University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 5th July 2023 at 9.30 am to 11.40 am
Via MS Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Staff Story	Information	Mrs J Haire	Verbal	
5 mins	**2.**	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 7th June 2023	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
10 mins	**6.**	Chief Executive's Report – June 2023	Information	Mrs T Bullock	Enclosure	
10:05		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (29-06-23)	Assurance	Prof A Hassell	Enclosure	1
15 mins	**8.**	Care Quality Commission – Maternity Inspection	Assurance	Mrs AM Riley	Enclosure	1
10:25		**PEOPLE**				
5 mins	**9.**	Transformation and People Committee Assurance Report (28-06-23)	Assurance	Prof G Crowe	Enclosure	2, 3, 4, 6, 9
10:30		**RESOURCES**				
5 mins	**10.**	Performance & Finance Committee Assurance Report (27-06-23)	Assurance	Ms T Bowen	Enclosure	5, 7, 8
10:35 – 10:50 COMFORT BREAK						
10:50		**RESPONSIVE**				
40 mins	**11.**	Integrated Performance Report – Month 2	Assurance	Mrs AM Riley Mr S Evans Mrs J Haire Mr M Oldham	Enclosure	1, 2, 3, 5, 8
11:30	**CLOSING MATTERS**					
10 mins	**12.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
	13.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 3rd July to** Nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
11:40	**DATE AND TIME OF NEXT MEETING**					
	14.	**Wednesday 2nd August 2023, 9.30 am, Trust Boardroom, Royal Stoke**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 7th June 2023 at 9.30 am to 12.10 pm via MS Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman (Chair)												
Mr P Akid	PA	Non-Executive Director												
Mrs T Bowen	TBo	Non-Executive Director												
Mrs T Bullock	TB	Chief Executive												
Mr P Bytheway	PB	Chief Operating Officer			KT									
Prof G Crowe	GC	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Dr M Lewis	ML	Medical Director												
Prof K Maddock	KM	Non-Executive Director												
Professor S Toor	ST	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse												

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

In Attendance:		
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mrs R Pilling	RP	Head of Patient Experience (item 1)
Mr Alex Smith	AS	Patient Representative (item 1)
Mrs K Thorpe	KT	Deputy Chief Operating Officer

Members of Staff and Public: 3

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
081/2023	Mrs Pilling introduced Mr Smith to the Board, who had been invited to discuss the care of his identical twins who were born prematurely at UHNM. He explained that at 20 weeks a possible abnormality was identified on one twin and they were referred to Birmingham Women and Children's Hospital whereby a congenital heart defect was identified. He stated that his wife was admitted to Ward 205 following one twin having torn waters and the babies were subsequently born via emergency caesarean section. He commented that despite the emergency situation, staff were calm and the family were put at ease, with explanations provided of what was happening to the twins before they were transferred to the	

Neonatal Intensive Care Unit (NICU).

Mr Smith explained that when visiting the twins in NICU, staff demonstrated their compassion and were supportive and added that the twins were moved to the lower dependency unit after a week which felt busier and due to the changes in staff to patient ratio, the staff seemed more pressured. He explained that after finding their babies in soiled sheets, he discussed this with the staff and they were invited to move into live in accommodation which he welcomed. He explained that they stayed on the unit due to continuing to have problems whereby one of the twins, Louie, had low oxygen saturation and one night he stopped breathing at which point the crash team were called. He described the ongoing tests which were undertaken to establish the causes for Louie's problems and following discharge the family were provided with guidance on how to care for Louie.

Mr Smith welcomed the thoroughness of the antenatal checks which initially identified the problem and without which he believed his son would not have survived. He also welcomed the aftercare and support, collaboration between UHNM and Birmingham and the mobilisation of the delivery team for the emergency caesarean section which was undertaken in a calm and collected way. Mr Smith particularly gave thanks to Consultant Neonatologists Lee Abbott and Jyoti Kapur.

Mr Smith noted his experience was overwhelmingly positive and he was extremely grateful to the Neonatal Service at UHNM for the care they gave to him, his wife and their two boys.

Dr Lewis thanked Mr Smith for sharing the story and referred to the pressures on the neonatal team and the previous attention spotlighted on the unit when things did not go as well which is the exception. He therefore appreciated Mr Smith's story providing balance.

Ms Bowen referred to the move of the twins to the lower dependency room and queried whether the transition was explained sufficiently. Mr Smith stated that the reason for the transfer was discussed with the family and it was seen as a celebration by all parents as a reflection on how well the babies were doing.

Dr Griffin thanked Mr Smith for the story and he queried if their continuing care and support was going well. Mr Smith explained that Louie had received corrective surgery and would always require monitoring.

Mrs Haire queried the support provided by UHNM to Mr Smith as a dad and employee and he explained that he took paternity leave and annual leave and welcomed the support and flexibility provided to him by his manager.

Professor Toor welcomed Mr Smith sharing the story with the Board and the balance provided. She also welcomed the holistic support provided by the team which was often overlooked.

Mrs Thomson explained the way in which Mr Smith had supported UHNM Charity with ideas to improve the environment in neonates and thanked him for his support.

Mrs Riley referred to the staffing changes as the babies moved to the different rooms and queried if the reasons for the change in staffing levels were explained. Mr Smith stated that change in staffing to patient ratio was not explained and Mrs Riley agreed to pick this up with the team so that explanations could be provided to families to reduce possible stress.

	Mr Wakefield thanked Mr Smith for the story and welcomed the news that the babies were thriving. He welcomed the diligence of the team and whilst being a frightening time for parents, he welcomed Mr Smith's comments in terms of the calmness and compassion shown by the team. Mr Smith and Mrs Pilling left the meeting. **The Trust Board noted the patient story.**	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
082/2023	Mr Wakefield welcomed Board members to the meeting. Apologies were received as recorded above, and the meeting was confirmed as quorate. Mr Wakefield welcomed Mrs Rodwell to her first meeting as Associate Non-Executive Director.	
3.	**Declarations of Interest**	
083/2023	There were no declarations of interest raised.	
4.	**Minutes of the Previous Meeting held 3rd May 2023**	
084/2023	Mrs Riley agreed to amend the fourth paragraph on page 4, referring to the improvement actions, to read: "Immediate actions were put into place and the Trust confirmed with the CQC that there were no *subsequent* **ac**tions to be taken …". With the exception of the above amendment, the minutes of the meeting held 3rd May 2023 were approved as a true and accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
085/2023	No further updates were provided.	
6.	**Chief Executive's Report – May 2023**	
086/2023	Mrs Bullock highlighted that the Trust had been notified that ballots had been issued from the British Dental Association and Society of Radiographers to consider strike action and the ballot for Consultant strike action was due to close imminently. Dates for Junior Doctor Strike action had been confirmed as 14th to 17th June and this was being planned for as per previous strikes. She added that she had also been made aware of strike action taking place on 12th June by the Ambulance Service. Mrs Bullock highlighted the Trust had appointed Mr Rob Irving as Freedom to Speak Up Guardian and stated that Mr Bytheway had resigned from his post as Chief Operating Officer and thanked Mr Bytheway for his significant contribution to UHNM which was outlined in more detail in her report. She explained that an interim appointment had been secured and the date for commencement would be issued once confirmed. The recruitment process for the substantive appointment was to commence following the Nominations and remuneration Committee later today. Mrs Bullock explained that the Same Day Emergency Care business case had received national approval for capital and revenue, although the total revenue was still being clarified. The full business case was due to be considered by the	

	Performance and Finance (PAF) Committee. Mrs Bullock also noted the 24/7 deli at Royal Stoke had been formally opened. Mrs Rodwell referred to the tier 1 process and queried the timelines associated with the actions being taken. Mrs Bullock stated that various and numerous pieces of work were underway and some actions were being taken immediately whilst some were medium and longer term therefore no one timeline could be given, however; further detail would be provided when discussing the performance report. Mr Wakefield referred to the tier 1 meetings and queried if there were any benefits from the meetings. Mrs Bullock stated that the weekly meetings with NHS England provided intense scrutiny on the number of patients waiting. **The Trust Board received and noted the report and approved eREAF 10811.**	
HIGH QUALITY		
7.	**Quality Governance Committee Assurance Report (01-06-23)**	
087/2023	Professor Hassell highlighted the following: • The medicines optimisation and safety report highlighted risks in relation to medicines supply chain although the Committee were assured of the mitigations in place. The risk related to the number of trained staff to deliver aseptic products was also highlighted. The Committee welcomed the achievement of the antimicrobial CQUIN, the support provided by the pharmacy team and the successful bid to recruit additional pharmacy technicians. • The Committee welcomed the paper presented in relation to the NHS Oversight Framework and in particular the exit criteria • The Committee welcomed the planned annual mortality report and whilst the Summary Hospital-level Mortality Indicator (SHMI) remained in the expected range, it had increased and national advice had been sought with regards to establishing the actions required Mr Wakefield referred to the delay in the Electronic Prescribing and Medicines Administration (EPMA) system and requested clarification of the reason for this. Mrs Freeman highlighted that the data from EPMA system was not transferring into the discharge summary as planned and therefore required review. **The Trust Board received and noted the assurance report.**	
8.	**2022/23 Quality Account**	
088/2023	Mrs Riley stated that the Quality Account had been developed and stakeholder comments had been received except from Healthwatch and commented that it was due to be published on the website by 30th June. Professor Maddock referred to the KPIs in the document and requested clarification that these were to be included to which Mrs Riley explained that they would be updated prior to publication. Ms Bowen referred to the section on clinical research and the Advanced Clinical Practitioners (ACP) strategy and queried how the Trust compared to peers for clinical research in this area. Mrs Riley highlighted that significant improvements had been made in expanding on the number of research opportunities for nursing and Allied Health Professional staff and outlined the work and success of the	**AMR**

	CeNREE (in full please). However, she also noted there was still more work to do to ensure the Trust was delivering research to the level it aspired. Dr Lewis stated that the research output overall needed to improve and as such recruitment had been made to a new managing director to take forward and deliver the Research Strategy. Ms Bowen referred to the reference to the quality of the data and given the outcomes of the external review whether the Board could be assured regarding this. Mrs Bullock stated that the independent review confirmed that data was accurate but there were differences in the way in which the data was used for reporting so was able to provide that assurance. Dr Griffin suggested that the content regarding further developments could be expanded upon and that the table of quality performance could refer to projections, rather than targets. Mr Wakefield referred to the section on complaints and queried if Mrs Riley was happy with the current processes for complaints. Mrs Riley stated that a review was underway which was due to complete in quarter 1, the outcome of which would be considered by the Quality Governance Committee (QGC) in July / August 2023. Mr Wakefield referred to the number of people accessing Emergency Medicine and Mrs Cotton explained that the numbers would be clarified as they related to different types and portals. **With the exception of the above comments, the Trust Board approved the 2022/23 Quality Account.**	**AMR**
9.	**Q4 Infection Prevention Board Assurance Framework**	
089/2023	Mrs Riley highlighted the following: • The business case for cleaning standards had been written and was going through due process • Fit testing for staff was to be managed centrally via the Infection Prevention team • Since April requirements for asymptomatic screening had ceased and this was to be undertaken for those with symptomatic respiratory symptoms or admitted to areas with clinically vulnerable patients • A new template had been received in May and was being reviewed, which moved away from Covid and was more in line with the 10 infection prevention standards. • A review of mask wearing in clinical areas was to be finalised and it was expected to move back to normal, and only wear masks in specific circumstances. **The Trust Board received and noted the document.**	
10.	**Maternity Quality Governance Committee Assurance Report (23-05-23)**	
090/2023	Professor Hassell welcomed the Patient Story and positive tribute to the neonatal and maternity department and highlighted the following: • The maternity services survey identified 3 areas for improvement and these were outlined. In addition the positive experiences were highlighted • Maternity dashboard for quarter 4 remained below target in a number of areas and these were outlined	

	• The percentage of women undergoing induction of labour was high and the reasons for this were outlined, such as an increase in mothers with diabetes, changes in guidance regarding overdue pregnancies and promotion of early birth to avoid stillbirth • The Committee welcomed the presentation from a bereavement midwife which provided significant assurance in respect of the service provided Ms Bowen referred to the action regarding challenges and risks with the medical workforce and requested clarity regarding timelines. Dr Lewis stated that work was being carried out and worked up in terms of a business case for additional staffing and a further update on the neonatal action plan was to be considered by the QGC in June 2023. Dr Griffin queried if there were any trends associated with the percentage of women who smoke, as this was above the national average in addition to the percentage of women with gestational diabetes. Mrs Riley agreed to establish the comparisons with national averages. **The Trust Board received and noted the assurance report.**	**AMR**
11.	**Maternity Serious Incident Report**	
091/2023	Mrs Riley explained that a summary had been provided of the number of incidents reported, and that a fuller report had been considered by the Maternity QGC. **The Trust Board received and noted the report.**	
PEOPLE		
12.	**Transformation and People Committee Assurance Report (31-05-23)**	
092/2023	Professor Crowe highlighted the following: • Positive assurance and updates were provided in relation to the approach to medical education and wraparound support for postgraduate and junior doctors. In addition positive assurance was provided regarding the dedication and commitment of the team to improve • There had been an increase in instances of physical assaults reported to staff from patients requiring dedicated security presence, although most instances were of low or no harm • In terms of statutory and mandatory training, the Committee received assurance of the work undertaken to understand how the Trust's approach compared to peers including the setting of target levels. As such actions were being taken to identify a trajectory for improvement • The Trust was above the 3.7% pay spending cap in relation to agency spending and the Committee noted the challenges associated with the ability to achieve this **The Trust Board received and noted the assurance report.**	
RESOURCES		
13.	**Performance & Finance Committee Assurance Report (30-05-23)**	
093/2023	Dr Griffin highlighted the following: • Work remained ongoing with the process to review business cases post implementation	

	• An update on medicines highlighted a spend of £1 in every £10 on medication which had increased significantly over the years, particularly due to the use of specialised commissioning drugs • The Committee noted the actions being taken to enhance theatre productivity and welcomed the information provided in relation to the NHS Oversight Framework **The Trust Board received and noted the assurance report.**	
RESPONSIVE		
14.	**Independent Review of Waiting List Management**	
094/2023	Mrs Bullock highlighted the following: • The report was commissioned due to the unexpected change in 78 week wait position • There were no surprises in the report and the reviewer noted the issues identified "were no different to other NHS Trusts", and the key issues related to differences in the interpretation of guidance • Difficulties with constant internal / external requests for additional reports / data had resulted in multiple reports referring to different data sets and times, although the data was accurate • A number of actions had been identified following the report which had been accepted and were in train and these had been graded in terms of their importance / urgency Mrs Thorpe highlighted the key recommendations relating to the rationalisation of waiting time reports and inclusion of fail safes within reports so that issues are identified immediately and actions taken. In addition, Mrs Thorpe stated that mass validation of patients in Care flow was underway. Mr Wakefield requested clarification regarding the comments made regarding the different dashboards being utilised and validation and Mrs Thorpe explained that this was a timing issue and whether data was pre or post validation. Professor Maddock queried how the actions were to be prioritised in addition to identifying the timelines. Mrs Thorpe stated that the action plan prioritised actions associated with patients who had waited a long time in the wrong part of a list and whether the issue would affect reporting of the 104 / 78 week position. Mrs Freeman referred to the use of dashboards and stated that sometimes this related to a filtering issue not just the timing of running the report. Ms Bowen queried whether there were any cost implications of accepting the recommendations and Mrs Bullock stated that there would be costs associated with some of the actions although these were not quantified as yet.. Dr Griffin referred to the commonalities with other Trusts and stated that this should be recognised by the system. He queried the confidence in the accuracy of current information and Mrs Thorpe stated that patients were expected to continue to 'pop up' into the reports, and the region was aware of this issue and that until validation had concluded the position could not be confirmed. Mrs Thorpe added that outpatient cancellations were being picked up via the outpatient cell to ensure patients were given notice for their appointments and Mrs Bullock added that the report had been shared with the Integrated Care Board (ICB) and would be shared with NHSE Midlands on Thursday although noted some verbal updates had been given with recognition that the issues identified	

	were similar to other Trusts. Professor Hassell queried once actions had been implemented if it was feasible to have an assurance thermometer of the accuracy of bottom line data. Mrs Thorpe stated that this indicator would be considered and added that a vital part was the fail safes and continuing to monitor the position given the possibility for human error. Professor Crowe welcomed the desire shown to understand the depth of the issues although acknowledged that the Trust was not yet assured of the position and this should be reflected on the risk register. He referred to the Trust's statutory obligations regarding data accuracy, governance and quality which should be taken into account as part of year end reporting. Mr Oldham stated that the internal audit programme was to be utilised to provide assurance in relation to data quality. Mr Wakefield welcomed the report and the actions being taken to provide one version of the truth and requested that an update on progress be provided to the Performance and Finance (PAF) Committee in due course. **The Trust Board noted the findings detailed in the report and supported initiation of a programme of work to take forward the actions, including the immediate priorities which needed to be addressed.**	
15.	**Integrated Performance Report – Month 1**	
095/2023	Mrs Riley highlighted the following in relation to quality and safety performance: • There had been some improvement in the friends and family test (FFT) • The number of serious incidents had reduced and a driver metric had been identified for each Division to reduce harm • Timely observations had remained static and a separate task and finish group was in place to review divisional A3s, the outcome of which was to be reported to QGC • In terms of overdue patient safety alerts, further assurance was to be included in report to QGC Mr Wakefield requested clarification in relation to the FFT improvements and Mrs Riley stated that whilst the position was improving further assurance was required in terms of consistency. Professor Maddock queried if the Trust was required to continue to report nosocomial data now it was not testing patients unless they were symptomatic and Mrs Riley stated that she had requested confirmation from the region on this. Mrs Thorpe highlighted the following in relation to urgent care performance: • Emergency Department conversion rates had slightly increased causing some issues with flow • Discharges remained static and there had been an increase in the length of stay of non-medically fit for discharge patients and a review of long length of stay patients was underway Mr Wakefield requested an update be provided to PAF on the numbers of patients with a long length of stay and how this compared to peers. Mr Wakefield commented that after the May Bank Holiday the Emergency Department became under increased pressure and suggested that further work	**KT**

be undertaken with GPs in terms of managing the message to patients.

Mrs Thorpe highlighted the following in relation to cancer performance:

- The 2 week wait position for April stood at 93.7% and May 93.9% for all tumour sites
- Performance against the 62 day standard for March was 62.21% and in April 60.18% with a deep dive being undertaken in relation to endoscopy
- The 28 day faster diagnosis standard for April was 65% unvalidated and this continued to be reported through the tier 1 process

Mr Wakefield queried how the Trust could solve the problem in relation to endoscopy and Mrs Thorpe stated that NHSE had undertaken a review to assist the Trust in determining the actions required. Dr Lewis stated that NHSE review was helpful and the Trust was focusing on surveillance cases, new referrals and ensuring endoscopies were only undertaken on appropriate patients. In addition work remained ongoing to improve the productivity of existing lists.

Mrs Thorpe highlighted the following in relation to planned care performance:

- Focus remained on the longest waiting patients and the Trust continued to utilise insourcing and additional staffing to reorganise lists to ensure patients were being prioritised correctly, with County Hospital being utilised where possible for elective work
- Actions were being undertaken with either a short or medium term timeline affecting different cohorts of patients
- The biggest risk related to orthopaedic and spinal patients as these patients often required treatment at Royal Stoke and were unsuitable for operations at County Hospital or the Independent Sector

Mr Wakefield referred to the expectation of reaching zero long wait patients by the end of June and Mrs Thorpe stated that the revised trajectory aimed to reach zero by mid-July although this would continue to be affected by patient suitability, patient choice and clinical presentation.

Mrs Thorpe stated that in relation to diagnostics performance the highest area of risk remained endoscopy. In terms of non-obstetric ultrasound, a trajectory had been agreed with NHSE and the waiting list was reducing due to the inclusion of additional capacity.

Mrs Haire highlighted the following in relation to workforce performance:

- The Trust was continuing to see an improving position with regards to vacancies and turnover and there had been a reduction in sickness absence
- The Being Kind large scale face to face events were to take place in June and July and were open to all colleagues, with 1000 colleagues booked on to date

Professor Crowe welcomed the recruitment campaign work being undertaken and colleague spotlights and stated that in terms of the Being Kind large scale events these were well framed and underlined the Trust's commitment to cultural improvement.

Mr Oldham highlighted the following in relation to financial performance:

- The Trust was £1 m behind plan at month 1 with cost improvement savings being the key driver for under-performance and the gap in identification of schemes
- £800,000 had been incurred due to continued use of winter escalation capacity and it had been assumed that discharge monies held by the ICB would be allocated to offset this although this carried risk

	• Cash was slightly behind plan, although some payments to be received were for the full year so this was not of concern Mr Wakefield queried if the Trust should be concerned at this stage in terms of the financial position and Mr Oldham stated that when the plan was agreed, it was noted that it was best case and with the risks and assumptions clearly articulated and advised that any risks coming to fruition would result in a difficultly to recover the position. **The Trust Board received and noted the performance report.**	
GOVERNANCE		
16.	**G6 & FT4 Self-Certification**	
096/2023	Mrs Cotton highlighted that the Trust had declared non-compliance due to the Care Quality Commission notices, waiting list challenges and underlying financial deficit. **The Trust Board confirmed the Trust's self-certification for G6 and FT4.**	
CLOSING MATTERS		
17.	**Review of Meeting Effectiveness and Review of Business Cycle**	
097/2023	No further comments were made.	
18.	**Questions from the Public**	
098/2023	No questions were received from the public.	
DATE AND TIME OF NEXT MEETING		
19.	**Wednesday 5th July 2023, 9.30 am, via MS Teams**	

Trust Board (Open)

Post meeting action log as at 29 June 2023

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/579	03/05/2023	Integrated Performance Report - M12	To provide a summary to board members of the nuances associate with vacancy and sickness rates and links to the nursing uplift.	Jane Haire Ann Marie Riley	~~30/06/2023~~ 30/08/2023		A deferred date has been requested pending the start date of the Assistant Director of Workforce Information who took up post on 26th June 2023. It is proposed that a briefing paper is provided through the Transformation and People Committee for discussion and this will be further consisdered alongside the next nurse establishment review due in October 2023.	GB
PTB/580	07/06/2023	2022/23 Quality Account	To update the Quality Account to reflect the comments made in relation to KPIs, and clarification of the number/type of patients accessing Emergency Medicine	Ann Marie Riley Jamie Maxwell	30/06/2023	29/06/2023	Complete. Final draft circulated to Board members for final comments before publication and no further comments received.	B
PTB/581	07/06/2023	Maternity Quality Governance Committee Assurance Report (23-05-23)	To provide comparisons of the percentage of women who smoke during pregnancy and the percentage of women with gestational diabetes with the national averages	Ann Marie Riley	05/07/2023		**Update to be provided.**	GB
PTB/582	07/06/2023	Integrated Performance Report – Month 1	An update be provided to PAF on the numbers of patients with a long length of stay and how this compared to peers.	Simon Evans Katy Thorpe	25/07/2023		Action not yet due.	GB

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

June 2023

Part 1: Contract Awards and Approvals

2.1 Contract Awards and Approvals

Since 15th May to 14th June, 1 contract award over £1.5 m was made, as follows:

- **Cytotoxic Dose Banded - Chemo, Immunotherapy and Monoclonal Medicines** supplied by Quantum Pharmaceutical, Sciensus Pharma, Qualasept, Bath ASU, Baxter, for the period 01.07.23 – 30.06.24, at a total cost of £14,000,000, approved on 10.05.23

In addition, the following eREAF was approved at the Performance and Finance Committee on 27th June, and also requires Trust Board approval due to the value:

Supply of Sutures (eREAF 10826)
Contract Value £2,115,184.68 incl. VAT
Duration 01/07/23 – 30/06/26
Supplier Johnson & Johnson / Medtroni
Savings – Cost Reduction £22,734.81 incl. VAT. In-Year Negated Inflation £21,151.85 incl. VAT

The Trust Board is asked to approve the above eREAF.

2.2 Consultant Appointments – June 2023

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Cardiologist in Cardiac Electrophysiology and Devices	Vacancy	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Locum Consultant Body Radiologist - Emergency Imaging	Vacancy	26/06/2023
Locum Consultant, Colorectal	New	07/06/2023
Specialist Doctor in Clinical / Medical Oncology	Vacancy	05/06/2023
Consultant Orthopaedic Foot and Ankle	New	01/06/2023

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

Post Title	Closing date	Note
Consultant Orthodontist	22/06/2023	No applications
Consultant Vascular Surgeon	22/06/2023	No applications
Locum Consultant in Oral Maxillofacial Surgery	25/06/2023	No applications

2.3 Internal Medical Management Appointments – June 2023

There were no medical management interviews during June 2023. The following provides a summary of medical management who have joined the Trust during June 2023:

Post Title	Reason for advertising	Start Date
Foundation Training Programme Director	New	08/06/2023

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

Part 2: Highlight Report

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

National / Regional

3.1 Platinum Award for 'Recondition the Nation'

On 16th June our Chief Nurse received a letter from NHS England to confirm that we have received a prestigious Platinum Award for 'Recondition the Nation'.

Recondition the Nation challenges teams to prevent deconditioning, which can lead to impaired physical, psychological and functional wellbeing. The NHS England regional team were really impressed with how we try to prevent deconditioning as 'business as usual' across our hospitals including positive language regarding falls, allowing patients to walk preventing harm. We have been held up as exemplars in looking at ways to capture deconditioning harm.

Our Chief Nurse, Ann-Marie Riley has also been commended for her personal demonstration of nursing leadership to support this programme and is regarded as inspirational at a national level. I am very proud of this achievement and my congratulations go to all involved in achieving this.

3.2 Government 2023 Mandate to NHS England

On 15th June, the Department of Health and Social Care published the 'Government's 2023 mandate to NHS England'. NHS England has a duty to seek to achieve the objectives set out within the mandate and the Secretary of State will monitor progress against it, through reporting at government level.

The mandate sets out a number of objectives and priorities, summarised below:

Priority 1: cut NHS waiting lists and recover performance

- Continue to deliver the NHS delivery plan for tackling the Covid-19 elective backlog and a focus on increasing outpatient productivity and transforming pathways. **By March 2025 95% patients needing a diagnostic test should receive it within 6 weeks.**
- Improving cancer outcomes in line with the NHS Long Term plan including 1 and 5 year survival, increased early diagnosis, expansion of diagnostic capacity so that **at least 75% people referred urgently receive a diagnosis within 28 days** and the provision of high quality personalised care.
- Recovery of cancer services and continuing to maintain and improve performance against the **62 and 31 day standards.**
- Strengthened **information** and **recovery** processes with patients being offered a **minimum of 5 providers to choose from**, with existing long waiters being given the option to move to a different provider to receive earlier treatment where clinically appropriate.
- Improved emergency department and ambulance performance, including **76% patients being admitted, transferred or discharged within 4 hours by March 2024.**
- Ambulance response times for **category 2 incidents to 30 minutes over 2023/2024** with further improvement in 2024/2025.
- **Increased bed and ambulance capacity** in place for the next winter alongside greater community response services and virtual wards.
- Continued improvement to **hospital flow and discharge processes** with every system having an effective care transfer hub.
- **Improved GP access** ensuring appointments within 2 weeks and same / next day for urgent needs alongside adoption of digital telephony.

Priority 2: support the workforce through training, retention and modernising the way staff work

Implementation of the NHS Long Term Workforce Plan and building on the work of Health Education England

Priority 3: deliver recovery through the use of data and technology

- Adoption of the latest innovation and technology to digitally transform the NHS with 90% trusts having electronic health records by December 2023 and 95% by March 2025.
- By March 2024, to adopt barcode scanning of high risk medical devices.
- Implementation of the national cyber strategy to ensure cyber resilience, maximised use of the federated data platform and use of national use case tools.
- Use of the NHS App as the 'digital front door' of the NHS, with 75% all adults to be registered by March 2024.

Continue to deliver the NHS Long Term Plan to transform services and improve outcomes

Improving patient safety, quality of care and health outcomes including the 3 year plan for maternity and neonatal services, the children's and young people's transformation programme, access to mental health support, community based care, access and quality for people with learning disabilities and autism, the Accessible Information Standard, prevention of ill health and inequalities and delivering a major conditions strategy.

Funding and Financial Tests

- Deliver overall revenue and capital financial balance every year with ICB's exercising their functions to deliver this with recovery plans in place for any deficit.
- Cash releasing efficiency savings of at least 2.2% in 2023/24 along with ongoing productivity improvement being integral to long term workforce planning.

Finally, the mandate sets out the education outcomes framework which includes expectations around excellent education, competent and capable staff, a flexible workforce receptive to research and innovation, widening participation, volunteering and NHS values and behaviours.

The full mandate can be accessed via: NHS mandate 2023 - GOV.UK (www.gov.uk)

System Focus

3.3 Keele University Quality Visit

On 9th June we received a letter from our partners at Keele University following a quality visit which took place on 2nd November 2022. The overarching conclusion of this visit was that we provide an effective learning environment for medical and physician associate students, through expert leadership, with excellent management provided by our UHNM Dean and her team. It was also recognised that our senior management clearly values and supports education and training.

This report is fantastic recognition of the work that we do with our medical students and again my thanks go to all those involved in achieving this.

3.4 NHS Oversight Framework with System Partners

On 13th June we had a meeting with ICB and NHSE colleagues to review progress against the NHS Oversight Framework (NOF). The purpose of these meetings is to understand our oversight, assurance and improvement arrangements against the key drivers that have placed us in NOF segmentation 3 (as defined in the NHS Oversight Framework). Key points of discussion were:

- Urgent and Emergency Care Issues and Impacts
- Elective Long Waits including cancer and diagnostics
- Quality including Care Quality Commission notices and progress
- Regulatory undertakings
- ICB / regional support

NHSE have commended the process that we have established internally to manage our progress against the expectations of the NOF and the agreed exit criteria. This was set out in a briefing paper which was shared with our Committees during May. We will continue to work with NHSE and our system partners to develop and streamline this.

3.5 Chief Operating Officer

I'm delighted to announce that Simon Evans has been appointed as the interim Chief Operating Officer (COO) until recruitment to the substantive role has been undertaken. Simon has a strong operational background spanning 25 years in the NHS working in a variety of NHS sectors and roles such as informatics, performance management, programme management and future operating models. Simon also has a good track record of working as a COO in large, complex and challenged organisations and systems.

Simon is spending one day a week with us until he can be fully released from his current role which will be the 14th August. On behalf of the organisation, we wish Simon a very warm welcome to UHNM.

During the month we have also welcomed Christine Atkinson as our interim Medical Division Divisional Operations Director.

3.6 Junior Doctors Strike Action

Week commencing 12th June we saw the third junior doctor's industrial action and while we are now well rehearsed in our plans it is not without its impact on patient care. We did unfortunately have to postpone a number of outpatient appointments and elective operations to ensure we could continue to provide urgent and emergency treatment to those who needed it most.

My thanks go to all of our staff who worked differently and flexibly during this time and for their continued support for further strikes. The next strike dates announced will be the 13th to the 18th July 2023, which to date will be the longest of the junior doctor strikes.

Whilst we have well-rehearsed plans and to date we have managed these strikes safely, they are not without consequence. As with the previous strikes this action will very unfortunately lead to the cancellation of some elective and planned activity, again at a time when we already have patients who are waiting for too long for their procedures. There is also the inevitable financial impact which is clearly seen within the month 1 and month 2 financial position as outlined in the financial report.

3.7 County Hospital Developments

As usual, I have spent time visiting and talking to staff at County Hospital during the month. They were keen to hear about some of the development schemes which are now coming on board such as the opening of the new treatment suite and the new modular theatre which is home to the Staffordshire Hand Centre which opened its doors on 21st June.

Whilst the clinical strategy for County Hospital is still in development, we will be sharing this as soon as it becomes available. We expect a first draft to be available in September 2023

3.8 Staff Side

I am very proud that we have great partnership working with our Staff Side colleagues and following recent job changes, staff side elections were undertaken to appoint Joanne Mallet as staff side secretary, Mike Way as staff side chair and Stewart Robinson as Vice Chair. We very much look forward to continuing our positive and constructive discussions with staff side colleagues who work very hard on behalf of our staff.

3.9 UHMM Charity

On 16th June, I was able to present the winning teams of golfers at Barlaston Golf Club with their awards following our UHNM Charity Golf Day. Last year's event raised more than £6,000 to help improve the experience and hospital environment for our patients. This year the event absolutely smashed that amount raising a huge £12,000. A huge thank you to all our sponsors and local businesses who donated all of the prizes and to everybody who took part. I would also like to give a special thank you to our UHNM Charity, without them these hugely successful events could not take place.

3.10 Chief Executive's Award

I was really pleased to be able to present Lisa Duncan, our integrated health and social care lead with my Chief Executive's Award for her efforts to discharge our patients safely and quickly. Specifically, Lisa went above and beyond to support a patient with failed asylum and through her perseverance was able to discharge the patient to ongoing care in the community.

3.11 Opening of 24/7 Deli

We held the official opening of our new automated 24/7 Deli at Royal Stoke. It is great that we are not just the first NHS organisation to make this offer to staff and visitors but we are the first NHS organisation to provide this facility. The machines provide high quality, fresh, hot and cold food and the feedback from our staff has been very positive. This is just one part of our wellbeing programme where we have listened and responded to requests from our staff for food to be available 24 hours a day.

3.12 National EFM Day 21st June 2023

We celebrated our second National EFM Day on 21st June 2023. Colleagues from across our Estates, Facilities and PFI Division held a series of events at the Royal Stoke and County sites celebrating and recognising the contributions of all Estates and Facilities staff. It was fabulous to see Board members participating in the day's events and helping to raise the profile of the vital role that Estates and Facilities staff play at UHNM and the difference they make to patient care and staff experience. An enjoyable day was had by all.

3.13 Being Kind

On 26th July, as part of our ongoing Culture Improvement Programme, the first of our 'Being Kind in Action' sessions took place with further sessions planned in June and July. The sessions are being delivered by Tim Keogh from A Kind Life and the impact and feedback from sessions so far has been excellent. The sessions are a practical, interactive, evidence based workshop covering:

- Why kindness; the evidence supporting the need for kinder cultures
- Promoting kindness; more good days at work in healthcare
- Tackling rudeness; fewer bad days at work in healthcare
- A speak up culture; empowering people to speak up safely
- Being Kind; a kinder way to resolve poor behaviour
- Recovering our wellbeing; supporting each other to thrive

The sessions are aimed at all colleagues working at UHNM, including students and our Sodexo partners, across all professional groups and pay bands.

3.14 Care Quality Commission Inspection Report

On 23rd June our CQC inspection report was published although feedback has already been given to the Board. The report is being taken through our formal governance routes which will include progress against our action plan.

Quality Governance Committee Chair's Highlight Report to Board

29th June 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • An update on the Getting It Right First Time programme highlighted the focus on elective recovery and challenges in terms of ensuring divisional ownership of the process and actions • The complaints update highlighted that the Trust continued to breach the response time target whereby the median response time was 60 days compared to the 40 day target • The cardiothoracic surgery action plan identified 3 actions which were particularly problematic, due to staff recruitment challenges and these risks were reflected on the Risk Register • The Neonatal Service – Overview and Action Plan Update report highlighted ongoing challenges in respect of workforce gaps although actions were in place to address these and positive progress had been made in respect of recruitment to the neonatal nursing workforce • The report following the Care Quality Commission (CQC) national maternity inspection in March 2023 was presented which highlighted the maternity service rating reducing to Requires Improvement although the two main concerns raised on the day were addressed immediately	• Further work required in terms of confirming the governance arrangements within Divisions in relation to Getting It Right First Time. It was agreed to consider this as part of the wider discussion in relation to Clinical Effectiveness and Performance Reviews • Work remained ongoing to disseminate and share learning associated with complaints which was expected to improve with the introduction of the Patient Safety Incident Response Framework (PSIRF) • Work ongoing to bring on board additional General Practices to refer deaths to the Medical Examiners Service in readiness for the statutory date • Ongoing actions being identified to take forward Human Factors training within cardiothoracic surgery • Actions arising from the CQC maternity inspection being incorporated into an action plan and updates on progress to be provided to future meetings • Update to be provided at a future meeting in relation to consistency of reporting of patient safety incidents to provide assurance in relation to the NHS Oversight Framework (NOF) criteria
✓ Positive Assurances to Provide	**Decisions Made**
• The research and innovation update highlighted 11 external monitoring visits having taken place which identified no significant issues. In addition the planned sponsorship of a Clinical Trial of Investigational Medicinal Product was highlighted to commence in April 2024 and the Committee welcomed this in addition to the study led by Medical Physics • A low escalation rate of complaints was highlighted whereby the number of formal complaints had reduced with more being routed through the PALS team • Medical Examiner Service highlighted a pilot of electronic death certificates due to the significant work which had been undertaken in readiness for the statutory date of April 2024, in addition to the Trust being highlighted as a case study. • The Committee welcomed the update in relation to the cardiothoracic surgery recommendations which identified 29 completed actions and 24 underway • The Committee welcomed the Neonatal Service – Overview and Action Plan Update provided to summarise the actions being taken to address the recommendations associated with the perinatal mortality 2021 report, local maternity and neonatal system insights visit and cultural review. • The Committee welcomed the recognition provided in relation to the Trust's approach to PSIRF which was being shared both locally with ICB colleagues, and nationally as an exemplar	• The Committee approved the Patient Safety Incident Response Plan including the five safety locally defined priorities

Comments on the Effectiveness of the Meeting

• Members welcomed the conversations which were appreciative, collaborative and supportive. Members also welcomed the balance between having a focussed discussion on some of the more difficult issues versus taking other items as read

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Research & Innovation Update	BAF 9	Ext 15	✓	Assurance	6.	Neonatal Service – Overview and Action Plan Update	BAF 1	ID22651	! ✓	Assurance
2.	GIRFT Update	BAF 1	ID24570 ID23518	!	Assurance	7.	Maternity CQC Report	BAF 1	Ext 20	!	Assurance
3.	Q4 Patient Experience Report 2022/23	BAF 1	Ext 20	! ✓	Assurance	8.	Quality Performance Report – Month 2 23/24	BAF 1	Ext 20	-	Assurance
4.	UHNM Medical Examiner Service Update			✓	Assurance	9.	Patient Safety Incident Response Plan (PSIRP)	BAF 1	Ext 20	-	Approval
5.	Cardiothoracic Surgery Review Update	BAF 1	Ext 20	! ✓	Assurance	10.	Quality & Safety Oversight Group Assurance Report	BAF 1	Ext 20	-	Assurance

3. 2023 / 24 Attendance Matrix

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

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th July 2023
Report Title:	Maternity CQC Report	**Agenda Item:**	8.
Author:	Sarah Jamieson, Director of Midwifery		
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

23834	Delayed induction of labour	Extreme 15
15993	Maternity Assessment Unit Triage	Extreme 15
13419	Midwifery safe staffing	High 12

Executive Summary

Situation

As part of the national maternity inspection programme the maternity service at Royal Stoke University Hospital were visited on the 7th March 2023. This was an announced focussed inspection looking at the SAFE and WELL LED key domains.

The rating for SAFE moved from REQUIRES IMPROVEMENT to INADEQUATE and the rating for WELL LED moved from GOOD to REQUIRES IMPROVEMENT.

The overall service rating moved from GOOD to REQUIRES IMPROVEMENT. The overall Trust rating stayed the same at REQUIRES IMPROVEMENT.

The inspection was carried out using data that we provided before, during and after the physical inspection. The CQC team conducted interviews with senior leaders and specialist roles within maternity and also gathered views from women and birthing people about their families and our Trust.

NB. The CQC report was published on the 22nd June 2023 and therefore this report aims to provide the Board with a broad overview of findings, ahead of a fully detailed action plan which will now be prepared by the maternity service and progress monitored via the Maternity Quality and Safety Oversight Group and Maternity Quality Governance Committee.

Background

Royal Stoke University Hospital is the main site for maternity services for the trust, with County Hospital providing a full range of antenatal and postnatal services. There were around 6400 over 12 months. It comprises of a delivery suite with maternity theatres, induction of labour beds and enhanced recovery area. There are post and antenatal wards, a midwifery birth centre, a day care assessment area and maternity

assessment unit (triage). The service also provides specialist substance misuse clinics, perinatal mental health and lifestyle clinics, fetal medicine and maternal medicine services. These services are available to women and birthing people from across Stoke-on-Trent and Staffordshire.

