University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 4th October 2023 at 9.30 am to 12.30 pm
Via MS Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	**2.**	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 2nd August 2023	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	**6.**	Chief Executive's Report – September 2023	Information	Mrs T Bullock	Enclosure	
10:15		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (28-09-23)	Assurance	Prof A Hassell	Enclosure	1
20 mins	**8.**	Stoke on Trent and Staffordshire System Surge Plan 2023/24	Approval	Mr S Evans	Enclosure	1, 2, 4, 5, 8
10 mins	**9.**	UHNM Patient Safety Incident Response Plan (PSIRP)	Approval	Mrs AM Riley	Enclosure	1
10:50		**RESOURCES**				
5 mins	**10.**	Performance & Finance Committee Assurance Report (26-09-23)	Assurance	Dr L Griffin	Enclosure	5, 7, 8
10:55 – 11:10 COMFORT BREAK						
11:10		**PEOPLE**				
5 mins	**11.**	Transformation and People Committee Assurance Report (27-09-23)	Assurance	Prof S Toor	Enclosure	2, 3, 4, 6, 9
10 mins	**12.**	2023 Workforce Disability Equality Standard Report and Action Plan	Assurance	Mrs J Haire	Enclosure	3
10 mins	**13.**	Appraisal and Revalidation Annual Report	Assurance	Dr M Lewis	Enclosure	3
11:35		**RESPONSIVE**				
40 mins	**14.**	Integrated Performance Report – Month 5	Assurance	Mrs AM Riley Mr S Evans Mrs J Haire Mr M Oldham	Enclosure	1, 2, 3, 5, 8
12:15	**CLOSING MATTERS**					
10 mins	**15.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
	16.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 2nd October to** Nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:25	**DATE AND TIME OF NEXT MEETING**					
	17.	**Wednesday 8th November 2023, 9.30 am, Trust Boardroom, Springfield**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 2nd August 2023 at 9.30 am to 11.50 am
Trust Boardroom, Third Floor, Springfield

MINUTES OF MEETING

Attended | **Apologies / Deputy Sent** | **Apologies**

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman (Chair)												
Mr P Akid	PA	Non-Executive Director												
Mrs T Bowen	TBo	Non-Executive Director					Obs.							
Mrs T Bullock	TB	Chief Executive												
Mr S Evans	SE	Interim Chief Operating Officer	PB	PB	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					ZD							
Prof K Maddock	KM	Non-Executive Director												
Professor S Toor	ST	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse												

Non-Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Ms H Ashley	HA	Director of Strategy												
Mrs C Cotton	CC	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)
Miss O Jenkins	OJ	Patient (item 1)
Mrs L Jenkins	LJ	Patient Representative (item 1)
Mrs D Meehan	DM	Lead Nurse – Quality & Safety (item 1)
Mr O White	OW	Deputy Chief Operating Officer (item 9)

Members of Staff and Public: 2

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
117/2023	Mrs Jenkins discussed the problems her daughter had experienced in that when she was 10 years old the shape of her wrists was questioned, and following a subsequent GP appointment she was referred to County Hospital. Miss Jenkins was diagnosed with Madelung Syndrome which required corrective surgery which was undertaken at Royal Stoke. Mrs Jenkins explained that Miss Carsi linked in with counterparts at Alder Hey due to the rareness of the condition and highlighted that the surgery took 5½ hours for each operation. Mrs Jenkins highlighted the care provided by Miss Carsi and also commended the x-ray team.	

	Mrs Jenkins explained that two days following Miss Jenkins being discharged from the care of the orthopaedics team, she was playing rugby and she thanked all of the staff involved in her daughters care as well as thanked her team in Estates, Facilities and PFI for the support provided to her. Mr Wakefield queried if Miss Jenkins was aware that the shape of her wrist was different and if this had impacted on her. Miss Jenkins stated that her wrist would not straighten and she could not hold things properly but she thought it was normal. Dr Griffin queried if there had been any problems with her wrists since surgery and Miss Jenkins explained that after some initial aches, there had not been any problems. Mr Wakefield asked if anything could have been improved and Miss Jenkins referred to the food whilst in hospital, whereby she was told to eat two slices of toast but could not. Mrs Whitehead stated that the catering provision was being reviewed and noted the lack of options due to being on a daycase ward. She agreed to consider further improvements in this area, as well as the option of a 24/7 deli at County Hospital, following the success at Royal Stoke. Mr Wakefield queried where the appointments took place and Mrs Jenkins highlighted that outpatients appointments were at County Hospital, whilst the MRI and CT scans were undertaken at Royal Stoke as well as the operation. Miss Jenkins referred to her MRI scan and highlighted that she was in the scanner for 3½ hours due to the difficulties in getting the right scan, and that she had to return the next day when a paediatric radiographer was available. Mr Wakefield referred to the rareness of Miss Jenkins' condition and welcomed the treatment provided at County. Miss Jenkins added that the 3D images helped to explain everything and that Miss Carsi always explained things in a way which was easy to understand. Mr Wakefield summaries that two issues needed further consideration; the food provision for daycase patients and any learning from the wait in the MRI scanner. Mr Wakefield thanked Mrs and Miss Jenkins for attending and sharing their story and Mrs Riley particularly thanked Miss Jenkins and provided her with a gift bag. **The Trust Board noted the Patient Story.** Mrs and Miss Jenkins left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
118/2023	Apologies were received as noted above and it was confirmed that the meeting was quorate. Mr Wakefield welcomed Mr Evans to the meeting.	
3.	**Declarations of Interest**	
119/2023	There were no declarations of interest raised.	
4.	**Minutes of the Previous Meeting held 5th July 2023**	
120/2023	The minutes of the meeting held 5th July 2023 and the minutes of the Extraordinary meeting held 28th June 2023 were approved as a true and accurate	

