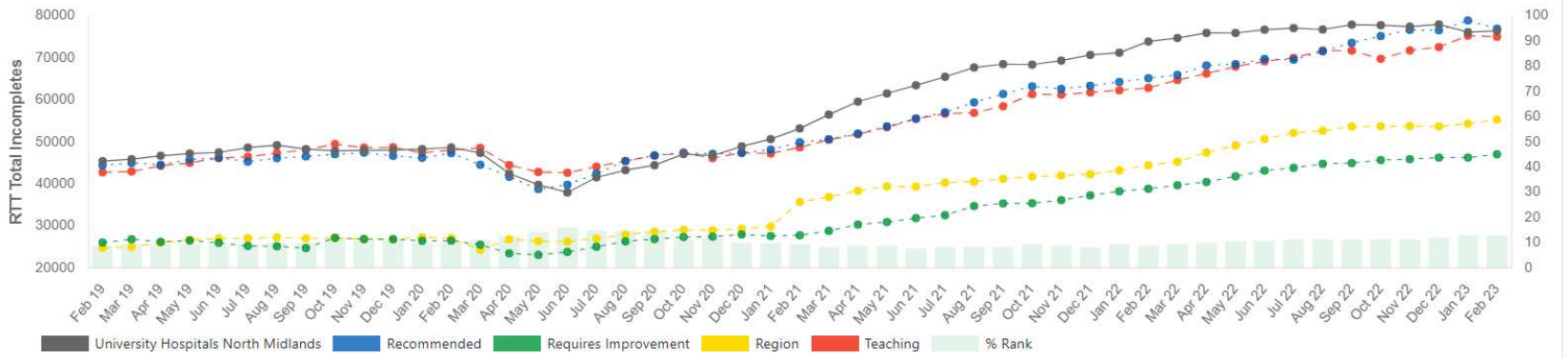
- The 28 Day Faster Diagnosis position for UHNM has seen a greater improvement since September 2022 compared to other peer groups.
- UHNM have moved from the bottom quartile to the third quartile.

Elective Care - RTT

RTT Total Incompletes

Feb 23 Performance: 76,374 | Rank: 149th of 171

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



	RTT Total Incompletes	Feb 23	-	76,374		13
	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
950	RTT 104 Week Breach	Feb 23	0	73		2
56	RTT 52 Week Breach	Feb 23	0	5,092		9
949	RTT 78 Week Breach	Feb 23	0	769		3
142	RTT 95th Percentile Admitted Waiting Time	Feb 23	18.0	80.4		19
144	RTT 95th Percentile Non-Admitted Waiting Time	Feb 23	18.0	58.2		28
135	RTT Admitted Treatment Within 18 Weeks	Feb 23	90.0%	53.4%		36
141	RTT Average (Median) Admitted Waiting Time	Feb 23	9.0	15.6		38
143	RTT Average (Median) Non-Admitted Waiting Time	Feb 23	5.0	9.4		51
55	RTT Average Wait for Incomplete	Feb 23	7.00	16.4		21
133	RTT Incomplete 92nd Percentile	Feb 23	-	48.9		20
134	RTT Incomplete Pathways With a DTA	Feb 23	25.0%	15.3%		44
136	RTT Non-Admitted Treatment Within 18 Weeks	Feb 23	95.0%	64.6%		35
138	RTT Total Clock Starts	Feb 23	-	16,322		85
137	RTT Total Clock Stops	Feb 23	-	13,906		86
132	RTT Total Incompletes	Feb 23	-	76,374		13

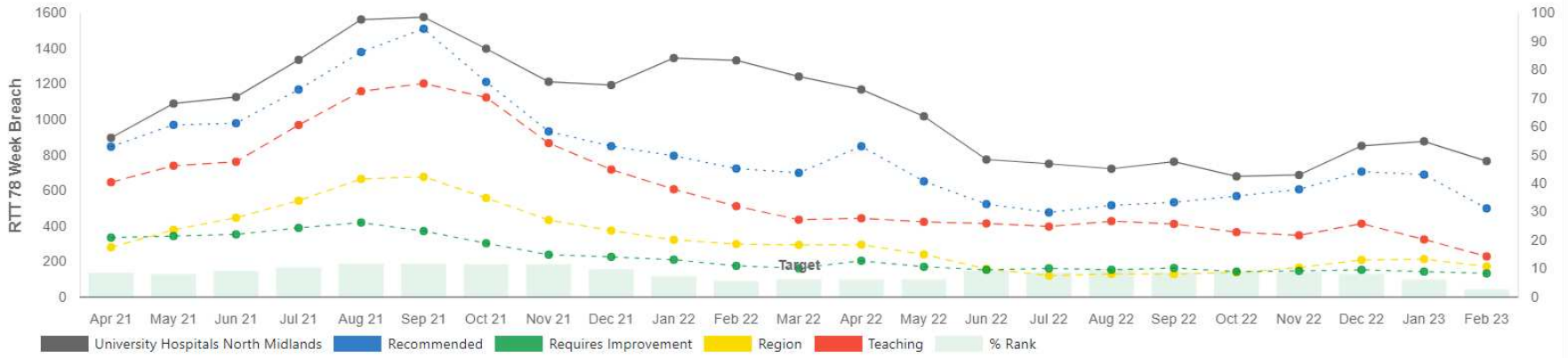
- Total incomplete pathways have seen significant growth across all peer groups.
- Although UHNM incomplete pathways are higher than all peers growth since May 2022 has been at a lesser rate than peers.
- UHNM remain in the bottom quartile.

Elective Care - RTT

RTT 78 Week Breach

Feb 23 Performance: 769 | Rank: 166th of 171

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



	RTT 78 Week Breach	Feb 23	0	769			3
	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
950	RTT 104 Week Breach	Feb 23	0	73			2
55	RTT 52 Week Breach	Feb 23	0	5,092			9
949	RTT 78 Week Breach	Feb 23	0	769			3
142	RTT 95th Percentile Admitted Waiting Time	Feb 23	18.0	80.4			19
144	RTT 95th Percentile Non-Admitted Waiting Time	Feb 23	18.0	58.2			28
135	RTT Admitted Treatment Within 18 Weeks	Feb 23	90.0%	53.4%			36
141	RTT Average (Median) Admitted Waiting Time	Feb 23	9.0	15.6			38
143	RTT Average (Median) Non-Admitted Waiting Time	Feb 23	5.0	9.4			51
53	RTT Average Wait for Incomplete	Feb 23	7.00	16.4			21
133	RTT Incomplete 92nd Percentile	Feb 23	-	48.9			20
134	RTT Incomplete Pathways With a DTA	Feb 23	25.0%	15.3%			44
136	RTT Non-Admitted Treatment Within 18 Weeks	Feb 23	95.0%	64.6%			35
138	RTT Total Clock Starts	Feb 23	-	16,322			85
137	RTT Total Clock Stops	Feb 23	-	13,906			86
132	RTT Total Incompletes	Feb 23	-	76,374			13

- 78 Week waits are reducing across all peer groups.
- The reduction at UHNM had been at a greater rate than other peers.
- Since December 2022 volumes at UHNM increased.
- UHNM remain in the bottom quartile, ranked 166th out of 171.