University Hospitals North Midlands NHS Trust comprises of Royal Stoke University Hospital and a Freestanding Midwifery Birth Unit (FMBU) at County Hospital, Stafford.

Analysis

Some immediate concerns were raised at the time of the inspection and the maternity service put in place a number of measures to provide assurance immediately whilst the team were still on site.

Despite the immediate actions taken the CQC were not sufficiently satisfied that these immediate changes were embedded and as such under Section 29A of the Health and Social Care Act 2008, the trust was served a warning notice requiring us to make significant improvements to the safety of the service. We wrote to the CQC and submitted an action plan and confirmed the immediate actions taken to improve the safety of the service. We have kept CQC informed of progress on our improvements.

The two main areas of concern were:

- Our maternity assessment unit and the implementation of the BSOTS model of triage (Birmingham Symptom Specific Obstetric Triage System).
- Our induction of labour process including our system for prioritisation of risk and delays.

Both main concerns were raised on the day of the inspection and discussed with the assessors. Both were already identified by the maternity service as areas for improvement and as such form part of our driver metrics as part of our Improving Together Programme. Additionally they were both on our risk register prior to this inspection with improvement work underway.

Our overall rating for maternity has reduced from GOOD to REQUIRES IMPROVEMENT, this was because:

- People were not always able to access the service when they needed it without having to wait longer than the trust targets and as recommended in national guidance. There was a lack of embedded processes to triage and prioritise care and treatment for women and birthing people who attended the service.
- Staff did not always have training in key skills, to ensure safe treatment of women and birthing people.
- The design, maintenance and equipment were not always suitable to meet the needs of women and birthing people. Equipment was not always available for use leading to delays in treatment for women and birthing people.
- Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.
- The service used systems to monitor performance and risks. However, staff did not always follow trust guidance to identify and escalate associated risks to women and birthing people. Leaders did not have effective oversight and there was a risk improvements were not always identified or made when needed. In addition, there were no plans in place to cope with unexpected events.
- Leaders had the skills and abilities to run the service. Leaders had identified and implemented systems to address and improve services in order to better manage priorities and issues the service faced. There were however, areas where the leadership could develop further. In particular, inconsistent incident reporting processes reduced effective oversight and reduced the ability to identify themes and trends. Staff mandatory training did not meet trust targets, and staff did not always follow processes as outlined in guidance.
- The service did not provide a local business continuity plan. We were unable to determine what the arrangements were should an unexpected major event occur.

However:

- The service-controlled infection risk well and managed clinical waste well. Staff kept detailed care records and they managed medicines well.
- The leadership team were visible and approachable in the service for women and birthing people and staff. Staff understood the service's vision and values, and how to apply them in their work. Most staff felt

respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services and all staff were committed to improving services continually.

Recommendations – the following actions will be incorporated in to the action plan:

Action the trust MUST take to improve:

- The service must ensure that systems are in place to ensure effective triage and escalation processes are in place to reduce risk of patient harm (Regulation 12 (2) (b)).
- The service must ensure staff are up to date with maternity mandatory training modules, including safeguarding adults and child protection training. Regulation (12 (1) (2)(c)).
- The service must ensure that staff complete regular skills and drills training (Regulation 12 (1) (2)(c)).
- The service must ensure the environment used to care for and treat service users is adequate for the needs the women and birthing people using them and that any identified risks are mitigated (Regulation 12 (2) (b)).
- The service must ensure systems or processes in place operating effectively in that they enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular risks identified with current maternity triage processes and effective oversight such as emergency equipment checks (Regulation 17 (2) (b)).
- The service must ensure persons employed in the provision of a regulated activity received training, professional development, supervision, and appraisal as was necessary to enable them to carry out the duties they were employed to perform (Regulation 18 (2) (a)).

Action the trust SHOULD take to improve:

- The service should ensure the correct level of harm is reported and reviewed when incidents are reported in line with national guidance (Regulation 17 (2) (b))
- The service should review current safeguarding processes in place to ensure staff complete safeguarding risk assessments at every appointment (Regulation 12 (2) (a) (b)).

Maternity Assessment Unit

Actions taken so far:

Immediate Actions taken:

- Immediate relocation of Maternity Assessment Unit (MAU) waiting area in order to increase visibility.
- UHNM MAU Triage guidance changed from 30 minutes initial assessment to 15 minutes.
- Immediate further bank shifts allocated to allow allocation of second triage midwife.
- Additional medical shifts at the weekend are also now being offered with a view to rostering a doctor to MAU.
- Full team safety huddle at 09:00hrs now extended to 7 days a week rather than 5 days, with effect from 11th March 2023.
- New MAU Safety Huddle introduced at 15:00hrs daily 7 days a week, attended by MAU midwife in charge, flow-coordinator and inpatient matron. The huddle now includes use of Birmingham Symptom Specific Obstetric Triage System (BSOTS) Board, the breach of triage assessment tool and the breach of medical review by priority rating tool.
- With effect from 11th March 2023, an update from the daily MAU Safety Huddle is given to the Maternity Escalation Group. This group includes the Chief Nurse, Divisional Associate Director, Director of Midwifery, Deputy Director of Midwifery, Directorate Clinical Director, Obstetric Clinical Lead, and Divisional Medical Director.
- 2 hourly oversight walkabouts/ assurance audit on MAU by the flow-coordinator daily, 7 days a week.
- BSOTS training package sent to all midwifery and medical staff on 10th March 2023.
- Clinical Education team allocated to support re enforcement of BSOTS training, with effect from 14th March 2023. (this training has now been delivered to the medical and midwifery teams).
- Sarah Kenyon, National BSOTS lead, from Birmingham Women's Hospital asked to attend to perform a

formal review of use of BSOTS at Royal Stoke University Hospital (has now attended).

Actions already taken at the time of the inspection:

- MAU breaches already part of escalation process, included in revised escalation guideline (currently in draft).
- MAU triage breach reporting already part of 09:00hrs Safety Huddle.
- Request to proceed for business case in draft (Increase in Obstetric Medical Cover) (now complete).
- Quarterly MAU Triage Audit performed and shared with directorate, division and Executive team via our executive performance reviews.
- Task and Finish steering group in progress to move activity of patients experiencing reduced foetal movements from MAU to Ante-natal Clinic. Estates commissioned to facilitate transfer.
- MAU Triage Assessment currently a divisional 'Watch Metric', utilising our Improving Together Quality Improvement methodology.

NB. All of the above actions continue, in addition

Additional actions since inspection:

- Building work has commenced to relocate the reception and waiting area and provide an additional triage room.
- Request to proceed for additional ward clerk and maternity support worker cover to ensure 24/7 support for the new triage and waiting area.
- We are progressing with plans for implementing advanced clinical practitioners into MAU and triage.
- Vitality Team Building and Leadership Behaviours Programme (Vitality Compact) being rolled out to all band 5's and 6's over the next 18 months.
- Human Factors 'train the trainers' for 21 leaders.
- Relocated day care to the antenatal clinic.
- Implementation of A-I-D (nationally developed tool RCOG/RCM/Each Baby Counts) – clinical situation & escalation communication tool.

Management of induction labour

Immediate Actions

- With effect from 14th March 2023, prioritisation of inductions of labour takes place daily prior to 09:00hrs Safety Huddle, so the risks can be discussed by the MDT at the Safety Huddle. This process previously took place after the safety huddle. Safety huddle SOP revised.
- With effect from 11th March 2023, an update from the daily MAU Safety Huddle, including management of induction labour, is given to the Maternity Escalation Group. This group includes the Chief Nurse, Divisional Associate Director, Director of Midwifery, Deputy Director of Midwifery, Directorate Clinical Director, Obstetric Clinical Lead, and Divisional Medical Director.

Actions already in progress at the time of the inspection:

- NHSE/I and LMNS support offer accepted. Task and Finish group in progress with NHSE/I, LMNS, Maternity Neonatal Voice Partnership (MNVP), representative from all clinical areas.
- Induction of labour breaches of guidance is a divisional driver metric, utilising our Improving Together Quality Improvement methodology.

Place Work stream:

- Conversion of Midwife Birth Centre side rooms to Induction suite from 4 bedded bay to improve women/ birthing people's experience of induction. Equalities Impact Assessment performed to consider the impact of change of use.
- This is now complete.

Guidelines/Policy Work stream:

- Induction of labour (IOL) guideline revised in line with regional framework for gestational age and induction of labour including management of post-mature women/birthing people in line with NICE guidance.
- Escalation policy and IOL guidelines amended to include trigger point for divisional escalation/ regional escalation/ mutual aid request.
- Induction of Labour Prioritisation SOP developed. Daily prioritisation of all women awaiting induction of labour is completed by Consultant and Delivery Suite Co-ordinator in accordance with UHNM guidance prior to safety huddle. All women/birthing people contacted and safety netted and given the option to attend MAU for CTG.

People Work stream

- Business Case approved to secure budgeted establishment to birth rate plus assessment.
- Budgeted establishment now increased and in line with Birthrate Plus.
- Request to proceed in progress to align theatre staffing model with Association for Perioperative Practice (AFPP) guidance. Still in progress.
- Induction of Labour specialist midwife appointed.
- Maternity & Neonatal Voice Partnership (MNVP) developing patient information leaflet for women who are having induction of labour.

Referral Process work stream:

- Electronic booking system implemented (previously paper) to include referral system, triage process and booking process.
- Twice weekly consultant MDT set up to review weekly inductions overview.
- Transition to 7 day booking system.

Delivery Suite Activity Work stream:

- Review of management of theatre activity list, non–clinical hours agreed for Theatre Lead Midwife to manage caesarean section list.
- Agreed to participate in trial of mechanical method of induction, i.e dilapan. This trial has now commenced.

In addition to the above actions, the following improvement work underway:

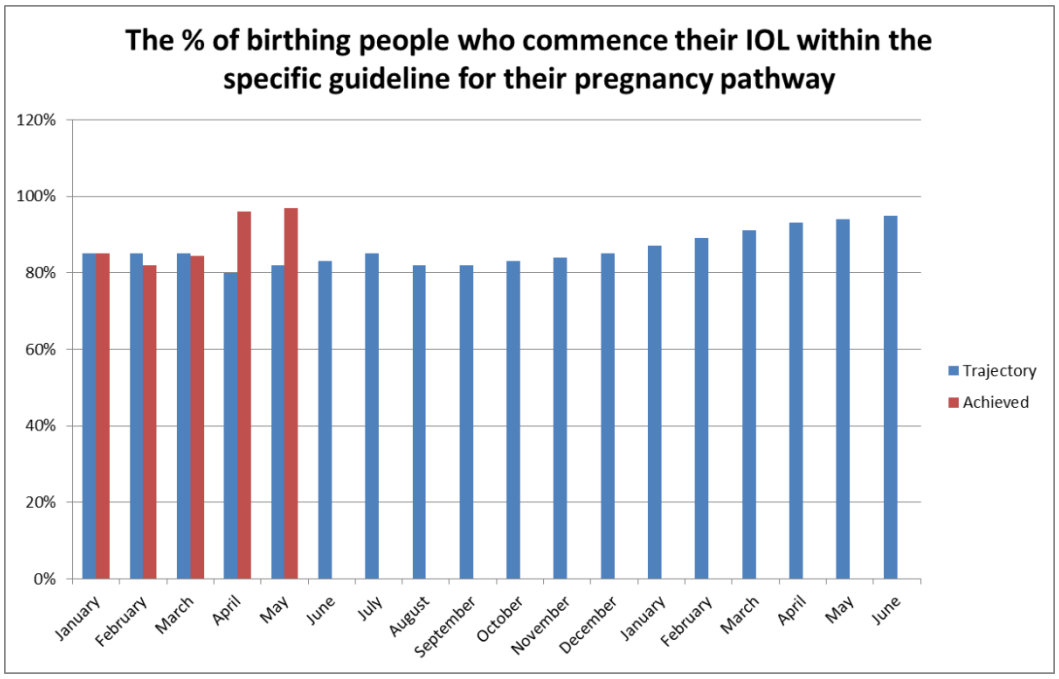
- During the CQC visit and subsequent feedback discussions, our Director of Midwifery acquainted the inspection team with our current cultural improvement plans for our Maternity Services. This includes our maternity leadership roadmap & toolkit and is underpinned by our Trust Values, supported by specific objectives & goals to enable us to work together to achieve UHNM's pledge: "To create a kind, respectful place to work".
- Development of the Vitality Team Building and Leadership Behaviour Programme, which is supported by Enono and has been endorsed by an NHSE/I intervention specialist – this was for 46 members of the maternity leadership team.
- UHNM Centre for Nursing, Midwifery and Allied Health Professionals Research and Education Excellence (CeNREE) launched a Director of Midwifery Fellowship Programme for early career midwives, which commenced in April 2023 and aims to:
    - To create new development opportunities for nurses, midwives and AHPs
    - Talent managing by identifying skills and supporting staff members earlier in their career
    - Up-skilling the workforce to provide high quality patient care
    - Appropriate succession planning
    - Retaining our highly skilled and experienced workforce for longer
    - Showing flexibility and innovation around workforce challenges
    - Ensuring UHNM is an attractive place to work - improving recruitment & retention
- Investment in two Professional Midwifery Advocates who use the Advocating for Education and Quality Improvement model to support the supervision of midwives and provide visible leadership in the workplace.
- Ongoing development of our Perinatal Mental Health Service
- Achievement of compliance with our PROMPT and K2 CTG training

Update on MAU and IOL Driver Metrics and Improvement trajectory:

May 2023

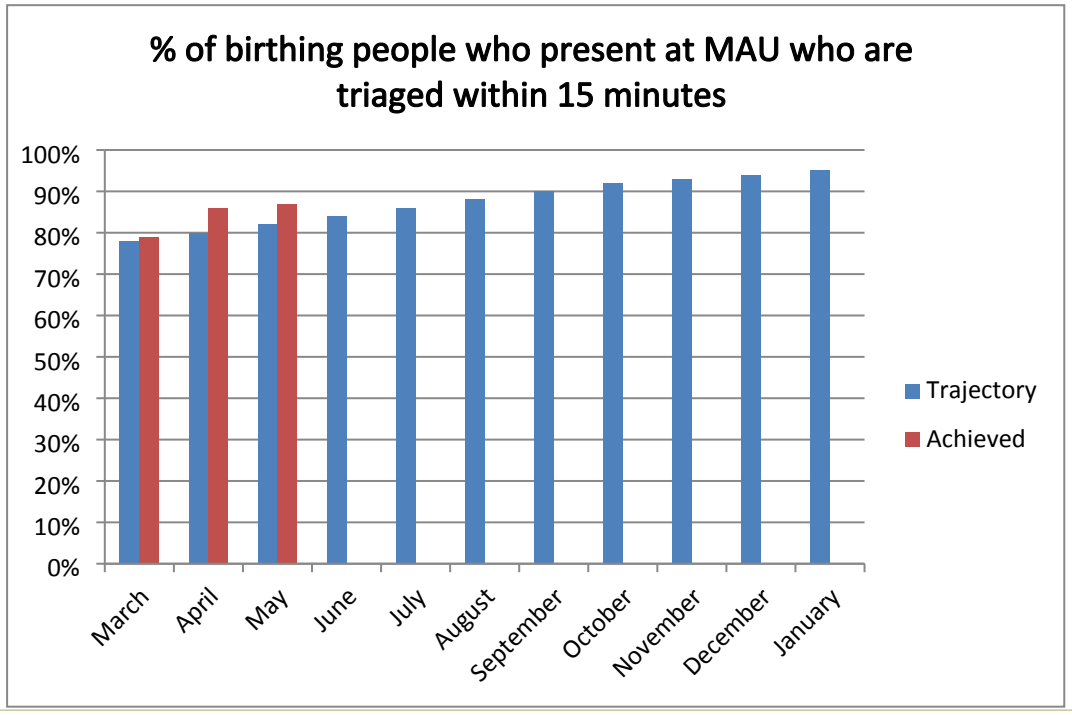
Measure: The percentage of birthing people who commence their induction of labour within the specific guideline for their pregnancy pathway.

Target: 95%



Measure: The percentage of birthing people who present at Maternity Assessment Unit who are triaged within 15 minutes

Target: 95%



Recommendations

- The Board is asked to receive the CQC Report for Maternity Services.
- The Board is asked to note that a full action plan will be developed in response to the report which will be monitored via Maternity and Neonatal Quality Governance Committee

University Hospitals of North Midlands NHS Trust

Royal Stoke University Hospital

Inspection report

Newcastle Road
Stoke On Trent
ST4 6QG
Tel: 01782715444
www.uhnm.nhs.uk

Date of inspection visit: 7 March 2023
Date of publication: 23/06/2023

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Inadequate**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Royal Stoke University Hospital

Requires Improvement ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Royal Stoke University Hospital.

We inspected the maternity service at Royal Stoke University Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out an announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

Our rating of this hospital stayed the same. The Royal Stoke University Hospital is rated as requires improvement overall.

The inspection was carried out using a post-inspection data submission and an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, reviewed policies, care records, medicines charts and documentation.

Following the site visit, we conducted interviews with senior leaders and reviewed feedback from women and birthing people and their families about the trust.

Royal Stoke University Hospital is the main site for maternity services for the trust, with County Hospital providing a full range of antenatal and postnatal services. There were around 6400 over 12 months. It comprises of a delivery suite with maternity theatres, induction of labour beds and enhanced recovery area. There are post and antenatal wards, a midwifery birth centre, a day care assessment area and maternity assessment unit (triage). The service also provides specialist substance misuse clinics, perinatal mental health and lifestyle clinics, fetal medicine and maternal medicine services. These services are available to women and birthing people from across Stoke-on-Trent and Staffordshire.

University Hospitals North Midlands NHS Trust comprises of Royal Stoke University Hospital and a Freestanding Midwifery Birth Unit (FMBU) at County Hospital, Stafford.

At the time of our inspection intrapartum care was suspended at County Hospital, however, all other antenatal and postnatal services at County Hospital were still available.

Demographic data shows a higher proportion of mothers were in the most deprived deciles at booking compared to the national average (18% in the most deprived decile compared to 14% nationally and 17% in 2nd most deprived decile compared to 12% nationally). A report completed in 2022 showed an increase in patient complexity for women using delivery suite services with many of those using the services categorised as moderate and high risk.

Our findings

Following this inspection, under Section 29A of the Health and Social Care Act 2008, the trust was served a warning notice requiring them to make significant improvements to the safety of the service. The trust wrote to CQC to submit an action plan and confirm the immediate actions taken to improve the safety of the service. The trust has kept CQC informed of progress on improvements. We found that the service had deteriorated since the last inspection on February 2020.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Requires Improvement ↓

Our rating of this service went down. We rated it as requires improvement because:

- People were not always able to access the service when they needed it without having to wait longer than the trust targets and as recommended in national guidance. There was a lack of embedded processes to triage and prioritise care and treatment for women and birthing people who attended the service.
- Staff did not always have training in key skills, to ensure safe treatment of women and birthing people. However, staff we spoke with could describe how to escalate safeguarding concerns. Staff took every opportunity to protect women and birthing people from abuse.
- The design and equipment were not always suitable to meet the needs of women and birthing people. Equipment was not always available for use leading to delays in treatment for women and birthing people.
- Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.
- The service used systems to monitor performance and risks. However, staff did not always follow trust guidance to identify and escalate associated risks to women and birthing people. Leaders did not have effective oversight and there was a risk improvements were not always identified or made when needed. In addition the service did not provide a local business continuity plan. We were unable to determine what the arrangements were should an unexpected major event occur.
- Leaders had the skills and abilities to run the service. Leaders had identified and implemented systems to address and improve services in order to better manage priorities and issues the service faced. There were however, areas where the leadership could develop further. In particular, inconsistent incident reporting processes reduced effective oversight and reduced the ability to identify themes and trends. Staff mandatory training did not meet trust targets, and staff did not always follow processes as outlined in guidance.

However:

- The service-controlled infection risk well and managed clinical waste well. Staff kept detailed care records and they managed medicines well.
- The leadership team were visible and approachable in the service for women and birthing people and staff. Staff understood the service's vision and values, and how to apply them in their work. Most staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Inadequate ↓

Our rating of safe went down. We rated safe as inadequate.

Mandatory training

Maternity

The trust provided mandatory training in a range of key skills to all staff. Systems were in place to monitor mandatory staff training compliance. Reports indicated improved staff training compliance rates showing that actions taken had been effective. At the time of the inspection however, not all staff were up-to-date with their mandatory training.

Records shared with us at the time of inspection identified that midwifery staff and antenatal medical staff had not all completed their mandatory training courses against a trust target of 95%.No information was shared for staff training compliance for level 3 safeguarding adults and records showed that safeguarding children training level 3 for the Nursing and midwifery registered staff group was at 72%". Records showed 73% of staff had completed neonatal life support training. However, improvements had been made with training reports between January 2022 and December 2022 showing improved staff compliance in cardiotocograph (CTG) with 93% of staff having completed cardiotocograph training as well as improved compliance in K2 training and Skills and drills.

Training programmes ensured staff received multi-professional simulated obstetric emergency training and included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies However, the service did not provide information on how many staff had completed this training.

Safeguarding

Staff had not always completed safeguarding training on how to recognise and report abuse in line with trust targets and in line with national guidance. However, staff we spoke with understood how to protect women and birthing people from abuse.

Training records showed staff had not always completed both safeguarding adults and safeguarding children training at the level required for their role as set out in the trust's policy and in the national intercollegiate guidelines. No information was shared for staff training compliance for level 3 safeguarding adults and safeguarding children training (level 3) was 58% overall compared with a target of 95%.

Staff we spoke with could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Equality Act (2010).

Staff knew how to identify adults and children at risk of, or suffering, significant harm. We found documented correspondence with social workers for women and their children who had known risk factors indicating possible safeguarding concerns.

Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Maternity

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted.

Cleanliness, infection control and hygiene

The service managed infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves, and others from infection. They kept equipment and the premises visibly clean.

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Wards had recently been refurbished to the latest national standards. Cleaning audits were completed, and records were up to date demonstrating that all areas were cleaned regularly.

The service generally performed well for cleanliness; a cleaning audit completed on 26 January 2023 in Maternity Theatre showed 95.5% overall compliance across 377 measures.

Staff followed infection control principles, including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last year compliance was consistently above 96%.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use with 'I am clean' labels to state when it had last been cleaned.

Staff regularly checked birthing pool cleanliness following a standard operating procedure and tested the water for legionella.

Environment and equipment

The design of the environment was not always suitable to meet the needs of women and birthing people. Equipment was not always available for use leading to delays in treatment for women and birthing people. However, staff managed clinical waste well.

The service did not always have suitable facilities to meet the needs of women and birthing people's or their families. We found that women and birthing people waiting to be triaged were being asked to wait alone without the support of their birth partners. Women and birthing people waiting areas were not visible to staff. Checks were not carried out by staff while women and birthing people were waiting, which may have resulted in delays for treatment. We raised this with leaders following the inspection and the trust took immediate action to relocate the waiting area to a more visible area allowing staff to effectively monitor people who were waiting.

Staff we spoke with described having to travel to other clinical areas to obtain cardiotocograph (CTG) machines as there were not enough of them. At the time of the inspection, the service was in the process of updating their CTG machines. There were pool evacuation nets in all rooms where they might be needed and on the day assessment unit, there was a portable ultrasound scanner and enough observation monitoring equipment to monitor women and birthing people.

Maternity

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called. However, signage and information leaflets were not visible in patient waiting areas in languages representative of the local population.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

Staff did not always identify and act on women and birthing people at risk of deterioration. Staff used risk assessments and took action to remove or minimise risks but were not always able to provide treatment within agreed timescales.

Staff did not always identify and escalate risks to women and birthing people within agreed timescales. The service used nationally recognised tools to identify women and birthing people at risk of deterioration, this included national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 7 MEOWS records and found staff completed them and knew how to escalate concerns to senior staff. However, on the day of inspection we could not be assured that all staff used these tools correctly. During the inspection we observed staff changing blood pressure cuffs sizes inappropriately thereby reducing the patients risk score. This increased the risk that women and birthing people were not identified as deteriorating and appropriate escalation taken when required. In addition, staff completed a quarterly MEOWS audit of 59 records to check they were fully completed and escalated appropriately. The audit showed consultants did not always review women and birthing people who were at risk of deterioration. Audit results showed the consultant reviewed women and birthing people with a MEOWS score >6 in 28.8% of cases between January and November 2022. It was not clear what the reasons were for this low rate of review, furthermore, it was not clear if any action had been taken to improve.However, following the inspection, we received additional assurance from the trust. The trust had changed their guidance and audit standard and had achieved 100% compliance with consultant attendance in incidents where the MEOWS score was >6.

Women and birthing people were not always seen within target time frames. Staff completed risk assessments for women and birthing people on arrival using a recognised tool. The maternity triage waiting times for review audit for October 2022 to December 2022 showed midwives reviewed 75% of women and birthing people within 30 minutes of arrival, however this meant that 25% of women were seen outside of target times. The triage tool used stipulates triage should be completed within 15 minutes. Following the inspection, the service reviewed their processes and made action plans to improve adherence.

Women and birthing people had access to a dedicated maternity triage telephone line which was staffed by a midwife at all times.

Leaders audited how effectively staff monitored women and birthing people who presented with reduced fetal movements. An audit 1 Oct 2022 to 31 December 2022 showed staff had used cardiotocograph (CTG) (a machine that issued to monitor the fetal heartbeat and the uterine contractions during pregnancy) monitoring 98% of the time for women presenting with reduced fetal movements and a known history of reduced fetal movements. An audit in August

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2022 showed 88% of women and birthing people had been monitored throughout their labour using continuous use of (CTG) every hour following 'fresh eyes' guidance (checks completed hourly by staff). This was outside of service targets. Following the inspection, the provider told us that a recent audit completed in March 2023 demonstrated 98% compliance.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks and used them to inform their clinical decisions.

Women had access to mental health support through the Perinatal Mental Health (PMH) service where clinics were offered at Royal Stoke University Hospital or at County Hospital. Staff could refer and seek assistance to support women and birthing people with risk indicators and/or mental health concerns.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. We attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 1 safety huddle a shift to ensure all staff were up to date with key information. There were additional localised team meetings staff shared key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

Staff completed new-born risk assessments when babies were born using recognised tools and reviewed this regularly.

At the time of the inspection, the service was not providing transitional care for babies who required additional care, the unit had been closed due to staff shortages, this meant that babies were then seen instead on the postnatal wards. The service had taken steps to increase staffing numbers.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge.

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. However, the service used recognised tools to assess staffing levels to meet the need of women and birthing people and their babies.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings (2015). A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing.

In December 2022, there were 143 red flags incidents of safe staffing reported via their electronic incident reporting tool, this being a low number in comparison to 358 (average number reported from July to December 2022.

Maternity

The service offered a supernumerary shift co-ordinator who had oversight of the staffing, acuity, and capacity to offer 1:1 care during active labour. The service also offered flo-co-ordinator with the role of flow improvement throughout the service. The delivery suite co-ordinator could focus on the delivery suite and was not responsible for any other flow. Additionally, staff were able to contact leadership on call if required, which was available 24 hours a day.

Managers accurately calculated and reviewed the number and grade of midwives and midwifery assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance on 22 February 2022. This review recommended 271.88 whole-time equivalent (WTE) registered midwives and midwifery support workers compared to the funded staffing of 228.98 WTE, a shortfall of 42.9 WTE staff.

In an attempt to reduce this shortfall, the service had developed a workforce plan with input from NHS England direct support and was working with the local university in order to recruit newly qualified midwives. The service funded midwifery apprentice positions as well as recruiting international midwives. In addition, the service had agreed a business case for further funding in November 2022, to recruit additional midwifery staff and ongoing midwife recruitment campaign. The service had planned a midwife recruitment event to be held on 22 March 2023. In response to the high vacancy rates, managers were able to request bank staff familiar with the service and made sure all bank and agency staff to ensure vacancies were covered. Agency staff were given a full induction and understood the service. At the time of the inspection the service had improved staffing numbers by 22 WTE reported, the service reported being on target to reduce this to 10 WTE by the end of 2023.

The service managers had the resources to adjust staffing levels daily according to the needs of women and birthing people when staffing was particularly tight. Managers could access additional staffing via bank staff and could move staff according to the number of women and birthing people in clinical areas on a priority basis allowing the service to mitigate risks more effectively.

According to electronic staff records sickness rates had improved with a 4.9% reduction in reported staff sickness for nursing and midwifery staff from November 2021 to November 2022.

Staff did not always receive annual appraisals. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. The leadership team recognising the need for improvement in this area. As a result, appraisal rates formed part of their improvement programme (Improving Together), which was discussed and monitored at trust executive level each month. At the time of the inspection approximately 60% of all staff groups had completed their yearly appraisal.

There was a well-structured team made up of a range of midwifery service and allied professionals, designed to meet the needs of people who accessed and used the services.

The service made sure staff were competent for their roles. There was a preceptorship programme for newly qualified midwives, and this included competence assessment in different skills. Managers told us staff received specialist training for their role supporting documents were provided detailing what training was offered to specialist staff however staff training compliance was not provided.

Medical staffing

Maternity

The service had enough medical staff in line with national standards in relation to the number of births with the right qualifications, skills, training and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

We found there were sufficient medical staff working at the service in line with national standards in relation to the number of births. Internal audits completed between October 2022 and February 2023 showed staff had not always attended situations where they "must" attend according to the standards set out by the trust (Delivery Suite Staffing Guideline (Dec 2022)). Following the inspection an audit completed in March 2023 showed all staff had attended where they "must" according to service guidelines. The service had low vacancy, turnover and sickness rates for medical staff.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. However, safeguarding checks were not always completed with women and birthing people during appointments.

Women and birthing people's notes were comprehensive however risk assessments and checks related to safeguarding had not always been completed. Staff could easily access the notes and the trust used a combination of paper and electronic records.

We reviewed a sample of 8 set patient records, records were clearly documented and safeguarding checks had been completed during appointments. Records were stored securely. The service used an end-to-end maternity information system. This allowed two way noting and service users to view their own records. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

The service had improved its medicines management and used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 7 prescription charts and found staff had correctly completed them.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Staff completed medicines records accurately and kept them up-to-date. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation outside the ideal range.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Of the 7 sets of medicine records, we looked at we found all 7 had been fully completed, were accurate and up-to-date.

Staff learned from safety alerts and incidents to improve practice.

Incidents

Staff recognised and reported incidents and near misses, but the level of harm was not always recorded correctly when staff reported an incident.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support, as well as issuing duty of candour letters in their 1st language. Managers ensured that actions from safety alerts were implemented and monitored.

Staff we spoke with could describe what incidents were reportable and how to use the electronic reporting system. Staff regularly reported incidents and knew how to report them. However, between January 2022 and January 2023 we found discrepancies in the level of harm reported which did not correlate with the length of time patients had waited to receive treatment. We reviewed a sample of incidents reported by the trust through the National Reporting and Learning System (NRLS) and Strategic Executive Information System (STEIS) data and found examples of incidents where significant harm had occurred with the potential for further complications that had been graded as "No harm" and "Low harm." Following the inspection, the trust agreed to complete a review of their incidents to ensure their staff were following their processes in line with their policy.

Managers reviewed incidents on a regular basis so they could identify potential immediate actions. Managers investigated incidents thoroughly. They involved women, birthing people, and their families in these investigations and recorded ethnicity as part of the review process. We reviewed 13 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 13 investigations, managers shared duty of candour and draft reports with the families for comment.

Managers shared learning with their staff about never events that happened. The service had Lead Midwives for Development and Education who shared learning from incidents with staff.

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Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed a serious incident and shared learning with those involved during follow up meetings. A quarterly report completed 7th December 2022 described what action was taken in response to learning identified through serious incident analysis. This included ensuring that further pilots for improving clinical escalation, to reminded staff of the importance of declaring the urgency of an emergency as well as implementation of tools to assist staff to escalate concerns through effective and assertive communication.

Managers debriefed and supported staff after any serious incident. Staff told us they were supported through feedback discussions, exploring incidents as well as potential improvements to the care of women and birthing people.

There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medication incident.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Following the inspection, the service told us when sending letters to patients this was done so in the patients first language. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. Systems were in place to understand and manage priorities and issues the service faced, however these systems did not always work as intended. The leadership team were visible and approachable in the service for women and birthing people and staff.

Leaders had the skills and abilities to run the service, however despite being aware of the challenges to quality and sustainability within the service and having plans in place to manage them, these plans had not achieved the targeted outcome at the time of inspection. Actions taken to address identified issues were not effective, for example staff training compliance and appraisal rates remained outside of trust target levels, in addition these were improvement requirements stipulated as part of the previous inspection carried out in 2020 and had not been met.

Leaders were visible and approachable in the service for women and birthing people and staff.

Most staff we spoke with told us that leaders were well respected, approachable, and supportive.

Staff told us they were well supported by their line managers, ward managers and matrons.

The service was supported by maternity safety champions and non-executive directors.

Maternity

Staff were supported to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations. An action plan had been created in response to the Ockenden findings and progress was measured against them.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The service worked alongside the Local Maternity and Neonatal System (LMNS), Maternity Voices Partnership and Healthcare Safety Investigation Branch in addition to other services to better respond to the needs of the local population.

Leaders and staff understood and knew how to apply them and monitor progress.

Culture

Most staff felt respected, supported, and valued. They were focused on the needs of women and birthing people and their babies receiving care. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Most staff we spoke with told us they felt respected, supported, and valued. However, some staff did not feel that all staff were treated equally and that disagreements between staff were impacting on patient care. Most staff we spoke with told us they felt safe to escalate their concerns within a supportive culture, however some staff working for the trust expressed a lack of faith in the leadership team and told us they were not always treated with dignity and respect. The service had taken steps to address issues related to staff culture. They had created a maternity leadership roadmap and toolkit, offered further staff training, and created fellowship programmes aiming to develop opportunities for staff and upskill the workforce.

Most staff we spoke with were focused on the needs of women and birthing people receiving care. However, staff we spoke with reported staff did not always demonstrate dignity and respect as part of the staff culture which had disrupted the effectiveness of systems used to provide high quality care. At the time of the inspection the leadership team had implemented several initiatives to address cultural concerns through a cultural improvement program and leadership development.

Leaders were aware of how health inequalities could affect the treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. Some systems had been

implemented such as smoking cessation to reduce unwanted outcomes for women and birthing people as a response to the needs of the local population. However, despite monitoring outcomes and investigating data to identify when ethnicity or disadvantage affected treatment and outcomes, responsive processes were not in place to improve outcomes for women and birthing people from ethnic minority groups.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear, staff were aware of who the freedom to speak up guardian was and were encouraged to speak with them or other specialist members of staff if they required support. Women and birthing people, relatives, and carers knew how to complain or raise concerns. We reviewed 28 complaints which had been made between August 2022 and March 2023 and concerns were in accordance with their policy the service used a formal approach applicable to each complaint. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes and shared feedback with staff through regular meetings across different levels where learning was used to improve the service.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Governance

Governance processes were not always effective, specifically related to leaders' ability to identify trends and themes around serious incidents as staff graded harm differently. Any learning that was identified was shared with staff at all levels, and they were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Although there were governance processes throughout the service and partner organisations, systems for oversight could be strengthened. In particular, staff did not always report incidents to reflect the potential harm level correctly in accordance with the trust's guidance. If incidents are not graded correctly effective validation cannot be fully assured, as the trust rely on input data to ensure oversight allowing trends or themes to be identified to improve treatment and care.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. The trust had an up-to-date maternity dashboard which was used to monitor performance and key metrics. Key staff took part in a quarterly perinatal mortality review tool (PMRT) meeting, which were held regularly as part of the Clinical Negligence Scheme for Trusts (CNST) these meetings were used to monitor the performance of the trust and identity any learning opportunities where improvements could be made and additionally monitored outcomes by ethnicity and deprivation.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored key safety standards of policies such as "Saving Babies Lives Care Bundle" through regular policy reviews every 3 years to make sure they were up to date.

Maternity

Management of risk, issues, and performance

The service used systems to monitor performance and risks. However, staff did not always follow trust guidance to identify and escalate associated risks to women and birthing people. This meant leaders did not have effective oversight and there was a risk. Improvements were not always identified or made when needed. In addition, the service did not provide a local business continuity plan so we could not be assured staff knew what to do if an unexpected event happened.

The service participated in relevant national clinical audits. According to the National Maternity & Perinatal Audit published 2022 as part of the Rapid Quarterly Reporting based on births from August 2021 to July 2022 showed service outcomes for women and birthing people were better than the national average for babies born

small for gestational age.

Babies and term babies scoring less than 7 on a test performed at 1 and 5 minutes after birth to determine the physical condition of the newborn (higher numbers indicate better health). Additionally, according to MBRACE (2021) still births were lower for the group average.

Although the service carried out audits these did not always lead to positive changes For example, not all staff had completed their mandatory training at the time of the inspection and although actions had been taken to improve triage processes in line with trust target times frames, 25% of women were triaged outside of these times.

Leaders identified and escalated relevant risks and issues through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team identified and took actions to reduce the impact of identified risks through the use of a risk register. However, we continued to observe delays for women attending triage despite serious incidents concluding triage process had not functioned as intended.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment outside maternity theatres was checked daily. However, during our inspection, we found not all items were in date. At the time of the inspection the trust relied on staff to complete the checks with limited oversight, in particular there were no audits being completed to ensure staff compliance.

The service did not provide a local business continuity plan at the time of inspection so we could not be assured comprehensive plans were in place to cope with unexpected events. However, whilst we were on site there was a security alert issued to the service, staff were observed responding swiftly to the potential risks.

Information Management

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

Maternity

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The information systems were integrated and secure with password protected IT systems**.**

Data or notifications were consistently submitted to external organisations as required including Healthcare Safety Investigation Branch (HSIB) and Local Maternity and Neonatal System (LMNS).

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. Communication between MVP and the service allowed for women raising concerns through social media to be flagged and addressed at the time of concern, including support for women struggling with anxiety whilst attending the service. The trust told us they were reviewing levels of literature and information leaflets representing the local diverse population in order to provide information to those population groups.

The service took part in maternity patient survey between 1 February to 28 February 2022 and received 220 responses. The survey found that people involved in the mother's care were not able to stay with mothers as much as the mother wanted during their stay in the hospital and were not as involved during labour and birth as they would have liked. Mothers were not always offered a choice where they would like to have during antenatal care, and felt they were not given enough information from either a midwife or doctor to help decide where to have their baby. Additionally, when contacting the midwifery team, women and birthing people reported not always receiving the help they needed during pregnancy.

The service made available interpreting services for women and birthing people and collected data on ethnicity.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

A team of specialist midwives were in place improve services through continuous learning and improvement. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted had plans in place to improve training and innovation. They had a quality improvement training programme and a quality improvement lead who co-ordinated development of quality improvement initiatives.

Areas for improvement

Action Royal Stoke University Hospital MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Maternity

Action the trust MUST take to improve:

Maternity

- The service must ensure that systems are in place to ensure effective triage and escalation processes are in place to reduce risk of patient harm (Regulation 12 (2) (b)).
- The service must ensure staff are up to date with maternity mandatory training modules, including safeguarding adults and child protection training. Regulation (12 (1) (2)(c)).
- The service must ensure that staff complete regular skills and drills training (Regulation 12 (1) (2)(c)).
- The service must ensure the environment used to care for and treat service users is adequate for the needs the women and birthing people using them and that any identified risks are mitigated (Regulation 12 (2) (b)).
- The service must ensure systems or processes in place operating effectively in that they enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular risks identified with current maternity triage processes and effective oversight such as emergency equipment checks (Regulation 17 (2) (b)).
- The service must ensure persons employed in the provision of a regulated activity received training, professional development, supervision, and appraisal as was necessary to enable them to carry out the duties they were employed to perform (Regulation 18 (2) (a)).

Action the trust SHOULD take to improve:

Royal Stoke University Hospital

- The service should ensure the correct level of harm is reported and reviewed when incidents are reported in line with national guidance (Regulation 17 (2) (b))
- The service should review current safeguarding processes in place to ensure staff complete safeguarding risk assessments at every appointment (Regulation 12 (2) (a) (b)).