	record.	
5.	**Matters Arising from the Post Meeting Action Log**	
121/2023	PTB/582 – Mr Evans stated that UHNM was in the upper quartile for long length of stay patients compared to peers i.e. those over 14 days, but this continued to be an area of focus. Mr Wakefield highlighted the need to know the range of the length of stay in addition to the length of stay for Medically Fit for Discharge (MFFD) patients and it was agreed to discuss this further at Performance and Finance Committee (PAF).	
6.	**Chief Executive's Report – July 2023**	
122/2023	Mrs Bullock highlighted a number of areas from her report. Mr Wakefield referred to the lack of applicants for the body imaging and breast radiology posts and queried the solution for these. Mrs Bullock stated that this was a national issue and Mrs Haire stated that alternatives would need to be considered such as further national or international recruitment. Mr Akid queried if Consultants who were on strike could undertake private work and Mrs Haire stated that if their job plan included time when they were not due to be working at the Trust, they could undertake private work but they should not be undertaking private work if are contracted to work at UHNM and were choosing to strike. Mrs Rodwell noted the positive removal of the Care Quality Commission (CQC) Section 31 notice and queried if there was any learning. Mrs Bullock stated that over a lengthy period of time there had been significant reviews of the Emergency Department, including workforce, use of advanced nurses, changes to those who could triage, size and lay out of the department etc, and noted that as a result multiple things had happened incrementally which had made an overall difference. She stated that this had been subject to a constant PDSA cycle since 2019. Dr Griffin referred to the Industrial Action and the financial cost of covering the strikes and the need to be mindful of the cost of cover for the Consultant strikes. Mr Wakefield queried if the impact in terms of number of delays / cancellations due to the strike was known as well as the impact on long waits. Mrs Bullock stated there had been no impact on 104 weeks due to the proactive action taken to move our longest waiters out of strike days although there had been some impact on 78 week waits of approximately 100 patients. Mrs Bullock agreed to circulate the impact of the strike action separately outside of the meeting. Mr Wakefield referred to winter planning and queried if this had been considered at the system planning event. Mrs Bullock stated that the event focussed on actions to be taken for recovery of system finances although added that internal and system winter planning was taking place. She stated that Mr White would provide a verbal update to PAF in August with the first draft of the winter plan to be received after that. Professor Hassell referred to the flu vaccinations and performance for 2022/23 not having been as positive as previous years. He queried that as some staff had received their vaccines outside of the Trust whether the ICB could help to capture the vaccinations undertaken elsewhere. Mrs Bullock stated that the ICB do have information on vaccinations, but this was unable to be correlated with where they worked. She added that the Trust asked staff to inform them if they had their	**TB**

	vaccine elsewhere and Mrs Riley added that due to a national change in the way the numbers were captured, the records could not be updated to capture the vaccinations provided elsewhere. **The Trust Board received and noted the report and approved e-REAF 11312.**	
HIGH QUALITY		
7.	**Quality Governance Committee Assurance Report (27-07-23)**	
123/2023	Professor Hassell highlighted a number of areas from his report: • In terms of healthcare associated infections there had been 1 MRSA case with lapses in care which was under review, and problems with the number of c-difficile infections were raised whereby the focus was on antibiotic prescribing and learning from others • Readmission analysis demonstrated consistently higher levels of readmissions, although the majority were in paediatrics due to current care pathways including an approach whereby monitoring was counted as a readmission. It was noted that assurance had previously been provided by the paediatrics team, that the approach was appropriate for care of the patients. In addition, rates with higher areas continued to be scrutinised • Despite scrutiny and previous actions, pressure ulcer rates remained relatively high and the Committee had requested further assurance to be provided in August. • The Committee welcomed the action being taken by the Vulnerable Patient Communications and Interactions Engagement Project, whereby the Trust was proactively engaging with patients regarding their care at UHNM, with the aim of identifying what could be better **The Trust Board received and noted the assurance report.**	
RESOURCES		
8.	**Performance & Finance Committee Assurance Report (25-07-23)**	
124/2023	Dr Griffin highlighted a number of areas from his report: • Escalation beds from last winter remained open • As the Trust looked towards winter, a consistency of approach from the system was required • Performance was fairly stable in June with a continuing reduction in long waits and continued challenges with endoscopy • Financial performance highlighted some concerns due to pressures on the system • The Committee welcomed the work on the Community Diagnostic Centre (CDC) but this carried some risk in terms of timescales and workforce availability • The Committee supported the business case for a further tranche of overseas nurses with previous cohorts demonstrating high retention rates Ms Ashley referred to the CDC case which has also been considered at the system finance and performance meeting. She stated that the revenue gap was considered, in particular the associated uncertainty of funding at the end of the current agreement. She highlighted that the Committee made a commitment that if funding was not available, this would be referred back to the ICB for consideration. Mr Wakefield highlighted that the Committee agreed to go at risk for the case, due to this being the only route available to access the required capital and it being the right thing to do for patients.	

