Trust Board (Open)

Meeting held on Wednesday 5th June 2024 at 9.30 am to 12.15 pm
Via MS Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	**2.**	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 8th May 2024	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	**6.**	Chief Executive's Report - May 2024	Information	Mrs T Bullock	Enclosure	
10:15		**HIGH QUALITY**				
10 mins	**7.**	Maternity Dashboard – April 2024	Assurance	Mrs S Jamieson	Enclosure	1
10 mins	**8.**	Maternity Serious Incident Report Q4	Assurance	Mrs S Jamieson	Enclosure	1
10 mins	**9.**	Quality Account	Approval	Mrs AM Riley	Enclosure	1
10:45 – 11:00 COMFORT BREAK						
11:00		**PEOPLE**				
5 mins	**10.**	People, Culture & Inclusion Committee Assurance Report (29-05-24)	Assurance	Prof G Crowe	Enclosure	2, 3, 4, 6, 9
10 mins	**11.**	Speaking Up Board Brief	Assurance	Mrs C Cotton	Enclosure	
11:15		**RESPONSIVE**				
45 mins	**12.**	Integrated Performance Report – Month 1	Assurance	Mrs AM Riley Mr S Evans Mrs J Haire Mr M Oldham	Enclosure	1, 2, 3, 5, 8
12:00	**GOVERNANCE**					
10 mins	**13.**	Fit and Proper Persons Annual Declaration	Assurance	Mr D Wakefield	Enclosure	
12:10	**CLOSING MATTERS**					
5 mins	**14.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
	15.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 3rd June to** nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:15	**DATE AND TIME OF NEXT MEETING**					
	16.	**Wednesday 10th July 2024, 9.30 am, via MS Teams**				

Trust Board (Open)

Meeting held on Wednesday 8th May 2024 at 9.30 am to 12:35 pm
Trust Boardroom, Third Floor, Springfield, Royal Stoke

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)												
Mrs T Bowen	TBo	Non-Executive Director												
Mrs T Bullock	TB	Chief Executive												
Mr S Evans	SE	Chief Operating Officer	KT											
Prof G Crowe	GC	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director												
Ms A Gohil	AG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Dr M Lewis	ML	Chief Medical Officer												
Prof K Maddock	KM	Non-Executive Director												
Prof S Toor	ST	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse												

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

In Attendance:	
Mrs N Hassall	Deputy Associate Director of Corporate Governance (minutes)
Mrs A White	Deloitte (Observing)
Mrs S Sale	Project SEARCH (Item 1)
Ms F Croxton	Project SEARCH Job Coach (item 1)
Mrs T Platt	Deputy Head of Governance & Compliance – Estates, Facilities & PFI (item 1)
Mr A Pattison	Sodexo Porter (item 1)
Miss M Stones	UHNM Outpatients Administrator
Mr L Bunn	Project SEARCH Intern (item 1)

Members of Staff and Public: 5

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Staff Story**	
066/2024	Mrs Sale introduced the members of the team and explained the partnership between Newfriars College and the Trust whereby students were provided with a 1-year unpaid internship at the Trust. She stated that the project commenced in 2018 which aimed at addressing the issue of approximately 4.8% of adults with	

autism and learning disability being in paid employment. She explained that Mr Pattison was one of the first participants in 2018 and as a result of this programme secured employment at UHNM and still works onsite, Miss Stones completed the project in 2023 and works in the outpatient administration team and Mr Bunn was a current intern and was due to graduate in summer. She thanked the Trust for the support provided and noted that the students were provided with support to train in the jobs they were doing.

Mr Pattison highlighted that he started in portering in Sodexo and applied for a job after his internship and gained employment in July 2019 on full time hours. He thanked Project SEARCH for helping him to get into paid employment.

Miss Stones explained that after she had attended a special needs school she applied to Stafford College and completed level 1 and 2 business courses, before applying for Project SEARCH. She had an interest in administration and commenced work in Springfield within Human Resources, before working on a Stroke ward and at County Hospital within Estates. She explained that at the end of her internship she applied for a job in outpatients which she started in July 2023, and she was waiting to see if this was to be made permanent. She highlighted how the project had helped to build her confidence.

Mr Bunn explained that he was currently an intern and had placements in Springfield and on the main reception in the atrium. He explained that he was going for an interview in relation to Oliver McGowan and had another interview scheduled. It was noted that Mr Bunn had provided a presentation to Mrs Whitehead and Mr Ruscoe on how the facilities at Springfield could be improved for disabled people such as access to bins within disabled toilets and Mrs Sale welcomed how well his presentation had been received, with actions taken

Mr Wakefield thanked the team for their presentations and asked whether all students had found the project to have helped with their confidence to which they all confirmed. Miss Stones explained that she was treated like an adult and as a worker which she welcomed.

Mrs Bullock advocated her strong support for the programme and thanked the team for continuing to develop the programme and welcomed the difference it had made which she has seen first hand when talking to students and parents.

Dr Griffin queried if there was anything the Trust could help with, to make the programme better and Mrs Sales stated that whilst not necessarily applicable to the Trust, she would welcome changes in making recruitment practices more inclusive, i.e. by not automatically excluding people if they did not have GCSE Maths and English if this was not required for the post.

Ms Bowen queried how further improvements could be made and Mrs Whitehead stated that placements could be widened to other areas i.e. Nursing Assistants. She thanked the students, Mrs Sales, and Ms Croxton for their continued support in addition to Mrs Platt who had championed the project within Estates.

Mr Wakefield welcomed the student's confidence and enthusiasm and added that it was positive to have two champions of the programme on the Board, in terms of Mrs Whitehead and Mrs Bullock.

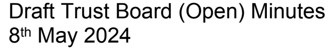
Mr Wakefield referred to the internships being unpaid, and he challenged Executives to consider how could be renumerated in a small way going forwards.

The Trust Board noted the staff story.

	Mrs Sale, Ms Croxton, Mrs Platt, Mr Pattison, Miss Stones, and Mr Bunn left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
067/2024	Mr Wakefield welcomed members to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate. Mr Wakefield welcomed Mrs White who was observing the meeting as part of the Trust's independent well-led review and added that the Board were trailing the use of a hybrid meeting, whereby Ms Gohil and Mrs Freeman were joining online.	
3.	**Declarations of Interest**	
068/2024	There were no declarations of interest raised.	
4.	**Minutes of the Previous Meeting held 3rd April 2024**	
069/2024	The minutes of the meeting held 3rd April 2024 were approved as a true and accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
070/2024	PTB/586 – It was noted that this was to be covered at the Board Seminar in May in addition to reference being included within the revised Integrated Performance Report. PTB/590 – It was noted that updated plans had been received and these were to be shared with Board members. PTB/595 – It was confirmed that HIE related to Hypoxic Ischaemic Encephalopathy.	
6.	**Chief Executive's Report – April 2024**	
071/2024	Mrs Bullock highlighted a number of areas from her report. Ms Bowen referred to the Consultant appointments and given current financial challenges queried whether it was possible to identify which appointments were linked to business cases in addition to where vacancies were replacing like for like posts. Mrs Bullock highlighted that those described as new posts related to business cases and others were replacing like for like. Mr Wakefield referred to the financial planning issue and Dr Griffin stated that whilst the position was not yet agreed, some of the commitments were challenging and it was important to gauge where the biggest risks were. It was agreed to consider this as part of the Board Seminar. Mr Wakefield thanked Mrs Whitehead and the team for delivering Project STAR early and in budget and in particular for securing the funding required to create the new car park. Mr Wakefield highlighted that the meeting was the penultimate meeting for Mrs Bullock and provided his thanks to her for her time at the Trust.	

	The Trust Board received and noted the report and approved the e-REAFs 13922, 13917 and 13838.	
HIGH QUALITY		
7.	**Quality Governance Committee (QGC) Assurance Report (02-05-24)**	
072/2024	Professor Maddock highlighted the following: • Of the 5 reported MRSA bacteraemia, 3 were due to failures in taking samples within a timely fashion and this was being reinforced to staff • C-difficile cases continued to be above trajectory and learning from other Trusts had identified that better performing Trusts had electronic prescribing (EPMA). Whilst the Trust waited to implement EPMA further controls were being identified including education on inappropriate and incorrect antibiotic prescribing • There had been a national change in sepsis reporting following updated NICE guidance and this is reported via Vital Pac in most areas, although the system was not being updated until 2025. As such this may impact on accuracy of data and alternative solutions were being considered • Positively, the Trust had been removed from the System Maternity Oversight and Assurance Group (SMOAG) due to the improvements made within maternity • A positive update was provided on the Johns Hopkins deconditioning programme which was progressing well • In terms of pharmacy medicines optimisation, the Trust remained one of the top performing Trusts in the region in reporting adverse drug reactions which should continue to be encouraged Mrs Bullock highlighted that EPMA was being rolled out at County from September 2024 and when concluded would commence roll out at Royal Stoke. Dr Lewis highlighted the matter of concern in relation to harm reviews and stated that the current process was not as robust as it could be as it relied on retrospective reviews on a small sample. He stated that a more robust prospective system was being considered. Mr Wakefield queried if the Trust was 'marking its own homework' by completing reviews internally and Dr Lewis confirmed this but stated that it was a reasonable approach. Mr Wakefield stated that the longer patients wait for care, the worse their outcomes are expected, and he queried whether the Board could be assured of the reviews undertaken given they had not identified any poor care. Dr Lewis reiterated the reason for requiring prospective reviews and identifying patients. Mr Evans added that the reviews needed to be built into business as usual whilst aiming to increase the sample size he also noted the approach taken at UHNM is no different to that across the NHS in terms of these being undertaken by the organisation themselves Dr Griffin queried if harm included psychological harm as well as physical and Dr Lewis stated that physical harm was easier to assess as the reviews were done via case note review. He stated that further enhancements to the system of review could ask patients to identify the impact of their wait which could be more informative. Ms Bowen referred to the statement regarding midwifery staffing, whereas 40% of shifts were up to 2 midwives short and this being due to increased annual leave. She queried whether resource planning took annual leave trends and persistent sickness trends into account. Mrs Riley stated that in terms of the robustness of rosters, staff taking leave was a factor in March which was due to people taking	

	leave in the last month of the financial year to avoid losing their entitlement. Mrs Haire confirmed that sickness absence was planned at 3.39% but an element for annual leave was included in bank projections. Mr Oldham highlighted that previously the Trust had carried forward annual leave therefore staff needed to use the leave by the end of March 2024, and therefore this should be a one off. **The Trust Board received and noted the assurance report.**	
8.	**Maternity Dashboard – March 2024**	
073/2024	Mrs Riley highlighted the following key points: • Training was being delivered in line with the CNST action plan with a continuing focus on statutory and mandatory training and Personal Development Review (PDR) compliance • 1-1 care in labour was maintained • Improvements had continued in terms of induction of labour • A rapid quality review had been undertaken by NHS England which resulted in the Trust being removed from SMOAG and reporting continuing via business as usual methods • Mrs Jamieson had secured a part time role within the national maternity advisory team which was a significant achievement for her Mr Wakefield referred to the escalation from QGC in terms of staffing acuity, but this was not highlighted within the report. Mrs Riley stated that acuity had improved due to the improvements in recruitment in addition to maintaining 1-1 care although the spike in March was due to an increase in annual leave as discussed in the previous item. Mrs Riley stated that the chart demonstrated where staffing did not match the roster, and this was mitigated by pulling staff from other areas to maintain 1-1 care. Mrs Bullock added that safety issues were not being highlighted, because of the way in which this was proactively managed. It was noted that the Trust expected to be fully recruited for midwives by the end of summer. Mr Wakefield queried if training of anaesthetists was a specific concern and Mrs Riley stated that this was a concern for the Division, but a plan was in place to address it and it was not causing any safety issues that she was aware of. Mr Wakefield queried why the delivery suite coordinator was not a substantive post and Mrs Riley explained that this has previously been funded via the Local Maternity and Neonatal system (LMNS) and future funding was being explored. **The Trust Board received and noted the report.**	
9.	**Infection Prevention Board Assurance Framework**	
074/2024	Mrs Riley highlighted two areas of concern; blood culture transfer times at County Hospital whereby detailed work was being undertaken to understand the rationale for the delay and any harm, which would be further considered by the Executive Quality and Safety Oversight Group (QSOG). In addition, staff immunity status in relation to measles continued to be a specific workstream, given the frequent changes to guidance and this would continue to be monitored through QGC.	



	Mrs Rodwell referred to criteria 2 where there were particular areas of partial compliance and queried how this correlated with the positive PLACE findings in relation to cleanliness. Mrs Whitehead stated that criteria 2 was wider than the scope of cleaning and added that there was 1 outstanding action in terms of cleaning which was provision of a cleaning manual. She stated that other related issues were for hard FM and estates. Mr Wakefield stated that it would be helpful to provide a summary of the 7 areas of partial compliance within the Executive Summary in addition to referring to the actions being monitored by QGC. Mrs Hassall added that it was agreed after the QGC meeting to review and strengthen the current Executive Summary. **The Trust Board received and noted the update.**	
10.	**PLACE Inspection Findings**	
075/2024	Mrs Whitehead highlighted the results whereby the Trust was above the national average across all 8 domains and within the top 6% of NHS Trusts and she thanked the team involved for the positive results. Dr Griffin stated that the pride in the environment was clearly demonstrated by the report, and welcomed the positive results over the past few years which was impressive. Professor Maddock highlighted the issues in relation to dementia clocks and Mrs Whitehead confirmed that funding had been sought from the charity. Mr Wakefield queried, given the inspections were voluntary, whether some Trusts may choose not to take part if they were aware issues may be raised and this needed to be considered when comparing results. Ms Bowen queried whether the scoring across all categories was weighted, and Mrs Whitehead explained that the percentage scores were weighted and calculated and confirmed by NHS England. Mr Evans referred to Mr Wakefield's point in terms of hospitals not choosing to take part in the inspection, and stated that Trusts were encouraged to participate, and that less modern hospitals may use it as rationale for securing funding. **The Trust Board received and noted the contents of the report and its findings following PLACE inspections which were undertaken during October and November 2023. It was noted that the associated action plan had been considered by QGC.**	
RESOURCES		
11.	**Performance & Finance Committee Assurance Report (30-04-24)**	
076/2024	Dr Griffin highlighted the following: • The emergent system financial plan had been considered and the submission committed to a range of improvements. The Committee agreed with the importance of focusing on quality and safety of patients and it was noted that the Trust was unable to confirm compliance with diagnostics given the particular challenges in endoscopy • The Trust delivered a small surplus for 2023/24 and delivered its largest capital programme with a small underspend • The sustainable improvements in cancer performance had been recognised by NHS England	

	• The Committee welcomed the effectiveness review and actions for improvement Mr Wakefield stated that the timescale to eradicate and eliminate backlogs would be covered as part of the Integrated Performance Report. **The Trust Board received and noted the assurance report.**	
12.	**Annual Plan 2024/25**	
077/2024	Ms Ashley highlighted the following: • The plan had been presented and discussed at Strategy and Transformation (STC) Committee following which slight changes had been made • The document sits alongside the Trusts planning submission and included a broader set of priorities which were more pertinent to UHNM • The priorities identified, were part of the Trust's Strategic Planning Framework as part of the Improving Together approach • Breakthrough objectives had been identified whereby a number had changed from 2023/24 and these were supported by strategic initiatives • Divisional priorities had also been identified which were supported by directorate metrics • It was noted that a glossary of terms was to be included in the final public facing version and some elements would be removed, such as divisional priorities. Mrs Rodwell referred to the Quality Strategy and the risk to clinical effectiveness and queried what aspects were expected to be identified from reviewing best practice. In addition, she queried the timeline to reduce the risk. Dr Lewis stated that this had been a focus for some time to ensure appropriate resources were available and reviews of outstanding and good Trusts were being undertaken, to establish the clinical effectiveness processes they had in place. He added that that resource had since been identified and he anticipated the risk to reduce by September 2024. Mrs Cotton added that an A3 was being undertaken to review the associated root causes and areas for improvement. Mrs Rodwell referred to the NHS overall objectives and weighted average activity target of 107% which she did not recognise and requested clarity on this. Ms Ashley stated that productivity improvement was a new strategic initiative, and this would be considered further at the Board Seminar. She stated that a national tool was being considered although she had not been sighted on it and in terms of value weighted activity, this formed part of the national submission which was to be discussed in part 2. Mrs Bullock referred to the productivity tool which NHS England were creating and stated that she had seen a demonstration which looked useful. She explained that organisations were being asked to test and critique the tool so that it could be refined and she noted that it went beyond workforce as it also included performance data. She noted that a similar tool would be produced for Community and mental health services over the next 6 to 9 months. Mr Wakefield stated that if the Trust aimed to be in the top 20%, there were several areas where the Trust incurred cost, and this needed to be articulated. Ms Ashley stated that the methodology and approach and focus for 2024/25 would be articulated and noted the deep dive taking place in the May Board Seminar. Ms Gohil referred to equality, diversity, and inclusion (EDI) and queried how this could be referenced more within the document. Ms Ashley stated that EDI was	

	included in respective people plans and Mrs Haire stated that positive and inclusive culture was a strategic initiative as well as forming part of the Trust's undertakings. Mrs Cotton added that the final piece of the strategy was to publish the refreshed overarching strategy, which included EDI more prominently. Ms Ashley highlighted that as part of the refresh of the Trust Strategy, the Trust had been disheartened at the lack of response from stakeholder and staff following engagement on the draft. She highlighted that it had been agreed at the STC to provide more time for engagement, given Mrs Bullock's departure and Dr Constable's appointment. As such it was noted that the strategy aimed to be approved before the end of the calendar year and the 2025/26 annual plan would be the delivery plan for the strategy. Ms Bowen welcomed the use of improving together and reference to the strategic planning framework. Mr Wakefield referred to the refresh of the strategy and reference to 2023/24 patient activity of 130,000 elective admissions which was a 14% increase from the previous year. Mr Evans stated that the largest proportion of growth related to the opening of the Clinical Decisions Unit within the Emergency Department and that plans would reflect how this increase in demand would be managed overall. **The Trust Board approved the Annual Plan and noted that assurance of its delivery would be undertaken via the Strategy and Transformation Committee, over the course of 2024/25.**	
PEOPLE		
13.	**Strategy & Transformation Committee Assurance Report (01-05-24)**	
078/2024	Ms Bowen chaired the inaugural STC and highlighted the following: • An area of escalation related to the funding available for development of services in line with the clinical strategy • Training compliance in relation to data security and protection continued to be an area of challenge • Concerns regarding the allocation of national digital funding were identified which could impact on the digital strategy and mitigation was being considered • The Committee agreed with the top 3 risks for 2023/24 • An outcomes framework was being developed to support the Health and Wellbeing Strategy in addition to considering associated population health metrics • A stocktake on the Trust as an anchor institute was to be brought to future Committee • A framework for the use of 'shadow' IT was in development • Plans were in place to improve compliance with the NHS impact standards Mr Wakefield referred to the issue regarding digital funding and requested an update on mitigation. Mrs Freeman stated that within the autumn budget, digital innovation monies had been identified which was to be used for EPR cases. However, further guidance had been issued with a focus on infrastructure and backlog IT maintenance, therefore the Trust was making a case that as it had already improved infrastructure, the Trust had a greater need for an EPR. The most recent update requested teams to work together to organise technology within their local system and Mrs Freeman had confirmed that the EPR case met those criteria.	

	Mr Wakefield queried the contingency plan if there was a delay on funding and Mrs Freeman stated that this was being considered, given the current contract was due to end in 2027. She stated that part of the plan was to look at what was being spent on IT across the system, to identify any potential savings opportunities, or whether to implement the EPR only for UHNM. **The Trust Board received and noted the assurance report.**	
RESPONSIVE		
14.	**Integrated Performance Report – Month 12**	
079/2024	Quality and Safety Performance Mrs Riley highlighted the following: • Following a further never event relating to wrong site surgery a patient safety incident investigation (PSII) was underway in addition to further thematic analysis of all wrong site surgery never events, as these related to skin lesions. Mrs Riley confirmed that the patients had recovered well as these were minor procedures, whilst noting these should not have occurred and outlined the negative experience of having to undergo an unnecessary procedure. In terms of pressure ulcers, an A3 had been developed to reduce incidence of pressure damage and further updates were to be taken to QSOG • Whilst falls with harm was above trajectory this was on a downward trend • Friends and family results had been reviewed to identify the top 10 areas which could improve the overall position, and this was being worked through with Divisions Mr Wakefield referred to the lack of improvement in pressure ulcers which was disappointing given the improvement in staffing and Mrs Riley stated that there had been fewer pressure ulcers as a result of lapses in care, which correlated with staffing levels and the focus was on the need to reduce pressure damage from occurring in the first place. Mrs Riley also noted that pre hospital pressure ulcers would also contribute to this. Dr Griffin referred to the rolling SHMI which was below 100 and improving but was highlighted as to be failing on the subsequent report. Mrs Riley highlighted that this was an error and would be corrected, as the position was improving. Mr Wakefield referred to maternity friends and family test results which had dipped and queried the reason for this since investment had been made. Mrs Riley stated that the reduction related to the antenatal friends and family question therefore this was being focussed on. In terms of response rates, she highlighted that the survey was optional, and this was a driver metric for the specialty. She highlighted that women were asked for their views on four occasions after each appointment e.g. antenatal, postnatal etc, therefore an element could be due to survey fatigue. In addition, the Trust was looking at a way in which the Trust could encourage patients to complete the friends and family test, as well as reviewing benchmarking where other areas were performing well. Mrs Haire referred to the data regarding essential to role and statutory and mandatory training and queried when incidents were being reviewed whether that information was being used to triangulate. Mrs Riley highlighted that this formed part of the Care Excellence Framework visits. Mr Evans referred to wrong site surgery and queried if the Trust was looking at learning outside of the organisation in terms of the thematic review. Mrs Riley	

stated that this had been previously considered and the further review was to consider if human factors was a particular issue.

Mr Wakefield referred to sepsis reporting in the Emergency Department and queried what was being done to improve this. Mrs Riley stated that this was a driver metric, and the sepsis lead visited the department each day. She added that whilst it was recognised that the department was under intensive pressure, which was contributing to performance, improvements were required, and this continued to be monitored. Mr Wakefield queried if all staff understood the criteria for sepsis and Mrs Riley stated that it was not thought to be a knowledge gap but rather timeliness of prescribing which was the responsibility of clinicians and nurses.
Dr Lewis referred to the issue with Vital Pac and the changes in criteria and queried how this could be escalated. Mrs Riley stated that this issue had been escalated alongside other organisations. Mrs Freeman added that Vital Pac was not yet in place within the Emergency Department and before this was introduced a risk assessment was being undertaken by the Chief Nurse Information Officer. Mrs Freeman added that this had been escalated to System C.

<u>Operational Performance</u>

Mr Evans highlighted the following for urgent care:

- March 4 hour performance was just over 70% which was positive, but the Trust did not achieve the national expectation
- During April performance continued to be above 70% although due to removing some of the winter measures during April, this was expected to impact performance for May
- The trajectory for 2024/25 was to achieve 78% by the end of the year and particular improvements were aimed to be delivered towards the back end of the year

Ms Gohil left the meeting.

Dr Griffin welcomed the improvement in 4 hour performance, whilst recognising the further work required in terms of discharges and the increase in long stay patients. Mr Evans highlighted that there had been an increase in simple discharges due to a change in approach and focusing on ward processes to reduce variation and overall long length of stay has improving.

Dr Lewis referred to the reference to readmissions and stated that for frail, complex patients the focus was on ensuring clinical staff were aware of RESPECT documentation and avoiding readmissions where this was indicated by the documentation.

Mrs Riley referred to the County Hospital performance and highlighted that the senor nurse who had been in place was due to complete their secondment and as such queried if standard work had been considered to consistency of approach. Mr Evans confirmed that this was being considered.

Mr Oldham queried progress in relation to demand management and Mr Evans highlighted that work had begun to bring together projects aimed at reducing demand with a view to closing the current 85 beds gap by October 2024. He stated that whilst some areas of focus would require investment, an evaluation of existing schemes was being undertaken to ascertain whether some services could be disinvested.

Ms Bowen referred to the reduction in demand, acute care at home and the large vacancy rate and queried if this related to UHNM staff. Mr Evans stated that the

model worked with Midlands Partnership NHS Foundation Trust (MPFT) and the largest proportion of vacancies were in relation to MPFT. He stated that further work could be done to increase the impact of the scheme, and this remained under constant review.

Mr Wakefield queried the opening of the discharge lounge and Mr Evans stated that this had not opened due to the impact on other services, including elective services. He stated that this was a possibility for 2024/25 and was being considered as part of demand management. Mr Wakefield requested further updates on this to be provided to PAF.

Mr Evans highlighted the following in terms of elective care performance:

- 78 week position continued to have breaches in March, and it was expected to clear these by June; it was noted that of the previous Industrial Action had affected performance
- 65 week performance was anticipated to be cleared by September although if left unmitigated this position would increase, therefore this was an area of focus and investment. Three specialties remained challenged respiratory, gastroenterology and ENT and although workforce and finances were aligned there remained more work to do.
- Given the national aim of reducing overall surveillance numbers the Trust had requested support from NHS England regarding endoscopy
- It was noted that funding had not yet been forthcoming for investment, and this would impact on the ability to achieve the September trajectory. This was discussed on a weekly basis with NHS England

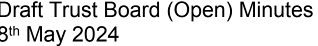
Dr Griffin referred to 52 week waits and queried whether it was feasible to eliminate 52 week waits as identified in the annual plan. Mr Evans confirmed that this would be achieved for certain specialties although it was not anticipated that all would be removed.

Mr Wakefield referred to the 103% versus 107% position and Mr Evans stated that the targets related to the financial value of elective work compared to 2019/20, which had been set nationally. It was noted that the organisational target was 103% for 2024/25 which was expected to be exceeded to bring in additional ERF income to support the financial position.

<u>Workforce Performance</u>

Mrs Haire highlighted the following:

- There had been continued positive reductions in turnover and vacancies and staff retention remained an area of focus
- There had been an improvement in sickness absence as anticipated and the focus was on supporting staff with stress and anxiety and a further update on the work being undertaken was to be considered by the People, Culture, and Inclusion Committee
- PDR performance had slightly improved, and Women's, Children's and Support Services had utilised improving together methodology to focus on improving their position which had resulted in positive movement from 70% to almost 95% in the past few months. As such, other Divisions are being asked to learn from the Division
- In terms of statutory and mandatory training, the position remained static at 93/94% and the focus in May was on core for all and essential to role training.
- Going forwards PDR compliance was expected to improve in addition to sickness absence.



- The recent staff engagement score was 6.61 although recent response rates were lower than before the staff survey and this was being explored

Ms Bowen welcomed the assurance regarding the low turnover and vacancies and associated stretch target. She queried sickness and the main driver being stress and anxiety and queried how sickness absence could be addressed, whilst not wanting to lose sight of being kind. Mrs Haire stated that policy compliance was being reviewed in addition to focussing on holding conversations with staff to identify any drivers.

Mrs Riley stated that as work continued to reduce vacancies, the Trust needed to ensure messages were continuing to be promoted in terms of the need to recruit our students and to maintain the pipeline for additional nurses in training.

Financial Performance

Mr Oldham highlighted the following:
- The Trust had delivered £0.2 m surplus
- 2024/25 remained a challenge in terms of the non-recurrent measures used to deliver 2023/24 performance
- Capital had underspent by £0.5 m on one of the biggest capital programmes the Trust had had
- To deliver the capital programme, some items from the backlog of medical devices / equipment were brought forward
- Cash position ended at £82 m which was more than expected due to accruals and capital valuations
- Reconciliation of retained earnings had identified movement around the PFI due to the reclassification of IFRS16 and this had subsequently changed the valuation of liability and required a technical adjustment in the accounts of £46.2 m. It was noted that this would show as a deficit within the accounts, but the Trust would not be held to account for that position.

Mr Wakefield congratulated the team on managing the financial pressures in year and delivering the investment programme.

The Trust Board received and noted the report.

GOVERNANCE

15.	**Audit Committee Assurance Report (02-05-24)**	

080/2024

Ms Bowen highlighted the following:
- There had been a delay with revising the Quality Impact Assessment policy and this was due to aligning the Trust's approach with the system
- An internal audit review of the Mental Capacity Act was being reviewed and as such it was expected that the opinion would improve
- 3 actions had arisen from the effectiveness review which were being considered
- 5 internal audit reports had been received, all of which received positive opinions and a positive Head of Internal Audit Opinion was expected for the year end
- A positive rating for the annual fraud assessment had been identified in addition to a positive review of the internal audit function

The Trust Board received and noted the assurance report.

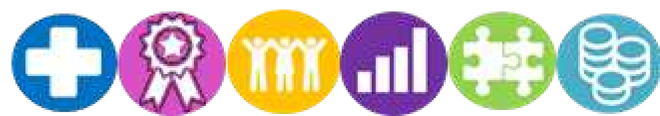
16.	**Q4 Board Assurance Framework (BAF)**	
081/2024	Mrs Cotton highlighted the following: • the BAF had been considered at each Committee and the summary document had also been included • Following comments within the board effectiveness review, work to integrate the summary BAF into the highlight report was to be considered • Key changes in terms of risk movement had been highlighted and the top 3 risks had been considered and approved at each Committee for inclusion within the Annual Governance Statement: sustainable workforce, sustainable finance and quality/responsive care • Following the Board Seminar discussion on risk appetite this will start to feature within the BAF from Q1. Mrs Cotton highlighted the ongoing work at system level in relation to strategic risks whereby the system were working towards a system BAF rather than ICB BAF. Ms Ashley referred to the need to be clear whether risks related to the ICB or ICS and stated that whilst provider organisations had mapped risks to their strategic priorities and these were broadly aligned, this alignment was not the case for the ICB. Mr Wakefield referred to the third line of defences for BAF 1 and the internal audit review of the Mental Capacity Assessments which was rated as an area for escalation. It was noted that this reflected the position at the end of Quarter 4 and any change in opinion following the re-review of the internal audit would feature within Quarter 1. **The Trust Board approved the BAF and the risk scores and assurance assessments in addition to agreeing the top 3 risks for 2023/24.**	
17.	**Annual Rules of Procedure and Outcome of Committee Effectiveness**	
082/2024	Mrs Cotton highlighted that the document had been updated following completion of the Committee Effectiveness reviews, which had been considered by each Committee. Mr Wakefield referred to the improvement actions in relation to report writing and suggested that this should be an action for each Committee as well as recognising that deep dives were now being undertaken for all Committees. **The Trust Board received and noted the outcome of Committee Effectiveness reviews in addition to approving the revised Rules of Procedure.**	
CLOSING MATTERS		
18.	**Review of Meeting Effectiveness and Review of Business Cycle**	
083/2024	No further comments were made.	
19.	**Questions from the Public**	
084/2024	No questions had been raised by any members of the public.	
DATE AND TIME OF NEXT MEETING		
20.	**Wednesday 5th June 2024, 9.30 am, via MS Teams**	

Trust Board (Open)

Post meeting action log as at 30 May 2024

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/586	03/01/2024	Integrated Performance Report – Month 8	To provide an update on admission avoidance schemes at a future Performance and Finance Committee.	Simon Evans	~~27/02/2024~~ ~~26/03/2024~~ 30/04/2024	15/05/2024	It was noted at May's meeting that this was to be covered at the Board Seminar in May in addition to reference being included within the revised Integrated Performance Report.	B
PTB/590	06/03/2024	Chief Executive's Report – February 2024	To share the plans for the Cancer Centre, as a result of the Coates Foundation donation, with members of the Board.	Lisa Thomson	08/05/2024	08/05/2024	Circulated to members.	B
PTB/591	06/03/2024	Maternity Dashboard - January 2024	To provide an update on the outstanding CQC actions to a future Maternity Quality Governance Committee.	Ann-Marie Riley	22/05/2024		Included on Maternity and Neonatal QGC 6th June 2024.	GA
PTB/595	03/04/2024	Maternity Dashboard – February 2024	To confirm with Dr Griffin what the HIE was in relation to with regards to HSIB referrals.	Ann-Marie Riley	08/05/2024	08/05/2024	Confirmed that HIE related to Hypoxic Ischaemic Encephalopathy.	B
PTB/596	03/04/2024	Gender Pay Gap Report	To consider the mode as opposed to the mean/medium for a different perspective on the gender pay gap.	Jane Haire	05/06/2024	28/05/2024	A review of the mode [the measure that represents the most frequently occurring pay point / appears more frequently than any other number] reveals that the most frequent pay points are on the lowest pay band (Band 2). This method has limitations as it only highlights this most common pay band and ignores the overall distribution of salaries when assessing gender pay. The national template for reporting looks at median and mean only as this helps to identify salary disparities more effectively.	B
PTB/597	03/04/2024	Integrated Performance Report – Month 11	To explore the possibility for follow-up text message surveys for the friends and family test for A&E.	Ann-Marie Riley	05/06/2024	30/05/2024	Text service already available, QR codes are displayed and there is access to paper copies. Texts are not available to follow up if FFT not completed. Meeting taking place on 10 June, between ED matron and Becci Pilling to consider any further actions.	B
PTB/598	03/04/2024	Integrated Performance Report – Month 11	To provide an update to a future meeting on the impact of interventions put in to improved sepsis screening compliance in the Emergency Department.	Ann-Marie Riley	10/07/2024		Action not yet due.	GB
PTB/599	03/04/2024	Integrated Performance Report – Month 11	To provide further information to the People, Culture & Inclusion Committee on sickness absences due to stress and anxiety in terms of the spread across different grades and types of staff.	Jane Haire	03/07/2024		Action not yet due.	GB



Chief Executive's Report to the Trust Board

May 2024

Part 1: Contract Awards

2.1 Contract Awards and Approvals

Since 14th April to 14th May 2024, 3 contract awards over £1.5 m were made, as follows:

- **NMCPS Blood Sciences Managed Service Contracts** supplied by Beckman Coulter UK Ltd & Siemens Healthineers UK, for the period 01/10/2022 to 30/09/2024, at a total cost of £2,563,743.23 incl. VAT, approved on 08/05/2024
- **New NMCPS Blood Sciences Managed Service Contract** supplied by Roche Diagnostics Ltd, for the period 01/10/2025 to 30/09/2032, at a total cost of £28,310,000.00 incl. VAT, with savings of £970,000.00 incl. VAT approved on 08/05/2024
- **In Centre Haemodialysis Consumables** supplied by Fresenius, TPS, Medical Access, Baxter, Medtronic, Nipro, B Braun, for the period 01/04/2024 to 31/03/2026, at a total cost of £2,126,280.00 incl. VAT, approved on 08/05/2024

2.2 Consultant Appointments – May 2024

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Primary Eye Care	New	TBC	TBC
Consultant Anaesthetist (Specialist interest in Trauma & Resuscitation	New	TBC	TBC
Consultant Anaesthetist with special interest in Neuro-anaesthesia	New	TBC	TBC

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

Post Title	Reason for advertising	Start Date
Consultant Anaesthetist special interest in Vascular & Pre-assessment	Vacancy	5/5/24
Consultant Anaesthetist with special interest in Pain	New	8/5/24

No medical staff vacancies closed without applications / candidates during May 2024:

2.3 Internal Medical Management Appointments – May 2024

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Ultrasound Lead - Imaging	New	Yes	1/5/24

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

Part 2: Highlight Report

High Quality Responsive People Improving & Innovating System & Partners Resources

National / Regional

1. Infected Blood Inquiry

An independent public statutory Inquiry was established to examine the circumstances in which men, women and children treated by the NHS, were given infected blood and infected blood products, since 1970. The Inquiry looked at why this happened, how authorities responded, the nature of support provided, questions of consent and whether there was any cover up involved.

The extensive report was published on 20th May 2024 and makes for uncomfortable reading. It sets out a broad range of lessons learned and recommendations associated with patient safety, management of risk, minimising delays in treatment / response, decision making, questioning the 'status quo', consent and communication, candour, transparency, involvement in decisions, record keeping, public health and complacency.

A gap analysis is being undertaken and will be taken through our quality governance structure, including Quality Governance Committee.

The full report can be found here: [The Inquiry Report | Infected Blood Inquiry]

2. General Election

The Prime Minister announced a General Election for Thursday 4th July which means we will need to consider the impact of the pre-election period (Purdah) on some of our business. As a public sector organisation, we must avoid anything that could be seen as favouring one election candidate or party at the expense of another.

System / Regional Focus

3. Integrated Care Board (ICB) Briefing May 2024

I have circulated the latest ICB briefing in full to Board colleagues, to keep them informed of the discussions at the meeting held in May. Key agenda items were as follows:

- Journey to Work, Health and Care People Team
- System Level Access Improvement Plan
- Quality & Safety Report
- 2024/25 Operating Plan
- Health and Care Senate Terms of Reference
- People, Culture and Inclusion Committee Report
- Audit Committee Chair Report

To view the papers or watch the video recording of the meeting visit the [ICB website].

4. Equality, Diversity and Inclusion (EDI) System Wide Event

The Chairman and I attended a system wide event focussed on equality, inclusion, and diversity with Roger Kline, who had been part of our independent cultural review a couple of years ago. This was an informative session and while we have done a great deal to support EDI as a system, we still have a great deal to do.

Making this organisation one which values equality, diversity and inclusion is everybody's responsibility and we must make sure that everybody understands this.

5. Operational and Financial Challenges

During the month, along with other CEO's, Operations Directors and Finance Directors from across the system, I met with our national and regional regulators from NHS England where we once again discussed the operational and financial challenges faced not just by ourselves but across the ICB. Our system had already significantly improved our projected deficit position and I am pleased that a very challenging £90M deficit for the system was agreed as an accepted position. It will however require all system partners to work collaboratively to achieve this and our own efficiency programme has an additional £10m stretch target to achieve on top of the £49m target we already had. We know that it will be tough and will require us to work together on viable solutions, whether that be productivity, increased activity or cost reduction.

Organisational Focus

6. Chief Registrar

I recently had the opportunity to meet with our first Chief Registrar, Dr Mehak Gupta. This role helps to provide a vital bridge between senior clinical leaders, managers and the wider doctors-in-training workforce. With a focus on service improvement, education and training, education, morale, workforce and sustainability, I am looking forward to hearing how she will be helping us make this a great place to work for everyone.

7. Reward and Recognition

I was pleased to present Employee of the Month to James Mycock, Nursing Assistant on Ward 227. Music therapy is something the ward team wanted to bring to their patients to aid their rehabilitation and James volunteered to help. Twice a week he brings his guitar, lifting the morale of patients and families at a very difficult time. Those working on the ward also enjoy the sessions. James went above and beyond to research and learn more about music therapy and rehabilitation and how he could adapt the weekly sessions to make them more interactive for patients.

I was also pleased to present my Chief Executive's Award to Caroline Belpomer, a discharge facilitator on ward 80. Caroline was nominated for her fast action whilst off duty to save a man's life. As the first on scene of a serious car crash, she performed lifesaving CPR before an ambulance arrived and thanks to her and the actions of the local community, he is alive and recovering.

Another award was given to the team at County Hospital involved in delivering our first day case hip replacement procedure. True to our values this was a real team effort to ensure the planning and delivery of the procedure went as well as it should. As a result of the pre and post operation planning, our patient was able to walk out of hospital on the same day! Board may recognise this as the patient attended a previous board meeting and outlined the merits of such surgery as a day case.

Judging of our annual Staff Awards has also taken place this month and like every year, it is such an uplifting and inspiring task although so difficult at the same time. There are so many moving nominations about how our staff are making a difference for the teams and the patients we serve, and my congratulations go to everybody who was nominated. Our Night Full of Stars awards ceremony takes place on 6th September.

8. Disability and Inclusion Conference

I had the pleasure of opening our first Disability and Inclusion Conference during the month. The mix of attendees, from allies, managers and employees with hidden and non-hidden disabilities made for a great event. We have made huge strides on our inclusivity agenda, but we know there is so much more we need to do to make everyone working here at UHNM feel welcome and valued. My thanks go to everybody who took time out of their busy schedules to attend and help us to shape the improvements we need going forward.

9. A Personal Note

Very sadly, today is my last Board meeting at UHNM and therefore my last Board briefing. My last working day is the 28th June and I have had regular contact with my successor, Dr Simon Constable to ensure a thorough handover.

I have had a fabulous 40 years in the NHS and am saddened that I am not able to continue further. However, the last five years at UHNM have most certainly been my career highlight. Whilst there have been obvious challenges, I can honestly say I have worked with some fantastic people and teams who do fantastic things.

I am also very grateful to our Board and my Executive Team for your support and commitment over the last five years and I feel privileged to have been your CEO. Whilst the changing of the guard can be unnerving, I am confident that our Board has the right skills, knowledge and experience to continue our path of making UHNM a centre of excellence in all we do. UHNM is definitely safe in your hands.

Executive Summary

Meeting:	Trust Board (Open)	Date:	5th June 2024
Report Title:	Monthly Maternity Dashboard: April 2024	Agenda Item:	7.
Author:	Sarah Jamieson - Director of Midwifery & Jill Whitaker – Deputy Director of Midwifery – Workforce & Gynaecology		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

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

Executive Summary

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

Background
The Maternity incentive scheme - year 6 requires evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board using a minimum data set. The measures within the dataset are included and additional information provided.
Based on the CQC report released 23.6.23, UHNM Maternity is rated “requires improvement”.

Though not part of the maternity support programme, UHNM is part of SMOAG (System Maternity Oversight Assurance Group) which provides additional support and guidance. The final meeting of this group was held and the feedback was extremely positive.

Assessment
- Compliance with training is good, focus required for anaesthetic training over coming months.
- Improvements with midwifery triage within 15 minutes and induction of labour within guidance continue.
- Acuity and staffing levels on the delivery suite and wards continue to be monitored.
- One to one care in labour maintained throughout the month.
- The delivery Suite coordinator has remained supernumerary throughout April

Key Recommendations

The Trust Board is asked to receive this report.

Maternity Monthly Dashboard

12th May 20242024 (April report)

1. Introduction

The Maternity incentivisation scheme - year 6 requires the Trust to:

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

Figure 1: Minimum Data Set

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

Report on:

- The number of incidents logged, graded as moderate or above and what actions are being taken.
- Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training.
- Minimum safe staffing in maternity services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover, versus actual prospectively
- Findings of review of all cases eligible for referral to HSIB
- Service User Voice feedback
- Staff feedback from frontline champions and walkabouts
- HSIB/NHSR/CQC or other organisation with a concern or request for action, made directly with the Trust
- Coroner Reg 28 made directly to the Trust
- Progress in achievement of CNST 10

2. Assessment

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

In April there was one after action review.

The thematic review was in relation to 3 cases regarding CTG interpretation and escalation.

The after-action review is combined with PICU and child health and related to a baby who died at 8 days of age on the paediatric unit and we are awaiting the paediatric timeline.

2.Training compliance for all maternity staff groups

Training continues in line with CNST requirements and compliance is good across all specialities.

Staff Training Figures FETAL WELLBEING Training

MAY 2023 – APRIL 2024 inclusive (compliance 100% staff)

	Doctors	Obs consultants	Obs trainees	Midwives/Bank	TOTAL
*Total number staff	52	16	36	337	389
Staff trained (inc PROMPT Trainers)	47	15	32	295	342
*Current compliance	90%	93%	88%	87%	87%

Compliance has dropped slightly in April; this is a continuous programme and we expect compliance to improve.

Staff Training Figures PROMPT Training

(MAY 2023 – APRIL 2024 inclusive (compliance 100% staff)

	Doctors	Obs consultants	Obs trainees	Anaesthetist	Anaes consultants	Anaes trainees	Midwives/Bank	CSW	TOTAL THEATRE NOT INC	Theatre	HDU NURSES
*Total number staff	63	17	46	69	27	42	337	106	575	7	4
Staff trained (inc PROMPT Trainers)	55	15	40	53	20	33	297	90	495	6	0
*Current compliance	87%	88%	86%	76%	74%	78%	88%	84%	86%	85%	

The HDU nurses are new in post and training has been booked.

Training of the anaesthetists is ongoing.

Training has continued through March.

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

There were no HSIB referrals in April.

4.Service User Voice feedback

Feedback below received from patient.

Had my little boy via c-section Monday 22nd April 2024. All staff were brilliant, so good at their jobs. And really looked after me and my little boy Frankie.

He was moved to Neonatal Intensive Care unit, I can't thank the staff enough, they saved my little boy, and they were all so nice.

I stayed in ward 205, and all the staff there were just amazing. The dinner ladies are so nice, always smiling and offering you hot beverages.

Once my little boy got better we were moved to the transitional care unit, the staff were unbelievable! They go above and beyond for you, they are all so so nice, I wish I could thank every single one of them!

Teresa on the transitional care unit, is the most amazing person, she is so caring and will do anything for you and make you feel at home. She'd help me with everything! I can't thank her enough; she is such a special lady.

I'm honestly so so grateful to every member of staff, they have been fantastic, every single one of them are so sweet and they all deserve a massive pat on the back! They are all just amazing at their jobs and make sure a massive difference in peoples lives.

Thank you all so so much for the love and care me and my little boy received. I will never forget any of you. You are all angels. Xxxx

5.Staff feedback from frontline champions and walkabouts

The following feedback was received following the April safety champion walkabout.

- *MAU – busy but felt very calm, no concerns raised and no staffing concerns.*

- *NNU – has been very busy but is currently seeing a reduced escalation level and the staff said it did feel calmer, no medical or nurse staffing concerns.*
- *Delivery Suite - again busy but the unit was calm, no concerns raised.*
- *Ante-Natal Clinic - staff noted the clinic wasn't as busy as it usually is, no concerns raised*
- *Spoke to the reception desk as you come into the maternity block and she noted that one side of the antenatal clinic doors is frequently sticking on one side and was worried it could cause harm to a member of the public or staff. She said it does get repaired then it stops working again - it isn't working today.*

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

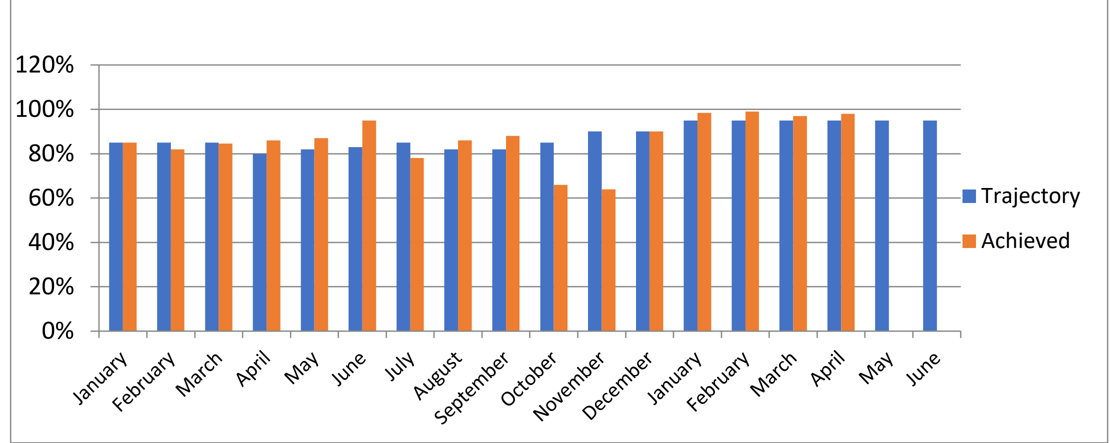
Following a CQC regulatory visit in March 2023, a section 29a safety warning was issued. This was in relation to MAU safety and the Induction of Labour process.

6.1 As part of the actions for this Maternity Assessment Unit Midwifery triage times are audited and monitored daily.
6.2 To provide assurance regarding the induction of labour process, breaches against maternity guidance are monitored each month.

6.3 Induction of labour

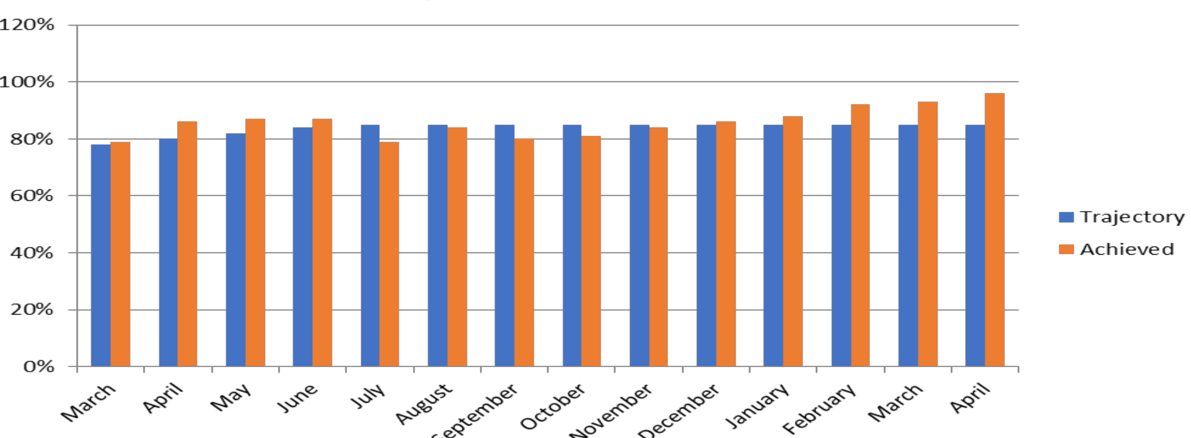
We continue to monitor the birthing people booked for induction of labour and the percentage that breach current guidance. There has been a steady improvement in the percentage of people commencing induction of labour in line with guidance and in April it was above the trajectory. 98.4% of service users were induced in line with guidance.
On analysis of the data, the cases that were delayed were because of neonatal unit acuity.
No harm was caused as a result of this delay.

Figure 4 - The percentage of people who commence their IOL within the specific guideline for their pregnancy pathway.



6.4 Midwifery triage within 15 minutes
The monitoring of midwifery triage times continues. 93% of service users were seen by a midwife within 15 minutes.
1606 people attended MAU in April, of which 65 breached the 15-minute midwifery triage target time.
This gave a compliance of 96%.

Figure 5 - Percentage of birthing people who present at MAU who are triaged within 15 minutes



Improvement work continues the MAU midwifery triage times. UHNM have set a stretch target of 95% compliance, it is recognised that, nationally there is no agreed level of compliance and many units are working to an 85% target.
Because we believe that we should always aim to provide the best care possible for the people who use our service, 95% will continue to be our target.

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

8. Progress in achievement of CNST 10 year 5

Year 5 was achieved; we are now working on year 6. Monthly meetings continue. There are no issues or escalations at the present time.

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

Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.
It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

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

10. Minimum staffing in maternity services

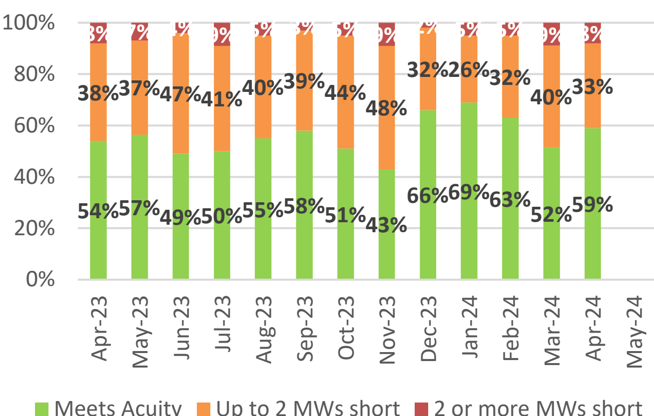
Based on 25.99% uplift the minimum staffing in maternity services for UHNM is 271.88 whole time equivalent midwives and 29.91 non-clinical/specialist midwife roles.