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care. In addition, the team comprised of two Midwife specialist advisors and a Consultant Obstetrician specialist advisor.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation

Transformation and People Committee Chair's Highlight Report to Board

28th June 2023

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• Following a review of the attendance data, ENABLE training uptake is behind plan although there are plans in place to address this • Electronic Prescribing has been delayed due an issue which has been identified; this is being worked through with the supplier and a risk assessment will be undertaken – a formal programme structure is in place with executive oversight • Adoption of Improving Together tools amongst trained teams remains static at 35%; lots of work is ongoing which is expected to improve this position • The volume and complexity of Freedom of Information has increased which has impacted on the timeliness of responses • The Data Security and Protection Toolkit has identified one area of concern whereby 90% staff have undertaken DSP training compared to the 95% target • The Health and Safety Group were advised of a new trend relating to vapes being a new cause of unwanted fire signals – this will form part of the face to face fire training • A report from the Authorising Engineer has undertaken an annual audit of fire safety management which concluded with 15 recommendations • Whilst June Staff Voice Survey responses have improved, there has been a decline in the overall staff engagement score which is being responded to via a comprehensive staff engagement plan	• A new style 'Chief People Officer Report' has been developed in line with Improving Together methodology, including key assurance questions for the Committee to consider along with driver / watch metrics for ongoing oversight and scrutiny • Further update / oversight of the network outage and follow up actions will be picked up by the Executive Data Security and Digital Group • A Task and Finish Group has been established to drive improvements in responding to Freedom of Information Requests; part of their work involves a development of an improvement plan and a Publication Scheme which will be made available via the intranet • Consideration to be given to the development of an accountability matrix for responding to Freedom of Information requests and this should include central functions co-ordination wherever possible • IM&T have planned 30 projects in 2023/24 with additional projects awaiting approval • Further work being undertaken to the reporting against the Digital Strategy • It was agreed to include a quarterly report on Cyber Security Assurance on the business cycle, to be reflected in the Board Assurance Framework • Work is being undertaken at a system level in response to a national letter regarding Musculoskeletal Disorders • Work is ongoing through a working group on the Smoking Policy
✓	**Positive Assurances to Provide**	**Decisions Made**
	• Improving Together training is running to the agreed trajectory • During 2022/2023 IM&T delivered 33 new projects and 15 system upgrades • The internal audit report on Data Security and Protection Toolkit was substantial assurance • A comprehensive report which frames the work being undertaken as part of the Transformation Programme was provided although it will be further developed to provide an overarching view of transformation via a heat map or similar • NHSE have approved the Community Diagnostics Centre business case which is now awaiting Secretary of State approval - aimed to be open before March 2025 • During 2022/23 the Fire Safety Team has been fully recruited to which has contributed to the delivery of key objectives associated with statutory fire responsibilities • Staffordshire Fire and Rescue Service undertook an audit in October 2022 of 3 departments with a conclusion of satisfactory • June Staff Voice Survey response rates have increased to the highest levels	• It was agreed to utilise the meeting time scheduled for July to visit areas who have adopted the Improving Together methodology • The Committee approved the proposed driver and watch metrics and key assurance ratings as outlined within the Chief People Officer's Report • The Committee will agree an assurance assessment for the Chief People Officers report at the meeting in August • The Committee approved the reframed objectives for the Cultural Improvement Programme for 2023 – 2025 along with an assurance assessment of acceptable assurance

Comments on the Effectiveness of the Meeting

- The Committee commended the new style Chief People Officer report as an example of good practice and adoption of Improving Together tools
- The meeting worked well, the quality of papers has significantly improved which has made preparation easier, as well as being well chaired
- Giving sufficient time for new reports was important and necessary
- Important to ensure that the action log is completed in advance of the meeting

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Improving Together Countermeasures Summary	-	ID27153	!✓	Assurance	6.	Community Diagnostic Centres Update	BAF 4	Mod 6	✓	Assurance
2.	Freedom of Information (FOI) Improvement Report	BAF 6	ID25537	!	Assurance	7.	Executive Strategy & Transformation Group Assurance Report	BAF 4	Mod 6	-	Assurance
3.	Digital Strategy Update	BAF 6	Ext 16	!✓	Assurance	8.	Executive Health & Safety Group Assurance Report	-		!	Assurance
4.	Cyber Security Assurance Report	BAF 6	ID28304 ID9036	-	Assurance	9.	Fire Annual Report 22/23	BAF 7	High 12	!✓	Assurance
5.	Executive Digital and Data Security & Protection Group Assurance Report	BAF 6	Ext 16	!	Assurance	10.	Chief People Officer Report and Cultural Improvement Programme	BAF 2/3	12 16	!✓	Assurance

3. 2022 / 23 Attendance Matrix

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

Attended | Apologies & Deputy Sent | Apologies

Performance and Finance Committee Chair's Highlight Report to Board

27th June 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • The Committee noted that nine business case reviews were overdue, three of which were going through the review process. It was noted the any wider learning from business cases was shared through Trust Executive Committee • In relation to urgent care performance in May 2023, there was a slight deterioration against most metrics, in part due to a 12% increase in attendances. The Committee challenged current decision to admit times and queried when performance was expected to improve; it was noted that an accurate estimate could not be provided until the conclusion of bed modelling • Cancer 62 day performance for May stood at 57.8% which remained an area of concern and the trajectory for improvement was to be mapped against the colorectal position due to ongoing challenges as all other specialities were performing much better than this • In terms of planned care, at the end of May 36 patients were waiting over 104 weeks and 523 patients waiting over 78 weeks. The expected reductions for June and July were outlined • Month 2 financial performance stood at £3.8 m deficit which was an adverse variance of £5.5 m, in the main due to escalation capacity remaining open, junior doctor strike action and underperformance against the Trust's cost improvement programme target. A detailed year-end forecast was expected to be undertaken following month 3 • The Executive Infrastructure Group highlighted delays in implementation of the Electronic Prescribing and Medicines Administration system (EPMA) and Laboratory Information Management System (LIMS), due to high priority issues being identified which required mitigation before being taken any further forward	• Ongoing transformation work being undertaken in relation to an integrated discharge hub • Challenges in demand and capacity had been highlighted by a NHSE review of endoscopy and it was agreed to provide the outputs of the review to a future Committee • To provide F&A/revenue information associated with the Acute Targeted Investment Fund to the next Committee for approval • To advise the Trust Board of how the revenue elements of the County Daycase and County Breast Unit Business cases will be addressed • It was agreed to consider future reporting of information from the Non-elective Improvement Group to the Committee
✓ Positive Assurances to Provide	Decisions Made
• The Committee welcomed the positive benefits delivered as highlighted by the business case review of the Urology Nephrectomy case • Cancer 2 week wait performance in May stood at 94% and for the 28 day faster diagnosis standard performance was 63.3%. • The Committee noted the positive overview of 22/23 financial statements and analytical review which had been prepared as part of finalising the financial statements	• It was agreed to hold a further discussion regarding the network and communication services business case in addition to the 12 month extension, on 30th June, before the cases were taken to the Trust Board in July • The Committee approved the following eREAFs; 10826 - Supply of Sutures, 11043 - Recombinant Factors, 11092 - Sub Contract for Endoscopy Diagnostics Services, 1152 Endoscopy Consumables – Boston, 11166 - Supply of Haemostatic Sealants and 11172 - In Centre Haemodialysis Consumables • At the extraordinary meeting held 28th June, the Committee supported the submission for the Acute Targeted Investment Fund Business Case and approved the bid for capital associated with County Daycase Unit and County Breast Unit
Comments on the Effectiveness of the Meeting	
• No further comments were made	

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
Meeting held 27th June 2023											
1.	Network and Communication Services Business Case	BAF 6	28451 25870 9036 22949	-	Approval	7.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-		-	Approval
2.	Network and Communication Services 12 Month Extension Nasstar		24580 25457 23753	-	Approval	8.	Executive Infrastructure Group Assurance Report	BAF 7	High 12	!	Assurance
3.	BC-0442 Urology Nephrectomy Demand Business Case Review	BAF 5	Ext 20	✓	Approval	9.	Non-Elective Improvement Group Highlight Report • Future Reporting	BAF 5	Ext 20	-	Information
4.	Business Case Review Update	-		!	Assurance	10.	Planned Care Improvement Group Highlight Report	BAF 5	Ext 20	-	Information
5.	Performance Report – Month 2 2023/24	BAF 1/5	Ext 20	! ✓	Assurance	11.	Overview of 2022/23 Financial Statements and Analytical Review	BAF 8	Mod 4	✓	Information
6.	Finance Report – Month 2 2023/24	BAF 8	Mod 4	!	Assurance						
Meeting held 28th June 2023											
1.	Acute Targeted Investment Fund – Business Case	BAF 5	Ext 20	-	Approval	3.	County Breast Unit and CTS Ph2 – Short Form Business Case	BAF 5	Ext 20	-	Approval
2.	County Daycase Unit – Short Form Business Case	BAF 5	Ext 20	-	Approval						

3. 2023 / 24 Attendance Matrix

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

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

Executive Summary

Meeting:	Trust Board	**Date:**	5th July 2023
Report Title:	Integrated Performance Report, Month 02 2023/24	**Agenda Item:**	11.
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & Safety; Operational Performance: Warren Shaw, Strategic Director of Performance & Information; Matt Hadfield, Associate Director of Performance & Information. Workforce: Paul Williams, Assistant Director of Human Resources; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Chief Operating Officer Jane Haire: Chief People Officer Mark Oldham: Chief Finance Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Executive Summary

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

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

Quality & Safety

During the increased operational pressures experienced by UHNM and health system there has been continued pressure on the achievement of the various quality and safety indicators but May2023 has seen some improvements in areas whilst other indicators have continued to fail the agreed targets.

Friends & Family Test for A&E has declined during May 2023 and remains below the 85% target of patients recommending the service. Whilst there has been improvement in the results in recent months and remains above the mean recommending rate there has also been a reduced response rate with 9% (896 returns) in May 2023 compared to over 1200 in April 2023. UHNM is now 31st out of 125 Trusts for number of responses completed.
Inpatient FFT results are still above the 95% target. Whilst the results score has decline slightly there has been an improved response rate with 23% compared to 20% response rate for Inpatient related FFT in April 2023. There were over 2500 responses returned in May 2023 from 65 different inpatient and day case areas across UHNM. There are key improvement initiatives identified previously are continuing and focus on key priorities identified within the FFT returns – timely medications, better pain management and improving the involvement of patients and/or family in care and decision making

There has been continued improvement for Maternity FFT has again achieved the 95% target and following the launch of the text messaging service. During May, 95.6% of the completed responses recommended the service with 91 completed responses and 47 from the Birth touchpoint.

Complaints rate remains below the target/benchmark rate of 35 and has remained below this target and long term mean rate for 14 months.

The number of reported patient safety incidents remain above the long term mean but has increased this month although the rate per 1000 bed days has continued to remain relatively stable.

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers continue to be Patient Falls, Medication, Patient Flow and then Clinical Assessment related incidents. Within these incidents 97 117 (reduction from 117 in April, 157 in March, 170 in February and 228 in January 2023) of the incidents identified as related to 'Your Next Patient' which accounted for 4.8% (6.2% in April, 7.4% in March, 9.8% in February and 12% in(January 2023) of total patient safety incidents. 34% (53% previously) were Tissue viability. However, 72.5% of these were NOT hospital acquired but recording pressure damage on admission/attendance at UHNM.

Moderate harm or above incidents, both raw numbers and rate per 1000 bed days have increased in May 2023 but remain within normal variation following previous increases reported in December 2022 and January 2023. There is still a longer term increase and remain above the long term mean although total and rate are now nearer to the mean averages. It is key to note that during May 2023 there have 2 'Your Next Patient' / patient flow related incidents however the harms were not as a result of utilising the YNP procedures. As noted previously the different working practices and patient flow pathways continue to show positive impacts.

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

There was1 new Never Event reported during May 2023 in relation to an incorrect lesion being removed. The incident has been reported on STEIS and is under ongoing investigation to identify learning and improvement. As part of the review of this incident the actions / recommendations from previous incidents relating to incorrect lesion removal are

to be reviewed to assess the effectiveness and whether the recommendations made previously have been followed.

Duty of Candour compliance for evidence in written notification has improved to 80% and is the best performance for 9 months since August 2022. The dedicated sessions with various Directorates and clinical teams appear to have had positive impacts along with the increased support and escalations from the Divisional Quality & Safety Managers.

Hospital Associated Thrombosis rate has reduced further in May 2023 with 17 cases and rate of 0.84 per 10,000 admissions.

The current position for received patient Safety Alerts shows that there were 3 new Patient Safety Alerts issued during May 2023 and they have all been assessed and closed within timescale during May 2023. There remains 1 overdue Nat/PSA 2021 005 MHRA - Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particles and volatile organic compounds. Thus remains open whilst the final risk assessment is signed off. The risk is being managed and reviewed at the Medical Devices Steering Group and plan is for the risk assessment to be finally agreed at July 2023 meeting.

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

Operational Performance

Emergency Care

- May saw slight deteriorations from the recent highs of April across the majority of Non-Elective Care KPI as a result of an approximately 12% increase in attendances month on month. This however maintains a continuation of an overall improvement from the October, November, and December baseline and importantly achieves both the Four Hour Standard and G&A Bed Occupancy targets for May against the Annual Operational Plan.

- In order to maintain compliance with the Annual Operational Plan progress must now be expedited against RSUH Non-Admitted Four Hour Standard in the ED ambulatory and CED areas as the largest single driver of overall performance against the Four Hour Standard. It has therefore been agreed through Workstream 1 and with the local leadership team that initiatives will commence at the start of July focussed on non-clinical administrative support (productivity), additional consultant support during known hours of challenge (capacity), and the final expansion of the modular Fit2Sit area (infrastructure).

- Final written confirmation has now been received for the £20m+ combined capital and revenue monies following a successful bid for the Additional Capacity Targeted Investment Fund. This investment will release 50 G&A beds for the Medical Division through the backfill of services moving into the new modular unit located outside of the SCH and CED entrance. Engagement with wider clinical teams is now underway to finalise the details of the proposed clinical model and early estimates place completion of the unit between January and March 2024. Given the significance and scale of this investment delivery will be robustly managed through Workstream 2 reporting through the Non-Elective Improvement Group on a monthly basis.

- The new National Oversight Framework reporting structure for UEC with UHNM in Tier 2 remains in place with the frequency of meetings decreasing to once every two weeks. Verbal feedback has again bean reaffirmed that continued performance against current levels will be sufficient to enable UHNM to exit Tier 2 for UEC oversight completely.

<u>Cancer</u>

- Two week wait performance continues to book within standard at 14 days, currently at 93.91%. This has been maintained in the face of high referral volumes.
- The 28 Day Faster Diagnosis position is currently 60.6% for May; this had been showing signs of improvement towards the 75%target, however is feeling the impact of the endoscopy backlog. This standard is the focus of an Improving together project covering all pathways.
- In May the backlog of patients needed at 513. This position had been improving, but had begun to increase again due to the challenges in endoscopy. This is described in detail on slide 24.
- The incremental decrease of the Skin and Colorectal backlogs have been modelled to continue past March 2023, this has been taken forward into the annual plan for the coming year. Colorectal is a pathway of concern feeling the impacts in the endoscopy delays.
- Most recent submitted Cancer Waiting Times position is April which was 61.3% for 62 day performance. May is currently predicted to be 50.3% although this will improve post validation, this is due to the number of treatments for our longest waiting patients increasing.
- The 62 day target has slipped its improvement trajectory due to the impact of endoscopy delays on the colorectal pathway, however capacity has been sourced to managing the backlog.
- Cancer will form a workstream as part of the Planned Care governance structure – this will initially focus on our challenged pathways of Skin and Colorectal, alongside 2WW and FDS more generally.
- The Trust has been escalated to Tier 1 for elective care and cancer will be included within weekly meetings with the Regional NHSE team, however due to the significant improvement in the cancer position this will be at summary level.

<u>Planned Care</u>

- Day case as a % of all elective work is currently 87.7%.
- There is a real focus on 104w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 78week+ patients however there remained 523 78 week patients at the end of May and number of 104 remain. The April 104 position ended at 36.
- Current modelling with additional capacity schemes a prediction on 94 78week patients at the end of July with 0 patients over 104 weeks.
- Theatre transformation has been added as an additional workstream under Planned Care and begins with a focus on moving from a 6-5-4 to a 6-4-2 booking process with support from the regional theatres team. This is now a driver for the surgical Improving together programme

<u>RTT</u>

- The overall Referral To Treatment (RTT) Waiting list currently sits at 78982, this has been relatively stable over the past few months, although significantly higher than were we would want it to be.
- The number of patients > 52 weeks currently sits at 4837, this is a decrease on the April month end of 5135.
- The Trust has been escalated to Tier 1 for 104> & 78> performance with weekly meetings with the National NHSE team and considerable scrutiny and on site presence.

Diagnostics

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

Workforce

Key messages

- Our two main areas of focus continue to be on addressing staff availability in relation to absence rates and turnover.
- The 12m Turnover rate in May 2023 sat at 9.58% figure sitting below the trust target of 11%.
- The M2 figure of 10.65% highlights a decrease in the overall vacancy rate over the previous month.
- For M2, the in-month sickness rate decreased by 0.22% to 4.39% (4.61% in April 2023). The 12-month cumulative rate decreased to 5.56% (5.65% in April 2023).
- Stress and Anxiety remains to be the top reason for sickness in May, which saw and increase of 0.14% in the last month to 22.9% (22.8% in April). Chest & respiratory problems saw a decrease of 0.56% in the last month to 19.0% (19.6% in April 2023).
- On 26 June 2023 covid-related absences stood at 29, which was 4.11% of the 705 open absences. This is 1.73% decrease on same time the previous month.
- On 31st May 2023, the PDR Rate decreased by 1.46% to 83.8% (85.3% on 30 April 2023).
- Statutory and Mandatory training rate on 31 May 2023 was 94.1% (93.8% on 30 April 2023) showing a slight increase. This compliance rate is for the 6 'Core for All' subjects only.
- The Being Kind e-learning is now mandated from 1 April 2023 and face-to face sessions have now started from June.
- The Staff Voice trust survey May 2023 received a total of 1062 submissions providing an overall colleague engagement score of 6.47.
- April 2023 received a total of 652 submissions providing an overall colleague engagement score of 6.31.

Finance

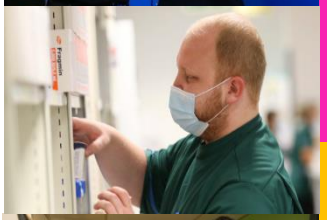
Key elements of the financial performance year to date are:

- For Month 2 the Trust has delivered a year to date deficit of £3.8m against a planned surplus of
- £1.7m; this adverse variance of £5.5m is primarily driven by underperformance against the Trust's in year CIP target and unfunded additional winter escalation capacity that remains open.
- The Trust has incurred £1.5m of costs relating to winter escalation capacity remaining open in April and May. The Month 2 position assumes that this additional cost will be not be funded by the local ICB.
- To date the Trust has validated £5.6m of CIP savings to Month 2 against a plan of £9.2m. The
- £3.5m under delivery of CIP is driving the in month overspend against plan. Schemes of £47m have been identified for delivery in 2023/24. The PMO is currently working with scheme leads to develop robust plan to deliver these savings. The £8.0m divisional schemes remain unidentified.
- There has been £4.3m of Capital expenditure which is £0.5m below plan.
- The cash balance at Month 2 is £82.4, which is £1.8m lower than plan. Cash holdings are below plan mainly due to additional accounts payable payments.

Key Recommendations

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

NHS
University Hospitals of North Midlands
NHS Trust



Integrated Performance Report

Month 02 2023/24

Delivering Exceptional Care with Exceptional People

NHS
University Hospitals of North Midlands
NHS Trust

Contents

A note on SPC

The following report uses statistical process control (SPC) methods to draw two main observations of performance data;

Variation - are we seeing significant improvement, significant decline or no significant change

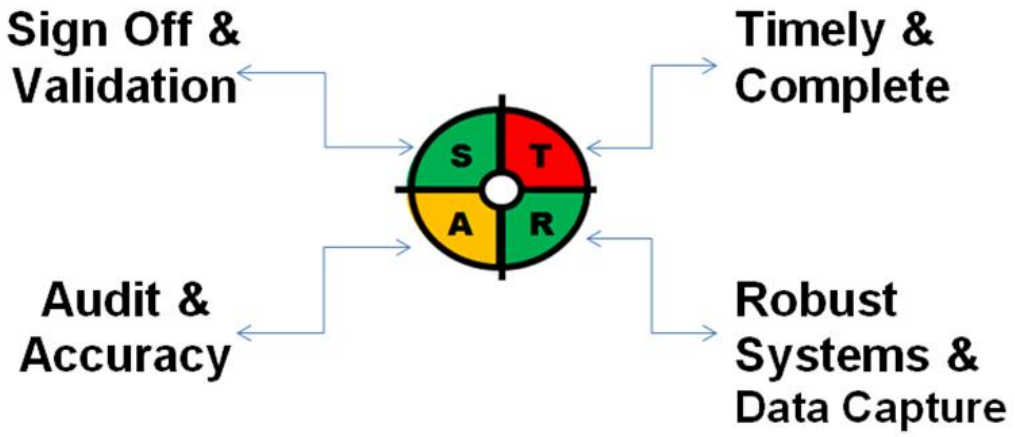
Assurance - how assured of consistently meeting the target can we be?

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

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

A note on Data Quality

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



Explaining each domain

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

RAG rating key

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

NHS
University Hospitals of North Midlands
NHS Trust

Quality

Caring and Safety

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

Quality Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

The Trust achieved the following standards in May 2023:

- Friend & Family (Inpatients) 95.2% and exceeds 95% target.
- Friend & Family (Maternity) 95.6% and exceeds 95% target.
- Harm Free Care improved and continues to exceed 95% target rate with 97.8%
- 100% verbal Duty of Candour compliance recorded in Datix
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues above 95% target with 98.5% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- Inpatient sepsis Screening and Sepsis IVAB within 1 hour achieved 98.8% and 97.0% respectively and above 90% target rate
- Children's Sepsis IVAB within 1 hour compliance improved to 100% and above the 90% target
- Maternity IVAB compliance 100% and above the 90% target for audited patients

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E has declined and remains below 85% target at 72.5%
- Falls rate was 6.2 per 1000 bed days for May 2023
- There were 27 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 80% compliance with Duty of Candour 10 working day letter performance following formal verbal notification and under review for completion and upload of letter on Datix
- 1 Never Event
- Timely Observations remain below the 90% target but has seen improvement during recent months
- E. Coli Bacteraemia cases above trajectory with 19 in May compared to target of 16.
- C Diff YTD figures above trajectory with 17 against a target of 8.
- Sepsis Screening compliance in Emergency Portals declined to 81.8% below the target 90%.
- Children's Sepsis Screening compliance improved to 92.9% but remains below the 90% target
- Emergency Portals Sepsis IVAB in 1 hour improved to 56.8% but remains below the 90% target for audited patients
- Maternity Sepsis Screening compliance improved to 88.9% against 90% target
- 1 overdue and open Patient Safety Alert in relation to replacement of Phillips ventilator, CPAP/BiPAP machines. Issue of risk register and manage through MDSC

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

- The rate of complaints per 10,000 spells is 28.72 and is below the target of 35 and within normal variation but with significantly lower variation with 14 months below the mean rate.. Majority of complaints in May 2023 continue to relate to clinical treatment.
- Total number of Patient Safety Incidents increased in month (2030) but the rate per 1000 bed days has remained relatively constant at 47.91 and is within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents remain in control limits and normal variation levels. Rate of incidents continue to reduce following peak in December 2022.
- Rate of falls reported that have resulted in harm to patients currently at 1.8 per 1000 bed days. The rate of patient falls with harm continues to be within the control limits and normal variation.
- Medication related incidents rate per 1000 bed days is 7.1 and patient related 5.9 which are higher than previous month and mean rates. The monthly variation is outside the normal expected variation but is in line with NRLS national rates..
- Pressure Ulcers per 1000 bed days developed under UHNM care is now 0.51 in May 2023 and above the target rate 0.5
- Hospital Associated Thrombosis has continued to decrease and is within normal variation and cases are under review.
- 14 Serious Incidents reported during with 8 falls related.
- SHMI has seen increases and under review for diagnosis groups but is within expected range (see funnel plot chart)

Quality Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Benchmark	Previous	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1920	2030		
Patient Safety Incidents per 1000 bed days	50.70	48.87	48.91		
Patient Safety Incidents per 1000 bed days with no harm	N/A	31.05	33.54		
Patient Safety Incidents per 1000 bed days with low harm	N/A	15.70	12.75		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.50	1.71		
Patient Safety Incidents with moderate harm +	N/A	22	37		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.56	0.89		
Harm Free Care (New Harms)	95%	95.7%	97.8%		
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		
Patient Falls per 1000 bed days	5.6	5.4	6.2		
Patient Falls with harm per 1000 bed days	1.5	2.0	1.5		
Medication Incidents per 1000 bed days	6	5.5	5.3		
Medication Incidents % with moderate harm or above	0.50%	0.00%	2.90%		
Patient Medication Incidents per 1000 bed days	6	4.8	4.3		
Patient Medication Incidents % with moderate harm or above	0.50%	0.00%	3.57%		

Metric	Benchmark	Previous	Latest	Variation	Ass
Serious Incidents reported per month	0	8	14		
Serious Incidents Rate per 1000 bed days	0	0.20	0.34		
Never Events reported per month	0	0	1		
Duty of Candour - Verbal/Formal Notification	100%	87.0%	100.0%		
Duty of Candour - Written	100%	47%	80.0%		
All Pressure ulcers developed under UHNM Care	TBC	76	64		
All Pressure ulcers developed under UHNM Care per 1000 bed day	N/A	1.93	2.10		
All Pressure ulcers developed under UHNM Care lapses in care	12	27	27		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.71	0.51		
Category 2 Pressure Ulcers with lapses in Care	8	6	7		
Category 3 Pressure Ulcers with lapse in care	4	2	2		
Deep Tissue Injury with lapses in care	0	16	7		
Unstageable Pressure Ulcers with lapses in care	0	4	5		

Delivering Exceptional Care with Exceptional People

Quality Dashboard

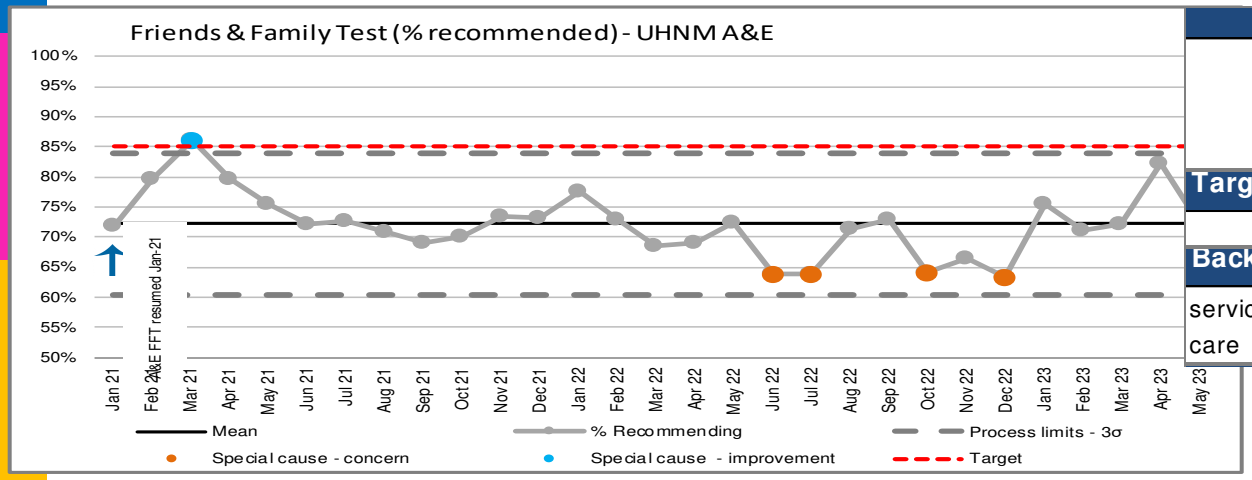
NHS
University Hospitals of North Midlands
NHS Trust

Metric	Benchmark	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	82.4%	72.5%		
Friends & Family Test - Inpatient	95%	95.4%	95.2%		
Friends & Family Test - Maternity	95%	100%	100.0%		
Written Complaints per 10,000 spells	35	25.49	28.72		
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	95.73	96.49		
Rolling 12 Month SHMI (4 month time lag)	100	106.64	105.66		
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	8	3		
VTE Risk Assessment Compliance	95%	98.0%	98.5%		
Timely Observations	90%	67.8%	68.6%		
Reported C Diff Cases per month	8	17	17		
Avoidable MRSA Bacteraemia Cases per month	0	0	0		
HAI E. Coli Bacteraemia Cases per month	16	22	19		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	50	13		

Metric	Benchmark	Previous	Latest	Variation	Ass
Inpatient Sepsis Screening Compliance (Contracte	90%	86.0%	98.8%		
Inpatient IVAB within 1hr (Contracted)	90%	97%	97.0%		
Children Sepsis Screening Compliance (All)	90%	83%	92.9%		
Children IVAB within 1hr (All)	90%	N/A	100.0%		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	85.3%	75.3%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	89.80%	71.4%		
Maternity Sepsis Screening (All)	90%	70%	88.9%		
Maternity IVAB within 1 hr (All)	90%	100%	100.0%		

Delivering Exceptional Care with Exceptional People

Friends & Family Test (FFT) – A&E



Variation	Assurance
	F

Target	Mar 23	Apr 23	May 23
85%	72.1%	82.4%	72.5%

Background

service to friends and family if they needed similar care or treatment

What do the results tell us?

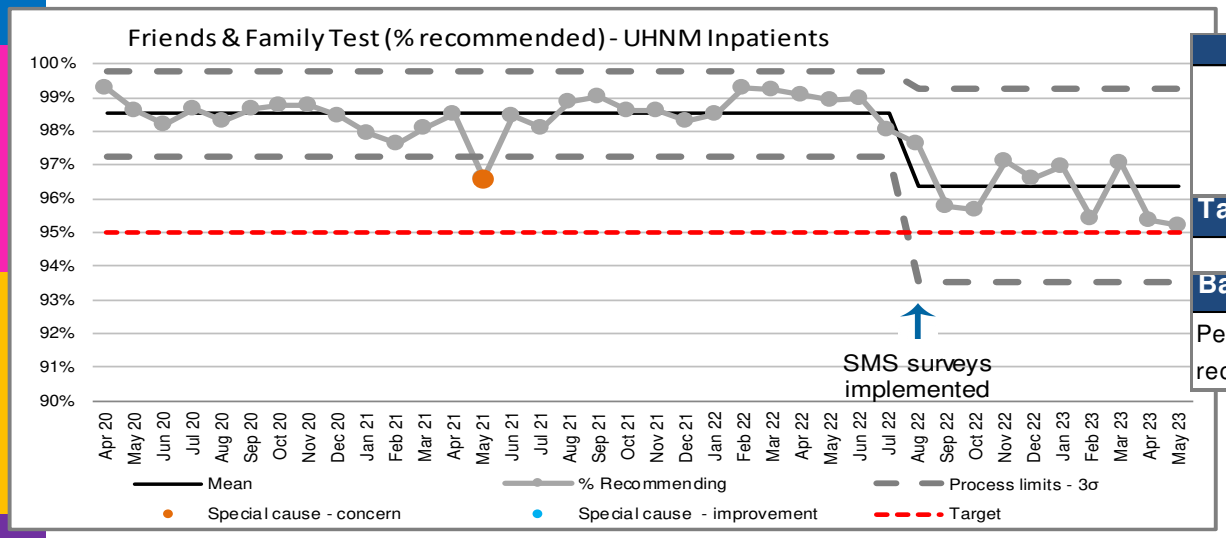
- The overall satisfaction rate for our EDs remains below our internal target at 72.5% for May 2023 despite improvements over the past 4 months .
- The Trust received 896 responses which is a decrease on the previous month with a 9% response rate for overall. The Trust's overall satisfaction rate is lower than the national average of 80% (NHS England February 2023 latest figure) at 73%. UHNM is 31st out of 125 Trusts for number of responses in ED (NHS England February 2023).
- Feedback from patient experience of using 111First and the kiosks is being monitored. 23% of respondents in May 23 reported to have used 111First prior to attending ED, which remains the same as for April 23. Key themes from May2023 remain the same: poor communication, long waits, especially related to Royal Stoke; lack of compassion and patient's feeling dismissed. And these are similar across RSUH and County Hospital.

Actions :

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

Friends & Family Test (FFT) - Inpatient

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Mar 23	Apr 23	May 23
95%	97.1%	95.4%	95.2%

Background

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

What do the results tell us?

- The monthly satisfaction rate for inpatient areas continue to exceed both the internal target rate of 95% and the national average of 94% (February 2023 NHS England) at 95.2% for May 2023.
- In May 2023 a total of 2579 responses were collected from 65 inpatient and day case areas (11401 discharges) equating to a 23% return rate which is a increase on the previous month however remains lower than the internal target of 30%. UHNM remain the 14th highest response rate for all reporting Trusts in the country (154) NHS England February 2023 (most recent data available).

Actions:

- Continue to ensure that FFT surveys are available in multiple formats to ensure accessibility for all patients.
- Focus on Medicine in June & July to try and increase response rate.

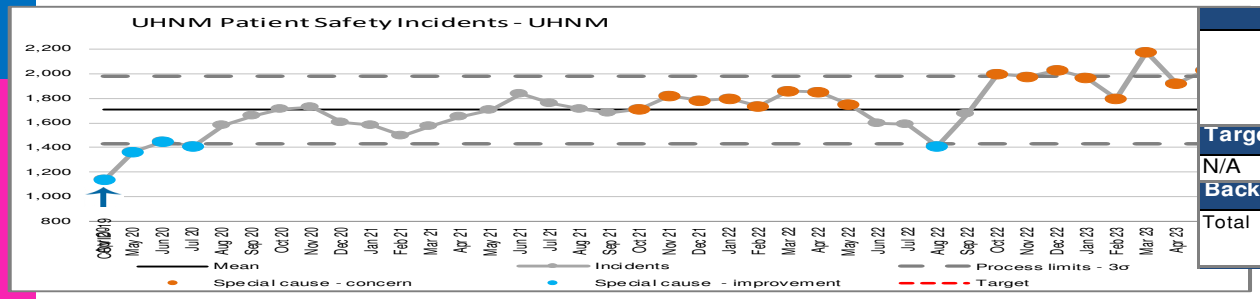
Work continues around a suite of patient priorities based on patient feedback:

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

Delivering Exceptional Care with Exceptional People

Reported Patient Safety Incidents

NHS University Hospitals of North Midlands NHS Trust

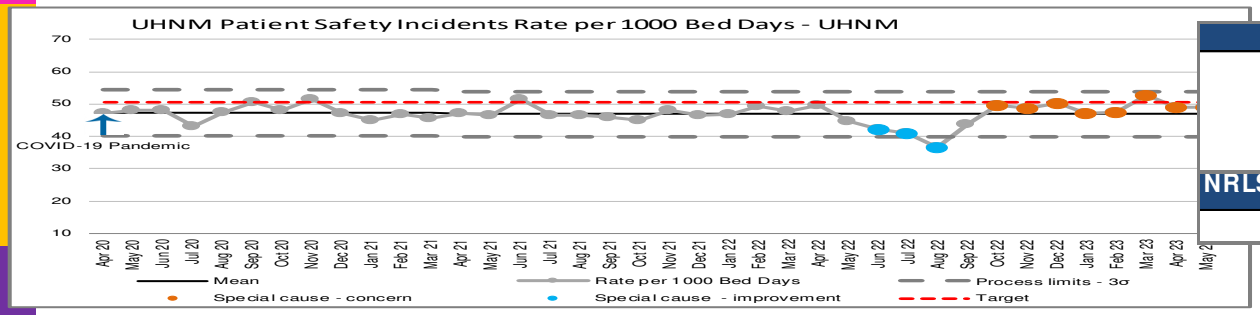


Variation	Assurance
	

Target	Mar 23	Apr 23	May 23
N/A	2177	1920	2030

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Mar 23	Apr 23	May 23
50.70	52.60	48.87	48.91

What is the data telling us:

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

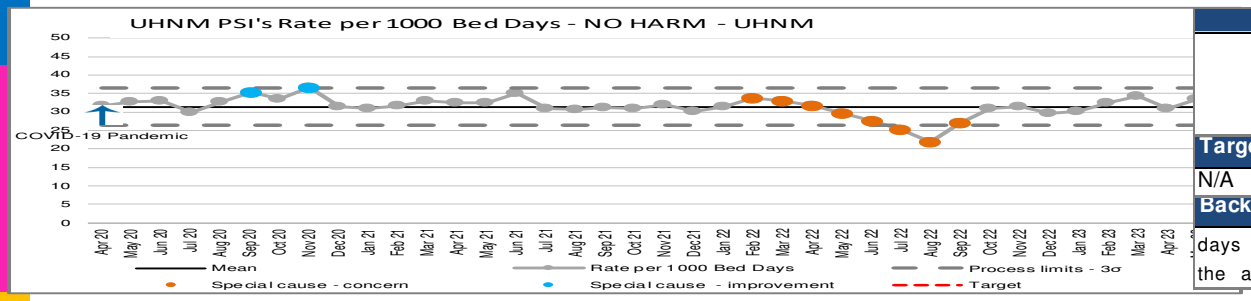
However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers are Patient Falls, Patient Flow, Medication, Clinical Assessment and Treatment related incidents. There has been no significant changes in these categories compared to previous months. There have been 97 (reduction from 117 in April, 157 in March, 170 in February and 228 in January 2023) of the incidents identified as related to 'Your Next Patient' which accounts for 4.8% (6.21% in April, 7.4%in March, 9.8% in February and 12% in(January 2023) of total patient safety incidents. 34% (52.99% previously) were Tissue viability. However, 72.5% of these were **NOT** hospital acquired but recording pressure damage on admission/attendance at UHNM.

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

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

University Hospitals of North Midlands NHS Trust

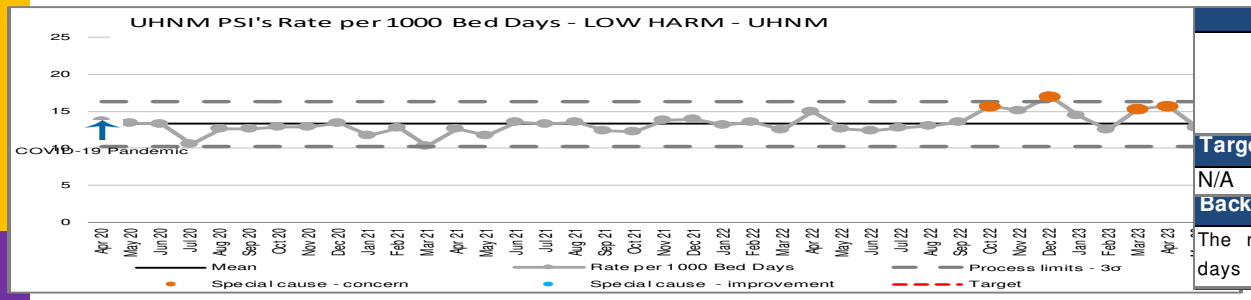


Variation	Assurance

Target	Mar 23	Apr 23	May 23
N/A	34.36	31.05	33.54

Background

days that are reported as resulting in No Harm to the affected patient.