	The Trust Board received and noted the assurance report.	
RESPONSIVE		
9.	**Integrated Performance Report – Month 3**	
125/2023	Mrs Riley highlighted the following in relation to quality and safety performance: • Work remained ongoing in relation to pressure ulcers, with actions being taken both internally and with the system to identify improvements • In terms of serious incidents, two maternity incidents were highlighted, the findings from which would be discussed at Maternity Quality Governance Committee • The current serious incident rate per 1000 bed days was lower than the long term mean, therefore highlighting a positive impact from the work undertaken to reduce avoidable harm • In terms of c-difficile cases, the Trust was working with NHS England on a regional programme of improvement as well as linking in with peers with lower rates, to determine the actions to be taken • The maternity dashboard and CNST requirements were considered at the Board Seminar in July 2023 and specific metrics were to be reported to the Board on a monthly basis from September 2023 Mr Wakefield referred to the inpatient friends and family test (FFT) results and the improvement initiatives listed, and queried how the Trust was able to measure the impact on patient experience, of things such as timely medications. Mrs Riley stated that audit data was utilised and when implemented, the Electronic Prescribing and Medicines Administration (EPMA) project would also provide further information. Mr Wakefield referred to the assessment of pain management and whether this was a valuable measure. Mrs Riley stated that Tendable was utilised to document pain assessments and stated that as this was based on patients experience and their perception of pain it was an important measure to explore. Dr Griffin referred to the increase in reporting of medication incidents and patient safety incidents and queried whether this was an increase in reporting or increase in incidence. Mrs Riley referred to the importance of focusing on the level of harm and for medication incidents the level of incidents with no harm or near misses had increased, which appeared to demonstrate an improvement in reporting culture. Professor Crowe referred to the maternity serious incidents and fall in maternity FFT results. He requested a reminder of what assurance was provided to the Board and Committees on maternity services. Mrs Riley stated that a separate Maternity Quality Governance Committee (MQGC) was in place and met quarterly, in addition she meets with the maternity team on a weekly basis to monitor metrics. It was noted that a maternity dashboard would be provided to the Board on a monthly basis and noted this would be scrutinised by the Quality Governance Committee on the months where no MQGC meeting was taking place, with any escalations being highlighted to the Trust Board. Mrs Cotton added that she had assisted the Division in outlining the governance structure for maternity and neonatal services, and how that feeds into the overall corporate governance structure. Mr Wakefield referred to incidents with moderate harm and the reference to different working practices showing positive impacts and queried what this meant. Mrs Riley stated that this referred to each Division's driver metrics and the quality	

improvement work which was underway. She stated that benefits were starting to be seen where the methodology was being used consistently. Mr Wakefield referred to a recent visit to PACU whereby some of the Non-Executive Directors observed the positive engagement and utilisation of the Improving Together methodology.

Mr White highlighted the following in relation to urgent care performance:

- June was the first month where the Trust did not achieve its 4 hour trajectory with a 1.2% variance to target. This was primarily driven by a rise in activity, a four week MFFD peak, which had since reduced, and non-admitted performance at Royal Stoke remaining flat
- A number of mechanisms had been identified to ensure delivery including short and medium term actions in support of the long-term actions

Mr Wakefield referred to the actions which had already been taken but had not delivered an improvement in performance and queried what assurance could be taken from this. Mr White stated that performance was starting to improve particularly non-admitted performance and that the meetings with teams were helping to focus on quicker wins. In addition, agreed escalation processes had also been identified.

Professor Crowe queried if the 80% target was realistic and whether any local Trusts were achieving the target. Mr White stated that whilst 80% was an ambitious target, some sites do achieve this such as Coventry and Warwick. Professor Crowe queried if this required further discussion at PAF given the size of the challenge and Dr Griffin agreed to consider a deep dive into this, considering what needs to be done to improve and the impact on other areas of performance.

Mr Wakefield referred to the improvement in performance during Industrial Action due to additional Consultants being in the Department and Mr Evans highlighted some caution to this, stating that some higher performing Trusts utilised Advanced Care Practitioners / Advanced Nurse Practitioners and alternative ways of working. In addition he stated that 80% was not an unreasonable target for non-admitted performance.

Mr White added that the Trust was in the top quartile of Trusts for having made the most improvement in the 4 hour standard in the past 12 months.