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

The current midwifery vacancy is 32.97WTE

Current vacancy	32.97 WTE
Awaiting start date	8.23 WTE
Offered and accepted post on completion of course	25.82 WTE
Predicted vacancy by October 2024	+ 1.08 WTE

Midwifery staffing acuity
The chart below shows acuity on the delivery suite.



It is also important to consider the acuity in the inpatient ward areas, particularly the post-natal areas (Ockendon 2022, IEA12.4)

In 2021 Birthrate plus for ward acuity was withdrawn and has recently been relaunched, we are now able to monitor and improve staffing on wards 205 and 206. The team are undergoing training and support and the data this provides will support staffing levels moving forward.
Initial analysis of data for March showed 71% compliance with data entry.86% of entries indicated that there was a shortage of midwives based on the acuity at the time.
The ward-based acuity tool does not differentiate between a small number of midwives needed and a significant number of midwives needed, (as does the delivery suite tool). The colours are simply red or green. It does, however, support the manager in planning her roster and allocation of staff.
Though midwifery numbers have increased on the wards, they are not yet fully established to birthrate plus numbers. There are also some training issues for data input which are being addressed by the ward manager. In its current format the tool does not give detailed reports of acuity and staffing, this is being discussed with the birthrate plus team.
The acuity on all wards is discussed at the daily safety huddle and reviewed two hourly by the flow coordinator.

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

12. The midwife to birth ratio

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

13.The percentage of specialist midwives employed

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

Total Clinical WTE	271.88
Non-Clinical	29.91

Clinical, Specialist 301.79

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

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

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

15. Medical staffing

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

16. PMRT, Stillbirths and Neonatal Deaths

In April 8 PMRT were completed.

Case 1	C+A
Case 2	C+B+A Transferred for NICU care from Warwick
Case 3	B+B+B
Case 4	B+A+B
Case 5	B+B++B
Case 6	B neonatal care only
Case 7	awaiting second reviewer for grading
Case 8	A +A

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

In March one case was jointly reviewed with Warwick and this is not yet published as waiting for the completion of the action plan.
2 further neonatal deaths have been reviewed, not yet published as waiting for input from other teams.

All cases will be reviewed using the PMRT tool.

17. Complaints
3 complaints regarding maternity services were received in April.
1 for neonatal unit and 2 for maternity.
Both cases are being reviewed.

18. Sepsis management

The data shows an improvement in screening and antibiotics given within an hour. There are still improvements to be made with screening, particularly in our emergency portals.

IVAB within hour

Month	April 2024				
Dept	**True Red Flag Pts**	**Already on Abx**	**Abx in 1 Hr Count**	**Late IV Abx**	**Abx in 1hr % of True RED Flag**
CAU	0	0	0	0	N/A
MAU	2	0	1	1	50.0%
Grand Total	**2**	**0**	**1**	**1**	**50.0%**

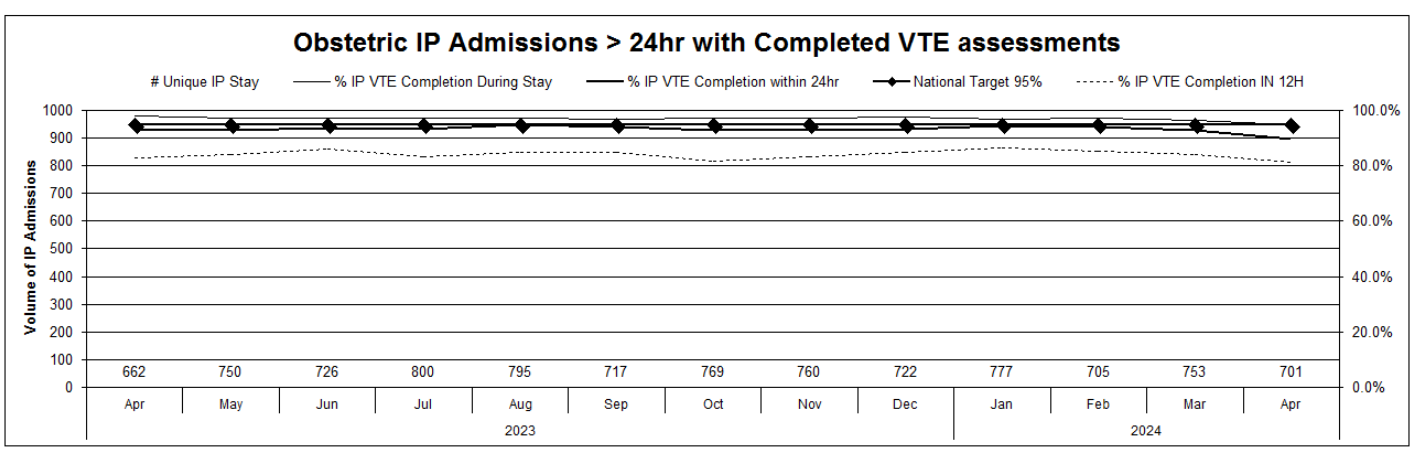
Screening Compliance

Month	April 2024		
Dept	**Pt Count**	**Screened Count**	**Screened %**
CAU	23	23	100%
MAU	7	5	71%
Grand Total	**30**	**28**	**93%**

The Advanced Midwifery Practitioner trainee is focusing on sepsis management, she is leading a team which is reviewing ach identified case and identifying actions and improvements.

19. Venous Thrombosis Embolism (VTE) management

Thrombosis and thromboembolism were the leading cause of maternal death in 2020-22 (MBRRACE- Jan 24)



All areas are over 95% compliance with VTE assessment within 12 hours of admission. Except for the maternity assessment unit which is 62.6% for April.
Data is pulled from the K2 electronic records, based on the current method of data collection it is difficult to establish if the patients for whom it was not completed were admitted as inpatients or ward attenders. More work will be commissioned to understand this further.

Summary and discussion

The elements required for compliance with The Maternity incentivisation scheme - year 5 are included in this report.

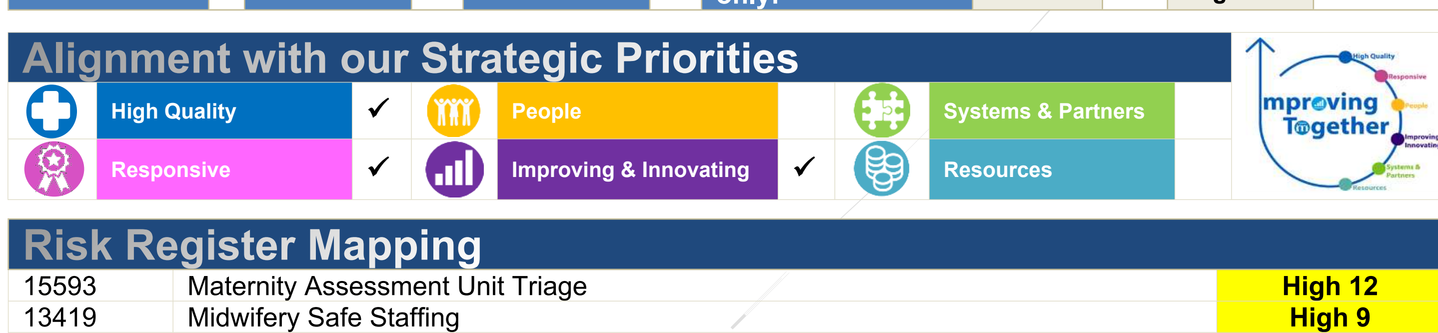
Improvement work in line with the CQC actions are ongoing, the progress is good but we recognise that there is always more work to do. Midwifery staffing and acuity will continue to be monitored; we will be focusing on the acuity tool in the ward areas to ensure that it is a reliable effective tool.

Executive Summary

Meeting:	Trust Board (Open)	Date:	5th June 2024
Report Title:	Maternity and Neonatal New Serious Incident (SI) Report Quarter 4(1st January – 31st March 2024)	Agenda Item:	8.
Author:	Catherine Hegarty, Quality & Risk Manager		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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



Alignment with our Strategic Priorities

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

Risk Register Mapping

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

Executive Summary

Situation

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

No of open maternity and neonatal Serious Incidents:	**17**
Investigation in progress:	6
Investigations completed/awaiting to be presented and closed by Risk Management Panel and ICB SI Group:	11

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 - 3 new PSII were reported:

- January 2024 0 incidents
- February 2024 3 incidents
- March 2024 0 incidents

Category of Incidents:
1 Maternity and Newborn Safety Investigations (MNSI) (previously HSIB) and 2 Perinatal Mortality Review Tools (PMRT).

There has been a reduction in Q4 of the number of uncompleted overdue serious incidents.

Recommendations:
Since the introduction of the new national patient safety incident response framework was introduced in the trust in December 2023, there has been a change in how incidents are investigated. Serious incidents are no longer STEIS reportable and are managed either through external reviews (MNSI), Perinatal Mortality Review Tool (PMRT) or PSII.

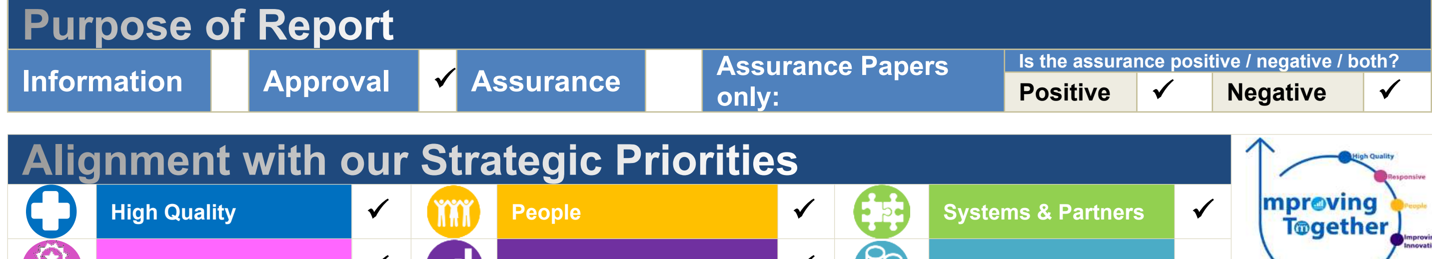
There requires further clarification and guidance on the pathway of managing serious incidents under the new PSIRF framework.

Key Recommendations

The Trust Board accepts and is assured by the report.

Executive Summary

Meeting:	Trust Board	Date:	5th June 2024
Report Title:	UHNM Quality Account 2023/2024	Agenda Item:	9
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 2023/2024. The content of the Quality Account is defined by the Quality Accounts letter issued by NHS England and the NHS Quality Accounts Guidance which continues to apply. It should be noted that NHS providers are no longer expected to obtain assurance from their external auditor on their Quality Account.

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. The received stakeholder comments have been included and the Quality Account was approved subject to some amendments, at the Trust's Quality Governance Committee on 30th May 2024.

Background

Part A of the Quality Account provides summary of Strategic Objectives, Quality Priorities and Objectives for 2023/2024 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 for 2024/25 is to enable our staff to provide compassionate, outstanding care, by listening to our patients and preventing hospital associated harm.

Part B of the account reviews the Trust's Quality Performance for 2023/2024 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 will be updated to include stakeholder comments.

Assessment

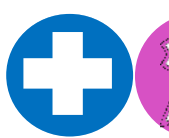
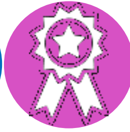
The Quality Account for 2023/2024 meets the statutory and regulatory requirements and includes all the required information, subject to inclusion of stakeholder comments.

Key Recommendations

The Trust Board is asked to approve the Final Draft version of the latest Quality Account 2023/2024 along with the priorities for 2024/2025, noting the links to existing Trust aims and objectives.

Quality Account

2023/2024

Delivering Exceptional Care with Exceptional People

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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 2023/2024. 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.

The Trust's Board of Directors have reviewed our previous quality data, led consultations across our clinical and non-clinical teams regarding them, and remain committed to driving improvements with our Improving Together methodology. Our priority for 2024/25 is to provide high quality, safe care for all patients, and to learn from our errors. When we fall short of our high standards, we review our processes with our patient safety partners, improvement teams and clinicians to make these work better. We are committed to driving improvement and a culture of excellence throughout the organisation. Despite the complex operational challenges and the high demand for our services the Trust has faced during 2023/24, we have sought to deliver care in accordance with the quality priorities set out last year. We have continued to work with our departments, organisational, regional and national level, with clinical audit, patient safety improvement programmes and statutory organisations, to drive quality improvement. Some of our key highlights over the past year include:

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 since the pandemic, and where we still have further improvements to make.

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Providing care in state-of-the-art facilities, we offer a full range of general hospital and specialised services for approximately 3 million people. We employ around 11, 000 members of staff and we have around 1450 inpatient beds across our two sites.

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 around 14,000 patients attending each month across both of our sites. Many emergency patients are brought to us from a wide area by both helicopter and ambulance because of our **Major Trauma Centre status**; as we are the specialist centre for the North Midlands and North Wales.

As a University Teaching Hospital, we work very closely with our partners at Keele and Staffordshire University and we are particularly proud of our **Medical School**, which has an excellent reputation. We also have strong links and relationships with our local schools and colleges. As a major teaching Trust, we also hold a large portfolio of commercial research.

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 play a key role within the **Staffordshire and Stoke-on-Trent Integrated Care System (ICS)**, which has partnership working at its very core as we work closely together to transform the way health care is delivered for the benefit of our population. This includes leadership and participation in partnership boards which bring together health, social care, independent and voluntary sector organisations across Stoke on Trent and Staffordshire.

We look to **involve our service users** in everything we do, from providing feedback about the services we provide, to helping us to deliver against our priorities. This work is coordinated by our dedicated Patient Experience Team.

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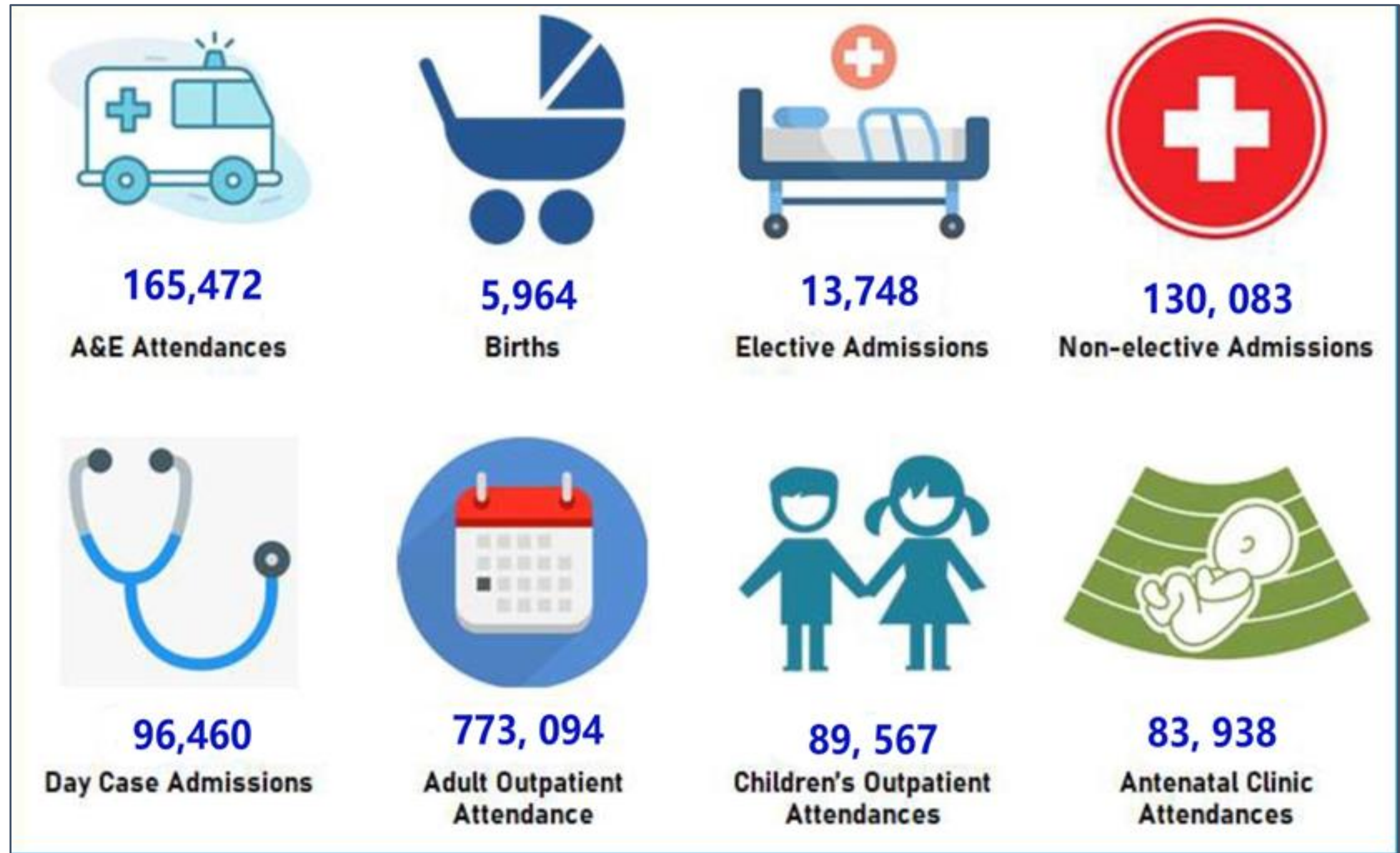
2023/2024 Headline Activity Data



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2. Statement on quality

The period covered by this Quality Account is from 1 April 2023 through to 31 March 2024.

The last twelve months highlighted the commitment of our organisation to continually improve patient experience and clinical outcomes and we are extremely proud of the way our staff have again delivered exceptional care. Throughout the year we faced unprecedented challenges including the lingering effects of the Covid pandemic, industrial action across much of the medical workforce and ever-increasing demands on our services. Despite this, our team demonstrated resilience and professionalism and they continuously focused on the welfare of our patients and the delivery of the highest standards of care. We can be justifiably proud of them.

As in previous years, during 2023/4 we focused on a number of key areas including Patient Safety and Clinical Effectiveness. The results are inspiring. During the year we made huge progress on improving key clinical processes, we invested heavily in both staff and technology, and we introduced new monitoring programmes that helped to safeguard patients from harm whilst in hospital. We also enhanced our feedback mechanisms from patients and built upon their suggestions. We similarly invested in better understanding staff wellbeing and how that can improve morale and culture and ultimately improve patient care. Importantly, we continued the expansion of our Continuous Improvement Methodology and engaged greater numbers of staff in developing new and innovative ways to influence improved patient care.

We recognise that, on a national scale, waiting lists for treatment have grown and we have plans to deal with those backlogs in our Trust and to eliminate them in the coming year. Our strategic priorities reflect the need to enhance both the experience that patients have in our hospitals and the outcomes that they deserve. We are working closely with our partners in Stoke and Staffordshire including Community Services, Mental Health, Local Authorities, and the Voluntary sector to ensure that patients experience a seamless and joined-up approach as they move between services. It is our collective aim to work collaboratively in addressing individual patient needs.

Our staff and patients alike have just come through a very difficult twelve months, but we have shown that we have the ability to deal with the pressures faced. Our thanks go to every member of staff for their personal contributions and to our patients for their support. We look forward to the coming year and to the delivery of the ambitious plans we have to enhance our services.

We have prioritised the following key areas that we will focus on:

Safeguarding

The Safeguarding agenda at UHNM comprises of a large portfolio of work inclusive of Adult and Child Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards, Domestic Abuse, PREVENT counter terrorism, people in a position of trust.   We are invested in providing services to meet the needs of our local vulnerable patient population in Stoke and Staffordshire and support out-of-area patients working with Local Authorities, Police, and specialist services. The team works with system partners to safeguard the unborn, children and adults. THINK FAMILY is embedded in policy and practice to safeguard all patients at risk of, or experiencing abuse. This year we have provided strategic direction for the development, implementation, and monitoring of the Safeguarding agenda across the Trust in line with our Trust policies.

We ensure Safeguarding training throughout our Trust is in line with the Training Needs Analysis (intercollegiate document) and we have been monitoring progress across our divisions and Trust compliance, reporting our

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performance to commissioners. We have continued to advise the Trust Quality and Safety Oversight Group on Trust priorities regarding our safeguarding agenda.

UHNM remains an active member of the Staffordshire and Stoke Safeguarding Partnership Board and the Children's Board/Partnership, along with other partners across the local area. Safeguarding Working Groups are held quarterly, and this is a forum to provide key updates of work from the safeguarding team and divisions. Also, this has been pivotal for divisions to highlight any areas for escalation, and to provide assurance relating to agenda. We remain committed to focusing on the strategic priorities as outlined by both Adult and Child Safeguarding Boards/Partnership to provide assurances regarding the implementation and monitoring of the safeguarding assurance framework which identifies all areas of work for the extensive portfolio and priorities for the next financial year for safeguarding at UHNM.

Vulnerable patients

Our Vulnerable Patient agenda covers Mental Health, Learning Disability, Autism, Dementia and CAMHS. This year we have planned our approach to the nationally required Oliver McGowan Training. We have employed a teacher and are advertising expert patients to support us in delivering this important training.

This year we planned and delivered an exercise of 'walking in our shoes' we wanted to understand where our patients who have a range of physical, mental health and learning difficulties encounter difficulties when navigating our trust for appointments, this led to some wonderful insight. As a result of this learning, we were able to take number of actions to support our patients which included:

- Using industrial sized stickers on shiny floors to support our dementia patients who reported shiny floors feeling scary and/or like walking on water.
- Changing white toilet seats to black toilet seats to support our patients with visual concerns.
- Using clear face masks for patients with hearing difficulties
- Providing extra translating equipment which supports British sign language.

We are invested and driven to continue to work hard within our Vulnerable Patients agenda. We are working hard on improving the needs of our local population with learning disability, autism and downs syndrome, Mental Health and Dementia. We have recently recruited a colleague who identifies as having a learning disability diagnosis and lived experience. This will be a full-time role to support UHNM in ensuring we capture continuous learning and improvements for our vulnerable patients. We have developed a new assurance framework for the vulnerable patient agenda which identifies the priorities and risks for the next financial year.

Tissue Viability & Continence

Ensuring that our patients receive care that enables them to maintain their skin integrity and continence is a priority for us. Our specialist team are dedicated to ensuring that we have the right equipment, competent staff who have the knowledge and skills to deliver this care at the bedside according to need and continual review. We are learning from care that does not meet our high standards and strive to reduce issues that have resulted in lapses of our care at ward level.

Skin integrity is an area of care that we are particularly challenged in, many of our frail, older patients have increasingly complex medical conditions which contribute to these concerns. However, we aim to provide a specialist service to support the wards and departments in delivering personalised care to each of our patients in this regard.

The Tissue Viability Team provide specialist input to Ward Teams for assessment and management of complex wounds including Pressure Ulcers, Surgical Incisions, Lower Limb Ulceration, Haematomas, Infected Skin Tears/Lacerations and Trauma Injuries. The Team also provides an advisory service for Continence and have developed the "Maintaining Continence Function" ambition. In collaboration with the Quality & Safety Team,

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the Tissue Viability Team facilitate learning from hospital acquired harm incidents and deliver a programme of education to Ward and Department Teams across the Trust.

The Lead Nurse for the Tissue Viability & Continence Service also works closely with the Procurement Team to ensure that our patients have access to appropriate dressings, pressure relieving devices and products to maintain continence function.

During 2023/2024 we have maintained the number of pressure ulcers developed under the care of UHNM, within expected limits. The team have delivered a range of education including an introduction to pressure ulcer prevention and continence management, assessment & management of pressure ulcers, wound care workshops and lower limb champion training. In order to improve the standard of documentation regarding Pressure ulcer prevention, the Team have developed a Skin Health Booklet for use across all clinical areas.

We will continue to strive to reduce the number of pressure ulcers developed whilst our patients are at UHNM and ensure that staff have the required knowledge and skills to deliver evidence-based care and comply with National Initiatives. We have just had funded two harm-free care ambassadors who are tasks with supporting teams in continuous learning around prevention and treatment of pressure ulcers.

Falls & Mobility

Promoting mobility and preventing falls remain a key focus of our dedicated Quality and Safety team.
The Quality and Safety team have highlighted multiple reporting areas and carried out bespoke falls training across these areas. This has included one-to-one training for all staff. To align to national PSIRF processes the Trust has introduced a bespoke falls toolkit incorporating a comprehensive after-action review. For areas where multiple toolkits are completed, and reoccurring themes are identified the Quality and Safety team have established assurance panels where support is offered, and learning is shared to reduce the number of actions identified. The Quality and Safety team continue to complete weekly audits across the Trust and from the findings offer education session specific to areas, for example the Emergency portals, care of the older adult and maternity.

Promoting mobility and prevention of deconditioning

Activity and Mobility Programme in Q1 2023 UHNM joined with Johns Hopkins Medicine in the United States of America and began work to introduce their activity and mobility programme to UHNM. This work has seen the development of an electronic patient record, using Johns Hopkins tools. This enables staff to document patient ability to complete activities of daily living and movement activities each day. Software built into the system generates a mobility goal based on the patient's ability. Education and training has been delivered to teams on the 8 wards in phase 1 of the project to ensure they understand the importance of movement and maintaining patient ability and independence in hospital. Staff are supporting patients to achieve their goal at least twice a day with the highest level of mobility they complete being recorded within the electronic record. Further emphasis is being given to movement by including goal achievement discussion in ward rounds to ensure the whole multidisciplinary team can acknowledge and highlight patients that may need extra support to achieve their mobility goal and prevent deconditioning and harm associated with loss of function.

Diversional Therapy

The Diversional Therapist role has been pivotal in providing an environment for our patients whereby activities are at hand to promote patient independence, enhance their mobility and to encourage and assist their recovery. Activities are tailored on patient requirements and play an active role in 'Reconditioning our patients' which also works in line with our Safer Mobility Ambition. This role advocates the 'sit up, get dressed, keep moving' campaign with the overall aim to improve patient experience, maintain patient ability, promote independence, and support a reduction in inpatient falls within Older Adults.

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Frailty

Supported by Getting It Right First Time (GIRFT) recommendations we are using our Improving Together methodology to ensure frailty services across UHNM address and acknowledge the issues of inappropriately admitting older individuals living with frailty. The work we are currently completing through improvement delivery groups acknowledges the harm that can occur due to prolonged hospital stays, potentially leading to a decline in mobility, functional deterioration, and an elevated risk of unavoidable harm. We know that even in cases where acute hospital care is deemed necessary, extended length of stays (48 hours or more) contribute to increased risks such as deconditioning, falls, and preventable harm, especially when acute care is no longer required. Our vision is to ensure patients aged 75 and over with frailty receive the right care at the right place by providing timely access to initiatives to enhance the well-being of the patient. The aim is to ensure frail patients spend the least amount of time in the hospital when needed.

- To deliver effective and timely frailty assessment and services which ensure that all clinically appropriate patients aged 75 and over are discharged from the ED/Acute Portals to their usual place of residence to support a reduction in conversion rates to 60% by October 2024 and 55% March 2025
- To ensure clinical care for frail patients is responsive and appropriate, so that patients who are admitted, do not experience extended length of stays. The impact of change will be monitored through the proportion of frail patients aged 75 and over with a LOS of <48 hours.
- Establish pro-active early supported discharge planning to ensure that patients aged 75 and over with frailty are discharged to their usual place of residence as soon as they are medically fit for discharge and with a comprehensive plan to meet any continuing care needs. The impact of change will be monitored through performance against the percentage of MFFD patients with a delayed discharge.

Medications

We have encouraged and undertaken work to ensure our medicine errors are captured and that staff are supported across all divisions in raising any medicine concerns or highlighting any learning. Promoting this adherence supports us in preventing errors and ensuring an open reporting culture. This is vital to ensure continuous learning and development within medicines management throughout our divisions. We feel passionate about continuing to learn from when we make mistakes and review our systems and processes to ensure that these are as effective and supportive as possible to support our staff in providing effective and timely medications. This enables us to thematically review and understand if harm has occurred and where lessons need to be quickly identified and learned and progress monitored thus ensuring a reduction in potential harms for our patients. The learning is then disseminated and monitored ensuring our mistakes are being learned from

Nutrition & Hydration

There is clear evidence that what we eat, and drink affects our health and wellbeing. Food provided at the Royal Stoke and County Hospitals must contribute to the health of our patients, visitors, and staff. As both a healthcare provider, and as an employer, we have a responsibility to support our staff, and those who use our services including visitors, to maintain a healthy lifestyle by offering appropriate food choices.

Good nutrition, optimal hydration and positive mealtime experiences are of vital importance for those recovering from illness and those at risk of malnutrition. Malnutrition and dehydration pose significant risk especially for older people and contribute to delayed recovery, development of co-morbidities, hospital acquired functional decline (deconditioning), increased risk of falls, risk to skin integrity and increased length of stay.

During 2023/2024, a new standard patient menu was introduced at Royal Stoke, using a new supplier Apetito, the menu has received positive feedback in patient experience surveys.

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An updated Nutrition Bundle and Nutrition Care plan has been introduced into adult inpatient areas; audit data shows that the use of these has increased. The dietetics team has trained over 2000 staff members within UHNM on identifying malnutrition and using nutrition care plans to support best nutrition in hospital.
A Gap analysis of compliance with National Hospital food standards has been completed and work commenced on the maturity matrix against NHSE guidance.

Emergency Care

Urgent elective and cancer services continued to be delivered and improvement plans are in place.
Urgent & Emergency Care GIRFT Review was completed in November 2023 and identified 5 key recommendations and implementation information for both RSUH and County Hospital which are continuing to be implemented.
The Trust's Non-Elective Improvement Plan has been established with aim that all patients receive the right care in the right place at the right time and no patient stays in the Emergency Department over 8 hours
Virtual appointments for both elective and emergency care have been introduced to help improve accessibility to appropriate and prompt care and services.
We are working with Acute Care at Home (AC@H) daily for Virtual ward for patients to discharge from our Emergency Department and Wards and to avoid further hospital admissions.
Emergency Department have a 12-month trajectory to achieve the 4 hours non admitted standard of 78% by March 2025 (76% target for 2023/24 and we achieved 70.2% at the end of year).

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

- 11% reduction in total patient falls per 1000 bed days and 15% reduction in falls resulting in any harm to patients per 1000 bed days in 2023/24 compared to 2022/23.
- Category 3 Hospital Acquired pressure ulcers with 'lapses in care' in 2023/24 compared to 2022/23 totals.
- Continued improvement in Sepsis Screening and IV antibiotics for inpatients, Emergency portals and Children
- Continuing to compare well against our national peers and remaining with expected ranges for both HSMR and SHMI mortality indicators.
- Continue to exceed national VTE risk assessment compliance over 95%.
- Introduced new national Patient Safety Incident Response Framework and approach to responding to incidents.
- 12% reduction in number Serious Incidents reported (prior to adoption of PSIRF in December 2023) compared to same period in 2022/23.
- Continued to exceed the national Friends and Family Test recommendation benchmark of 95% for Inpatients and Maternity Services
- Appointed 4 Patient Safety Partners as part of Patient Safety Incident Review Framework (PSIRF) implementation.

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

- Improving ED waiting times to ensure that as a minimum 78% of patients are seen, treated, admitted, or discharged within 4 hours of arrival, by March 2025
- Improving our cancer performance for 28, 31 and 62-days treatment standards
- Significantly reduce ambulance Handover delays
- Continued improvement in Sepsis screening compliance and pathway
- To further reduce harm from falls
- To improve recording of Timely Observations using Vitalpac electronic system
- To reduce Hospital Acquired pressure ulcers and deep tissue injuries with lapses in care.
- To reduce the number of C Difficile cases

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Whilst we have had another challenging year, with high demand for our services and complex operational pressures, our staff have continued to work tirelessly to deliver safe, compassionate, and high-quality care to as many patients as possible.

Although there have been ongoing challenges this year for all of us 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 continue to rise and meet these challenges. 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.

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2.2 Our 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 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

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Our Values and Promises

Values & Promises

Co-created by our colleagues, patients and carers

NHS University Hospitals of North Midlands NHS Trust

We love our values

We are a team first and foremost, one large, diverse, and growing team.

We will learn from each other, support each other, take time to share best practice and celebrate our successes.

We will be kind and considerate, help each other to achieve our goals and support colleagues to make positive changes.

We will work collaboratively to provide the very best care and services.

We are compassionate and inclusive. We will take time to listen, understand and respond to the needs of our people.

We value the importance of Being Kind and supportive, respecting and valuing individual difference by creating a sense of belonging in our teams.

We are respectful and will role model our Being Kind behaviour expectations, to ensure people feel valued, supported and cared for.

We are friendly and will be welcoming and approachable, make eye contact, introduce ourselves and say #hello my name is…

We look after ourselves and each other, as our wellbeing is important to deliver safe quality services.

We will speak up whenever we have a concern or see or experience behaviour(s) that does not meet our shared values.

We will undertake the relevant and necessary training to support us to undertake our roles and keep us safe.

We will not tolerate any form of harassment, discrimination, bullying or violence.

We will provide equal access to opportunities to learn and develop, supporting all our people to reach their potential.

We will welcome and listen to people's views and ideas, using feedback to help shape and develop our services.

We will enable our people and teams to drive forward improvements together and provide them with tools to do so.

We will continue to make positive changes to ensure our organisation is a great place to work and receive care.

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

Priorities for improvement

3.1 Our quality priorities and objectives for 2024/25

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.

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Quality Improvement

This has been the third year for the roll-out of our organisation wide quality improvement (QI) programme 'Improving Together' and we have seen some fantastic progress being made.

The programme has progressed on plan and our QI Academy have continued to provide our wards and departments with training, skills, tools, and support. Just short of 5000 colleagues have received some level of Improving Together training, which is delivered through different approaches, including a 5 month change programme for frontline teams and a 2-day bootcamp for managers. An online offering is also available and has been refined during the year as this is the most accessed form of training to underpin the more detailed sessions. At the beginning of April, the Quality Improvement Academy was accredited by the Lean Competency System organization which is affiliated with the University of Cardiff. This means that staff completing several of our training programmes will now be eligible for a transferable, nationally recognized qualification.

> I really enjoyed Bootcamp. It gave me lots of ideas about how I can introduce the tools into my day to day work and I've made some really positive improvements as a result.
>
> Jason Dutton
> Corporate Governance Support Manager

We use a dedicated Business Intelligence (BI) dashboard to measure the progress we are making with the programme and have provided regular reports on this to our Transformation and People Committee.

The impact of our training has been measured by the adoption of tools by teams who have been trained and during 2023/24 we saw a 15% improvement when compared to the previous year. Importantly, this was sustained through the winter months, which are the most challenging for us. We have set a target to increase adoption of tools by a further 15% for 2024/25. What has become clear in our data is that where these tools are used the performance of the teams improves. Some of the best examples of this are the improvement in the timeliness of induction of labour by our maternity team and the achievement of the 28-day faster diagnosis standard by our surgical teams, both of which resulted in regional and national recognition.

To compliment the work, we have done within the clinical divisions, embedding this approach to working we have successfully extended this to several Executive Oversight Groups. Non- elective and planned care boards have now established the format of their meetings and the way they seek improvement to align to this methodology. In addition, the Executive R&I oversight group will also take this format from this next year.

Over the next 12 months, the application of a continuous improvement methodology as the way we work at UHNM will be embedded in our employees' life cycle. From first exploring our website to understand the organization, to inclusion in job descriptions, forming part of the discussion in personal development reviews to signposting to the appropriate training.

We share the successes of our teams through monthly Spotlights on success (Improving Together spotlight - Team of the month | University Hospitals of North Midlands NHS Trust) and quarterly production of podcasts (Stream Improving Together | Listen to Improving Together Podcast playlist online for free on SoundCloud) of our conversations with UHNM's Exceptional People. In addition, we share news and updates regularly through a number of social media platforms.

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Working together, learning together, Improving Together

Improving Together is our long-term cultural improvement programme designed to move us to a culture where everyone feels empowered to make small changes in their day-to-day work that result in improved care for our patients and work experience for our colleagues.

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.

Our first cohort of 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

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More recently CeNREE has extended its portfolio of internal and external fellowship opportunities to provide staff of all professions 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 their second year CeNREE:

- Have provided support to over 120 NMAHPs
- Is hosting two NIHR Senior Research Leaders
- Is supporting four prestigious NIHR PCAF fellowships, one NIHR DCAF fellowship, one Cystic Fibrosis Trust fellowship, one North Staffs Medical Institute grant and one West Midlands Clinical Research Network Personal Development grant which have been awarded since CeNREE's launch
- Have hosted two successful symposia
- Have hosted an internship programme for a PhD student
- Is a member of CNO Research Transformation Leaders Network and the CoDH Clinical Academic Roles Implementation Network (CARIN) through the CeNREE Lead providing a voice at a national level
- Have hosted two NHS England Clinical Leadership Fellows
- Have supported eight staff to graduate from the first cohort of the Chief Nurse Fellow Programme, two of which have secured promotions and one of which is working on a national project
- Cohort 2 of the fellowship programme sees 29 fellows join the programme and the opportunity to become a fellow has been extended to pharmacy technicians, pharmacists, and clinical scientists
- Have appointed 12 Research Ambassadors to signpost staff to CeNREE support and encourage evidence-based practice

Delivering our Quality Strategy in 2023/2024

Taking account of the views of our people, our patients, their carers and relatives and our healthcare partners, we have developed our Quality Strategy which sets our priorities for our patients, which align with the NHS Long Term Plan, our obligations under the Health and Social Care Act (2012) and the expectations of our regulators.

Matthew Lewis & Ann-Marie Riley
Chief Medical Officer & Chief Nurse

Priorities for Our Patients

To develop consistently positive practice environments recognising our staff are safety critical

To deliver consistently safe and reliable care

To prevent avoidable delay in patient assessment, treatment and discharge

To ensure that our patients have access to services that meets their needs and delivers positive outcomes and experiences

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.

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.

Our overall goal for 2024/25 is:

To enable our staff to provide compassionate, outstanding care, by listening to our patients and preventing hospital associated harm.

Aims

To reduce patient harm, learn from experience and incidents and improve clinical effectiveness and outcomes for our patients.

How will we do this:

- To reduce our patient waiting lists and backlogs (62-day Cancer, 2 week waits for Cancer along with 104, 78 and 65-day waiting list reductions) and maintain patient safety.
- To reduce ambulance handover delays of more than 60 minutes in conjunction with our partner providers and improve patient flow
- To continue to reduce avoidable harm
- To benchmark against national best practice and assess our outcomes and effectiveness
- Improve how we share learning
- Embed and refine UHNM PSIRP and approach to incident reviews and responses
- To promote mobility and improve management and prevention of deconditioning whilst in hospital with continued implementation of the Johns Hopkins project
- 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
- Continued delivery of the Improving Together Programme
- Participate in national and local clinical audit and effectiveness programmes and further develop our local clinical effectiveness structures
- To utilise Getting It Right First Time (GIRFT) information and service reviews to focus service improvements

We will measure this through:

- Quality Performance Report
- Integrated Performance Report for reduction of waiting list backlogs with agreed trajectories
- 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

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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 utilise Patient Safety Partners to support and enhance the patients' voices in learning from incidents and improving services.
- 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 employee Wellbeing and Experience

How will we do this:

- Delivery of our People Strategy and its four domains
- Continue to embed the NHS People Promise (People Promise Exemplar Programme)
- 'We will look after our people' and 'Create a sense of belonging' our Drivers (using QI methodology to measure improvements) to create a great place to work
- Foster a culture of kindness and respect to ensure UHNM is a great place to work for everyone (embed Being Kind Compact, our organisational Values, compassionate and inclusive leadership)
- Support the implementation of the Sexual Safety in Healthcare Charter and commit to deliver the 10 key actions
- Single system wide Occupational Health Collaborative Contract (Optima Health), bringing together the four NHS system partners, to deliver enhanced health and wellbeing services for all our colleagues in Staffordshire and Stoke on Trent
- Support colleagues in the access of formal and informal support services such as Staff Support & Counseling and the system Staff Psychological Hub
- Deliver Critical Incident Stress Management training to support UHNM colleagues
- Co-create wellbeing initiatives in line with Trust and national requirements and have a continued to focus on People Promise element 4 'We are safe and healthy'
- Support our Carers (Carers Passport)
- Ensuring that staff are working within COVID-19 secure environments
- Supporting staff and services in providing care in 'new ways'
- Promoting mental health wellbeing and support; new Women's Network, Men's Health Group
- Empower our Staff Networks to drive forward positive change, raise awareness and work with us to continue to improve employee experience
- Delivering the Improving Together programme; and
- Provide staff with research, professional and academic development opportunities through CeNREE.

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We will measure this through:

- The national NHS staff survey results
- Pulse Checks
- Quarterly Staff Voice survey results
- Our key people metrics which include staff engagement, vacancy and turnover rates, sickness absence rates, appraisal rates and statutory and mandatory training compliance rates
- Freedom to Speak Up report and number of referrals made

Commissioning for Quality and Innovation (CQUIN) Indicators for 2023/24

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 was 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 were 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.

The same approach was adopted for 2023-2024.

ICB scheme- In 2023/2024, there were eight clinical priority areas highlighted for adoption in Acute Trusts. Four were the same areas highlighted in 2022/2023 and four were new CQUINS. Comprehensive instructions concerning the specific indicators were contained within the Indicator Specification document. The CQUIN financial incentive (1.25% as a proportion of the fixed element of payment) was only earnable on the five most important indicators for each contract, as agreed by commissioners.

UHNM again agreed an Intelligent Fixed Payment Contract with local commissioners and so there was no incentive CQUIN funding or need to negotiate the five most important indicators. Likewise, there was no risk of claw-back if the schemes are not successful.

Although UHNM was not required, from a contract perspective to adopt all eight CQUINS, there was a quarterly reporting requirement for all schemes and the Trust were keen to make improvements in patient care. In conjunction with the Clinical Teams, the Clinical Audit Department undertook quarterly audits to demonstrate progress and provide assurance against the below schemes.

The identified schemes for acute Trusts are as follows:

- CQUIN01: Flu vaccinations for frontline healthcare workers (Continued from 2022/2023)
- CQUIN02: Supporting patients to drink, eat and mobilise (DrEaMing) after surgery (Continued from 2022/2023)
- CQUIN03: Compliance with timed diagnostic pathways for cancer services (New CQUIN)
- CQUIN04: Prompt switching of Intravenous to oral antibiotic (New CQUIN)
- CQUIN05: Identification and response to frailty in emergency departments (New CQUIN)
- CQUIN06: Timely communication of changes to medicines to community pharmacists via the discharge medicines service (Continued from 2022/2023)
- CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions (Continued from 2022/2023)
- CQUIN12: Assessment and documentation of pressure ulcer risk (New CQUIN)

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Specialised Services (PSS) scheme – UHNM were required to adopt three PSS schemes as detailed below, which were selected by the Specialised Commissioners. 100% CQUIN funding was again included in the contract up front. However, there was potential for claw-back if the schemes were not successful.

The set of clinical priority areas highlighted for adoption by Specialised Commissioners were as follows:

- CQUIN08: Achievement of revascularisation standards for lower limb ischaemia (Continued from 2022/2023)
- CQUIN10: Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway (New CQUIN)
- CQUIN11: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery (Continued from 2022/2023)

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

2024/2025 schemes have been proposed by NHSEI and are optional for Trust's to adopt.

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4. Patient stories

I come from a long line of farmers. Our farm, with over 200 sheep, has been in our family for over 100 years and it's been ours since 1984. As you can imagine, it's hard work.

In August 2022, I saw Mr. Lim, Consultant Orthopaedic Surgeon, who agreed I needed 2 hip replacements due to severe arthritis. By this time, I was walking with 2 crutches and my family were helping on the farm because I was struggling. I had the first hip replacement in July 2023 For this one, I was admitted to Royal Stoke on the Monday and had my surgery. I stayed in hospital until the Thursday.

For my next surgery, I had a telephone call from Mr Lim who asked if I would like it as a "day job"… I told him "you just say the word". I went to Stoke for my pre-assessment the following day, 10th October 2023. Mr. Lim told me to be at County for 7am the following Monday, 16th October 2023. I was to be the first patient to undergo this procedure as a day case.

On 16th Oct, I got up at 5am and had a shower then went to County hospital EOU. When I got there, the staff made me have another shower, which confused me but wasn't really an issue.

I went to theatre at 10am and was out by 11:30. At 1pm, the physios made me walk a few steps. They said they'd be back later in the afternoon and that I needed to walk about 20 steps. Once I could do that, I was discharged later that day!

I definitely recovered better being at home sooner with the second surgery- the worst thing was getting used to sleeping on my back, which I managed with a pillow between my legs. I had a few check-up telephone calls and regular physio at Leek moorlands. The only thing that could be better is not having had my follow-up appointment cancelled twice.

The surgeries have changed my life. I hadn't been able to get in the bath for 2 years. If it wasn't for the surgery, I would have had to have given up the farm. I am now fully independent apart from occasionally needing help putting on my socks.

My husband is currently in Critical Care Pod 6 and I just want to thank all the staff on this pod, and I mean everyone, for their support to myself and our children. They have been amazing and continue to support us daily. Obviously, I want to thank them for their hard work caring for my husband, keeping him comfortable and taking care of all his needs currently. Without this specialised area it would be extremely difficult.
I would also like to thank all the staff on SSCU because they have also supported our family during this emotional time. Our son works as a Nurse on SSCU, and his colleagues have been amazing.
I also work for the NHS and it's equally important to praise staff for their dedication and commitment to their work and continued supportive nature to families. PALS is not all about complaining. We need to take time to thank those who are helpful, supportive, and dedicated to continually deliver quality care to all.
Thank you again everyone involved we couldn't do this without you.

Our son has had two recent admissions to Ward 128. My husband and I have felt the need to share our recent experiences.
Matthew has complex medical needs and additionally has learning challenges. The whole staff on this ward have been nothing short of amazing. They have treated him with kindness and compassion and maintained his dignity at all times. The whole ethos of this ward is brilliant. I t has provided a reassuring environment for us his parents. So many staff have gone the extra mile to make him feel safe, comfortable and secure during his stay. You should be so proud of this team and we cannot thank them enough

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5. Statement of Assurances

5.1 Review of services

Care Quality Commission

The Trust last received a rated inspection on 24 and 25 August 2021 and the inspection followed the new regime for inspection. 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 Notices

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. Following the submission of evidence to demonstrate that we have met the Section 29a warning notice, we are awaiting a response from the CQC.

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. 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 has provided the CQC evidence of significant improvement in relation to the Section 29A warning notice and at the current time are awaiting the CQC to revisit Maternity Services.

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Section 31 Notices

As noted in previously published Quality Accounts, on 19th June 2019 the Care Quality Commission served notice to us under Section 31 of the Health and Social Care Act 2008 following an unannounced inspection at Royal Stoke between 5th and 28th June 2019. Following detailed actions and regular reporting to the CQC with assurances on the actions being implemented we were thrilled that the Section 31 conditions were removed in July 2023.

Recent Inspection of Emergency Department, Royal Stoke University Hospital

On 14th and 26th March 2024, The CQC undertook an unrated inspection of the Emergency Department, Royal Stoke University Hospital, with a particular focus on corridor care. No immediate concerns were raised and at the current time, UHNM is awaiting the report.

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. These toolkits are reviewed with subject matter experts.

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 2023. Following consultation with staff groups, changes have been made to the CEF tool kits which include:

- The addition of anonymous staff comments 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 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.
- Overall Bronze areas meet monthly with the Depuy Chief Nurse, Lead Nurse Quality and Safety and Matron Quality and Safety alongside a patient leader to discuss what support is needed to no longer be a bronze ward. The meeting is supported by subject area experts such as Patient Experience, Pharmacy, Dietetics, Estates and facilities and People Directorate.
- All overall Bronze areas will be revisited after 6 months of the published report for assurance.
- Wards achieving 2 consecutive bronze awards will have intense support offered by the Quality and Safety team and will have a nominated point of contact.
- We have joined the Nursing and Midwifery Excellence Group–UK (NAME-UK) where each organisation can share their best practice/toolkits and ideas for further assurance.

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PLACE Inspection

UHNM completed its PLACE inspections in Autumn 2023. UHNM achieved above the national average for all of the domains and was within the top 6% nationally for its cleaning scores. The PLACE scores achieved in 2023 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 2023.

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	99.98%	95.34%	93.40%	95.86%	91.47%	99.89%	89.52%	92.72%
THE COUNTY HOSPITAL	100%	95.97%	94.10%	97.22%	93.24%	99.56%	92.15%	92.35%
UHNM TRUST SCORE	99.98%	95.43%	93.50%	96.04%	91.71%	99.85%	89.88%	92.67%
NATIONAL AVERAGE	98.10%	90.86%	N/A	N/A	87.49%	95.91%	82.54%	84.25%

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:

“I was really impressed with the overall standard of cleanliness within the hospital”.

“Staff were generally very helpful and friendly. This was particularly so on Renal Unit and Elective Orthopaedic”.

“Compassion, enthusiasm of the staff really stood out in the majority of areas, very clean hospital, well done”.

Royal Stoke Hospital:

“The general cleanliness was of a high level throughout new and old building estate”.

“Overall, the standards of cleanliness, care, maintenance of the environment were very good”.

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"No improvements needed. Exceeded my expectations. Older building are well maintained, signage was excellent".

"All in all aspects of the environment lend themselves to excellent patient experience".

"All staff were extremely friendly and took pride in their area with a willingness to accompany the assessment team".

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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 monitoring 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 2023/24 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: Alcohol-Related Liver Disease (Update)	Yes	Action Planning
NCEPOD: Testicular Torsion	Yes	Completed
NCEPOD: Endometriosis	Yes	Awaiting Report
NCEPOD: Juvenile Idiopathic Arthritis	Yes*	Awaiting Report
NCEPOD: End of Life	Yes	Awaiting Report
NCEPOD: Rehabilitation following critical illness	Yes	Data collection

** UHNM provided data and completed data where possible, as this condition is treated at another organisation*

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.