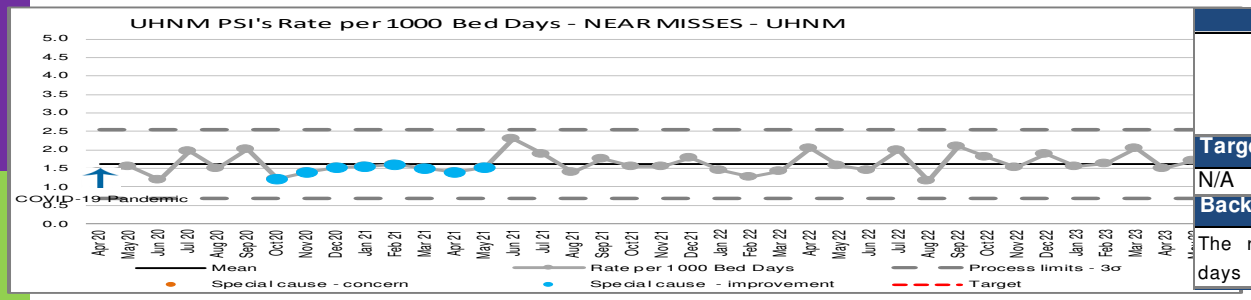


Variation	Assurance

Target	Mar 23	Apr 23	May 23
N/A	15.37	15.70	12.75

Background

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



Variation	Assurance

Target	Mar 23	Apr 23	May 23
N/A	2.05	1.50	1.71

Background

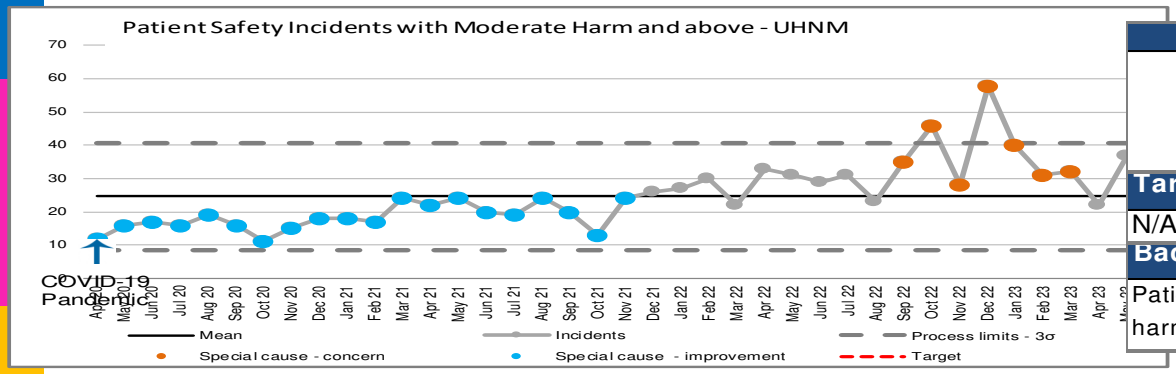
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

What is the data telling us:

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

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

Reported Patient Safety Incidents with Moderate Harm or above

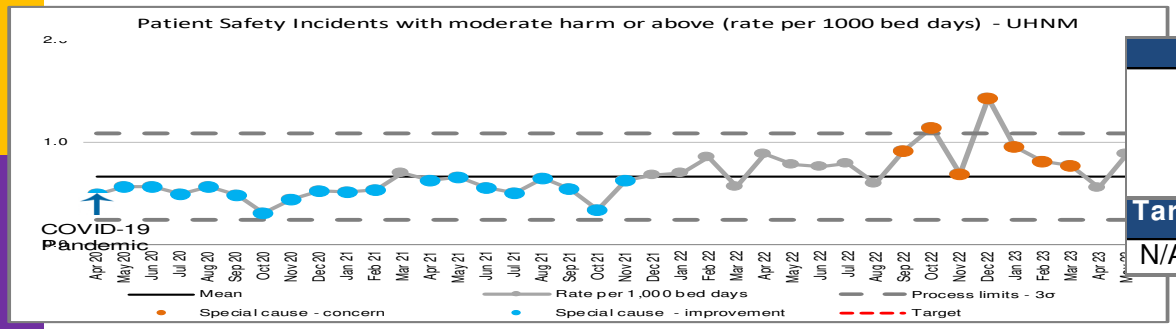


Variation	Assurance
	

Target	Mar 23	Apr 23	May 23
N/A	32	22	37

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance
	

Target	Mar 23	Apr 23	May 23
N/A	0.77	0.56	0.89

What is the data telling us:

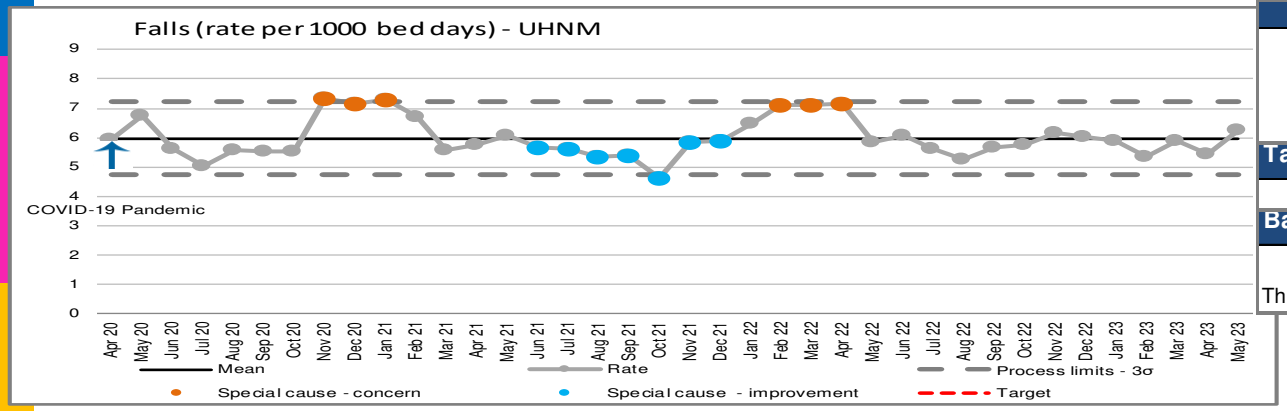
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within control limit but has shown increasing total numbers since August 2022. The rate of moderate harm and above has also increased in May but is also within normal variation.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 6 Falls, 5 Pressure Ulcer (Hospital acquired), 4 Treatment/Procedure, 3 Medication and Clinical assessment

Two of these moderate harm and above incidents were noted as relating to **'Your Next Patient'** but the harm was not as result of utilising YNP procedure. 1 was patient fall when got out of bed and second was related to delay in porter and access to CT Scan in A&E

Patient Falls Rate per 1000 bed days

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Mar 23	Apr 23	May 23
N/A	5.9	5.4	6.2

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

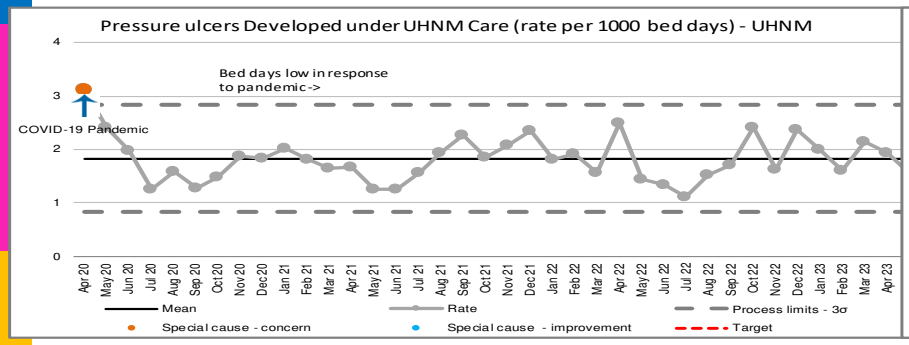
The Trust's rate of reported patient falls per 1000 bed days was within the normal range in May.

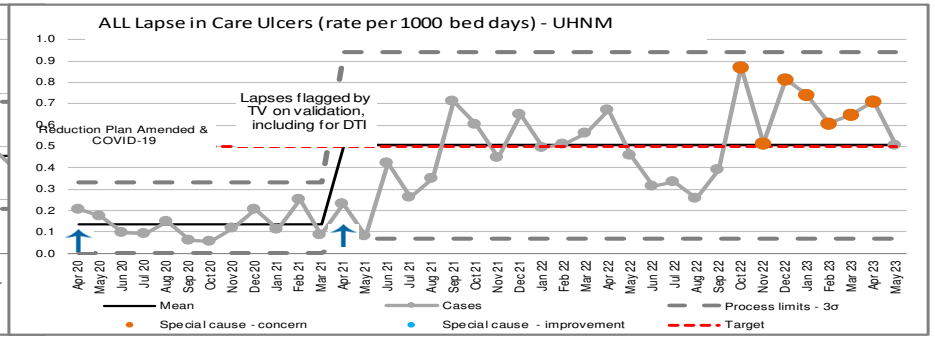
The areas reporting the highest numbers of falls in May 2023 were:
Royal Stoke AMU – 23 falls, Royal Stoke ECC – 21 falls, Ward 223 – 10 falls, Ward 110 – 10 falls
ED falls numbers per month have doubled since Autumn 2020, however, the rate per 1000 attendances has also been 77% higher since Autumn 2020 indicating that increased activity may not be the only factor behind increased falls.

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

- Audits continue to be undertaken in all of the TOP 5 reporting areas. Results have been fed back to the ward managers and their teams. Time is given for the wards to action the findings and then there is a re-audit undertaken. Support is given to the areas where no improvement is made and communication is made with the matron of the area.
- The ECC team held a falls awareness week on the 16.5.23. A meeting is taking place to discuss any changes to be made to the ECC admission booklet regarding falls.
- Call bell signs have been placed into each cubicle in the emergency department, encouraging the patients to utilise these.
- A discussion has been held between ECC and AMU in order to identify the patient that has falls factors on transfer. ECC were to be trialling yellow wristbands for these patients. However other areas of the hospital use yellow wristbands for other meanings and therefore this will be taken back to the falls steering group next week.
- AMU have updated the current risk assessment booklet so that this includes the multifactorial risk assessment. This has been sent out for approval.
- A discussion has taken place between Matrons in both ECC and AMU. A new falls champion training day is to take place to ensure the areas have enough champions to deliver the training.

Pressure Ulcers developed under care of UHNM per 1000 bed days





Variation	Assurance

Target	Mar 23	Apr 23	May 23
N/A	2.15	1.93	1.54

Background

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

Variation	Assurance

Target	Mar 23	Apr 23	May 23
0.5	0.65	0.71	0.51

Background

whilst under the care of UHNM with lapses in care identified

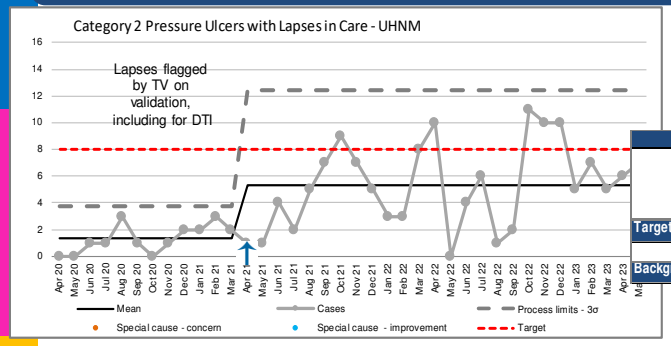
What the data is telling us

The rate of pressures ulcers reported as developed under UHNM care and the rate of cases with lapses in care identified were within expected limits in May.
Where a patient can not be repositioned due to acuity, this must be documented, otherwise a potential lapse in care may be identified.
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.
Pressure Ulcer prevention is an annual objective and a key driver metric as part of the Trust's Improving Together programme.

Actions

- Training continues for nursing assistants induction, ED mandatory training, Preceptorship days, and oveseas nurses
- Pressure prevention days are arranged for all trust staff to attend, it will be a rolling programme for the remainder of the year
- Requests being made by wards for further training on skin bundles, investigation process, categorisation and dressing selection
- ESR approved by Stat/mand group has been approved - package awaiting NWCSP updates on PU terminology
- Skin health booklet has been approved – again waiting NWCSP updates on PU terminology
- Stakeholder group created for patient seating. To update the chair and mattress audit with IP and start re-auditing areas
- CQUIN for a sample of 100 patients has been completed 23/24. Poor compliance for patient preference
- Clinical Audit underway to cover period of October – December 23
- A3 on urethral erosions have been completed, actions identified. Catheter audits have been completed, currently awaiting continence audits

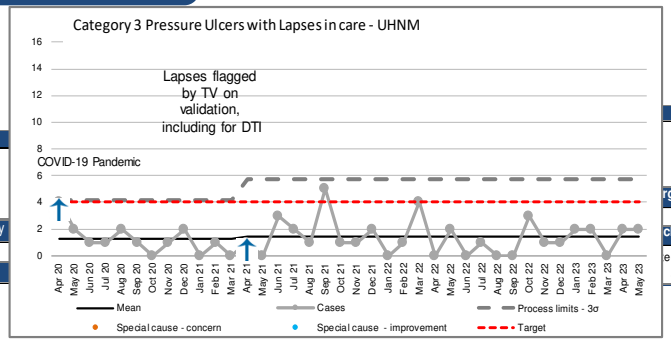
Pressure Ulcers with lapses in care



Variation	Assurance

Target	Mar 23	Apr 23	May
	8	5	6

Background

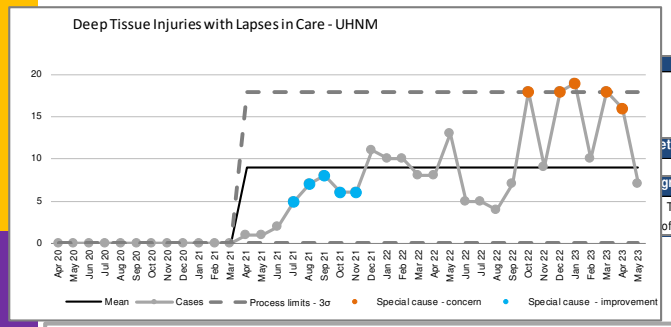


Variation	Assurance

rget	Mar 23	Apr 23	May 23
	4	0	2	2

ckground

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

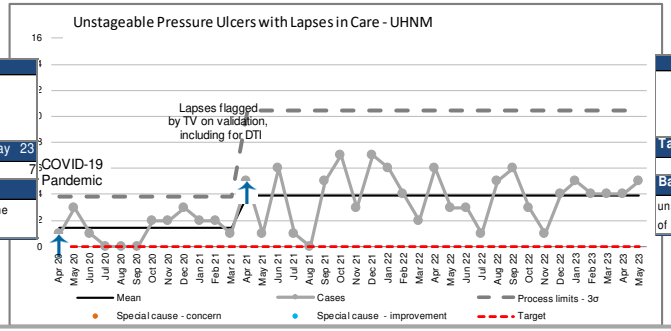


Variation	Assurance

t	Mar 23	Apr 23	May 23
	18	16	7

ground

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



Variation	Assurance

Target	Mar 23	Apr 23	May 23
0	4	4	5

Background

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

What is the data telling us:

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

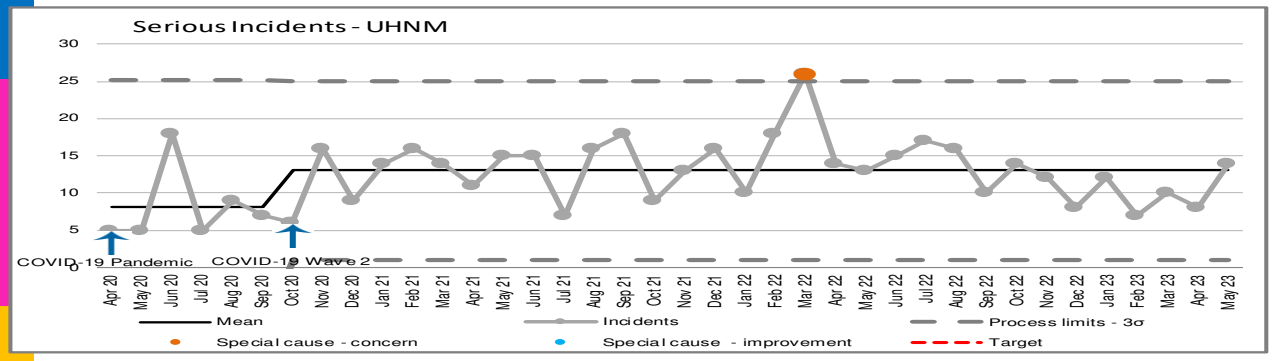
Locations with more than 1 lapse in May 2023 were:
Ward 111 (3), AMU Stoke (2), SSCU (2), Ward 123 (2)

Root Cause(s) of damage - Lapses - May 2023	Total
Management of repositioning	14
Management of heel offloading	6
Management of non-concordance	3
Management of device	1

Actions:

- Review of investigation process to implement PSIRF and review the tools
- High reporting wards and wards of concern are visited by Quality and Safety and Tissue Viability to complete audits and deliver education
- Bespoke panels are held for areas of concern and multiple reporting areas and areas are encouraged to bring along staff for learning experience
- Training video on accountability and documentation will be an action following RCA panel
- Training video has been made for care of catheters after an increase in urethral damage, along with the catheter life chart being updated and plans to re-launch. Continence master classes have released dates for training. This will be proposed as an action through RCA panels

Serious Incidents per month

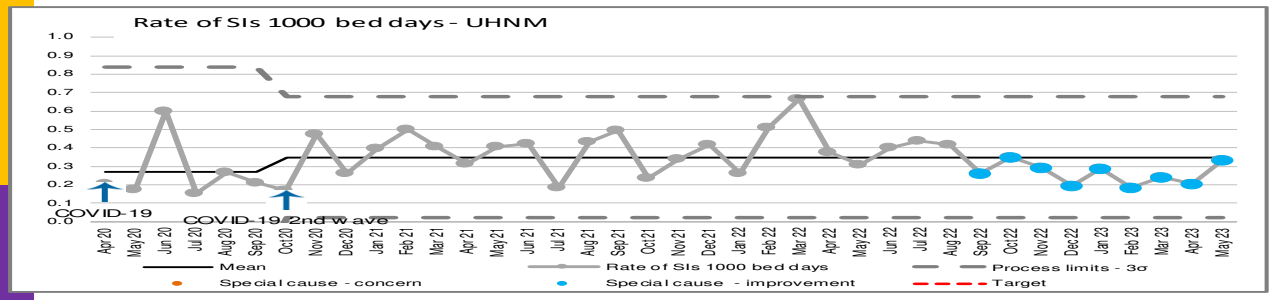


Variation	Assurance
	F

Threshold	Mar 23	Apr 23	May 23
0	10	8	14

Background

The number of reported Serious Incidents per month



Variation	Assurance
	F

Target	Mar 23	Apr 23	May 23
0	0.24	0.20	0.34

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

Monthly variation is within normal limits. Target has been set at 0 for serious incidents but this remains under review to develop trajectory for reducing serious incidents across UHNM. May 2023* saw 14 incidents reported:

- 8 Falls related incidents
- 3 Surgical/Invasive procedure related
- 1 Diagnostic related including delay making diagnosis
- 1 Blood product/transfusion related [1]
- 1 Treatment delay related

[1] The Blood product related incident dates back to November 2022 and was removed from the ICB database in error. This was identified on completion of the RCA action plan and submission for closure back to the ICB. As a result , the incident has been re-submitted and has therefore been included in this months SI total.

The rate of SIs per 1000 bed days has varied consistently within confidence limits indicating normal variation and there has not been any significant trends. The current rate of SIs per 1000 bed days is 0.234 and is lower than the long term mean of 0.4 since COVID-19 started in December 2020. The previous 9 months have seen reporting rate lower than log term mean.

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

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

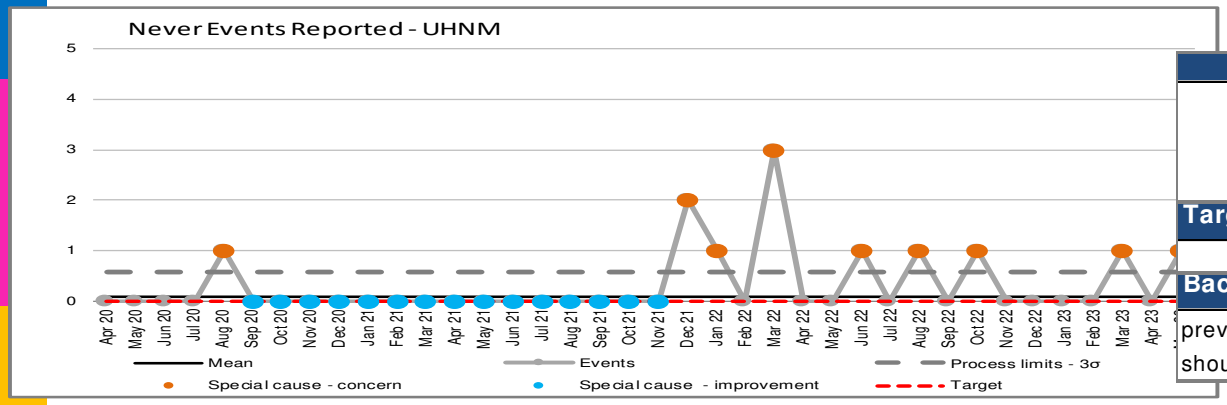
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during May 2023. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

There was 0 Maternity related Serious Incidents reported on STEIS during May2023

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

Never Events



Variation	Assurance
H	?

Target	Mar 23	Apr 23	May 23
0	1	0	1

Background

preventable, as strong systemic protective barriers should be in place

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

Log No.	STEIS Category	Never Event Category	Description	Target Completion date
2023/9207	Surgical invasive procedure incident meeting SI criteria	Wrong site surgery	Incorrect lesion removed – identified following contact from patient relative	28/07/2023

As part of the review of this incident, previously reported incorrect lesion cases will be reviewed to assess whether the previously identified and actioned recommendations were followed to assess their effectiveness

Duty of Candour Compliance

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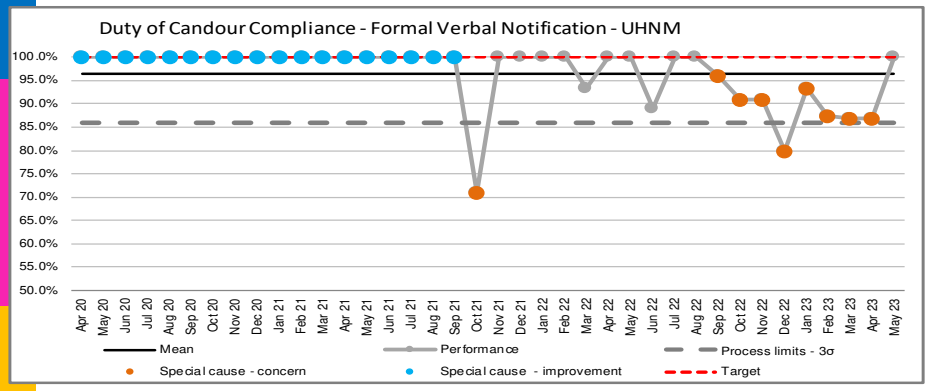
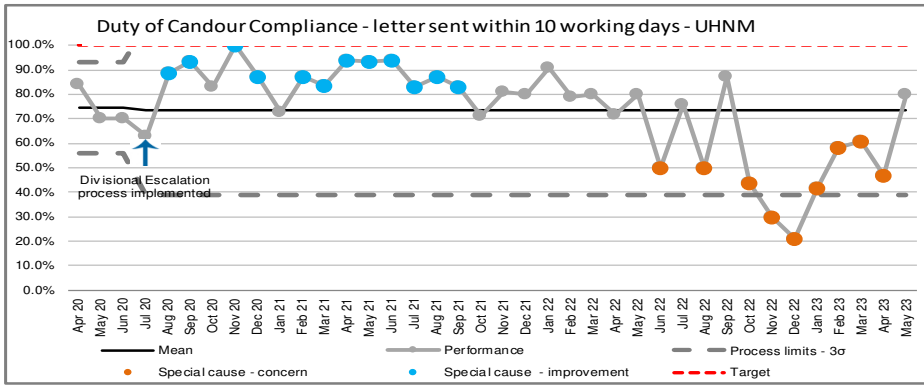




Variation	Assurance
	

Target	Mar 23	Apr 23	May 23
100%	87.0%	87.0%	100.0%

Background

reported per month with verbal notification recorded/undertaken

Variation	Assurance
	

Target	Mar 23	Apr 23	May 23
100%	60.9%	47.0%	80.0%

Background

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

What is the data telling us:

During May there were 20 incidents reported and identified that have formally triggered the Duty of Candour. 100% have recorded that the patient/relatives been formally notified of the incident in Datix and within normal variation.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification **and recorded in Datix**) during May 2023 was 80% as at 8th June 2023 including those letters that are still within timescale. The cases that have not met the 10 day target have all had written notification forwarded and therefore 100% of the cases have received formal duty of candour follow up.

Actions taken:

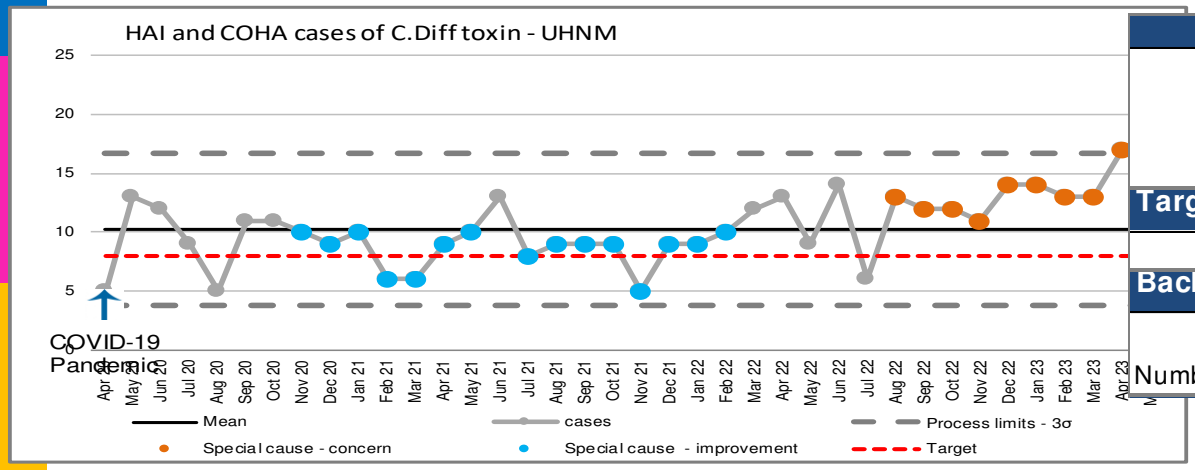
Divisions are continuing to work with and support clinicians and Q&S teams to raise further awareness and education on how and why Duty of Candour is to be completed.

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

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

Reported C Diff Cases per month

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
H	?

Target	Mar 23	Apr 23	May 23
8	13	17	17

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

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

There have been 17 reported C diff cases in May 2023 with 9 being Hospital Associated Infection (HAI) cases and 8 COHA cases.
HAI: cases that are detected in the hospital three or more days after admission (day 1 is the day of admission)
COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
There has been three clinical areas that has had more than one Clostridium *difficile* case in a 28 day period. FEAU 2x toxin, Ward 78 1 x toxin HAI and 1 x COHA. ward 81 toxin HAI 1 and 1 x COHA, Ward 15 2 x toxin COHA.

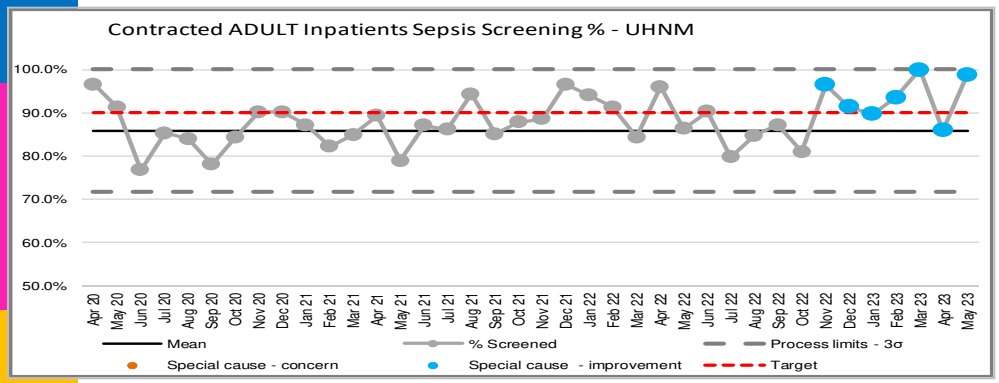
The top 3 areas for C Diff toxin during May were FEAU , Ward 78, Ward 81

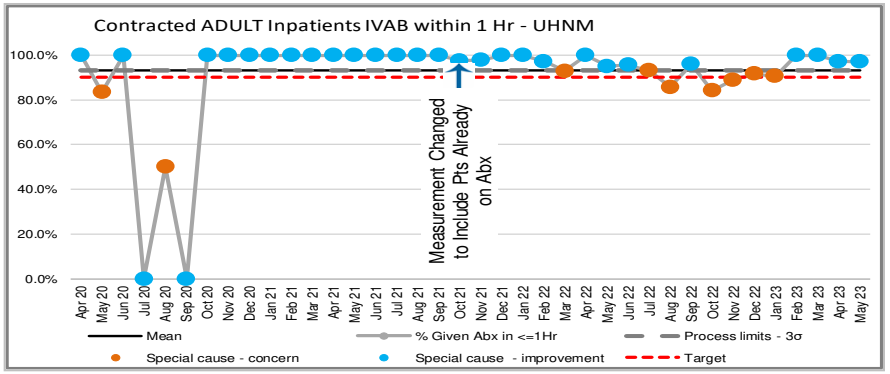
Actions:

- Routine ribotyping of samples continues
- Recruitment to the C Diff Nurse role has been successful and commenced 20th February 2023. This role is 50% patient reviews/50% staff training.
- The bi-weekly Cdiff MDT meeting has been re-commenced
- Review of the RCAs demonstrate that patients had received antibiotics prior to CDI results, with sepsis, UTI , pneumonia being the most common indications from antibiotics.
- To remind clinical areas send urine samples when UTI is suspected
- CDI Task and Finish Group for West Building to be reinstated
- RCAs continue to be reviewed by ICB in relation to avoidability

Sepsis Screening Compliance (Inpatients Contract)

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
H	?

Target	Mar 23	Apr 23	May 23
90%	100.0%	86.0%	98.8%

Background

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

Variation	Assurance
H	P

Target	Mar 23	Apr 23	May 23
90%	100.0%	97.1%	97.0%

Background

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

What is the data telling us:

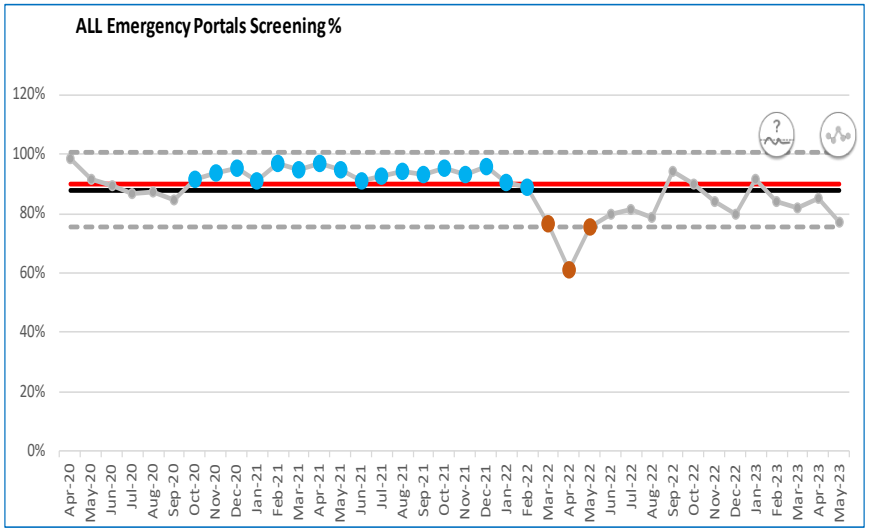
Inpatient areas achieved the screening and the IVAB within 1 hour target for May 2023. There were 84 cases audited with 1 missed screening from different ward areas or divisions. Out of 84 cases audited, 56 cases were identified as red flags sepsis with 23 cases having alternative diagnosis and 33 cases were true red flags. Out of 33 true red flag cases, 31 were already on IVAB treatment and 1 was given IVAB treatment within 1 hour target. However 1 screening identified 1 IVAB was given over the 1 hour target.

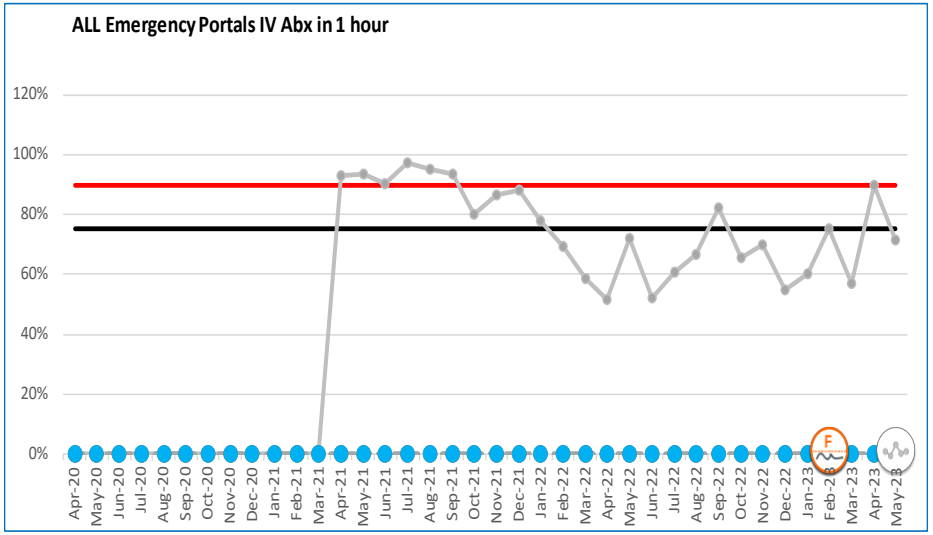
Actions:

- Sepsis training/ kiosks continue to all levels of staff
- The Sepsis Team continue to raise awareness the importance of sepsis screening and IVAB compliance by being involved in HCA, students and new nursing staff induction programmes; on-going
- The Sepsis team will continue to promote sepsis awareness in both sites and will prioritise areas to visit with the sepsis clinical lead consultant; on-going
- Sepsis Champion training (5 hours CPD) will be available to all level of clinical and medical staff, date arranged on 11th July 2023

Sepsis Screening Compliance (Emergency Portals Contract)

NHS
University Hospitals of North Midlands
NHS Trust





What is the data telling us:

Adult Emergency Portals screening did not meet the target rate for May 2023. There were 78 cases audited with 18 missed screening in total from the emergency portals. The performance for IVAB within 1 hour achieved 72.9%. Out of 78 cases, there were 66 red flags sepsis in which the 18 cases already on IVAB, 31 cases were newly identified sepsis and 18 cases have alternative diagnosis. There were 13 delayed IVAB within 1 hour, this is mainly contributed by both ED RS and SAU. Missed screening contributed by both ED sites, FEAU and SAU.

Actions:

- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E daily. Provide sepsis session when staffing and acuity allows.
- The Sepsis team is working collaboratively with the A&E Quality nurses, sepsis champions, senior team and A&E sepsis clinical lead to provide support with late IVAB incidents and missed screens. Issue with holding ambulances remain a challenge.
- Face to face A&E sepsis induction/ training for new nursing staff, nursing assistant and medical staff already recommenced. Sepsis kiosks also recommenced by the sepsis team.
- Regular meeting with A&E senior team reinstated to review current process and actions; on-going
- Monitoring impact of long ambulance waits on timely assessment and treatment of sepsis; on-going
- Sepsis champion day training (5 hour CPD) will be available to clinical and medical staff, date arranged on 11th July 2023

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

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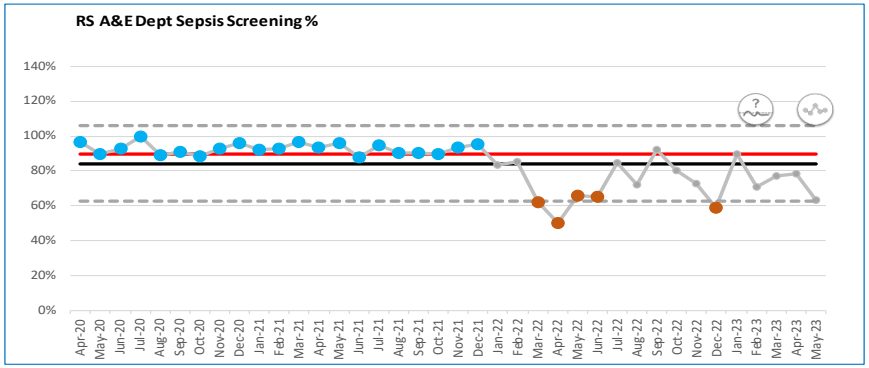
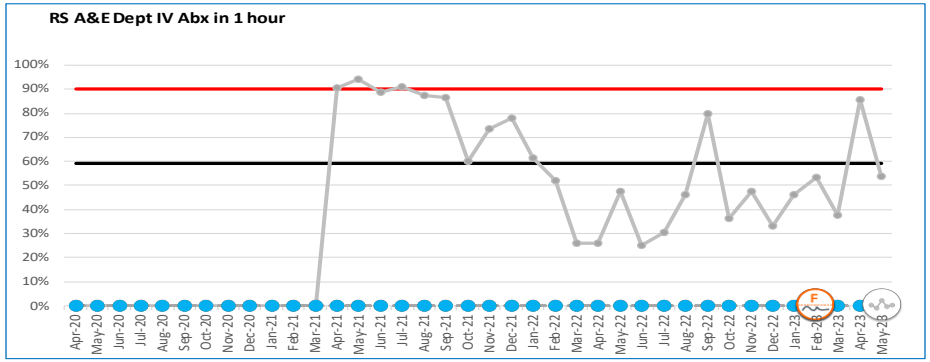
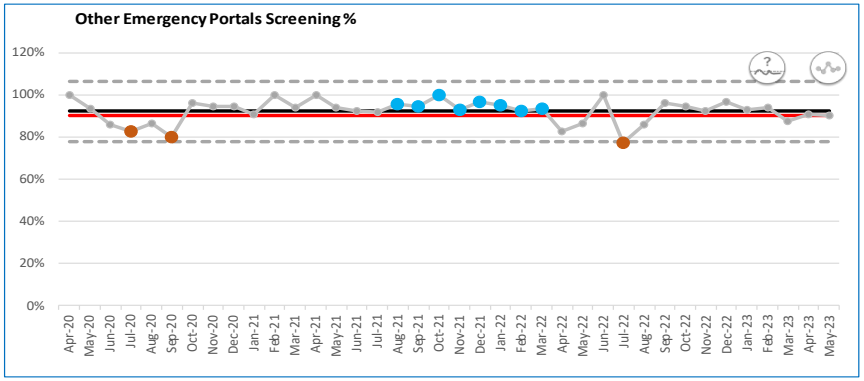
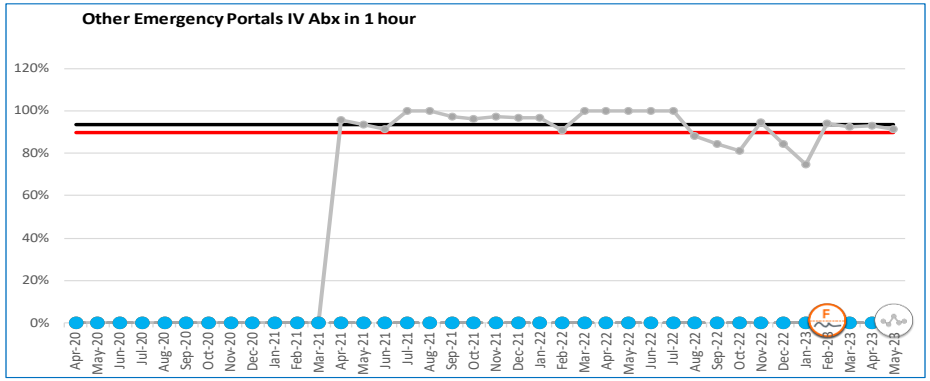
University Hospitals of North Midlands
NHS Trust









What is the data telling us:

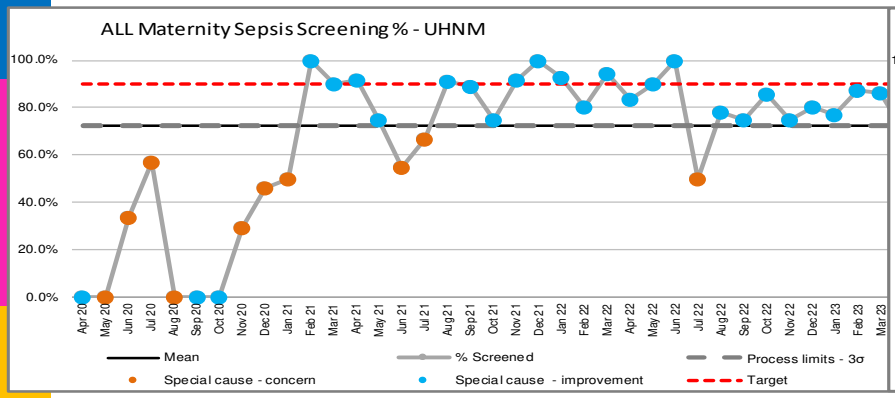
RSUH Emergency Department performance in May 2023 remains below target rate. The RSUH ED is driving the overall Emergency Portals performance as other emergency portals are achieving Screening compliance and IVAB within 1 hour. However, this month it is slightly below target for screening (ED County, FEAU and SAU) and IVAB within 1 hour for SAU.