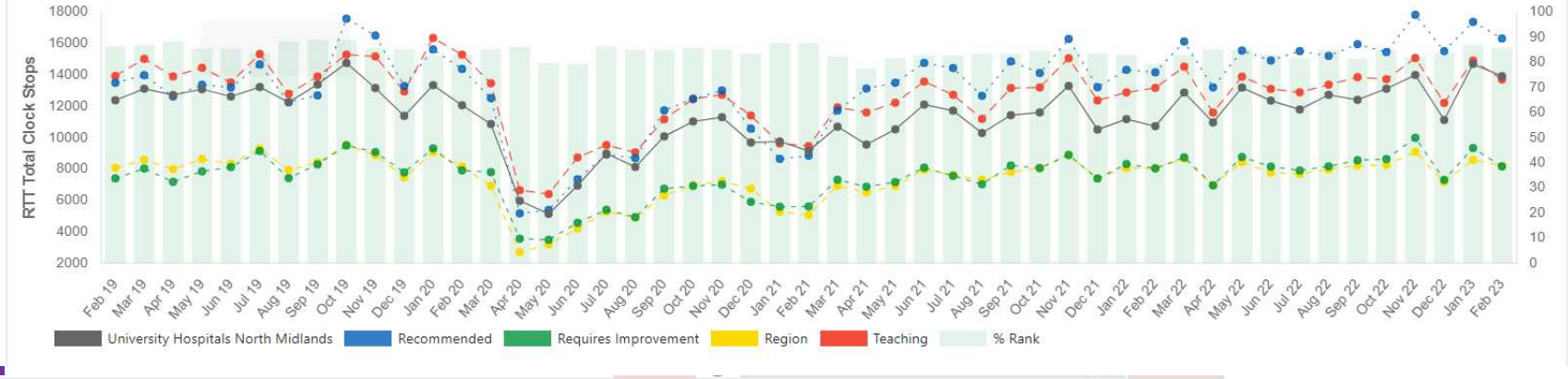
Delivering Exceptional Care with Exceptional People

Elective Care - RTT

RTT Total Clock Stops

Feb 23 Performance: 13,906 | Rank: 25th of 171

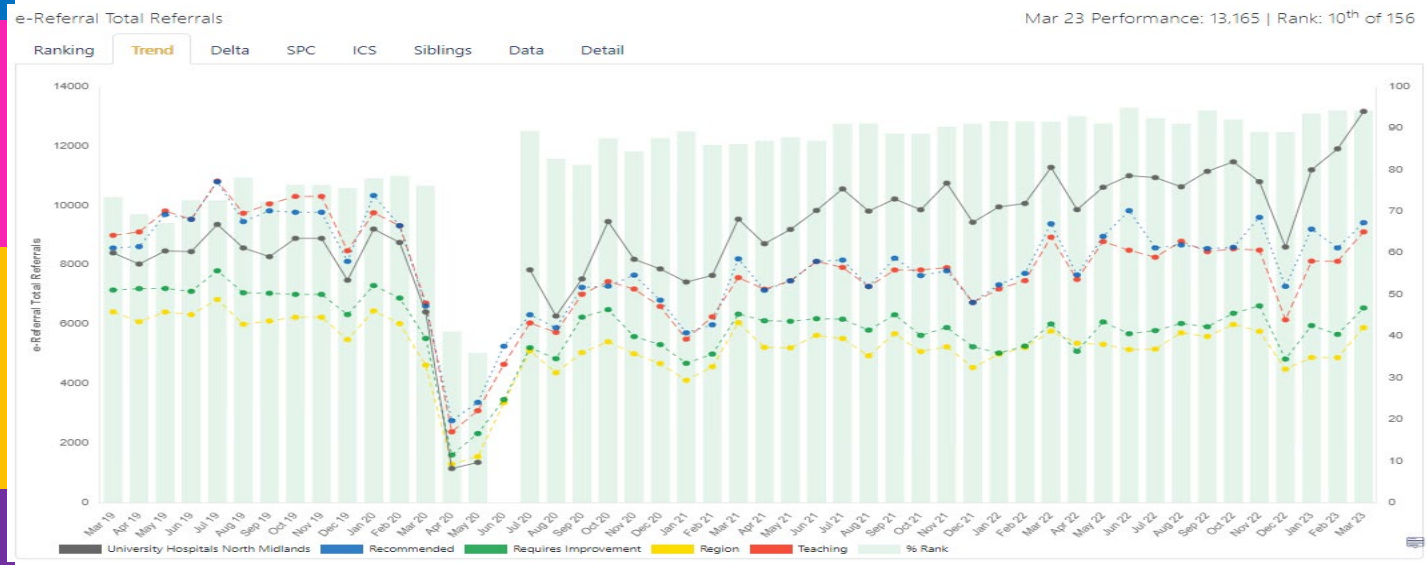
Ranking | Trend | Delta | SPC | ICS | Siblings | Data | Detail



	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
137	**RTT Total Clock Stops**	**Feb 23**	-	**13,906**			**86**
950	RTT 104 Week Breach	Feb 23	0	**73**			2
56	RTT 52 Week Breach	Feb 23	0	**5,092**			9
949	RTT 78 Week Breach	Feb 23	0	**769**			3
142	RTT 95th Percentile Admitted Waiting Time	Feb 23	18.0	**80.4**			19
144	RTT 95th Percentile Non-Admitted Waiting Time	Feb 23	18.0	**58.2**			28
135	RTT Admitted Treatment Within 18 Weeks	Feb 23	90.0%	**53.4%**			36
141	RTT Average (Median) Admitted Waiting Time	Feb 23	9.0	**15.6**			38
143	RTT Average (Median) Non-Admitted Waiting Time	Feb 23	5.0	**9.4**			51
55	RTT Average Wait for Incomplete	Feb 23	7.00	**16.4**			21
133	RTT Incomplete 92nd Percentile	Feb 23	-	48.9			20
134	RTT Incomplete Pathways With a DTA	Feb 23	25.0%	15.3%			44
136	RTT Non-Admitted Treatment Within 18 Weeks	Feb 23	95.0%	**64.6%**			35
138	RTT Total Clock Starts	Feb 23	-	16,322			85
137	RTT Total Clock Stops	Feb 23	-	13,906			86
132	RTT Total Incompletes	Feb 23	-	76,374			13

- RTT total clock starts and stops are in the upper quartile showing the volume of demand and throughput at UHNM is high
- UHNM are seeing a gradual increase in the number of clock stops
- UHNM continue to remain in the middle of all peers.