Mr White highlighted the following in relation to cancer and planned care performance:

- The Trust continued to achieve above the 95% two week wait standard and had achieved the first milestone for the 28 faster diagnostic standard
- The backlog was reducing and a number of actions had been agreed to support endoscopy following a review by NHS England
- The RTT position for June ended with 10, 104 week waiters and 322, 78 week waiters with pre-validated July numbers demonstrating a further reduction
- There had been a deterioration in diagnostics performance primarily driven by endoscopy challenges and a recovery plan was in place which would be monitored through the Planned Care Improvement Group

Mr Wakefield queried the actions being taken for endoscopy and Mr White referred to the external support provided and the improvements to better map capacity and demand. He referred to the previous challenges in the booking team which had since been fully recruited to as well as highlighting the external outsourcing support, to be used to bridge the gap while waiting for internal capacity.

Mr White left the meeting.

Mrs Haire highlighted the following in relation to workforce performance:

- Turnover had improved as had the vacancy rate reflecting the continued work being undertaken with Divisions
- Performance had remained static in terms of sickness absence, appraisal rates and statutory and mandatory training, although there were no areas of concern to be escalated
- Completion of the Staff Voice for June saw the highest response rate, demonstrating the work undertaken by employee engagement champions and divisional teams. However, the results highlighted a lower employee engagement score
- Over 2000 colleagues attended the Being Kind face to face events with very positive feedback provided. In addition, the Trust was providing additional virtual events led by Tim Keogh which were fully booked
- The Trust held a number of successful events for Pride month in addition to a positive launch of the Men's Health Group and Women's Network
- A virtual work experience project had been undertaken with the system which was positively received, in particular the virtual operation

Mr Wakefield welcomed the attendance at the Being Kind events. Professor Crowe agreed that attendance and the content of the sessions was fantastic and demonstrated the Trust's recognition of the importance of this in tackling some of the cultural issues, given the investment and commitment made. Professor Crowe referred to the lower engagement score, and the need to increase the number of responses in the staff survey in order for actions for improvement to be identified.

Mr Oldham highlighted the following in relation to financial performance:

- Month 3 reported a deficit of £5.9 m, whereby the break even plan was a best case scenario. The deficit was driven by significant matters which were not anticipated in the plan such as strike action at a cost of £2.6 m, additional escalation beds which had been kept open over the summer, costing an additional £2.6 m and the cost improvement savings required.
- Some issues regarding Microsoft licences had been identified and this was being considered at a national level, as the Trust had expected this to provide a saving whereas this was creating a cost pressure of c£500k
- Some investments had been made to drive the reductions in the waiting list and deliver more than 103% cost weighted activity which had not been delivered due to the impact of the strike action
- National discussions were ongoing with regards to the strikes and for April a 2% reduction on cost weighted activity was to be provided, with the intention that this would drive additional income as Trusts would over achieve the target which would subsequently compensate for the strike action. Final guidance was awaited although this was expected to improve the position
- Discharge monies held with the ICB had not been factored into the position and it had been agreed for £2 m to be provided to UHNM
- £47 m CIPs had been identified against the target
- A forecasting was to be provided to PAF in August

Dr Griffin referred to the scenario planning being undertaken and queried the implications from the reduction in cost weighted activity. Mr Oldham stated that the position was unknown in terms of the impact of future strikes and the payment mechanisms for June and July.

	Mr Wakefield referred to the number of escalation beds remaining open and queried how this would impact on December, January and February as the beds would already be open. It was agreed to discuss this further at PAF as part of the winter plan discussion and Ms Ashley clarified that some escalation capacity at County had closed. Mr Oldham stated that capital was slightly ahead of plan and a mechanism was in place to address the over commitment for Project Star. In addition, the Trust had a positive cash position of £102 m. **The Trust Board received and noted the report.**	
GOVERNANCE		
10.	**Audit Committee Assurance Report (27-07-23)**	
126/2023	Professor Crowe highlighted a number of areas from his report: • The Committee received the latest internal audit reviews of the Board Assurance Framework (BAF) and annual data security protection which concluded with substantial assurance • The External Auditors value for money annual assessment was received with no significant weaknesses identified, but some improvement recommendations, reinforcing the actions regarding the tracking of CIP, the tracking of workforce improvements, and ensuring the follow up of actions from CQC inspections and receiving assurance that these are embedded into practice • An Internal Audit review concluded with improvements being required for data quality of annual leave indicators and CQC implementation of actions • Stock write offs and procedural issues were highlighted with regards to Single Tender Waivers and Standing Financial Instructions, whereby the learning from any breaches was shared Mr Wakefield referred to SFI breaches and the value of these. Mr Oldham stated that the breaches were usually in relation to a requisition being submitted after a commitment of the resource, due to urgent operational need, therefore it was important to focus on areas where procurement involvement would have added value. **The Trust Board received and noted the assurance report.**	
11.	**Board Assurance Framework – Quarter 1**	
127/2023	Mrs Cotton highlighted the following: • The BAF had been scrutinised by each Committee and a number of improvements had been made to the format with the most notable change to the content of BAF 4 which had been changed to focus on improving the health of the population • The Internal Audit finding was the fifth substantial assurance opinion which was positive and reflected the work and engagement undertaken • The next focus would be the creation of a summary version for Board consumption as the document had become large and detailed • A further development was the system approach to risk, whereby work was being undertaken to create a system BAF which would highlight the strategic risks across the system and this was being worked on with system partners Dr Griffin welcomed work being undertaken to consider the system strategic risks.	