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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
Adult Respiratory Support Audit	Yes	100%
BAUS Nephrostomy Audit	Yes	100%
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: Care of 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%
Improving Quality in Crohn's and Colitis (IQICC)	Yes	100%
Learning from Lives and Deaths in People with a Learning Disability and Autistic People (LeDeR)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE – UK Collaborative)	Yes	100%
National Adult Diabetes Audit: National Diabetes Footcare Audit	Yes	100%
National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit	Yes	100%
National Adult Diabetes Audit: National Pregnancy in Diabetes Audit	Yes	100%
National Adult Diabetes Audit: National Diabetes Core Audit	Yes	100%
National Asthma and COPD Audit Programme: COPD Secondary Care	Yes	100%
National Asthma and COPD Audit Programme: Adult Asthma Secondary Care	Yes	100%
National Asthma and COPD Audit Programme: Children and Young People's Asthma Secondary Care	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 Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer	Yes	100%
National Cardiac Arrest Audit *	No	N/A *

National Cardiac Audit Programme: National Adult Cardiac Surgery Audit	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 Cardiac Audit Programme: National Audit of Cardiac Rhythm Management Devices and Ablation	Yes	100%
National Cardiac Audit Programme: Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Cardiac Audit Programme: National Audit of Percutaneous Coronary Interventions	Yes	100%
National Cardiac Audit Programme: National Audit of Mitral Valve Leaflet Repairs (MVLR)	Yes	100%
National Cardiac Audit Programme: The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	100%
National Child Mortality Database (NCMD)	Yes	100%
National Comparative Audit of Blood Transfusion: 2023 Audit of Blood Transfusions against NICE Quality Standard 138	Yes	100%
National Comparative Audit of Blood Transfusion: 2023 Bedside Transfusion Audit	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Gastro-Intestinal Audit Programme (GICAP): National Bowel Cancer Audit (NBOCA)	Yes	100%
National Gastro-Intestinal Audit Programme (GICAP): National Oesophago-gastric Cancer (NOGCA)	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: National Cataract Audit **	No	- **
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Vascular Registry	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Perinatal Mortality Review Tool (PMRT)	Yes	100%
Perioperative Quality Improvement Programme	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%
The Trauma Audit and Research Network (TARN)	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	Yes	100%
UK Renal Registry National Acute Kidney Injury 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.*

*** University Hospitals of North Midlands NHS Trust is currently not signed up to this national audit as the Ophthalmology Team do not have access to the electronic system required to participate. A funding review is currently in progress.*

Corporate and local clinical audits

A total of 109 clinical audit projects were completed by clinical audit staff and a further 551 clinician led audit projects were registered during 2023/24. 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:

Audit of the Treatment of Pulmonary Embolisms

Action	Co-Ordinator	Status of Action
In order to streamline the process of referring Pulmonary Embolism patients for a Respiratory Follow Up (3 and 6 months) on discharge; a referral form to the Pulmonary Embolism Multidisciplinary Team will be developed and added to iPortal.	Consultant in Respiratory Medicine	In progress
In order to improve the management of patients presenting with Pulmonary Embolism, the following actions will be undertaken:		
Severity predication (sPESI) rules will be incorporated into the iPortal PE MDT Referral Form. Training and increased awareness of the importance of the use of sPESI will also be provided.	Consultant in Respiratory Medicine	In progress
Training and increased awareness will be provided in the use and documentation of the Well's Risk Stratification Tool and Severity Prediction rules (sPESI).	Consultant in Respiratory Medicine	In progress
Training sessions will be provided to increase the awareness of the importance of comprehensively completing VTE Assessments and Reassessments (where appropriate).	Consultant in Respiratory Medicine	In progress
UHNM Medical Guidelines will be updated in line with NICE 2020 / ESC 2019 Guidelines.	Consultant in Respiratory Medicine	In progress
Echocardiography will be requested after review in the Respiratory Clinic (exceptions are high risk patients like unprovoked PE, massive PE esp. if not thrombolysed, sub massive PE in which echocardiography can be requested at discharging physician's discretion)	Consultant in Respiratory Medicine	In progress
A re-audit will be undertaken to monitor the above actions and to ensure improvements in practice.	Clinical Audit Team	April 2025

5.4 Clinical Effectiveness

A Clinical Effectiveness Strategy has been drafted with an accompanying delivery plan detailing the different steps to be taken to enable UHNM to provide patients with the best possible clinical outcomes for their individual circumstances.

The strategic aims are:

- **We will do the right thing for patients by ensuring decisions about health care are based on the best available, current, valid, and reliable evidence.**
- **We will work in the right way by ensuring information is up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance.**
- **We will ensure patients have the right outcome through a robust mechanism of continuous improvement, assurance, and evaluation.**

A **Clinical Effectiveness Framework** will be developed and rolled out across the Divisions / Directorates. The document will provide a comprehensive framework **to support Divisions in meeting and exceeding expectations regarding the function of Clinical Effectiveness**. The document will empower the Divisions to take ownership of their Clinical Effectiveness priorities, providing them with the necessary guidance and resources to optimise their management practices, drive improvement and deliver maximum health gain for every patient based on their clinical circumstance. Requirements around the following will be included:

- Divisional Meetings – Governance Packs, terms of reference, attendance
- Provision of a Clinical Effectiveness Champion within each Division
- Reporting
- Risk management.

Other key workstreams underway:

- Provision of a Divisional Scorecard to highlight areas for improvement based on the Divisional Delivery Plans
- Meetings and Presentations with Clinical Governance Lead and Audit meetings
- Obtaining reports for all National Audits published over the last year - ensuring action plans are developed and shared within the Divisions.
- Review all outstanding NICE guidance - meet with Leads to implement.
- Relaunch of the WHO Surgical Safety Checklist
- Obtaining GIRFT reports - ensuring action plans are developed and shared within the Divisions.
- Identifying 8 – 10 Model Hospital priorities per Division to focus and action.
- Develop and implement Divisional Clinical Audit Programmes to provide assurance against clinical effectiveness priorities.

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5.5 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. Improving participation and engagement with clinical research is a high priority for UHNM and is included as part of Divisional key quality driver metrics.

As a centre of clinical and research excellence we participate in clinical trials from across the healthcare sector including novel interventions, new drugs, and device innovations. These cutting-edge developments are translated into our day-to-day clinical practice.

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.

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 2023/24 more we saw a record number of patients taking part in our clinical research trials with more than 2000 patients taking part, across both of our hospital sites. In total, 2035 patients agreed to take part in one of 262 studies.

This represents a **25% increase** on figures from the previous year, with **41 new research studies** also being opened.

We also support commercial research, and during 2023/24 **we ranked in the top three trusts regionally** with 127 patients taking part in commercial research.

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.

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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.

5.6 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 2023/24. 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 expanded to provide additional support, training, and assurance of user understanding.
- The Data Quality Team provided specialist knowledge to various validation projects to support the national targets for Waiting Lists including the Elective Improvement Programme, amongst others.
- Support for IT projects was also continued with testing, validation and systems expertise provided by the team.
- A new group was established to review and approve the content of RTT and Data Quality training materials and guidance documents for accuracy before implementation.
- The divisional data quality groups are well established, with representation from all directorates in attendance. These groups fulfil 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 24/25 ensuring they address data quality obligations to the Data Security and Protection Assurance Framework.
- The calendar of business for the Data Quality Assurance Group has been approved to ensure all necessary documents and actions are completed for assurance purposes.

2023/24 has been another productive year for the data quality team and we aim to build on this throughout 2024/25, supporting the strategic aims of the Trust.

5.7 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) included in the latest published data. This is a single source of comprehensive data which enables a range of reporting and analysis in the UK. The figures below are for the period April 2023 to February 2024. The percentage of UHNM records in the published data which included the patient's valid **NHS number** was:

- 99.9% for admitted patient care; national performance is 99.7%.
- 100% for outpatient care; national performance is 99.8%.
- 100 % for Maternity care; national performance is 99.8%.

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

- 100% for admitted patient care; national performance is 99.8%.
- 100% for outpatient care; national performance is 99.5%.
- 100% for Maternity care; national performance is 97.4%.

Additional benchmarking is carried out using the NHSE Data Quality Maturity Index (DQMI) dashboard. Throughout 2023/24 UHNM has consistently reported above the national average on all Inpatient, Outpatient and Maternity metrics. These are reported to the Data Quality Assurance Group and the Trust's Executive Business Intelligence Group for assurance purposes.

5.8 Clinical coding accuracy rate

The annual internal Data Security and Protection Toolkit (DSPT) clinical coding audit took place during 2023/24, achieving an overall '**mandatory**' rating in all areas of the audit: primary & secondary diagnoses and procedures. All recommendations from the 2022/23 audit have been actioned. The Trust's clinical coding auditors carried out this year's audit.

The internal Staff Audit Programme continued throughout 2022/23 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 carried out a review of the two-year training programme for trainee coders in 2023, including feedback from previous Trainees. The Trainer provides all mandatory national training, ensuring all coders are compliant with training requirements. All clinical coders have access to online training modules to enhance their knowledge and skill sets.

5.9 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 Trust submitted its final assessment for the period July 2022 to June 2023 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 2024). 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 2023 to June 2024 an internal audit is scheduled for May 2024; 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 Strategy and Transformation Committee.

5.10 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 based on 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 programme of occasional clinical audit has been designed to monitor compliance, delegations of authority under Standard 8, and evidence of appropriate staffing levels, focusing 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.

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Part B: Review of quality performance

6. Quality priorities 2023/24

In 2023/24, in partnership with our stakeholders we identified three specific priorities to focus on:

- **To reduce patient harm and improve clinical effectiveness and outcomes for our patients;**
- **To further develop staff engagement and wellbeing; 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.

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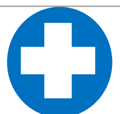

Quality Performance

Key Performance Indicator	Target	2023/24 Performance	2022/23 Performance
Patient Falls (per 1000 bed days)	5.6	5.3	5.9
Patient Falls with harm (per 1000 bed days)	1.5	1.8	1.91
Medication Errors (per 1000 bed days)	6.0	6.7	5.2
Never Events	0	6	4
Duty of Candour (verbal / formal notification)	100%	96.0%	92.9%
Duty of Candour (written within 10 days)	100%	80.2%	55.9%
Pressure Ulcers (category 2 hospital acquired with lapses in care)	96	91	69
Pressure Ulcers (category 3 hospital acquired with lapses in care)	48	12	12
Pressure Ulcers (category 4 hospital acquired with lapses in care)	0	0	0
Friends and Family Test (% A&E recommededations)	85%	70.2%	62.9%
Friends and Family Test (% inpatient recommendations)	95%	95.5%	97.3%
Friends and Family Test (% maternity recommendations)	95%	91.1%	90.2%
Written Complaints (rate per 10,000 spells)	35	27.82	22.57
Hospital Standardised Mortality Ratio (HSMR) (rolling 12 month)	100	95.03 (01/23 – 12/23)	97.27 (01/22 – 12/22)
Standardised Hospital Mortality Indicator (SHMI) (rolling 12 months)	100	98.50 (01/23 – 12/23)	104 (11/21 – 10/22)
VTE Risk Assessment Compliance	95%	95.2%	99.0%
Reported C-Difficile	96	180	144
Avoidable MRSA Bacteraemia Cases	0	3	1
Inpatient Sepsis Screening Compliance	90%	95.1%	89.7%
Inpatient IV Antibiotics (given within 1 hour)	90%	98.6%	93.4%
Children Sepsis Screening Compliance	90%	89.7%	89.7%
Children IV Antibiotics (given within 1 hour)	90%	100%	66.7%
Emergency Portals Sepsis Screening Compliance	90%	82.3%	81.8%
Emergency Portals IV Antibiotics (given within 1 hour)	90%	75.8%	63.9%
Maternity Sepsis Screening	90%	71.1%	80.6%
Maternity IV Antibiotics (given within 1 hour)	90%	85.5%	83.9%

Priority 1:
To reduce patient harm and improve clinical effectiveness and outcomes for our 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:

- Reducing our patient waiting lists and backlogs and maintain patient safety.
- Reducing ambulance handover delays in conjunction with our partner providers
- Reducing avoidable harm
- Benchmarking against national best practice and assess our outcomes and effectiveness.
- Improving how we share learning.
- Introducing new national PSIRF programme and approaches
- Improving sepsis treatment and recognition of deteriorating patients.
- Evaluating and introducing new technologies and techniques for treating patients.
- Increasing the visibility of research and the capability of staff to lead research and provide evidence-based practice; and
- Continuing the delivery of the Improving Together Programme.

Performance against this priority and its aims has been monitored during 2023/24 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.

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Patient Safety Incidents

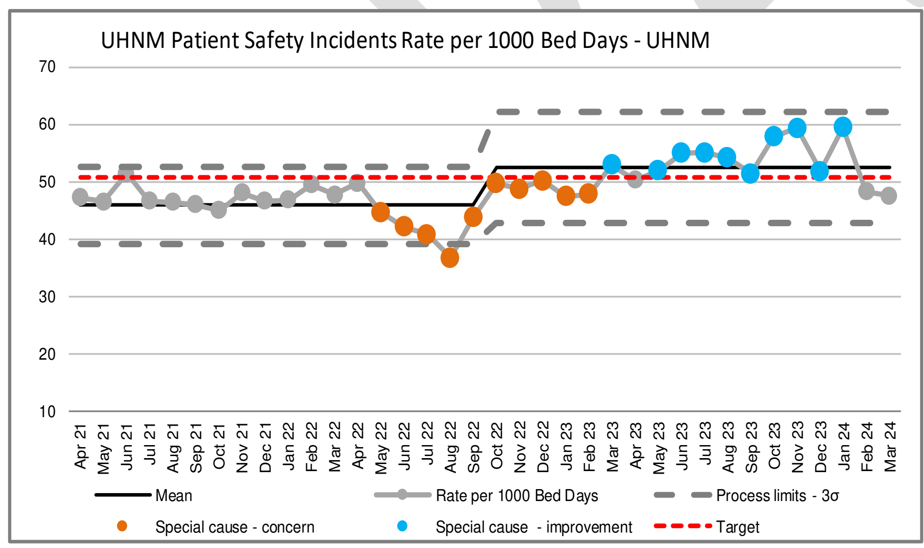
We continue to focus on aiming to reduce harm to our patients and a key indicator of this is the number of patient safety incidents* reported and the rate per 1,000 bed days and the number and rate of patient safety incidents with moderate harm or above.

Reporting, reviewing, and identifying learning from our reported incidents allows us to improve our services and care provided to our patients. Therefore, during 2023/2024, we have continued to positively encourage and promote the increased reporting of patient safety incident and near misses and we have seen the total number of reported patient safety incidents increase compared to 2022/2023. The total number of reported incidents has increased by 19.7% with 26,158 incidents and near misses during 2023/2024.

As well as the total numbers we also assess the rate of reported incidents per 1000 bed days as this allows us to compare and make allowances for changes in activity throughout the year. The rate of patient incident has also increased from 2022/2023 average rate of 46.2 to 53.5 during 2023/2024.

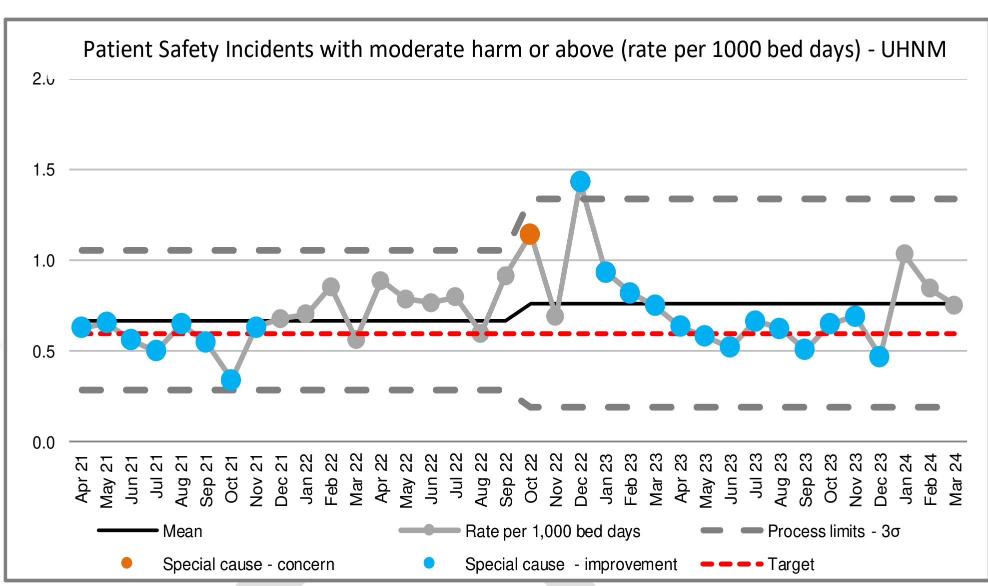
It is important to note that whilst we have seen increases in the overall total of patient safety incidents during 2023/2024 there has been a reduction in the rate of patient safety incidents resulting in moderate harm or above. This is positive trend for increased open reporting but lower levels of patient harm.

The increase in reported incidents is due to improved reporting and more incidents with low or no harm and near misses being reported. This in turn allows for reviews of these incidents and identification of learning before a patient suffers more serious harm. In addition, the reduction in harm is due to improved treatment and care provided to the patients that mitigate and reduce the risk of patient harm whilst in our care.



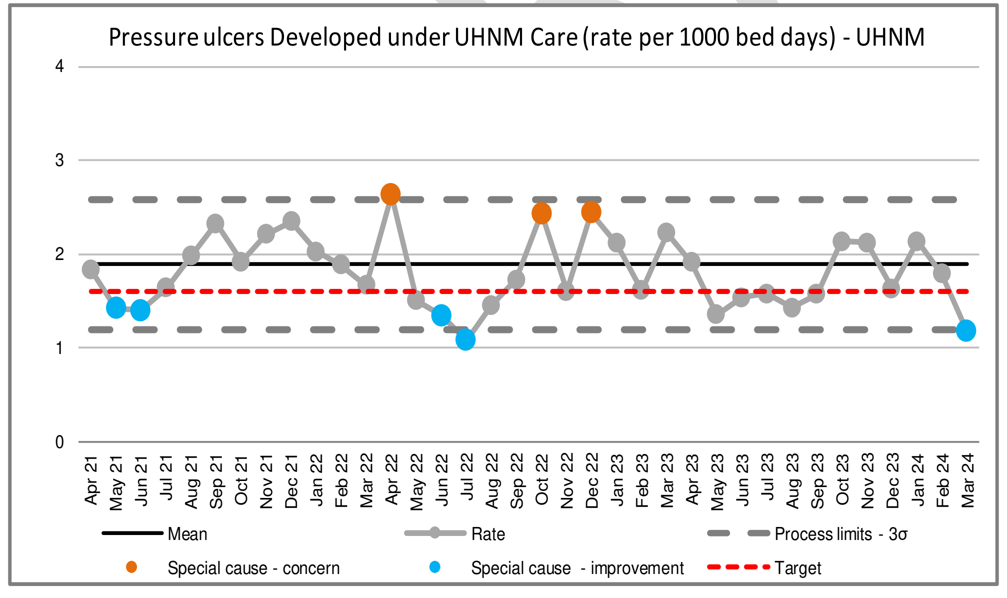
15.8% increase in the average rate of reported patient safety incidents from 2022/2023 to 2023/2024

Rate of reported patient safety incidents with moderate harm or above per 1,000 bed days in 2023/2024 has decreased from 0.9 to 0.66.



Pressure ulcers developed under UHNM Care

We have seen a decrease in pressure ulcers developed whilst under the care of UHNM. During 2023/2024 there were 830 reported pressure ulcers developed at UHNM compared to 875 in 2022/2023. This equates to 5% reduction in both the total number and rate per 1000 bed days for identified pressure ulcers.



5% decrease in rate of reported pressure ulcers developed whilst under care of UHNM.

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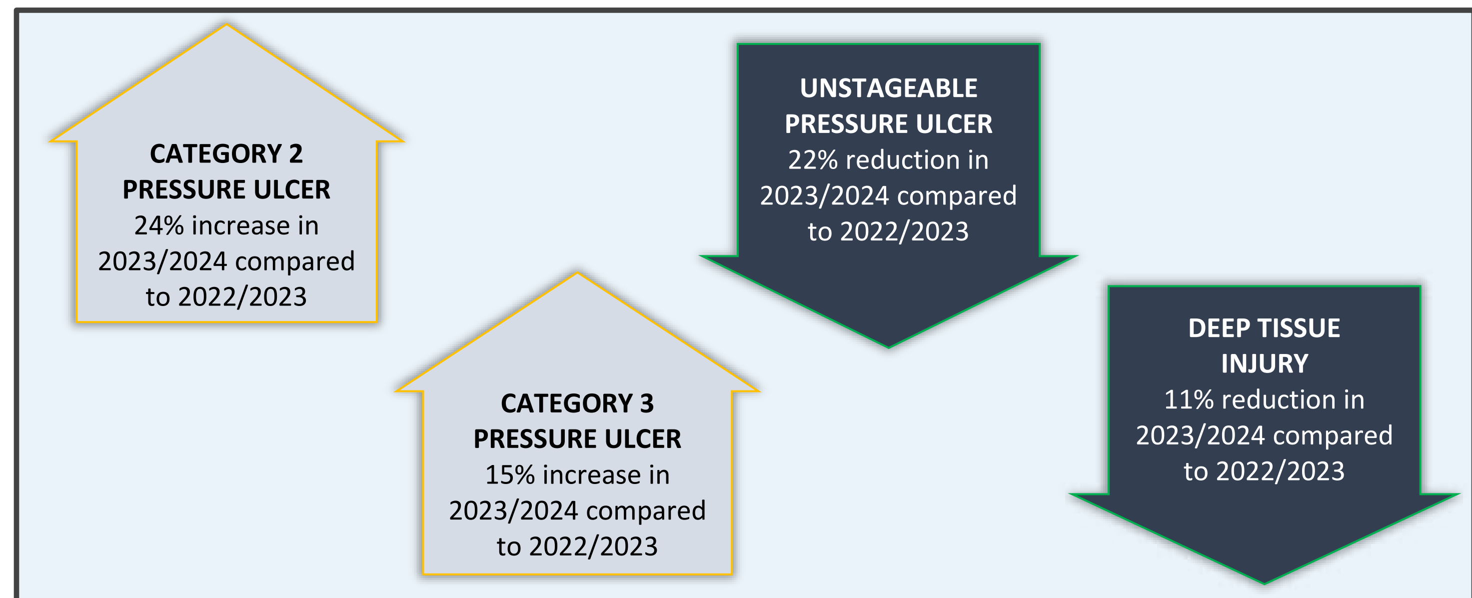
During 2023/2024 there have been changes in the number of pressure ulcers reported compared to 2022/2023



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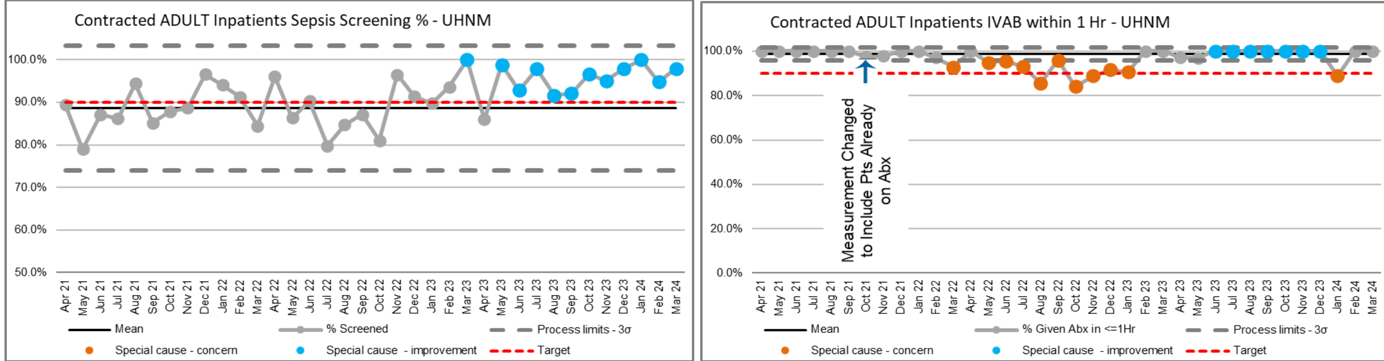
Sepsis recognition and treatment

Inpatient areas have seen improvements in sepsis screening and Intravenous Antibiotics (IVAB) in one hour during 2023/2024. Sepsis screening improved from 88.9% to 95.1%. The IVAB in one hour has improved from 92.5% to 98.9%.



Emergency Portals have seen improvement in screening and IVAB in one hour during 2023/2024. Sepsis screening increased from 82.1% to 82.5% and the IVAB in one hour from 63.9% to 75.5%.

Actions and Next Steps

- The Sepsis team continued to work collaboratively with the ED Quality nurses, sepsis champions, senior team, and Sepsis ED lead to improve sepsis screening and IVAB compliance.
- Continued regular visits and sepsis audits in emergency portals particularly in ED RSUH
- Regular meeting with ED RSUH senior team continues to review current process and ensure robust actions in place, including specific training for ED nursing assistants, nursing, and medical staff.
- The sepsis team continue to raise awareness of the importance of sepsis screening and IVAB compliance by being involved in HCA induction and qualified nurse's preceptorship programmes.

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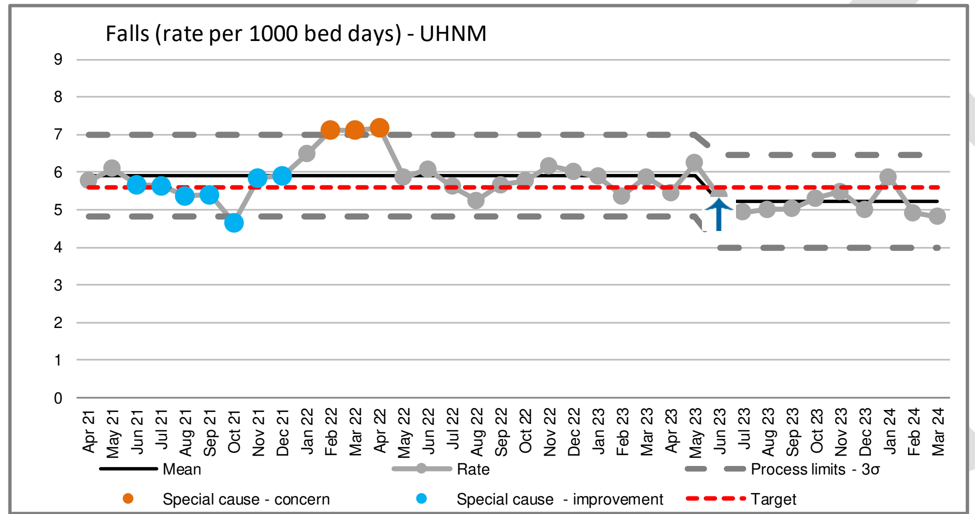
Patient falls

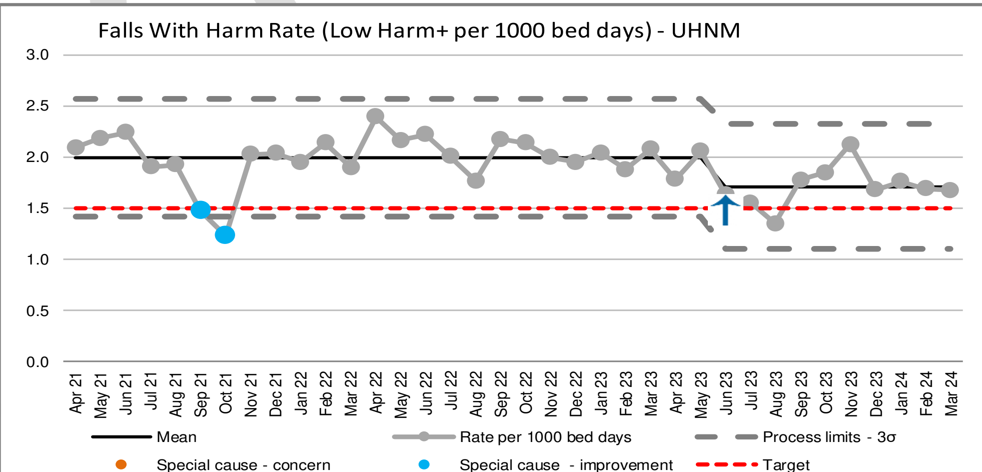
Patient falls continue to be the largest category of patient related incidents within our organisation, however, during 2023/2024 we have started to see improvements in reducing the numbers of patients falling with a 7% reduction in total falls with 2585 this year compared to 2780 in 2022/2023. Not only has there been a reduction in total numbers but the rate of falls per 1000 bed days has also reduced from 5.9 to 5.3. This continues the steady improvement in reducing patient related fall across our organization with 2020/2021 rate noted as 6.2. These reductions are improving the experience and outcomes for our patients.

UHNM continues to use 5.6 falls per 1,000 bed days as an internal benchmark for improvement. However, this is likely to be changed in 2024/2025 with the Trust consistently seeing rates below this.



The 2022/2023 mean Falls rate has reduced in 2023/2024 to 5.3 from 5.9.

19% decrease rate of harm to patients as result of falls per 1,000 bed days in 2023/2024 with 1.7 compared to 2.1 in 2022/2023.



Linked to the overall reductions in falls, it is important to note that there has been an even larger reduction in the rate of patient falls that have resulted in harm. The average rate of patient falls with harm during 2023/2024 was 1.7 falls per 1000 bed days. This compares to 2.1 in 2022/2023. As noted previously, these reductions are evidence that the actions being taken by our Falls Prevention team and the staff on the wards and departments are having positive impacts on our patients.

Patient Safety Incident Response Framework and Incident reviews

From Quarter 4, we introduced the Patient Safety Incident Response Framework (PSIRF) which replaces the Serious Incident Framework. The national PSIRF approach is to review incidents based on system reviews and focus learning on improvement and not just focus on incidents based on the level of harm.

To support PSIRF we published our Patient Safety Incident Response Plan which outlines our approach and focus for patient safety incidents during 2023/24 and 2024/25.

Never events

We review all incidents and during 2023/24 have undertaken reviews for incidents reported under the NHS Serious Incident Framework and Never Events list. We undertook Root Cause Analyses of these serious incidents and Never Events to identify and focus learning.

There were 6 reported Never Events during 2023/2024.

During 2023/24, we reported six never events compared to four reported in 2022/23.

2023/9207	**Wrong site surgery (April 2023)**
2023/22173	**Retained foreign object post procedure (November 2023)**
2024/2408	**Wrong site surgery (January 2024)**
2024/1527	**Retained foreign object post procedure (January 2024)**
2024/1537	**Wrong site surgery (February 2024)**
2024/2024	**Wrong site surgery (March 2024)**

As part of the reviews of the incidents we have adopted PSIRF approach to review the individual incidents and also thematic approach to the wrong site surgery incidents to establish any common themes and learning to help try and prevent similar incidents reoccurring in the future

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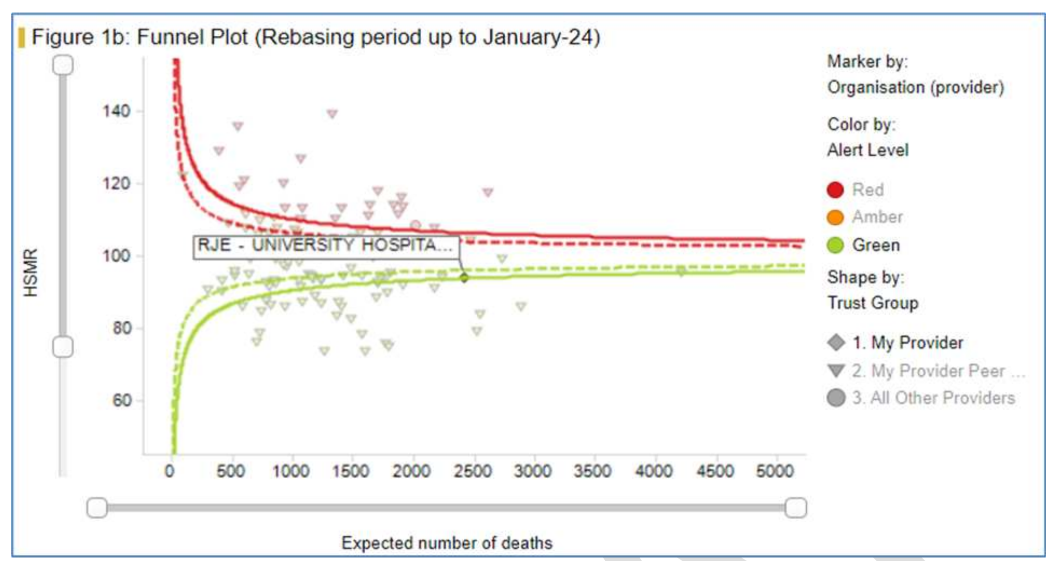
Mortality

The Trust's mortality rate with the current 12 month rolling Hospital Standardised Mortality Ratio (HSMR) score (February 2023 – January 2024) is 93.92. This means that UHNM's number of in hospital deaths is lower than the expected range based on the type of patients that have been treated. This compares to 95.89 for February 2022 to January 2023.



UHNM continues to compare well against peers during 2023/24 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 98.50 (as expected). This is a rolling 12-month measure and covers the period January 2023 – December 2023. The value for January 2022 to December 2022 was 107.18.

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.

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Learning from deaths - mortality reviews

Of 3,447 inpatient deaths during 2023/24 (Apr 23 to Mar 24) 2,410 have been reviewed and scored A to E (70%).

The Overall number of patients with a review scored A to E submitted during 2023/24 is 3,487

During 2023/2024, 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 Assurance Report presented at the Trust's Quality Governance Committee and reported to the Trust Board.

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 and also use the more detailed review proforma based on the Royal College of Physicians Structured Joint Review form as required following review of these deaths and in line with agreed review categories.

The Trust has completed 2,410 online proformas accounting for 70% of hospital deaths recorded during 2023/24. 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 2023/24 is 3,487.

It should be noted that the mortality reviews are currently ongoing, and these figures relate to deaths in 2023/2024 that have also had completed reviews submitted by 29th April 2024. 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 2023/2024, the reviews will be completed in 2024/2025.

	2023/24 Total		Q1		Q2		Q3		Q4[1]	
Total number of deaths in reporting period	3447		793		789		949		916	
Total number of deaths in reporting period reviewed (% of total deaths)	2410	70%	637	80%	648	82%	738	78%	387	42%
Total number of reviewed deaths with suboptimal care identified – NCEPOD grade E (% of reviews)	1	0%	0	-	0	-	1	0.1%	0	-

* 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 aspects of all of the above

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.

[1] As at time of updating the list of inpatient deaths ran up to March 2024 deaths

The following provides a summary of issues identified during the Structured Judgment Review process that could be improved for SJRs submitted during 2023/2024:

- Importance of ordering and following up on investigative tests and reviewing results in timely way to facilitate diagnosis and decision making.
- Importance of timely clinical reviews and adherence to monitoring guidelines
- 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, falls proformas, nutritional assessments, learning disability hospital passports and treatment plans, ward clerking.
- 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 discontinuation) and review of medication (especially antibiotics and anticoagulants); timeliness of prescribing; ensuring decisions around medication are fully documented in notes.

Hospital associated 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 2023/2024, the Trust has seen increase in like for like numbers compared to 2022/2023 for Clostridium Difficile.

Indicator	2023/24 Target	2021/22	2022/23	2023/24
To reduce C Difficile infections	101	112	144	180
To reduce MRSA infections (Trust apportioned)	0	2	1	4

Actions and Next Steps

- Ribotyping of samples continues where periods of increased incidence are identified
- C Diff Nurse role fully embedded with the role is being 50% focussed on patient reviews/50% staff training.
- Bi-weekly Cdiff MDT meetings continue to take place.
- Themes are reviewed on a monthly basis and learnings shared across the Trust as well being presented at IPCC and the ICB.

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Priority 2: To further develop staff wellbeing and experience

We said we would do this by:

- Delivering our commitments as set out in the People Strategy 2022-2025.
- Supporting the Trust's wellbeing programme and activities that focus on staff wellbeing and empowerment including Being Kind 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.

Performance against this priority and its aims has been monitored during 2023/24. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

Freedom to Speak Up 2023/2024

During 2023/2024 we revised our Speaking Up Policy in line with the national policy and we took time as a Board to self-reflect on our Speaking Up arrangements and identify plans to develop our service further.

In line with our People Strategy and our communication and engagement plan we have continued to promote our speaking up service across the organisation.

In October 2023 we participated in national Freedom to Speak Up Month where we organised a series of events and encouraged staff to wear green each Wednesday to raise awareness through social media.

Professor Andrew Hassell is our designated Non-Executive Director Lead for Speaking Up and we have four 'Associate Guardian's' to support the Lead Guardian.

Each quarter we provided our Transformation and People Committee with a comprehensive, confidential report on the work undertaken by the service in line with national and local priorities. The report also provides a breakdown of the types of concerns we have received as well as comparisons with data available from the National Guardian's Office (NGO).

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Throughout the year we have seen an increase in the concerns being raised with our service (compared with 169 in 2022/23), which we see as a positive reflection of the healthy speaking up culture we are building.

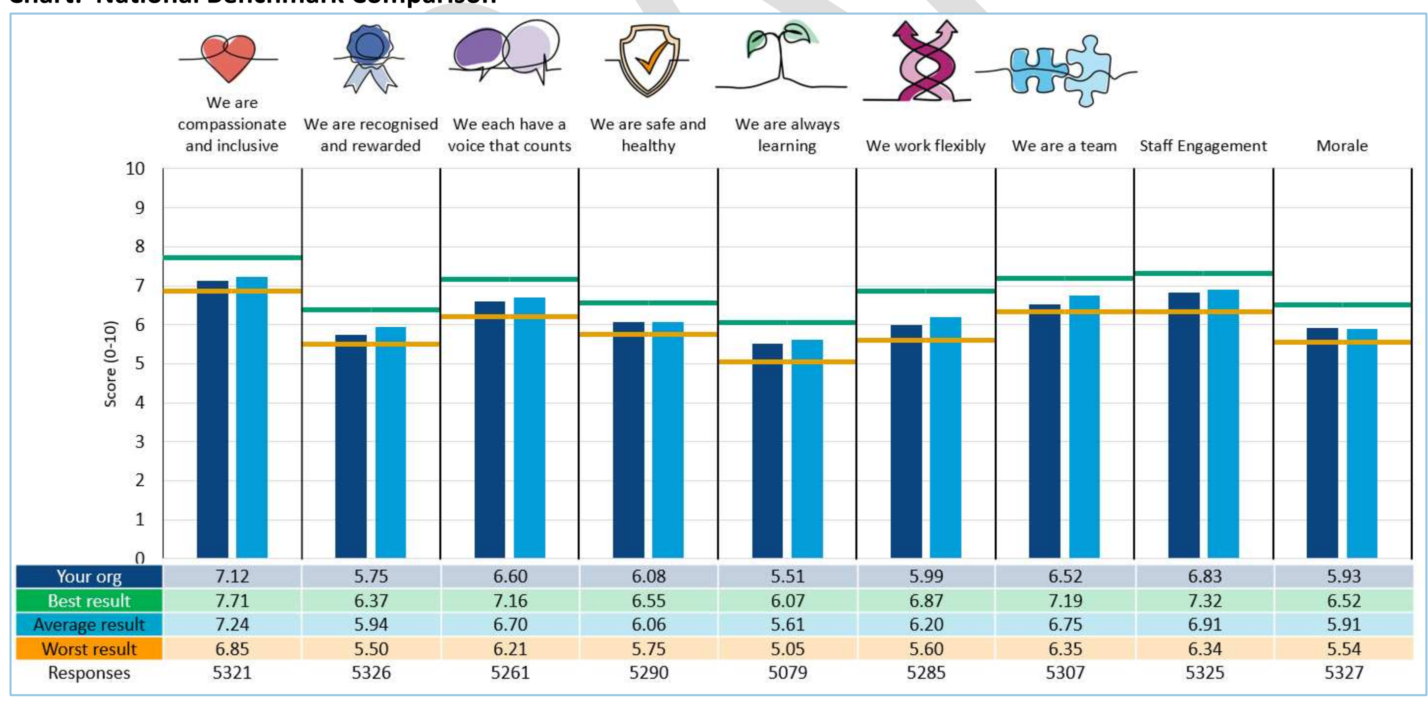
2023 National NHS Staff Survey

The national staff survey measures staff engagement and morale as well as mapping the whole result set against the 7 national people promises. This year we invited 11,895 substantive staff and 1,659 bank workers to participate in the national staff survey. Considerable efforts were made corporately and divisionally to encourage all staff members to complete the staff survey in 2023 and we achieved a response rate of 45% (which is in line with the benchmark group).

The overall Staff Engagement score for the organisation is 6.8 (improving from 6.6 in 2022) and the score for Morale is 5.92 (improving from 5.5 in 2022).

Whilst 2022 was a low year for the staff survey results, we can see improvements from the 2021 results across all the people promises and the results show that the movement is statistically significant.

Chart: National Benchmark Comparison



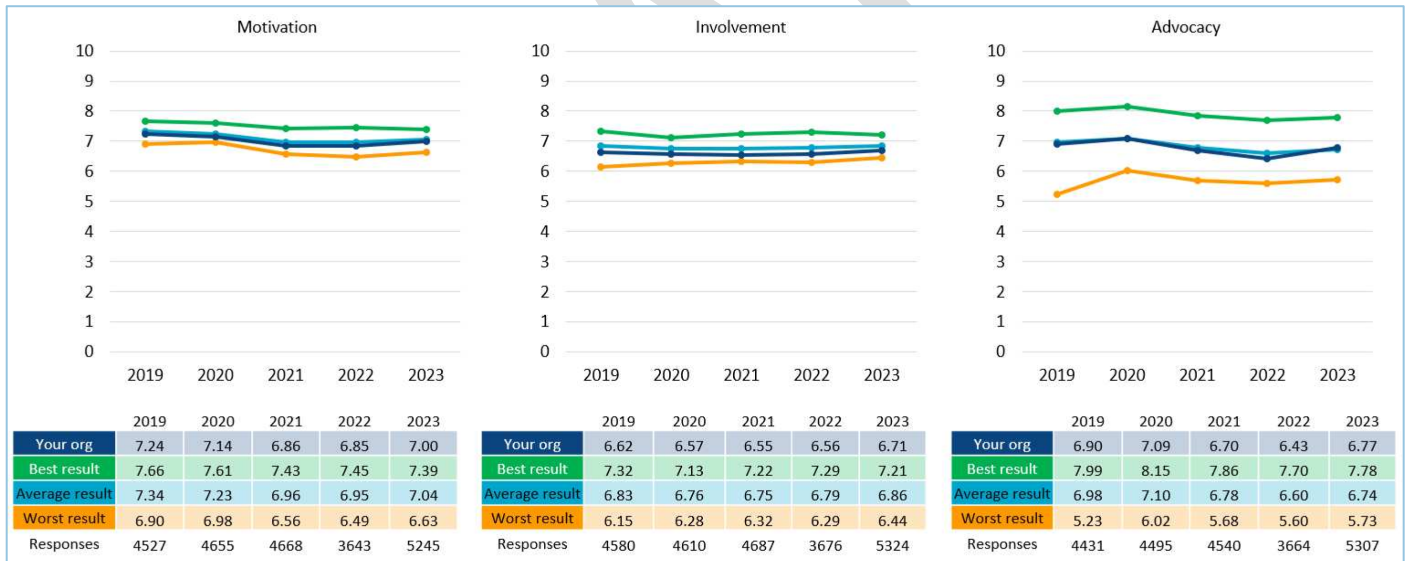
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.12	5.75	6.60	6.08	5.51	5.99	6.52	6.83	5.93
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	5321	5326	5261	5290	5079	5285	5307	5325	5327

The key successes to celebrate:

- Response rates have improved, showing significantly more staff are engaged with the survey and the action the Trust is taking.
- The Trust has made significant improvements in Staff Engagement and Morale scores as well as 5 of the 7 People Promises and we must continue to build on these improvements.
- When comparing the UHNM results from 2022 to 2023 of the 107 question areas, we have improved in 73 questions, remained static on 33 questions, and declined on only 1 question.
- 14 question scores are ahead of the sector benchmark, including staff recommending the organisation as a place for friends and family to receive care.
- The change from 2022 to 2023 staff survey scores for UHNM has shown a statistically significant change.
- Bank staff scores are broadly in line with substantive scores. Bank staff are engaged and enjoy working with their colleagues but score questions about line management and being involved in changes lower than substantive staff.

Staff Engagement

The staff engagement score increased from 6.6 to 6.8 and is now just below the score for the benchmark group at 6.9. UHNM made progress within each of the 3 sub-scores, most significantly with "advocacy" and "motivation" which are now on par with the benchmark group. Within the advocacy sub-score there is a question about whether colleagues would be happy with the standard of care if a friend/relative needed treatment and UHNM scored significantly higher than average on this.



Motivation

	2019	2020	2021	2022	2023
Your org	7.24	7.14	6.86	6.85	7.00
Best result	7.66	7.61	7.43	7.45	7.39
Average result	7.34	7.23	6.96	6.95	7.04
Worst result	6.90	6.98	6.56	6.49	6.63
Responses	4527	4655	4668	3643	5245

Involvement

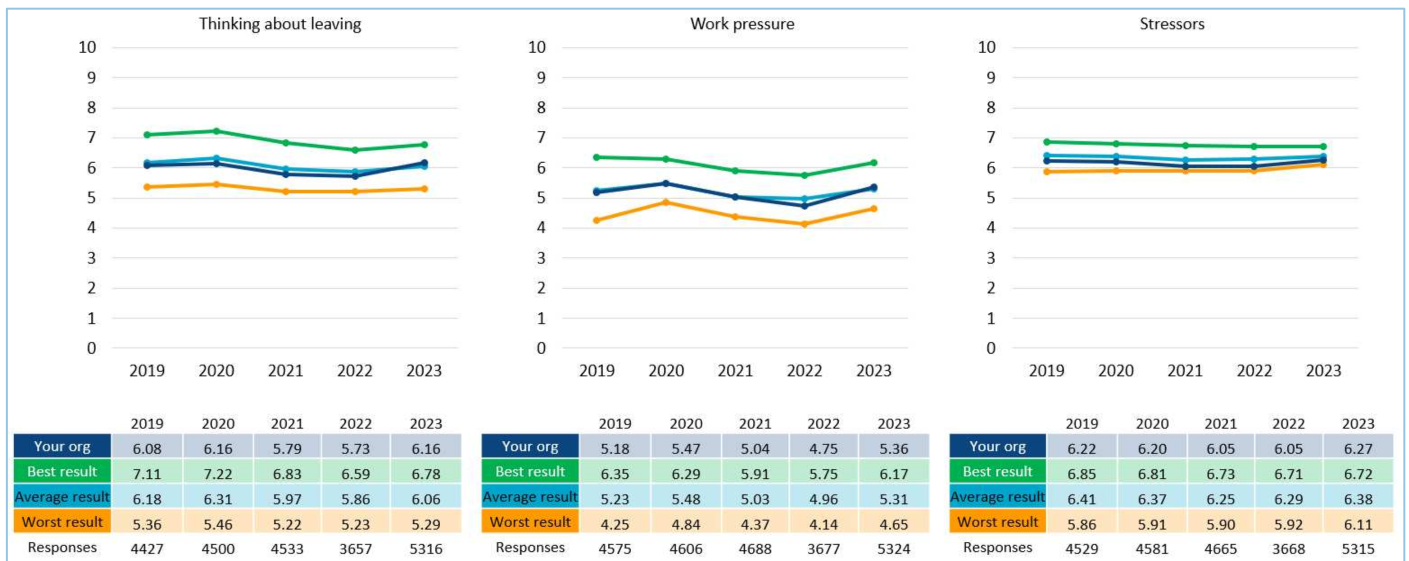
	2019	2020	2021	2022	2023
Your org	6.62	6.57	6.55	6.56	6.71
Best result	7.32	7.13	7.22	7.29	7.21
Average result	6.83	6.76	6.75	6.79	6.86
Worst result	6.15	6.28	6.32	6.29	6.44
Responses	4580	4610	4687	3676	5324

Advocacy

	2019	2020	2021	2022	2023
Your org	6.90	7.09	6.70	6.43	6.77
Best result	7.99	8.15	7.86	7.70	7.78
Average result	6.98	7.10	6.78	6.60	6.74
Worst result	5.23	6.02	5.68	5.60	5.73
Responses	4431	4495	4540	3664	5307

Staff Morale

The benchmark group results increased by 0.2 whilst the Trust's score increased by 0.4 bringing it up to 5.93 which is equivalent to the Acute Trust average. UHNM has less staff than average who are considering leaving, and scores for "work pressure" questions have improved. Scores around work stressors have improved but continue to have the biggest negative impact on morale. These include unrealistic time pressures and lack of encouragement from immediate manager.



Thinking about leaving

	2019	2020	2021	2022	2023
Your org	6.08	6.16	5.79	5.73	6.16
Best result	7.11	7.22	6.83	6.59	6.78
Average result	6.18	6.31	5.97	5.86	6.06
Worst result	5.36	5.46	5.22	5.23	5.29
Responses	4427	4500	4533	3657	5316

Work pressure

	2019	2020	2021	2022	2023
Your org	5.18	5.47	5.04	4.75	5.36
Best result	6.35	6.29	5.91	5.75	6.17
Average result	5.23	5.48	5.03	4.96	5.31
Worst result	4.25	4.84	4.37	4.14	4.65
Responses	4575	4606	4688	3677	5324

Stressors

	2019	2020	2021	2022	2023
Your org	6.22	6.20	6.05	6.05	6.27
Best result	6.85	6.81	6.73	6.71	6.72
Average result	6.41	6.37	6.25	6.29	6.38
Worst result	5.86	5.91	5.90	5.92	6.11
Responses	4529	4581	4665	3668	5315

Areas of focus for 2024

We will concentrate on the following areas of focus:

- Continue to build on our work from 2022 aligned to our culture improvement programme to understand how we can continue to foster a culture of kindness and respect, strengthening communication around the compassion strand of the Trust values (People Promise 1: We are compassionate and inclusive)
- Providing a safe and healthy work climate, identifying actions to address workload pressures and improve wellbeing, as well as reducing violence and aggression, harassment, bullying or abuse in the workplace (by colleagues and service users). (People Promise 4: We are safe and healthy)
- Continue to improve the opportunities for staff to share ideas for improvements to processes and systems. Gain commitment from leaders to respond to these proposals constructively and empower staff to implement changes through the Improving Together programmes. (People Promise 5: We are always learning)
- We will build on the work that started in 2022 by reviewing flexible working policies and encourage managers to have open conversation with employees about flexible working patterns and promote a healthy work life balance. (People Promise 6: We work flexibly)

A review of the workforce race equality indicators demonstrates an improvement in the experience of our colleagues from other ethnic groups in 2 of the 4 questions, but this is still not showing improvement at the rate we would aim to see and is not yet line with our peer average. There is clear improvement and working with our staff networks we will continue to focus our equality, diversity and inclusion programme using the data from the staff survey to help direct the work.

A review of the workforce disability equality indicators demonstrates an improvement in 7 of the 9 questions but this is still not showing improvement at the rate we would aim to see and is not yet line with our peer average. There is clear improvement and working with our staff networks we will continue to focus our equality, diversity and inclusion programme using the data from the staff survey to help direct the work.

The national staff survey data doesn't sit in isolation and must be seen in the context the wider people metrics.

We have seen a clear progress during 2023 on our vacancy and turnover rates which will have a significant impact on our staff survey results if our people feel that there is sufficient resource to undertake their roles.

Through our divisional leaders, we will encourage teams to discuss the results and share their understanding of the issues. Divisions are producing a refreshed driver report (A3) using the insight form the staff survey to inform their key areas of focus. These will be reported at the monthly divisional performance reviews.

We have been successful in securing funding from NHS England for a People Promise Manager and have submitted a High-Level Action Plan to improve employee experience and retention. We are part of a national cohort that is focusing on flexible working.

During 2024 we will be undertaking a Trust wide engagement campaign to inform the next People Strategy (2025-2028) and the staff survey results and our engagement work will be key to shaping this.
We will identify ways to measure impact of our actions and share regular updates with all staff on the progress we are making throughout the year.

In conclusion, we are pleased overall with our progress (scoring significantly better than last year) yet acknowledge that we have still further to go in comparison to peer average and will continue to focus on embedding the people promise across our organisation through key programmes of activity and engagement. Through our collective work at a corporate and a divisional level we aim to improve beyond the average and ensure that UHNM is a great place to work for everyone.

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Priority 3: To improve patient experience

We said we would do this by:

- Improving the sharing of learning from patient feedback and involving patients in learning and improvement with a particular focus on ''seldom heard' patient groups.
- Developing the role of Patient Safety Partners and PSIRF implementation
- Ensuring that all research is aligned with Trust strategic priorities and includes outcomes that will benefit our patients.
- Formalising patient engagement and coproduction in research, patient safety programmes and improvement initiatives.

Performance against this priority and its aims has been monitored during 2023/24. 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 are continuing to actively seek 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.
- The recruitment of four Patient Safety Partners to support with PSIRF and individual projects, ensuring the voice of the patient is at the front and centre of our improvement work.
- Healthwatch – our close relationship with Healthwatch has been further strengthened through regular meetings alongside 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.
- Maternity and Neonatal Voices partnership
- Patient Information Ratification Group has continued to meet monthly to ensure a robust process for the production of literacy appropriate Trust patient information leaflets.