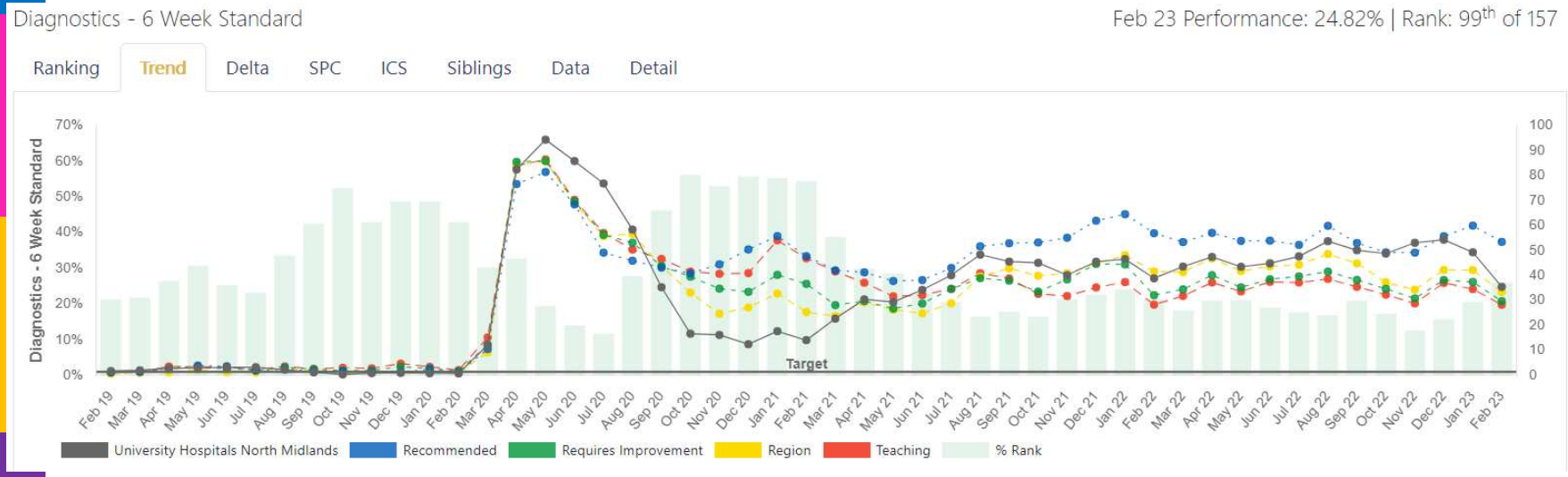
Elective – E-Referrals



e-Referral Total Referrals	Mar 23	-	13,165			94
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
e-Referral 2WW ASI Rate	Mar 23	4.00%	0.0%			100
e-Referral ASI Number	Mar 23	-	6,973			93
e-Referral Slots Issues Rate	Mar 23	4.0%	53.0%			38
e-Referral Total Referrals	Mar 23	-	13,165			94

- Pre pandemic E-referral UHNM volumes were aligned to all peers groups.
- Since 2021 e-referrals to UHNM have increased above all peers groups.
- During 2023 the gap has widened further for UHNM compared to other peer groups.
- UHNM currently have the 10th highest number of referrals nationally.

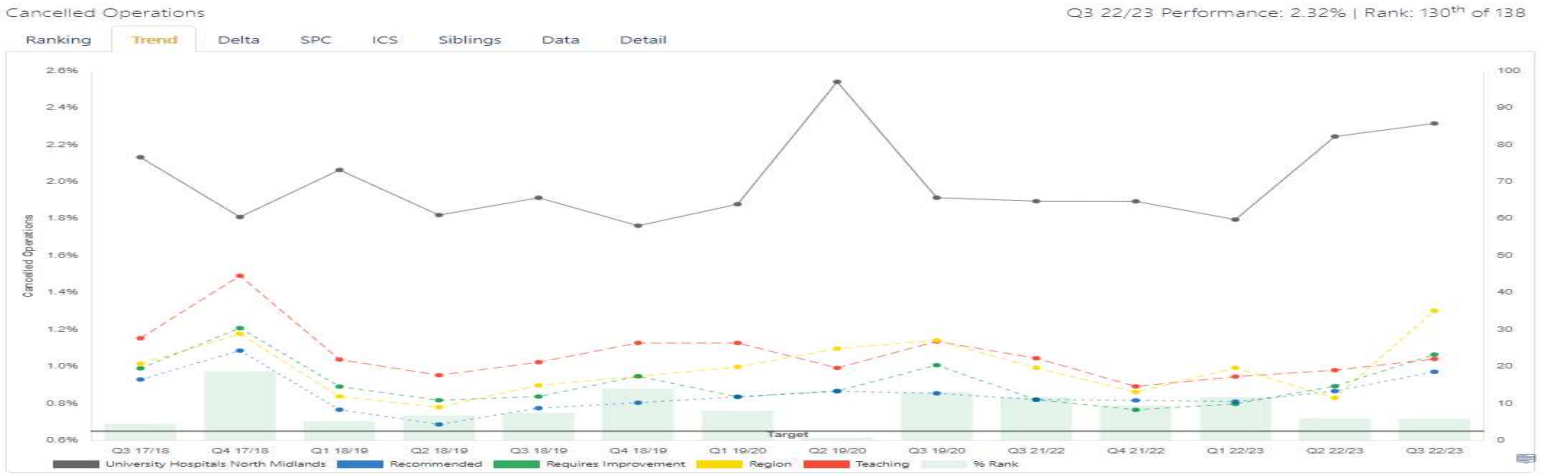
Elective Care - Diagnostics



	Diagnostics - 6 Week Standard	Feb 23	1.00%	24.8%			37
	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
	Audiology	Feb 23	1.00%	2.1%			67
	Colonoscopy	Feb 23	1.00%	64.3%			9
	Computed Tomography	Feb 23	1.00%	0.6%			67
	Cystoscopy	Feb 23	1.00%	12.5%			65
	DM01 Waiting <13 Weeks	Feb 23	100.00%	94.3%			52
	Diagnostics - 6 Week Standard	Feb 23	1.00%	24.8%			37
	Diagnostics - 6 Week Standard Reversed	Feb 23	99.00%	75.2%			37
	Echocardiography	Feb 23	1.00%	39.8%			25
	Electrophysiology	Feb 23	1.00%	-			-
	Flexi Sigmoidoscopy	Feb 23	1.00%	64.0%			7
	Gastroscopy	Feb 23	1.00%	37.7%			23
	Magnetic Resonance Imaging	Feb 23	1.00%	13.0%			36
	Neurophysiology	Feb 23	1.00%	0.0%			100
	Non-obstetric Ultrasound	Feb 23	1.00%	33.5%			16
	Sleep Studies	Feb 23	1.00%	8.9%			62
	Urodynamics	Feb 23	1.00%	0.0%			100

- Performance at UHNM continues to be better than “Recommended” peers.
- UHNM have seen a greater improvement than other peers over the last three months.
- Since January UHNM have moved from the bottom quartile to the third quartile.

Elective Care - Theatres – Cancelled Ops



	Cancelled Operations	Q3 22/23	0.65%	2.3%		1.89%	6
	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
4	Cancelled Operations	Q3 22/23	0.65%	2.3%			6
121	Treated Within 28 Days of Cancellation	Q3 22/23	99.0%	86.1%			61
123	Urgent Operations Cancelled	Feb 20	0.0	2.0			25
125	Urgent Operations Cancelled Twice or More	Feb 20	0.0	0.0			100

% of cancelled operations at last minute for non clinical reasons.

- UHNM continue to have a higher rate of last minute cancelled operations than all peer groups.
- Currently ranked 130th out of 138.

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

University Hospitals of North Midlands NHS Trust

Key messages

The Trust's People Strategy 2022-2025 sets identifies the workforce priorities required to support delivery of the Trust's strategic ambitions, vision and objectives whilst demonstrating our values in all that we do. To deliver this four key domains of focus have been identified within the strategy.

- We will look after our people
- We will create a sense of belonging
- We will grow and develop our workforce for the future
- We will develop our people practices and systems

Overall, the level of workforce risk remains at ext16 due to the cultural issues highlighted by the brap report, high sickness levels and the impact on workforce availability. There are measures in place to mitigate risks including a recruitment pipeline

The Cultural Improvement Plan has been updated following a monthly review of progress.

- The Being Kind e-learning is now mandated from 1 April 2023 and face-to face sessions will be starting in June and July.
- The PowerBI Cultural heatmap dashboard has gone live and can be accessed by divisions. The indicators have been cross referenced with the cultural improvement plan to ensure that most aspects of improvement are being measured.

Stress and Anxiety has moved into the top reason for sickness in April, which saw an increase of 1.12% in the last month to 20.6% (19.58% in March 2023). Chest & respiratory problems saw a decrease of 5.8% in the last month to 13.7% (19.5% in March 2023). Focusing specifically on Covid related absence by 30 April 2023 covid-related absences stood at 30, which was 5.84% of the 514 open absences. This is 11.84% decrease on same time the previous month.