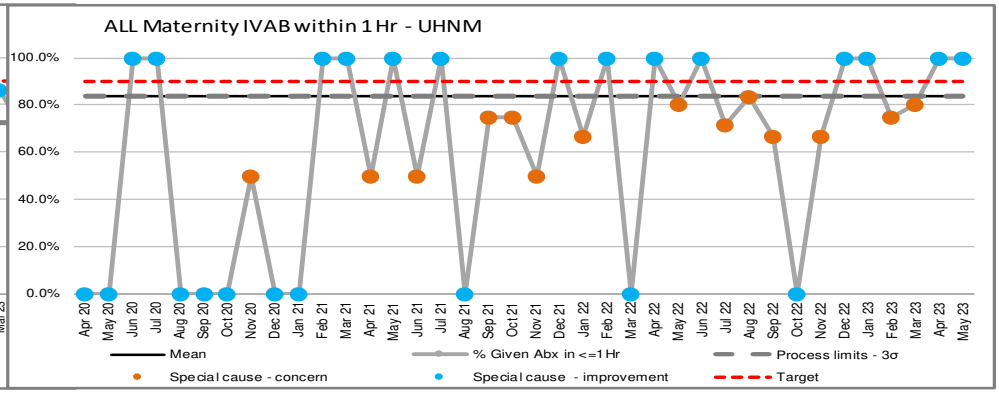
Actions:

- CAS card has been further updated to reflect the sepsis pathway and to ensure all staff are following the correct guidance (awaiting new printing from Harlow)
- Directorate devised a SOP for nursing staff to advise of agreed actions of Ambulance assessment nurse to escalate NEWS and sepsis trigger to the Resus Consultant. The Vocera call system will be used throughout the department for patients sepsis trigger and to ensure correct urgent antibiotic prescription and administration.
- Sepsis kiosks re-instated in ED focusing the importance of sepsis screening documentation and urgent escalation for true red flag sepsis triggers

Sepsis Screening Compliance ALL Maternity

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
H	F

Target	Mar 23	Apr 23	May 23
90%	86.2%	70.0%	88.9%

Background

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

Variation	Assurance
H	F

Target	Mar 23	Apr 23	May 23
90%	80%	100%	100%

Background

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

What is the data telling us:

Maternity audits in screening compliance is below the target at 90% however IVAB within 1 hour continue to improve to 100% in May 2023. This compliance score is based on a small number, however a regular spot checks audit is being conducted monthly.

There were 20 cases audited from emergency portal (MAU) and inpatients with 3 missed screening. There were 8 true red flags identified from the randomise audits, 1 alternative diagnosis, 1 already on IVAB and 6 cases received IVAB within 1 hour

Actions:

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

Sepsis Screening Compliance ALL Children

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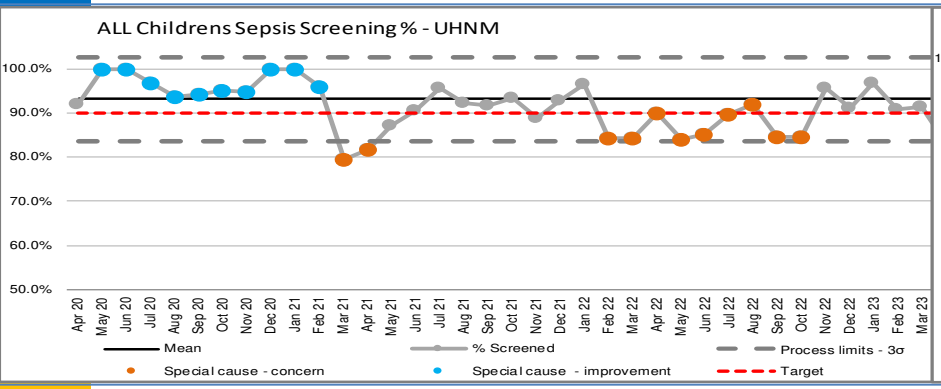

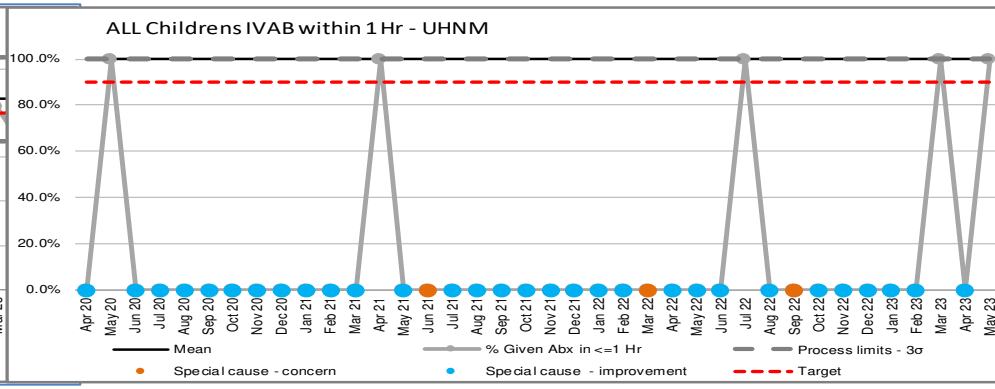

Variation	Assurance
	?

Target	Mar 23	Apr 23	May 23
90%	91.4%	83.3%	92.9%

Background

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

Variation	Assurance
	P

Target	Mar 23	Apr 23	May 23
90%	100.0%	N/A	100.0%

Background

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

What is the data telling us:

Children's Services target rate of > 90% was achieved for May. Still seen small numbers of children trigger with PEWS > 5 & above in Inpatients areas. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks). There were 28 cases audited for emergency portals and inpatients areas with 2 missed screening (from 217 & Children's ED). One true red flag sepsis was identified from the randomise audits in inpatients.

Actions:

- The Sepsis Team continue to deliver sepsis drop in session (ward base training) as well as providing sepsis Induction session for newly qualified staff
- The Sepsis Team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective; on-going
- Plan of collaborative work with Children education lead and aiming to deliver 3-5 hour Sepsis CPD champion training and ward based sessions: on- hold but plan to reinstate in the next few months

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Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Non-Elective Care

- Context
  - ED Conversion decreased to 31.0% in May from 33.0% in April
  - 12 Hour Trolley Waits increased from 286 in April to 665 in May (although this still represents an overall improvement trend)
  - Type 1 A&E Attendances also increased by approximately 12% April to May from 13024 to 14525
- Driver Metrics
  - 12+ Hours In ED deteriorated from 1437 in April to 1757 in May (although this again represents an overall improvement trend)
  - Ambulance Handovers <60 Minutes decreased from 95.8% in April to 89.7% in May (remaining above baseline performance)
  - Four Hour performance remained static from 70.1% in April to 69.4% in May against a target of 66.9%

Cancer

- Trust overall 2WW Performance achieved 93.7% in April 23 – a sustained achievement since last month.
- The Trust also predicted to achieve the 2WW in May. This sustained improvement is as a result of schemes such as the Lower GI Community Referral hub and Community Teledermatology pathways being successfully implemented.
- Breast symptomatic (where cancer is not suspected) achieved at 100% in April and is predicted to achieve the target again in May.
- The 62 Day Standard achieved better than predicted in April at 60.2%. The current provisional position for May is 53.6%. This is an un-validated and incomplete position that is expected to change as pathology confirms or excludes cancer for treated patients. Contributing factors include treatment and diagnostic capacity, with robust plans in place to tackle the most challenged specialties (LGI) over the next quarter.
- The 31 Day Standard remained the same as last month and achieved 90.2% for April. It is predicted to land at 86% in May.
- The 31 day Subsequent Radiotherapy achieved 93.9% in April, just shy of the 94% target, and is expected to achieve 80.4% in May.
- The 28 Day Faster Diagnosis Standard achieved 63.2% for all referral routes combined in April. The May position is currently incomplete and will be validated once Pathology confirms cancer or non cancer on high volume pathways such as Skin. Areas of best practice consistently achieving the standard are Breast and Upper GI.
- Suspected Breast Cancer, Skin and Lower GI continue to book 2WW referrals within 7 days, for first appointments.
- In August last year the PTL was over 6000 – this has now reduced to around 3500 in total.

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Planned Care

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

- Day Case activity and Elective Activity have moved from delivering 73% and 83% in April to 74.22% and 72.82% respectively for May. There is a real focus on the reintroduction of 6-5-4 with support from the regional theatres team. Day case as a % of all elective work is currently 87.7%.
- The focus has moved to 65 week waiters with an Annual Plan to reduce them to below 200 patients by end of March 2024. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge as soon as possible so any treatment can be carried out to meet the 65 week standard. The unvalidated number of 78 week breaches for end of May is 523.
- At the end of May the validated numbers of >104 patients was 36, a significant decrease from 53 at the end of April. The Trust has continued to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment. The Trust remains challenged in the delivery treating all patients waiting over 104 weeks, and the current unmitigated risk for the end of June is 9. This is predicted to be 5 with mitigating actions.

RTT

- The overall Referral To Treatment (RTT) Waiting has increased again from 78,094 in April to 78,982 (unvalidated) in May. This is within the normal monthly variation.
- The number of patients > 52 weeks has decreased, currently standing at 4,837 (unvalidated), down from 5,135 in April.

Diagnostics Summary

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

Histology position – as at 29th May 2023:

- **Urgent:** 95% reported at Day 23 (previously Day 20), with 80% of cases reported by Day **11** (previously Day 13)
- **Accelerated:** 95% reported at Day **30** (previously Day 35)**,** with 80% of cases reported by Day **20** (previously Day 25)
- **Routine:** 95% reported at Day **29 (previously 36),** 80% of cases reported by Day **22** (Previously Day 19)

Radiology reporting backlog:

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

Endoscopy:

- In-sourcing continues with expansion planned
- Outsourcing/mutual aid being explored
- Booking Team skills bank being developed

Section 1: Non-Elective Care

Headline Metrics

Non-Elective Care – monthly *(context)*

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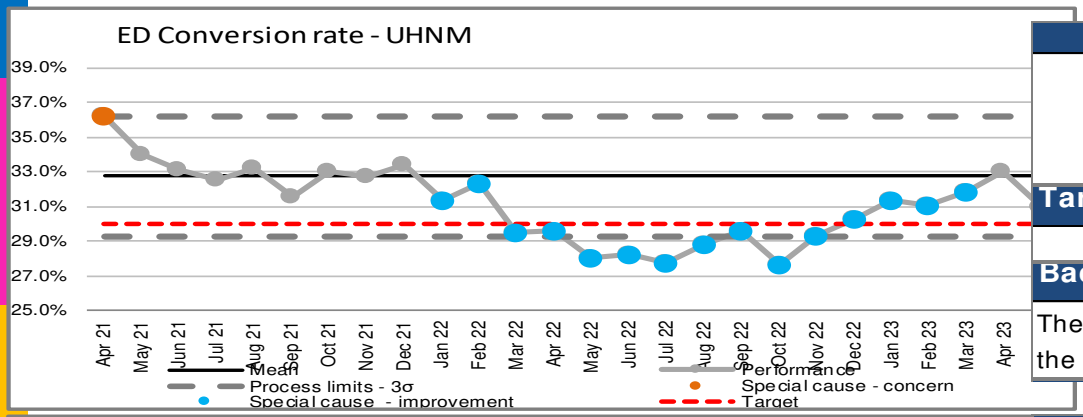
NHS Trust

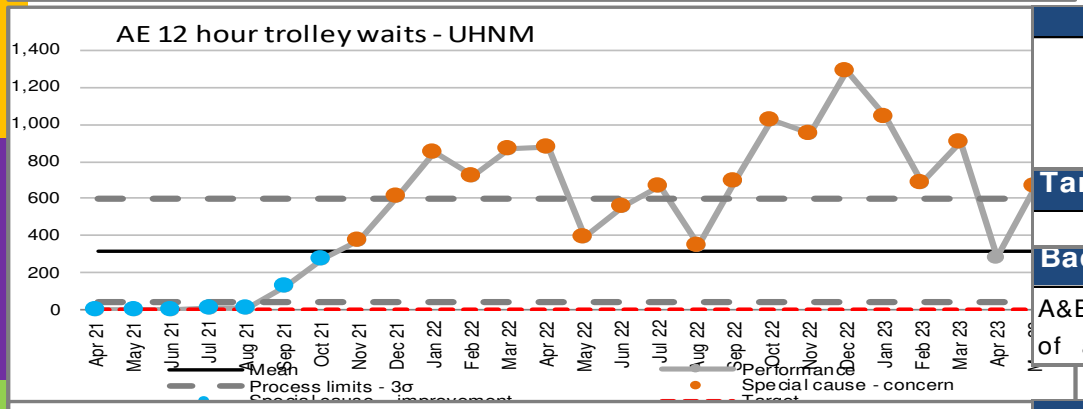


Variation	Assurance
	?

Target	Mar 23	Apr 23	May 23
30%	31.8%	33.0%	31.0%

Background

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

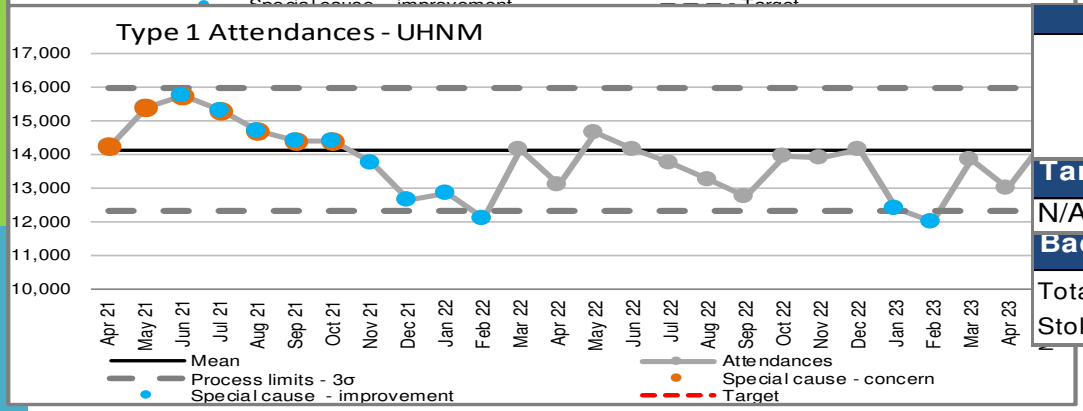


Variation	Assurance
H	F

Target	Mar 23	Apr 23	May 23
0	906	286	665

Background

A&E from the decision to admit time to the time of actual admission.



Variation	Assurance

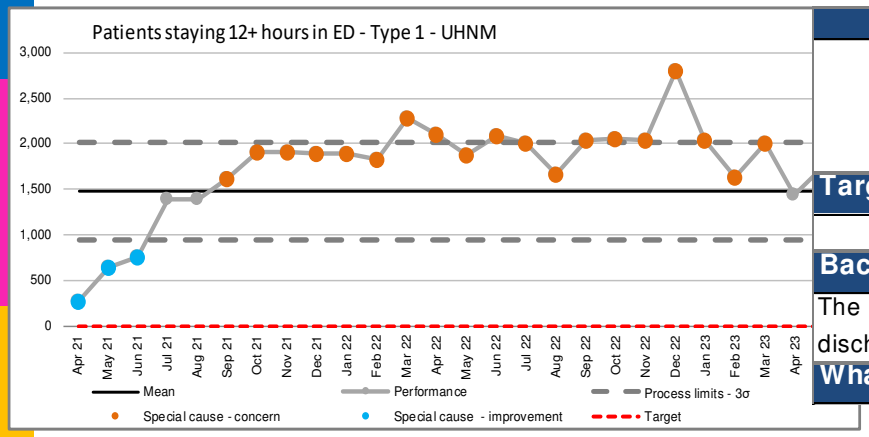
Target	Mar 23	Apr 23	May 23
N/A	13868	13024	14524

Background

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

Non-Elective Care – Headline Metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

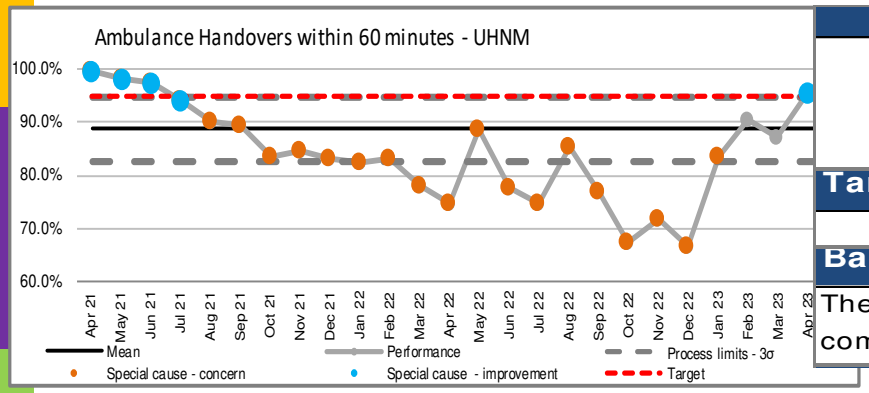
Target	Mar 23	Apr 23	May 23
0	2010	1437	1757

Background

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

What is the data telling us?

Patients waiting over 12 hours in ED increased during May above the two year average.



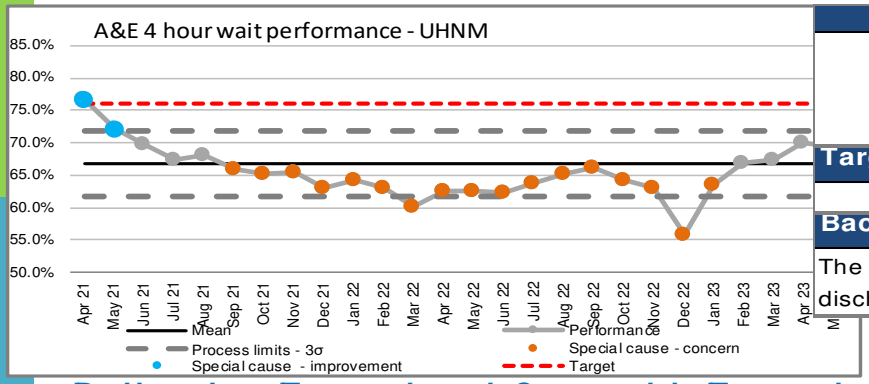
Variation	Assurance
	F

Target	Mar 23	Apr 23	May 23
95.0%	87.0%	95.8%	89.7%

Background

The percentage of ambulance handovers completed within 60 minutes.

Ambulance handovers within 60 minutes dropped in May, but still remain above the two year average.



Variation	Assurance
	F

Target	Mar 23	Apr 23	May 23
76%	67.4%	70.1%	69.4%

Background

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

4 hour performance remains below the 76% target but above the two year average.

Non-Elective Care – DTA waits over 12 hours

NHS
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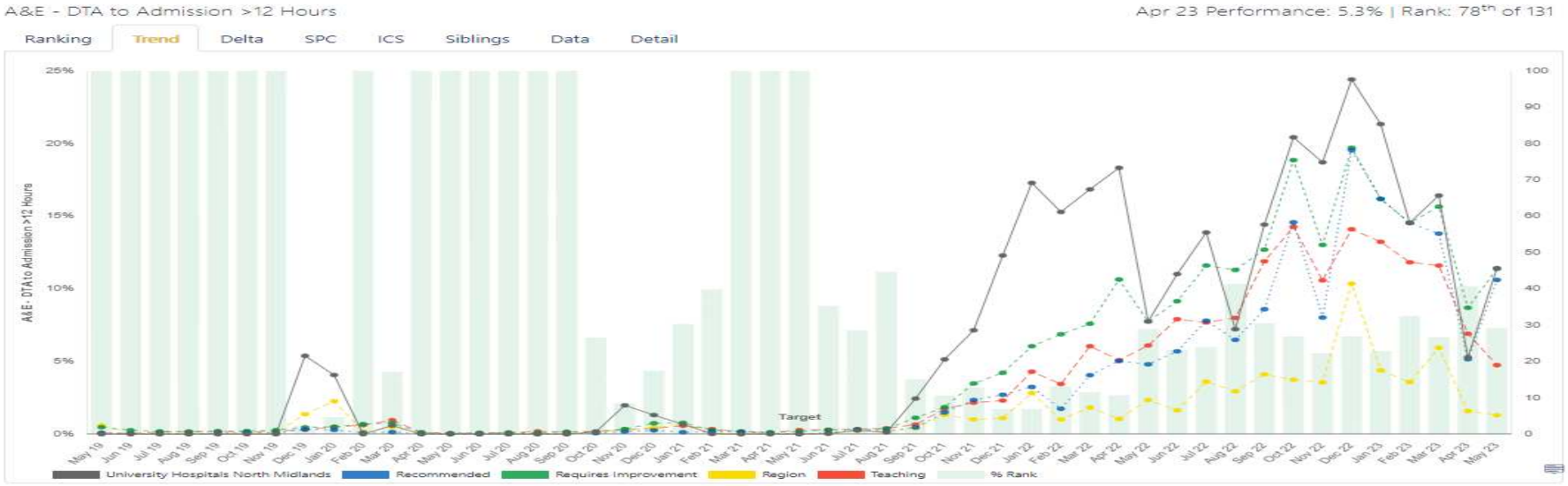
NHS Trust



A&E - DTA to Admission >12 Hours

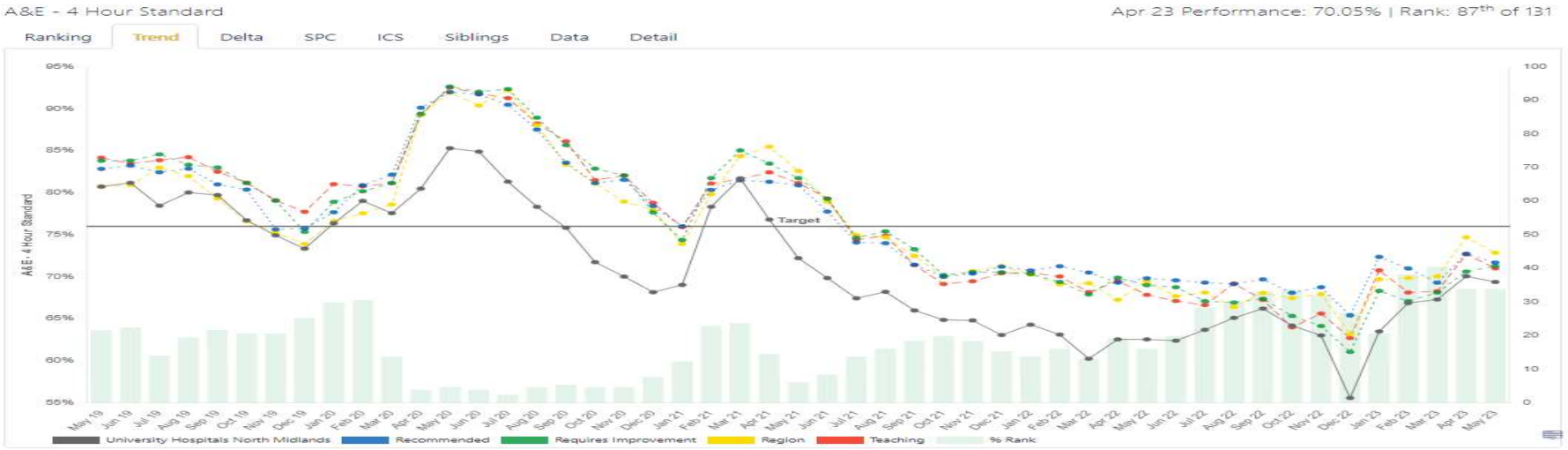
Apr 23 Performance: 5.3% | Rank: 78th of 131

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

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 12 Hour Standard	Apr 23	1.0%	11.3%			29
A&E - 4 Hour Standard	Apr 23	76.00%	70.1%			34
A&E - 4 Hour Standard (Type 1)	Apr 23	76.0%	52.6%			19
A&E - 4 Hour Standard (Type 2 or 3)	Apr 23	95.0%	97.7%			44
A&E - Conversion Rate	Apr 23	25.0%	25.4%			20
A&E - DTA to Admission >12 Hours	Apr 23	0.0%	5.3%			41
A&E - DTA to Admission >12 Hours#	Apr 23	0.0	286.0			27
A&E - DTA to Admission >4 Hours	Apr 23	10.00%	32.1%			46
A&E - Left Without Being Seen	Mar 23	5.00%	5.3%			38
A&E - Reattendance Rate	Mar 23	5.0%	9.1%			23
A&E - Time to Initial Assessment	Mar 23	15.0	7.0			69
A&E - Time to Treatment	Mar 23	60.0	78.0			48
A&E - Total Time in A&E	Mar 23	160.0	175.0			64
A&E - Total Time in A&E (Admitted)	Mar 23	180.0	371.0			50
A&E - Total Time in A&E (Non-Admitted)	Mar 23	140.0	151.0			66

- Following the peak in the percentage of patients waiting over 12 hours from the point of DTA during Q3 2022/23, performance has since been aligned to other peer groups.
- UHNM are now following performance at the same level as it's Recommended peer.
- UHNM have moved to the second quartile.

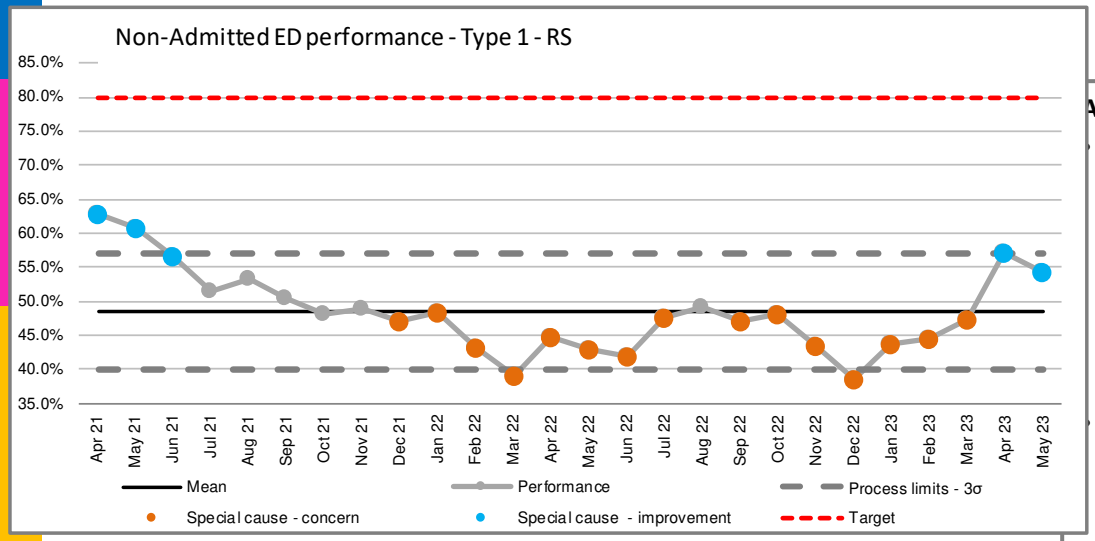
Non-Elective Care - 4 hour standard



Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	**Mar 23**	**76.00%**	**67.3%**			**40**
A&E - 4 Hour Standard	Mar 23	76.00%	**67.3%**			40
A&E - 4 Hour Standard (Type 1)	Mar 23	76.0%	**48.2%**			18
A&E - 4 Hour Standard (Type 2 or 3)	Mar 23	95.0%	98.1%			56
A&E - Conversion Rate	Mar 23	25.0%	24.5%			25
A&E - DTA to Admission >12 Hours	Mar 23	0.0%	**16.4%**			27
A&E - DTA to Admission >12 Hours#	Mar 23	0.0	**906.0**			6
A&E - DTA to Admission >4 Hours	Mar 23	10.00%	**33.2%**			61
A&E - Left Without Being Seen	Feb 23	5.00%	**5.1%**			43
A&E - Reattendance Rate	Feb 23	5.0%	**9.1%**			23
A&E - Time to Initial Assessment	Feb 23	15.0	8.0			58
A&E - Time to Treatment	Feb 23	60.0	**73.0**			51
A&E - Total Time in A&E	Feb 23	160.0	**174.0**			63
A&E - Total Time in A&E (Admitted)	Feb 23	180.0	**361.0**			55
A&E - Total Time in A&E (Non-Admitted)	Feb 23	140.0	**149.0**			68

- UHNM 4 hour performance continues to be below all peer groups and ranked in the third quartile.
- Since December 2022 UHNM have seen improvement in the 4 hour performance.

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



Variation	Assurance
H	F

Target	Mar 23	Apr 23	May 23
80%	47.3%	57.2%	54.3%

Actions

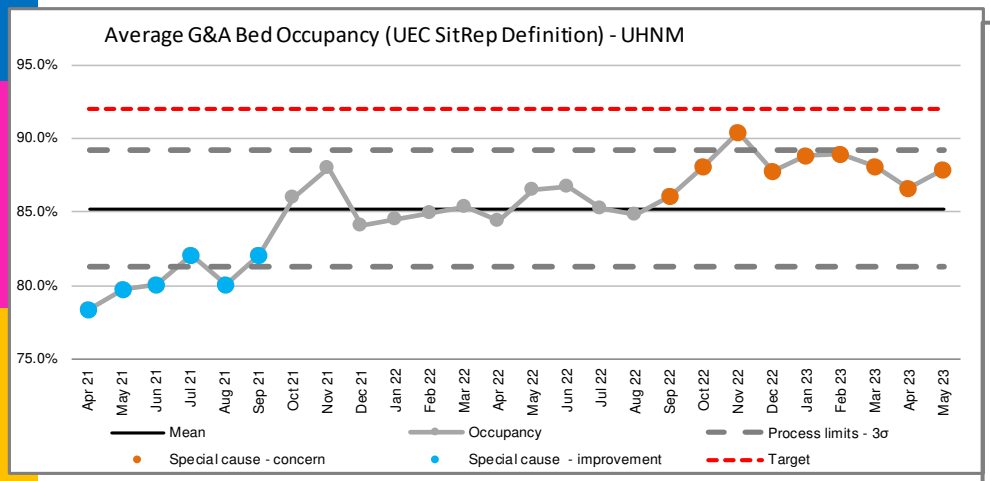
- Standard Work for Senior Decision Makers in the ambulatory and CED areas of the ED has now agreed to be supplemented with the addition of a nominated PAC (Patient Administration Consultant). This role supports medical productivity as a prompt to act timely on results and reduce coding and DQ errors. This will be further supported by the introduction of a dedicated Progress Tracker trial commencing in July.
- The maintenance of performance between midnight and the morning shift commencing remains a critical area for improvement. Options are currently being appraised by the ED Leadership Team to extend additional senior cover into the night (or to commence earlier in the morning) with a focus on ambulatory performance. The outcome of this has been committed to be implemented in July.
- ED modular works are scheduled to be completed WC 19/06/2023 which will allow for the final expansion of the ambulatory footprint and Fit2Sit area. This this will support further performance improvements across the ambulatory and CED footprint.

Summary

- RSUH ED Non Admitted 4 Hour Performance fell slightly by 2.9% in May. This is against a trajectory of 55% meaning a deficit to target of 0.7%. This is as a result of significantly increased attendances and subsequently utilisation of the ED ambulatory areas to hold DTA patients in order to facilitate the continued offloading of ambulances. In order to meet the target of 60% for June significant progress will need to be made against identified actions. It is positive to note that the planned Industrial Actions will in fact support the delivery of this target given the increased Consultant presence within the ED for the duration.

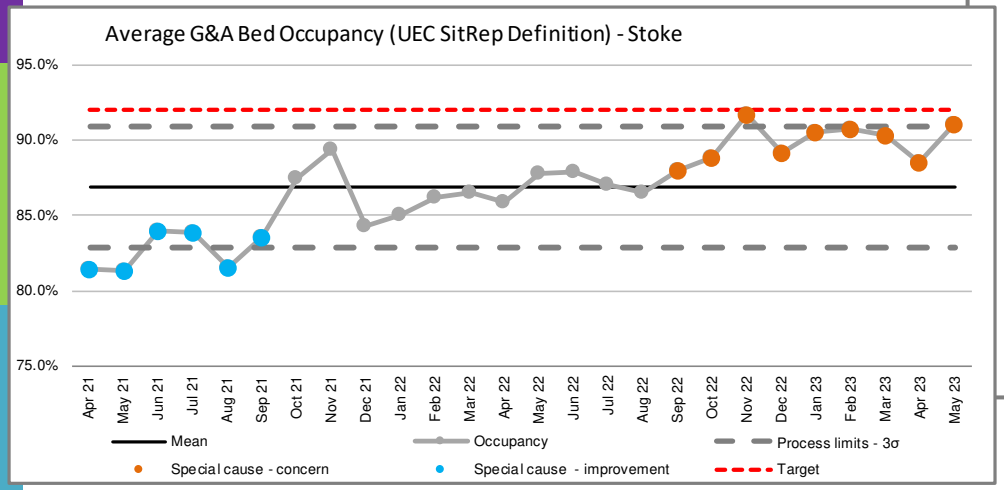
Workstream 2; Acute Patient Flow
UHNM G&A Bed Occupancy

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	P

Target	Mar 23	Apr 23	May 23
92%	88.1%	86.6%	87.9%



Actions

- Workstream 2 constituent Working Groups have now commenced focussing on LOS Improvement, Digital Tools, Reverse Bed Chaining, and Capacity & Demand. Project Plans are being completed in each of these areas all focussed on contributing to achievement of G&A Occupancy as per the Annual Operational Plan.
- Confirmation of funding for the proposed additional modular capacity has now been formally received. Engagement with clinical colleagues has commenced to confirm the final details of the clinical model with a current estimated completion date of January 2024. This investment will provide 50 G&A beds to Medicine by backfilling clinical space made available by the transfer of clinical services into the modular located outside of the CED.

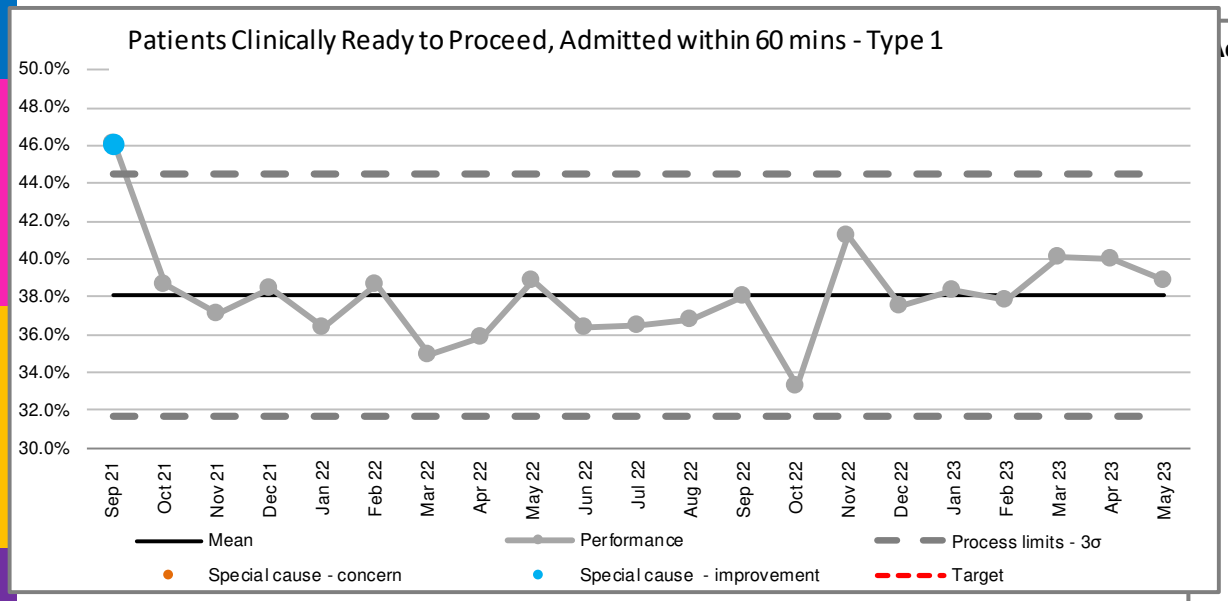
Summary

- G&A Bed Occupancy rose slightly by 1.3% in May against a low in April. This is likely driven by an approximate 12% increase in attendances at the front door converting to high admissions. While this is well above target occupancy it can be seen from the second SPC that G&A Bed Occupancy across RSUH rose more steeply to in excess of 91%.

  Efforts to ensure the underlying data reflects recent reconfigurations, appropriately documents open escalation capacity, and accurately records exact bed types will conclude in June. This is likely to increase reported occupancy levels although the difference is not expected to be significant.

Workstream 3; Acute Portals & Navigation
CRTP+1

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Mar 23	Apr 23	May 23
90%	40.1%	40.0%	38.9%

Actions

Workstream 3 constituent Working Groups have now commenced focussing on Portal Preparedness, Portal Standard Work, and Frailty. Project Plans are being completed in each of these areas all focussed on contributing to the ambitious objective of 90% CRTP+1.

In advance of completion of Working Group Project Plans it has been identified that immediate steps to support the collaborative working between the Acute Medical Portal (AMU), and both the ED and Site Operations Team is required. The leaders of these three teams now are in regular meetings and are documenting progress against a cultural improvement plan in order to ensure foundational work is completed that will be critical to the success of future improvement works.

Summary

- CRPT+1 deteriorated slightly by 1.1% to 38.9% in May from 40.0% in April. This represents poorer performance from the previous month CRPT+1 has been largely static around the 38% mean for in excess of a year and a half. While performance remains slightly above the mean for the third month in a row, the slight deterioration in May & demonstrates the scale of significant improvement still required. Following on from comments with regards to G&A Bed Occupancy data in April, CRTP+1 will continue to require significant scrutiny applied to Divisional specific performance given the variation of quantity and performance.