	Mr Wakefield referred to the amount of work undertaken to date and the need for Committees to be provided with assurance of the completion of particular actions. Mrs Cotton referred to the proposal to undertake deep dives into each area of the BAF whereby assurance could be provided in terms of the actions and mitigation being taken. Professor Crowe referred to BAF 4 and the scoring of Extreme 20 and stated that given the context of the system and the target date of March 2025, further assurance was required in terms of how this would be achieved. Mr Wakefield reiterated the need to ensure actions were identified which would aim to reduce the risk score bearing in mind the trajectory towards the target score. **The Trust Board considered the risk scores for quarter 1 and assurance assessments, and agreed that further deep dives would be undertaken by Committees to obtain assurance on completion of actions.**	
12.	**Board Development Programme 2023/24**	
128/2023	Mrs Cotton highlighted the following: • The document accompanied the broader development programme which was discussed at the Board Seminar in July 2023 • The Board Seminar Programme highlighted the limited time available to consider all items and as such time in the Closed Board was being used Mr Wakefield reiterated the importance of keeping the dates for the seminars in the diary going forwards. Professor Crowe welcomed the programme set out for the year. **The Trust Board approved the Board Development Programme and noted the timing of the remaining sessions although agreed that flexibility would be provided if the content were to change.**	
CLOSING MATTERS		
13.	**Review of Meeting Effectiveness and Review of Business Cycle**	
129/2023	Professor Crowe welcomed the work undertaken to improve the technology in the Boardroom.	
14.	**Questions from the Public**	
130/2023	Mr Syme referred to maternity governance, safety and performance. He highlighted that he had been attending UHNM Board meetings since 1997 and referred to maternity services being under the 'microscope' given the significant safety failings in other maternity units. He referred to the previous discussion at July 2023 Board meeting regarding the CQC Maternity report and stated that he felt the Board was searching for the 'excusable' and prioritising the limiting of damage to organisational reputation. He queried if organisational reputation had superseded the priority of providing safe services. Mr Wakefield stated that the Trust was proud in terms of its openness and transparency and commitment to being patient focussed, which had been demonstrated by bringing a number of reports to the Board which all had the potential for reputational damage such as the brap / Kline cultural review, the	

	independent review of data and the neonatal deaths report. These are not the actions of a trust that is prioritising reputation over patient safety. Mr Wakefield also stated that he did not recognise Mr Syme's points from his recollection of the discussion held in July, nor the minutes of that discussion. Mr Wakefield stated that the Board were clear that the standards had changed and this was welcomed as was anything done to improve the safety of women and their babies, and confirmed that the Trust's priority was to ensure patient safety at all times. Mr Syme referred to The NHS Resolution Maternity Incentive Scheme discussion at the January 2023 Board meeting which concluded that the Trust Board confirmed it was satisfied that the evidence provided, demonstrated achievement of the ten maternity safety actions, and provided permission to the Chief Executive to sign the Board declaration form prior to submission to NHS Resolution. He asked for clarity as to how the Board were satisfied regarding maternity safety in January 2023 yet in March 2023 the CQC provided the rating of inadequate for maternity safety and he queried the implications for the Trust's assurance processes. Mrs Riley clarified that the two assessments were looking at different things and assessed based on different criteria. She highlighted that the assurance regarding the CNST submission was independently verified by the independent Local Maternity and Neonatal System (LMNS) which confirmed the Trust's view as to having met the CNST standards. Mrs Riley highlighted that the CNST requirements were different from the CQC i.e. in terms of training, CNST were content if a clear plan was in place with a compliant trajectory, whereas this would not satisfy the CQC. She stressed the importance of not conflating the two and confirmed that the assurance processes at that time were appropriate and robust given the external independent verification. Mr Syme referred to the Board meeting in May 2023 whereby he questioned the Board if, in the light of the CQC section 29 letter, that too many women had suffered sub-optimal care and he queried the Trust's position in light of the findings from the CQC report. Mrs Bullock stated that CQC report did not state that any women came to harm whilst recognising that at times there are occasions when women do come to harm or are unhappy with the care received. She stated that in these instances, the Trust investigated and reviewed all incidents and complaints. She stated that this was not an issue that the CQC had found in their report and she also noted that the number of harm incidents at UHNM were low given the ration of births and compared to peer. Mrs Bullock also advised that for those Trusts who had recently been assessed as good for their maternity services, the Trust was contacting them to identify any learning. Mr Wakefield stated that nationally maternity was a big issue and the Trust did take this seriously and as such this was considered in Committees as well as the Board.	
DATE AND TIME OF NEXT MEETING		
15.	**Wednesday 4th October 2023, 9.30 am, via MS Teams**	

Trust Board (Open)