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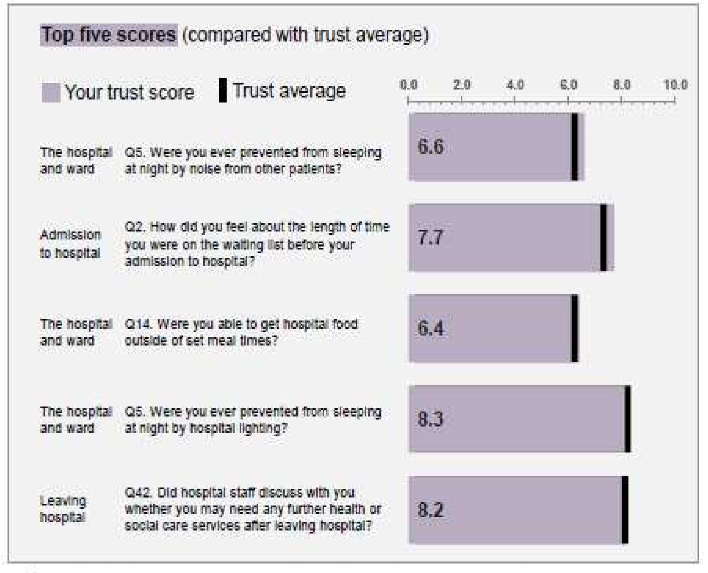
- Assist, dDeaflinks and Language Line have continued to provide interpretation services. The Trust has successfully launched the on demand “interpreter on wheels”, providing access to over 200 languages, 24 hours a day. There are now 15 machines across the Trust with more to come.
- UHNM membership of the CCG Community and Engagement Group to provide consistent messaging to the general public and seldom heard groups throughout Staffordshire.
- The launch of the new Trust Carer’s strategy to demonstrate our commitment to working in partnership with carer’s.
- 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 2022 Inpatient Survey results were published by the CQC in September 2023. 1,250 patients who were in hospital in November 2022 were invited to participate in the survey and the Trust had a 36% 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 44 questions. There was 1 question where we performed worse than expected compared to all other trusts:

“Thinking about any medication you were to take at home, were you given any of the following: an explanation of the purpose of the medication; an explanation of how to take the medication; an explanation of side effects; written information”.

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:

- Involving our Patient Leaders more robustly in our CEF process, including at Bronze panels to ensure appropriate challenge and that the patient voice is represented.
- The implementation of End-of-Life Volunteers to work alongside the Palliative Care team to offer support and companionship to patients and family in the last days of life.
- A redesign of the Trusts Patient Property Leaflet and the launch of new Property Boxes to make support with keeping patient's property safe.
- Working with our Spiritual, Pastoral and Religious Care (SPaRC) team to ensure wider inclusivity in our Patient Representatives.
- The implementation of the "Interpreter on Wheels" software to provide accessible interpretation services 24 hours a day, 7 days a week.
- A review of the "Accessible Communication Alerts" with a view to expanding these in-line with feedback from our d/Deaf community.
- A relaunch of the inpatient 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; allocation of specific "harms" to each of the Patient Safety Partners to support with improvements and ensure the patients have a voice.
- Supporting "Project Search" with placements in the Patient Experience Team
- Continuing to provide Health literacy training across the Trust and more widely.
- Expansion 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 2023/24 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 2023/24, which is 48% lower than the pre-COVID 3-year average of 112.

During 2023/24, 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.

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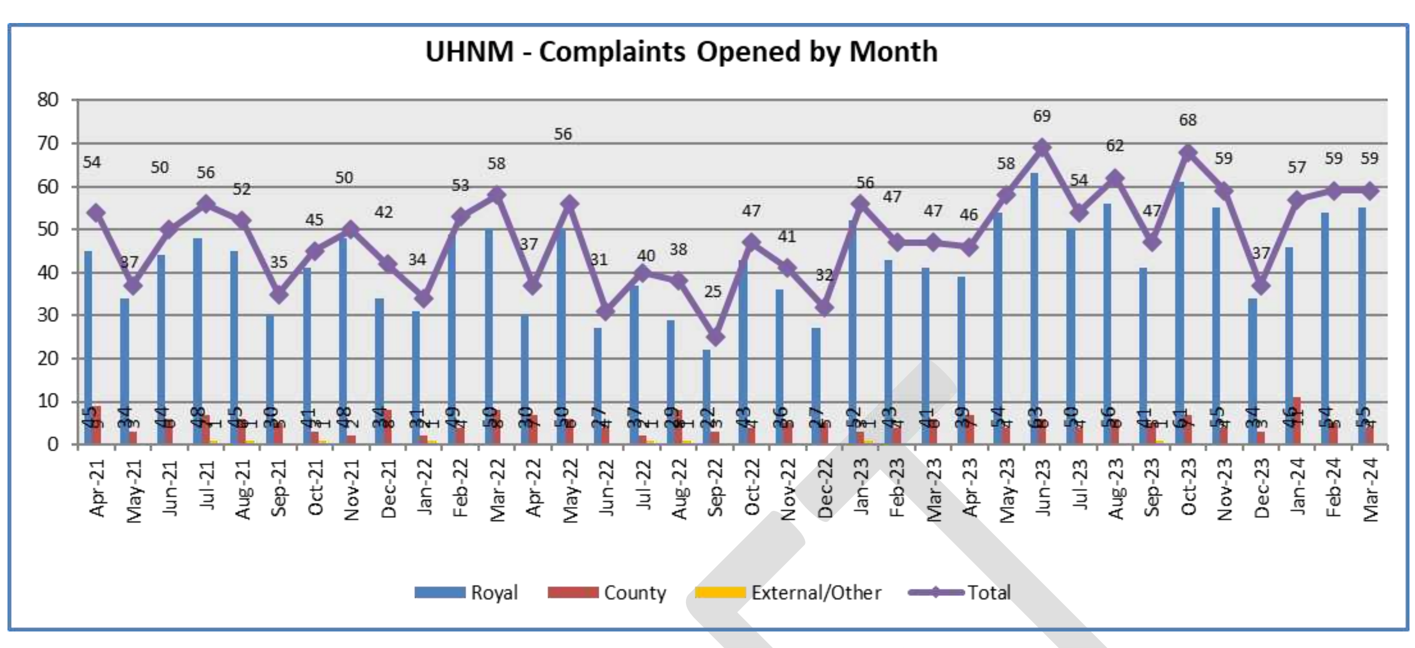

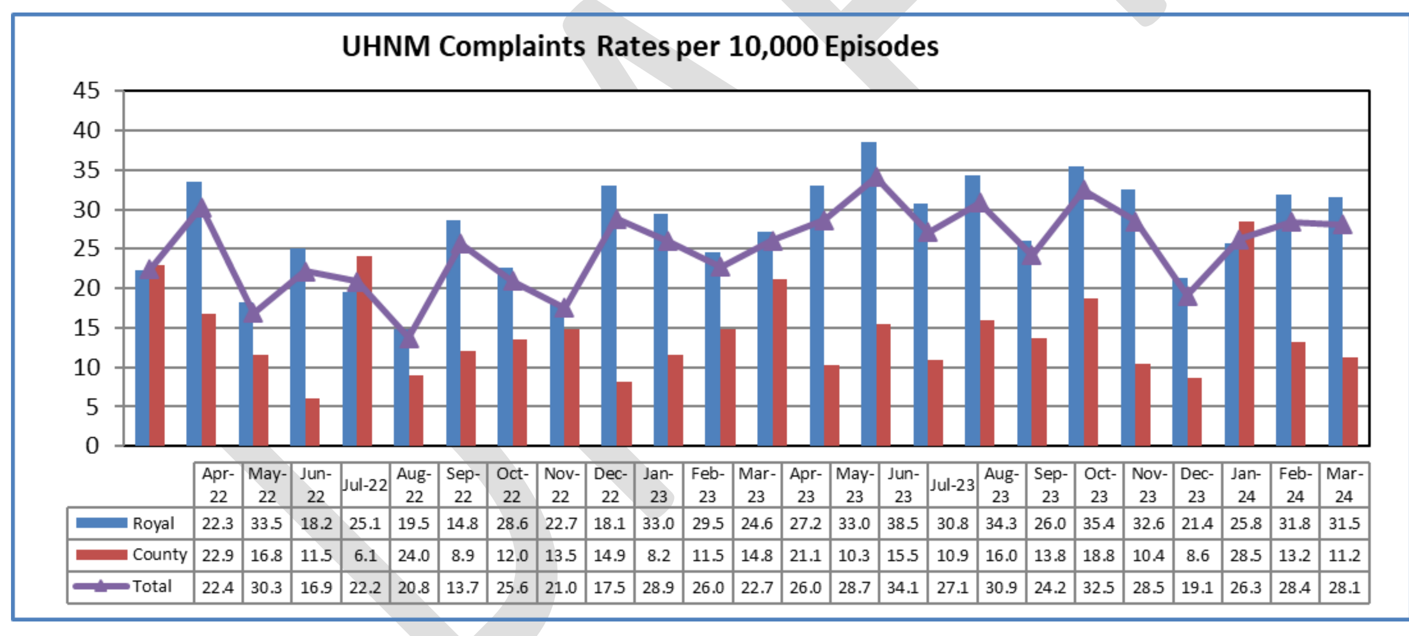

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Royal	22.3	33.5	18.2	25.1	19.5	14.8	28.6	22.7	18.1	33.0	29.5	24.6	27.2	33.0	38.5	30.8	34.3	26.0	35.4	32.6	21.4	25.8	31.8	31.5
County	22.9	16.8	11.5	6.1	24.0	8.9	12.0	13.5	14.9	8.2	11.5	14.8	21.1	10.3	15.5	10.9	16.0	13.8	18.8	10.4	8.6	28.5	13.2	11.2
Total	22.4	30.3	16.9	22.2	20.8	13.7	25.6	21.0	17.5	28.9	26.0	22.7	26.0	28.7	34.1	27.1	30.9	24.2	32.5	28.5	19.1	26.3	28.4	28.1

Patient Priorities

As part of UHNM Quality Strategy 2022-2025, five patient priority areas were identified from patient feedback as focus for improvement.

Timely medications

- The Parkinson's Team have been working together to ensure the best patient experience by ensuring the teams caring for them both in the hospital and in the community have a good understanding of the importance of medications in Parkinson's.
- Resource boxes have been provided on several wards across the Trust, alongside specific training regarding the contents to support with medication administration.
- Training sessions provided via Teams for trauma regarding Parkinson's including importance of medication and mobility.
- The Trust webpage for Neurosciences is currently under development to provide wider access to information and resources.
- Training has been provided to students at Keele University on Parkinson's symptoms, treatment and management, alongside further training for local hospices and the Acute Community Care Team.
- The use of 'Get it on Time' stickers within the Trust for prescription charts and above the beds for all patients with Parkinson's has been implemented and promoted. admitted to hospital.
- The Trust's Carer's strategy has been completed to support with ensuring staff listen to the voice of the carer around the support of vulnerable patients, including critical medications. New health passports have been launched across the ICB.
- Alongside over 100 acute Trusts, for 2024/2025, UHNM is working in collaboration with Parkinson's UK and has pledged to improve the delivery of time-critical medication for patients with Parkinsons disease.

Oncology- improving the patient experience

- Work has commenced on the new cancer centre and is planned to be completed by Autumn 2024. Patients with lived experience have supported with the design and development of this new facility to ensure a holistic approach to care.
- Significant work around waiting times and scheduling on the Chemotherapy Units has been undertaken to improve this.
- Friends & Family Test survey feedback has significantly increased for Royal Stoke cancer services. Work will continue with Chemotherapy Unit at County to improve their response rates.

Maternity- the Voice of the Patient

- Midwife advocates in place for patients wishing to raise concerns/speak to someone. This service is widely advertised in all areas in the Maternity Units.
- Patient Experience Team and Maternity Teams have been collaboratively working with Maternity & Neonatal Voices Partnership to gain specific feedback regarding induction of labour and other areas.
- Friends & Family Test survey via text messaging was launched to increase the volume of surveys and therefore the patient voice.
- Patient Experience Team providing regular workshop sessions with Maternity staff regarding themes, trends, outcomes of complaints/PALS.

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- Following the CQC visit to Maternity in March 2023, there has been a focus on enhancing the Maternity Assessment Unit waiting area and reducing the waits for Induction of Labour.

Shared Decision Making

- Patient Experience Team continue to deliver health literacy training to ensure staff are communicating with our patients in a way they understand to allow them to make informed choices.
- Clinic letters are now written directly to patients and with copies to GP's. There was collaborative work with our Hospital User Group to support communication with this new initiative.
- New "interpreter on wheels" trial was very successful in supporting successful and improved communication with patients who have support needs. There are now 15 machines in use across the Trust.
- Carer's strategy completed to support with staff hearing the voice of the carer around the support of vulnerable patients. New health passports launched across the ICB.
- UHNM participated in the Commissioning for Quality & Innovation (CQUIN) financial incentive scheme adopted by specialised commissioners to achieve high quality shared decision-making conversations in specific specialised pathways to support recovery. The Trust focused on the Cardiothoracic service to seek patient feedback on their involvement in shared decision making.

Pain Relief

- This has been identified as an on-going issue in the Emergency Department and from feedback from Maternity. Results from the most recent CQC survey correlate with this and will be an area for focused improvement in 2024/2025.

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Part C: Statements from our key stakeholders

NHS
Staffordshire and
Stoke-on-Trent
Integrated Care Board

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

Quality Account – Staffordshire County Council Overview and Scrutiny Committee

Statement regarding the UHNM Quality Account 2023/2024

Simon Fogell – Chief Executive, Healthwatch Stoke-on-Trent

Highlight Report

People, Culture and Inclusion Committee to Trust Board

Matters of Concern / Key Risks to Escalate

For information:

- 166 **Guardian of Safe Working** reports during Q4, with 7 immediate safety concerns raised which were later determined not to be immediate safety concerns and action will be taken to de-escalate. Exception reports and fines being levied resulted in a ***Partial Assurance*** rating; a number of priority actions were strongly supported.
- Inappropriate attitudes and behaviours, bullying and harassment and policy and procedure account for 25% of **Freedom to Speak Up Concerns** raised during the quarter. Improvement actions form part of the Culture Improvement Programme, and a ***Partial Assurance*** assessment was concluded by the Committee.
- Strategic Workforce Planning will be included on the Risk Register given the challenges highlighted through the **Learning & Education Report;** Apprenticeships is a Strategic Priority Metric and will be used to support the mitigation of this risk.
- Whilst **essential to role training** remains below target, progress has been made although it is now a driver metric for all divisions to drive improved performance.
- **UK Visa & Immigration** compliance remains a high risk due to change in eligibility criteria for sponsorship; a paper and mitigation plan are being developed.
- The level of case work being managed by the People Directorate due to increased **Resolution** cases has placed increased pressure upon the team; this is under regular review to focus on themes, managing expectations and priorities.
- **Health & Safety Report** identified numerous regulatory risks including unsafe sharps identification, manual handling training and measles immunity checks (in particular, Occupational Health capacity) and combined with the findings of the recent HSE Inspection, a rating of ***Partial Assurance*** was concluded.
- **Fire Safety** training remains below target and an increase in **false alarms** is being seen although actions are in place to improve this position and these areas are high priority areas.
- **Theatres** was identified as a 'hotspot' area in relation to culture and health and safety and the Surgical Division are working with the team around this.

Major Actions / Work Underway

- A paper is being prepared for Executive Directors summarising themes / trends arising from **Speaking Up**. This will be provided in the next report to the Committee which will move to 6 monthly. A business case is also underway to develop the service.
- **Staff Engagement** is a key area of focus and the Staff Voice Survey has moved to quarterly to allow time for analysis and completion of actions.
- Deep Dive at Executive Workforce Assurance Group focussed on increased number of **Resolution Cases** in comparison to grievance / conduct cases the previous year; a revised Employee Relation report including thematic analysis will be provided to the Committee.
- The work of the **Triangulation Panel** will continue to be developed and consideration will be given as to how the outputs can be reported to the Committee.
- Additional **fire safety** processes being adhered with buildings as a result of changes brought in following Grenfell.
- A paper is being presented to the Executive Team regarding the risks associated with **measles** immunity and Occupational Health requirements.
- An investigation is underway in relation to **aspergillus** and the findings will be reported to the Executive Health & Safety Group.

Positive Assurances to Provide

- The number of **Freedom to Speak Up (FTSU)** cases which have reported detriment has reduced and this is as a result of the work undertaken to clarify the definition. An internal audit review of **FTSU** concluded with a ***Reasonable Assurance*** rating, with a number of actions having been now completed. Improvement seen against the four specific FTSU questions in the latest Staff Survey which was commended
- **Learning & Education Report** demonstrated good progress with some significant achievements in apprenticeships, partnerships with local education providers, work experience initiatives and placement capacity for T-Level students with an assurance rating of ***Acceptable Assurance***.
- **People Promise Retention Manager** now in post as part of National Exemplar Programme; completed and submitted assessment tool to NHSE which included a High Impact Plan.
- **Chief People Officer's Report** concluded with an ***Acceptable Assurance*** rating due to the positive impact of the programmes of work being seen.
- Positive findings were reported as a result of the **Effectiveness Reviews** of the Executive Health & Safety and Workforce Assurance Groups.

Decisions Made

- The Committee supported the provision of administrative support to the **FTSU Guardian** in line with the Internal Audit Recommendations, as approved by the Executive Team.
- Approval of **Terms of Reference for the Executive Health & Safety Group**.

Comments on the Effectiveness of the Meeting

- High quality papers were commended by the Committee, along with sufficient opportunity to discuss key issues – a balance was achieved and key matters identified for escalation
- Members regarded the meeting as being well chaired, in particular the use of assurance ratings as agreed as part of the Board Effectiveness Review
- An observer commented on the quality of papers, flow of meeting and psychological safety of the meeting

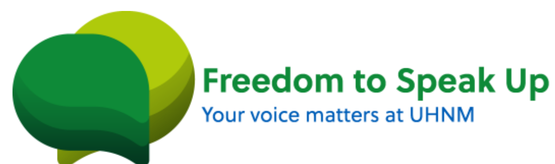
Summary Agenda

No.	Agenda Item	BAF No.	Risk	Assurance	Purpose	No.	Agenda Item	BAF No.	Risk	Assurance	Purpose
1.	Speaking Up Report Q4 23/24	BAF 3	High 12	● (orange)	Assurance	6.	Executive Workforce Assurance Group Highlight Report	BAF 2 BAF 3	Ext 16 High 12	-	Assurance
2.	Internal Audit Report: Freedom to Speak Up	BAF 3	High 12	● (green)	Assurance	7.	Fire Safety Annual Report 2023/24	BAF 7	High 12	● (red)	Assurance
3.	Q4 Guardian of Safe Working	BAF 2	ID28655 ID24272 ID18842 ID23787 ID10868	● (red)	Assurance	8.	Q4 Health & Safety Report		ID18673 ID22876	● (red)	Assurance
4.	Learning, Education and Widening Participation / Apprenticeship Report	BAF 2	Ext 16	● (orange)	Assurance	9.	Executive Health & Safety Group Highlight Report	BAF 7		-	Assurance
5.	Chief People Officer Report M12 & M1/2	BAF 2 BAF 3	Ext 16 High 12	● (green)	Assurance	10.	Executive Groups Terms of Reference	-		-	Approval

Attendance Matrix

No.	Name	Job Title	M	J	J	A	S	O	N	D	J	F	M	A
1.	Gary Crowe	Non-Executive Director / Vice Chair	Attended											
2.	Claire Cotton	Director of Governance	Attended											
3.	Arvinda Gohil	Non-Executive Director	Apologies											
4.	Jane Haire	Chief People Officer	KM											
5.	Katie Maddock	Non-Executive Director	Attended											
6.	Ann-Marie Riley	Chief Nurse	Attended											
7.	Lisa Thomson	Director of Communications	Apologies											
8.	Sunita Toor	Non-Executive Director	Attended											

Attended | Apologies & Deputy Sent | Apologies



Speaking Up

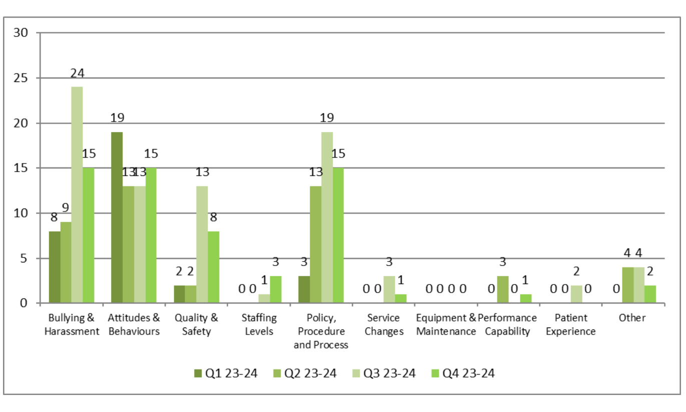
Board Brief – Quarter 4, 2023/24

1. Headlines

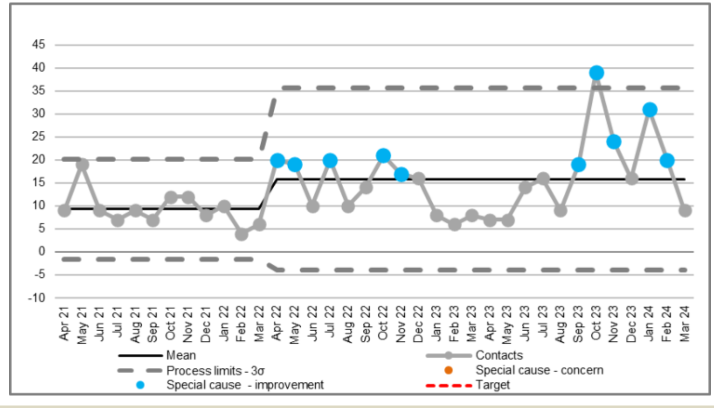
- **60 concerns** raised through the Freedom to Speak Up (FTSU) Guardian's Office during Quarter 4 2023/24
- **'Bullying and Harrassment', 'Inappropropriate Attitudes and Behaviours' and 'Policy and Procedure'** were the highest themes accounting for 75% concerns raised during the quarter
- Highest reporting staff group continued to be **Registered Nurses and Midwives** (20 concerns, 34%)

2. Summary of Concerns Raised During the Quarter

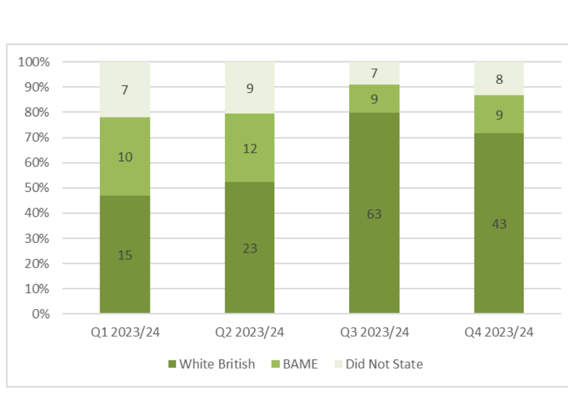
Types of Concerns Raised 2023/24



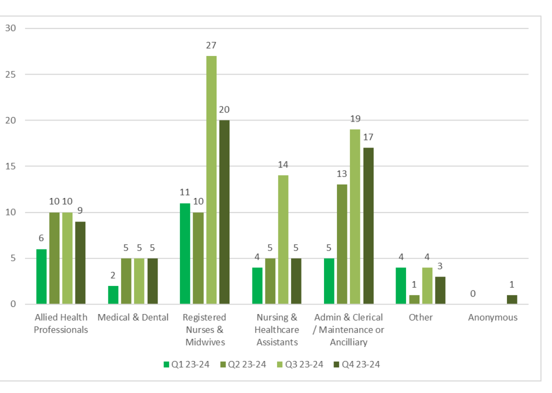
SPC – Concerns Raised April 2021 to March 2024



Ethnicity of Reporters Q4 23/24



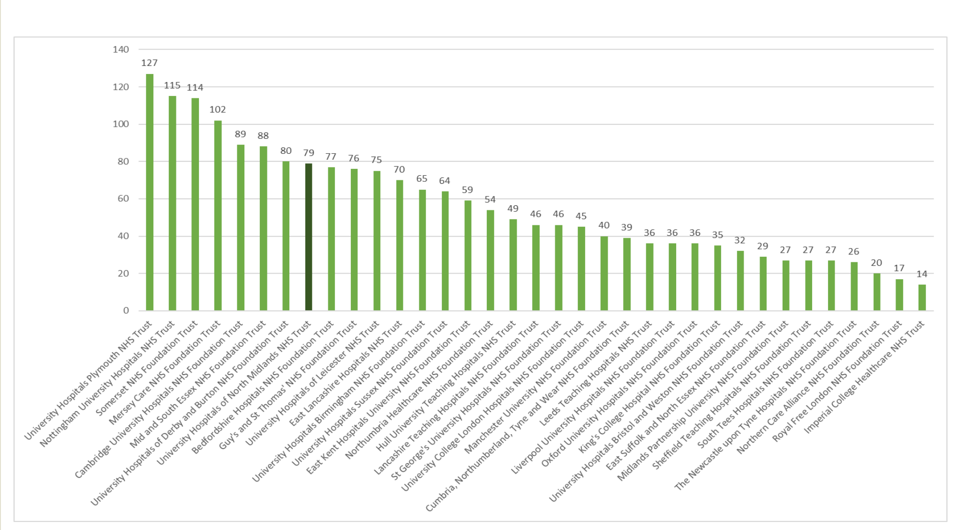
Type of Staff Raising Concerns 2023/2024



Overview

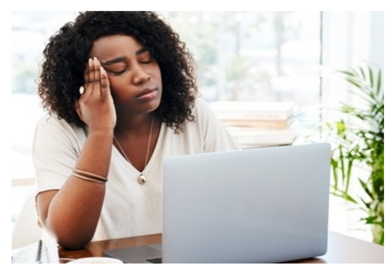
- 60 concerns raised during the quarter, higher than any other other (excepting Q3)
- In comparison to Q4 2022/2023 this is an increase of 172%

National Benchmarking – Quarter 3 2023/24



- UHNM ranked 26 / 210 NHS Trusts, for number of concerns raised during the quarter in the national benchmarking
- Above average for all areas in national benchmarking (number of cases raised anonymously, with an element of patient safety/quality, with an element of worker safety or wellbeing, with an element of bullying or harassment, with an element of other inappropriate attitudes or behaviours and cases of detriment

Detriment



- Of the 60 cases reported during Quarter 4, two cases were reported as there being detriment as a result of raising their concern.
- This is a reduction from the previous quarter where 7 cases were reported
- All of these cases are discussed with the Non-Executive Director for Speaking Up
- Materials to provide further details of detriment have been developed

3. Key Developments During the Quarter

National / Regional Developments

	Attendance at National Guardian's Office Annual Conference 2024		Increases in all four applicable staff survey question responses for 2023

Local Developments

	Ongoing work to increase the scope of the Freedom to Speak Up Service		Internal Audit into Freedom to Speak Up concluded with Reasonable Assurance
	Continued working and engagement with UHNM Staff Networks / Task and Finish Groups		Continued involvement with Data, Culture, Learning and Understanding Group

4. Priorities for the Next Quarter

No.	Strategic Priorities	Action
1.		To continue to increase visibility of the service via ward/department visits, social media presence, communications
2.		To continue to implement the recommendations from the internal audit
3.		To further develop the business case for expansion of the FTSU service and the introduction of FTSU Champions
4.		To produce an action plan to address the themes developing around Speaking Up Culture within the organisation
5.		To revisit the self-reflection tool and develop an improvement plan for 2024/25

5. Key Conclusions

	The highest category of concerns continues to be inappropriate attitudes and behaviours, bullying and harassment and policy and procedure
	Whilst there was a fall in the number of concerns raised during Quarter 4, compared to Quarter 3, they remain at a higher level than any other quarter. This indicates the continued success of the measures implemented by the Guardian
	Review of the 2023 Staff Survey Results demonstrated that for all four questions, the Trust improved on its 2022 results
	The number of detriment cases has reduced, and this reflects the work undertaken to clarify the definition of detriment in terms of suffering detriment as a result of raising a concern versus suffering detriment which is the basis of raising the concern in the first instance

Integrated Performance Report (IPR)

Month 1 Performance 2024/2025

Delivering Exceptional Care with Exceptional People

Contents

No.	Title	Page
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2.	Assurance Grid	4
3.	High Quality: Overview | Dashboard | Metrics	5 – 30
4.	Responsive: Overview | Dashboard | Metrics	31 – 47
5.	People: Overview | Dashboard | Metrics	48 – 55
6.	Improving & Innovating: Overview | Dashboard | Metrics	56 – 61
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8.	Resources: Overview | Dashboard | Metrics	65 – 79

Data Quality & Statistical Process Control

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:

Colour	Meaning
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

This report uses Statistical Process Control (SPC) methods to draw two main observations of performance data and the below key, and icons are used to describe what the data is telling us.

Variation	Are we seeing significant improvement, significant decline or no significant change?
Assurance	How assured of consistently meeting the target can we be?

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

Assurance Grid

Strategic Priority Domain Metrics Key

Assurance / Variation Key

Assurance

?	P	F
Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation

Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

Aiming Here

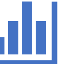
Failing

Worsening

VARIATION	ASSURANCE: Pass	Hit and Miss	Fail
Special Cause - Improvement	Turnover Rate	Maternity Triage Family & Friends Test - Maternity Sepsis - Adult Inpatient Screening Sepsis - Childrens Screening	Vacancy Rate Cancer 28 Day FDS UEC 4 Hour Performance RTT No. of Patients Waiting >65 Weeks RTT No. of Patients Waiting >104 Weeks RTT No. of Patients Waiting >78 Weeks
Common Cause	Medication Incidents % with moderate harm or above Increase Clinical Academic Posts/Honorary Contracts Increase Research Active Employees	Induction of Labour Patient Safety Incidents rate per 1000 bed days Patient Safety Incidents with moderate harm and above per 1000 bed days Patient falls with harm per 1000 bed days Never Events per month Pressure ulcers developed under UHNM per 1000 bed days Sepsis - Adult Inpatient IVAB Sepsis - ED Portals Screening Sepsis - ED Portals IVAB Sepsis - Maternity Screening Increase Clinical Trial Participation UEC Cat Handover Average Time Daycase / Elective Activity Outpatients' 1st Outpatients' Follow Up Subject Access Request Performance	Medication Incidents per 1000 bed days Employee Engagement Sickness Absence (In Month) Agency Cost Cancer 31 Day Combined Cancer 62 Day Combined Diagnostics DM01 Performance Freedom of Information Performance
Special Cause - Concern	Family & Friends Test - Inpatient	Non-Elective Activity	Family & Friends Test - ED UEC 12 Hour Trolley Wait RTT No. of Patients Waiting >52 Weeks Treating patients in a timely manner (Hospital Combined Performance Score)

High Quality | Overview

Provide safe, effective and caring services



Overview from the Chief Nurse and Chief Medical Officer

How are we doing against our trajectories and expected standards?

In general, the Quality & Safety Indicators included in the report are showing variable performance in terms of variation and assurance and majority of the indicators are showing normal variation.
Continue to see consistent levels of reporting incidents following introduction of new national LFPSE incident reporting via Datix. The harm profiles of the reported incidents has noted reduction in recent months for moderate harm and above.
We are off trajectory for Never Events with 4 reported during the past 4 months
We have seen significant improvement in written duty of candour compliance against our internal 10 working day target for the past 7 months all being above the long term mean rate.
Pressure Ulcers developed under our care have increased and with exception of March 2024 has been consistently above our target rate of 1.6 per 1000 bed days for the past 6 months.
Friends & Family Test results show lower reporting rates in UHNM compared to national average.

What is driving this?

The increase in Never Events has been driven by wrong site surgery incident and specifically incorrect lesions being removed during the past 4 months.
Friends & Family Test results are lower than national average and target recommendation percentage and there is lower response rates at UHNM.
Timely Observations not showing enough improvement and being driven by improvements needed in compliance with data entry and timing on VitalPack system

Overview from the Chief Nurse and Chief Medical Officer

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

We are continuing to work with all services across the Trust to implement PSIRF methodologies and principles for incident responses and learning. This is planned to improve the identification of system-based learning and recommendations to support our wider learning for improving the quality of care provided
Thematic Review is being undertaken to assess the system issues and factors involved in the recent Never Events as well as reviewing previous wrong site surgery incidents during 2022/23.
Tissue Viability Team are undertaking an A3 Improvement Project for improving pressure damage developed under UHNM care
The patient experience team are constantly working with clinical teams to promote and increase completion rates for patients and assessing new approaches to try and increase completion of the FFT questions including efficacy of text messaging in Maternity, improving access to paper questionnaires in Emergency Departments along with greater visibility of QR codes. Inpatient areas to focus on Medicine and Surgery Divisions to improve response rates and working on suite of patient priorities based on the feedback received (timely medications, pain management, involvement in decision making and improving experience)

What can we expect in future reports?

There will be continued reporting of these indicators in future reports and progress / outcome to the identified actions will be included in future reports.
Focus on Timely Observations actions to improve compliance.

High Quality | Dashboard

Provide safe, effective and caring services

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Induction of Labour	95.0%	97.2%	98.4%						
Maternity Triage	85.0%	93.0%	96.0%						
Patient Safety Incidents rate per 1000 bed days	50.7	47.5	48.9						
Patient Safety Incidents with moderate harm and above per 1000 bed days	0.6	0.8	0.7						
Patient falls with harm per 1000 bed days	1.5	1.7	1.8						
Medication Incidents per 1000 bed days	10.0	5.5	5.6						
Medication Incidents % with moderate harm or above	5.0%	0.9%	0.0%						
Patient Safety Incident Investigation (PSII's) instigated	0.0	0.0	0.0						
Never Events per month	0.0	1.0	0.0						
Pressure ulcers developed under UHNM per 1000 bed days	1.6	1.2	1.8						
Family & Friends Test - Inpatient	95.0%	93.9%	95.4%						
Family & Friends Test - ED	85.0%	68.4%	70.9%						
Family & Friends Test - Maternity	95.0%	90.5%	90.0%						
Sepsis - Adult Inpatient Screening	90.0%	97.9%	98.0%						
Sepsis - Adult Inpatient IVAB	90.0%	100.0%	90.6%						
Sepsis - ED Portals Screening	90.0%	72.7%	82.9%						
Sepsis - ED Portals IVAB	90.0%	89.7%	77.8%						
Sepsis - Childrens Screening	90.0%	100.0%	97.1%						
Sepsis - Childrens IVAB	90.0%	100.0%	n/a						
Sepsis - Maternity Screening	90.0%	66.7%	75.0%						
Sepsis - Maternity IVAB	90.0%	100.0%	75.0%						

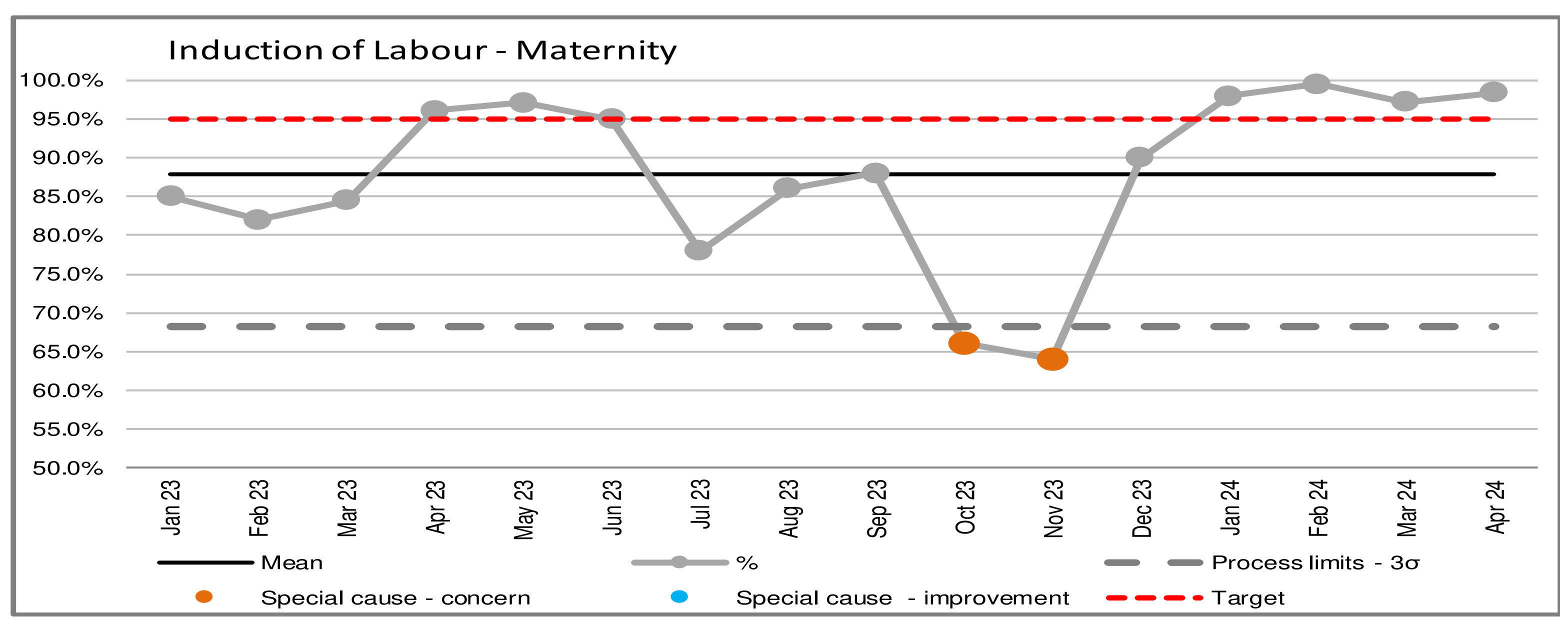
Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 1: Delivering Positive Patient Outcomes								

High Quality

High Quality | [Induction of Labour]

Provide safe, effective and caring services



Variation		Assurance	
Target	Feb 24	Mar 24	Apr 24
95%	99.5%	97.2%	98.4%

Background

Induction of Labour Compliance

What is the data telling us?

There has been a consistent improvement in timely admission of women for induction of labour since November 2023.

The target of 95% has been achieved since January 2024 despite the increase in IOL rate in comparison to the previous year.

The introduction of the opening of 8 beds for IOL on the MBC in December 2023 and the development of the IOL improvement project have contributed to this improvement.

What are we doing about it?

The IOL improvement group continues to meet monthly to review the A3 improvement plan and identify any trends and further actions.

Any IOL breaches are safety netted and incident reported for full review through the internal governance process.

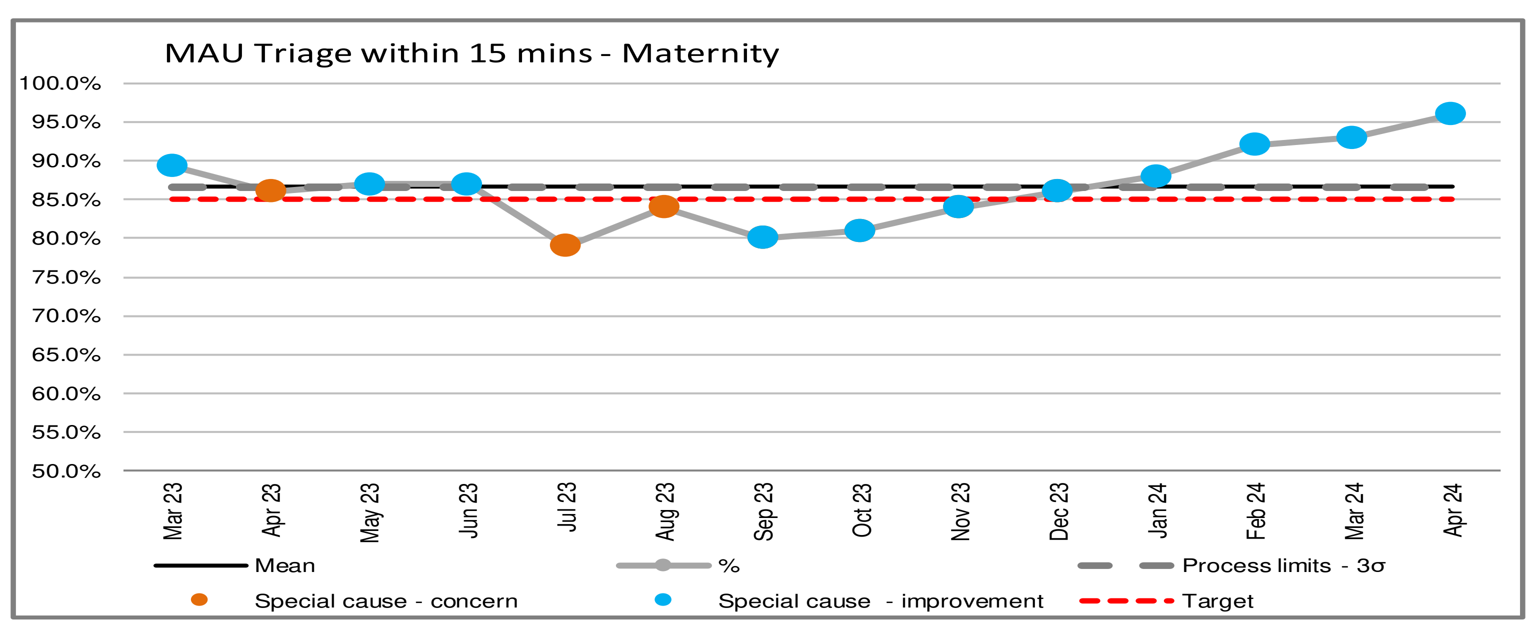
Any IOL breaches are discussed daily at the patient safety huddle and escalated.

Any IOL breaches will have a well being appointment with a medical review and if necessary admitted for observation.

Prioritisation occurs daily by the on call Consultant Obstetrician for all IOL's booked for that day

High Quality | [Maternity Triage]

Provide safe, effective and caring services



Variation	Assurance		
H	P		
Target	**Feb 24**	**Mar 24**	**Apr 24**
85%	92.0%	93.0%	96.0%

Background

Percentage of patients receiving MAU Triage within 15 minutes

What is the data telling us?

There has been a consistent improvement in MAU patients being triaged within 15 minutes since September 2023.

The target set of 85% of patients to be seen within 15 minutes on MAU has been consistently met since December 2023.

The development of the MAU improvement group in December 2023 and implementation of actions have contributed to the improvement in MAU breaches

What are we doing about it?

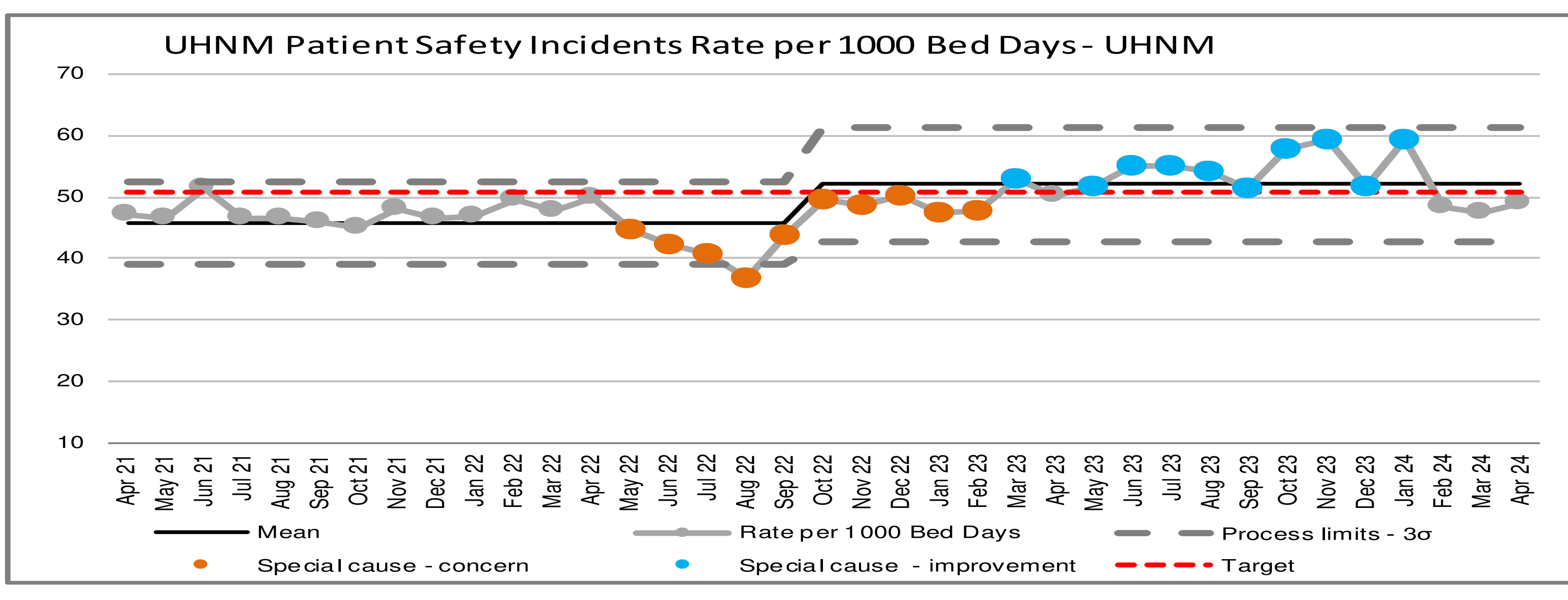
The MAU improvement group continue to meet monthly to review the A3 improvement plan and identify any trends and further actions

All MAU timing breaches are incident reported and reviewed in relation to impact and outcome

MAU triage breaches are included in daily patient safety huddle

High Quality | [PSIs per 1000bed days]

Provide safe, effective and caring services



Variation		Assurance	
NRLS Mean	**Feb 24**	**Mar 24**	**Apr 24**
50.70	48.25	47.51	48.91

Background

Patient Safety Incidents rate per 1,000 bed days

What is the data telling us?

There is consistent levels of reporting across the Trust and maintaining the improvements and higher mean rate since October 2022. LFPSE reporting and additional NHSE mandated questions introduced in February 2024 and whilst there has been slight decrease in rate compared to January 2024 the reporting rate is similar to the same months during 2023.

January 2024 appears to be 1 off higher rate and reporting rates have returned to around previous monthly rates.

There is no significant variation in reporting rates.

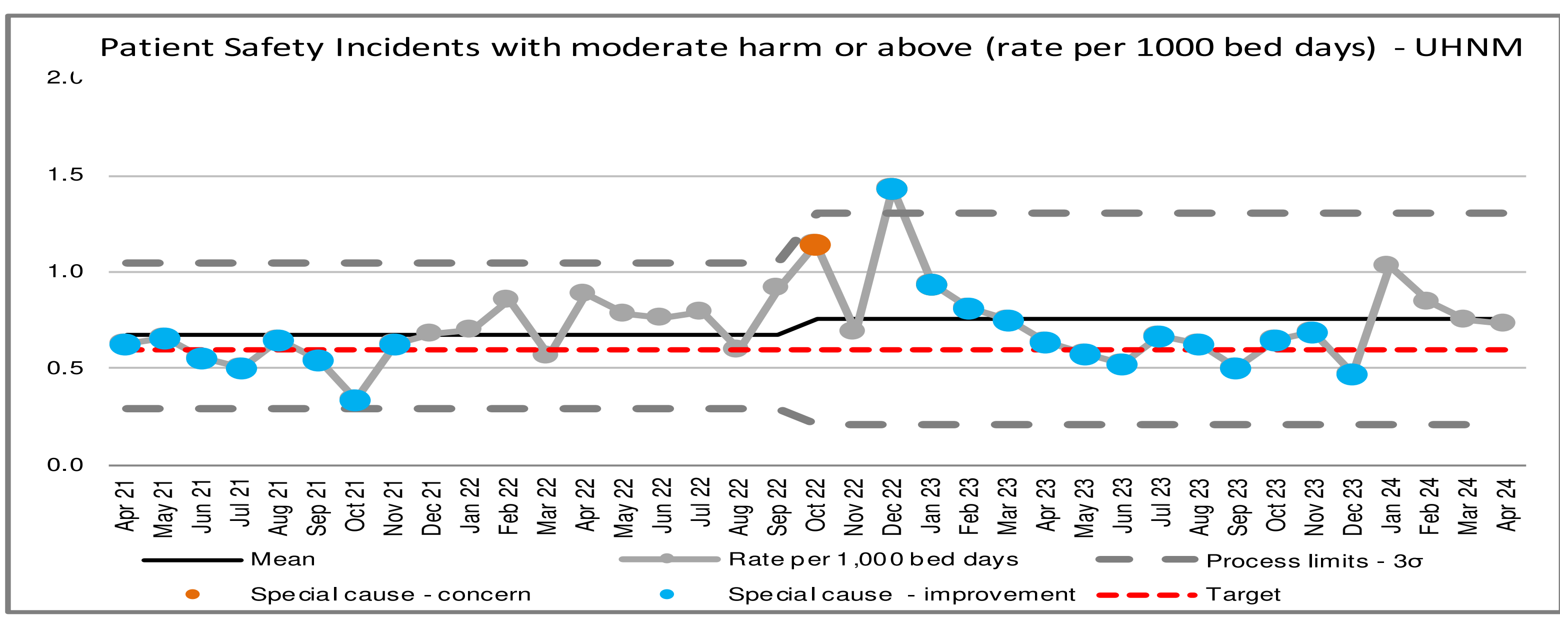
What are we doing about it?

Reviewing incident categories ad locations to see if any focus areas and to continue to promote reporting incidents and near misses. Will adopt PSIRF principles re thematic reviews / improvement works to identify potential learning along with ant recommendations.

To utilise any available LFPSE data published to assess/benchmark our reporting and outcomes.

High Quality | [PSIs moderate harm & above per 1000 bed days]

Provide safe, effective and caring services



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
0.60	0.84	0.75	0.73

Background

Patient safety incidents reported with moderate harm and above rate per 1,000 bed days

What is the data telling us?

The rate of PSIs reported with moderate harm or above is returning to previous lower levels noted in 2023. Following increases in January 2024 the rates have been reducing for the past 3 month and returned below the long term mean rate.

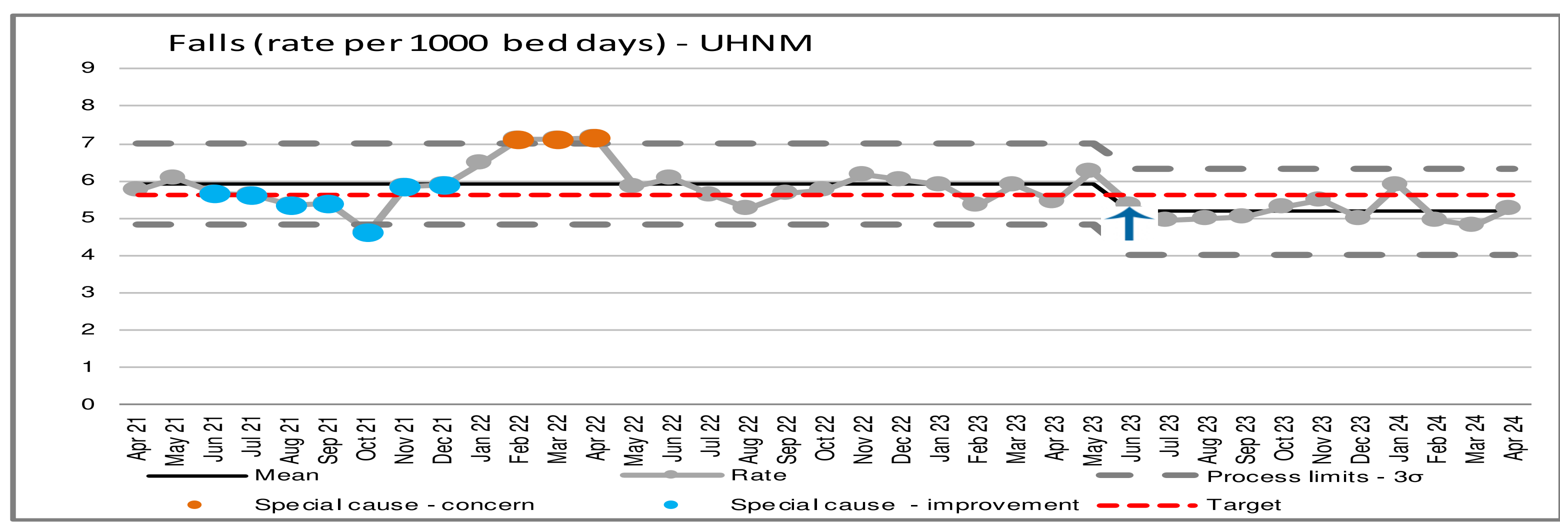
As noted in overall PSI rate, January 2024 increase appears to be the anomaly and 1 off exception/increase compared to the longer-term reducing trend during 2023.