Section 2: ELECTIVE CARE

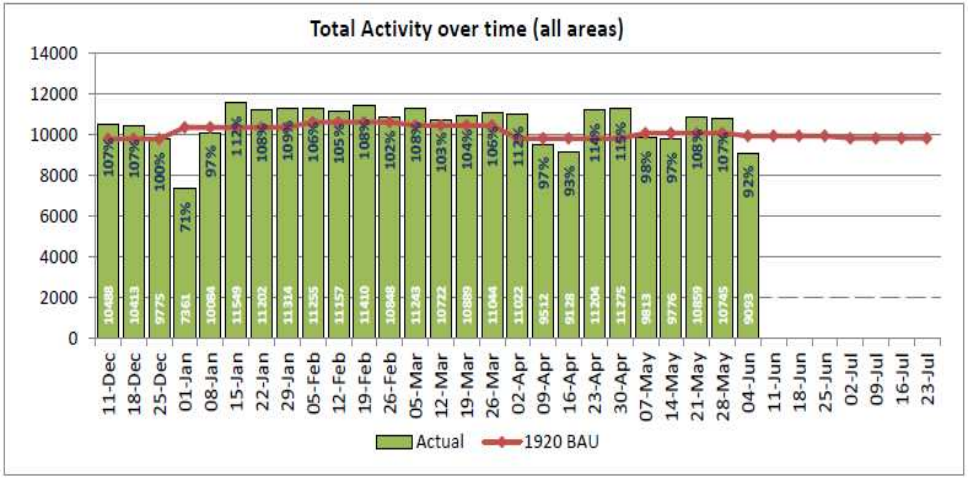
Planned Care - *Diagnostics*

NHS University Hospitals of North Midlands NHS Trust

		2019 Method For Imaging Activity				2019 Method For Imaging Activity				Going through Valdidation Stage			
		Mar-23				Apr-23				May-23			
Area	DM01 Test	Total WL	6+	%	Activity	Total WL	6+	%	Activity	Total WL	6+	%	Activity
Imaging	Magnetic Resonance Imaging	3,674	24	99.3%	7,583	3,005	27	99.1%	7,051	3,315	33	99.0%	
	Computed Tomography	3,948	84	97.9%	14,120	3,351	41	98.8%	13,419	3,883	27	99.3%	
	Non-obstetric ultrasound	7,436	2,315	68.9%	6,688	7,032	2,567	63.5%	5,408	7,529	2,627	65.1%	
	Barium Enema	0	0		0	0	0		0				0
	DEXA Scan												
Physiological Measurement	Audiology - Audiology Assessments	352	14	96.0%	395	438	12	97.3%	299	451	41	90.9%	
	Cardiology - echocardiography	2,929	1,091	62.8%	1,362	3,091	1,493	51.7%	982	3,682	1,868	49.3%	
	Cardiology - electrophysiology	0	0		2	0	0		1	0	0		
	Neurophysiology - peripheral neurophys	316	0	100.0%	250	301	16	94.7%	257	333	3	99.1%	
	Respiratory physiology - sleep studies	493	58	88.2%	351	502	73	85.5%	275	637	120	81.2%	
	Urodynamics - pressures & flows	0	0		0	0	0		0	0	0		
Endoscopy	Colonoscopy	1,326	661	50.2%	253	1,339	798	40.4%	140	1,580	1,116	29.4%	
	Flexi sigmoidoscopy	812	355	56.3%	49	942	552	41.4%	59	1,125	828	26.4%	
	Cystoscopy	146	4	97.3%	236	135	5	96.3%	171	209	67	67.9%	
	Gastroscopy	818	379	53.7%	545	1,086	489	55.0%	342	1,315	843	35.9%	
	Totals	22,250	4,985	78%	31,834	21,222	6,073	71%	28,404	24,059	7,573	69%	0

>> Sunday Snapshot - Unvalidated Waiting List (Imaging Is un Validated)

Area	DM01 Modality	13+	Total	% 13+
Imaging	Magnetic Resonance Imaging	1	3,231	0.0%
	Computed Tomography	1	3,922	0.0%
	Non-obstetric ultrasound	8	7,355	0.1%
	Barium Enema	0	0	
	DEXA Scan			
Physiological Measurement	Audiology - Audiology Assessments	27	497	5.4%
	Cardiology - echocardiography	367	3,658	10.0%
	Cardiology - electrophysiology	0	0	
	Neurophysiology - peripheral neurophysiology	0	299	0.0%
	Respiratory physiology - sleep studies	34	648	5.2%
	Urodynamics - pressures & flows	0	0	
Endoscopy	Colonoscopy	812	1,567	51.8%
	Flexi sigmoidoscopy	484	1,114	43.4%
	Cystoscopy	44	223	19.7%
	Gastroscopy	473	1,258	37.6%
	Total	2,251	23,772	9.5%



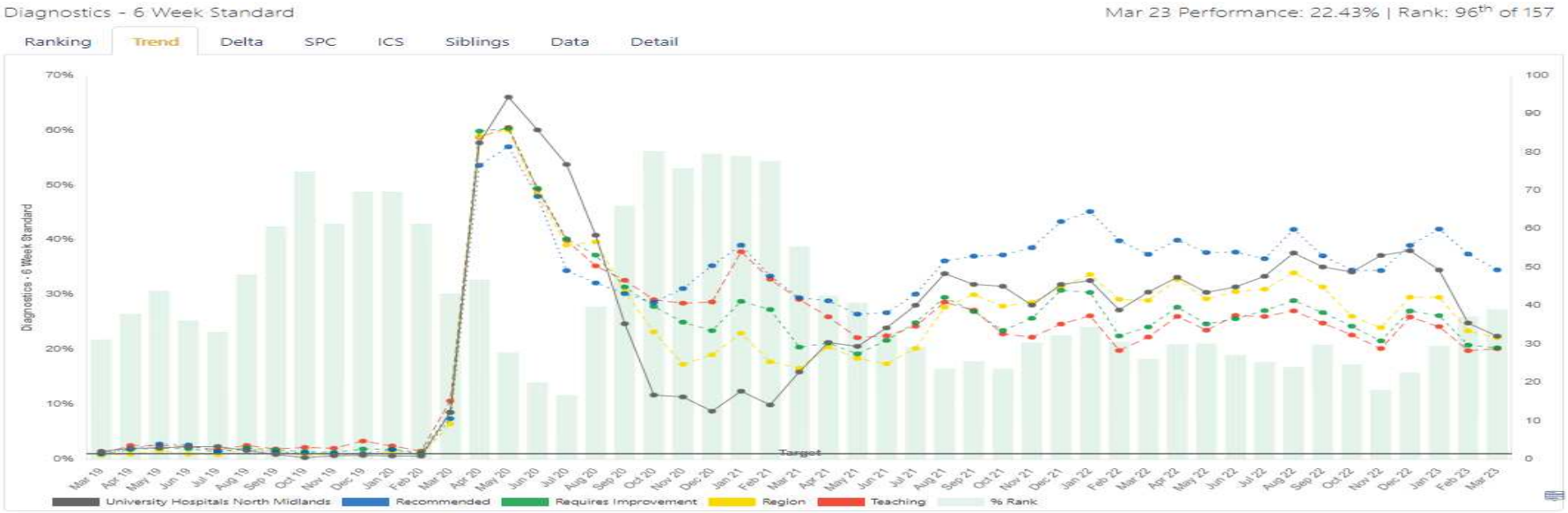
Pathology TAT chart will be added for July 23 report. While this is awaited the pathology performance currently is:

The following represents performance as at 29th May 2023;

- **Urgent** (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day **23** (Previously day 20), with 80% of cases reported by Day **11** (Previously Day 13) A
- **Accelerated** (include all Cancer Resections): 95% reported at Day **30** (Previously day 35) with 80% of cases reported by Day **20** (Previously day 25)
- **Routine** (all Specimens not in above categories): 95% Day reported at 29 (Previously day 36) 80% of cases reported by Day **22** (Previously day 19)

Our 7 day reporting turnaround time (TAT) for Urgent cases is at 59.2% against the Royal College of Pathologists' target of 80% within 7 days (up from 50.2% previously)

Diagnostics - benchmarked



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

- UHNM have seen an improvement since December 2022 with March performance aligned to most other peer groups and significantly above the Recommended peer.
- UHNM are currently in the third quartile.

Planned care - *Diagnostics*

NHS University Hospitals of North Midlands NHS Trust

Diagnostics Summary

- During May the Diagnostic activity remained consistent with the April position.
- DM01 performance was 69% un-validated overall which was slight decrease on March's 71%. Endoscopy performance is the main contributor to this performance

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

7573 patients waiting 6 weeks+;

Top Contributors – in order of highest breach %

1.	Flexi Sigmoidoscopy (26.4%)	828 breaches of 1125 patients
2.	Colonoscopy (35.3%)	1116 breaches of 1580 patients
3.	Gastroscopy (35.9%)	843 breaches of 1315 patients
4.	Echo (49.3%)	1868 breaches of 3682 patients
5.	Cystoscopy (67.9%)	67 breaches of 209 patients

Actions - Imaging

Radiology reporting backlogs;

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

Non – obs Ultrasound capacity for routine patients:

Approval on 11.05.23 to procure outsourced capacity – progressing procurement process

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

Actions - Endoscopy

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

Actions – Pathology

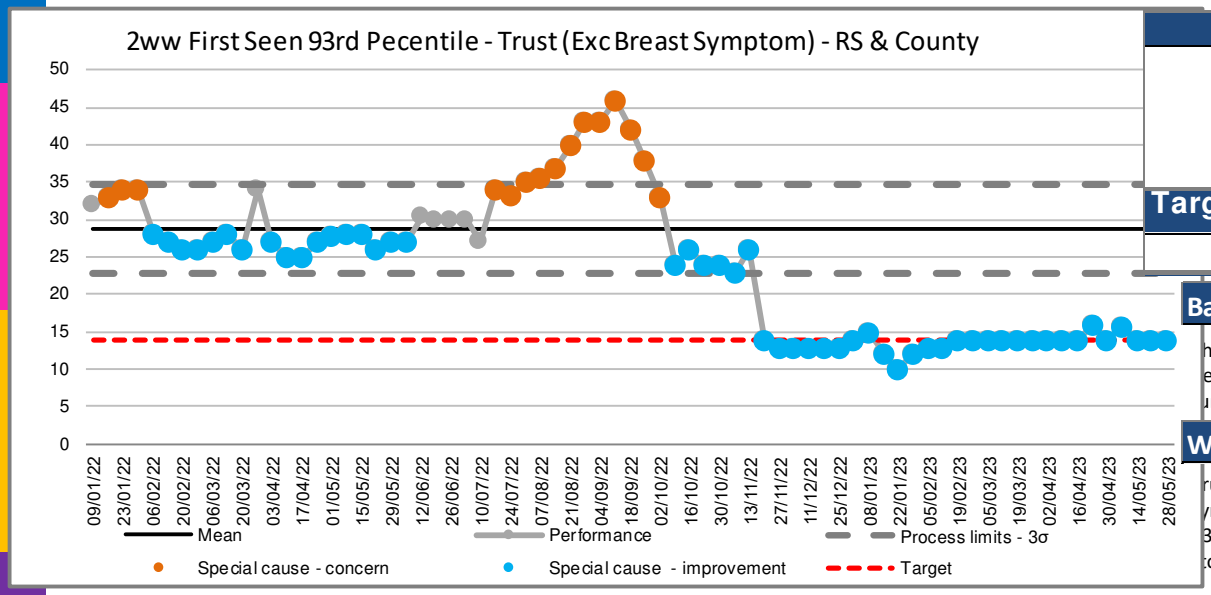
Histology Position – as at 29st May 2023:

- **Urgent** (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day 23 (previously Day 20), with 80% of cases reported by Day **11** (previously Day 13)
- **Accelerated** (include all Cancer Resections): 95% reported at Day **30** (previously Day 35)**,** with 80% of cases reported by Day **20** (previously Day 25)
- **Routine** (all Specimens not in above categories): 95% reported at Day **29 (previously 36),** 80% of cases reported by Day **22** (Previously Day 19)

Our 7 day reporting turnaround time (TAT) for Urgent cases is at 59.2% against the Royal College of Pathologists' target of 80% within 7 days.

Cancer – Headline metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

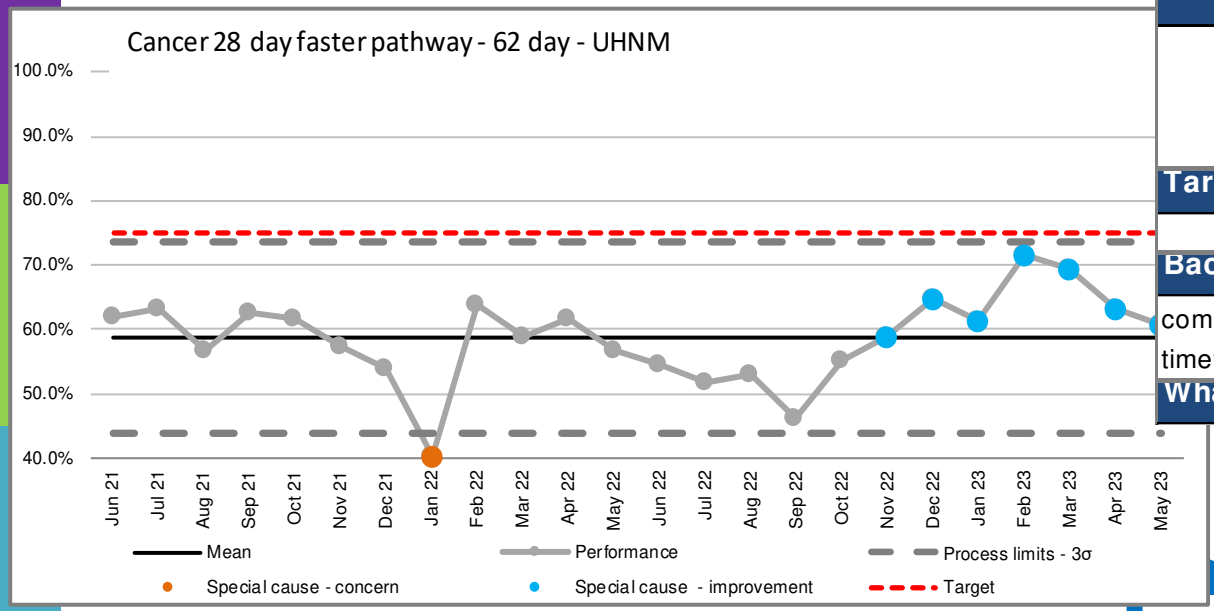
Target	14/05/2023	21/05/2023	28/05/202
14	14	14	1

Background

he standard is for 93% of patients to be seen within 14 days. This SPC emonstrates within which day 93% of patients were seen on across all umour sites.

What is the data telling us?

rust wide – all suspected cancer 2WW referrals. Excluding Breast ymptomatic referrals where cancer is not suspected.
3 % of patients first seen for the last week in May had a 14 day clock top within day 14 of the pathway.



Variation	Assurance
H	F

Target	Mar 23	Apr 23	May 2
75%	69.3%	63.1%	60.6

Background

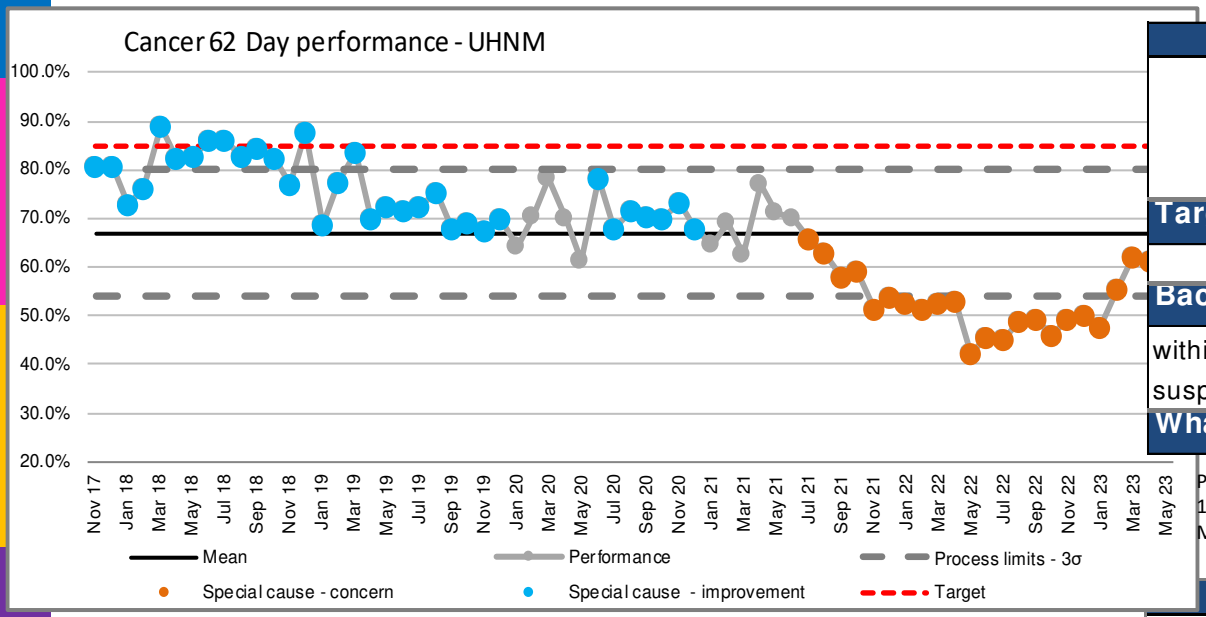
communicated with patients within the 28 day timeframe.

What is the data telling us?

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

Cancer – Headline metrics

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

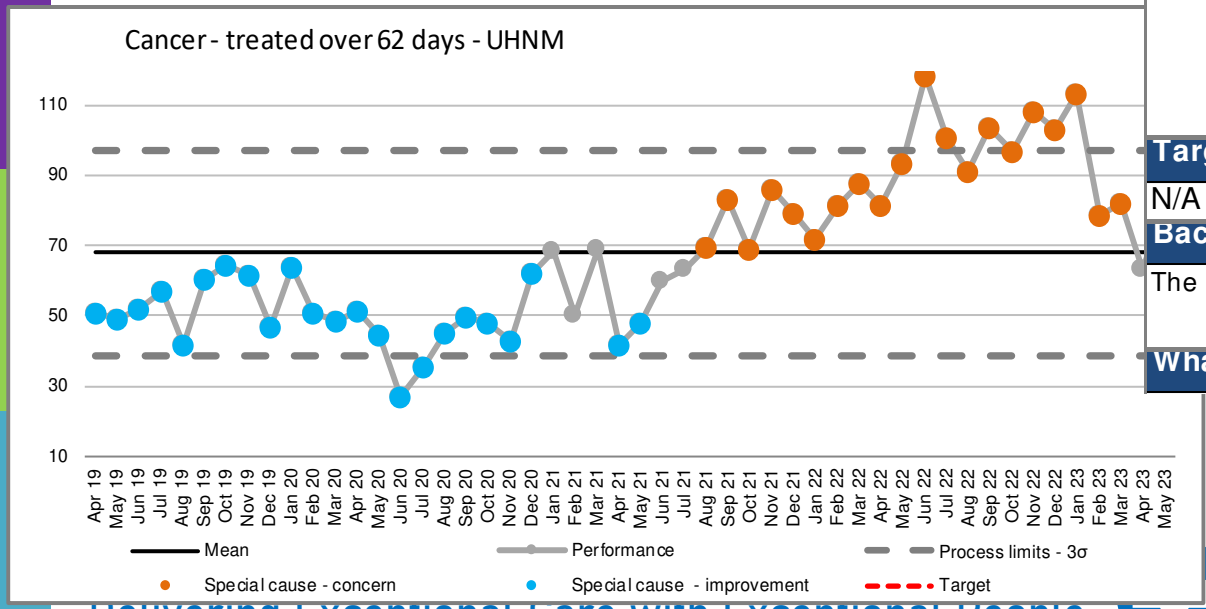
Target	Mar 23	Apr 23	May 23
85%	62.2%	61.3%	50.3%

Background

within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

Performance significantly challenged and below standard for the past 12 months with a steep decline in May21 and landed at 62.2% in March23, the April23 position is still being validated.



Variation	Assurance
	

Target	Mar 23	Apr 23	May 23
N/A	82.0	63.5	80.5

Background

The number of patients treated over 62 days

What is the data telling us?

Demonstrates total volume of patients who have been treated beyond day 62 is a cause for concern and has been rising over the past 12 months. As the trust has significantly reduced the backlog of patients waiting, we've seen an improvement in Feb , March, April and May 23 position.

Cancer – benchmarked

Cancer - 28 Day Faster Diagnosis

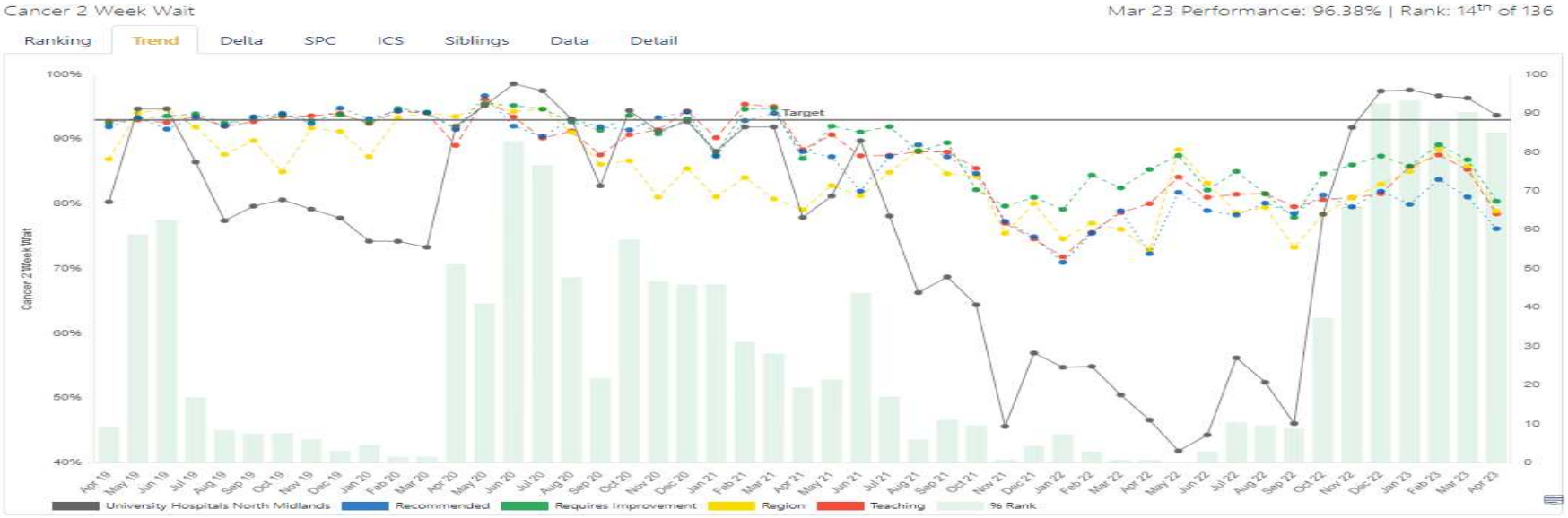
Mar 23 Performance: 69.3% | Rank: 108th of 138

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

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer - 28 Day Faster Diagnosis	Mar 23	75.0%	69.3%			22
FDS Acute Leukaemia	Mar 23	75.0%	-			-
FDS Brain Tumours	Mar 23	75.0%	-			-
FDS Breast Cancer	Mar 23	75.0%	92.6%			48
FDS Breast Symptoms	Mar 23	75.0%	94.9%			58
FDS Children's Cancer	Mar 23	75.0%	64.3%			5
FDS Gynaecological Cancer	Mar 23	75.0%	44.4%			13
FDS Haematological Malignancies	Mar 23	75.0%	28.9%			14
FDS Head & Neck Cancer	Mar 23	75.0%	70.7%			30
FDS Lower Gastrointestinal Cancer	Mar 23	75.0%	51.0%			30
FDS Lung Cancer	Mar 23	75.0%	72.7%			27
FDS Missing or Invalid	Mar 23	75.0%	-			-
FDS Other Cancer	Mar 23	75.0%	-			-
FDS Sarcoma	Mar 23	75.0%	66.7%			51
FDS Skin Cancer	Mar 23	75.0%	70.9%			10
FDS Testicular Cancer	Mar 23	75.0%	88.9%			54
FDS Upper Gastrointestinal Cancer	Mar 23	75.0%	92.1%			97
FDS Urological Malignancies	Mar 23	75.0%	59.7%			58

- The 28 Day Faster Diagnosis position for UHNM has been lower than all peer groups since May 2021.
- During Q2 and Q3 2022/23 UHNM improved significantly, aligning to other peer groups.
- Whilst all peer groups performance dropped in April 2023, UHNM dropped more significantly.
- UHNM remain in the bottom quartile.

Cancer – benchmarked



Cancer 2 Week Wait

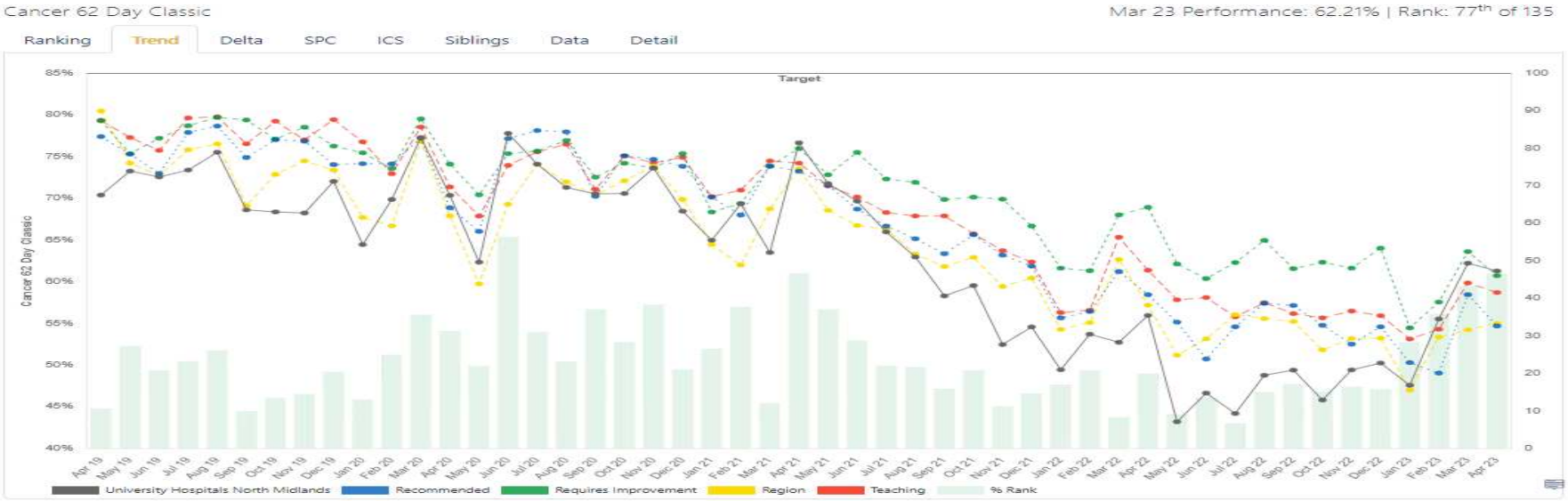
Mar 23 Performance: 96.38% | Rank: 14th of 136

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

Key Performance Indicator	Period	Target		SPC Last 12 Months	Centile
Cancer 2 Week Wait	Mar 23	93.00%	96.4%		90
Cancer 2 Week Wait Breast Symptomatic	Mar 23	93.0%	92.9%		65
Cancer 31 Day First Treatment	Mar 23	96.00%	90.5%		26
Cancer 31 Day Subsequent Treatment	Mar 23	96.0%	91.0%		33
Cancer 62 Day All Sources	Mar 23	85.00%	68.0%		40
Cancer 62 Day Consultant Upgrade	Mar 23	85.0%	80.0%		52
Cancer 62 Day Screening	Mar 23	90.0%	71.0%		46
Cancer Sub Treat Drugs	Mar 23	96.0%	94.9%		14
Cancer Sub Treat Radiotherapy	Mar 23	96.0%	93.9%		41

- Since September 2022 UHNM have seen a significant improvement.
- Exceeding all other peers and the national target of 93% since December 2022.
- UHNM are ranked 14th in the country.

Cancer - Benchmarked



Cancer 62 Day Classic

Mar 23 Performance: 62.21% | Rank: 77th of 135

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

Key Performance Indicator	Period	Target		SPC Last 12 Months	Centile
Breast Cancer	Mar 23	85.00%	56.0%		11
Cancer 62 Day Classic	Mar 23	85.00%	62.2%		43
Lower Gastrointestinal Cancer	Mar 23	85.00%	52.6%		56
Lung Cancer	Mar 23	85.00%	65.0%		66
Other Cancer	Mar 23	85.00%	48.4%		22
Skin Cancer	Mar 23	85.00%	77.8%		21
Urological Cancer	Mar 23	85.00%	70.2%		75

- UHNM have seen an improvement since May 22, where other peer groups have either seen no improvement or seen a deterioration.
- In April UHNM's performance exceeded all peer groups.
- UHNM remain in the 3rd quartile.

Cancer Actions

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For the month of May 2023, the weekending backlog position was 513 – which is a reduction of over 500 patients since August. This position includes patients with a decision to treat and a future treatment date scheduled. The majority of the backlog is attributable to Colorectal, Skin and Urology. A high proportion of patients waiting over 62 days in both tumour sites have future scheduled treatment dates. The May 23 position is challenged by increasing turn around times in diagnostic services, and additional capacity schemes being sustained. Business cases have been worked up to describe activity that will sustain the improvements in Skin, awaiting sign off. Further additional capacity cases have been funded through the Elective Recovery Fund, and the Cancer Alliance has also been approach for transformation funding, outcome awaited.

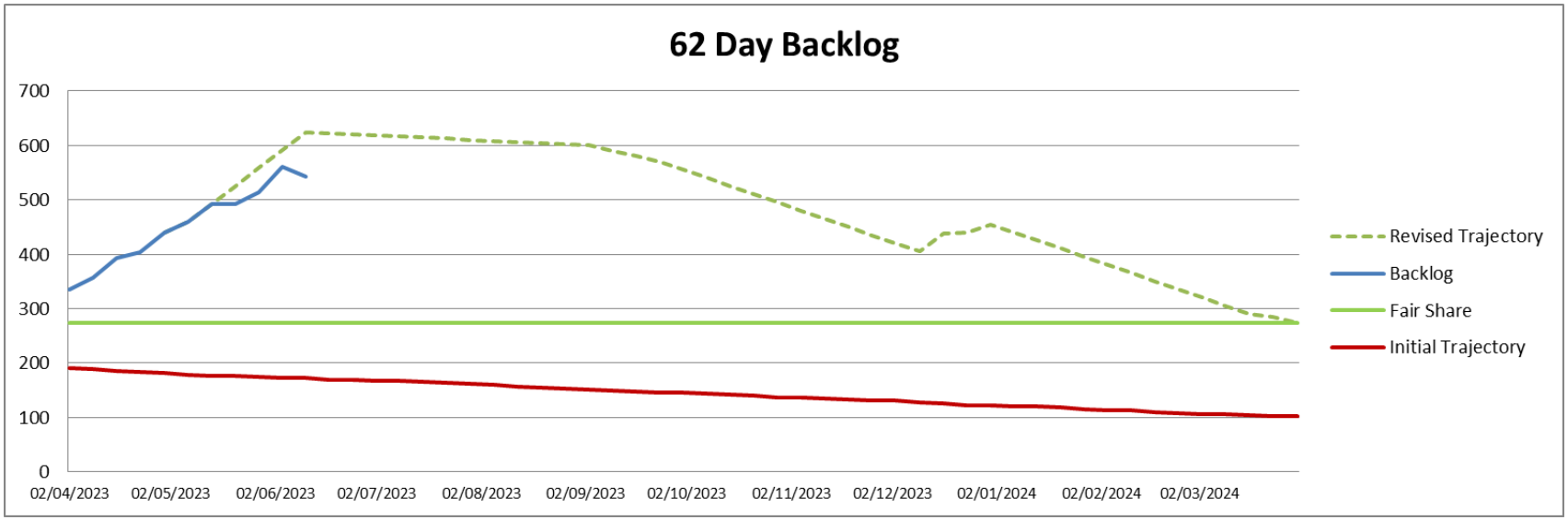
There are further multiple contributing factors to the backlog, including delays to diagnostic reporting in pathology and imaging, urology robotic surgery capacity, oncology capacity, complex pathways, and an increasing element of patient choice and outstanding clinical reviews. UHNM are working with GPs and commissioners to ensure all patients are aware of the urgency of their appointments and to attend when scheduled. Cancer Navigator positions have been implemented across the trust, acting as the single point of contact for patients referred on a cancer pathway. These positions have been proven to reduce DNAs and provide a better experience for patients, particularly on complex pathways and pathways with known diagnostic delays.

UHNM have presented their Prostate pathway as an example of best practice to UHDB. We have also shared operational details of the referral hub with neighbouring ICSs – which has optimised referrals and enabled specialist consultant triage within 3 days. The ambitions is that this referral hub could scale up to optimise referrals for all tumour sites, which is being discussed with the ICB. UHNM have also presented their Skin pathway to Lincolnshire due to the significant recovery of the PTL position which was enabled by community Teledermatology, whereby all Skin 2WW referrals are sent accompanied with photographs, enabling virtual triage by consultants.

All divisions are focusing on the backlog and discharge patients where appropriate. All diagnostic modalities have submitted plans for a reduction in waiting times which includes additional staffing, insourcing and outsourcing and building additional capacity through CDC's. Twice weekly PTL level meetings have been set up with Endoscopy – to review the inpatient waiting list triangulated against the Cancer PTL and including clinical urgency, to ensure priority booking and a reduction of the number of endoscopy investigations waiting to be scheduled.

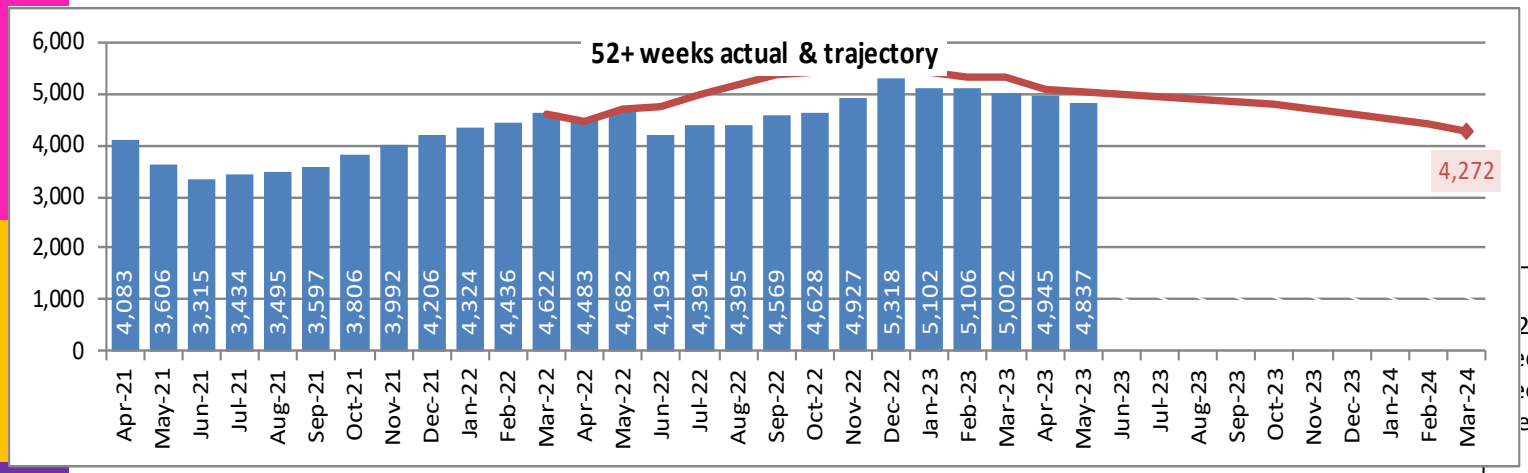
Cancer Trajectories

- National planning guidance 23/ 24 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. The guidance also allocated a fair share total to Trusts, shown in green on the graph below. An internal PTL Backlog trajectory for UHNM is shown by the green dotted line below, which was revised and modelled to bring us back in line with the fair share target by March 23 taking into account the unpredicted workforce challenges in Endoscopy.
- The actual total of patient waiting over 62 days on a 2WW pathway are shown in blue below, and are a snap shot in time of the PTL position. This is for the week ending last full week of the month per PAF report.
- UHNM provide assurance to the regional NHSEI team, with detailed plans on a weekly basis. Tiered Progress to date:
    - The 62 day backlog has reduced by over 500 patients since August.
    - The number of days waited for 1st OPA (93rd Percentile) has reduced by 35 days since August.
    - The total PTL has reduced by around 2300 since August.
    - The number of patients waiting over 104+ has halved.
    - The Faster Diagnosis Standard has improved from 46% in September to a final March position of 69%



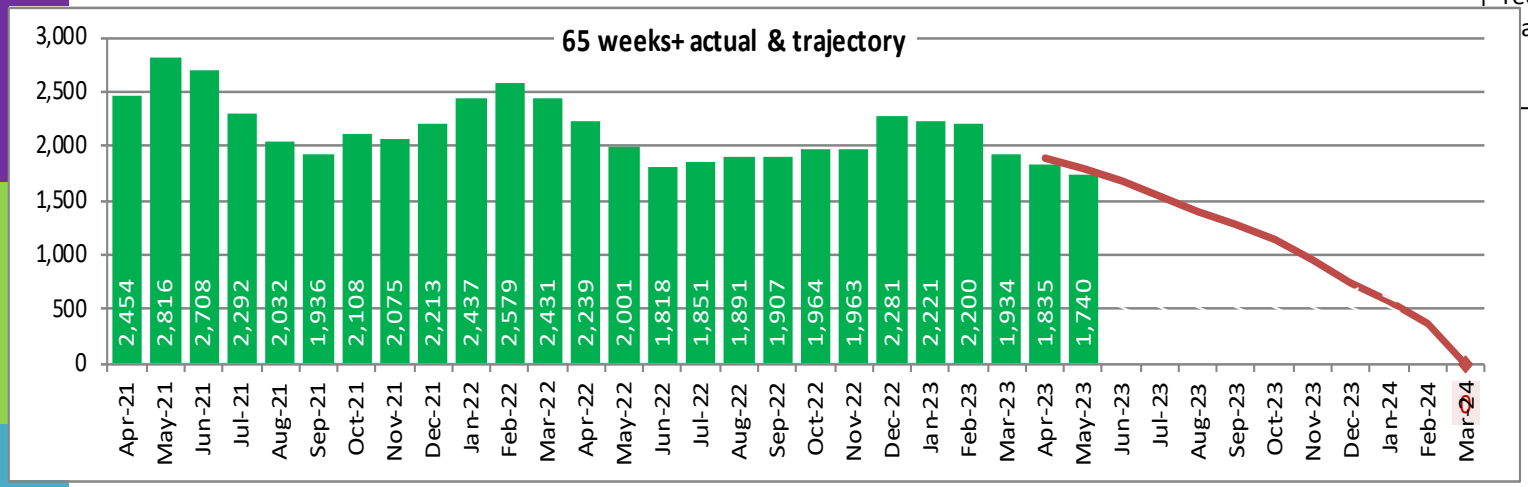
- Impacting the position in 23/24 are new challenges such as strike action, additional capacity scheme continuity, and diagnostic capacity in Endoscopy and Pathology.
- The West Midlands Cancer Alliance have been approached to continue to fund the additional capacity which contributed to the significant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

Planned Care – *RTT*



2+ week waiters have
educed marginally over
ecent months and continue to
e within trajectory.

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



Planned Care – *RTT Long Waiters*

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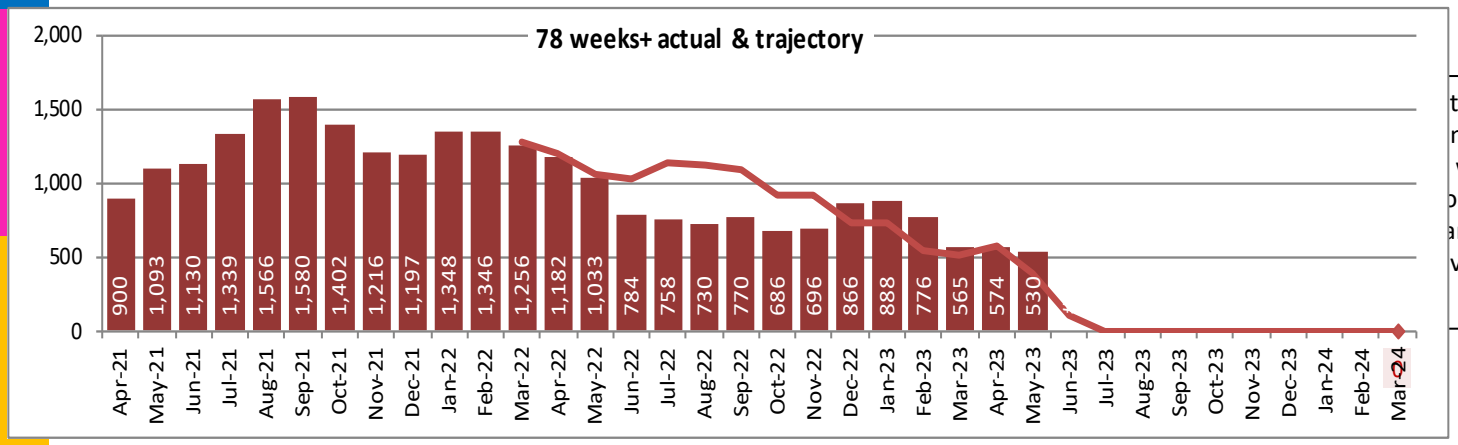
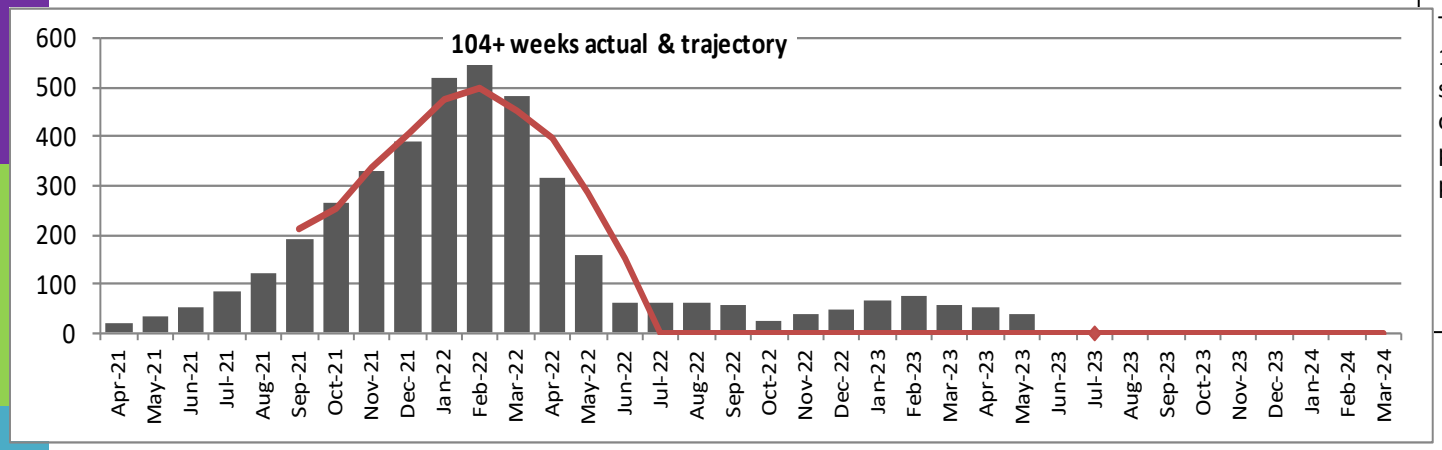


tween February and March the mber of patients waiting more than weeks reduced considerably. om March to May there has been a arginal reduction. May data is validated.