The Staff Voice trust survey for April 2023 received a total of 652 submissions providing an overall colleague engagement score of 6.31.

Internal measures to monitor reduction is agency expenditure continue. Divisional targets for agency ceilings have been calculated. As part of the monitoring divisions were asked to present an update on their action plan to reduce expenditure to Executive Workforce Assurance Group (EWAG). New targets for the upcoming year will be provided based on 3.75% of total pay spend.

The Loop app officially launched on the 3rd April, Fully integrated with our eRostering solution, it allows your people to view their personal schedule anytime as well as provide input back into the roster with simple to use features such as leave request, logging call-outs and requesting bank duties.

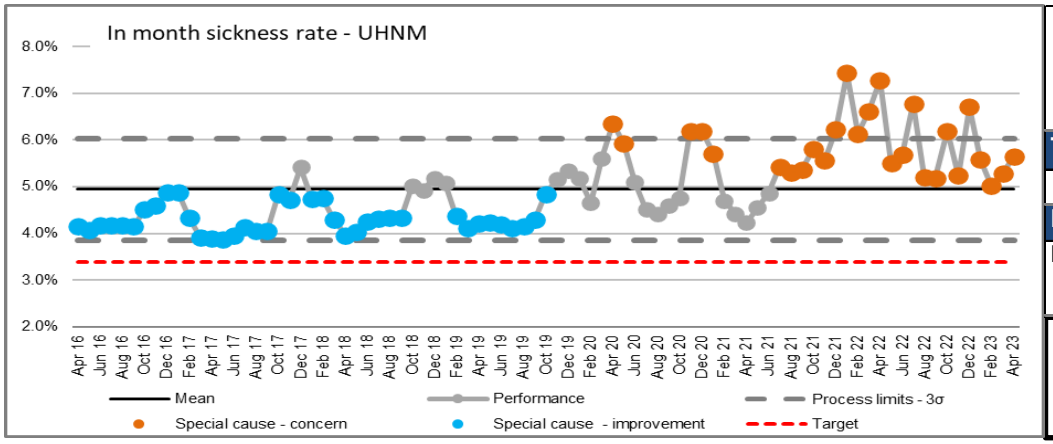
Workforce Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.65%		
Staff Turnover	11%	9.32%		
Statutory and Mandatory Training rate	95%	93.75%		
Appraisal rate	95%	85.25%		
Agency Cost	N/A	4.13%		

Sickness Absence

University Hospitals of North Midlands NHS Trust



Target	Feb 23	Mar 23	Apr 23
3.4%	5.0%	5.3%	5.7%

Background

Percentage of days lost to staff sickness

Sickness rate is consistently above the target of 3.4%.

Summary

(12m cumulative Absence FTE%)

Org L2	Divisional Trajectory - March 2024	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Trajectory
205 Central Functions	3.39%	4.13%	4.11%	4.19%	4.21%	4.20%	3.74%	3.71%	3.85%	3.79%	3.90%	3.88%	3.73%	↓
205 Women's, Children's & Clinical Support Services	5.25%	5.94%	5.97%	6.03%	6.07%	6.25%	6.35%	6.29%	6.32%	6.22%	6.19%	6.01%	5.72%	↓
205 Estates, Facilities and PFI Division	5.25%	5.75%	5.76%	5.85%	5.98%	6.04%	6.20%	6.22%	6.15%	6.02%	6.00%	5.75%	6.02%	↑
205 Medicine and Urgent Care	5.25%	6.64%	6.67%	6.76%	6.82%	6.85%	6.94%	6.86%	6.90%	6.55%	6.41%	6.22%	5.98%	↓
205 Division of Network Services	5.25%	5.47%	5.69%	5.89%	5.81%	5.78%	5.73%	5.75%	5.80%	5.59%	5.48%	5.34%	5.06%	↓
205 Division of Surgery, Theatres and Critical Care	4.50%	7.18%	7.30%	7.45%	7.39%	7.31%	7.30%	7.20%	7.12%	6.94%	6.81%	6.73%	6.53%	↓
205 North Midlands & Cheshire Pathology Service (NMCPS)	5.25%	N/A	N/A	N/A	N/A	N/A	5.57%	5.61%	5.64%	5.65%	5.68%	5.56%	5.37%	↓

For M1, the in-month sickness rate decreased by 0.67% to 4.61% (5.28% in March 2023). The 12 month cumulative rate marginally decreased to 5.65% (5.86% in March 2023).

Stress and Anxiety has moved into the top reason for sickness in April, which saw an increase of 1.12% in the last month to 20.6% (19.58% in March 2023). Chest & respiratory problems saw a decrease of 5.8% in the last month to 13.7% (19.5% in March 2023).

Divisional trajectories for achieving a reduction in Sickness Absence can be seen in the table above. All of the Divisions saw a decrease sickness against the previous month.

Focusing specifically on Covid related absence by 30 April 2023 covid-related absences stood at 30, which was 5.84% of the 514 open absences. This is 11.84% decrease on same time the previous month.

Actions

The focus remains on managing areas of high sickness, and continued daily monitoring of sickness absence rates:

For the Medicine division Sickness absence continues to be monitored at monthly directorate performance reviews and areas with over 8% or of concern are meeting with their People advisor on long term sickness cases

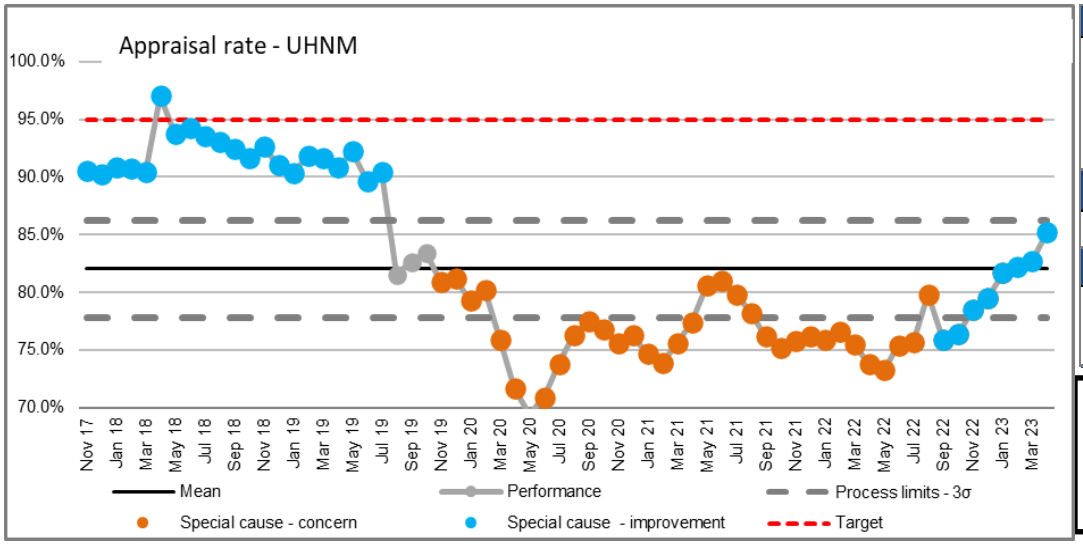
Surgery Division have been identifying hotspot areas for both long and short term sickness and providing targeted support. There has also been targeted training for low compliance areas in relation to Empactis .

Network Division have commenced sickness assurance meetings.

Women's Children's and Clinical Division. Will be undertaking a deep dive into specific areas of high absence. Alongside sickness surgeries to support managers.