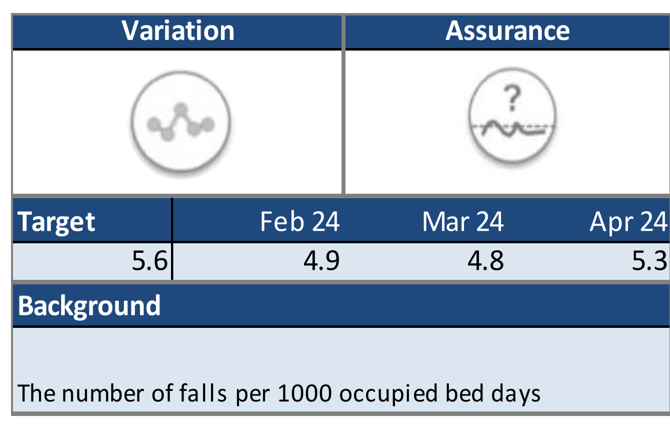
What are we doing about it?

Reviewing harm profile and locations / categories for moderate harm and above incidents. To support PSIRF principes re learning and proportionate responses to incident reviews. Will work with divisions and specialist services re any safety recommendations and themes identified to improve.

High Quality | [Patient Falls per 1000 bed days]

Provide safe, effective and caring services





Target	Feb 24	Mar 24	Apr 24
5.6	4.9	4.8	5.3

Background

The number of falls per 1000 occupied bed days

What is the data telling us?

The average rate of reported patient falls per 1000 bed days has been significantly lower since June 2023. The rate for April 2024 is within expected limits.

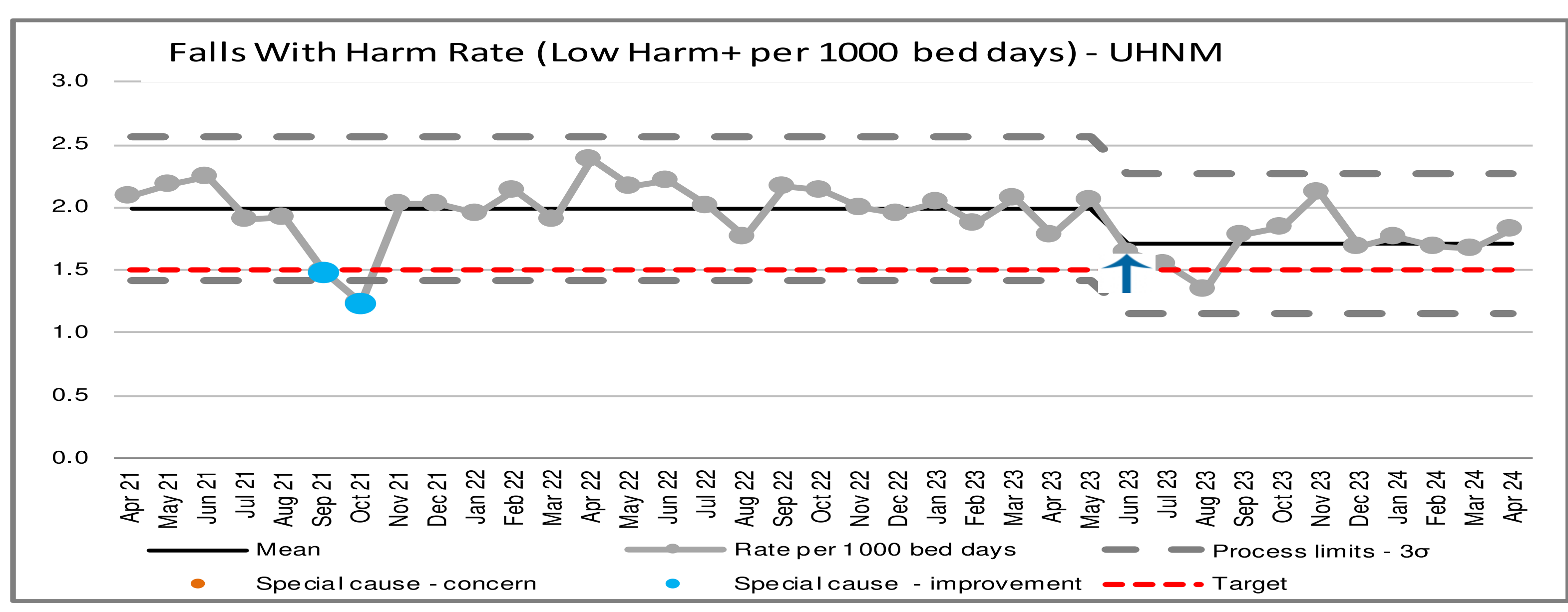
The areas reporting the highest numbers of falls in April 2024 were:
Royal Stoke AMU – 21 falls, Royal Stoke ECC – 14 falls, Ward 15 – 12 falls

What are we doing about it?

From the 47 falls across the 3 areas there was 1 injury from each. PSIRF toolkits were completed in conjunction with the areas and improvements and actions were discussed.
AMU have had a multiple faller for this month.
ECC and AMU are consistently in the Top 5 areas for falls. Therefore, discussions take place with the falls links weekly to discuss areas of improvement.
Education continues to be provided on a 1:1 basis in ECC to ensure documentation and mitigation for risks are in place. A meeting is scheduled with the quality and education team in ECC to discuss falls. The area are discussing introducing assurance panels within the department. The team will also be introducing yellow wristbands for the patients that are at risk of falls in the coming weeks.
AMU have stated that they will order tables and trial staff sitting in the bays whilst they are completing documentation to improve observation of patients. The team will also be updating their risk assessment booklet to align with the trusts current booklet once this has been approved.
County ward 14 had a day where staff were able to receive falls training from their champion, this was open to ward 15. Ward 15 have recently had a CEF inspection where documentation and aspects of falls were discussed.
Falls audits have been completed on the above wards and areas of good practice were noted. Areas of improvements were fed back and discussed.
New falls Champion and refresher training has been advertised and a session has taken place last week.
New N/A induction has taken place.

High Quality | [Patient Falls with harm per 1000 bed days]

Provide safe, effective and caring services



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
1.5	1.7	1.7	1.8

Background

The rate of patient falls reported with low harm or above per 1000 bed days. Excludes collapses and managed falls

What is the data telling us?

The rate of patient falls with harm has also been significantly lower since June 2023. The rate was within expected range in April 2024.

Wards with falls reported as resulting in serious injuries in April (5 incidents):
Stoke AMU, Stoke ED, Ward 15, Ward 76A, SSU

What are we doing about it?

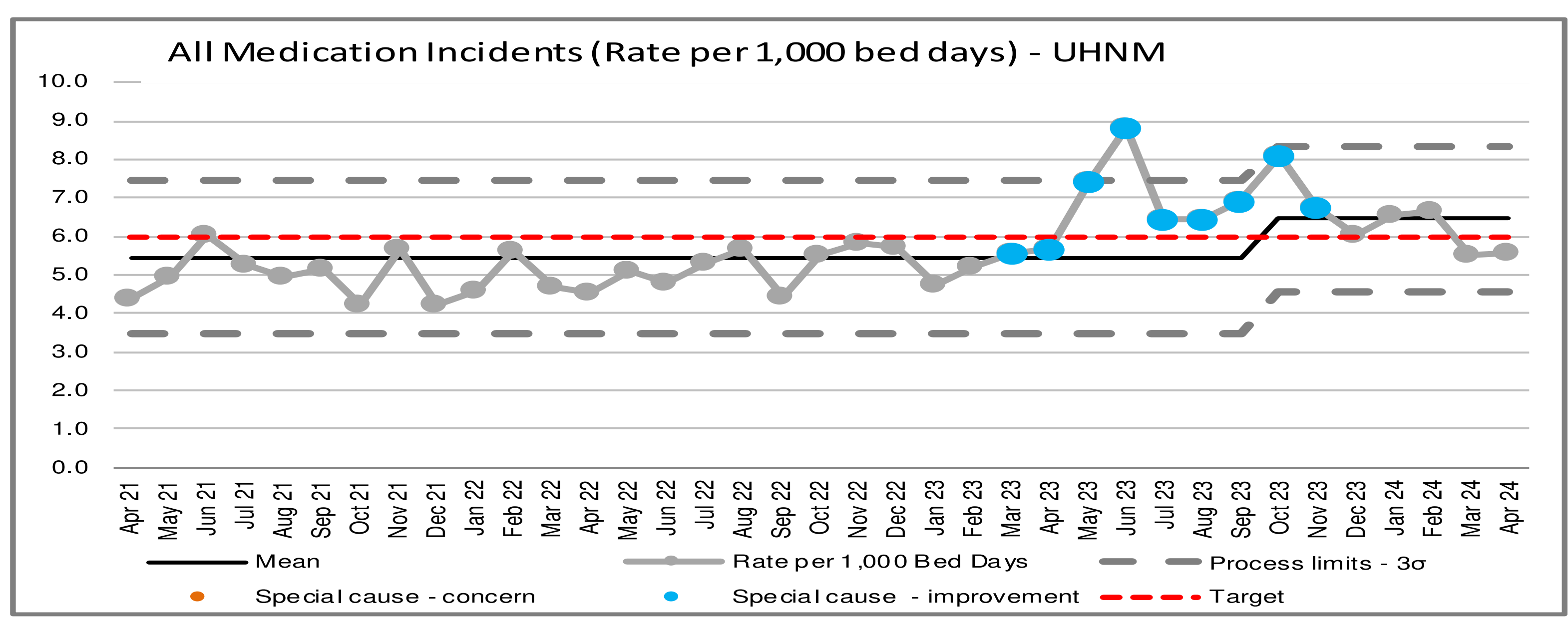
The wards listed opposite have been visited and the new falls toolkit (PSIRF) have been completed with the staff and the Q&S team, all aspects of the fall's agenda were discussed and improvements documented. Findings from the 5 falls included the below:

- 1 patient had not pressed the call bell to ask for assistance and had mobilised independently.
- 1 patient who could mobilise independently with frame had mobilised without their frame.
- 1 patient had collapsed from a seizure.
- 1 patient was being nursed in a cohort bay; however, the staff had closed the curtains to attend to another patient.
- 1 patient was found to have postural hypotension.

The team are currently awaiting notes from the recent hip fractures to complete a thematic review.
The team continue to work with all areas, this includes audits, spot checks, 1:1 discussion with staff on walkabouts, multiple fallers, training, PSIRFS and action plans.

High Quality | [Medication Incidents per 1000 bed days]

Provide safe, effective and caring services



Variation		Assurance	
NRLS Mean	Feb 24	Mar 24	Apr 24
6.0	6.6	5.5	5.6

Background

Reported Medication incidents rate per 1,000 bed days

What is the data telling us?

In recent months the rate of medication related incidents had reduced following increases during 2023 with promotion of reporting medication errors as PSIs. However, the longer-term trend is showing improvement/increased reporting compared 2021 and 2022.

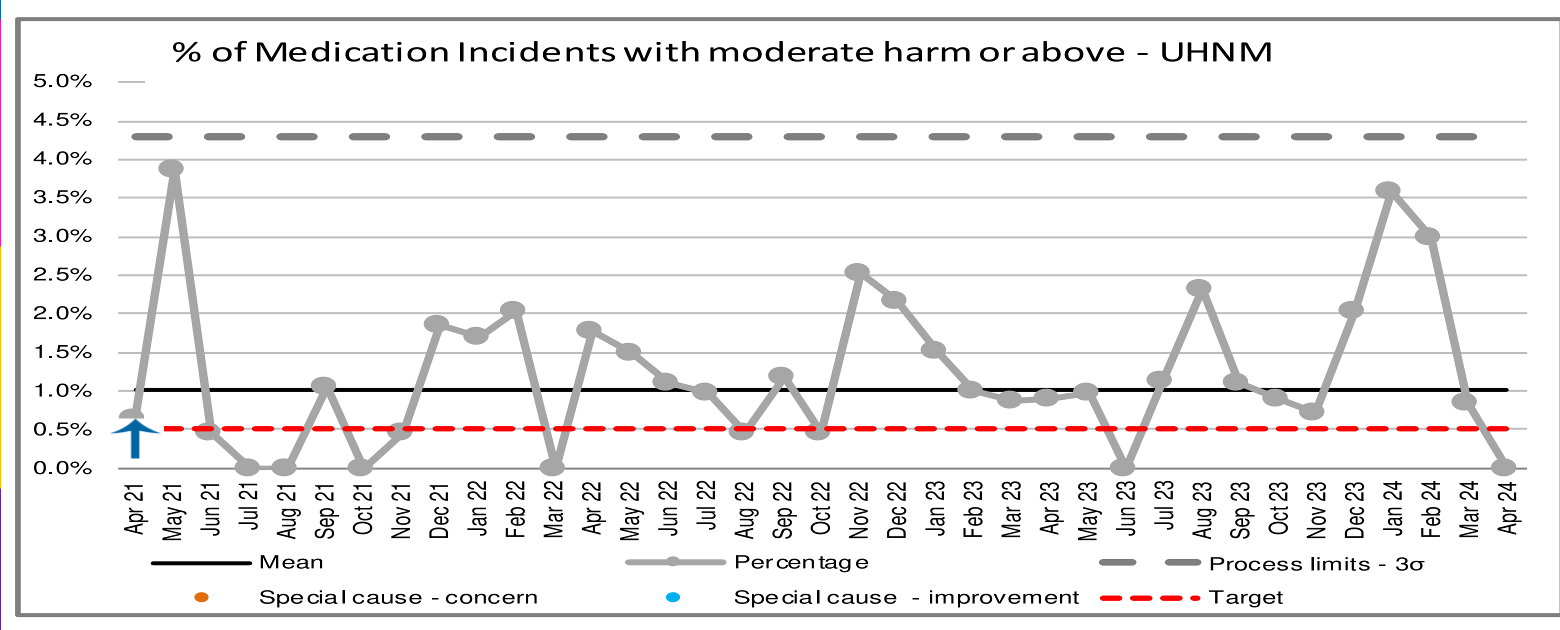
What are we doing about it?

Pharmacy Team reviewed all incidents relating to missed doses and identified that the top categories for missed doses were anticoagulants, antimicrobials, insulins and anti-epileptic medicines. In order to support wards and departments in addressing the missed doses the Pharmacy Team developed key actions for the wards.

OBTAIN – get medicines via Pharmacy / dispensary or on call pharmacist
COMMUNICATE – nil by mouth does not mean nil by mouth for medicines, give medicines before patients are transferred, include information re critical meds in handover
DOCUMENT – when recording medicine not available document steps taken to obtain the drug, code missed doses correctly using codes on prescription charts
ESCALATE – raise any missed doses to the prescriber

High Quality | [Medication Incidents % with moderate harm or above]

Provide safe, effective and caring services



Variation	Assurance
	?

Target	Feb 24	Mar 24	Apr 24
0.5%	3.00%	0.85%	0.00%

Background

The percentage of medication incidents reported as causing moderate harm or above

What is the data telling us?

The number of medication incidents reported with moderate harm or above has been reducing recently following increase during January 2024 (as per overall PSIs). The overall trend for medication incidents with moderate harm or above has been around the long term mean even when there were noted increases in overall medication related incidents reported.

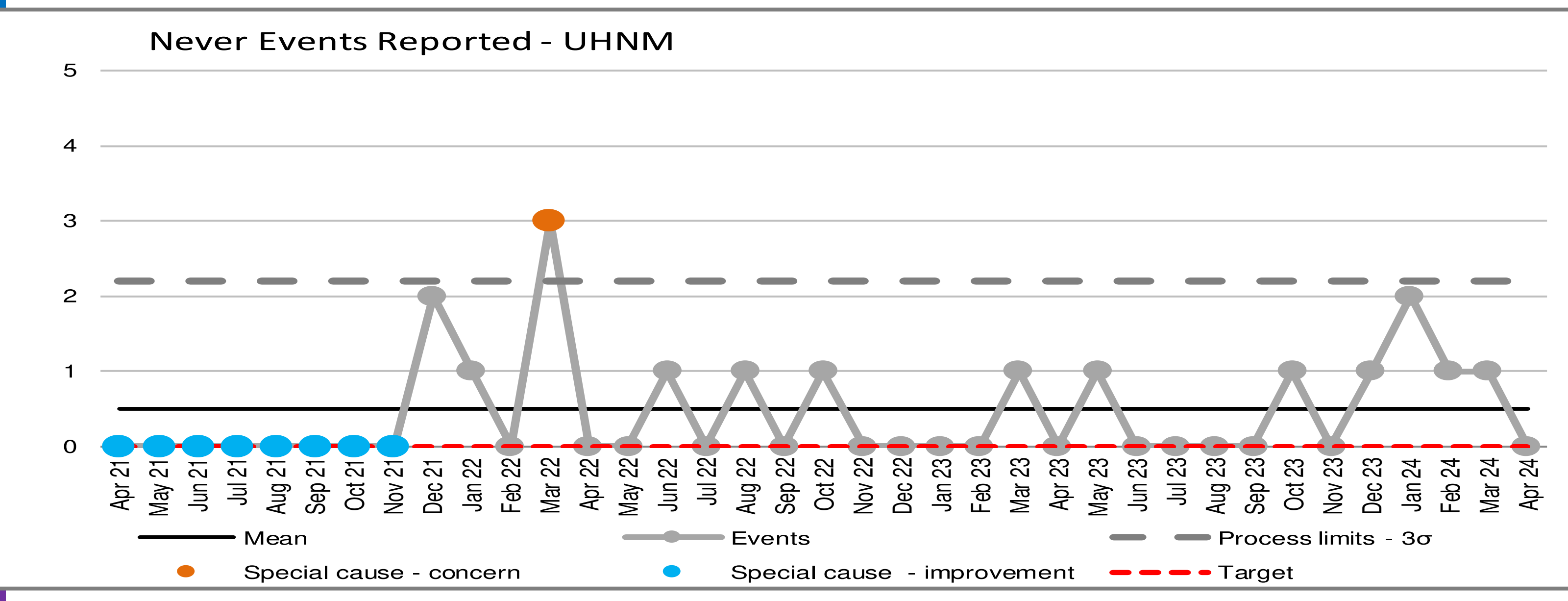
This demonstrates that there are lower numbers of patients suffering harm as result of the reported errors and actions being taken to prevent serious harm.

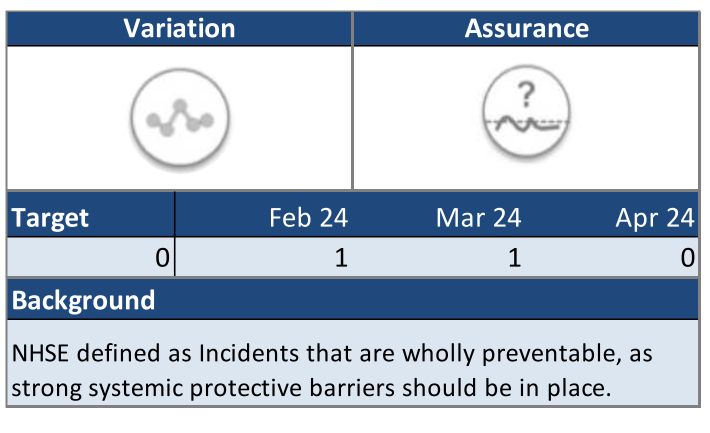
What are we doing about it?

The reported incidents are reviewed and assessed via the Pharmacy Safe Medications Team along with input from the relevant clinical areas to share learning and actions

High Quality | [Never Events per month]

Provide safe, effective and caring services





Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
0	1	1	0

Background

NHSE defined as Incidents that are wholly preventable, as strong systemic protective barriers should be in place.

What is the data telling us?

4 never events in recent months. Under SPC rules normal variation but no new Never Event recorded during April 2024.

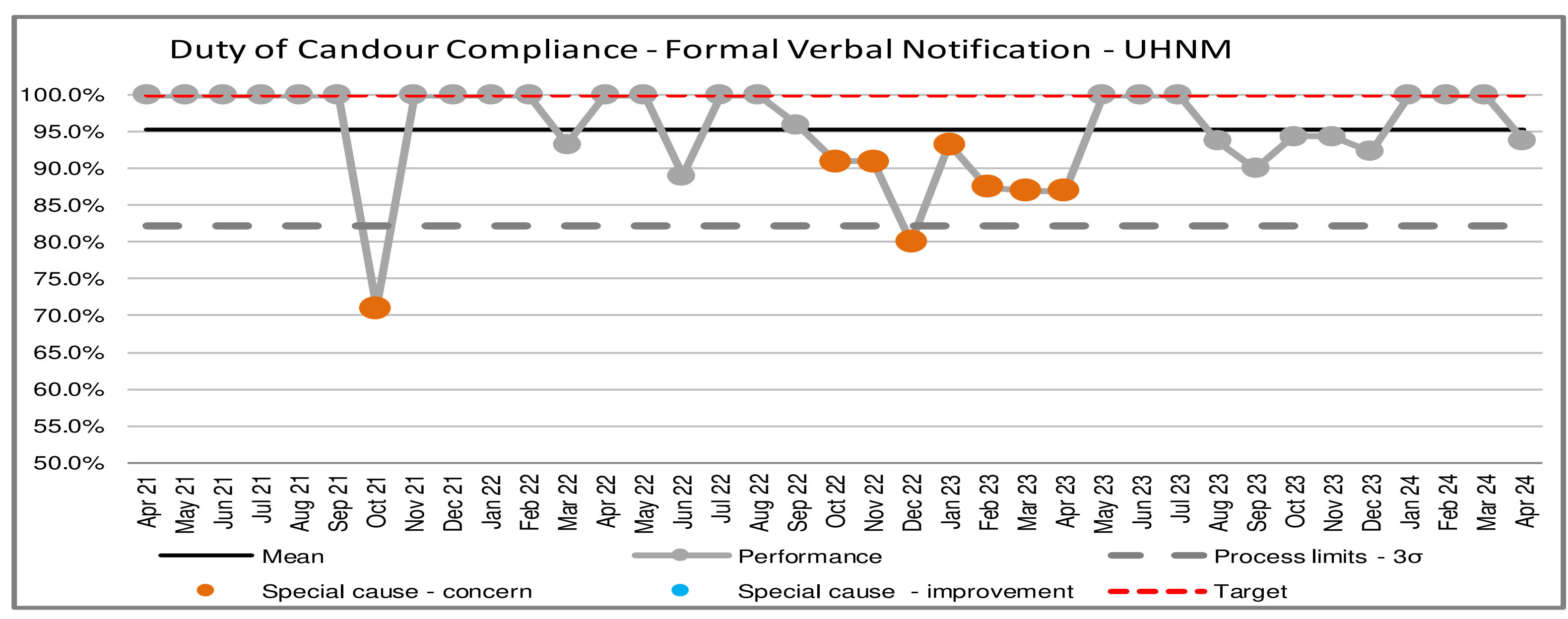
What are we doing about it?

We are reviewing the latest Never Events reported during 2024 which relate to Wrong site surgery (incorrect lesions removed or biopsy) within specialised Surgery services utilising PSIRF Patient Safety Incident Investigation and also undertaking a thematic review of these new incidents and previously reported wrong site surgery / incorrect lesion removed from previous years to assess the actions and system solutions to mitigate these type of incidents.

We are also reviewing learning from nationally available reports relating to Never Events to assess the robustness of our actions and current practice.

High Quality | [Duty of Candour – verbal/formal notification]

Provide safe, effective and caring services



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
100%	100.0%	100.0%	93.8%

Background

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

What is the data telling us?

The achievement of verbal duty of Candour has been inconsistent with the recording of the completion of this in Datix. During April 2024 we have noted 1 case that has not had verbal Duty of Candour completed out of 14 total cases.

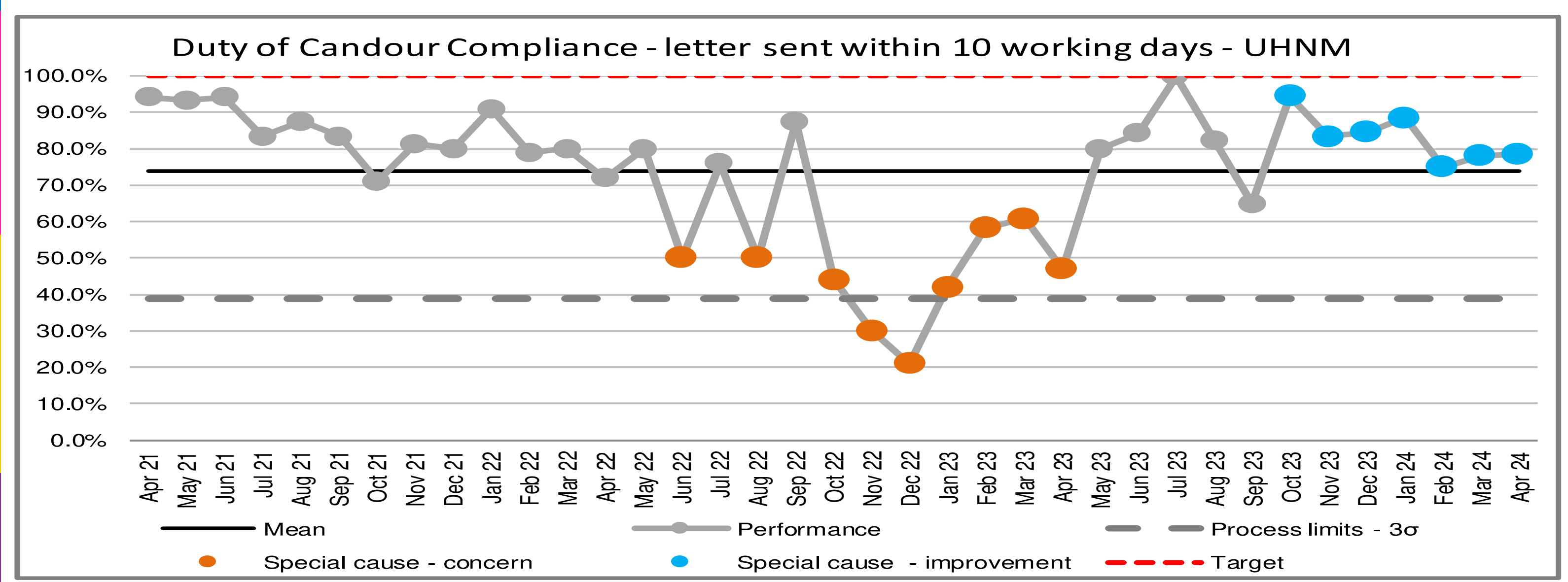
What are we doing about it?

We are working with individual areas and with Divisional Teams to continue to raise the importance of undertaking Duty of Candour and being open with patients and their relatives when things go wrong.

Teams are reminded that evidence of verbal Duty of Candour must be recorded in Datix and notes to demonstrate that conversations have been completed. When reviewing and discussing with staff the discussions are being held but these are not always being appropriately recorded in Datix.

High Quality | [Duty of Candour – written notification]

Provide safe, effective and caring services



Variation	Assurance		
Target	Feb 24	Mar 24	Apr 24
100%	75.0%	78.0%	78.6%

Background

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

What is the data telling us?

Whilst we are still not achieving the target 100% rate for all Duty of Candour letters to be provided to patients and/or relatives within 10 working days of the incident being identified, there has been a significant improvement in the consistency of performance.

The last 7 consecutive months have all achieved performance above the long-term mean.

Important to note that whilst there are cases that are recorded as over our 10 working day target, all the cases do complete the process and provide written notification to the patients and/or relatives.

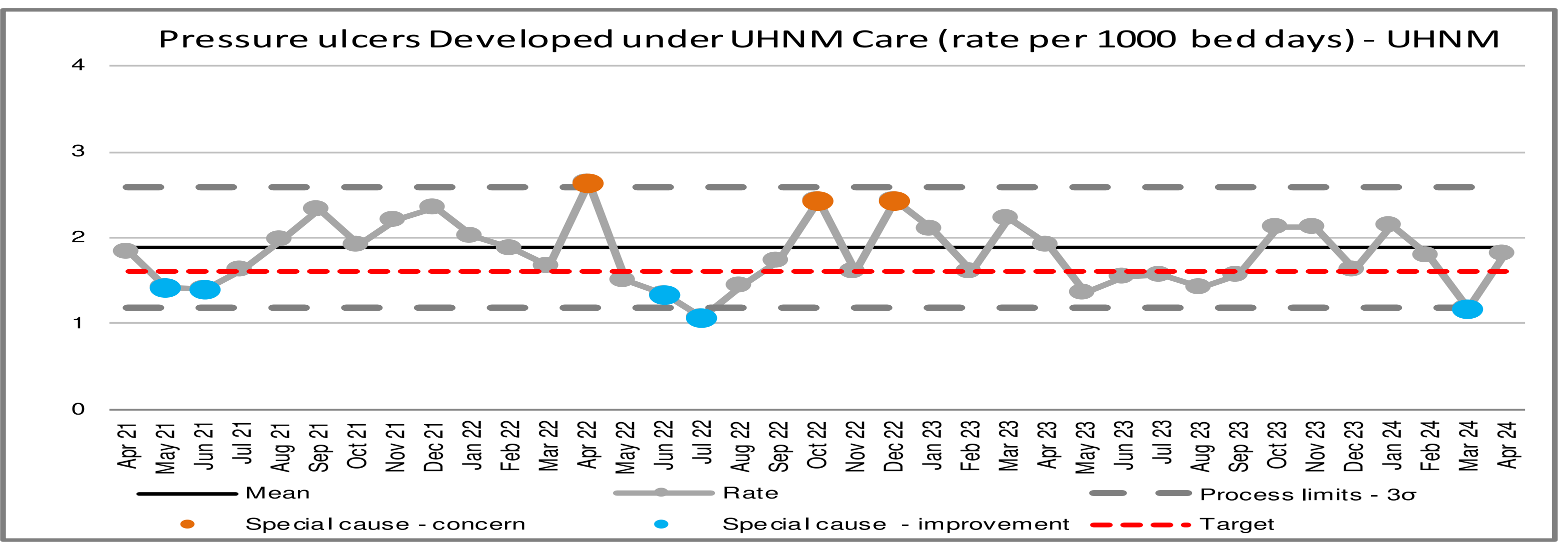
What are we doing about it?

We continue to work with and support al the clinical teams in completing the written Duty of Candour notification letters.

Divisions have instigated new escalation processes to try and support teams further in completing these letters within the timeframes

High Quality | [Pressure ulcers developed under UHNM per 1000 bed days]

Provide safe, effective and caring services



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
1.6	1.79	1.18	1.82

Background

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

What is the data telling us?

The rate of pressures ulcers reported as developed under UHNM care was within expected limits in April.

Numbers within all individual categories of damage were within normal range in April.

What are we doing about it?

Education available for pressure prevention, continence, wound assessment, and lower limb.

All pathways have been updated and available to staff on the Trust internet.

The Corporate team are commencing an A3 for pressure damage developing under UHNM care.

Chair and mattress audit to go live on Tendable to improve compliance in audit submissions. Videos have been developed to support auditing equipment.

Peer review for Tendable audit ongoing with an assurance plan to include Matrons, HON's, and DND's.

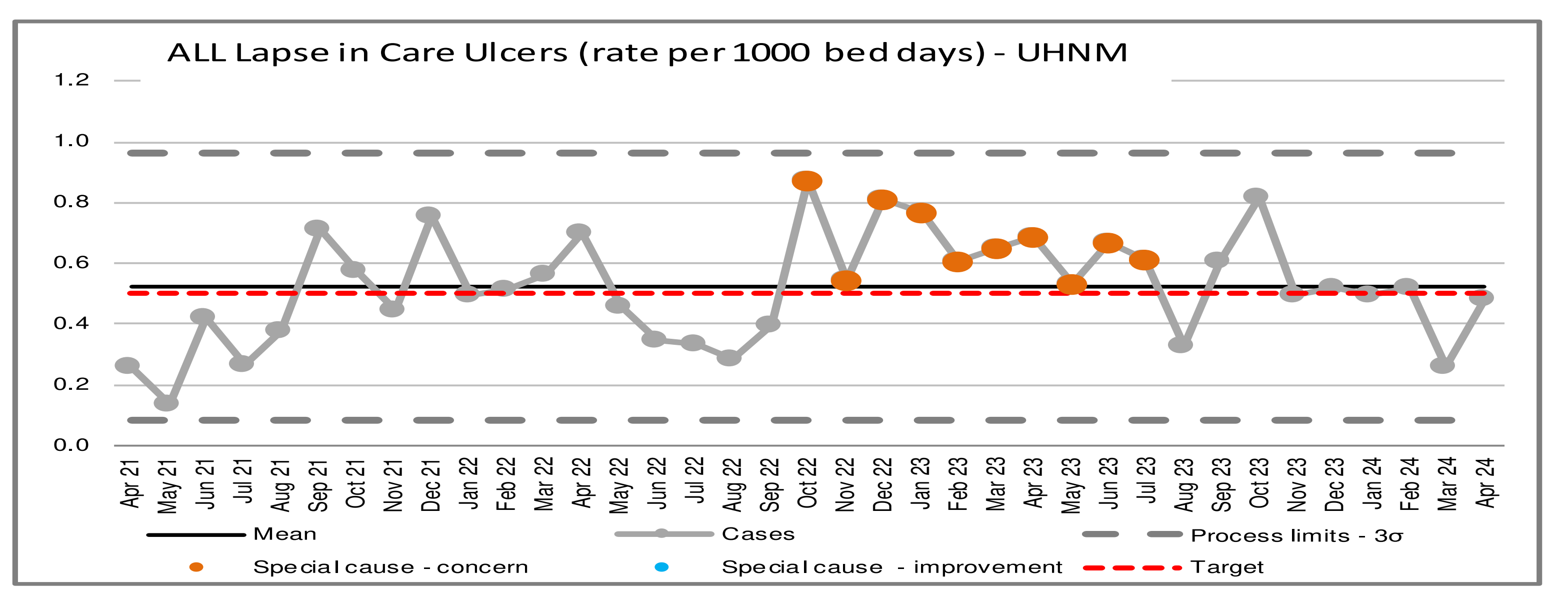
The skin health booklet is being is currently with Harlow being formatted.

Wound guidance booklet created which is going through Governance for approval.

High Quality

High Quality | [Pressure ulcers with lapses in care per 1000 bed days]

Provide safe, effective and caring services



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
0.5	0.52	0.26	0.49

Background

Rate of ALL pressure ulcers which developed whilst under the care of UHNM with lapses in care identified

Root Cause(s) of damage - Lapses - Apr 2024	Total
Management of repositioning	10
Management of device	6
Management of heel offloading	3

What is the data telling us?

The rate of pressure ulcers with lapses in care identified was within expected range in April. The most common lapses in care identified are shown in the table above right.

22% of Pressures Ulcers developed under UHNM Care were identified with lapses in care to date in March. (This figure is not quoted for the latest month because a number of cases remained to be checked for lapses on the 3rd of the month when the data snapshot was taken).

As well as pressure ulcers, 11 urethral splits were reported in April, 6 with lapses identified (0 TBC).

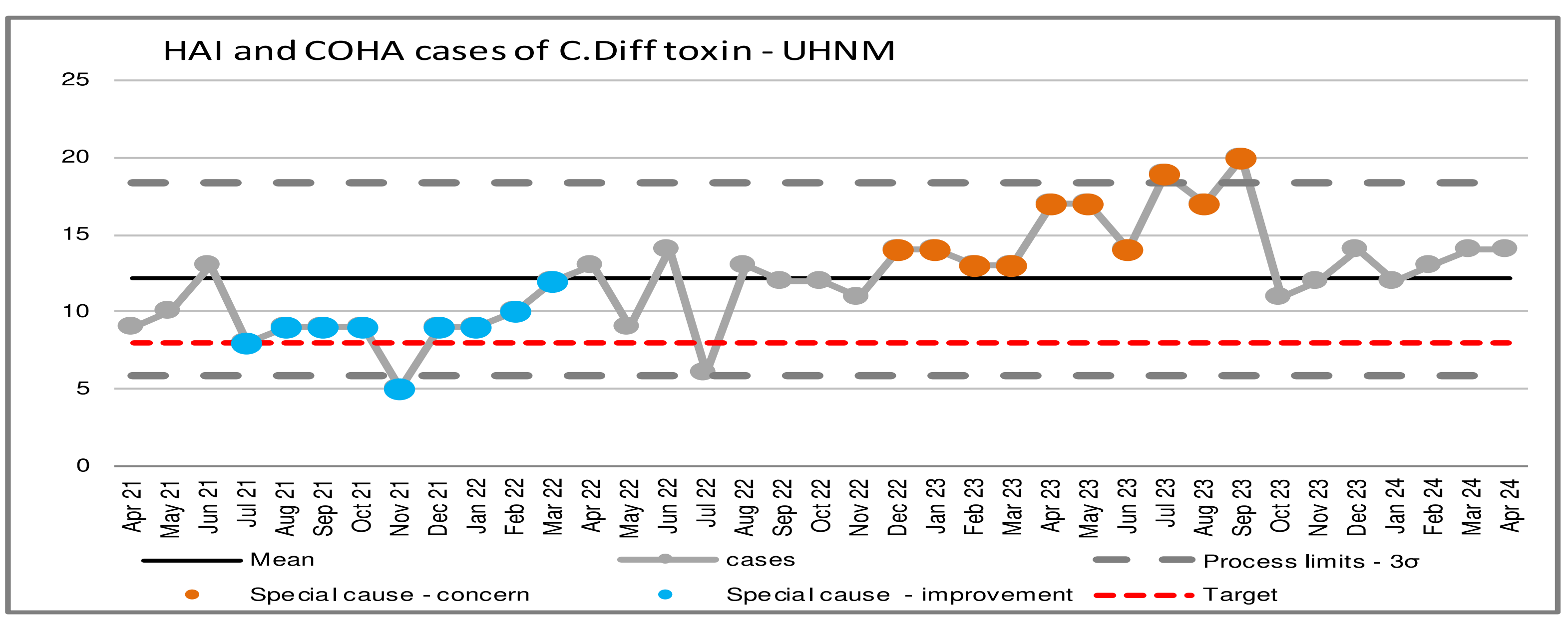
What are we doing about it?

Multiple reporting areas are invited to an assurance panel to present learning and assurances from incidents.
Concerns about slide sheets not being used have been escalated to Ann Humphries.
Working alongside clinical educator in Surgery to put link nurse in place.
Purpose T to be implemented to support with holistic assessments being completed.
Trial for the management of category 2 to be investigated at ward level is ongoing with other areas to be involved.
Meeting with company rep and IP to approve a new surface within ED, which then a trial for 10 surfaces will commence.
Implementation of Consultant Connect to capture images of damage on admission within ED and AMU wish to take part.
Key action across the Trust is promotion of catheter fixation devices and learning alert has been shared.

High Quality

High Quality | [Reported C Diff cases per month]

Provide safe, effective and caring services



Variation		Assurance	
Target	Feb 24	Mar 24	Apr 24
8	13	14	14
Background			
Number of HAI + COHA cases reported by month			

What is the data telling us?

Number of Cdiff cases are above trajectory and remains a concern
There have been 14 reported C diff cases in April 2024. 10 x HAI and 4 x COHA
HAI: cases that are detected in the hospital three or more days after admission (day 1 is the day of admission)
COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
There has been three clinical areas with more than one Clostridium difficile case within in a 28 day period which triggered in February . Where ribotypes are different person to person transmission is unlikely.

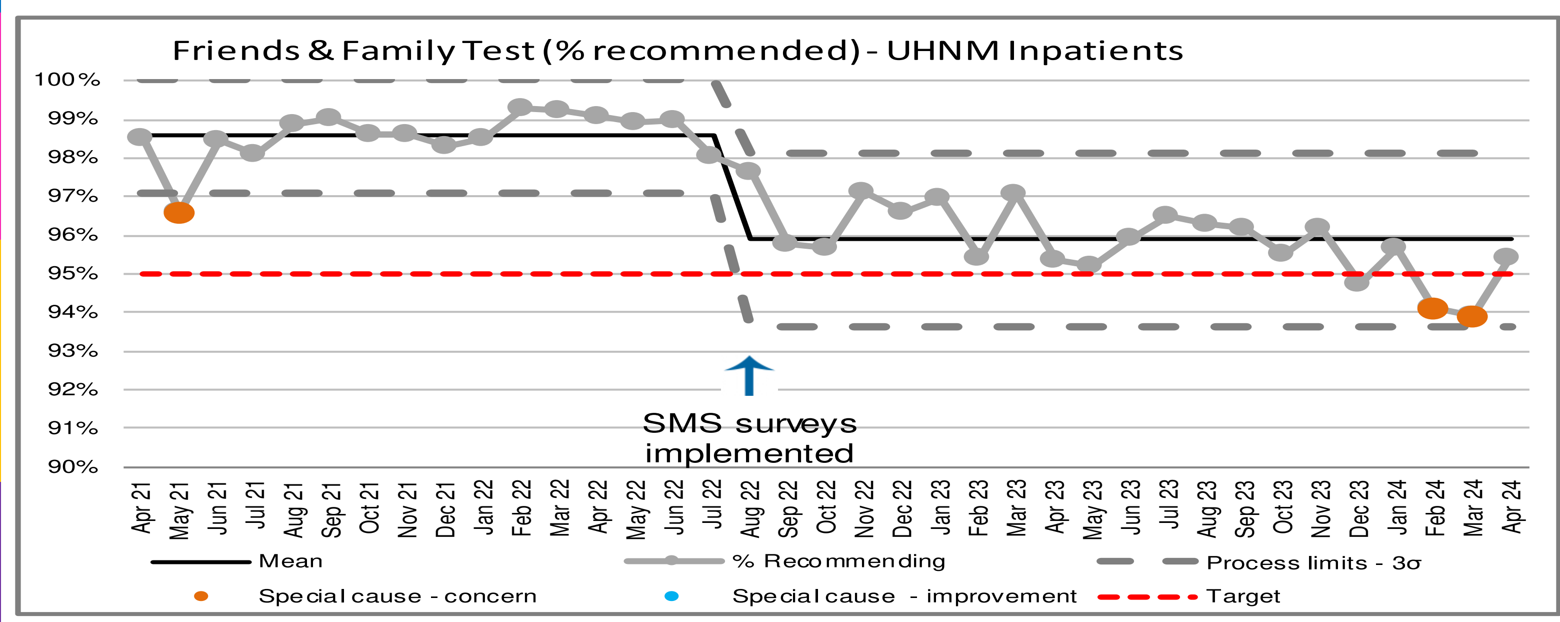
- Ward 15 x 2 - Different ribotypes
- Ward 121 x 2 – Awaiting ribotype results
- Ward 113 x 2 – Awaiting ribotype results

What are we doing about it?

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- Task and Finish Group for West Building is in place
- CURB -95 score added to CAP antimicrobial Microguide .
- CURB - 95 Score and UTI work discussed at the Weekly Clinical Group
- Antimicrobial working group to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- Additional oversight of C-Diff cases is being implemented where there is potential learning in terms of antibiotic use
- Consultant Microbiologist presented to ED and Elderly Care Doctors on Cdiff and antibiotic guidelines
- Relaunch of the pooh help line and timely sending of stool samples

High Quality | [Friends & Family Test - Inpatients]

Provide safe, effective and caring services



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
95%	94.1%	93.9%	95.4%

Background

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

What is the data telling us?

The monthly satisfaction rate for inpatient areas was within expected limits in April 2024. The rate remains above the national average of 94% (December 2023 NHS England).

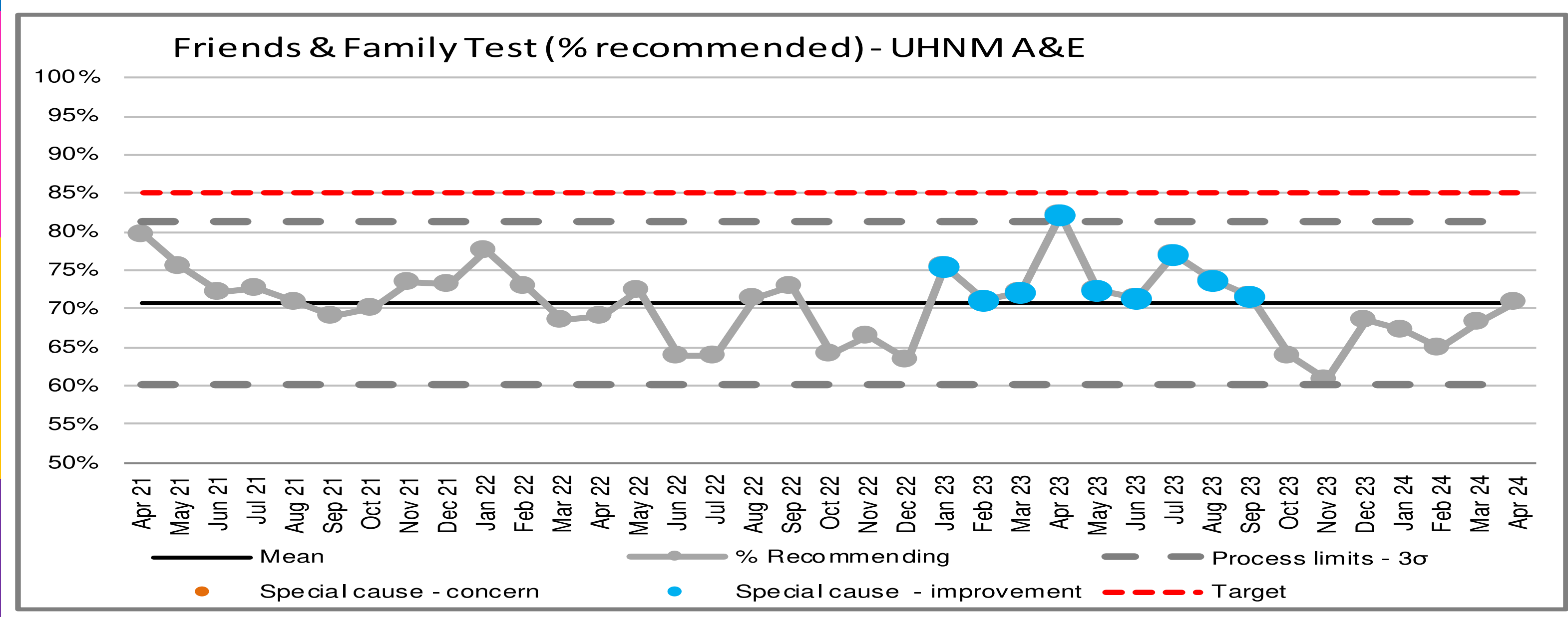
In April 2024 a total of 2687 responses were collected from 67 inpatient and day case areas (11396 discharges) equating to a 24% return rate which is higher than last month but lower than the internal target of 30%. UHNM have the 18th highest response rate for all reporting Trusts in the country (153) and are 102nd for percentage positive responses (NHS England March 24 latest data)

What are we doing about it?

All areas are now using the most up to date version of the FFT survey
Continue to focus on Medicine and Surgery to increase response rate.
Work continues around a suite of patient priorities based on patient feedback:
Timely medications- a new task & finish group is being set up to include Patient Rep and PSP
Pain management
Involvement in care and decision making
Improving the experience of our oncology patients

High Quality | [Friends & Family Test - ED]

Provide safe, effective and caring services



Variation	Assurance
	F

Target	Feb 24	Mar 24	Apr 24
85%	65.0%	68.4%	70.9%

Background

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

What is the data telling us?

The overall satisfaction rate for our EDs was within expected limits in April 2024.
The Trust received 1280 responses which was 8% and is a decrease on the previous month. The Trust's overall satisfaction rate is lower than the national average of 78% (NHS England March 24- latest figures) at 71%, however this is a further 3% increase on previous months. UHNM is 38th out of 125 Trusts for the number of responses in ED (NHS England March 24), and 84th out of 125 Trusts for the percentage positive results.

Feedback from patient experience of using 111First and the kiosks continues to be monitored with 24% of respondents in April 2024 reported to have used 111First prior to attending ED, which is an increase on the previous few months. Key themes from April 2024 were regarding patients being unable to get a GP apt due to Bank Hols, communication, staff attitude, long waits – all across both sites.

What are we doing about it?

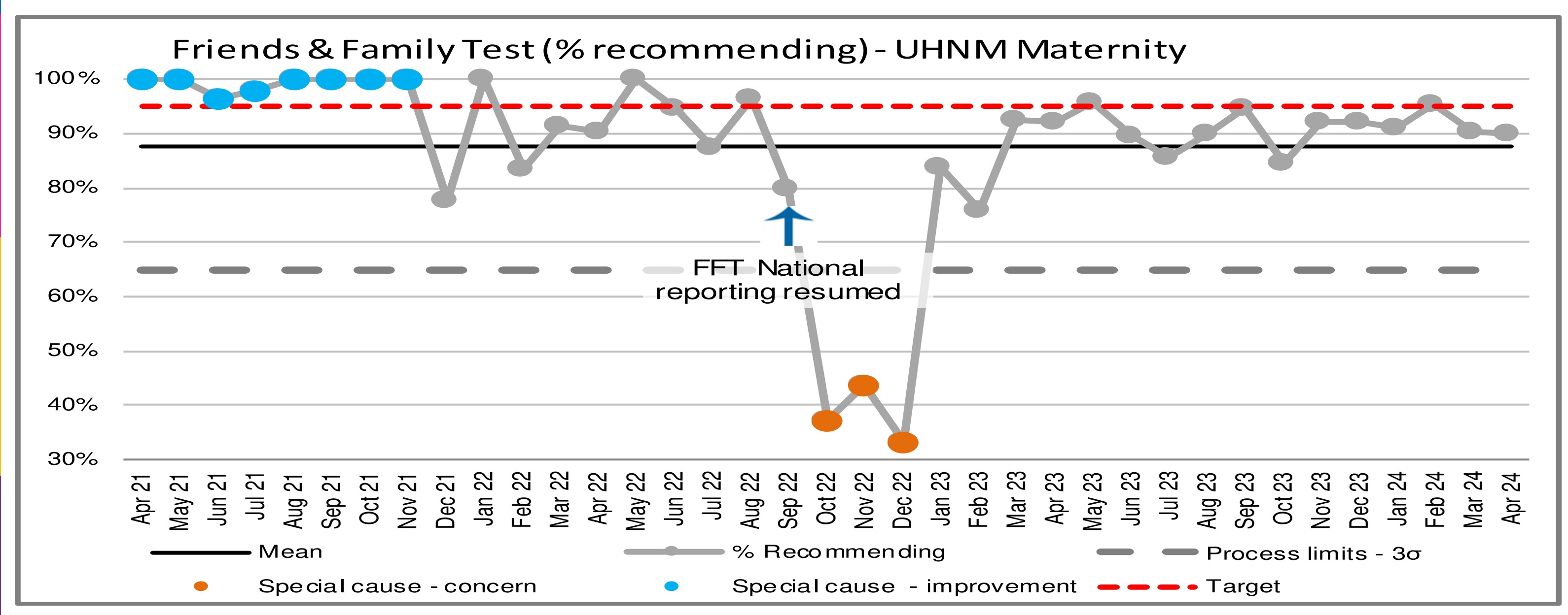
Need to revisit process for handing out FFT paper survey as minimum submission of FFT via this modality.