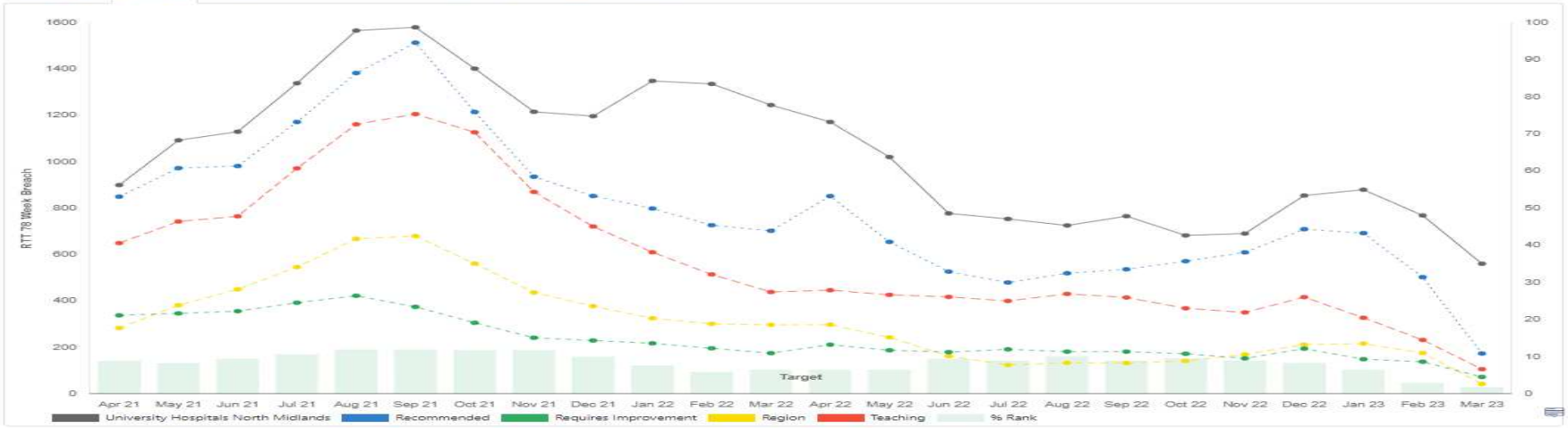
The number of patients waiting 104+ weeks is reducing gradually since winter 22/23. This is made up of patient choice, patients presenting unwell or complex pathways. May data is unvalidated.

RTT - Benchmarked

RTT 78 Week Breach

Mar 23 Performance: 561 | Rank: 168th of 171

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



RTT 78 Week Breach

Mar 23 Performance: 561 | Rank: 168th of 171

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

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT 104 Week Breach	Mar 23	0	56			1
RTT 52 Week Breach	Mar 23	0	4,992			9
RTT 65 Week Breach	Mar 23	-	1,927			6
RTT 78 Week Breach	Mar 23	0	561			2
RTT 95th Percentile Admitted Waiting Time	Mar 23	18.0	84.6			11
RTT 95th Percentile Non-Admitted Waiting Time	Mar 23	18.0	56.6			28
RTT Admitted Treatment Within 18 Weeks	Mar 23	90.0%	50.7%			28
RTT Average (Median) Admitted Waiting Time	Mar 23	9.0	17.4			27
RTT Average (Median) Non-Admitted Waiting Time	Mar 23	5.0	7.5			59
RTT Average Wait for Incomplete	Mar 23	7.00	16.0			24
RTT Incomplete 92nd Percentile	Mar 23	-	48.6			18
RTT Incomplete Pathways With a DTA	Mar 23	25.0%	15.3%			42
RTT Non-Admitted Treatment Within 18 Weeks	Mar 23	95.0%	67.5%			40
RTT Total Clock Starts	Mar 23	-	17,960			83
RTT Total Clock Stops	Mar 23	-	15,362			86
RTT Total Incompletes	Mar 23	-	76,836			13

- Since the increased during Dec 22/Jan 23, volumes at UHNM have reduced.
- UHNM remain significantly above all peer groups and the 3rd worst performing Trust in the country.

Planned care - *RTT*

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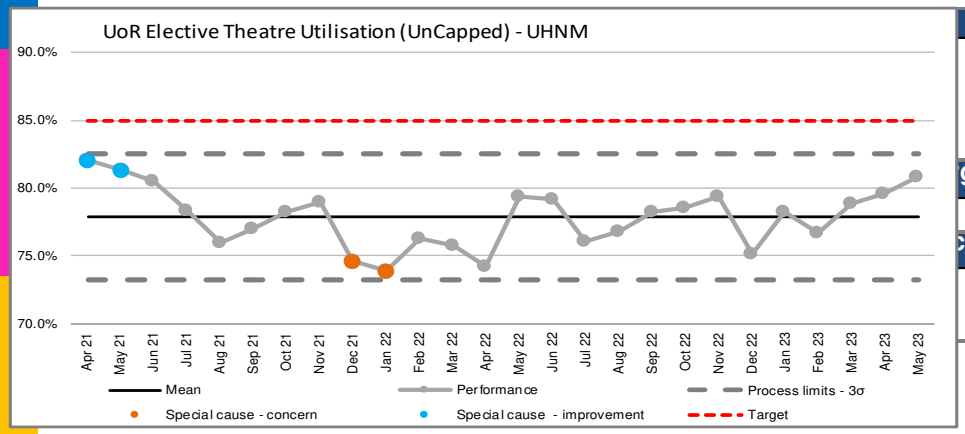
Summary

- 52+ week patients increased during May to 4,837 (un-validated)
- 78+ patients have been gradually reducing, but had reached a plateau in November at 725. This has increased in December to 863, due to winter pressures in combination with industrial action and in January rose to at 936. The number has decreased throughout since February, achieving 565 at March month end, 574 for April, 523 for May and projected to be around 291 for June (as yet un-validated) and 96 for July.
- The trust did not achieve the national ask of eliminating 78 weeks waits by end of March 2023. Plans are in place to minimise the number of breaches, so that only patients who choose not to be treated before end of March or who have a highly complex case are still waiting at 78+ weeks.
- The overall Referral To Treatment (RTT) Waiting list now sits 78,094 end of March (un-validated).
- There is a real focus on 104w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 78week+ patients with the introduction of a weekly elective management oversight group.
- At the end of May the number of > 104 weeks was 36, a significant improvement from 53 in April. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity. There is a challenge for some specific directorates in treating some of our long waiting complex patients within timeframe due to the size of the backlog. Current forecast for June is 5 patients, a further significant improvement.
- The IS have taken 46 patients from Orthopaedics & Spinal (out of 151 considered), with a further 200 patients being worked through to contact & transfer.

RTT

- Validation has increased slightly with some additional resource in the short term. The team are currently looking at validation capacity to provide an accurate picture of the resource required in the medium term to reduce the list, this may include electronic solutions.
- RTT Performance sits at 53.85%, a slight improvement from 53.7% for February.
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.
- The Trust is currently at 99.7% of all pathways over 52 weeks having ben validated within the last 12 weeks. The next national ask is to have all patients waiting longer than 12 weeks validated by 28th April 2023. The number currently not validated in the last 12 weeks last month was is 37,545, but we are now at 37,400 due to the validation team working on the NON-RTT sample validation.
- Trust wide revamp of validation & training underway, focusing on tracking long waiters, exposing and addressing bottlenecks in pathways. Phase 1 to deep dive training needs analysis complete. Phase 2 underway – RTT Bitesize training now available to divisions., focused on key areas requiring improvement.
- NHSE's RTT training lead to deliver lecture style training and engagement sessions with specialty groups to enhance shared knowledge and address issues where national rules are not always followed.
- RTT Training now available on 'Articulate' eLearning software.
- Active reporting focus on ensuring the right patients (urgent and longest waiters) are the patients booked into all available capacity so that the limited resource available continues to be used for the right patients by clinical need. This is being scrutinised through a divisional weekly meeting with COO/Deputy
- Patient by patient monitoring by each specialty and by the corporate team on the patients at risk of the breaching 104 and 78 weeks by end of month, and month following.
- Key enablers to the continued focus on long waiting patients are ring fencing of beds for Orthopaedics as RSUH, modular theatre at County and improvement in theatre utilisation and booking.
- Increased focus on non-admitted patients and increasing outpatient & diagnostic capacity, improving utilisation and business processes to move patients to a decision to admit. This will be supported by the IST RTT training programme which takes place in Spring
- Roll-out of Palantir's Foundry platform underway, with working group to be up and running.

Planned Care – *Theatres*

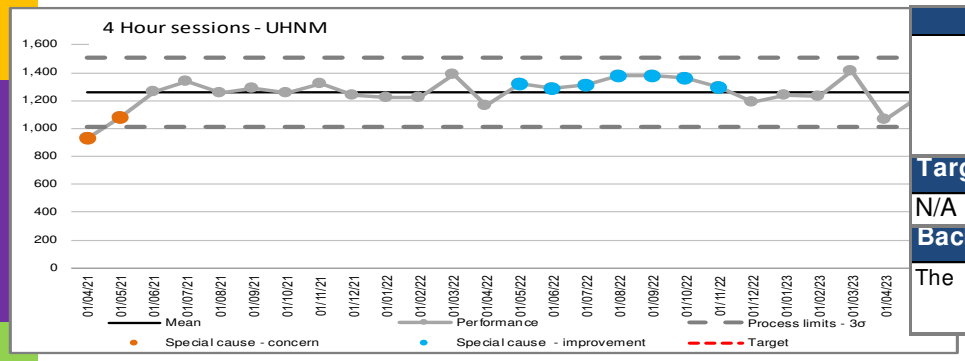


Variation	Assurance
	F

get	Mar 23	Apr 23	May 23
85%	78.9%	79.6%	80.8%

ckground

percentage of theatre time used (capped).

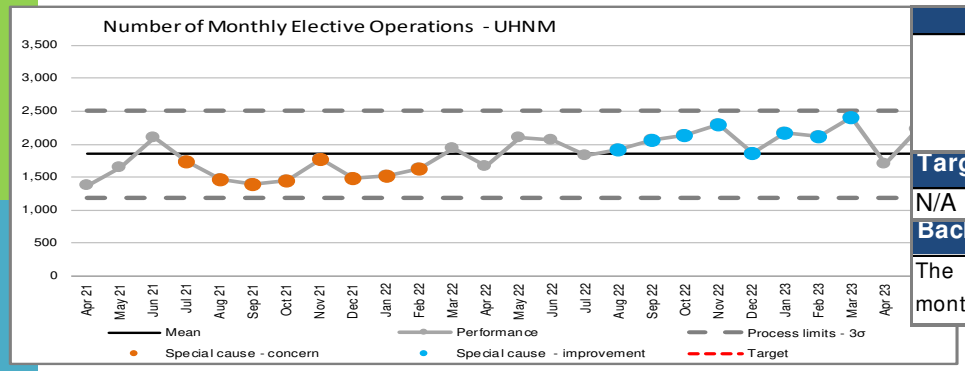


Variation	Assurance

Target	01/03/23	01/04/23	01/05/23
N/A	1411	1069	1221

Background

The number of 4 hour sessions during the month.



Variation	Assurance

Target	01/03/23	01/04/23	01/05/23
N/A	2404	1709	2222

Background

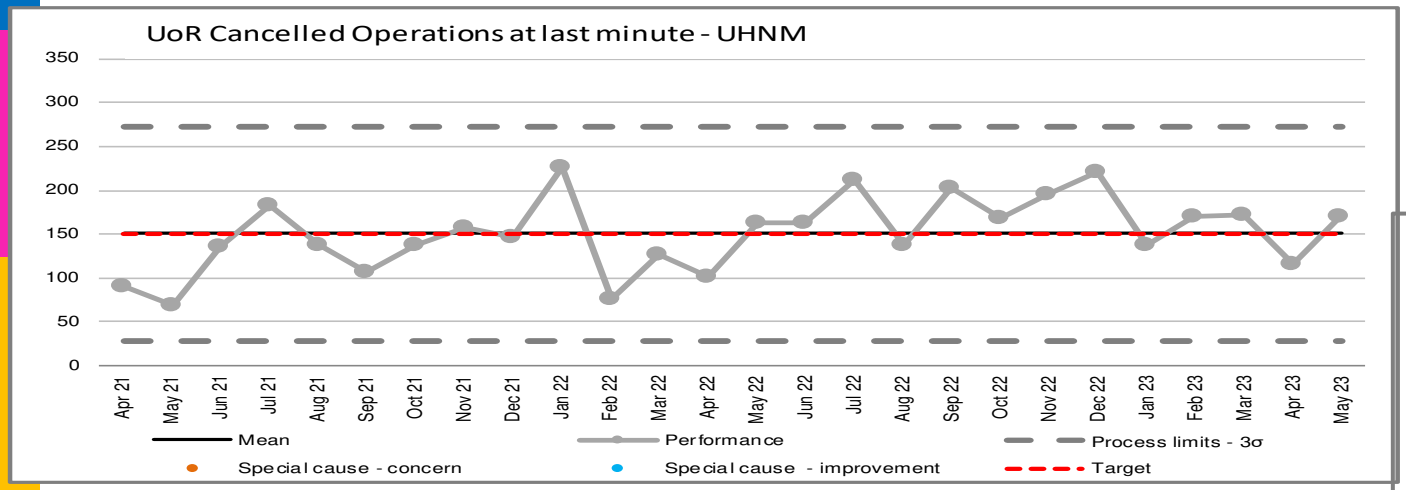
The total number of elective operations during the month.

Theatre Utilisation performance continues to see an improving trend since December 2022.

The number of 4 hour sessions has been relatively stable during 2022, with May seeing levels aligned to the two year average.

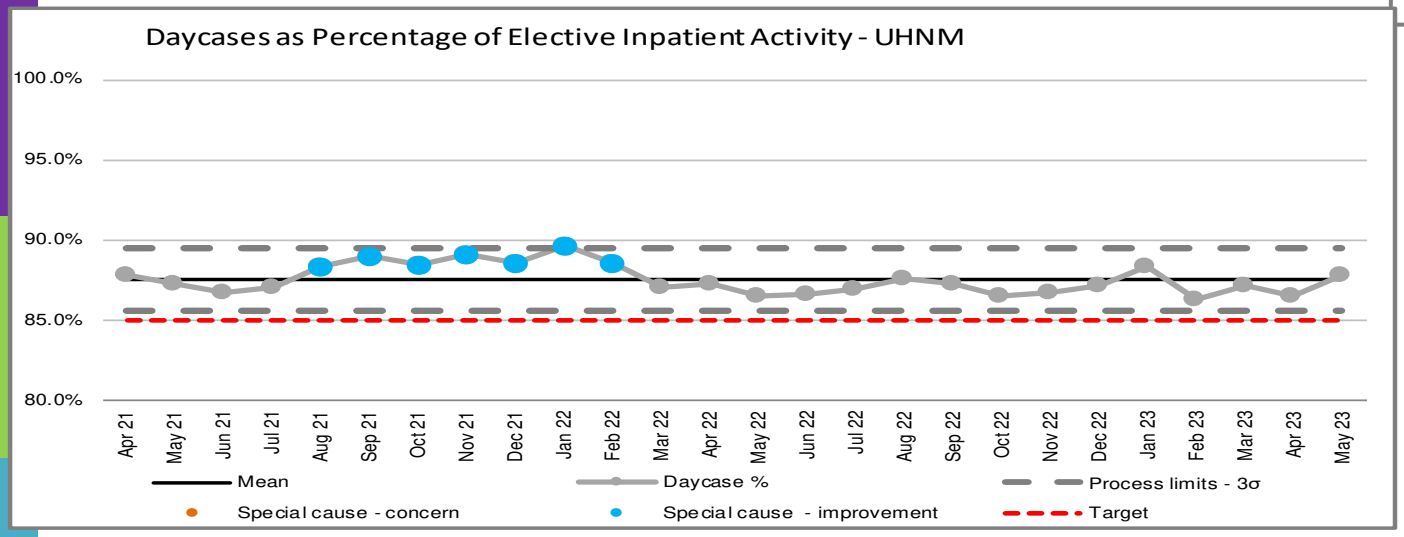
Following the dip in Elective Operations in April, May returned to levels seen since October 2022.

Planned Care – *Theatres*



The numbers of patients cancelled in 2023 is lower than the average in 2022.

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



Theatres - Benchmarked

- UHNM seeing an improvement and have moved from Quartile 1 last month to Quartile 2 this month.

Planned Care - *Theatres*

University Hospitals of North Midlands NHS Trust

Elective inpatients Summary

- Day case as a % of all elective work for May is currently 87.68%.
- Productivity in terms of Touchtime Utilisation & Case numbers is equal or above Pre-Covid (April-June)
- Weekend activity continues for numerous specialties including Colorectal, Plastics, Urology, T&O, Breast & Ophthalmology supported by both UHNM staff as ECH and SHS
- All Performance metrics for Theatre Productivity showed improvement in May, driving increased activity of sessions that ran
- Uncapped Utilisation 81%, Capped Utilisation 75.6%, Start times 57% (within 15mins), OTD cancellations 10.3%.

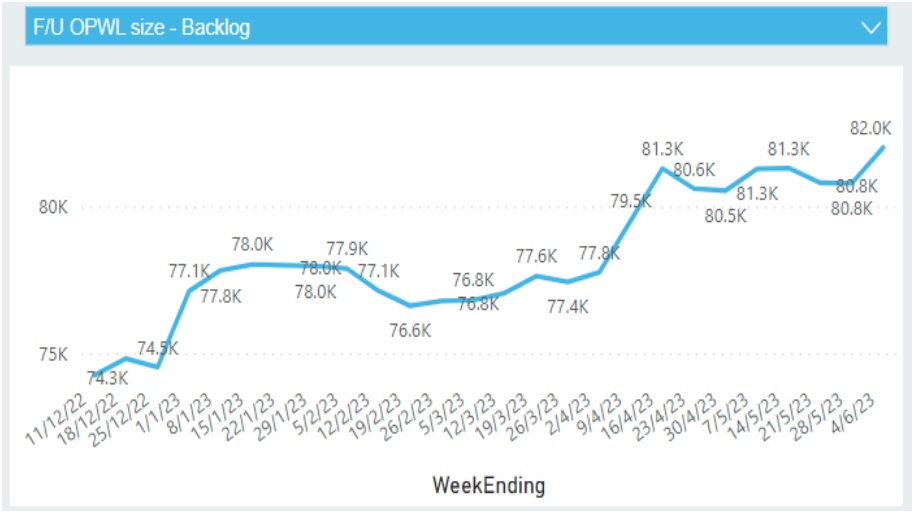
Actions

- Continued focus on Start times to drive improved activity, utilisation and reduce cancellations
- Countermeasures for Theatres A3 updated to include introduction of "List Lockdown" at 1 week in the aim of reducing last minute un-communicated changes to list and thus improve flow and productivity
- Inaugural TTC (Trust Theatre Committee) took place on 9th June chaired by Deputy Medical Director.
- Contract review of Portering service progressing with agreement to trial enhanced model for the Hub Theatres pending Business case to adjust contract .
- PACU trialling step down area for patients deemed fit for transfer back to ward –aim to reduce bottlenecking in theatre.
- STS at county live with Gynae, Urology and Plastics activity running through the 2 procedure rooms, productivity opportunity now being monitored through 6,5,4 process.
- Workforce plan submitted following review identifying key areas adversely impacting productivity
- Exit strategy for SHS contract being monitored closely and linked to recruitment and Sickness Absence management
- Supporting development of Enhanced Monitoring Facility at County in support of Enhanced Recovery pathway for T&O
- Meeting with NHSE to review options for restarting RPRP programme
- Commence review of opportunity for Enhanced Recovery Programme for all specialities at County supported by Perioperative Medicine and Patient Pre-optimisation

Planned Care – *Outpatients*

New Outpatient Performance to Plan

Follow Up Outpatient Performance to Plan



Planned care – *Outpatients*

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Actions

- **OP Cell Programme Structure** revising to reflect latest Elective Recovery Guidance (reducing follow ups). Meeting with NHSE confirmed main elements all covered from Reducing F Ups focus slide. A3 drafted by task & finish group with OP Cell. Engaging with Faster First Appointment NHSE network initiative.
- **Work stream 1 Outpatient Service Delivery & Performance**

  Utilisation; OP Cell Dashboard revised, alongside booking & DNA Divisional / UHNM target & trajectories. Utilisation May 86.1% vs 88.4% plan. Top 2 specialties for improvement per division targeted, & those with longest waits. From NHSE 'Action on DNAs' initiative, 2 Way Messaging (see below).

  Unoutcomed; DQ leading remedial actions, escalating to Divisions. Tail cleared, prior to previous month at circa 300 (13/05), focus.
- **Work stream 2 Outpatient Transformation**

  OP GIRFT: issued Nov/Dec, aimed at clinicians & operational teams in 15 specialties. Seen as key enabler for OP Transformation. UHNM baseline assessment vs customised maturity model. Initial review of actions & comments held with clinician & mgt leads for 8/15 specialties. Working vs timeline for further Specialty Meetings & Reviews to challenge ongoing progress. Identifying clinical lead for OP GIRFT.

  PIFU; >5% May 2023. Benchmarking vs national median April - UHNM: 24th of 143 providers (5.1% vs 2.4%). Additional PIFU pathway opportunities from OP GIRFT guidance. Divisional PIFU targets 23/24 drafted in line with UHNM plan. Action on Outpatients PIFU initiative starting June 2023, identifying clinical lead. Clarifying requirements for new CDS from July 2023.

  Enhanced Advice & Guidance ICS Referral Optimisation Steering Group re-launched in April. Focus expected to be specialty & pathway-specific.

  Virtual Care >25%; SUS submission 'fix' implemented from Nov 2021 (with BI); longer term, alignment of clinic booking and media type outcomes. NHS Remote Monitoring Toolkit issued early December, baseline assessment submitted. One Consultation now live, IM&T updated at OP Cell April.

  Digital Enablers

  - **Waiting List Validation (OP/IP) & 2 Way Messaging; DNA reduction / Short Notice Booking**

    Now confirmed that PKB to have functionality required. Validation & 2 Way SMS will be included in the funding approved from NHSE/I – IM&T to submit an internal business case. Risk around timescales vs waiting list pressures.
  - **Robotic Process Automation (RPA); OP Outcomes** c.200K attendances annually with 'simple' outcomes eg discharge, could be completed via RPA. & **RPA; PIFU Discharge Letters (at Review Date) -** Scoping with UHNM BI (where pre-agreed by specialties), to pilot with Neuro & Urology.

    Agreed IM&T to lead on requesting funds for robots to cover these two Outpatient-wide RPA approaches.
  - **Patient Portal (PKB)**; IM&T monthly slot at OP Cell for updates. Digital letters live from June 2023 with patient letter to encourage enrolment.

Risks

- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, on Divisional Risk Registers.
- Clinical Validation requirement; risk of achieving vs resources available. PKB functionality to support waiting list validation and 2 way SMS: timeline risk.
- Lack of pace on schemes linked to System Partners, escalated at Planned Care Improvement Board.

Inpatient and Outpatient Decile & Ethnicity

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

Inpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	10.45%	9.31%	8.92%	7.62%	7.59%	11.34%	12.97%	10.31%	13.94%	6.87%	0.67%
Weeks Waited- 78-104	12.30%	11.62%	9.16%	8.48%	7.12%	11.54%	10.35%	10.01%	11.96%	6.62%	0.85%
Weeks Waited- 52-77	14.63%	12.48%	10.16%	9.55%	7.47%	10.64%	9.48%	8.80%	11.26%	4.43%	1.09%
Weeks Waited- Under 52	13.71%	11.42%	10.48%	9.28%	7.44%	10.56%	10.08%	9.01%	11.28%	5.51%	1.23%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.27%	10.17%	9.27%	8.84%	7.79%	11.17%	11.48%	10.07%	12.75%	6.18%	1.00%
Weeks Waited- 78-104	12.02%	10.73%	9.34%	8.75%	7.78%	11.10%	10.66%	8.90%	12.18%	7.28%	1.27%
Weeks Waited- 52-77	12.94%	11.20%	10.23%	8.66%	7.78%	10.59%	10.73%	8.87%	11.80%	5.89%	1.30%
Weeks Waited- Under 52	13.33%	11.37%	10.08%	8.96%	7.47%	10.52%	10.53%	9.06%	11.35%	6.03%	1.30%

Inpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.17%	0.39%	0.08%	0.39%	0.30%	0.69%	0.06%	0.11%	0.19%	0.33%	0.39%	0.28%	0.03%		93.32%	0.36%	0.78%	1.83%	0.30%
Weeks Waited- 78-104	0.17%	0.34%	0.17%	0.34%	0.76%	0.68%	0.08%	0.17%	0.25%	0.76%	1.19%	0.08%		0.08%	89.74%	0.51%	2.37%	1.61%	0.68%
Weeks Waited- 52-77	0.41%	0.44%	0.34%	0.92%	0.78%	1.23%	0.07%	0.24%	0.17%	0.55%	1.71%	0.34%	0.07%	0.27%	86.97%	0.24%	1.94%	1.64%	
Weeks Waited- Under 52	0.46%	0.74%	0.34%	0.68%	0.60%	1.31%	0.12%	0.17%	0.16%	0.49%	1.60%	0.35%	0.16%	0.24%	83.94%	0.27%	2.82%	2.43%	3.11%

Outpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.29%	0.58%	0.18%	0.44%	0.46%	0.75%	0.10%	0.18%	0.12%	0.54%	1.43%	0.27%	0.13%	0.20%	88.05%	0.31%	2.51%	2.16%	1.30%
Weeks Waited- 78-104	0.32%	0.53%	0.21%	0.48%	0.49%	1.13%	0.21%	0.13%	0.17%	0.67%	1.49%	0.28%	0.09%	0.20%	86.61%	0.21%	2.64%	2.09%	2.01%
Weeks Waited- 52-77	0.55%	0.58%	0.19%	0.60%	0.60%	1.19%	0.13%	0.17%	0.18%	0.58%	1.68%	0.35%	0.20%	0.26%	84.54%	0.33%	2.88%	2.42%	2.57%
Weeks Waited- Under 52	0.50%	0.66%	0.21%	0.64%	0.58%	1.33%	0.15%	0.17%	0.15%	0.62%	1.81%	0.35%	0.18%	0.23%	82.56%	0.30%	3.24%	2.71%	

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APPENDIX 1

Operational Performance

Constitutional standards

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	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	Percentage of Ambulance Handovers within 15 minutes	0%	68.51%	H		
	Ambulance handovers greater than 60 minutes	1	1		F	
	Time to Initial Assessment - percentage within 15 minutes	85%	62.74%	H	F	
	Average (mean) time in Department - non-admitted patients	180	264		F	
	Average (mean) time in Department - admitted patients	180	366		F	
	Clinically Ready to Proceed	90	451	H	F	
	12 Hour Trolley Waits	0	665	H	F	
	Patients spending more than 12 hours in A&E	0	1757		F	
	Median Wait to be seen - Type 1	60	88		F	
	Bed Occupancy	92%	87.88%			
Cancer Care	Cancer 28 day faster pathway	75%	60.60%	H	F	
	Cancer 62 GP ref	85%	50.31%	L	F	
	Cancer 62 day Screening	90%	61.54%		?	
	31 day First Treatment	96%	87.08%	L	?	
	2WW First Seen (exc Breast Symptom)	93%	93.91%	H	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.4%		?	
	Cancelled Ops	150	171		?	
	Theatre Utilisation	85%	80.8%			
Inpatient / Discharge	Same Day Emergency Care	30%	37%	H	?	
	Super Stranded	183	205		?	
	MFFD	100	85	L	?	
	Discharges before Midday	25%	19.7%		F	
	Emergency Readmission rate	8%	8.8%	L	F	
Elective waits	RTT incomplete performance	92%	53.90%	L	F	
	RTT 52+ week waits	0	4837	H	F	
	Diagnostics	99%	68.48%		F	

Delivering Exceptional Care with Exceptional People

Cancer – 62 Day

NHS University Hospitals of North Midlands NHS Trust

Target	Mar 23	Apr 23	May 23
700	771	901	935

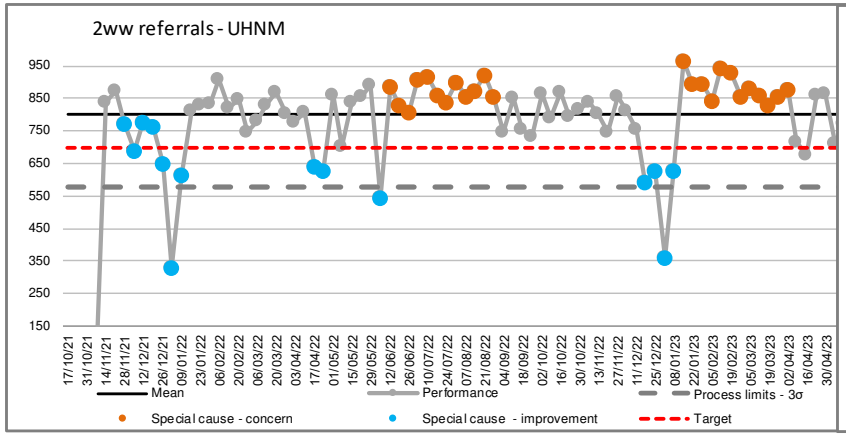
Background

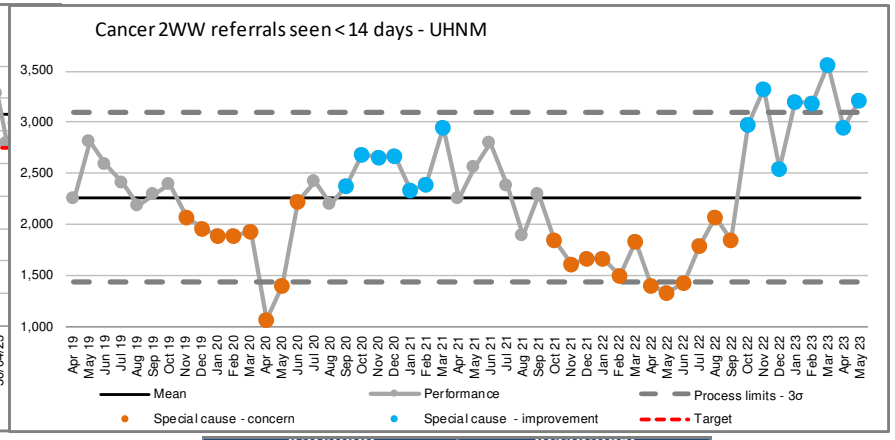
The number of patients referred on a cancer 2ww pathway.

Target	Mar 23	Apr 23	May 23
N/A	3567.0	2945.0	3223.0

Background

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





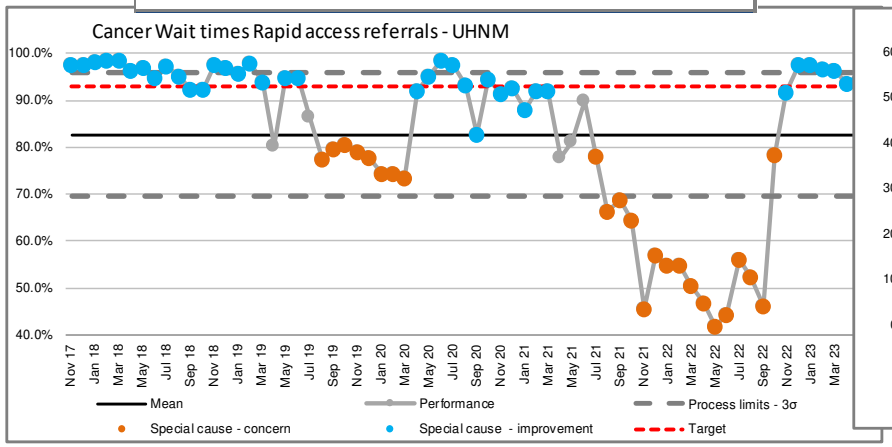
Target	Mar 23	Apr 23	May 23
93%	96.4%	93.7%	93.9%

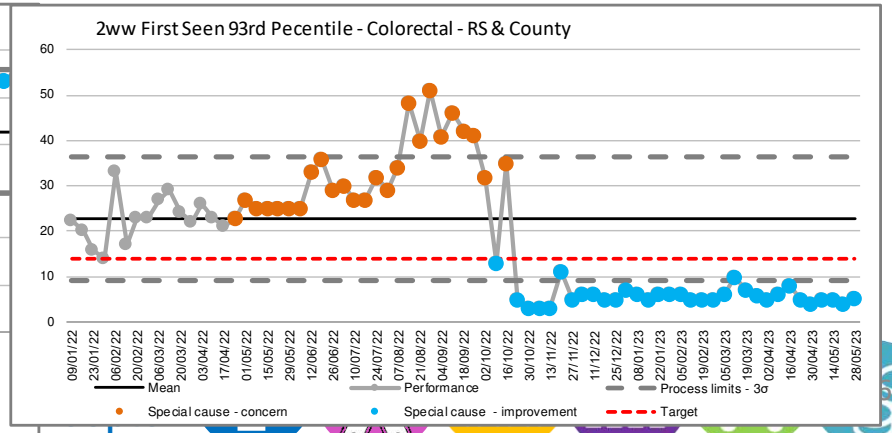
Background

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

Variation	Assurance
	

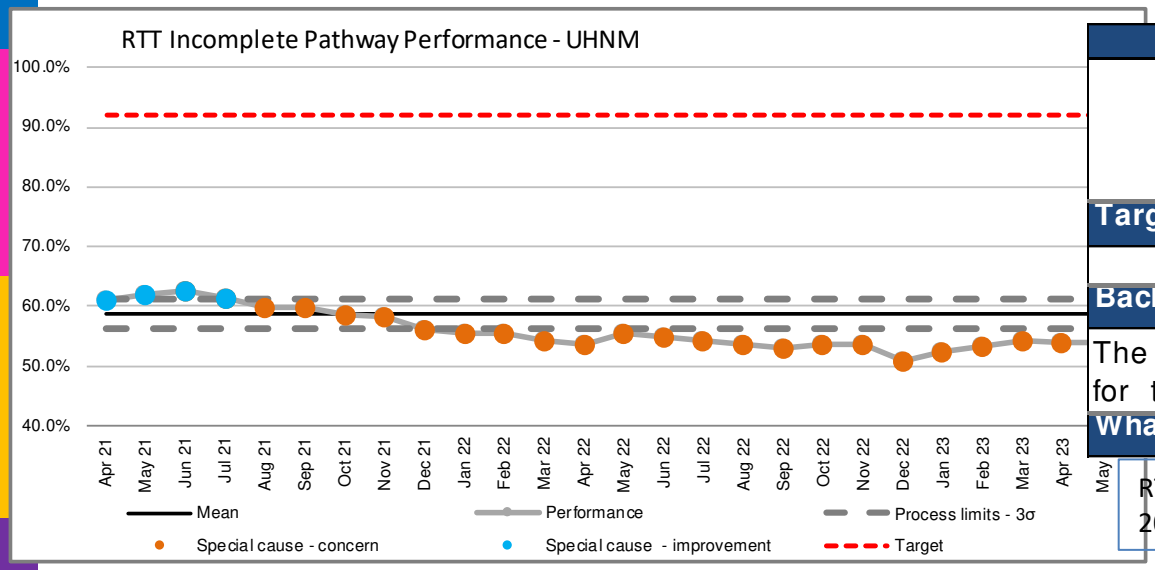
Target	May 23	May 23	May 23
14	5	4	5





Referral To Treatment

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
L	F

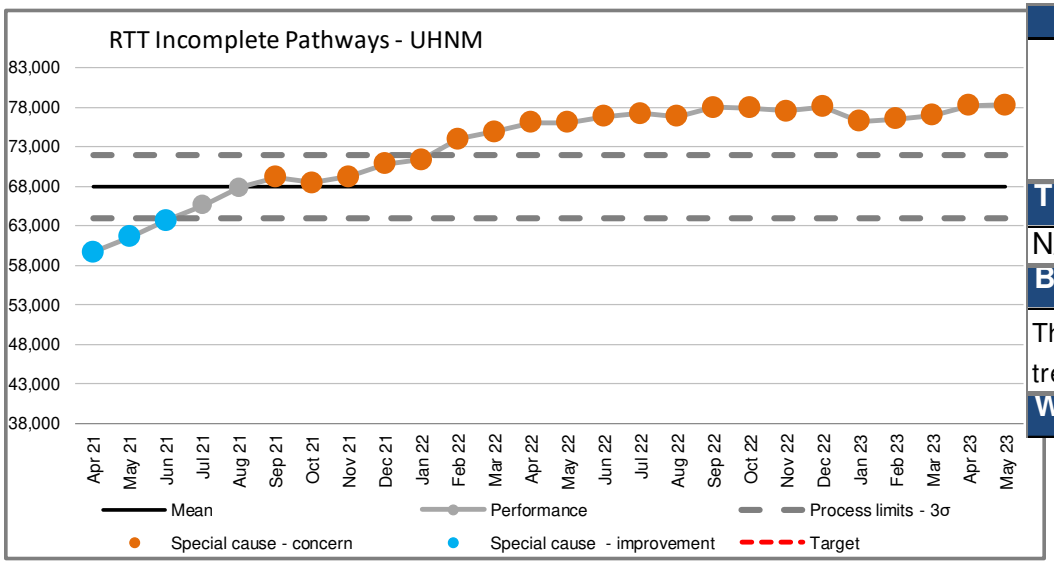
Target	Mar 23	Apr 23	May 23
92%	54.1%	53.9%	53.9%

Background

The percentage of patients waiting less than 1 for treatment.

What is the data telling us?

RTT performance has stabilised at c. 53% during 2023.