Appraisal (PDR)

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Feb 23	Mar 23	Apr 23
95.0%	82.2%	82.7%	85.3%

Background

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

The appraisal rate is consistently below the target of 95%.

Note: Completion of PDRs was suspended during covid-19 unless there was capacity to complete them.

Summary

At 30 April 2023, the PDR Rate increased by 2.6% to 85.3% (82.7% at 31 March 2023)

This is a continuing upward trend over the last six months; however, this figure still sits 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 also making the process enhance employee experience.

Actions

The focus on ensuring completion of PDRs is continuing with:

NMCPS are working on putting all out of date PDRs in the manager diaries, Identifying any manager training gaps and reconfirming Manager hierarchies within ESR.

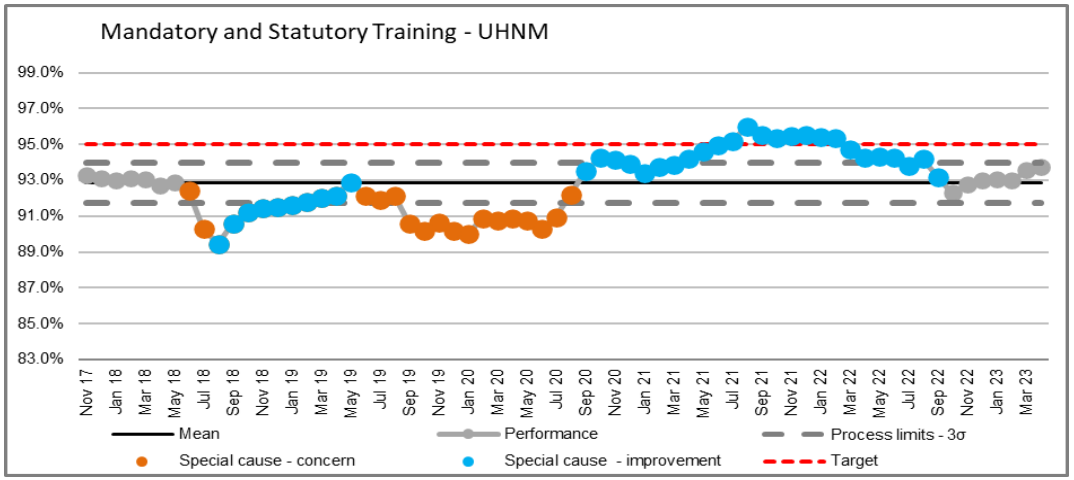
Network Division hold a dedicated weekly PDR compliance hotspot and assurance meetings

Surgery Division are undertaking a monthly compliance reporting and identifying hotspots areas to engage with.

Medicine Division are having 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	Feb 23	Mar 23	Apr 23
95.0%	93.0%	93.6%	93.8%

Background

Training compliance

At 93.6%, the Statutory and Mandatory Training rate is just below the Trust target for the core training modules

Summary

Statutory and Mandatory training rate on 30 April 2023 was 93.8% (93.6% at 30 April 2023) showing a slight increase. This compliance rate is for the 6 'Core for All' subjects only.

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	11329	11329	10621	**93.75%**
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	11329	11329	10637	**93.89%**
NHS|CSTF|Health, Safety and Welfare - 3 Years|	11329	11329	10650	**94.01%**
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	11329	11329	10644	**93.95%**
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	11329	11329	10713	**94.56%**
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	11329	11329	10460	**92.33%**

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	11329	11329	10135	**89.46%**
NHS|CSTF|Information Governance and Data Security - 1 Year|	11329	11329	10251	**90.48%**

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.

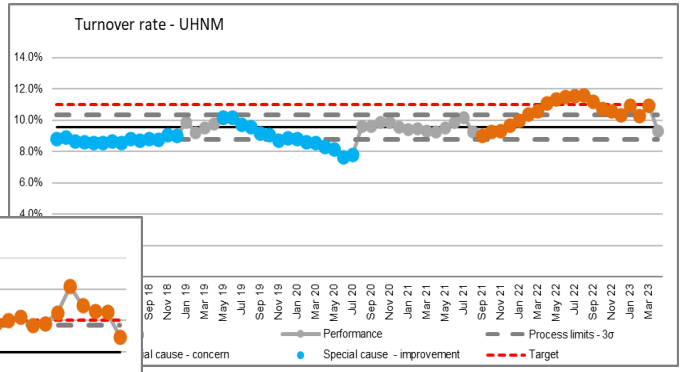
The Oliver McGowan Mandatory Training on Learning Disability & Autism is now live and will be reported separately for 12 months.

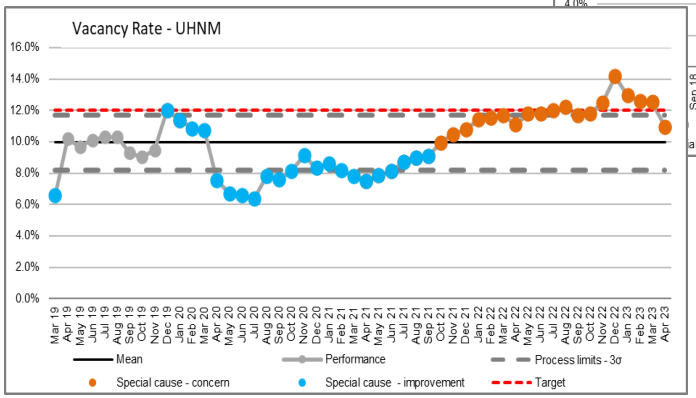
The Being Kind e-learning is now mandated from 1 April 2023 and face-to face sessions will be starting in June and July

Workforce Turnover

University Hospitals of North Midlands NHS Trust

The SPC chart shows the rolling 12m cumulative turnover rate.





Variation	Assurance

Target	Feb 23	Mar 23	Apr 23
11.0%	10.3%	10.9%	9.3%

Background

Turnover rate

What is the data telling us?

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.

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

Vacancy rate has decreased from 12.54% last month to 10.95%

Summary

The 12m Turnover rate in April 2023 sat at 9.3% figure sitting below the trust target of 11%.

The summary of vacancies by staff groupings highlight a small decrease in the vacancy rate over the previous month.

Vacancies at 30-04-23	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,550.70	1,349.60	201.10	12.97%	15.38%
Registered Nursing	3,562.88	3,091.33	471.55	13.23%	14.07%
All other Staff Groups	6,609.62	5,999.05	610.57	9.24%	11.07%
Total	11,723.20	10,439.99	1,283.21	10.95%	12.54%

The M1 figure of 10.95% highlights a decrease in the overall vacancy rate over the previous month. The colleagues in post increased in April 2023 by 60.71 FTE, budgeted establishment decreased by 143.87 FTE, which decreased the vacancy fte by -204.6 FTE overall[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 30/04/23]

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.

The Loop app officially launched on the 3rd April.

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 1 Trust has delivered a small actual surplus of £0.1m against a planned surplus of £1.1m; this adverse variance is primarily driven by underperformance against the Trust's in year CIP target.
- The Trust incurred £0.8m of costs relating to winter capacity remaining open in April. The Month 1 position assumed this additional cost will be funded by the local ICB.
- To date the Trust has validated £3.0m CIP savings to Month 1 against a plan of £4.6m. The £1.6m under delivery of CIP is driving the in month overspend against plan. Schemes of £47m have been identified for delivery in 2023/24. The PMO is currently working with scheme leads to develop robust plan to deliver these savings. The £8.0m divisional schemes remain unidentified.
- There has been £0.75m of Capital spend in Month 1 and the paper sets out the revised plan which has been adjusted to reflect conversations with NHSE.
- The cash balance at Month 1 is £77.9m, which is £8.0m lower than plan. Cash holdings are below plan mainly due to additional accounts payable payments in April.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	87.0		
	Expenditure - Pay	variable	29.0	L	F
	Expenditure - Non Pay	variable	29.0	H	F
Activity	Daycase/Elective Activity	variable	7,416		?
	Non Elective Activity	variable	9,950	H	P
	Outpatients 1st	variable	23,943		?
	Outpatients Follow Up	variable	35,975		?