Post meeting action log as at **28 September 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	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 associated with vacancy and sickness rates and links to the nursing uplift.	Jane Haire Ann Marie Riley	~~30/06/2023~~ 30/08/2023	30/08/2023	Action Complete. A briefing paper was provided through the Transformation and People Committee in August 2023 to support future discussions on the nurse establishment.	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~~ 23/08/2023	23/08/2023	Update provided at July's meeting. Mrs Riley explained that national data was available and this had been included within the maternity dashboard	B
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	19/09/2023	Answer provided and update given on Long length of stay. This was also followed up at Trust Board and at the Board Seminar. Feedback was given on the concern about which indicator was being used as well so as not to confuse the difference between stranded super stranded and long length of stay patients.	B
PTB/583	02/08/2023	Chief Executives Update	To circulate the impact of the strike action to Board members for information.	Tracy Bullock	06/09/2023		Information being prepared and to be circulated to Board members.	GA

NHS University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

September 2023

Part 1: Contract Awards and Approvals

2.1 Contract Awards and Approvals

Since 14th August to 14th September, 1 contract award over £1.5 m was made, as follows:

- **Surgical Drapes & Gowns Service** supplied by Berensden (Elis), for the period 01.08.23 – 31.07.25, at a total cost of £2,252,857, providing cost avoidance savings of £15,775 approved on 08/09/23

In addition, the following eREAFs were approved at the Performance and Finance Committee on 28th September (additional information was requested on two eREAFs which was subsequently provided after the meeting). These require Trust Board approval due to the value:

11529 – Spinal Implants
Contract Value £4,455,579.20 incl. VAT
Duration 31/10/23 to 31/10/26
Supplier Globus UK Medical and Johnson & Johnson (Depuy Synthes UK)

11515 - Acute Medical Rapid Assessment Unit (AMRA) Same Day Emergency Care (SDEC)
Contract Value £9,404,072.11 incl. VAT
Duration Capital Bid 6837
Supplier Integrated Health Projects (IHP)

11502 - Supply of Hips and Knees
Contract Value £6,332,757.90 incl. VAT
Duration 31/10/23 to 30/10/26
Supplier Stryker and Smith & Nephew

Savings – £1,362,206.69 incl. VAT

11453 -Energy Management Procurement Services
Contract Value £18,527,789.00 incl. VAT
Duration 01/04/24 - 31/03/25
Supplier Energy Industries Council (EIC)

11241 - Supply of Ministry of Defence Consultants
Contract Value £707,297.24 incl. VAT
Duration 01/01/2020 – 01/01/2025
Supplier Ministry of Defence

The Trust Board is asked to approve the above eREAFs.

2.2 Consultant Appointments – September 2023

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Orthopaedic Pelvic and Acetabular Surgeon	Vacancy	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Consultant Cardiologist in Cardiac Electrophysiology and Devices	Vacancy	4/9/23
Consultant Paediatric Anaesthetist	Vacancy	4/9/23
Locum Consultant in Emergency Medicine	Newly created post	11/9/23
Consultant Cardiologist in Cardiac Electrophysiology and Devices	Vacancy	20/9/23

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

Post Title	Closing date	Note
Locum Neonatal Consultant	6/9/23 and 24/9/23	Advertised twice, will be re-advertised

2.3 Internal Medical Management Appointments – September 2023

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Director – Oncology & Haematology	Vacancy	Yes	TBC

The following table provides a summary of Medical Management who have joined the Trust during September 2023:

Post Title	Reason for advertising	Start Date
Royal College of Radiologists College Tutor	Vacancy	1/9/23

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

Post Title	Closing Date	Note
Royal College of Physicians College Tutor	11/9/23	No applicants

Part 2: Highlight Report

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

National / Regional

3.1 National Staff Survey

We have now launched the national staff survey, which is an invaluable way of receiving feedback from the people who work for us. This is a little earlier than usual as we are keen to maximise the opportunity for our staff to have their say. To support this we have launched a campaign which describes some of the actions we have taken as a direct response to the survey and we are actively encouraging all leaders to take responsibility for setting time aside to allow themselves and their staff to do this.

3.2 World Safety Day

We participated in World Safety Day during the month and took the opportunity to promote the new approach to managing patient safety incidents. The national Patient Safety Incident Response Framework (PSIRF) replaces the Serious Incident Framework and focuses more on understanding how and why incidents have happened, including looking at system issues and avoiding blame.

We were also able to celebrate being finalists in the Health Service Journal (HSJ) Patient Safety Awards and I am delighted that we were recognised for our work in refreshing and re-launching our bespoke quality and safety assurance scheme, the Care Excellence Framework. This was designed to promote and deliver care excellence through an internal accreditation system providing assurance from ward to board. Huge congratulations go to everybody involved.

3.3 Industrial Action

During the month, we have seen further industrial action with the latest being by junior doctor members of the British Medical Association. For the first time this included a 24 hour period where both consultants and junior doctors were on strike together. We all respect the right of our staff to strike in order to defend their profession's ability to look after patients in the future. However, the strikes do cause our hospitals and more so our patients considerable difficulties and require significant amounts of planning and flexibility from our staff so that we can continue to provide good patient care. Unfortunately, there was significant disruption to services at County Hospital and Royal Stoke with many appointments and elective procedures either being postponed or rearranged and we apologise to any patients and their families who were affected by this.