QR code made visible throughout the department.

'You said we did' board in waiting room.

High Quality | [Friends & Family Test - Maternity]

Provide safe, effective and caring services



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
95%	95.3%	90.5%	90.0%

Background

FFT Maternity % patients Recommending Service

What is the data telling us?

There were a total of 110 surveys were received in April 2024 across all 4 touch-points (ante-natal, birth, post natal ward; post natal community) with 36 of these being collected for the "Birth" touch-point, providing an increased 7% response rate (based on number of live births) and 88% satisfaction score which is a decrease on the previous month's figures. The Antenatal touch point scored 79% recommendation (14 surveys) which is a decrease on the previous month (82%). The post-natal ward touch point scored 94% satisfaction rate (48 surveys) which a decrease in response rate but increase in satisfaction percentage. Compared to the latest national data available (March 24) out of 112 reporting Trusts, UHNM were 59th for number of responses for antenatal & 101st for percentage positive; 75th for number of responses for birth & 68th for percentage positive, 45th for post-natal ward & 85th for percentage positive; and 52nd for post-natal community & 85th for percentage positive.

What are we doing about it?

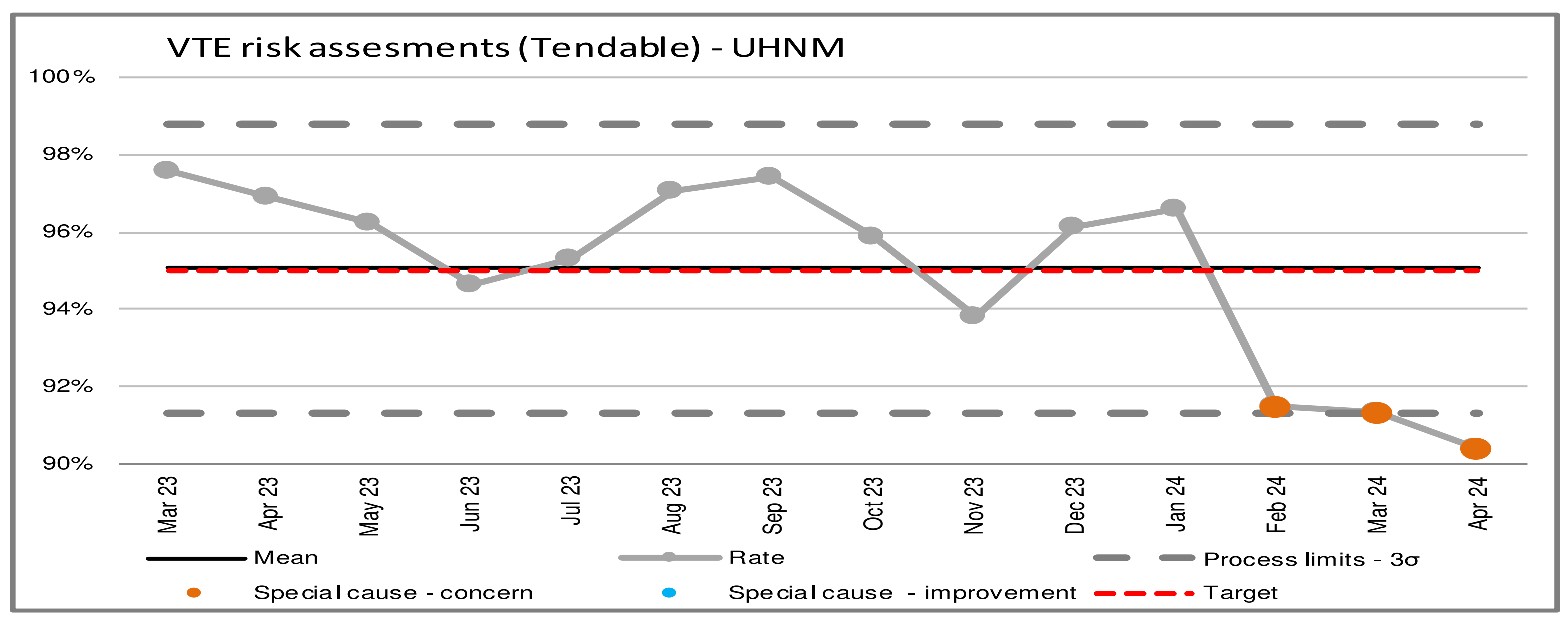
Continue to monitor the efficacy of collecting feedback via text message

Look at incorporating the questions from the National Maternity Survey which requires the most improvement into the FFT survey.

Discuss with management team with regards to increasing survey completion for post-natal community

High Quality | [VTE Risk Assessment Completion]

Provide safe, effective and caring services



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
95%	91.5%	91.3%	90.4%

Background

The percentage of patients assessed for risk of VTE within 12 hours of admission to hospital (Source: Tendable)

What is the data telling us?

The NICE standard is for initial VTE risk assessment to be carried out within 12 hours of admission and the national target is 95%.

Wards are asked to audit the VTE assessment in 10 sets of patient notes per month, using Tendable and this provides assurance. The question asked on Tendable is "Has the VTE risk assessment been completed within 12 hours of admission?"

418 patient records were audited in April 2024 via Tendable and 90% had VTE risk assessment completed within 12 hours of admission. Compliance has been significantly lower since February 2024 which may be due to work with Quality Nurses to encourage rigorous audit standards.

What are we doing about it?

An audit of risk assessment completion and compliance has been carried out between February-April 2024 across 47 wards following the introduction of the new assessment document. 10 prescription charts in each ward were reviewed. 91% of prescription charts reviewed had at least a partially complete VTE risk assessment, but only 55% had evidence of being done within 12h of admission, date and time recorded and a signature.

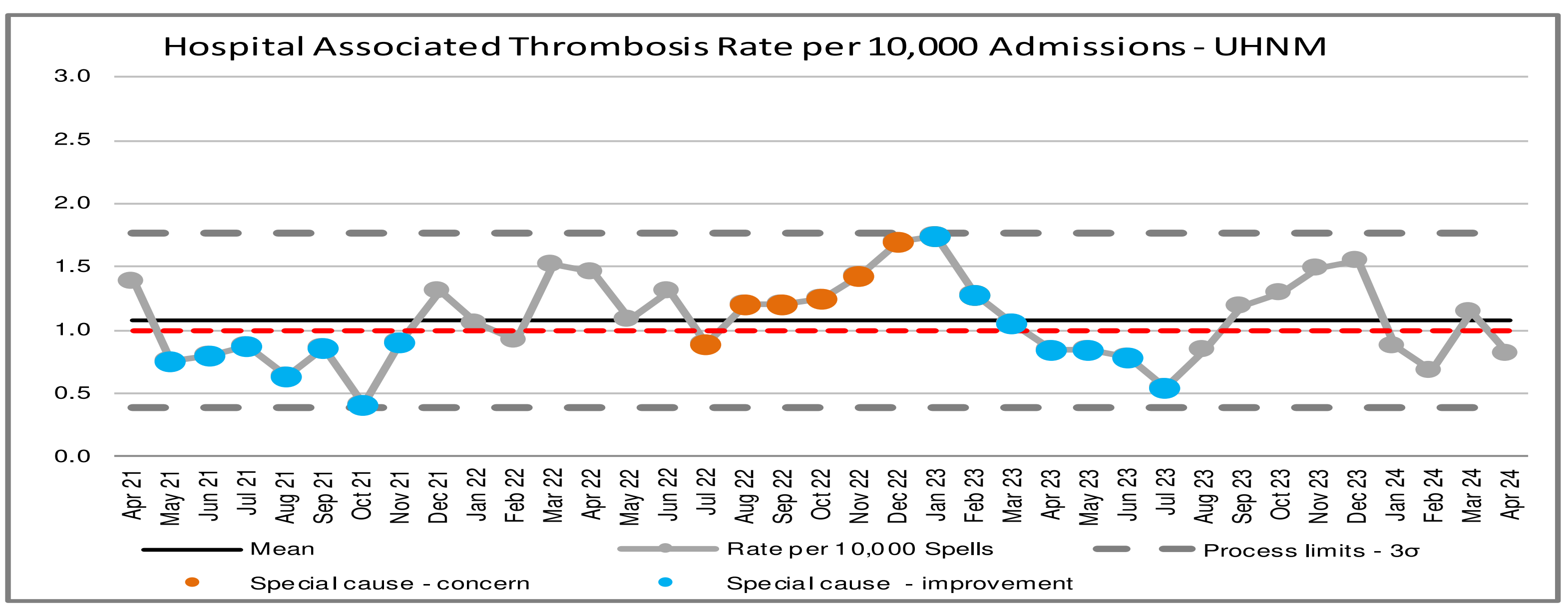
ePMA once introduced will provide accurate assurance of VTE risk assessment completion.

Notification has been received that national data collection is resuming in April 2024 having been suspended since 2020, and data from Tendable is to be submitted.

High Quality

High Quality | [Hospital Associated Thrombosis rate]

Provide safe, effective and caring services



Variation		Assurance	
Target	Feb 24	Mar 24	Apr 24
1	0.68	1.14	0.82

Background

Venous thromboembolisms identified more than 72 hours after admission, or within 90 days of an inpatient episode, are considered to be Hospital Associated.

What is the data telling us?

The rate of Hospital Associated Thrombosis was within expected limits in April 2024

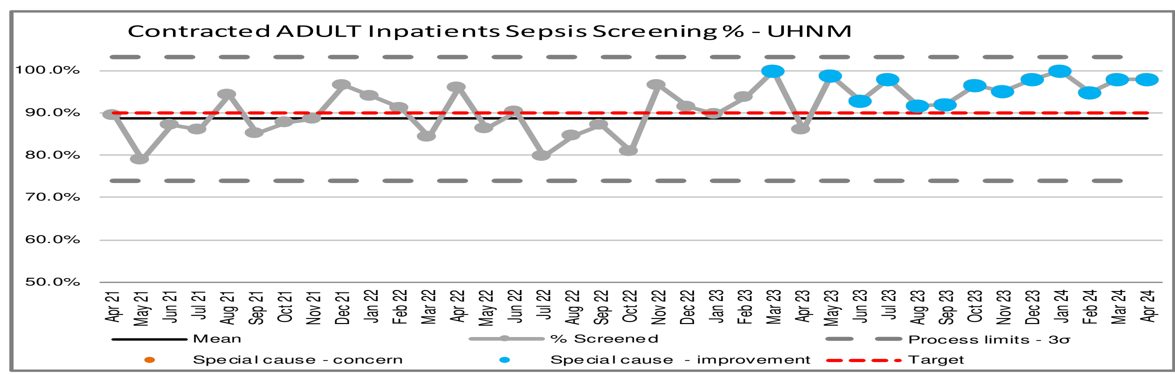
What are we doing about it?

17 cases of Hospital Associated Thrombosis (HAT) were identified April 2024 and investigations are in progress.

Key Themes identified from HAT Investigations; Missed doses of Prophylactic Dalteparin with no clear rationale recorded and inconsistent daily recording of mechanical thromboprophylaxis.

High Quality | [Sepsis – Adult Inpatient]

Provide safe, effective and caring services



Variation	Assurance		
Target	Feb 24	Mar 24	Apr 24
90%	94.8%	97.9%	98.0%

Background

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

Contracted ADULT Inpatients IVAB within 1 Hr - UHNM

Measurement Changed to Include Pts Already on Abx

Variation	Assurance		
Target	Feb 24	Mar 24	Apr 24
90%	100.0%	100.0%	90.6%

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 IVAB within the 1 hour target for April 2024.

There were 102 cases audited with 2 missed screening. Out of 102 cases audited 71 were identified as red flag sepsis with 42 having alternative diagnosis. 25 patients were already on IVAB treatment.

All true red flag sepsis patients received IVAB within 1 hour.

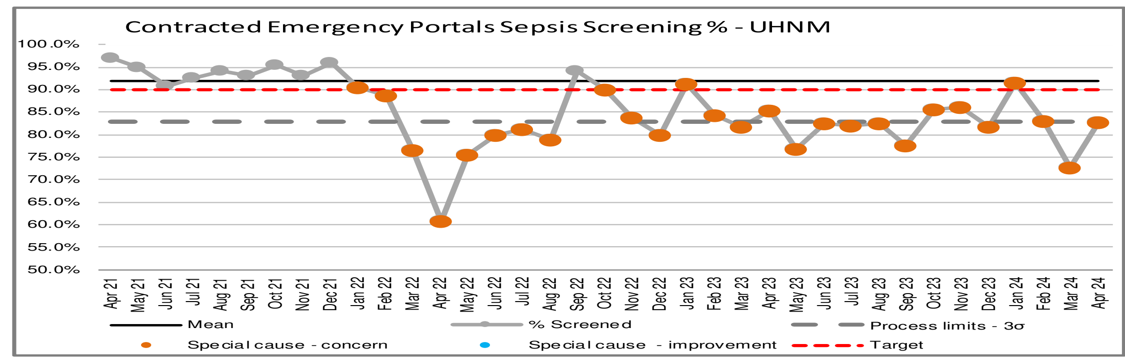
What are we doing about it?

Sepsis sessions / kiosks continue to all levels of staff in the clinical areas that require immediate support.

The sepsis team continue to raise awareness of the importance of sepsis screening and IVAB compliance by being involved in HCA induction and qualified nurses preceptorship programmes.

High Quality | [Sepsis – Emergency Portals]

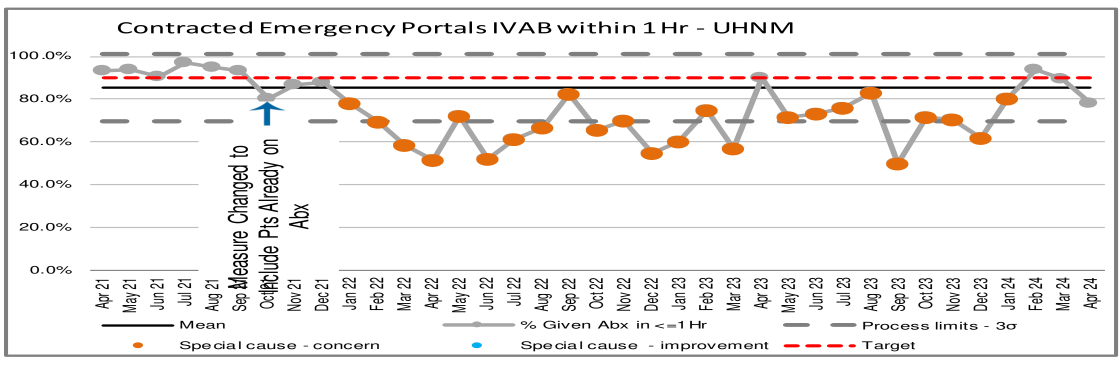
Provide safe, effective and caring services

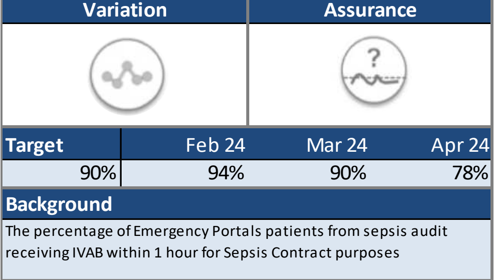


Variation	Assurance		
Target	Feb 24	Mar 24	Apr 24
90%	83%	73%	83%

Background

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





Variation	Assurance		
Target	Feb 24	Mar 24	Apr 24
90%	94%	90%	78%

Background

The percentage of Emergency Portals patients from sepsis audit receiving IVAB within 1 hour for Sepsis Contract purposes

What is the data telling us?

Adult Emergency portals screening did not meet the target for April 2024. Contributed to Ed Royal Stoke. There were 76 cases audited with 13 missed screening in total from the emergency portals. The performance for IVAB within 1 hour achieved 77.8%

Out of 76 cases there were 57 red flag sepsis in which 10 patients were already on IVAB. 21 patients had an alternative diagnosis leaving 26 newly identified sepsis 8 patients received IVAB outside the target 1 hour window with 2 patients greater than a 2 hours delay.

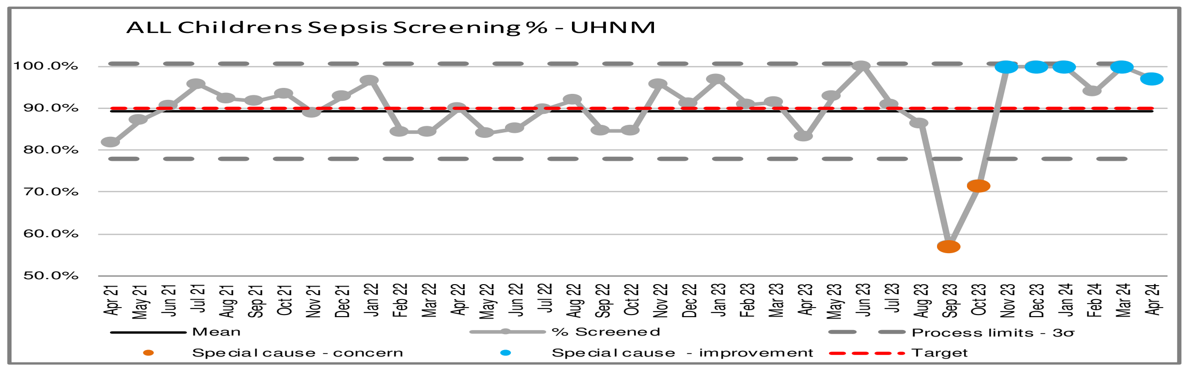
What are we doing about it?

- The sepsis team continue by closely monitor compliance by visiting and auditing ED regularly.
- Regular meetings with ED senior team with robust actions in place.
- Face to face sepsis induction / training for new nursing staff, nursing assistant and medical staff continue.
- Introduced Deteriorating Patient Vocera devices and assigned clinician role (Tier 3) in resus to review patients and make timely decisions re: sepsis or other significant condition. Reviewing usage following introduction and outcomes are awaited.
- Sepsis focus week completed for SAU during April with excellent uptake from staff.
- Working towards implementation of electronic screening for ED Royal Stoke.

High Quality

High Quality | [Sepsis – Children]

Provide safe, effective and caring services



Variation	Assurance		
Target	Feb 24	Mar 24	Apr 24
90%	94.1%	100.0%	97.1%

Background

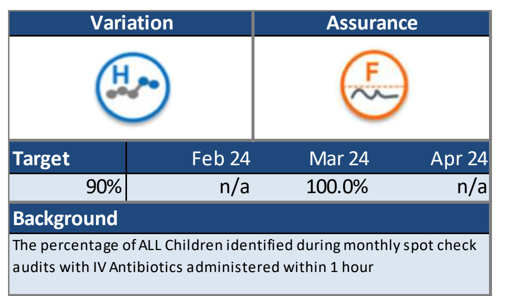
The percentage of ALL Children identified during monthly spot check audits with Sepsis Screening undertaken

ALL Childrens IVAB within 1 Hr - UHNM

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22, Apr 22, May 22, Jun 22, Jul 22, Aug 22, Sep 22, Oct 22, Nov 22, Dec 22, Jan 23, Feb 23, Mar 23, Apr 23, May 23, Jun 23, Jul 23, Aug 23, Sep 23, Oct 23, Nov 23, Dec 23, Jan 24, Feb 24, Mar 24, Apr 24

Mean; % Given Abx in <=1 Hr; Process limits - 3σ; Special cause - concern; Special cause - improvement; Target



Variation	Assurance		
Target	Feb 24	Mar 24	Apr 24
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?

Childrens services target rate of >90% was achieved for April 2024. We are still seeing a small number of children trigger with PEWS >5 and above inpatient areas. Most inpatient paediatrics are already on oral or IV antibiotics prior to trigger of PEWS >5

There were 29 cases audited for emergency portals with no missed screening.
No true red flag sepsis was identified from the randomised audits in the emergency portals or inpatients.

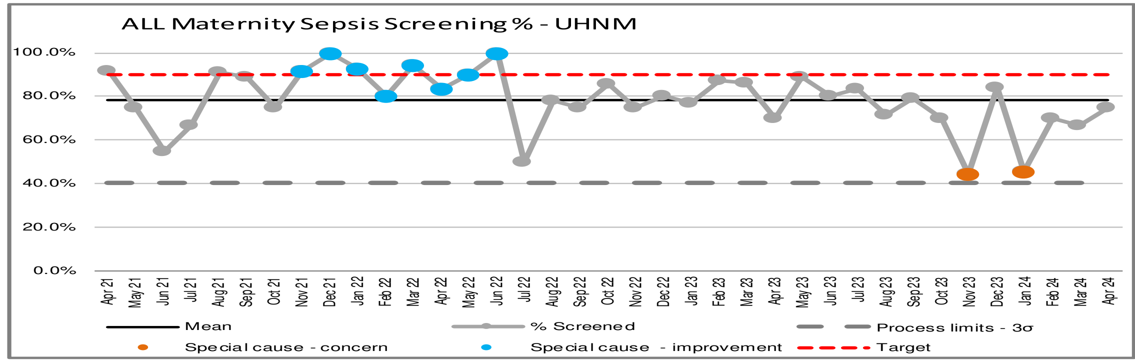
What are we doing about it?

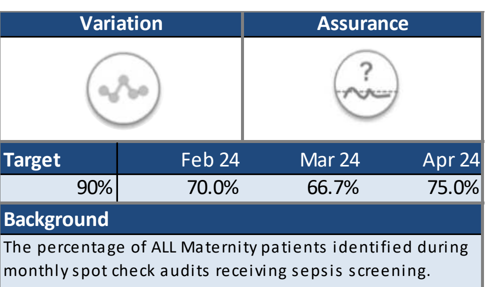
The sepsis team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective.

The children department is aiming to implement the national PEWS chart and sepsis screening tool guidelines soon.

High Quality | [Sepsis – Maternity]

Provide safe, effective and caring services

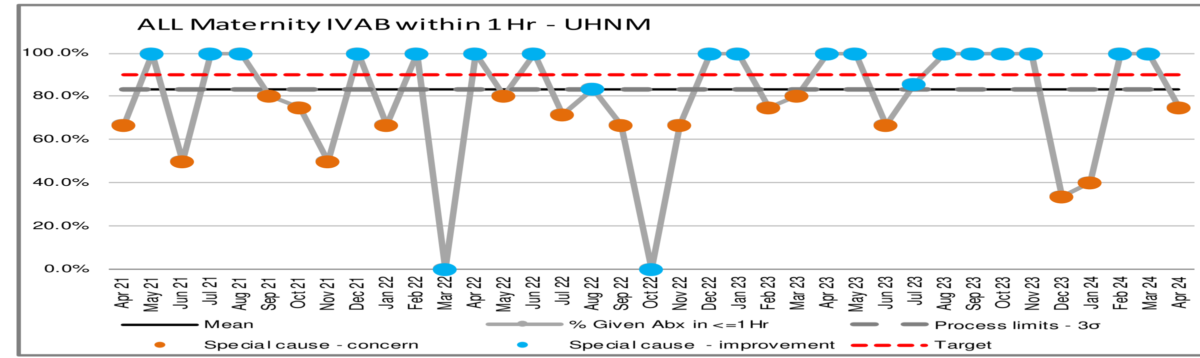




Variation	Assurance		
Target	Feb 24	Mar 24	Apr 24
90%	70.0%	66.7%	75.0%

Background

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



Variation	Assurance		
Target	Feb 24	Mar 24	Apr 24
90%	100%	100%	75%

Background

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

What is the data telling us?

Maternity audits in screening compliance is below target for this month for emergency portals. Inpatient areas are also well below target for screening. The compliance was above target for IVAB within 1 hour for impatient but below target for emergency portal. The compliance is based on a very small number of cases.

There were 7 cases audited from emergency portal MAU with 2 missed screenings. Inpatient had 9 cases audited with 2 missed screenings. (has been escalated but no documentation in the screening tool)

What are we doing about it?

Maternity antibiotic PGD has been drafted and is currently under review by the pharmacy team. Monthly maternity skills drill is now replaced with ad hoc sepsis sessions in each clinical area.

Sepsis sessions will focus and highlight the importance of screening documentation.

The sepsis team will create further awareness and plan collaborative work with maternity educators and senior team.

Responsive | Overview

Provide efficient and responsive services

Overview from the Chief Operating Officer

How are we doing against our trajectories and expected standards?

Non-Elective

The 4-hr performance standard is 76% climbing to 78% in March 2025. April validated is 70.7% which is equal to the March outturn and in line with our trajectory. However, this is the second month in a row where we have achieved over 70% and this has not been achieved since 2021. The only dates we achieved the 76% standard were 27th April 2024 at 76.5% and 28th April at 76.9%. Our relative performance was largely within 3rd quartile of Trusts, however in 2024/25 a number of Trusts previously not reporting as part of the Clinical Standards Trial have now restarted which for the first month means despite seeing some of our best performance since 2021 we have dropped down into the 4th quartile.

April has seen a decrease in the number of 12-hour trolley waits since March of 104 and lower than February which demonstrates that the number waiting is reducing. This demonstrates a 10.07% reduction on the March position. The target is zero, however this is an improving picture.

The WMAS data release is a month in arrears. The Cat 2 mean recorded for March was 33.01 mins. For April, the data suggests a further improvement, and the Cat 2 mean was c28mins. The standard is handover within 15 minutes from arrival.

Elective

We met the cancer diagnostic performance standard for the first time in February, and this was maintained in March. It is predicted that this will be more challenging during April, however data is still incomplete for reporting.

Cancer 62-day standards have shown three consecutive months of improvement, and the backlog remains within fair shares allocation; this is within trajectory. This performance reflects an improvement in several tumour sites; Breast and Skin notably. The focus now is on maintaining the position to begin to support overall cancer performance % against the standard. There is a significant amount of cancer alliance funding supporting this position which remains in discussion for Q1 24/25, although support to endoscopy and Skin has been approved.

Diagnostic performance had been improving however both February and March dipped. The largest contribution to this coming from Endoscopy delays, however ultrasound performance also fell along with MRI replacement having a temporary impact on this modality.

The number of patients waiting 78 weeks or more post validation ended at 23 for April. As a Tier 1 trust NHSE region and national and regional teams have weekly oversight of improvement trajectories. Trajectories originally had factored in a reduction of capacity in January with the ambition of 0 patients waiting by March. The 0 trajectory is now planned for June. There are now no patients waiting over 104 weeks in line with trajectory and we have been able to offer some mutual aid for patients waiting for Corneal transplants.

Overview from the Chief Operating Officer

What is driving this?

Non-Elective

Increased emergency department attendances and acuity have impacted on the delivery of the 4-hr standard on the admitted pathway and contributed to sub-optimal flow for our patients requiring inpatient treatment. The non-admitted pathway, however, is managed well in core hours period but deteriorates out of hours and overnight. Compliance with the 4-hr standard reflects this. The mean time in the emergency department for April was 5hrs 11minutes verses an 'out of hours' position of 6hrs 43minutes. The emergency department staffing is relatively unchanged. Despite this we remain in line with our trajectory.

Whilst the number of 12-hour waits following a decision to admit for onward care decreased in April, the timeliness of access to inpatient care is below expectation. The expectation and standard associated with Clinically Ready to Proceed is within 60 minutes of final intervention by the emergency department and is set at 95%, however in April only 46.67% of our patients accessed their onward pathway in that time.

Both the capacity of Emergency Departments (overcrowding) and the profile of ambulance arrivals (variation can be 0 to 22 ambulances/hours) has impacted on the ability to offload in a timely manner. There have been a number of concerns raised regarding the accuracy of handover time recorded for handover by teams within ED, in particularly around the practice of 'pinning off.' As a result during April and May we have jointly instructed our Internal Auditors to review practice, recording and published datasets with ICB and WMAS support.

Elective

As previously reported Endoscopy performance is contributing to both planned care and cancer standards. Backlogs in cancer are now reducing and the service is increasing its capacity however the recovery period will be staged initially recovering cancer 28-day faster diagnostics standard and then planned care 6 weeks standard. Additional capacity has been secured in Q1 2024 and this will be required throughout 2024/25 with business cases being developed to right size the service permanently.

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

Our longest waiting patients over 78 weeks continue at a reducing trend, however there are challenges in patients waiting in the 65-week cohort; with particular focus on Gastro, respiratory and paediatric ENT.

Responsive | Overview

Provide efficient and responsive services

Overview from the Chief Operating Officer

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

Non-Elective

Work continues within workstreams 1, 2, 3 and 4 to improve our non-elective flow and responsiveness to meet demand, improve patient experience and safety.

Having developed our internal Rapid ambulance handover protocol our longest offload times are reducing however at this stage we are not reducing the average handover time. There have been many more promising days of handover performance with several days now recorded with 0x60 minute delays.

The Test of Change programme on the inpatient wards within Medicine and Emergency Care continues and will be rolled out throughout all Divisions. There is also a renewed focus with Executive colleagues and their deputies attending board rounds on wards at both Royal Stoke and County to support to promote and champion this.

Elective

Endoscopy services continue their three-part improvement plan for the resolution of demand versus capacity. Having completed a recent high level of demand and capacity review it is possible to quantify some of the impact of these schemes. There is an improvement programme in place for our endoscopy services which is being supported by Four Eyes. We continue to insource in order to increase capacity, this has been supported by cancer alliance and ERF funding for Q1 24/25. All vacant in week sessions are being covered by insourcing service, Trust TI session or locum consultants/Dr's.

ERF cases for extra capacity through insourcing & WLIs to support the ongoing reduction in our longest waiting patients have now been approved and are being mobilised. This however is later than hoped due to the financial planning round and trajectories for the planning submission have been amended to reflect this.

There is a focus on utilisation and productivity in theatres and outpatients; in addition Divisional level Finance, activity and performance meetings have been introduced with executive oversight to support the divisional improvement work.

Cancer performance and the protection of capacity for cancer recover will remain a focus for our elective capacity. This will include the ring fencing of funding for cancer improvement which if mobilised should deliver performance in line with our trajectories.

Responsive | Overview

Provide efficient and responsive services

Overview from the Chief Operating Officer

What can we expect in future reports?

Non-Elective

We expect our performance to follow our trajectory which considers the pressures over the summer months with incremental improvement as part of our Non Elective Improvement Programme. We expect August to be the first step change in performance as a result of the new SDEC modular build.

Alongside improvements in 4-hour performance we expect 12 hour and ambulance handover delays to improve at a similar rate. We have seen the correlation between improvements in flow and these indicators although we note the concern regarding the accuracy of recording ambulance handover delays which may require further investigation as it appears to be less sensitive to urgent care flow improvements.

Elective

We have a continued focus on diagnostics and planned care, and the planning submission has reflected the challenged position for these areas. We have submitted a plan which has a trajectory of zero 78-weeks by June, and zero 65 weeks by September, however the 65 week position deteriorates before improvement is seen. The diagnostics plan does not see us being compliant with DM01 standards this year while there is a focus on recovery of backlogs.

Cancer services have the greatest protection of services (including cancer diagnostic services), and recovery trajectories are set to continue in 24/25, although there is a reliance in the cancer alliance funding of which we await full confirmation. Referral numbers have remained high during April, and we are working with partners in SSOT to support efficient pathways for our patients at first presentation.

Ongoing discussions are taking place with regulators on both undertakings and NOF3 exit criteria.

Responsive | Dashboard

Provide efficient and responsive services

Responsive

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Cancer 28 Day FDS	75%	75.8%	69.7%						
Cancer 31 Day Combined	96%	92.5%	90.1%						
Cancer 62 Day Combined	85%	63.6%	65.7%						
Diagnostics DM01 Performance	99%	70.8%	67.6%						
UEC 4 Hour Target	76%	70.7%	70.7%						
UEC 12 Hour Trolley Wait	0	1,033	929						
UEC Cat 2 Handover Average Time	00:18:00	00:36:07	00:33:01						
RTT No. of Patients Waiting >52 Weeks	0	5,016	5,216						
RTT No. of Patients Waiting >65 Weeks	0	806	908						
RTT No. of Patients Waiting >104 Weeks	0	1	0						
RTT No. of Patients Waiting >78 Weeks	0	67	27						
Treating patients in a timely manner (Hospital Combined Performance Score)	7,000	3,921	3,983						

Related Strategy and Board Assurance Framework (BAF)

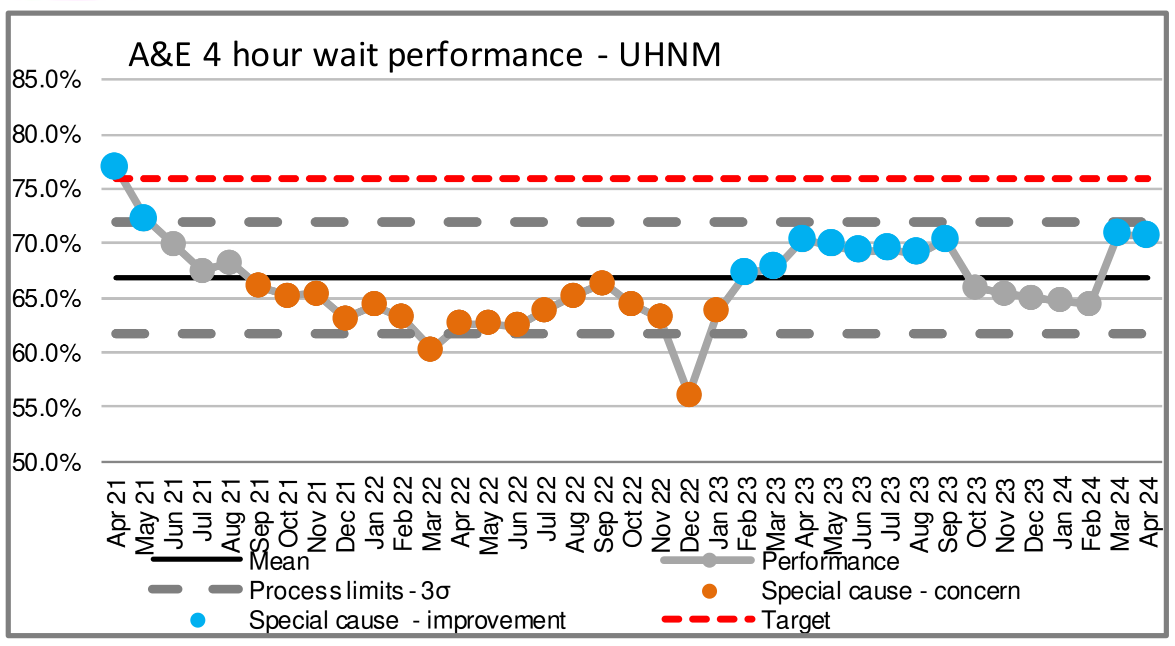
BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 5: Delivering Responsive Patient Care								

Responsive

Responsive | UEC 4 hour Target

Provide efficient and responsive services

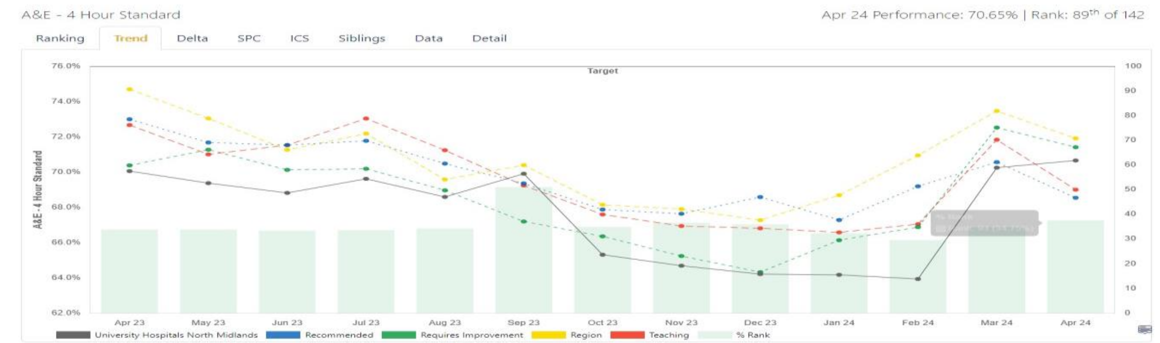
NHS University Hospitals of North Midlands NHS Trust



Variation		Assurance	
H		F	
Target	**Feb 24**	**Mar 24**	**Apr 24**
76%	64.4%	70.7%	70.7%

Background

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



What is the data telling us?

Validated Performance is 70.7% for April which was equal to the previous month. from last month and 6.8% overall improvement in the last 2 months.
We have experienced an incremental improvement over the last 2 months, and this is the most positive improvement since 2021.
The agreed compliance target is 76%. The only dates we achieved this was 27th April 2024 at 76.5% and 28th April at 76.9%.
Type 1 4hr performance for Royal Stoke was 46.3% verses 47.4% in March (a negative variance of 1.1%and for County 63.4% verses 60.4% (a positive variance of 3%).
The improvement trajectory against the 4hr standard set for April has not been met.
We are ranked 89th of 142 Acute Trusts against the chosen parameters of comparison.

What are we doing about it?

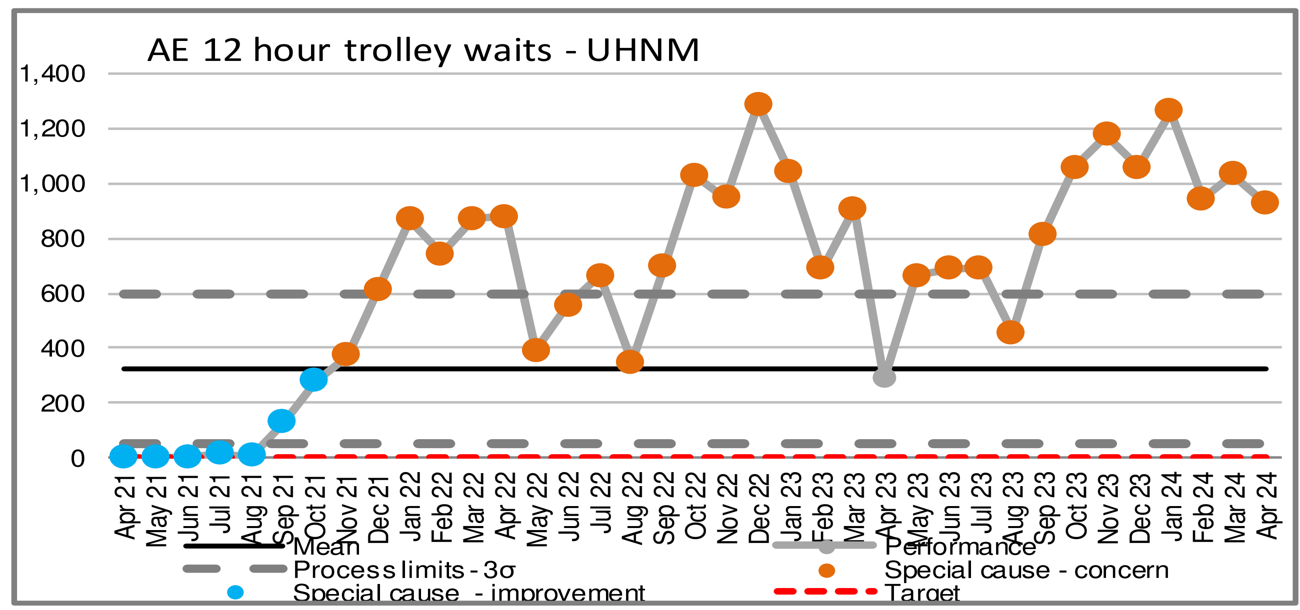
- Ambulatory standard work across Royal Stoke and County sites.
- CDU and SDEC utilisation reviews on Royal Stoke to identify further opportunities.
- EhPC review of criteria following missed opportunity audit.
- Management of surges to support triage at County site including room conversion and staffing review.
- SDEC expansion including new AMRA unit to open in July which will provide increased capacity and AEC exploring extending opening hours to support demand.
- A focus on 4hr performance overnight is now in train, This focus should result in increasing and sustaining 4hr performance – this will be monitored closely and where the performance 'dips', a route cause analysis will be undertaken.

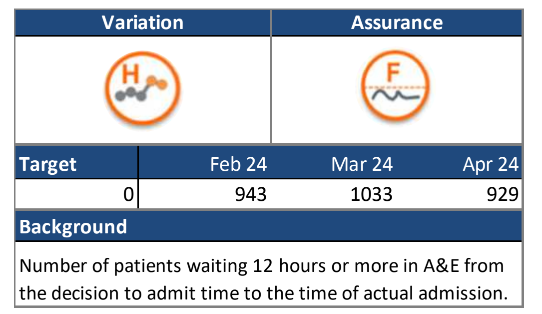
Responsive | UEC 12-hour Target

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive





Variation	Assurance
H	F

Target	Feb 24	Mar 24	Apr 24
0	943	1033	929

Background

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

What is the data telling us?

April has seen a decrease in the number of 12-hour trolley waits since March of 104 and lower than February which demonstrates that the number waiting is reducing.
April demonstrated a reduction of 104 patients waiting greater than 12-hour post decision to admit which was a 10.07% reduction on the March position. Our overall ranking changed negatively though to 100th of 124 Acute trusts from 93rd out of 124 Acute Trusts in March
However, this chart does not describe the associated decrease in total aggregated time of arrival (TOA) to clinically ready to proceed in the Emergency Department > 12hrs and > 24hrs. Aggregated TOA for March was 10.76% verses 10.98% in April.
Mean time in the emergency department varies in and out of hours.

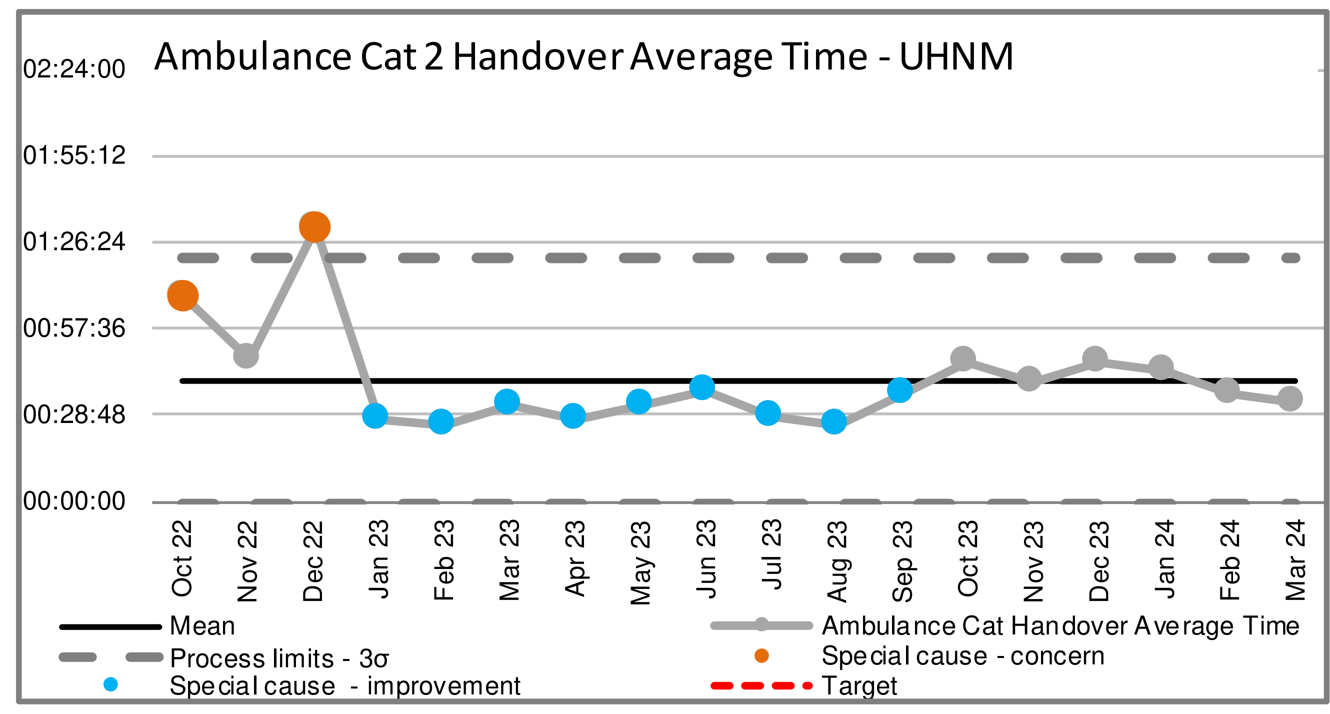
What are we doing about it?

Rollout of standard work is being implemented across Medicine wards to support timely discharges.
Task and finish groups developed to address issues identified including TTO's, Transport, Diagnostic Delays and Discharge processes to support earlier in the day discharges.
Frailty >75, single document for CGA & admissions. Test of change for IDH in-reach to ED and support to FEAU.
Move of the AMRA unit will create additional capacity in SSU on 1st July.
Effective implementation of 'Your Next Patient (YNP)' and resolution.
Command and Control principles adopted in Medicine and Emergency Care to respond to increased demand and pressures.

Responsive

Responsive | UEC Cat 2 Handover Average

Provide efficient and responsive services



Variation		Assurance	
Target	**Jan 24**	**Feb 24**	**Mar 24**
00:00:00	00:43:34	00:36:07	00:33:01

Background

The average time taken for patients to be handed over from Ambulances arriving at UHNM.

What is the data telling us?

The data provided by West Midlands Ambulance Service (WMAS) is provided a month in arrears.
Ambulance Cat 2 mean time has continued to reduce since January 2024, January saw an average Cat 2 mean of 43.34 minutes compared to 33.01 minutes in March 2024.
Handover within 15minutes of arrival for March is not recorded but April demonstrated a 22.15% compliance.
The Cat 2 mean for April was recorded as 28 minutes – unvalidated.

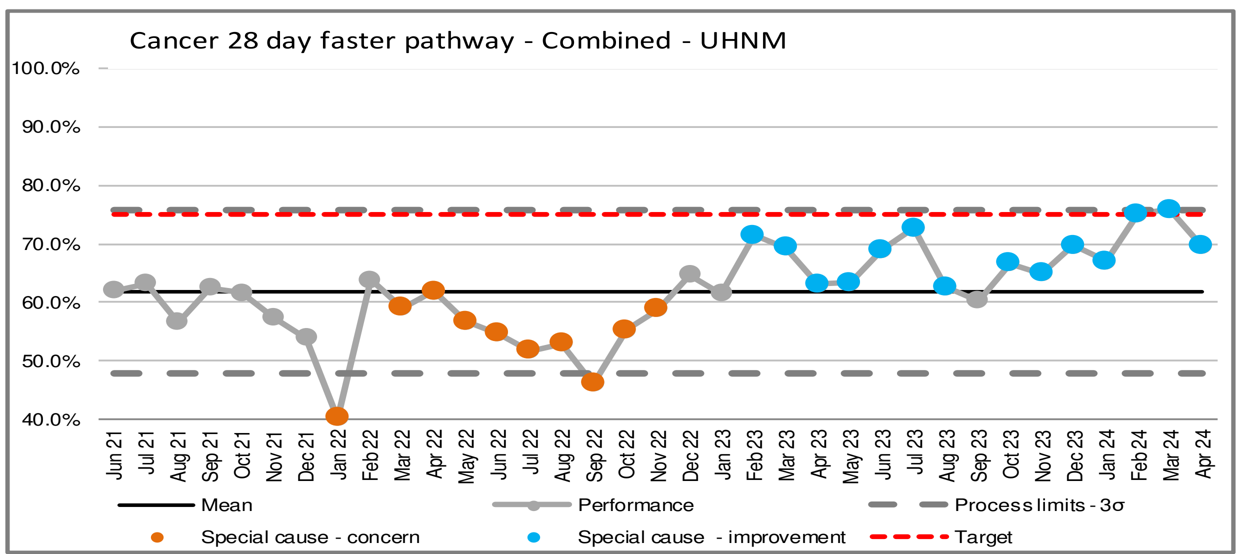
What are we doing about it?

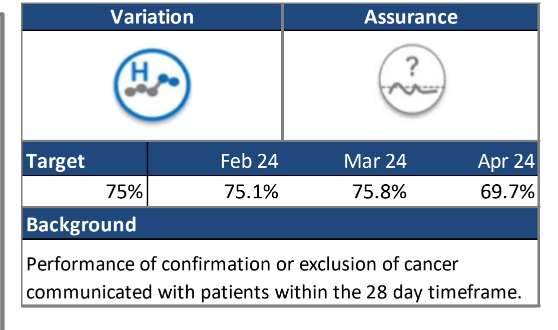
We have instigated an internal rapid handover process, which when triggered and enacted, drives the off load of 2 ambulances every 30 minutes until the pressure is reduced and the risk removed.
The 'corridor' in the emergency department is utilised to support the risk of reducing the waiting ambulances.
'Your Next Patient' protocol is enacted to decompress the emergency department to further support flow and off load capability.
Regular daily contact with WMAS is in place to ensure confidence in actions taken and where possible deflects or diverts to County or Burton are agreed to support timely ambulance release.

Responsive | Cancer 28 Day FDS

Provide efficient and responsive services

Responsive





Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
75%	75.1%	75.8%	69.7%

Background

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

What is the data telling us?

The combined faster diagnosis standard performance has demonstrated a special cause improvement over the past year. UHNM achieved the national standard for the first time in February 24 and again in March 24.
We are now ranked 87th out of 136 re FDS performance.
April 24 performance is more challenged however still high at around 70%.
When broken down at tumour site level, some pathways perform better than others; Upper GI, Skin and Breast being consistent and high achievers.
Pathways that require a higher number of investigations such as Gynaecology and Urology perform lower than the standard.

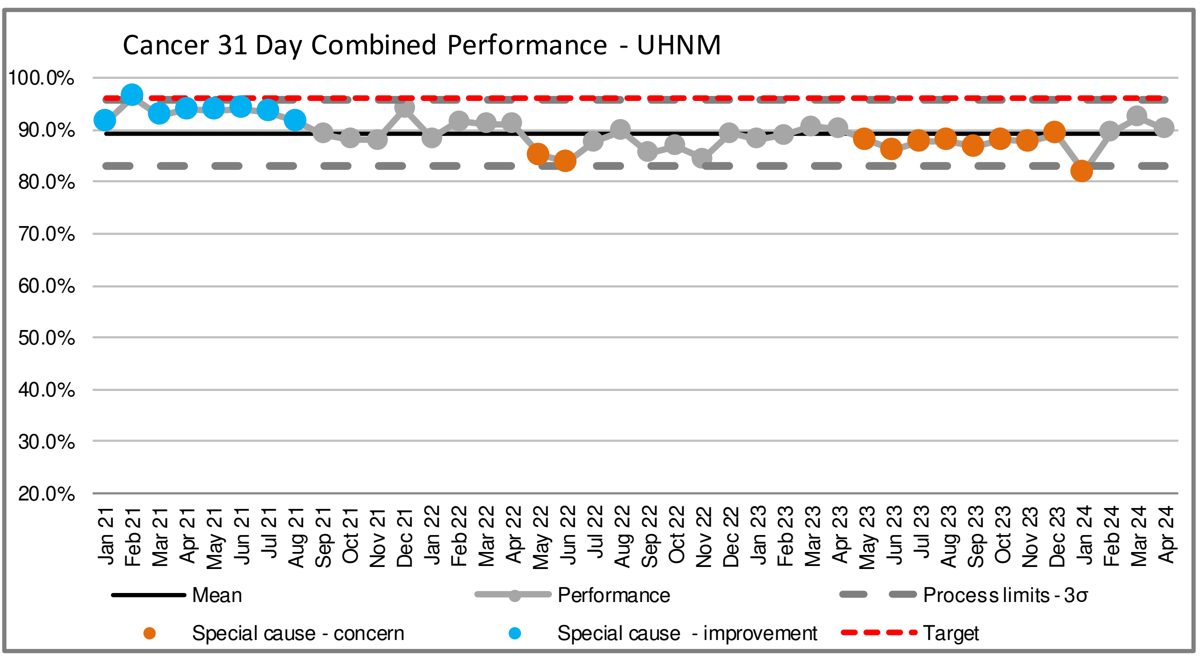
What are we doing about it?