Variation	Assurance
H	

Target	Mar 23	Apr 23	May 23
N/A	76961	78219	78307

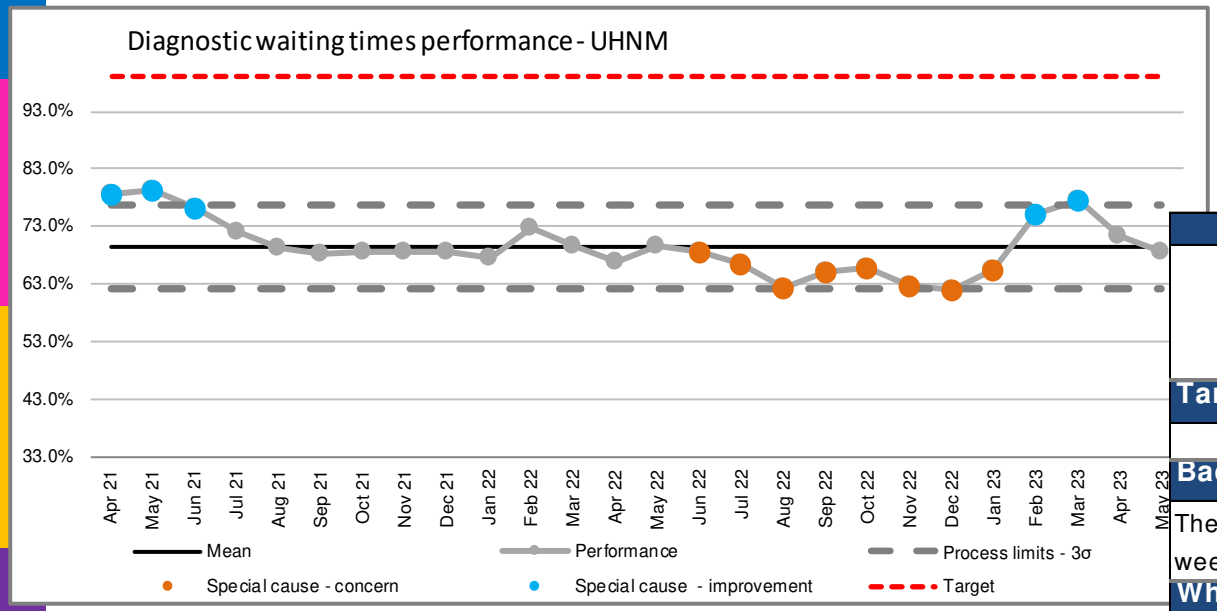
Background

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

What is the data telling us?

The number of RTT Open pathways continues to increase.

Diagnostic Standards



Variation	Assurance
	F

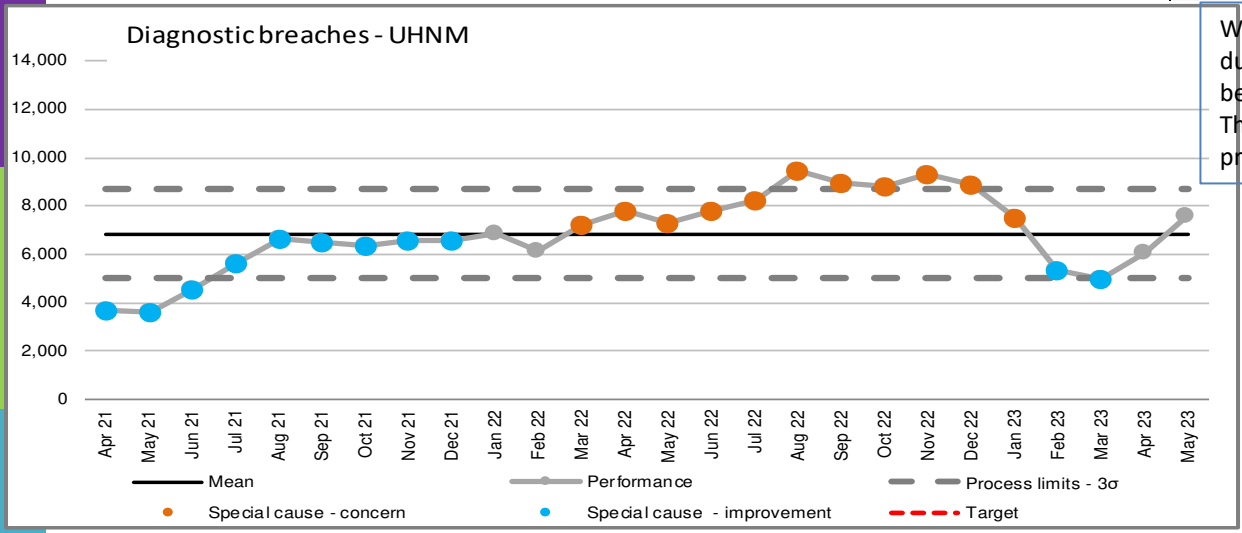
Target	Mar 23	Apr 23	May 23
99%	77.6%	71.4%	68.5%

Background

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

What is the data telling us?

Waiting times performance saw a sharp improvement during early 2023, since April this has deteriorated to below the 2 year average.
The volume of breaches increased in May, predominantly due to Endoscopy modalities.



Workforce

University Hospitals of North Midlands NHS Trust

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

Delivering Exceptional Care with Exceptional People

Workforce Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key messages

The Trust's People Strategy 2022-2025 sets identifies the workforce priorities required to support delivery of the Trust's strategic ambitions, vision and objectives whilst demonstrating our values in all that we do. To deliver this four key domains of focus have been identified within the strategy.

- We will look after our people
- We will create a sense of belonging
- We will grow and develop our workforce for the future
- We will develop our people practices and systems

Overall, the level of workforce risk remains at ext16 due to the cultural issues highlighted by the brap report, high sickness levels and the impact on workforce availability. There are measures in place to mitigate risks including a recruitment pipeline

The Cultural Improvement Plan has been updated following a monthly review of progress.

- The Being Kind e-learning is now mandated from 1 April 2023 and face-to face sessions have now started from June.
- The PowerBI Cultural heatmap dashboard has gone live and can be accessed by divisions. The indicators have been cross referenced with the cultural improvement plan to ensure that most aspects of improvement are being measured.

Stress and Anxiety remains to be the top reason for sickness in May, which saw and increase of 0.14% in the last month to 22.9% (22.8% in April). Chest & respiratory problems saw a decrease of 0.56% in the last month to 19.0% (19.6% in April 2023). Focusing specifically on Covid related absence by 26 June 2023 covid-related absences stood at 29, which was 4.11% of the 705 open absences. This is a 1.73% decrease on the previous month.

The Staff Voice trust survey May 2023 received a total of 1062 submissions providing an overall colleague engagement score of 6.47.

Internal measures to monitor reduction in agency expenditure continue. Divisional targets for agency ceilings have been calculated. As part of the monitoring divisions were asked to present an update on their action plan to reduce expenditure to Executive Workforce Assurance Group (EWAG). New targets for the upcoming year will be provided based on 3.75% of total pay spend.

The Loop app officially launched on the 3rd April, Fully integrated with our eRostering solution, it allows your people to view their personal schedule anytime as well as provide input back into the roster with simple to use features such as leave request, logging call-outs and requesting bank duties.

Workforce Dashboard

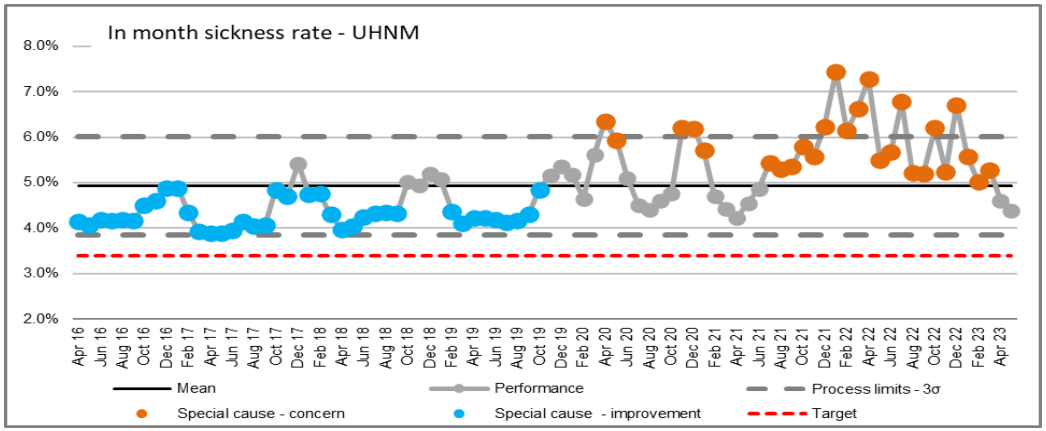
NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	4.39%		
Staff Turnover	11%	9.58%		
Statutory and Mandatory Training rate	95%	94.07%		
Appraisal rate	95%	83.84%		
Agency Cost	N/A	4.44%		

Delivering Exceptional Care with Exceptional People

Sickness Absence

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Mar 23	Apr 23	May 23
3.4%	5.3%	4.6%	4.4%

Background

Percentage of days lost to staff sickness

Sickness rate is consistently above the target of 3.4%.

Summary

Org L2	Divisional Trajectory - March 2024	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Trajectory
205 Central Functions	3.39%	4.11%	4.19%	4.21%	4.20%	3.74%	3.71%	3.85%	3.79%	3.90%	3.88%	3.73%	3.66%	↓
205 Women's, Children's & Clinical Support Services	5.25%	5.97%	6.03%	6.07%	6.25%	6.35%	6.29%	6.32%	6.22%	6.19%	6.01%	5.72%	5.68%	↓
205 Estates, Facilities and PFI Division	5.25%	5.76%	5.85%	5.98%	6.04%	6.20%	6.22%	6.15%	6.02%	6.00%	5.75%	6.02%	6.07%	↑
205 Medicine and Urgent Care	5.25%	6.67%	6.76%	6.82%	6.85%	6.94%	6.86%	6.90%	6.55%	6.41%	6.22%	5.98%	5.87%	↓
205 Division of Network Services	5.25%	5.69%	5.89%	5.81%	5.78%	5.73%	5.75%	5.80%	5.59%	5.48%	5.34%	5.06%	4.96%	↓
205 Division of Surgery, Theatres and Critical Care	4.50%	7.30%	7.45%	7.39%	7.31%	7.30%	7.20%	7.12%	6.94%	6.81%	6.73%	6.53%	6.37%	↓
205 North Midlands & Cheshire Pathology Service (NMCPS)	5.25%	N/A	N/A	N/A	N/A	5.57%	5.61%	5.64%	5.65%	5.68%	5.56%	5.37%	5.34%	↓

For M2, the in-month sickness rate decreased by 0.22% to 4.39% (4.61% in April 2023). The 12-month cumulative rate decreased to 5.56% (5.65% in April 2023). Stress and Anxiety remains the top reason for sickness in May, which saw an increase of 0.14% to 22.9% (from 22.8% in April 2023). Chest & respiratory problems decreased by 0.56% in the last month to 19.0% (19.6% in April 2023). Divisional trajectories for achieving a reduction in Sickness Absence can be seen in the table above. All of the Divisions apart from Estates, Facilities & PFI Division saw a decrease sickness against the previous month.

Focusing specifically on Covid related absence by 26 June 2023 covid-related absences stood at 29, which was 4.11% of the 705 open absences. This is 1.73% decrease on same time the previous month.

Actions

The focus remains on managing areas of high sickness, and continued daily monitoring of sickness absence rates:

For the Medicine division Sickness absence continues to be monitored at monthly directorate performance reviews and areas with over 8% or of concern are meeting with their People advisor on long term sickness cases

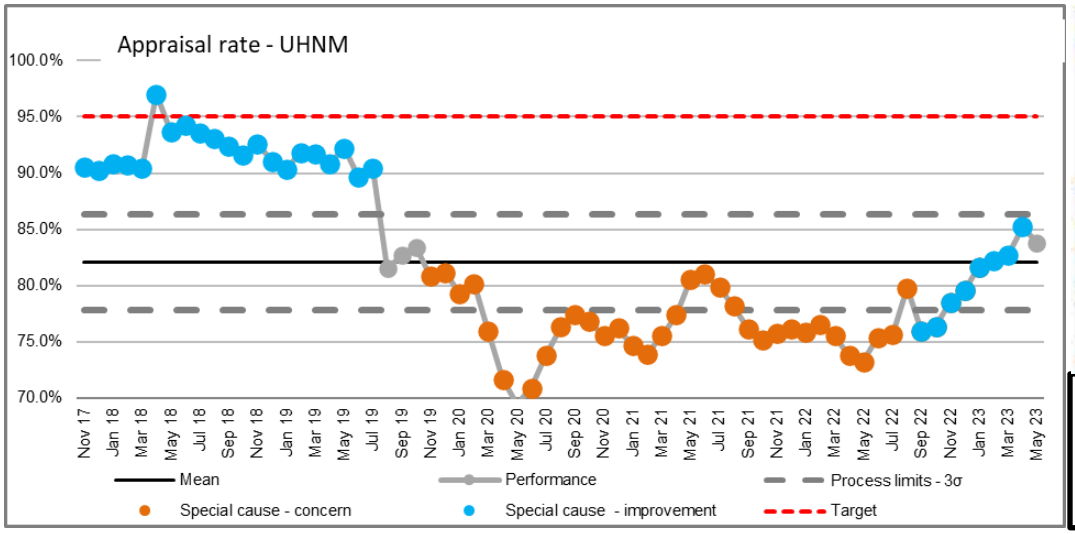
Surgery Division have been identifying hotspot areas for both long and short term sickness and providing targeted support. There has also been targeted training for low compliance areas in relation to Empactis .

Network Division have commenced sickness assurance meetings.

Women's Children's and Clinical Division. Will be undertaking a deep dive into specific areas of high absence. Alongside sickness surgeries to support managers.

Appraisal (PDR)

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Mar 23	Apr 23	May 23
95.0%	82.7%	85.3%	83.8%

Background

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

The appraisal rate is consistently below the target of 95%.

Note: Completion of PDRs was suspended during covid-19 unless there was capacity to complete them.

Summary

On 31st May 2023, the PDR Rate decreased by 1.46% to 83.8% (85.3% on 30 April 2023).

There is a decrease from the previous month figure and this figure remains below the overall target and divisions have been asked to review key issues and actions to work towards meeting target.

The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance and making the process enhance employee experience.

Actions

The focus on ensuring completion of PDRs is continuing with:

NMCPS are working on putting all out of date PDRs in the manager diaries, Identifying any manager training gaps and reconfirming Manager hierarchies within ESR.

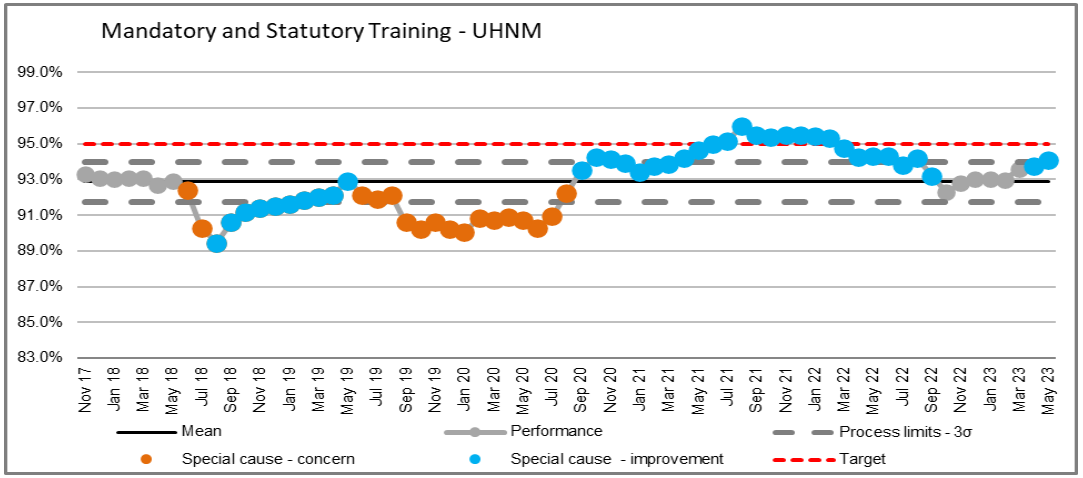
Network Division hold a dedicated weekly PDR compliance hotspot and assurance meetings

Surgery Division are undertaking a monthly compliance reporting and identifying hotspots areas to engage with.

Medicine Division are having weekly updates reports on compliance. With focused assistance on those areas with the lowest compliance.

Statutory and Mandatory Training

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
H	F

Target	Mar 23	Apr 23	May 23
95.0%	93.6%	93.8%	94.1%

Background

Training compliance

What is the data telling us?

At 94.1%, the Statutory and Mandatory Training rate is just below the Trust target for the core training modules

Summary

Statutory and Mandatory training rate on 31 May 2023 was 94.1% (93.8% on 30 April 2023) showing a slight increase. This compliance rate is for the 6 'Core for All' subjects only.

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	11088	11088	10428	94.05%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	11088	11088	10443	94.18%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	11088	11088	10429	94.06%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	11088	11088	10459	94.33%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	11088	11088	10522	94.90%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	11088	11088	10303	92.92%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	11088	11088	9879	89.10%
NHS|CSTF|Information Governance and Data Security - 1 Year|	11088	11088	10098	91.07%

Actions

We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

Compliance is monitored and raised via the Divisional performance review process.

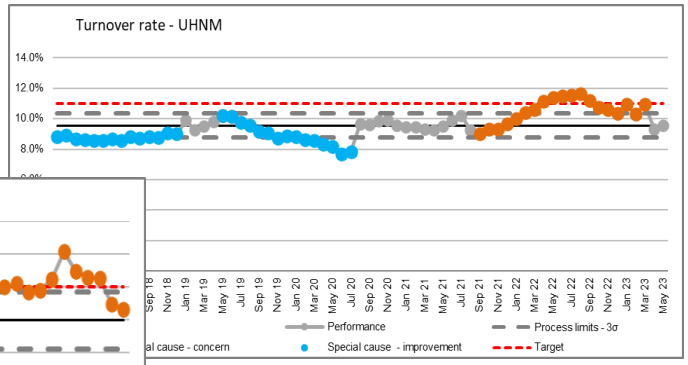
The Oliver McGowan Mandatory Training on Learning Disability & Autism is now live and will be reported separately for 12 months.

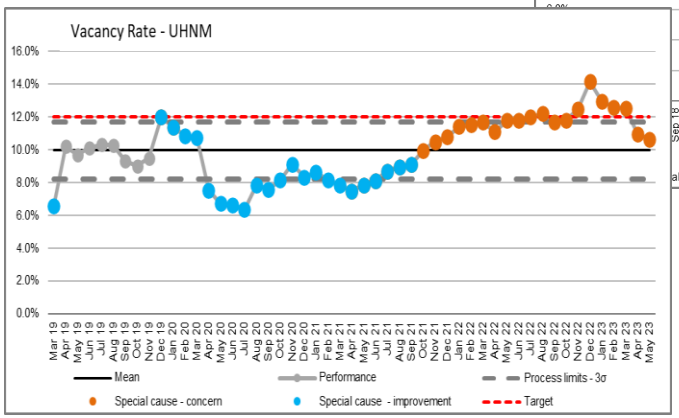
The Being Kind e-learning is now mandated from 1 April 2023 and face-to face sessions have now started from June.

Workforce Turnover

University Hospitals of North Midlands

The SPC chart shows the rolling 12m cumulative turnover rate.





Variation	Assurance

Target	Mar 23	Apr 23	May 23
11.0%	10.9%	9.3%	9.6%

Background

Turnover rate

What is the data telling us?

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

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

Vacancy rate has decreased from 10.95% last month to 10.65%

Summary

The 12m Turnover rate in May 2023 sat at 9.58% figure sitting below the trust target of 11%.

The summary of vacancies by staff groupings highlight a small decrease in the vacancy rate over the previous month.

Vacancies at 31-05-23	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,558.00	1,357.93	200.07	12.84%	12.97%
Registered Nursing	3,575.34	3,126.39	448.95	12.56%	13.23%
All other Staff Groups	6,628.58	6,024.47	604.11	9.11%	9.24%
Total	11,761.92	10,508.79	1,253.13	10.65%	10.95%

The M2 figure of 10.65% highlights a decrease in the overall vacancy rate over the previous month. The colleagues in post increased in May 2023 by 68.80 FTE, budgeted establishment increased by 38.72 FTE, which decreased the vacancy fte by -30.08 FTE overall[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 30/05/23]

Actions

Significant amount of recruitment events targeting specific roles across multiple divisions.

Continued targeted social media campaign. Recruitment are actively updating LinkedIn pages and have created a new UHNM recruitment Facebook group.

The Loop app officially launched on the 3rd April.

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key elements of the financial performance year to date are:

- For Month 2 the Trust has delivered a year to date deficit of £3.8m against a planned surplus of £1.7m; this adverse variance of £5.5m is primarily driven by underperformance against the Trust's in year CIP target and unfunded additional winter escalation capacity that remains open.
- The Trust has incurred £1.5m of costs relating to winter escalation capacity remaining open in April and May. The Month 2 position assumes that this additional cost will be not be funded by the local ICB.
- To date the Trust has validated £5.6m of CIP savings to Month 2 against a plan of £9.2m. The £3.5m under delivery of CIP is driving the in month overspend against plan. Schemes of £47m have been identified for delivery in 2023/24. The PMO is currently working with scheme leads to develop robust plan to deliver these savings. The £8.0m divisional schemes remain unidentified.
- There has been £4.3m of Capital expenditure which is £0.5m below plan.
- The cash balance at Month 2 is £82.4, which is £1.8m lower than plan. Cash holdings are below plan mainly due to additional accounts payable payments.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	88.3		
	Expenditure - Pay	variable	55.5	H	F
	Expenditure - Non Pay	variable	31.4	H	F
Activity	Daycase/Elective Activity	variable	9,271	H	?
	Non Elective Activity	variable	10,642	H	P
	Outpatients 1st	variable	28,749		?
	Outpatients Follow Up	variable	43,485		?

Income & Expenditure

Income & Expenditure Summary Month 02 2023/24	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	981.1	82.3	81.2	(1.1)	163.2	161.5	(1.7)
Other Operating Income	82.4	7.2	7.1	(0.1)	14.0	13.8	(0.2)
Total Income	1,063.4	89.4	88.3	(1.1)	177.1	175.3	(1.9)
Pay Expenditure	(652.8)	(54.7)	(55.5)	(0.8)	(107.5)	(108.2)	(0.7)
Non Pay Expenditure	(347.3)	(28.8)	(31.4)	(2.6)	(57.2)	(60.4)	(3.2)
Total Operational Costs	(1,000.0)	(83.5)	(86.9)	(3.4)	(164.7)	(168.6)	(3.9)
EBITDA	63.4	5.9	1.4	(4.5)	12.4	6.6	(5.8)
Depreciation & Amortisation	(36.3)	(3.1)	(3.1)	0.0	(6.2)	(6.2)	0.0
Interest Receivable	2.8	0.2	0.3	0.1	0.5	0.7	0.2
PDC	(11.0)	(0.9)	(0.9)	0.0	(1.8)	(1.8)	0.0
Finance Cost	(19.0)	(1.6)	(1.6)	0.0	(3.2)	(3.2)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Total	0.0	0.5	(3.8)	(4.4)	1.7	(3.8)	(5.5)

Key issues to note within the Month 2 position include the following

- The overspend of £5.5m is mainly driven by the under delivery of CIP by £3.5m and additional unfunded costs relating to additional winter escalation capacity that has remained open in April & May of £1.5m.
- The two main CIP schemes behind plan at Month 2 are the ICB non-recurrent stretch of £1.8m and the recurrent divisional schemes of £1.3m. The Trust is planning on delivering the stretch target in full through a reduction in the Annual Leave accrual with the impact of this likely to be transacted later in the year.
- Additional costs of £1.5m have been incurred for winter escalation capacity that has remained open in April and May. It has been assumed in the Month 2 position that no additional funding will be received from the local ICB. Discussion are on-going across the system on the level of funding available for additional escalation capacity and the actual and potential commitments against this funding with a clear position expected for Month 3.
- The Month 2 pay costs for Agenda for Change staff has been included at 5% in line with the nationally agreed increase; Month 1 pay costs assumed an increase of 2%. Income to cover this increase in costs has also been assumed in the Month 2 position; this will be reviewed at Quarter 1 when the actual level of funding is confirmed.

Capital Spend

NHS
University Hospitals of North Midlands
NHS Trust

UHNM Capital Expenditure Plan	2023/24 Plan/forecast £000	YTD Plan M02 £000	YTD Actual M02	YTD Var M02 £000
Total PFI & Loan Commitments	(19.6)	(2.8)	(2.8)	0.0
Pre-committed investment items (ICB allocation)				
PFI enabling costs	(0.2)	-	-	-
Project Star	(20.7)	(0.6)	(0.5)	0.0
Emergency Department (restatement costs)	(0.2)	-	-	-
Air heat boiler replacement Trust Contribution	(0.7)	-	-	-
Wave 4b Funding - Lower Trent Wards	(0.2)	-	-	-
EPMA (Electronic Prescribing) BC	(0.7)	(0.1)	(0.1)	0.0
Pathology LIMS BC	(0.6)	(0.1)	(0.1)	(0.0)
Pathology MSC Siemens refresh	(0.1)	-	-	-
Patient Portal roll out costs (BC 462)	(0.4)	(0.0)	(0.0)	(0.0)
Bi plane enabling (BC 425)	(0.2)	-	-	-
CT8 enabling works	(0.6)	(0.0)	(0.0)	0.0
Nasstar equipment refresh/buy out	(1.2)	-	-	-
Pharmacy Robot BC487 - equipment	(0.5)	-	-	-
Pharmacy Robot BC487 - enabling and other	(0.8)	-	-	-
Electronic Patients records BC/specification	(0.8)	(0.1)	-	0.1
ED ambulance off - enabling ward moves	(0.7)	(0.0)	(0.1)	(0.1)
County CTS equipment (TIF) remaining equipment	(0.2)	(0.2)	(0.1)	0.1
County Modular remaining equipment	(0.1)	(0.1)	(0.1)	0.0
I-refer	(0.0)	(0.0)	-	0.0
Investment funding - minor cases *	(0.4)	-	-	-
Funding to be confirmed (on-call, PODS, ED doors)	-	-	-	-
Central Contingency & risk	-	-	-	-
Required NHSE plan re-phasing adjustment	7.2	-	-	-
Remaining 2022/23 commitments	(0.3)	(0.2)	(0.0)	0.2
Total Pre committed Investment items	(22.3)	(1.4)	(1.0)	0.4
Capital sub-group (ICB allocation)				
IMT Sub Group Total Funding	(2.3)	(0.1)	(0.1)	0.0
Medical Devices Sub Group Total Funding	(2.4)	(0.3)	-	0.3
Estates Sub Group Total Funding	(3.6)	(0.1)	(0.0)	0.1
Health & Safety compliance	(0.2)	-	-	-
Net zero carbon initiatives	(0.1)	-	-	-
Central funding beds, mattresses, hoists	(0.8)	-	-	-
Total Sub Groups	(9.3)	(0.5)	(0.1)	0.4
New IFRS16 leases (previously classified as operating leases and charged to revenue)				
IFRS 16 leases	(0.2)	-	-	-
Endoscopy works - 22/23 PDC ICB allocation	(0.4)	(0.0)	(0.0)	0.0
Total Internal Capital Expenditure programme	(51.9)	(4.7)	(4.0)	0.8
Additional CRL / Externally Funded PDC				
Wave 4b Funding - Lower Trent Wards	(1.6)	(0.0)	-	0.0
TIF 2 PDC CTS phase 1 - enabling slippage	(0.4)	(0.1)	-	0.1
TIF 2 PDC (Day Case Unit)	(2.7)	(0.0)	(0.0)	0.0
TIF 2 PDC (Women's Hospital)	(1.2)	(0.0)	(0.0)	0.0
PDC - UEC SDEC facility	(13.4)	-	-	-
CDC - diagnostic centre	(0.4)	-	-	-
Air heat boiler replacement PSDS Grant BC 510	(2.9)	(0.0)	(0.0)	(0.0)
Charitable funded expenditure	(5.1)	-	(0.3)	(0.3)
Total Additional CRL / PDC Funded expenditure	(27.7)	(0.1)	(0.4)	(0.3)
Total Capital Expenditure	(79.6)	(4.8)	(4.3)	0.5
Planned (under)/over spend	5.9			

The table above sets out the capital plan for 2023/24 as per the plan resubmitted to NHSE on 4 May 2023. The planned overspend of £5.9m has reduced from the previous plan submission of £13.6m as the ICB was required to submit a balanced capital plan over 2 years (within the allowable 5% over commitment). The underspend of £5.9m in 2024/25 has been reduced from £13.6m in the previous plan. In the Month 2 submission to NHSE the Trust was required to show a forecast in line with the submitted capital plan rather than a forecast overspend of £7.2m.

The plan for 2023/24 and 2024/25 is dependent on a significant level of capital receipts in respect of the Project Star business case. In 2023/24 the sale of Sharman Close is included in the capital plan to fund the current level of capital expenditure. In 2024/25 the funding of the £5.9m underspend is dependent on a £9.2m capital receipt in respect of the surplus land at the RI and COPD. There is a significant risk in terms of achieving either the timing or value of the capital receipt as planning permission will not be received within this timescale and indications are that capital receipts received would be significantly lower than plan for a sale without planning permission in place.

At Month 2 capital expenditure was £4.3m against a plan of £4.8m, an underspend of £0.5m. Of the £4.3m expenditure, £2.8m is related to pre-committed items for the repayment of PFI and IFRS16 lease liabilities and PFI lifecycle expenditure.

The main areas of underspend at Month 2 relate to the medical devices capital sub-group (£0.3m) where there have been minor delays to the ordering of equipment early in the financial year. There are minor underspends on remaining 2022/23 commitments and County CTS enabling and equipment.

The underspends above are due timing issues and are not expected to be variances from plan.

Balance sheet

Balance sheet as at Month 2	31/03/2023	31/05/2023			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	650.1	647.2	647.0	(0.2)	
Right of Use Assets	18.8	18.1	18.1	(0.0)	
Intangible Assets	18.4	17.8	17.5	(0.3)	
Trade and other Receivables	1.4	1.4	1.4	0.0	
Total Non Current Assets	688.6	684.4	684.0	(0.5)	
Inventories	16.8	16.8	16.9	0.1	
Trade and other Receivables	57.9	57.9	65.5	7.7	Note 1
Cash and Cash Equivalents	84.0	84.2	82.4	(1.7)	Note 2
Total Current Assets	158.7	158.9	164.8	6.0	
Trade and other payables	(134.0)	(131.0)	(141.9)	(10.9)	Note 3
Borrowings	(14.0)	(14.0)	(13.7)	0.3	
Provisions	(5.6)	(5.6)	(5.6)	0.0	
Total Current Liabilities	(153.5)	(150.6)	(161.2)	(10.6)	
Borrowings	(256.8)	(254.4)	(254.5)	(0.1)	
Provisions	(2.7)	(2.7)	(2.6)	0.0	
Total Non Current Liabilities	(259.5)	(257.0)	(257.2)	(0.1)	
Total Assets Employed	434.3	435.7	430.5	(5.2)	
Financed By:				-	
Public Dividend Capital	665.0	665.0	665.0	-	
Retained Earnings	(429.1)	(427.7)	(432.9)	(5.2)	Note 4
Revaluation Reserve	198.4	198.4	198.4	-	
Total Taxpayers Equity	434.3	435.7	430.5	(5.2)	

The balance sheet plan reflects the forecast included within the 2023/24 Financial Plan submitted on 4 May 2023. Variances to the plan at Month 2 are explained below:

Note 1. Trade and other receivables are £7.7m higher than plan at Month 2 reflecting a £6.1m increase in non-NHS prepayments compared to Month 12. The main reason for the increase is the payment of annual business rates for the 2023/24 financial year of £4.7m for the Royal Stoke and County sites in April 2023. The remaining increase reflects the payment of other annual and quarterly invoices in April 2023 including invoices for pathology managed service contracts.

Note 2. At Month 2 our cash balance was £82.4m. This is £1.7m lower than plan and is a combination of higher than plan cash payments of £4.6m and higher than planned cash receipts of £2.8m. Cash received from ICBs is £2m higher than plan and general payments are also £3.7m higher than plan, which includes the payment in April 2023 of annual business rates for the 2023/24 financial year.

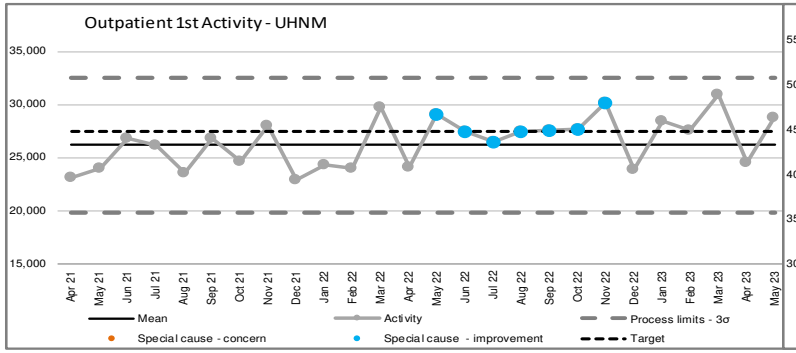
Note 3. Payables are £10.9m higher than plan at Month 2. Deferred income has increased by £7.5m in the year to date to £21.9m. The main increase in deferred income compared to Month 12 relates to Education contract income of £5m (now received from NHS England). The deferred income balance also includes significant balances relating to cash received from Staffordshire and Stoke on Trent ICB for a number of schemes (£5.3m); digital pathology (£2.1m); and high cost devices (£5.6m).

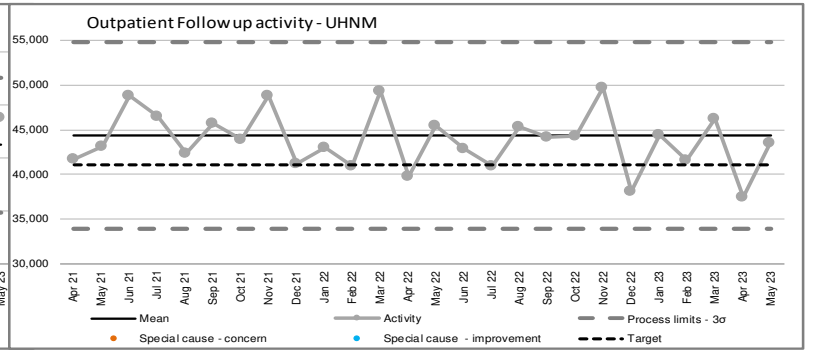
Note 4. Retained earnings are showing a £5.2m variance from plan reflecting the revenue variance from plan at Month 2.

Activity

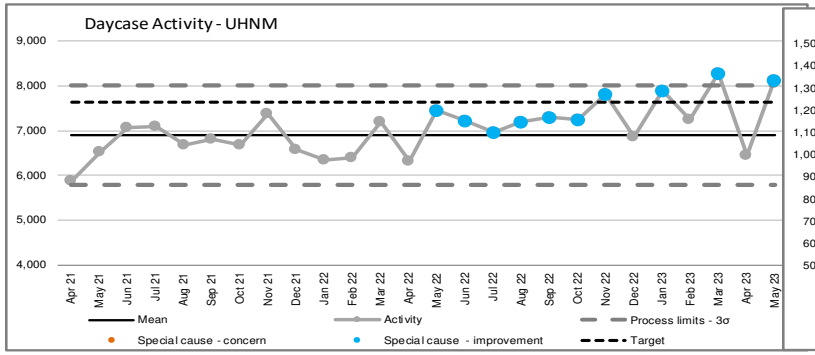
NHS
University Hospitals of North Midlands
NHS Trust

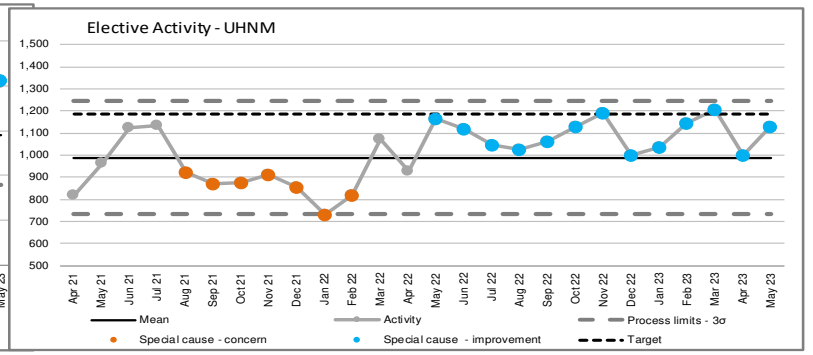
Planned care Outpatient



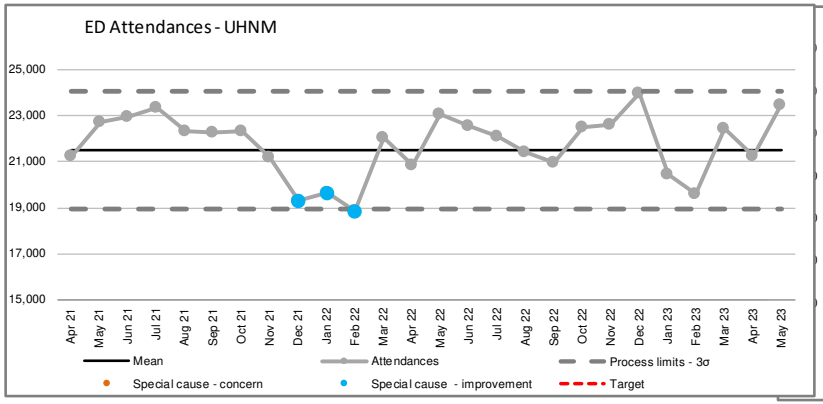


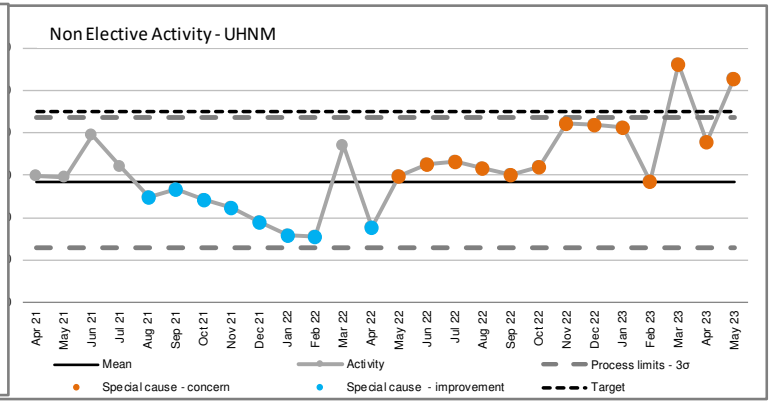
Planned care Inpatient





Urgent Care





Delivering Exceptional Care with Exceptional People

Trust Board

2023/24 BUSINESS CYCLE

KEY TO RAG STATUS	
Paper rescheduled for future meeting	
Paper rescheduled for next meeting	
Paper taken to meeting as scheduled	

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		5	3	7	5	2	6	4	8	6	10	7	6	
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse		Staff		Staff				Staff			Staff		
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Quality Strategy Update	Chief Nurse													TBC
Clinical Strategy	Director of Strategy													TBC
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													
Quality Account	Chief Nurse													
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													
Infection Prevention Board Assurance Framework	Chief Nurse	Q3		Q4		Q1			Q2			Q3		
RESPONSIVE														
Integrated Performance Report	Various	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
PEOPLE														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Chief People Officer													
People Strategy Update	Chief People Officer													TBC
Revalidation	Medical Director													
Workforce Disability Equality Report	Chief People Officer													
Workforce Race Equality Standards Report	Chief People Officer													
Staff Survey Report	Chief People Officer													
Raising Concerns Report	Associate Director of Corporate Governance					Q4 & Q1			Q2			Q3		
IMPROVING AND INNOVATING														
Research Strategy	Medical Director													TBC
SYSTEM AND PARTNERS														
System Working Update	Chief Executive / Director of Strategy													
RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy	N/A	N/A											
Digital Strategy Update	Director of Digital Transformation													TBC
Going Concern	Chief Finance Officer													
Estates Strategy Update	Director of Estates, Facilities & PFI													TBC
Annual Plan	Director of Strategy													
Board Approval of Financial Plan	Chief Finance Officer													Approved at PAF April 2023
Final Plan Sign Off - Narrative/Workforce/Activity/Finance														Approved at PAF April 2023
Activity and Narrative Plans	Director of Strategy													Approved at PAF April 2023
Capital Programme 2022/23	Chief Finance Officer													Approved at PAF April 2023

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		5	3	7	5	2	6	4	8	6	10	7	6	
Standing Financial Instructions	Chief Finance Officer													Next due for review February 2026
Scheme of Reservation and Delegation of Powers	Chief Finance Officer													Next due for review February 2026
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
Accountability Framework	Associate Director of Corporate Governance													
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													Board review to be considered at Trust Board Seminar in May
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													Initial Board Development Programme to be considered at Board Seminar in May 2023