Income & Expenditure

Income & Expenditure Summary Month 01 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	961.4	80.9	80.3	(0.6)	80.9	80.3	(0.6)
Other Operating Income	81.1	6.8	6.7	(0.1)	6.8	6.7	(0.1)
Total Income	1,042.4	87.7	87.0	(0.7)	87.7	87.0	(0.7)
Pay Expenditure	(632.1)	(52.8)	(52.7)	0.1	(52.8)	(52.7)	0.1
Non Pay Expenditure	(346.9)	(28.4)	(29.0)	(0.6)	(28.4)	(29.0)	(0.6)
Total Operational Costs	(979.0)	(81.2)	(81.8)	(0.5)	(81.2)	(81.8)	(0.5)
EBITDA	63.4	6.5	5.2	(1.3)	6.5	5.2	(1.3)
Depreciation & Amortisation	(36.3)	(3.1)	(3.1)	(0.0)	(3.1)	(3.1)	(0.0)
Interest Receivable	2.8	0.2	0.4	0.1	0.2	0.4	0.1
PDC	(11.0)	(0.9)	(0.9)	0.0	(0.9)	(0.9)	0.0
Finance Cost	(19.0)	(1.6)	(1.6)	0.0	(1.6)	(1.6)	0.0
Other Gains or Losses	0.0	0.0	0.1	0.1	0.0	0.1	0.1
Total	0.0	1.1	0.1	(1.1)	1.1	0.1	(1.1)

Key issues to note within the Month 1 position include the following

- Additional costs of £0.8m have been incurred for winter capacity that has remained open in April. It has been assumed in the Month 1 outturn that additional funding of £0.8m will be received from the local ICB
- The overspend of £1.1m is mainly driven by the under delivery of CIP by £1.6m. The two main schemes behind plan in month are the ICB non recurrent stretch £0.9m and the recurrent divisional schemes of 0.7m

Capital Spend

NHS
University Hospitals of North Midlands
NHS Trust

UHNM Capital Expenditure Plan	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000
Total PFI & Loan Commitments	**19,616**	**17,056**	**17,420**	**17,420**
Pre-committed investment items (ICB allocation)				
PFI enabling costs	200	200	200	200
Project Star	20,732	500	0	0
Emergency Department (restatement costs)	177	0	0	0
Air heat bolier replacement Trust Contribution	575	804	0	0
Wave 4b Funding - Lower Trent Wards	203	0	0	0
EPMA (Electronic Prescribing) BC	718	377	0	0
Pathology LIMS BC	400	0	0	0
Pathology MSC Siemens refresh	78	0	4,298	0
Patient Portal roll out costs (BC 462)	375	110	0	0
Bi plane enabling (BC 425)	207	0	0	0
Printer lease refresh	0	692	0	0
CT8 enabling works	600	0	0	0
Nasstar equipment refresh/buy out	1,000	1,000	1,000	1,000
Pharmacy Robot BC487 - equipment	540	0	0	0
Pharmacy Robot BC487 - enabling and other	807	0	0	0
County Medical Records Building Purchase	0	2,000	0	0
Electronic Patients records BC/specification	815	0	0	0
ED ambulance off - enabling ward moves	651	0	0	0
County CTS equipment (TIF) remaining equipment	160	0	0	0
County Moduluar remaining equipment	104	0	0	0
I-refer	45	0	0	0
Investment funding - minor cases *	455	0	0	0
Funding to be confirmed (on-call, PODS, ED doors)	150	0	0	0
Central Contingency & risk	300	0	300	300
Balance to allocate/reduce	0	(4,041)	1,095	5,393
Required NHSE plan re-phasing adjustment	(7,225)	7,225	0	0
Remaining 2022/23 commitments	255	57	0	0
Total Pre committed Investment items	**22,322**	**8,924**	**6,893**	**6,893**
Capital sub-group (ICB allocation)				
IMT Sub Group Total Funding	2,340	3,219	4,677	4,677
Medical Devices Sub Group Total Funding	2,355	4,089	3,825	3,825
Estates Sub Group Total Funding	3,646	5,157	6,426	6,426
Health & Safety compliance	150	150	150	150
Net zero carbon initiatives	100	100	100	100
Central funding beds, mattresses, hoists	75	75	75	75
Total Sub Groups	**8,666**	**12,790**	**15,253**	**15,253**
IFRS 16 leases	240	140	140	140
Endoscopy works - 22/23 PDC ICB allocation	370	0	0	0
Total Internal Capital Expenditure programme	**51,214**	**43,445**	**40,206**	**40,206**
Additional CRL / Externally Funded PDC				
Wave 4b Funding - Lower Trent Wards	1,645	0	0	0
TIF 2 PDC CTS phase 1 - enabling slippage	400	0	0	0
TIF 2 PDC (Day Case Unit)	2,650	7,102	0	0
TIF 2 PDC (Womens Hospital)	1,220	11,793	0	0
PDC - UEC SDEC facility	11,754	0	0	0
Air heat bolier replacement PSDS Grant BC 510	2,898	2,533	0	0
Charitable funded expenditure	5,094	500	500	500
Total Additional CRL / PDC Funded expenditure	**25,661**	**21,928**	**500**	**500**
Total Capital Expenditure	**76,875**	**65,373**	**40,706**	**40,706**
Total Capital Expenditure (excluding PFI deductions)	**57,259**	**48,317**	**23,286**	**23,286**
Planned (under)/over spend	**5,892**	**(5,892)**	**0**	**0**

The planned overspend of £5.9m in 2023/24 has reduced from the previous plan submission of £13.6m as the ICB was required to submit a balanced capital plan over 2 years (within the allowable 5% over commitment). The underspend of £5.9m in 2024/25 has been reduced from £13.6m in the previous plan.

As a result of the changes required by NHSE a re-phasing of £7.2m between the 2 financial years has been included in the plan but has not been allocated against specific schemes. NHSE has indicated that the Trust will be allowed to overspend by £7.2m against the submitted plan and would require an equal underspend in 2023/24.

The plan for 2023/24 and 2024/25 is dependent on a significant level of capital receipts in respect of the Project Star business case. In 23/24 the sale of Sharman Close is included in the plan to fund the current level of capital expenditure.

In 2024/25 the funding of the £5.9m underspend is dependent on a £9.2m capital receipt in respect of the surplus land at the RI and COPD. There is a significant risk in terms of achieving either the timing or value of the capital receipt as planning permission will not be received within this timescale and indications are that capital receipts received would be significantly lower than plan for a sale without planning permission in place.

The current plan includes unallocated funds of £0.9m relating to contingency and investment funding to be allocated. There are also uncertainties around the timing of a number of schemes for example the pharmacy robot business case and TIF2. A decision on whether to allocate funding or to bring forward expenditure to cover slippage will need to take in to account the planned overspend and whether this should be reduced in the first instance.

In month overall capital expenditure was £0.75m against a plan of £0.8m. The main areas of expenditure were in relation to PFI lifecycle costs, commitments carried forward from 2022/23 and charitable funds.