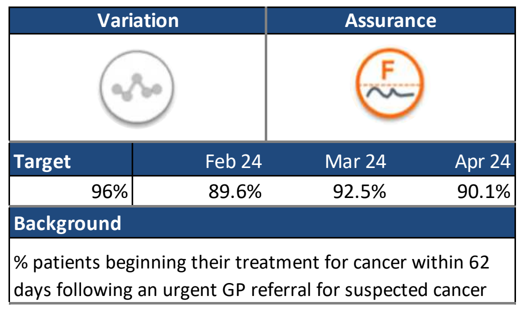
Improvement plans for lower performing pathways are in place; Gynae and Urology. Best practice from better performing providers is being sought for Haematology pathways. Teams have implemented national priorities such as Cancer Navigators who expedite patient pathways. Referral optimisation plans will support faster timelines for patients receiving diagnosis or all clear for cancer.

Responsive

Responsive | Cancer 31 Day Combined

Provide efficient and responsive services





Variation		Assurance	
Target	Feb 24	Mar 24	Apr 24
96%	89.6%	92.5%	90.1%

Background

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

What is the data telling us?

The 31-day combined cancer treatment standard achieved 92.5% in March 24. There is varying performance when broken down by tumour site. Consistent and high achievers are Breast, Skin and Upper GI. However, the most challenged tumour sites are Urology and Colorectal. Urology reported the longest waits due to access to surgical capacity. This was mainly for Kidney patients waiting for a Partial Nephrectomy.
The longer waits on the Colorectal pathway were either due to access to surgery or therapeutic endoscopy procedures.
We are now ranked 80th out of 137 verses 101st out of 137.

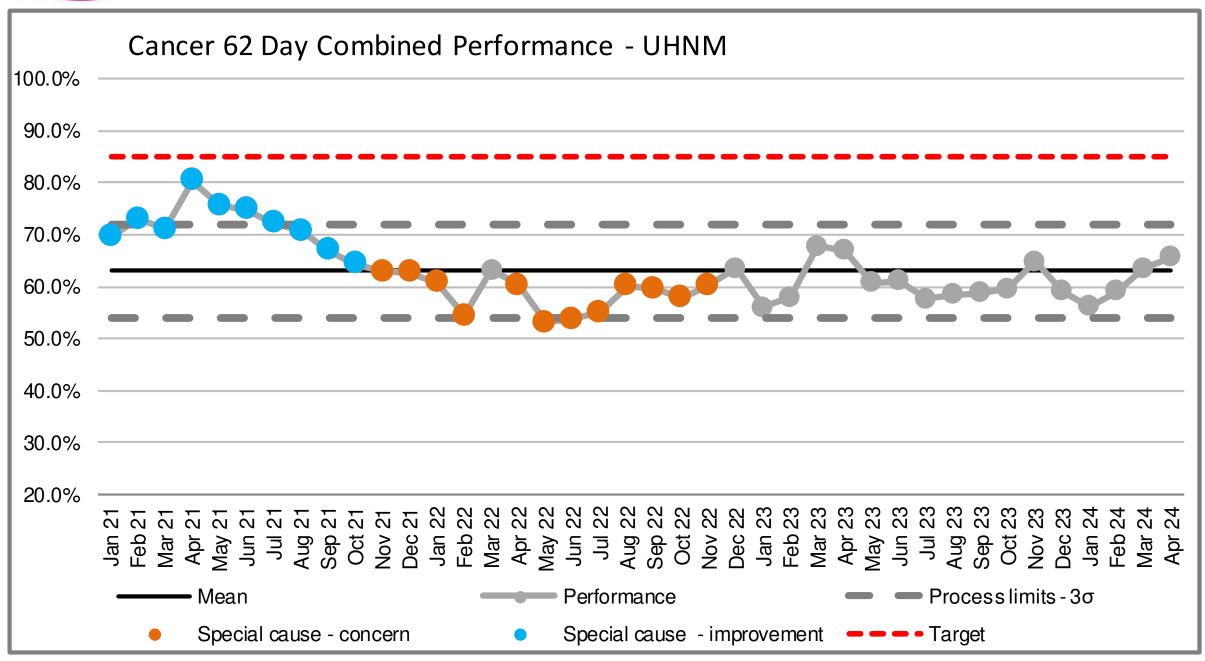
What are we doing about it?

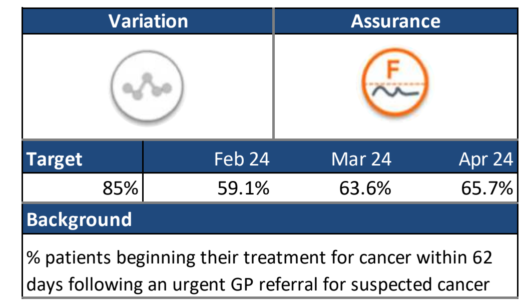
Access to robotic procedures are prioritised through the oversight group.
The endoscopy improvement plan is underway and a business case which considers required capacity to meet demand and clear backlogs is progressing through the sign off process.
Partial Nephrectomy capacity has been escalated through the Tier 1 route with a request for mutual aid. 31 day treatment capacity is inherent to 62 day improvement plans.

Responsive | Cancer 62 Day Combined

Provide efficient and responsive services

Responsive





Variation	Assurance		
Target	Feb 24	Mar 24	Apr 24
85%	59.1%	63.6%	65.7%

Background

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

What is the data telling us?

The combined 62-day performance was reported at 63.6% for March 24, an improvement for the third consecutive month. April 24 is still being validated for upload.
When broken down by tumour site, there are no consistent achievers however pathways with better performance than most include Breast and Skin.
Pathways with the most challenged performance are Gynae, H&N, Lung and Colorectal.
Contributing factors include delay to diagnostics including Hysteroscopy and pathology reporting which impacts significantly for Gynae and Lung, and timely access to Colonoscopy for Colorectal patients. Oncology capacity also impacts timely treatment.

What are we doing about it?

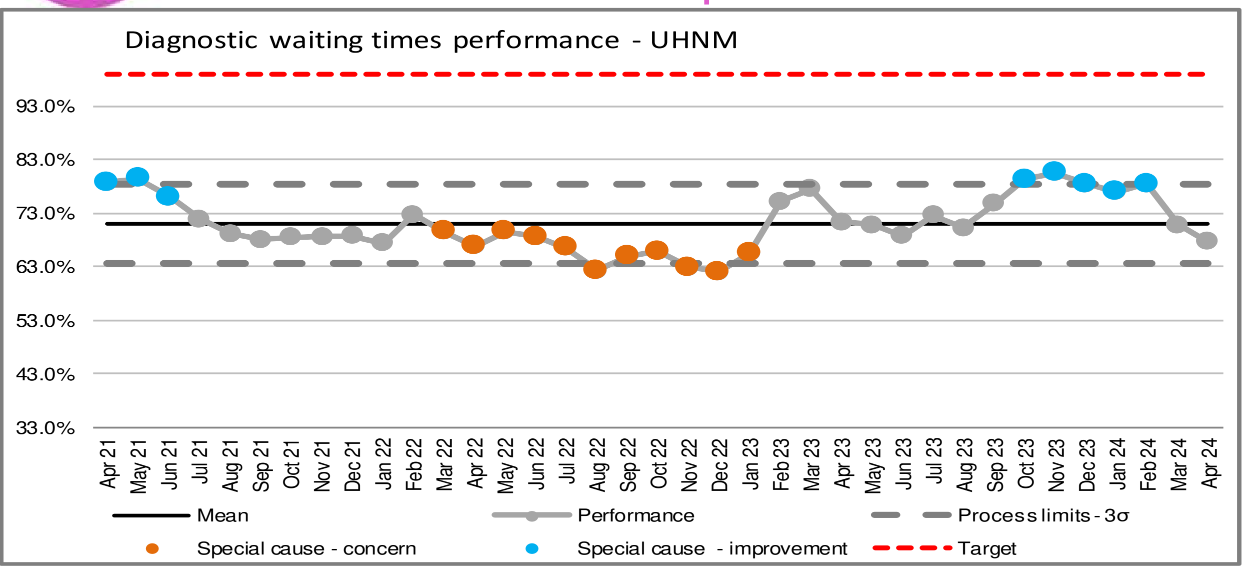
62 day treatment improvement plans are being worked up to include most challenged treatment modalities; surgery and oncology. Longest breaching pathways are being analysed with clinical input. A new 104+ breach analysis governance process has been enacted to ensure oversight of long waiters. The annual peer review process ensures tumour site treatment challenges are visible and escalated through the trust.

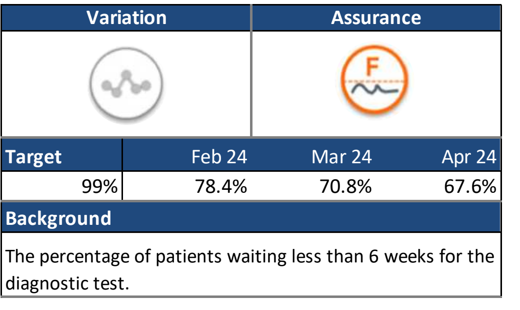
Responsive | Diagnostics DM01 Performance

University Hospitals of North Midlands NHS Trust

Responsive

Provide efficient and responsive services





Target	Feb 24	Mar 24	Apr 24
99%	78.4%	70.8%	67.6%

Background

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

What is the data telling us?

DM01 performance overall has shown signs of improvement March demonstrated a further improvement of 7.64% (29.20% in March verses 21.56% in February). April back within process limits. There remains several contributing factors:

- Endoscopy diagnostics waits are still challenged with 2083 diagnostic patients waiting >6weeks. However, to note, the waiting list continues to reduce with April decreasing by 319 (total reduction of 1884 patients October 23).
- Echocardiograms are still challenged with a slight increase in wait times seen since March 24.
- MRI performance deteriorated whilst the 2 Valley scanners were being replaced, this is now completed, and performance is planned to improve.
- Non – obstetric ultrasound performance is a focus for improvement but there are some fundamental issues relating to staffing levels and training.

What are we doing about it?

There is an improvement programme in place for our endoscopy services which is being supported by Four Eyes.
We continue to insource in order to increase capacity, this has been supported by cancer alliance and ERF funding for Q1 24/25. All vacant in week sessions are being covered by insourcing service, Trust TI session or locum consultants/Dr's.
A business cases for endoscopy recovery is currently in progress through governance structures.
Endoscopy are also validating both through administration and Clinical pathways all DM01 patients waiting beyond 52wks. This is alongside a focused piece to improve DNA and cancelation rates.

Our Echo capacity is being supported through ongoing use of Xyla. This is against vacancies to reduce wait times as much as possible and for Neurophysiology the use of Elective Services to continue to deliver testing into 2024_25 has been approved.

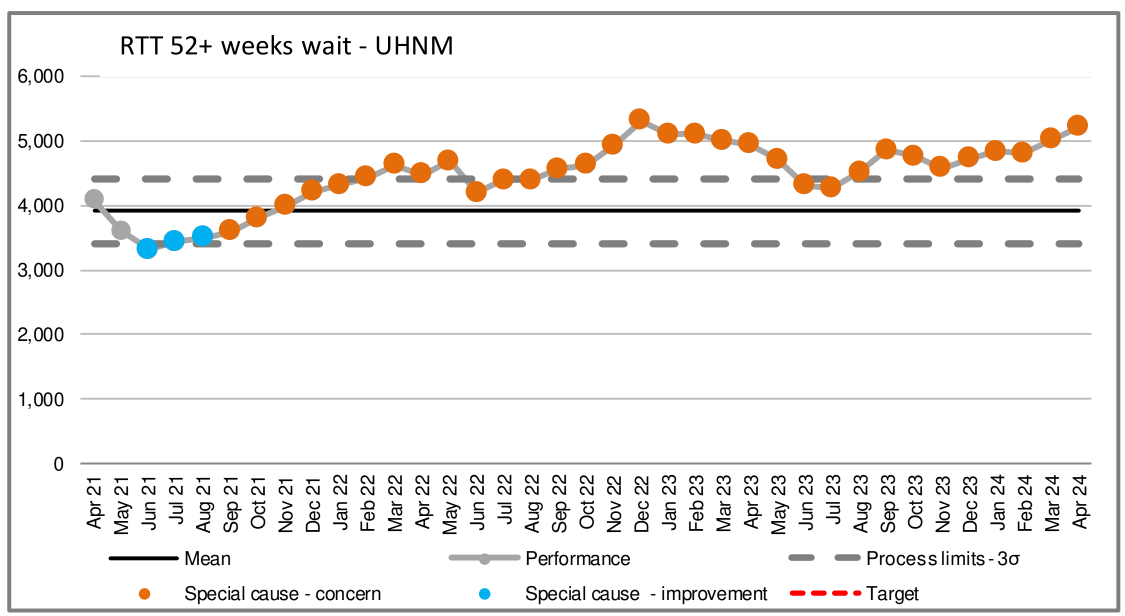
Non- obstetric Ultrasound – a review of the root causes is being undertaken, this includes staffing, training and the reasons why demand in increasing in specific areas – a remedial action plan will be developed.

Responsive

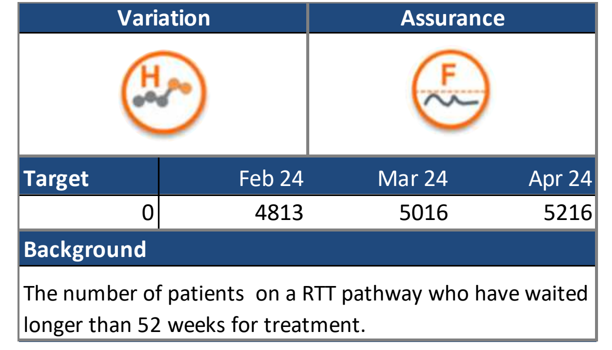
Responsive | RTT No. of Patients Waiting Over 52 Weeks

Provide efficient and responsive services

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance



Target	Feb 24	Mar 24	Apr 24
0	4813	5016	5216

Background

The number of patients on a RTT pathway who have waited longer than 52 weeks for treatment.

What is the data telling us?

52-week waits have continued to grow from October 2023 and are at their highest point since January 2023.
There has been a reduction in total PTL size in the longer waiters over 65 weeks and 18-51 weeks brackets.
The proportion of patients waiting 52+ weeks who have reached a decision to admit is currently 25%. This is compared with 45% in May 2023, and 58% in May 2022. Patients are taking longer to reach a decision to admit, due to delays in Outpatient, Diagnostics & administrative processes, including clinical review of diagnostics and enacting clinical decisions.
We are now ranked 147th for March as opposed to 150th in February.

What are we doing about it?

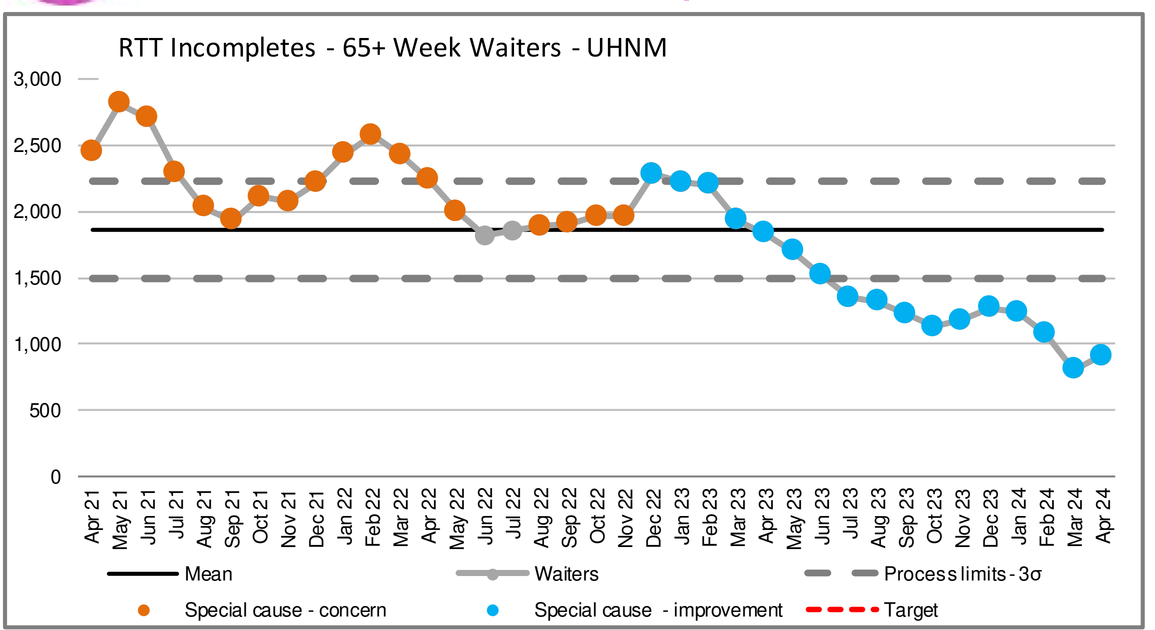
- Revamped RTT & Planned Care training offering now available, including Intermediate Training.
- Clinician training now available combined with Clinic Outcome Form training
- Exploring utilisation of digital tools (Palantir's CCS) to focus validation to pathways with DQ issues and/or missing pathway milestones
- Further Patient Validation Forms to be sent in May, with improved reporting of responses to aid Divisions in dealing with responses
- Divisions supported with tracking and admin process improvements where resource allows

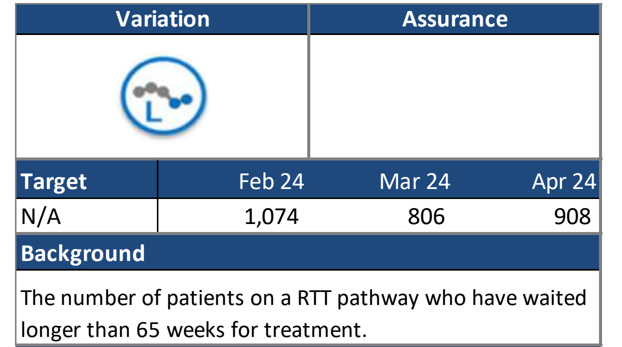
Responsive | RTT No. of Patients Waiting Over 65 Weeks

University Hospitals of North Midlands NHS Trust

Provide efficient and responsive services

Responsive



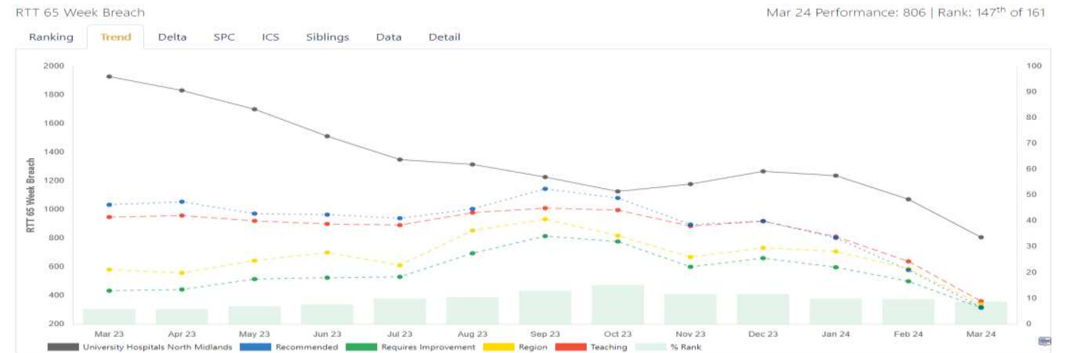


Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
N/A	1,074	806	908

Background

The number of patients on a RTT pathway who have waited longer than 65 weeks for treatment.



What is the data telling us?

The 65-week reduction had been following special cause for improvement from December 22, however rates of reduction have started to slow down, with a small increase from March to April.

March ranking was 147th verses 148th in February.

What are we doing about it?

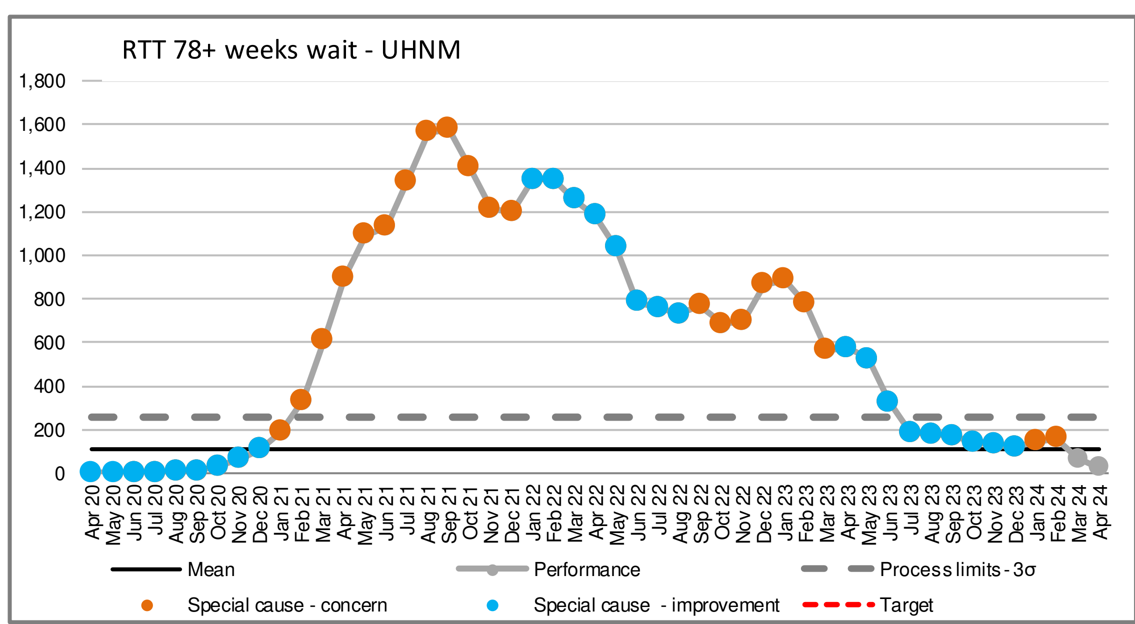
- ERF business cases for extra capacity through insourcing & WLIs now approved, so capacity secured and booking commenced.
- Focus on utilisation and productivity in theatres and outpatients
- Targeted validation on Respiratory, Gastro & ENT pathways

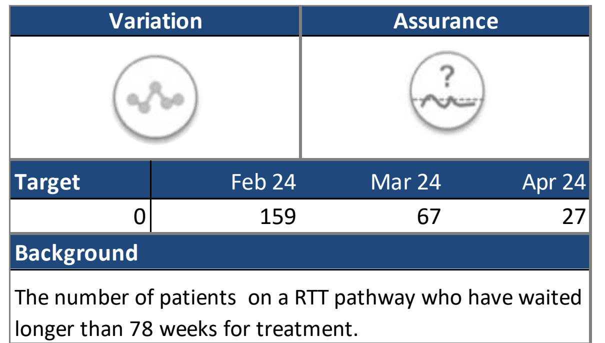
Responsive | RTT No. of Patients Waiting Over 78 Weeks

Provide efficient and responsive services

NHS University Hospitals of North Midlands NHS Trust

Responsive





Variation	Assurance
	?

Target	Feb 24	Mar 24	Apr 24
0	159	67	27

Background

The number of patients on a RTT pathway who have waited longer than 78 weeks for treatment.

What is the data telling us?

78-week waits have reduced dramatically, with an unvalidated month end position of 23 for April. For comparison, February was 158 and March out turned at 67.
There are 5 cornea patients who are mutual aid transfers from Royal Wolverhampton Trust who are long waiters, but these are not attributed to UHNM by NHSE although now held on our waiting list.
The trust is predicting 9 patients will waiting 78+ weeks at the end of May, and 0 at the end of June.

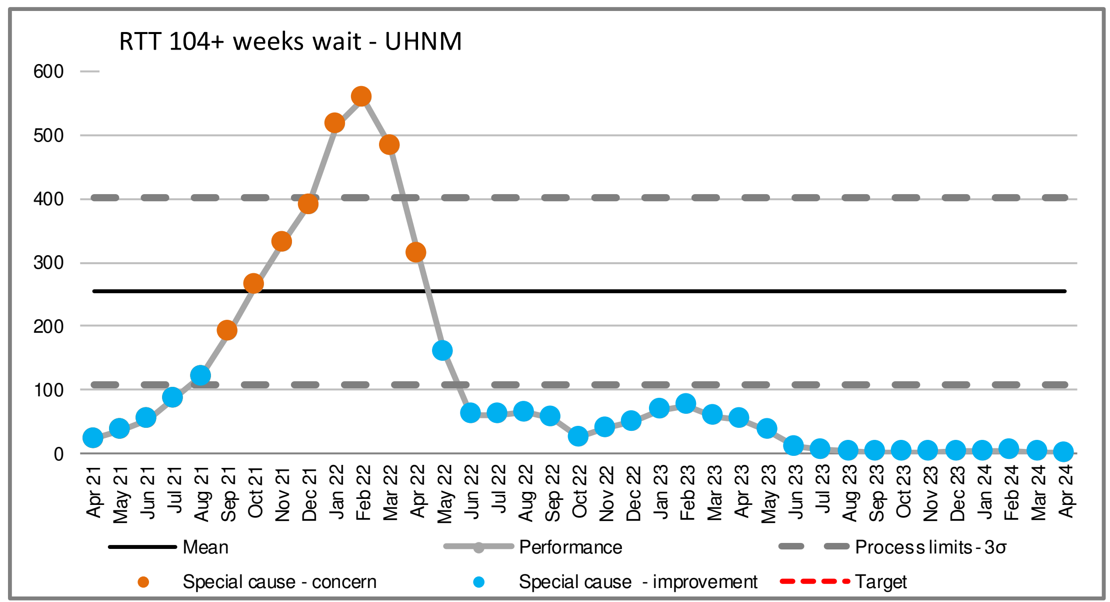
What are we doing about it?

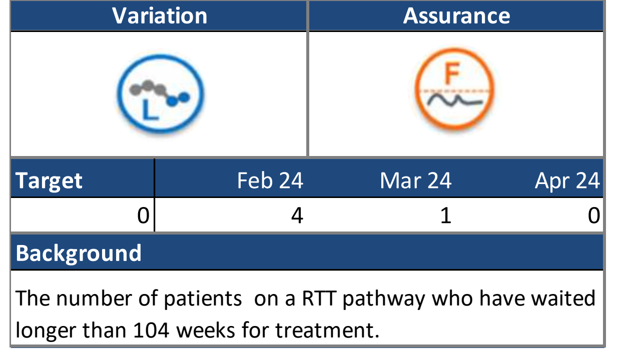
Actions as per those patients over 65 weeks along with continuing tracking and micromanaging of long waiting patients, with regular PTL meetings with each relevant directorate, and support functions.

Responsive | RTT No. of Patients Waiting Over 104 Weeks

University Hospitals of North Midlands NHS Trust

Provide efficient and responsive services





Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
0	4	1	0

Background

The number of patients on a RTT pathway who have waited longer than 104 weeks for treatment.

What is the data telling us?

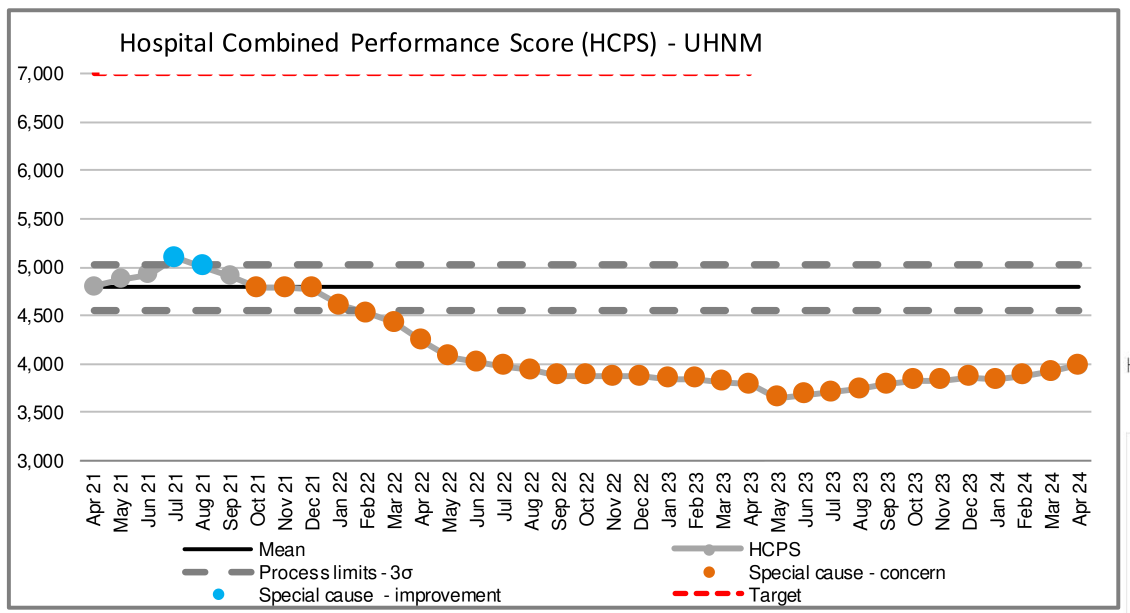
The Trust achieved zero 104-week breaches for April, and are projecting zero for May, & June & July.

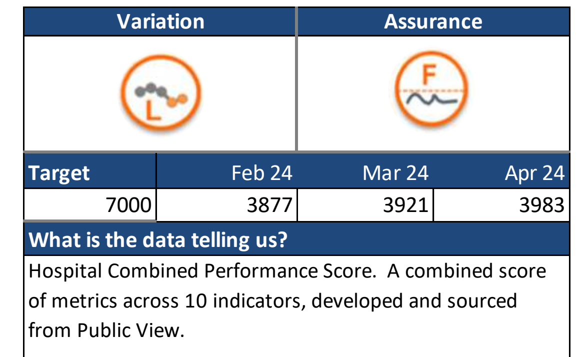
What are we doing about it?

Continuing tracking and micromanaging of long waiting patients, with regular PTL meetings with each relevant directorate, and support functions.
There are 6 patients who risk breaching 104 weeks at the end of August; all have plans to be treated in May or June.

Responsive | Treating Patients in a Timely Manner (HCPS)

Provide efficient and responsive services



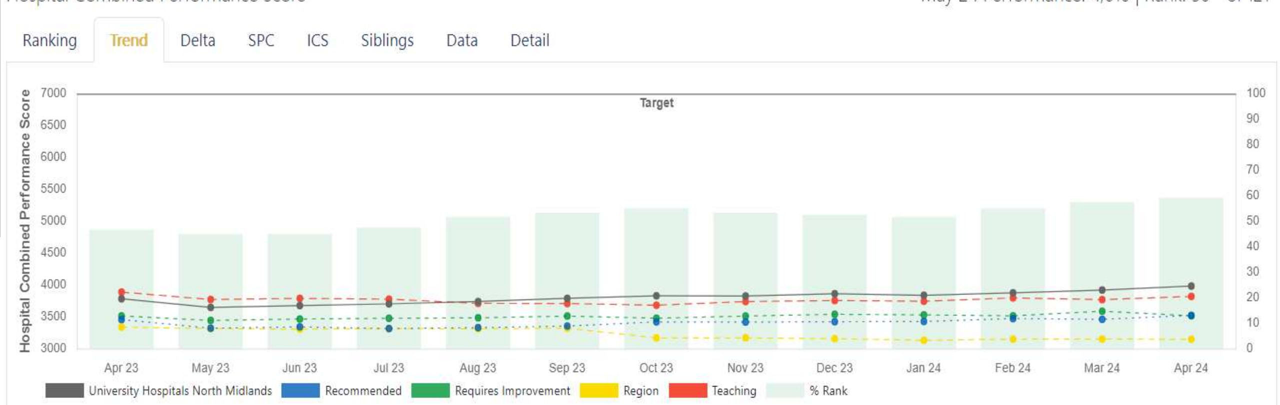


Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
7000	3877	3921	3983

What is the data telling us?

Hospital Combined Performance Score. A combined score of metrics across 10 indicators, developed and sourced from Public View.



What is the data telling us?

The Hospital Combined Performance Score has seen improvement every month over the last 12 months. Since January 2024 improvement to this score has been as a result of increased performance in the 4-hour standard, a reduction in the DTA to admission over 4 hours, Cancer 31-day standard, Cancer 62-day standard and the RTT 18-week standard.

What are we doing about it?

We are focused on improvements in the indicators which feed the combined hospital score, and these are included in the A3 improvement programmes for both the elective and non-elective programmes.

Overview from the Chief People Officer

How are we doing against our trajectories and expected standards?

Our *Staff Engagement* score was 6.42 for April 2024, down from 6.61 for March 2024, against a target of 7.2

Sickness absence continues to be above our expected standard of 3.39%. In month we have seen a 0.07% decrease to 4.90%, while the 12-month cumulative rate remains static at 5.2%. The main driver of this continues to be stress and anxiety, followed by gastrointestinal problems and other musculoskeletal problems as the second and third most common reasons.

Turnover and *vacancy* metrics continue to perform well against our expected standards. The turnover rate in April 2024 remains at 7.8% and has been consistently below our 11% target, for the last 19 months. The vacancy metric has also improved to 7.6% which also remains within our expected standard of 10%. The main driver of the vacancy % is due to an increase in the total FTE for actual people in post.

Agency costs increased by 0.7%, in April 2024, from 2.6% in March 2024. However, this was driven by reduced overall pay costs being less in April, causing the overall agency cost to be a greater percentage of the total pay spend. In real-terms though, overall agency usage reduced by 63 WTE, to 240 WTE in April 2024 (303 WTE in March 2024).

What is driving this?

Sickness absence is driven by many factors, including stress and anxiety and seasonal changes such as colds, cough and chest & respiratory problems.

Agency expenditure is being driven by the continued need for escalation capacity, and activity relating to the elective recovery programme.

People

Overview from the Chief People Officer

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

The staff survey has moved to quarterly (with the survey open for 14 days) for FY24/25 to prevent survey fatigue and to allow more time for the divisions to review and respond to feedback 'you said, we will'.

Sickness absence continues to be monitored at directorate performance reviews. Areas with over 8% or of concern are supported by the People Advisors, focusing on long term sickness cases. Our people are also provided with many online and in-person resources, to improve their personal resiliency when coping with work-related stress.

Agency Expenditure remains subject to continued scrutiny through the Divisional Performance Reviews and the Medical Workforce Assurance Group. There is also regular focus at ICB level on workforce numbers, agency spend and controls.

System level controls have been implemented in our Electronic Rostering solution, for all nursing & midwifery rosters, which now require Matron level authorisation prior to being filled by either bank and/or agency. It is anticipated that this will show as a reduction in overall agency WTE, and a commensurate reduction in agency expenditure/cost (£) over the coming months.

What can we expect in future reports?

We should anticipate further incremental improvements in sickness absence, as we head into the Summer months, resulting from less Covid-19 and seasonal chest & respiratory cases being reported.

Updates regarding the uptake of the Wagestream solution, which is currently starting a three months trial, before a decision is made to rollout this solution out to our substantive workforce as well, as part of our employee benefits package.

We expect to see a gradual reduction in agency spend, resulting from the additional system level controls which have been implemented.

People

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Employee Engagement	7.2	6.6	6.4		F				
Sickness Absence (In Month)	3%	5%	5%		F				
Vacancy Rate	8%	8%	8%	L	?				
Turnover Rate	11%	8%	8%	L	P				
Agency Cost	0%	3%	3%		F				

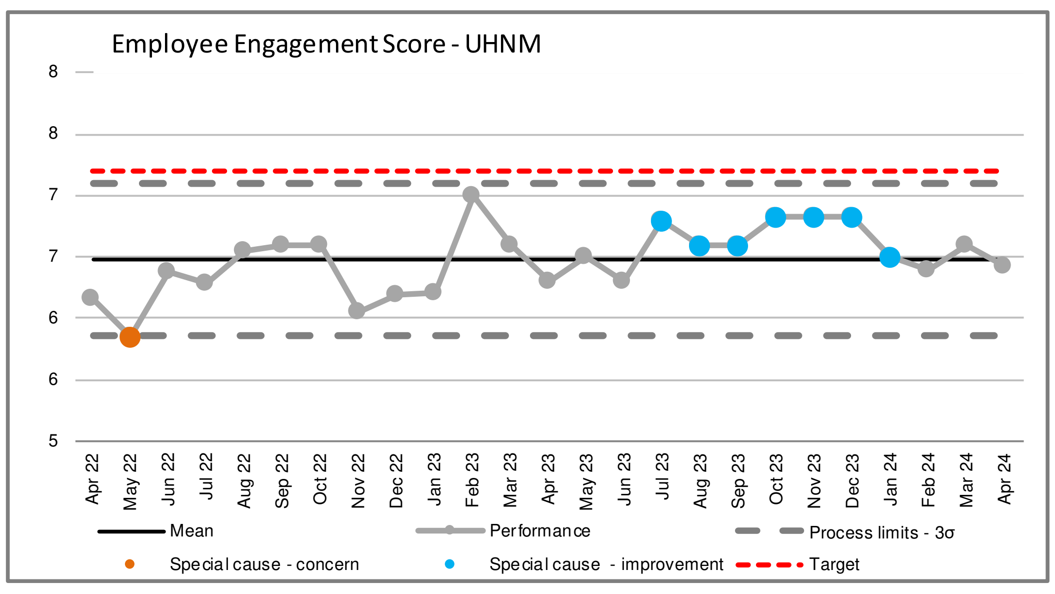
Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 2: Sustainable Workforce								

People | Employee Engagement

Creating a great place to work for everyone

People



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
7.2	6.4	6.6	6.4

Background

What is the data telling us?

Our Staff Engagement score was 6.42, for April 2024, down from 6.61 for March 2024, against a target of 7.2.

What are we doing about it?

The survey has moved to quarterly (with the survey open for 14 days) for FY24/25 to prevent survey fatigue and to allow more time for the divisions to review and respond to feedback 'you said, we will'.

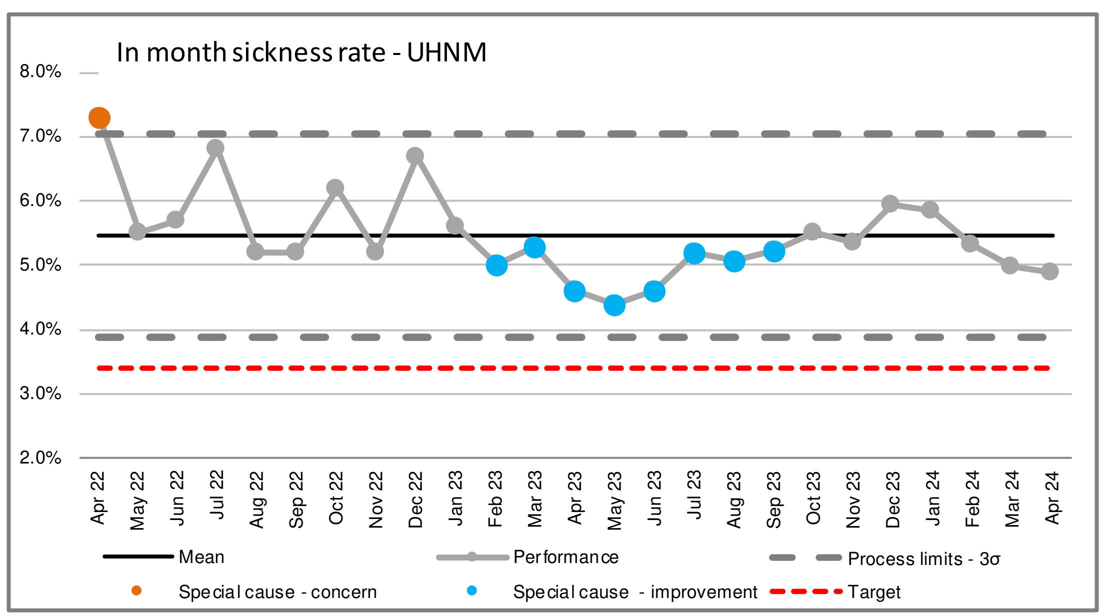
Sustained operational pressures continue to impact on overall employee engagement.

All Divisions are developing staff survey response plans and have a driver metric for staff engagement.

People

People | Sickness Absence in Month

Creating a great place to work for everyone



Variation		Assurance	
Target	**Feb 24**	**Mar 24**	**Apr 24**
3.4%	5.3%	5.0%	4.9%

Background

Percentage of days lost to staff sickness

What is the data telling us?

Rolling 12-month average sickness absence rates remained static at 5.2% for the last 5 months against the target of 3.4%.

However, the in-month sickness absence % has improved in the last two months, being 4.97% for March and 4.90% for April 2024.

In rank order (highest first), the top 3 reasons for absences during March and April were: (1) Anxiety/stress/depression/other psychiatric illnesses, (2) Gastrointestinal problems, and (3) Other musculoskeletal problems.

What are we doing about it?

Medicine Division - sickness absence continues to be monitored at directorate performance reviews. Areas with over 8% or of concern are supported by the People Advisor focusing on long term sickness cases.

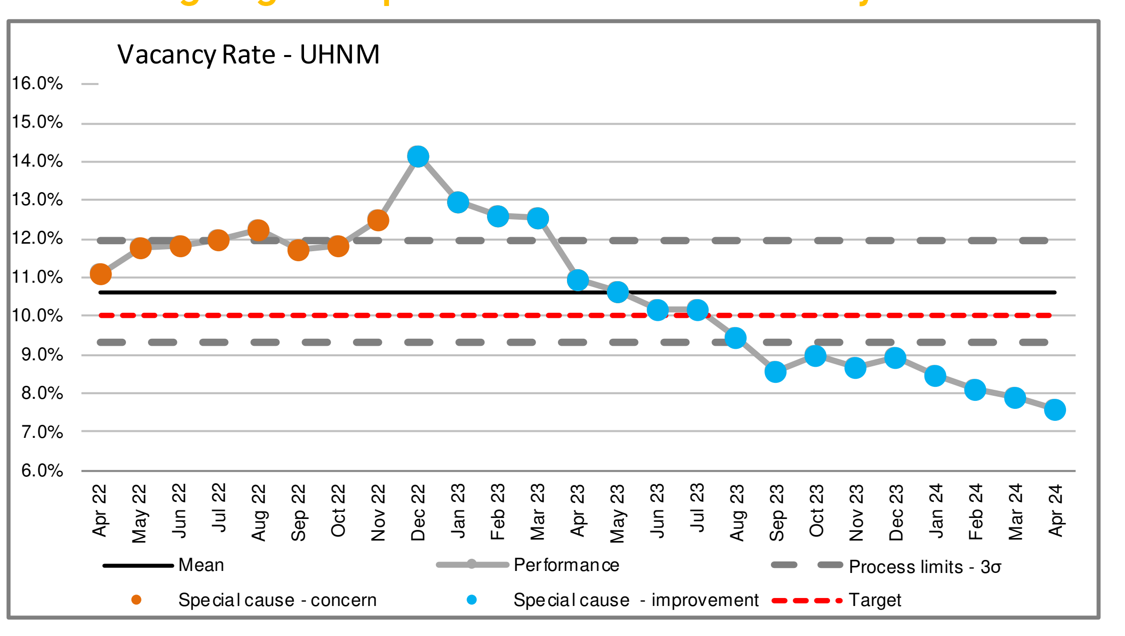
Surgery Division – assessment of hotspot areas for long and short term absences to provide targeted support including re-training.

Network Division - commenced sickness assurance meetings.

Women's Children's and Clinical Division - Deep dives into hot spot/high absence areas to target interventions as well as continuing absence surgeries.

People | Vacancy Rate

Creating a great place to work for everyone



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
10%	8.1%	7.9%	7.6%

Background

Vacancies at 30-04-24	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,626.07	1,474.66	151.41	9.31%	13.21%
Registered Nursing	3733.03	3377.69	355.34	9.52%	9.04%
All other Staff Groups	6747.08	6332.01	415.07	6.15%	5.97%
Total	12,106.18	11,184.35	921.83	7.61%	7.91%

What is the data telling us?

The summary of vacancies, by staff groupings, highlights a further 0.3% improvement in the overall vacancy rate.

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

Colleagues in post increased in April 2024 by 16.72 fte, budgeted establishment decreased by 21.30 fte, which reduced the vacancy fte by 38.02 FTE overall.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 34/04/24]

What are we doing about it?

We continue with our successful recruitment events, targeting specific roles across multiple professions and divisions.

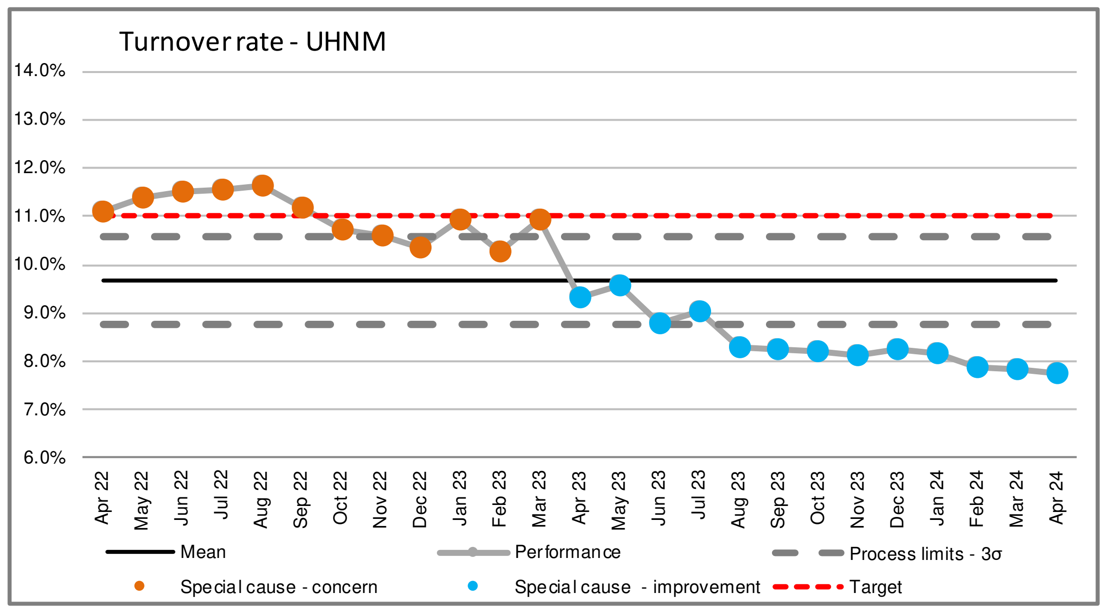
Targeted social media campaigns continue, advertising that our organisation is a great place to work.

We continue our targeted spotlights on our colleagues, which supplement our recruitment campaigns.

People

People | Turnover Rate

Creating a great place to work for everyone



Variation		Assurance	
Target	Feb 24	Mar 24	Apr 24
11.0%	7.9%	7.8%	7.8%

Background

Turnover rate.

What is the data telling us?

The turnover rate in April 2024 has remained at 7.8% which is consistently below the Trust's 11% target, for the last 19 months.

What are we doing about it?

Turnover continues to perform well against our expected standards, reflecting our programmes of work which make this a great place to work. Some recent examples include :

- Medical Staffing finishing school.
- Employment of a People Promise (Retention) Manager who started in a fixed term post.
- Implementation of the Wagestream solution, for bank staff, including our people who work both substantively and on the bank.
- Monthly targeted campaigns aligned to our four People Promise areas of focus (Apr-Oct 2024). For example, People Promise 4 'We are safe and Healthy': April – we have promoted Stress Awareness Month, shared messages of support, launched Suicide Prevention Toolkit, communicated Wellbeing services.

People | Agency Cost

Creating a great place to work for everyone

Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
N/A	3.3%	2.6%	3.3%

Background

Agency cost as a percentage of total pay cost

What is the data telling us?

Agency costs increased by 0.7%, in April 2024, up from 2.6% in March 2024.

Agency cost is calculated as a percentage of the total Pay Costs. Because the total pay costs were lower than in March 2024, meant that the agency costs appear as a larger percentage of the total overall Pay Cost.

For example, the total Pay Cost for March 2024 was circa £84m, against a total agency spend of £2.1m, versus £58.3m against a total agency spend of £1.9m, in April 2024.

In real-terms, overall agency usage reduced from 303 WTE in March 2024 to 240 WTE in April 2024, indicating a reduced reliance on agency, which is not reflected in the agency cost (£).

What are we doing about it?

- Agency use is monitored and discussed at monthly divisional meetings. This includes reviewing long-term agency use.
- All current in-sourcing contracts are reviewed monthly, to ensure that they do not breach rules regarding off-framework agency use.
- All off-framework agency arrangements have been reviewed and exit-plans agreed to ensure that all off-framework use ceases by the end of June 2024.
- System level controls have been implemented in our Electronic Rostering solution, for all nursing & midwifery rosters, which now require Matron level authorisation prior to being filled by either bank and/or agency. It is anticipated that this will show as a reduction in overall agency WTE, and a commensurate reduction in agency expenditure/cost (£).

Overview from the Chief Medical Officer and Chief Nurse

How are we doing against our trajectories and expected standards?

Metric 1: Increasing clinical trial participants: Research Participants April 23 total was 96, April 24 total 154. Research Delivery is on target for April 24

Metric 2: Increasing clinical academic/joint/honorary contracts: This is the first time of reporting on this metric. The A3 and scorecard are under development. The A3 has shown us that we do not know how many of these appointments are held in UHNM. The data provided indicates what we know only from those staff who have made this known to CeNREE or the R&I department.

Metric 3: Increasing research active staff: This is the first time of reporting on this metric. The A3 and scorecard are under development. The A3 has shown is that we do not know how many research active staff we have in UHNM. The data provided indicates what we know only from those staff who have made contact with CeNREE or the R&I department for research support or who are current CIs/PIs.

What is driving this?

Metric 1: The Home-Grown Study VIBES, CI Professor Will Carroll, looking at vaccine beliefs of parents in our local school population, this is a questionnaire study and supports the varied portfolio of research on offer to assist with an increase in research participant numbers.

Metric 2: The A3 has shown that we do not collect this data in a systematic way.

Metric 3: The A3 has shown that we do not collect this data in a systematic way and that we do not have an agreed definition of ‘research active’.

Improving & Innovating | Overview

Excellence in development and research

Overview from the Chief Medical Officer and Chief Nurse

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

Metric 1: We are monitoring recruitment against recruitment targets monthly through lead practitioner meetings

Metric 2: We have a countermeasure to conduct a quarterly census via Divisional Leads.

Metric 3: We have two countermeasures in place: 1) we will agree a definition of 'research active' with stakeholders in the Research and Innovation Strategy Oversight Group and Executive Research and innovation Group, and 2) we will conduct a quarterly census via Divisional Leads.

What can we expect in future reports?

Metric 1: We will begin to look at the distribution of targets over the number of studies being set up, we are working towards proportionality in the offer of research activities to our patients

Metric 2: Data will become more accurate as census data is analysed. SPC charts will become available, and trends will be apparent.

Metric 3: Data will become more accurate as census data is analysed. SPC charts will become available, and trends will be apparent.