3.4 Second Opinions

It has been shared in the national news that the Government is considering introducing 'Martha's rule' in England to make it easier for patients and their families who believe their concerns are not being taken seriously by medical staff to get a second opinion.

Martha Mills was 13 years old when she died in hospital two years ago after a failure to spot and treat her sepsis and her parents are calling for hospitals to implement the rule, ensuring that patients and their families are given the right to an urgent second opinion.

We have communicated this case widely across UHNM and have reminded all doctors of their General Medical Council (GMC) obligation to tell our patients about their right to see another doctor and to ensure they have enough time to exercise that right; we consider this to be standard practice.

System Focus

3.5 System Planning Session

On Friday 29th September we got together with our partners across the system for a System Planning Event to discuss the delivery of our joint priorities and our system recovery plan. The session involved a number of speakers from across the system including colleagues from UHNM and there were also a number of 'market stalls' which were used as a prompt for discussion, followed by a plenary discussion.

The session was very well attended and provided a great opportunity for us to come together as a system.

Organisational Focus

3.6 Vaccination Programme

We have now launched our annual vaccination programme with Covid-19 and flu vaccines available to our staff including our partners and our contractors. We are actively encouraging all staff to take up the offer in order to protect our patients, our families and the wider community.

3.7 Leadership Development - Connects

During the month I was delighted to join Jane Haire, Chief People Officer in the re-launch of our Gold and Platinum Connects Programmes and welcoming our new delegates. The Connects programme is a bespoke leadership development programme developed to harness the leadership skills of our staff and has been a huge success for us for a number of years now. We look forward to seeing and hearing more about the journey of our latest cohort.

3.8 National Inclusion Week

As part of National Inclusion Week (25th September to 2nd October) we have organised a series of events with a key focus on sharing, savouring and embracing different cultures. This included our 'Bring and Share' food event where staff were invited to bring a dish which represents their heritage, culture or just their favourite cuisine. However, the event was not just about the food – it provided an opportunity for us to come together, connect and learn from each other's experiences.

3.9 Culture Improvement Programme

We have continued to make good progress with our Culture Improvement Programme and I'm really pleased with how well our 'Being Kind' sessions have been received. Following our initial 'face to face' launch, we are now rolling out eLearning sessions for those who were unable to attend.

We also have our Leaders Network Event taking place on Friday 6th October, where we will be welcoming guest speak Roger Kline who was involved in supporting our organisation wide culture review. I'm looking forward to seeing as many of our leaders as possible at that session.

Throughout October we will be promoting Black History Month and Freedom to Speak Up Month and we have a range of activities planned, including the annual 'Show Racism the Red Card' day where we encourage staff to wear red and to share their photographs on social media.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Integrated Care Board Briefing

Staffordshire and Stoke-on-Trent ICB Meeting

21 September 2023

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

This briefing aims to keep partners informed of the discussions at the NHS Integrated Care Board (ICB) meeting in public. To watch the recording and read the papers visit the ICB website.

ICB Chair and Executive update

- David Pearson, ICB Chair, and Peter Axon, ICB Chief Executive Officer, introduced the report.
- David Pearson congratulated Support Staffordshire for achieving the Volunteer Centre Quality Accreditation (VCQA).
- David confirmed that in light of the Lucy Letby verdict, we will build upon and review the structures that are in place.
  - For example, the new Patient Safety Incident Response Framework is being reviewed and will be implemented through the Quality and Safety team.
  - The Fit and Proper Persons Framework implementation will start this month and will involve all members of the Board. David has met with system NHS chairs to discuss how this will be implemented comprehensively locally.
  - In addition, Freedom to Speak Up roles will be strengthened. We have an Executive and Non-Executive Director as the Freedom to Speak Up Guardians, with a series of Champions across the system.
  - Finally, the Sexual Safety and Health Care Organisational Charter has been recently released by NHS England. It identifies ten initiatives that organisations should sign up to and benchmark to make sure they meet these requirements. David informed the board that our ICB will sign up to achieving the standards following the meeting.
- Earlier this week, the Health Service Journal Patient Safety Awards took place. David shared that Midlands Partnership University NHS Foundation Trust won Primary Care Initiative of the Year for their Psychological Therapy Service. Trusts across the system were also finalists in other categories:
  - Midlands Partnership University NHS Foundation Trust were finalists in the Patient Safety Team of the Year category for their Harm Engagement and Reduction Team (HEART) and University Hospitals of North Midlands NHS Trust were finalists in the same category for their Care Excellence Framework – Refresh project.
  - In the Urgent and Emergency Care Safety Initiative of the Year category local finalists included University Hospitals of Derby and Burton NHS Foundation Trust for their 'How our cancer assessment unit freed up a whole ward project'.
- Peter Axon shared that we are facing significant financial pressures, which has come at a time when we have an elective backlog, pressure in urgent and emergency care and Industrial Action. During times of pressure like this, Peter reflected on the fantastic job the workforce is doing right now. He shared that he feels confident that we will manage these pressures because of the building blocks we have put in place over the last year.