Balance sheet

Balance sheet as at Month 1	31/03/2023	30/04/2023			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	650.1	648.3	647.9	(0.4)	
Right of Use Assets	18.8	18.6	18.4	(0.2)	
Intangible Assets	18.4	18.1	17.9	(0.1)	
Trade and other Receivables	1.4	1.4	1.5	0.2	
Total Non Current Assets	688.6	686.3	685.8	(0.5)	
Inventories	16.8	16.8	16.8	-	
Trade and other Receivables	57.9	57.9	64.4	6.5	Note 1
Cash and Cash Equivalents	84.0	86.0	77.9	(8.1)	Note 2
Total Current Assets	158.7	160.7	159.1	(1.5)	
Trade and other payables	(134.0)	(133.9)	(132.9)	1.0	Note 3
Borrowings	(14.0)	(14.0)	(14.0)	0.0	
Provisions	(5.6)	(5.6)	(5.6)	0.0	
Total Current Liabilities	(153.5)	(153.4)	(152.4)	1.0	
Borrowings	(256.8)	(255.6)	(255.4)	0.2	
Provisions	(2.7)	(2.7)	(2.7)	-	
Total Non Current Liabilities	(259.5)	(258.3)	(258.1)	0.2	
Total Assets Employed	434.3	435.3	434.4	(0.9)	
Financed By:				-	
Public Dividend Capital	665.0	665.0	665.0	-	
Retained Earnings	(429.1)	(428.1)	(429.0)	(0.9)	Note 4
Revaluation Reserve	198.4	198.4	198.4	-	
Total Taxpayers Equity	434.3	435.3	434.4	(0.9)	

Note 4. Retained earnings are showing a £0.9m variance from plan. Retained earnings reflect the £1.1m overspend on financial performance and the net movement between donated capital income and depreciation on donated capital assets.

The balance sheet plan reflects the forecast included within the 2023/24 Financial Plan submitted on 4 May 2023. Variances to the plan at Month 1 are explained below:

Note 1. Trade and other receivables are £6.5m higher than plan at Month 1 and reflects a £6.3m increase in non-NHS prepayments compared to Month 12. The main reason for the increase is the payment of annual business rates for the 2023/24 financial year of £4.7m for the Royal Stoke and County sites in April 2023. The remaining increase reflects the payment of other annual and quarterly invoices in Month 1 including for pathology managed service contracts.

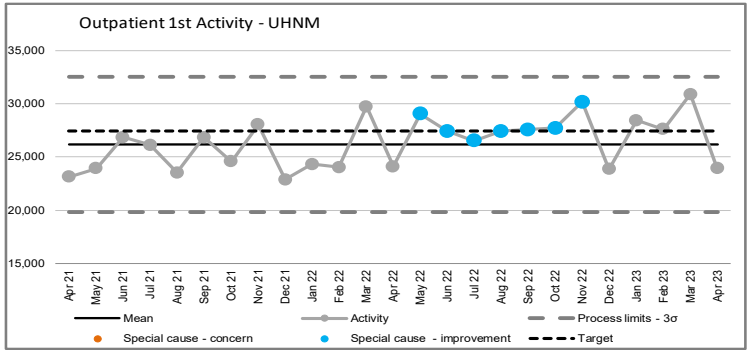
Note 2. This variance is due to higher than plan payments of £8.4m, cash received is in line with plan at Month 1.
General payments are £6.9m ahead of plan at Month 1 and reflect the payment of annual business rates for the 2023/24 financial year of £4.7m for the Royal Stoke and County sites in April 2023. Capital payments are £1.2m ahead of plan and reflect invoices received and approved relating to Month 12 capital expenditure including for Project Star.

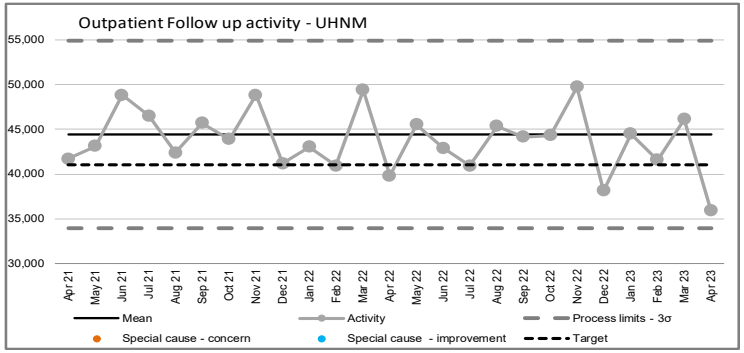
Note 3. Payables are £1m lower than plan mainly at Month 1. In comparison to Month 12 the accruals and goods received but not invoiced balances have reduced by £9.4m and deferred income has increased by £7.3m to £21.7m
The main increase in Month 1 relates to Education contract income of £7.6m (now received from NHS England). The deferred income balance also includes significant balances relating to cash received from Staffordshire and Stoke on Trent ICB for a number of schemes (£2.9m); digital pathology (£2.1m); and high cost devices (£5.1m).

Activity

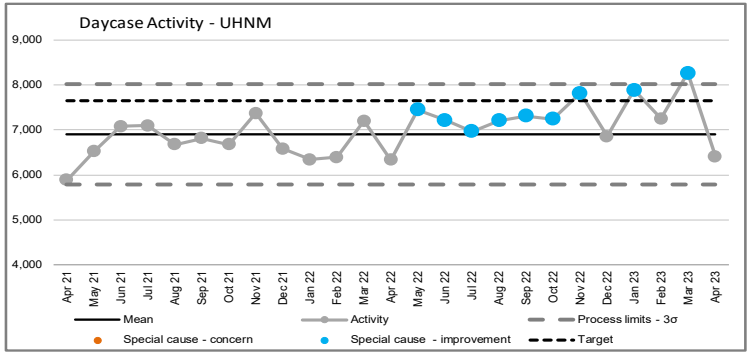
NHS
University Hospitals of North Midlands
NHS Trust