Improving & Innovating | Dashboard

Excellence in development and research

Improving & Innovating

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Increase Clinical Trial Participation	0.0	130.0	152.0						
Increase Clinical Academic Posts/Honorary Contracts	0.0	8.0	8.0						
Increase Research Active Employees	0.0	300.0	303.0						

Related Strategy and Board Assurance Framework (BAF)

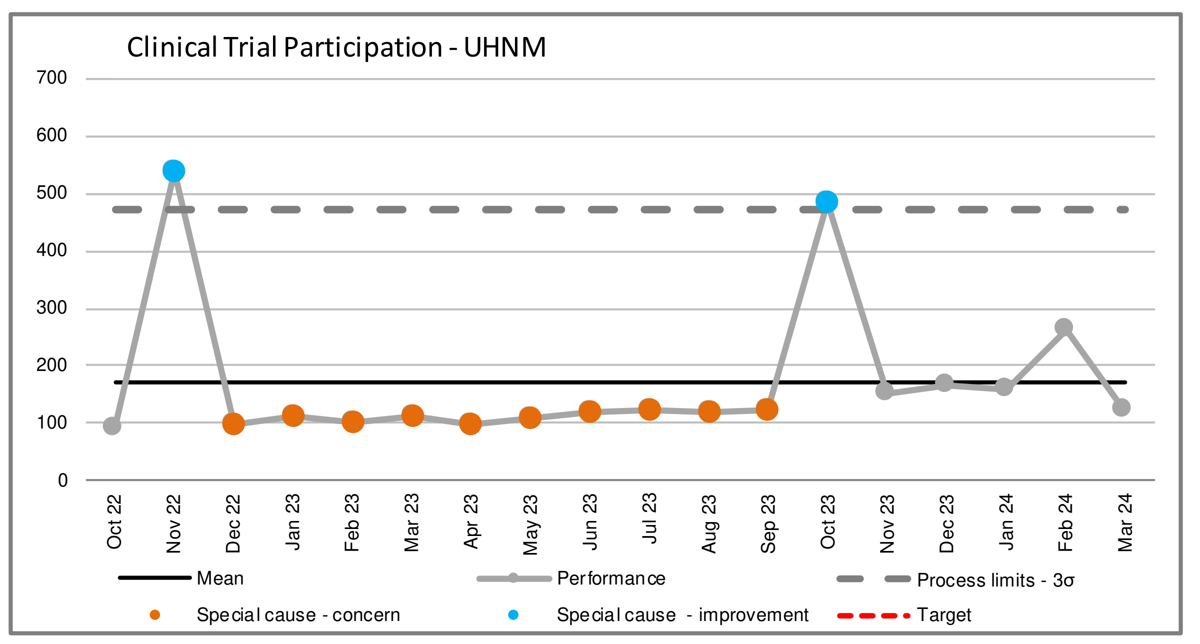
Quality Strategy

Research Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 9: Research Innovation								

Improving & Innovating | Clinical Trial Participation

Excellence in development and research



Variation	Assurance

Target	Jan 24	Feb 24	Mar 24
N/A	158	264	123

Background

The number of patients starting Clinical Trials each month.

Improving & Innovating

What is the data telling us?

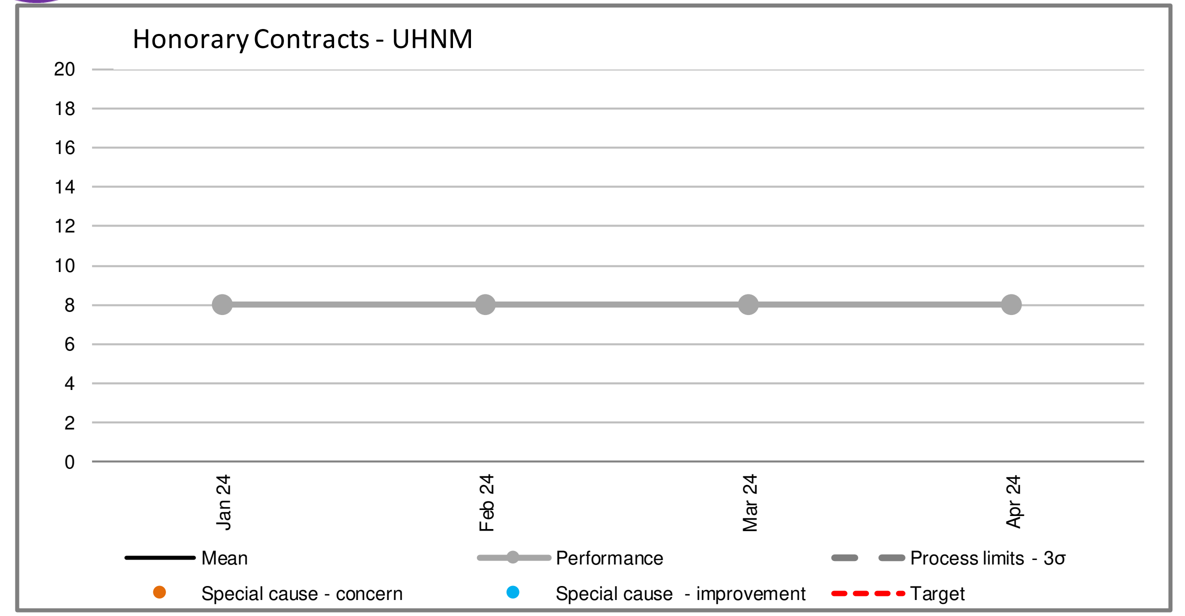
To increase numbers is to also increase the variety of studies we offer, the spikes show our quick turnaround studies, these studies are important and help with increasing our numbers, which in turn will increase our reputation regionally.

What are we doing about it?

The directorate are mindful that a balanced portfolio is required, from research participation of questionnaire studies, through to full clinical trial, it will take time to balance the portfolio, and ensuring we are aware of studies that are in set up and their potential to support this direction.

Improving & Innovating | Clinical Academic Posts/Honorary Contracts

Excellence in development and research



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
N/A	8	8	8

Background

The number of UHNM staff with clinical academic or honorary appointments.

What is the data telling us?

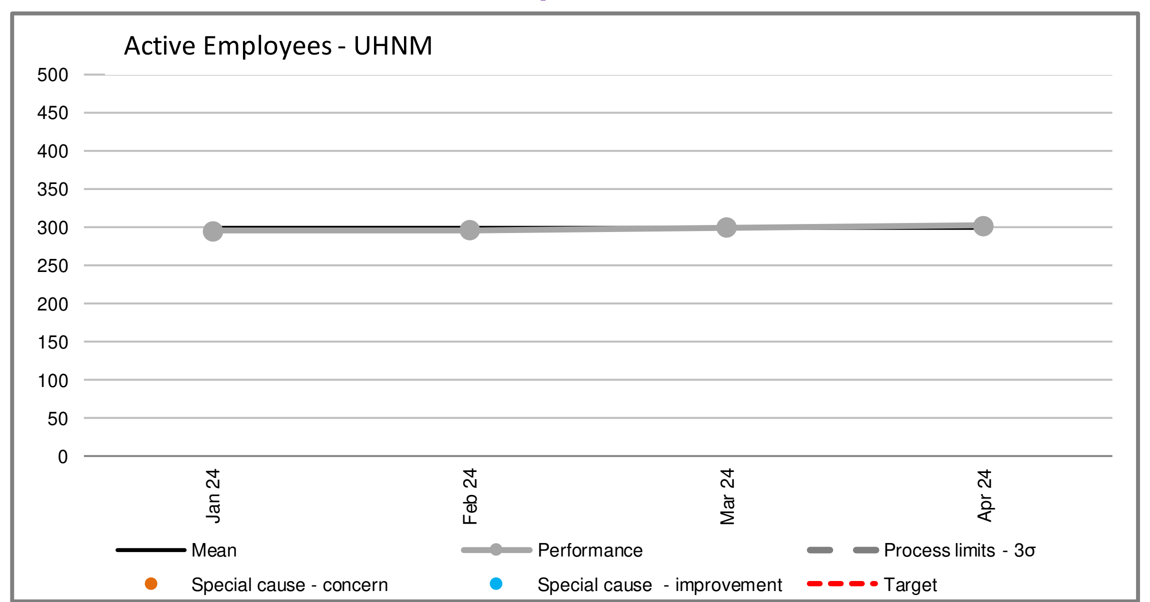
We do not currently have a process for collecting this data, so this number appears smaller than anticipated.

What are we doing about it?

We will conduct a quarterly census via Divisional leads to obtain more accurate data. This will indicate where we need to prioritise our negotiations with Higher Education Institutions (HEIs).

Improving & Innovating | Research Active Employees

Excellence in development and research



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
N/A	297	300	303

Background

The number of research active employees in UHNM.

Improving & Innovating

What is the data telling us?

We do not have a confirmed definition of 'research-active' or a process for collecting this data, so this number appears smaller than anticipated.

What are we doing about it?

We will agree a definition with stakeholders and then conduct a census via Divisional Leads. This will highlight the areas where there is a shortfall in research activity where we can focus our attentions for development and support.

Overview from the Director of Strategy & Transformation

How are we doing against our trajectories and expected standards?

This Domain is in development

What is driving this?

System & Partners

System & Partners | Overview

Working together to improve the health of our population

Overview from the Director of Strategy & Transformation

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

What can we expect in future reports?

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System & Partners

System & Partners | Dashboard

Working together to improve the health of our population

In Development

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Increased Partnership Working	0.0	0.0	0.0						
Improve the health of our population	0.0	0.0	0.0						

Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 4: Improving the Health of our Population								

Resources | Overview

Getting the most from our resources including staff, assets and money

Overview from the Chief Operating Officer and Chief Digital Information Officer

How are we doing against our trajectories and expected standards?

Non – elective
Non-elective activity continues to at very high levels and above plan.

Elective
Against plan April delivered: Demonstrating a positive performance and early signs of extending our elective recovery and accessing the Elective Recovery Fund required this year.
Day case 106.02%
Elective 99.41%
First Outpatient 103.16%
Follow up 112.15%

Freedom of information requests are not being completed against the nationally mandated standard. It is expected that this will improve when the new information management system is introduced. Subject Access Requests are on target for April 2024. There have been 0 data breaches. Two projects have been completed in month. The outstanding projects to deliver is significant and prioritisation is being undertaken.

What is driving this?

Non – elective

Although demand management schemes were in place over winter and past the East period this was not necessarily seen through a reduction in admissions.
An important not on admissions is the use of the Clinical Decisions Unit which was for a period of time close with the result of patients waiting in ED for 24hours+ receiving treatment in an inappropriate environment.
Those patients are now accessing the CDU and that will have contributed to the increased admissions shown from October 2023.

Elective
Elective and day case combined are delivering as expected, however there is specialty level variation which is causing the slight underperformance elective and over performance in day case.
Outpatients both first and follow up are over performing and the % of cases in April that were Outpatients of FU with a procedure was 54.4%.

An increase in the complexity of the Freedom of Information requests. An increase in demand for digital solutions, upgrades or replacements.

Resources | Overview

Getting the most from our resources including staff, assets and money

Overview from the Chief Operating Officer and Chief Digital Information Officer

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

Non – elective
The System Demand Management Collaborative is tasked with identifying schemes to reduce demand. This programme commenced in April and is likely to have its greatest impact in October 2024.

Elective
There are now monthly meetings with all divisions to review their activity outputs. This sits alongside Outpatient and Theatre improvement workstreams to support improvements in utilisation.
The County strategic programme also is looking at the utilisation and development of work across count theatres and its STS facilities.

For both FOI and SARs the introduction of a new information management system to help manage the workflow and approvals.

What can we expect in future reports?

Non – elective
Further detail will be made available regarding the schemes being targeted to reduced non-elective admissions

Elective
We will continue to focus of delivering activity to the plan with workstreams through the Planned Care Group that support improving utilisation.
As the Executive Finance, Activity and Performance Groups with the divisions embed there will be specific feedback where escalation is required.

An increase in FOI performance from August 2024 onwards.

Resources | Overview

Getting the most from our resources including staff, assets and money

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Daycase / Elective Activity	8,835	9,759	9,390		?				
Non-Elective Activity	10,260	11,161	11,047	H	?				
Outpatients' 1st	27,430	27,423	28,333		?				
Outpatients' Follow Up	41,048	41,523	43,422		?				
Freedom of Information Performance	90.0%	63.0%	63.0%		F				
Subject Access Request Performance	1.0%	1.0%	1.0%		?				
Data Security Breaches	0.0	0.0	0.0						

Related Strategy and Board Assurance Framework (BAF)

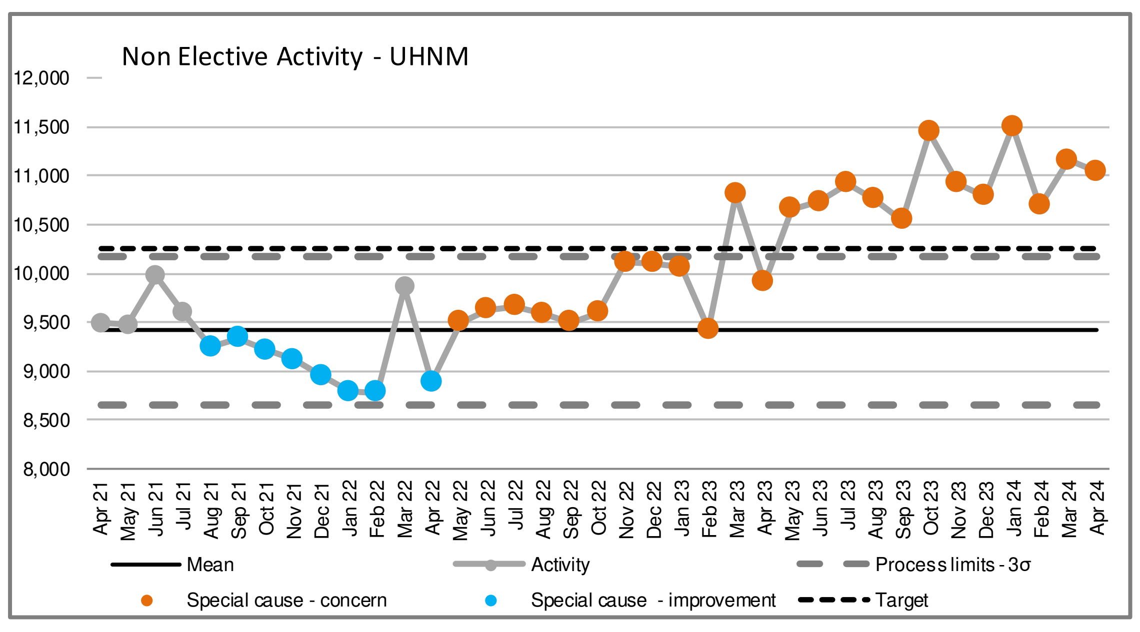
Digital Strategy

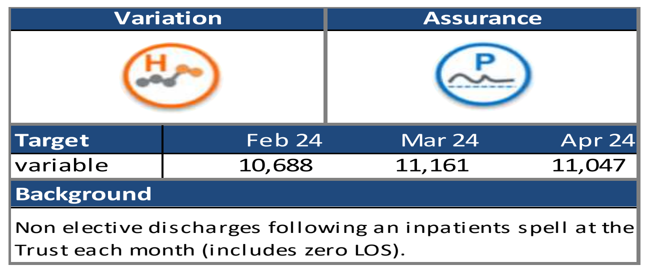
BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 8: Financial Sustainability								
BAF 6: Digital Transformation								

Resources

Resources | Non elective Activity

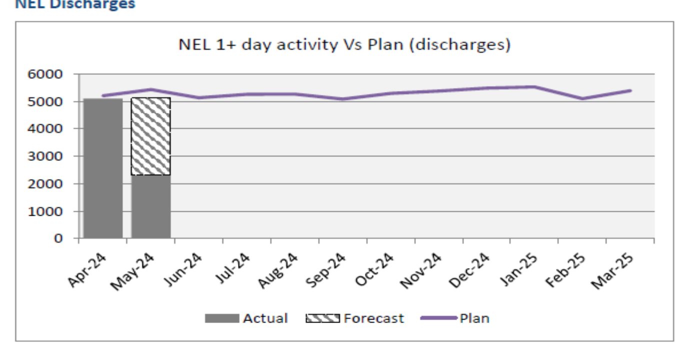
Getting the most from our resources including staff, assets and money





Variation	Assurance		
Target	Feb 24	Mar 24	Apr 24
variable	10,688	11,161	11,047
Background			
Non elective discharges following an inpatients spell at the Trust each month (includes zero LOS).			

NEL Discharges



What is the data telling us?

We continue to experience a high demand in respect of our non-elective activity, and this is consistently above expectation. April did, however, see a slight reduction in activity to that experienced in March. 11,047 in April compared to 11,161 in March. A reduction of 1.03% (114 patients).

The associated discharge profile for non-elective achieved 98% against plan. Plan 5,208 verses an actual of 5,108, which is 100 below expectation. However, CDU is currently nor being factored into this as it is not recorded as an inpatient spell. If included this would likely add 300 – 400 more to the actuals.

What the data does not tell us is any variation in average length of stay by pathway and the expected daily discharges by pathway.

What are we doing about it?

The attends and admission profile is somewhat out with our control; however, we continue to focus on and further develop alternative pathways to admission avoid.

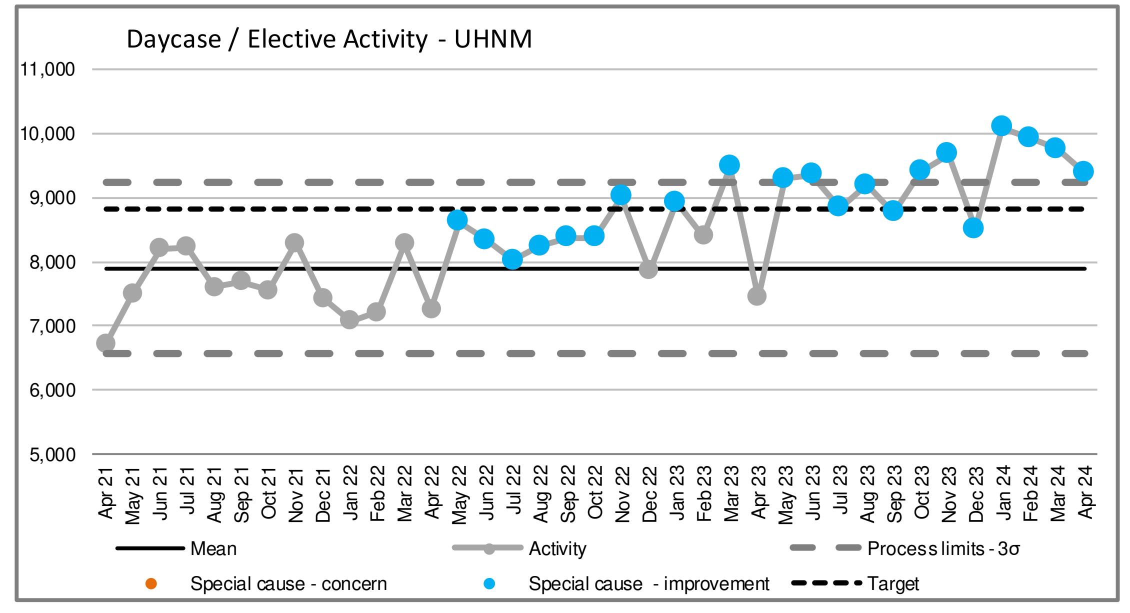
Renewed focus through Acute Care at Home (ACaH), should positively impact on the utilisation of 'virtual ward' capacity.

'Call before Convey' does not yet yield the benefit anticipated. Through collaboration with key system partners, this agreed process should prevent attend and admission and work is in train to explore how we maximise this process and fully exploit access to all alternative nonhospital pathways.

In periods of extremis, the ACaH Team are present on site to in reach. Discussions are now beginning to explore how this becomes business as usual (BAU) as opposed to 'waiting' for a capacity crisis.

Resources | Daycase/Elective Activity

Getting the most from our resources including staff, assets and money



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
variable	9,937	9,759	9,390

Background

Daycase and overnight elective activity provided by the Trust each month

What is the data telling us?

There has been a special cause improvement since April 22 across day case and elective activity.

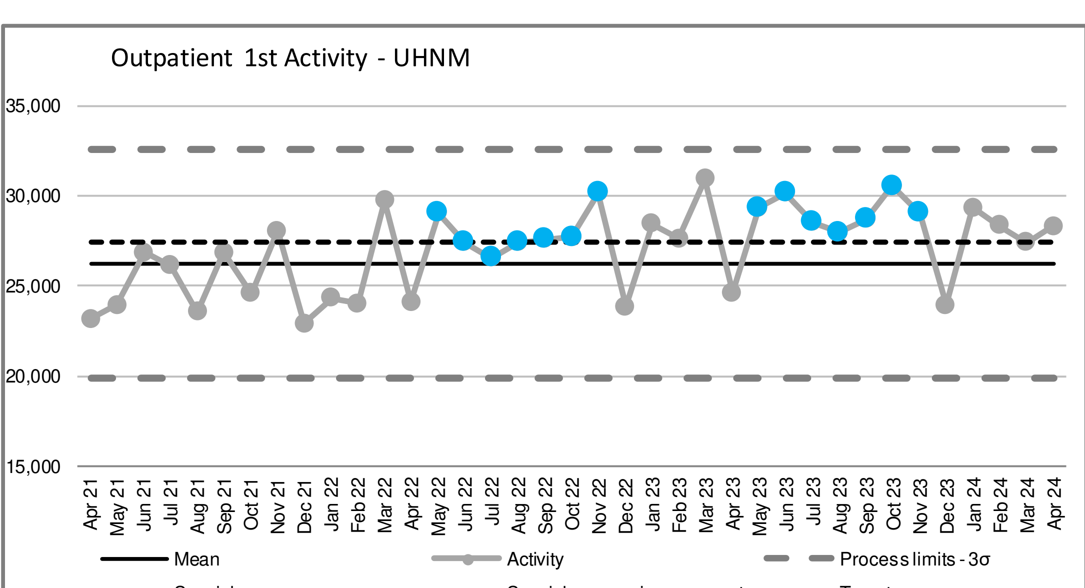
Theatres:
Capped utilisation has dropped slightly but continues on a relatively unchanged trajectory (76.73%) as does total number of elective operations (2005).
Cancelled ops remains below 24mnth mean but above plan.
Inclusion of STS and CTS activity where appropriate will capture productivity improvements resultant of ERF bids. Assessment of Utilisation criteria for these areas is underway to ensure reporting is consistent.
Delays and Cancellations are the prevailing hinderance to improved productivity evidenced in the case opportunities linked to late starts, early finishes and OTD cancellations.

What are we doing about it?

- Established Perioperative Care Working group and sub delivery groups. ERF Bid for delivery of increased Pre-Ams capacity & Project Management. Reduce delays and cancellations
- STS Phase 1 operational & BC reviews underway – to establish increased activity opportunity
- County Elective Hub – Operational meetings diarised to facilitate increased activity
- County Elective Hub Productivity subject of Theatres A3 – to improve productivity
- Pilot of Stand-by Pts commenced for Gynae & Urology LA cases – backfill cancellations/DNA's
- Theatre Directorate developing A3 on "Golden Patient " – to reduce delays
- Start times - Reinforcing the default sending times - to reduce delays
- Scheduling feeding into 6,,4,2 oversight meeting with an established weekly view of 15 best and worst performing lists and a dashboard of monitored lists driving informed action at TPG
- A3 of Surgical Flow developed aimed at reducing delays and cancellations

Resources | Outpatient First Appt

Getting the most from our resources including staff, assets and money



Variation	Assurance
	?

Target	Feb 24	Mar 24	Apr 24
variable	28,352	27,423	28,333

Background

The number of 1st Outpatient appointments at the Trust each month

What is the data telling us?

Activity saw a sustained increase vs 3 year mean from May to November 2023.

Whilst not specifying follow ups with/without procedure, this implies an improvement vs the new OP National Guidance metric: % of all outpatients that are firsts or follow ups with a procedure.

OP Cell 2024/25:
In order to “increase proportion of news / follow ups with a procedure”, effectively making ‘best use of available capacity’, the countermeasures will aim to address one or more of the following:

- Increase 1st appointments
- Reduce follow ups without a procedure

Any capacity released should therefore be used for additional new patients, or to address the long waits / backlog.

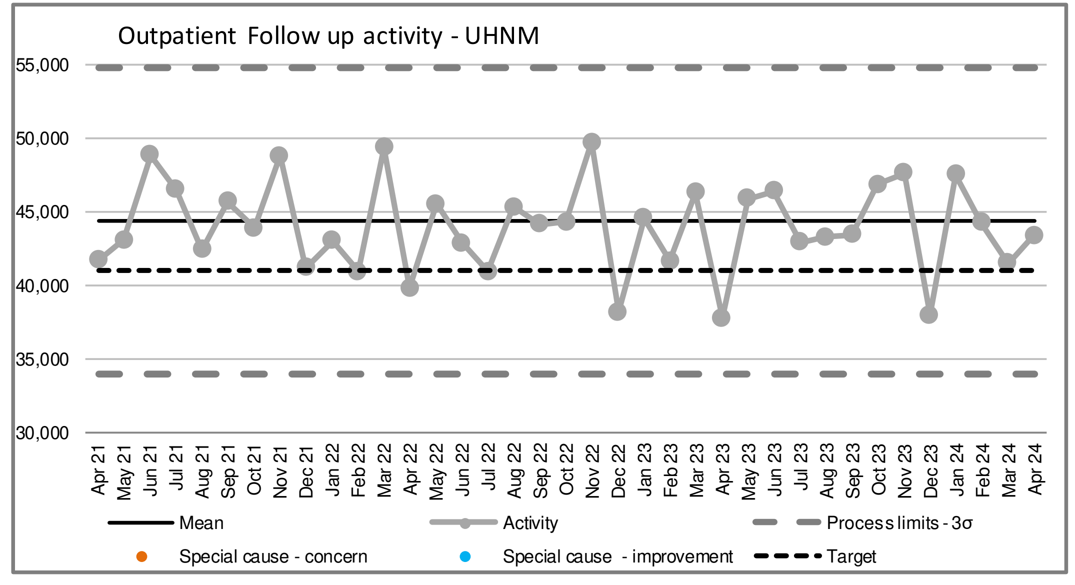
What are we doing about it?

Countermeasure	Potential impact	Latest performance	Update / Next Steps
Advice & Guidance (A&G)	Increase (or decrease?) first OP Support timeliness of patient care	Revised measures to be clarified	Advice & refer (triage by default) –scoping external support at System A&G Group 21/05/24
Patient initiated Follow Ups (PIFU)	Reduce follow ups (release capacity for backlog) Improve timeliness of patient service access when needed	April ’24: 5.4% ↑ (Mar ’24: 25th of 143 vs National: 3.0%)	Extend use of Move to PIFU in Ophthalmology. Clinical & Mgt meeting to be arranged with ENT based on NHSE benchmarking. Rollout RPA for PIFU Discharges at Review Date in Gynae
Clinic Utilisation	Increased throughput	April ’ 24 90.9% ↑ (Bookings 96.5% vs 96.3%, Missed Appts 6.5% vs 6.5%)	See Missed Appointments
Missed Appointments: • 2 Way messaging • Health Inequalities Audits	Release capacity for backlog (first & f up) (unless overbooked) Improve pt experience	n/a (see missed appointment rate)	• 2 Way Messaging; purchase order raised, go live June. • Health Inequalities Audits – benchmarking & initial analysis complete, scoping with specialty ahead of proposal for pilot.
Outcomes process review	Timeliness of next step	n/a	Scoping approach
Results Waiting List review	Timeliness of next step	n/a	Scoping approach
GIRFT Further Faster (ENABLER)	Reducing long waits	73% checklist actions reviewed	Various specific schemes (wider than Outpatients)

Resources | Outpatient Follow Up Appts

Getting the most from our resources including staff, assets and money

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	?

Target	Feb 24	Mar 24	Apr 24
variable	44,257	41,523	43,422

Background

The number of follow up outpatient appointments at the Trust each month

What is the data telling us?

No significant change at this level.

Whilst not specifying follow ups with/without procedure, this implies an improvement vs the new OP National Guidance metric: % of all outpatients that are firsts or follow ups with a procedure.

OP Cell 2024/25:
In order to "increase proportion of news / follow ups with a procedure", effectively making 'best use of available capacity', the countermeasures will aim to address one or more of the following:

- Increase 1st appointments
- Reduce follow ups without a procedure

Any capacity released should therefore be used for additional new patients, or to address the long waits / backlog.

What are we doing about it?

Countermeasure	Potential impact	Latest performance	Update / Next Steps
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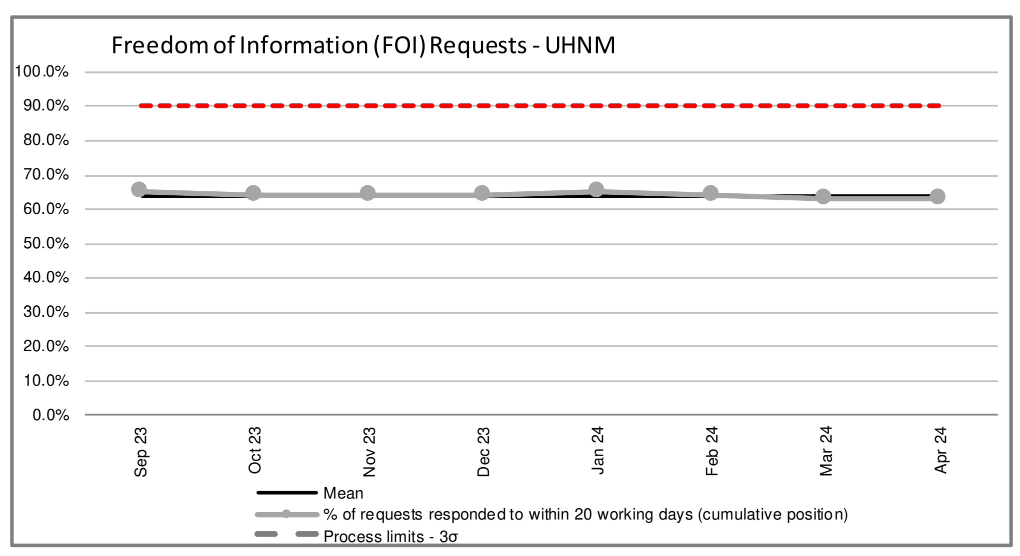
Resources

Resources | Freedom of Information Performance

Getting the most from our resources including staff, assets and money



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
90%	64%	63%	63%

Background

Freedom of Information Act requires 90% of requests to be responded within 20 working days

What is the data telling us?

The turnaround time is set at 20 working days as per the FOI Act.

The turnaround times for responding to Freedom of Information (FOI) requests is below the 90% target.

The data shows performance remains static at 63% – 64% with little evidence of improvement since September 2023.

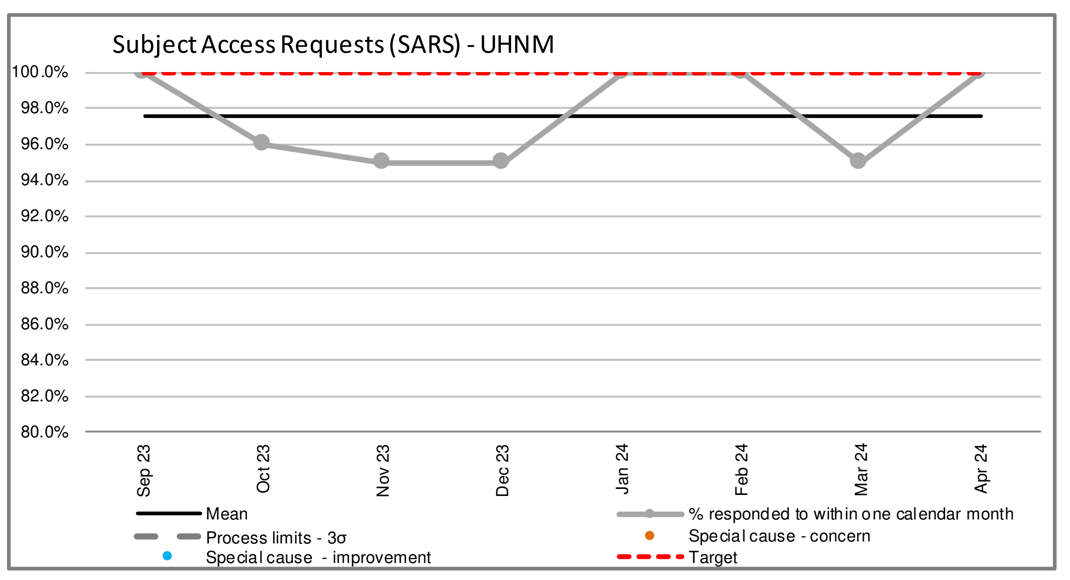
What are we doing about it?

A task and finish group has been established to review the process and identify areas for improvement:

- A triage checklist has been developed and implemented to ensure the FOI request is sent to the correct team.
- Identified FOI champions have been nominated for Estates, Facilities PFI and Central Functions who co-ordinate FOI requests on behalf of their Directorate/Division.
- A digital system has been procured following consultation with key stakeholders. The Data, Security & Protection team are currently developing a project plan ready for implementation.
- A review of the disclosure log will be undertaken alongside the implementation of the digital system. The aim will be to make the disclosure log more intuitive for the requestor and hence reduce the need to make a formal FOI request.

Resources | Subject Access Request Performance

Getting the most from our resources including staff, assets and money



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
100.0%	100.0%	95.0%	100.0%

Background

Data Protection Act requires subject access requests (SARs) to be responded within one calendar month. The figure includes Health Records/ CCTV/ Staff records plus information contained within emails

What is the data telling us?

The Data Protection Act states all SARs must be responded to within one calendar month unless an extension is agreed with the requestor (for more complex requests).

Overall we are averaging 98% in meeting subject access requests (SARs) within one calendar month.

The number of subject access requests continues to increase.
The People Directorate, who co-ordinate staff subject access requests are experiencing several complex cases which is impacting on the response times.

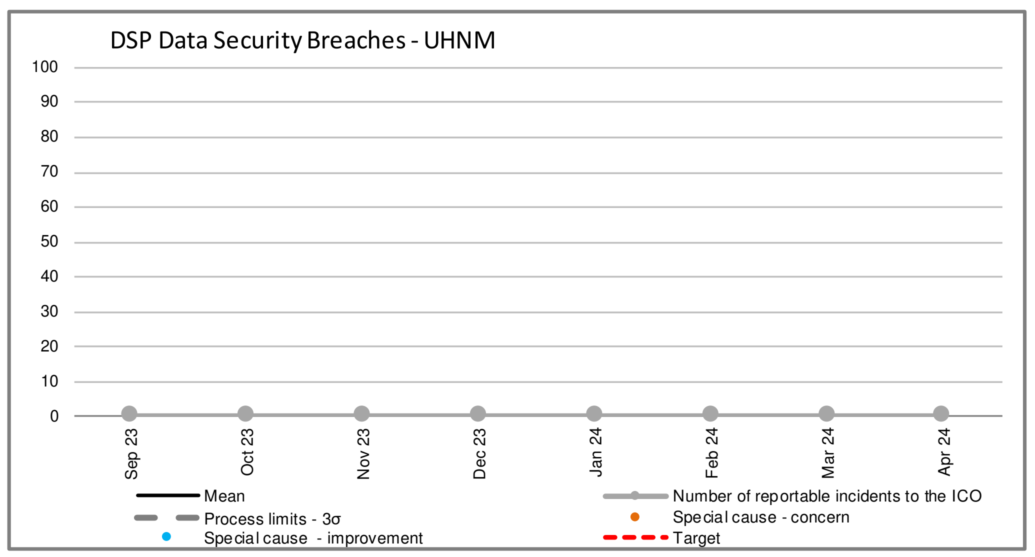
What are we doing about it?

The Data, Security & Protection team are implementing a digital system for Freedom of Information Requests. This will also suppose the management of SARs. The People Directorate have agreed to move to the digital solution. This will facilitate a review of practice across DSP/Health Records and People Directorate in the management of SARs with the aim of standardising practice across the Trust.

A project plan is being developed (as per the detail outlined on the FOI slide).

Resources | Data Security Breaches

Getting the most from our resources including staff, assets and money



Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
0	0	0	0

Background

A serious incident (as per ICO) guidance must be reported to the ICO

What is the data telling us?

A data security breach must be reported to the Supervisory Authority; the Information Commissioner's Office (IC), if it meets the ICO criteria threshold.

Since September 2023 we have not reported any serious security breaches to the ICO.

What are we doing about it?

A governance and assurance programme is in place to support staff in understanding Data, Security & Protection (DSP) and hence minimise a data security breach.
Policies and Standard Operating Procedures, which are reviewed in line with latest/best practice.
Statutory and Mandatory training
DSP manual, outlining key material to support staff in their day-to-day duties.
Training awareness survey to identify staff's understanding of DSP.
Dedicated training material, for example Information Asset Owners, responsible for the management of digital systems.
Data Protection Officer (DPO) review of DSP incidents to assess if they meet the threshold for reporting.

Resources | Digital Project Delivery Lifecycle

Getting the most from our resources including staff, assets and money

	Progress Status					
Project Priority	COMPLETE	IN PROGRESS	MOVED TO BAU	NOT STARTED	ON HOLD	Grand Total
Essential	1	17	3	7	5	33
Essential – Proof of Concept (PoC)			1	6		7
Mandated		23	2	21	11	57
Other - High Priority		4		4	3	11
Other - Low Priority	1	1	1	3	8	14
Other - Medium Priority				5	1	6
Parked					1	1
PoC					1	1
TBC		1		3		4
Grand Total	2	46	7	49	30	134

Variation	Assurance

Target	Feb 24	Mar 24	Apr 24
N/A	-	-	125

Background

There is no specific overarching target for the Digital Project Delivery Lifecycle however the count provided above identifies the number of projects presently on the IM&T project pipeline with a status of In Progress, Not Started or On Hold. The adjacent table and associated narrative describes the status and priority of all IM&T projects for 2024_25.

What is the data telling us?

There are currently 46 IM&T projects that are in progress. 2 projects have been completed during April 2024 and 7 have been transferred to BAU. 79 projects have either not started or are currently on hold. It is noted that based on project delivery during 2023_24 where 69 projects were either completed or moved to BAU, there is already a large volume of IM&T projects slated for delivery during 2024_25.

What are we doing about it?

To ensure that projects are prioritised correctly, IM&T will periodically undertake a review of priorities utilising a defined scoring mechanism based on criteria such as alignment to national/local strategy, benefits and risk reduction. IM&T have also introduced a new project request process and are also developing a new Project Management tool to provide a centralised view and oversight of IM&T projects in addition to associated standardised project management processes.

Resources | Financial Summary

Getting the most from our resources including staff, assets and money

This report presents a high level summary of the financial performance of the Trust for April (Month 1).

Key elements of the financial performance for month 1 are:

- For the first month of 2024/25 the Trust has delivered a deficit of £3.0m against a planned deficit position of £0.1m; this is a negative variance of £2.9m. The £2.9m adverse variance is within pay £1.6m and non-pay £1.9m. The overspend is pay and non-pay is primarily driven by the undelivered CIP.

- The Trust has a CIP target of £56.6m. Whilst no CIP has been transacted at month 1; performance to date suggests a contribution of £1.4m given a CIP target in month of £4.4m however until schemes have been fully validated it suggests these are non-recurrent in nature.

- A revised capital plan including expenditure will be included in the month 2 report.

- The cash balance at Month 1 was £81.6m. The cash balance is £2.6m higher than the planned £79.0m.

Resources | Income and Expenditure

Getting the most from our resources including staff, assets and money

The Trust has delivered a £3.0m deficit for month 1. The £3.0 deficit is £2.9m below the planned deficit of £0.1m. The table below summarises the I&E position at Month 1.

Income & Expenditure Summary Month 1 2024/25 £m	Annual Budget	Month 1 Budget	Month 1 Actual	Month 1 Variance
Income From Patient Activities	1,045.2	87.3	87.5	0.2
Other Operating Income	83.0	7.0	7.0	0.1
Total Income	1,128.2	94.3	94.6	0.2
Pay Expenditure	(686.8)	(56.9)	(58.4)	(1.5)
Non Pay Expenditure	(407.9)	(34.7)	(36.6)	(1.9)
Total Operational Costs	(1,094.7)	(91.6)	(95.0)	(3.4)
EBITDA	33.5	2.7	(0.4)	(3.2)
Interest Receivable	3.9	0.3	0.6	0.2
Non operating expenditure	(37.4)	(3.1)	(3.1)	(0.0)
Surplus / (Deficit)	(0.0)	(0.1)	(3.0)	(2.9)

Key issues to note within the Month 1 position include the following.

- The major variance at Month 1 is.
  - Pay is overspent by £1.5m. The overspend is mainly due to the undelivered CIP.
  - Non-Pay is overspent by £1.9m. The overspend is mainly due to the undelivered CIP.

Resources | CIP

Getting the most from our resources including staff, assets and money

The Trust has a £56.6m CIP target for 2024/25. The CIP target have been phased equally throughout the year except for the Investment slippage scheme £5.0m and the additional CIP to breakeven £10.2m. The table below summarises the allocated targets.

CIP Savings Target by Month 2024/25	Annual Target	Mn 1	Mn 2	Mn 3	Mn 4	Mn 5	Mn 6	Mn 7	Mn 8	Mn 9	Mn 10	Mn 11	Mn 12
Divisional position													
Medicine & Urgent care	3.9	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Surgery, Theatres & Critical Care	3.6	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Network services	2.8	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Womens, Childrens & Clinical Support Services	2.6	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Central functions	1.6	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Estates, Facilities & PFI	1.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
North Midlands & Cheshire Pathology Services	1.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Divisional CIP	16.6	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4
Pay Underspend	6.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Bank interest	2.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Energy savings	3.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Investment slippage	5.0	1.0	1.0	0.6	0.6	0.6	0.6	0.1	0.1	0.1	0.1	0.1	0.1
Other non recurrent	5.0	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
To be identified	2.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Additional CIP to 4% of cost base	6.3	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Additional CIP to achieve breakevem	10.2							0.9	0.9	0.9	0.9	0.9	0.9
Total CIP	56.6	4.4	4.4	4.0	4.0	4.0	4.0	4.4	4.4	4.4	4.4	4.4	4.4

The table below highlights the phasing of the CIP plan through the year and split between income pay and non-pay.

2024/25 CIP target phasing	Annual Target	Mn 1	Mn 2	Mn 3	Mn 4	Mn 5	Mn 6	Mn 7	Mn 8	Mn 9	Mn 10	Mn 11	Mn 12
Income	2.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Pay	14.0	1.6	1.6	1.3	1.3	1.3	1.3	0.9	0.9	0.9	0.9	0.9	0.9
Non Pay	40.6	2.6	2.6	2.5	2.5	2.5	2.5	4.2	4.2	4.2	4.2	4.2	4.2
Total CIP target	56.6	4.4	4.4	4.0	4.0	4.0	4.0	5.3	5.3	5.3	5.3	5.3	5.3

Resources | Conclusion

Getting the most from our resources including staff, assets and money

The Trust I&E position is £2.9m adverse variance to the 2024/25 plan at month 1. The variance is primarily driven by the undelivered CIP position. The PMO is continuing to collaborate with the divisional team to develop and delivery robust saving plans.

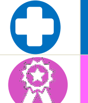
Executive Summary

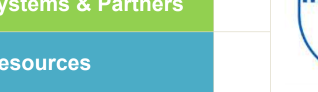
Meeting:	Trust Board (Open)	Date:	5th June 2024
Report Title:	Fit and Proper Persons Annual Assurance 2023/24	Agenda Item:	13.
Author:	Nicola Hassall, Deputy Associate Director of Corporate Governance		
Non-Executive / Executive Leads:	David Wakefield, Chair		

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

	No associated risks identified	

Executive Summary:

Situation

This paper provides the Board with an update on the actions undertaken to complete the annual fit and proper persons checks in line with the revised NHS England Fit and Proper Person Test Framework for Board Members (2023) and requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The report is being presented to the Trust Board in accordance with the guidance, whereby it is suggested that the results are considered in the public domain, on an annual basis, for information.

Background

Following the updated framework being published in September 2023, updates in relation to implementation of the revised Fit and Proper Person Test (FPPT) Framework have been considered by the Nomination and Remuneration Committee. This paper summarises the checks which have been undertaken on all Board Members (irrespective of voting rights).

Assessment

The process to undertake all relevant checks as part of the revised Fit and Proper Person Guidance commenced in January 2024, and this incorporated all Board Members completing the Fit and Proper Persons Test Self-Attestation. Additional checks were subsequently undertaken and reviewed by the Deputy Associate Director of Corporate Governance. Subsequently, the outcome of the checks were reviewed by the Chair (for the Chief Executive and Non-Executives), Chief Executive (for Executives) and Senior Independent Director (for the Chair). These checks were undertaken for 19 Board Members, the outcomes of which were included on the Electronic Staff Record (ESR). In addition, two on appointment checks have been undertaken for a Non-Executive Director and the incoming Chief Executive.

In conclusion, the Chair has determined that 17 / 19 Board Members have met all the requirements of the Fit and Proper Persons Test Framework. It should be noted that for 2 Board members, a 3 yearly updated Disclosure and Barring (DBS) check remains outstanding. Therefore, if the DBS checks for the 2 Board members are not received before the deadline of 30th June, further guidance will be sought from NHS England and the required next steps.

Key Recommendations:

The Trust Board is asked to note the contents of the paper and record that the Fit and Proper Persons Test checks have been conducted for the period 2023/24 and that 17 / 19 Board members satisfy the requirements. Further

consideration will be given to next steps if the 2 outstanding DBS checks are not received before the deadline of 30th June 2024.

High Quality	Responsive	People	Improving & Innovating	System & Partners	Resources

Fit and Proper Persons Annual Assurance Report 2023/24

1. Background

Previously, the Care Quality Commission identified eight requirements within Fit and Proper Person Regulation 5 of the Health and Social Care Act 2008 (regulated Activities) Regulations (2014). The new FPPT Framework takes these requirements in account, but also builds upon the seven recommendations made by the Kark Review. The framework suggests that the results of the annual checks on Board members, are considered in by the Trust Board in the public domain, therefore this paper provides a summary of the checks undertaken to inform the Chair's conclusion in confirming whether Board Members are fit and proper.

2. Annual Assurance Checks

The following is undertaken on an annual basis and was completed by the Deputy Associate Director of Corporate Governance between January and May 2024:

- Confirmation of Fit and Proper Person Signed Self-Attestation
- Confirmation of DBS Disclosure (undertaken every 3 years)
- Professional Register Check (if applicable - Executives only)
- Checks in relation to Insolvency, CCJ, Disqualified Directors Register, Disqualification from being a Charity Trustee & Employment Tribunal Judgement
- Social Media Check
- Confirmation of any Disciplinary Findings or Grievances (outstanding, upheld or discontinued in relation to gross misconduct, serious misconduct or mismanagement)
- Confirmation of any Whistleblowing Claims
- Confirmation of any Behaviours not in accordance with organisational values and behaviours or related local policies
- Confirmation of any Settlement Agreements
- Confirmation of Last Appraisal
- Confirmation of annual training and development (Executives only)

3. On Appointment Checks

The following is undertaken prior to a Board member commencing in post, and has been undertaken for the appointment of a Non-Executive Director and incoming Chief Executive:

- Standard employment checks including application form, curriculum vitae (including career history of at least 6 years, covering at least two roles, stating organisations/ departments, dates and role descriptions and gaps in employment, job description and person specification, interview and selection pack, conditional offer and acceptance letters and copies of qualifications, medical clearance, verified evidence of right to work in the UK, working time regulations opt out and contract
- References requested via the Board Member Reference Template
- Declaration of Interest Form
- Signed Fit and Proper Person Self-Attestation

- DBS Disclosure
- Professional Register Check (if applicable - Executives only)
- Confirmation of Checks: Insolvency, CCJ, Disqualified Directors Register, Disqualification from being a Charity Trustee & Employment Tribunal Judgement
- Social Media Check

4. Outcome of the Annual Fit and Proper Persons Checks

Following completion of the above, 17 / 19 Board members were confirmed as fit and proper by the Chair (for the Chief Executive and Non-Executives), Chief Executive (for Executives) and Senior Independent Director (for the Chair).

It should be noted that for 2 Board members, a 3 yearly updated Disclosure and Barring (DBS) check remains outstanding (all other checks have been confirmed). Therefore, if the DBS checks for the 2 Board members are not received before the deadline of 30th June, further guidance will be sought from NHS England and the required next steps.

The results of the checks and subsequent agreement with the Chair have also been confirmed on the Electronic Staff Record (ESR) and relevant information / evidence saved within each personnel file.

5. Conclusion

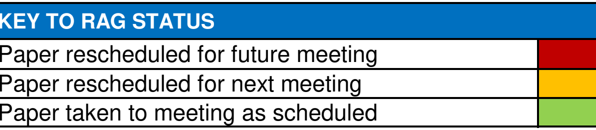
17 / 19 Board Members of the Trust Board satisfy the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test. The 2 remaining Board members are required to provide evidence of an updated DBS check, although all other checks have been completed.

6. Recommendation

The Trust Board is asked to note the contents of the paper and record that the Fit and Proper Persons Test checks have been conducted for the period 2023/24 and that 17 / 19 Board members satisfy the requirements. Further consideration will be given to next steps if the 2 outstanding DBS checks are not received before the deadline of 30th June 2024.

Trust Board

2024/25 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
		3	8	5	10	7	4	9	6	4	8	5	12
HIGH QUALITY													
Chief Executives Report	Chief Executive												
Patient Story	Chief Nurse		Staff			Staff			Staff			Staff	
Quality Governance Committee Assurance Report	Director of Governance			NA									
Quality Strategy Update	Chief Nurse / Medical Director												
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												
RESPONSIVE													
Integrated Performance Report	Various												
Clinical Strategy Update	Director of Strategy												
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer												
PEOPLE													
Transformation and People Committee Assurance Report	Director of Governance			PCI									
People Strategy Update													
Gender Pay Gap Report	Chief People Officer												
Revalidation	Medical Director												
Workforce Disability Equality Report	Chief People Officer												
Workforce Race Equality Standards Report	Chief People Officer												
Staff Survey Report	Chief People Officer												
Raising Concerns Report	Director of Governance												
IMPROVING AND INNOVATING													
Research Strategy Update	Medical Director / Chief Nurse / Director of Strategy												
SYSTEM AND PARTNERS													
System Working Update	Chief Executive / Director of Strategy												
Population Health and Wellbeing Strategy	Director of Strategy												
RESOURCES													
Performance and Finance Committee Assurance Report	Director of Governance			N/A									

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		3	8	5	10	7	4	9	6	4	8	5	12
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above	Director of Strategy	NA											
Estates Strategy Update	Director of Estates, Facilities & PFI												
Digital Strategy Update	Chief Digital Information Officer												
Going Concern	Chief Finance Officer												
Annual Plan	Director of Strategy												
Board Approval of Financial Plan	Chief Finance Officer												
Final Plan Sign Off - Narrative/Workforce/Activity/Finance	Chief Finance Officer												
Activity and Narrative Plans	Director of Strategy												
Capital Programme 2022/23	Chief Finance Officer												
Standing Financial Instructions	Chief Finance Officer												
Scheme of Reservation and Delegation of Powers	Chief Finance Officer												
GOVERNANCE													
Nomination and Remuneration Committee Assurance Report	Director of Governance												
Fit and Proper Persons Annual Assurance Report	Director of Governance												
Audit Committee Assurance Report	Director of Governance												
Trust Strategy	Director of Strategy												
Board Assurance Framework	Director of Governance												
Annual Evaluation of the Board and its Committees	Director of Governance												
Annual Review of the Rules of Procedure	Director of Governance												
Board Development Programme	Director of Governance												
Well-Led Self Assessment	Director of Governance												
Risk Management Policy	Director of Governance												
Complaints Policy	Chief Nurse												