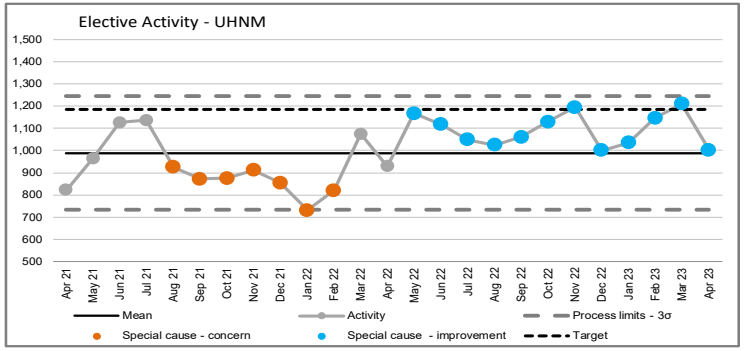
Planned care Outpatient



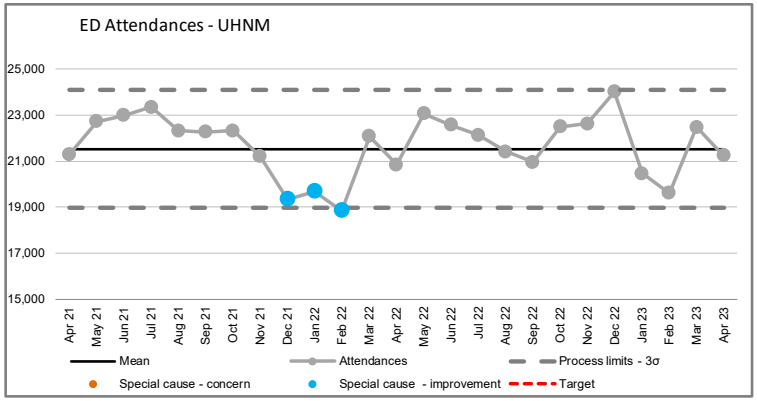


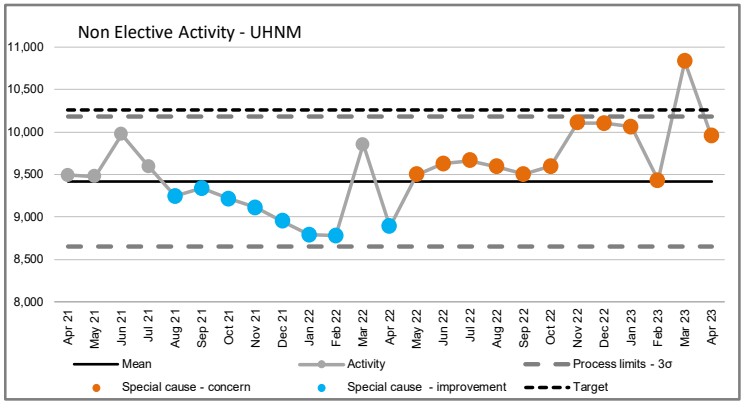
Planned care Inpatient





Urgent Care





University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th June 2023
Report Title:	G6 and FT4 Annual Declaration	**Agenda Item:**	16.
Author:	Claire Cotton, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Executive Summary:

Situation

NHS Trusts are required to self-certify that they meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements.

The enclosed FT4 and G6 declaration fulfils the self-certification obligation for 2022/23 and is presented for approval of the Board.

Background

Up until 31st March 2023, NHS Trusts were exempt from needing the provider licence, although directions from the Secretary of State require NHSE to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate. The enclosed submission includes updated narrative for each section of the declaration.

It should be noted that modifications to the licence process came into effect from 1st April 2023 and which time NHS Trusts were required to be licenced. The new provider licence aims to support effective system working; enhance the oversight of key services provided by the independent sector; address climate change; and make a number of necessary technical amendments.

Assessment

The Executive Team have considered the attached and agreed to continue to provide a response of not confirmed for FT4 (No. 4) as although financial performance has improved, there remain major risks in relation to long waiting lists, an anticipated deficit for 2023/24 for both UHNM and the system, in addition to an outstanding Section 31 and 29 Notices. In addition it was agreed to provide a response of not confirmed for the G6 declaration due to the same issues.

Key Recommendations:

The Board is asked to formally consider and confirm the Trust's self-certification.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2022/23**

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board's corporate governance framework is set out within the Rules of Procedure, which is reviewed and approved by the Board. This is supported by a number of key policies, for example, Standing Orders, Scheme of Delegation, Standing Financial Instructions, Risk Management Policy and Standards of Business Conduct. Key risks are recorded on the organisation wide risk register in accordance with Trust policy and key strategic risks are reviewed and monitored by the Board and its Committees. During 2022/23, the Trust has continued to implement its strengthend Corporate Governance Structure, including further embedding the Executive Groups, reporting through to Committees, with alignment to the organisations strategic objectives.	OK
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	A process is in place to ensure that any guidance on good corporate governance issued by regulators, and other national arms lengh bodies, is considered by the Executive Directors. Each week, guidance is shared with relevant Executive and Operational Leads for consideration and action.	OK
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	As referred to above, the Rules of Procedure set out the Board and Committee structures, responsibilities and reporting lines, along with an independent review being undertaken in year, which led to subsequent changes which were approved by the Board. The Rules of Procedure includes business cycles for the Board and its Committees, which identifies the reporting required by Executive Directors. Each Committee of the Board provides an exception based highlight report, to the Board at each meeting which is presented by the Non-Executive Chair. These reports provide a 2 page summary of items to escalate, key actions, positive assurance and decisions made, along with a summary agenda and attendance matrix. This reporting arrangement has also continued in year, for executive groups reporting into Committees. Clear reporting lines and accountabilities are in place, and these form part of a number of Trust-wide policies and procedures, set out in (1) above.	OK
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Not confirmed	Although financial performance has improved, there remain major risks in relation to long waiting lists and backlogs associated with elective recovery, the need to demonstrate sustainable improvements in urgent care performance, a planned deficit for UHNM and the system, in addition to outstanding Care Quality Commission Section 31 and 29 notices.	OK

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Chief Nurse and Medical Director jointly hold executive leadership for quality, both of whom are voting members of the Board. In addition, the 2025Vision sets out our key objectives, including the provision of safe, effective, caring and responsive services. In addition, the 2025Vision is supported by the Quality Strategy which was approved in 2022. The associated strategic objective is measured via a number of critical success factors covering CQC ratings, reductions in harm arising from falls and pressure ulcers, maintaining mortality rates, infection control measures and PLACE inspection performance. We have a Quality Impact Assessment process in place which provides assurance that the quality of care is not compromised for any financial planning decisions taken. The Annual Business Cycles for the Trust Board and the Quality Governance Committee provide a framework for reporting on all aspects of quality and this includes regular Patient Experience Reports and our Annual Quality Account, which demonstrate the mechanisms by which information from stakeholders and patients on the quality of our services, is taken into account. The Board has continued to enhance its processes for patient engagement through the scheduling of Patient Stories at each Public Board.	OK
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	An ongoing process is in place to ensure compliance with the Fit and Proper Persons Test, with work undertaken in year to review and strengthen the processes in place. Appointments have been made in year to recruit to the positions of Non-Executive Director, and Medical Director.	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	**Signature**
Name David Wakefield, Chairman	**Name** Tracy Bullock, Chief Executive

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A	Although financial performance has improved, there remain major risks in relation to long waiting lists, an underlying UHNM and system deficit, in addition to outstanding CQC Section 31 and 29 notices.	OK

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates **2022/23** Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Not confirmed Please complete the explanatory information in cell E36

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. Please Respond

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. Please Respond

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	David Wakefield	**Name**	Tracy Bullock
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Although financial performance has improved, there remain major risks in relation to long waiting lists and backlogs associated with elective recovery, the need to demonstrate sustainable improvements in urgent care performance, an anticipated UHNM and system deficit, in addition to outstanding CQC Section 31 and 29 notices.

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	10	7	6	
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse		Staff		Staff				Staff			Staff		
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Quality Strategy Update	Chief Nurse													TBC
Clinical Strategy	Director of Strategy													TBC
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													
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													
PEOPLE														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Chief People Officer													
People Strategy Update	Chief People Officer													TBC
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	Associate Director of Corporate Governance					Q4 & Q1			Q2			Q3		
IMPROVING AND INNOVATING														
Research Strategy	Medical Director													TBC
SYSTEM AND PARTNERS														
System Working Update	Chief Executive / Director of Strategy													
RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy	N/A	N/A											
Digital Strategy Update	Director of Digital Transformation													TBC
Going Concern	Chief Finance Officer													
Estates Strategy Update	Director of Estates, Facilities & PFI													TBC
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														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

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	10	7	6	
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	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
Accountability Framework	Associate Director of Corporate Governance													
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													Board review to be considered at Trust Board Seminar in May
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													Initial Board Development Programme to be considered at Board Seminar in May 2023
Well-Led Self Assessment	Associate Director of Corporate Governance													
Risk Management Policy	Associate Director of Corporate Governance													
Complaints Policy	Chief Nurse													Next due for review June 2024