  For example:
  - How our urgent and emergency care teams are now working together to break down barriers and focus on the patient journey
  - How the system has responded to the recovery programme
  - How the Provider Collaboratives have built the foundations for collaboration across the system.

The Board asked that we include key 'people' data that supports the key 'performance' data that we include in this report. Peter agreed we will include this narrative going forward.

System Recovery Plan

- Paul Brown, Chief Financial Officer, presented the System Recovery Plan. He shared that to recover we need to address the whole patient pathway.

- Paul shared at the end of month four, we had a deficit of £48million. In light of this, Paul has met with the Regional Finance Director to share that it is unlikely we can get to breakeven. The recovery plan will be essential to ensure we keep as close to target as possible this financial year and improve our services, so that we move into 2024/25 in a sustainable financial position.
- This year we have seen £50million worth of excess inflation and a substantial increase in the cost of continuing health care (CHC), both of which have significantly impacted our ability to achieve breakeven.
- At the System Planning Event on 14 July, it was agreed that there would be a focus on CHC to see how we can improve the patient experience and enable us to get back on track financially.
- The System Recovery Plan is being considered for final approval over the next month.
- Neil Carr, Chief Executive - Midlands Partnership University NHS Foundation Trust, Physical Health, Board Partner Member, updated the Board on the Continuing Health Care (CHC) Provider Collaborative, which is the vehicle in which the CHC system recovery work will be delivered. Neil shared that the work of this Provider Collaborative has been exceptional, and the system has fully committed to this agenda.
- Neil shared we will see an impact of this work from October onwards.

The Board thanked Paul and Neil for their updates. The Board agreed that the success of this work is in the system's responsiveness to share ownership and work collaboratively.

Quality and Safety Report

- Lynn Tolley, Director of Nursing – Maternity and Safeguarding, and Josie Spencer, Non-Executive Director, introduced the report.
- Lynn confirmed the Quality and Safety Committee (QSC) meeting has now moved to bi-monthly and the group has now had their first deep dive into harm reviews and maternity services.
- Lynn shared that the CQC undertook an inspection of University Hospitals of North Midlands NHS Foundation Trust (UHNM) maternity and neonatal services as part of the national maternity inspection programme. The full report was published in June 2023 and UHNM's Maternity CQC ratings have declined. The ICB, in collaboration with NHS England, will be developing a system oversight and assurance group to follow the action plan and maintain improvements that have been happening since June.
- Josie shared that two safeguarding policies were presented for approval at the QSC which have been updated as per their annual review:
  - The Safeguarding Childrens and Young Peoples Policy
  - The Safeguarding Training Policy
- Josie confirmed that over 300 staff have been trained in Continuous Quality Improvement methodology.

The Board thanked Lynn and Josie for the report, and ratified the revised Safeguarding policies.

Finance and Performance Report

- Phil Smith, Chief Delivery Officer, presented the Performance Report.
- Phil shared that Industrial Action continues to have a significant impact on the system. For elective backlogs we remain in Tier 1, but there has been a strong improvement path.
- There is a national focus to look at patients who would breach the 65 week-wait by March, that they have a first outpatient appointment by the end of October. The system is working through how they can achieve this, but it is looking achievable in most specialties.
- For Urgent and Emergency Care, we remain in Tier 2, but there has been some strong overall progress with delivery of the Urgent Care Improvement Plan. The Integrated

Discharge Hub went live in September, which brings partners together in a new way to support patient flow.

- There was a national winter planning event this week. The focus, this winter, is to build on the learnings from last year and to keep a collective view on demand, capacity, and escalation.
- Megan Nurse, Non-Executive Director, discussed the Partnership Agreement for the direct award of the contract for NHS Community Services in East Staffordshire from 1 October for a period of 18 months. The Committee recommend the Board approve the direct award (in line with PCR Regulation 12.7) of the contract for Community Services for an 18-month term commencing on 1 October 2023 at £10.3million per annum (£15.45million total contract value).
- Megan also shared that the Committee supported the business case for a centralised repeat prescription management service. The service will be piloted in Burton and Lichfield subject to positive Quality, Equality and Data Protection Impact Assessments and delivered in partnership with the Primary Care Networks (PCNs).

The Board thanked Phil and Megan for the reports and took assurance from their reports.

Committee Assurance Reports

- Audit Committee: Julie Holder, Non-Executive Director asked the Board to note the change in frequency of meetings and for to note there will be an exceptional Audit Committee report in June 2024 to consider draft Statements, followed by an exceptional Board meeting to approve the Annual Report and Accounts.
- People, Culture and Inclusion Committee: Shokat Lat, Non-Executive Director, shared how important it has been to recognise the implications on workforce of the system planning that is happening.

The Board thanked Julie and Shokat for their reports.

Date and time of next meeting in public: 19 October 2023 at 1.00pm held in public.

More information about the upcoming Board meetings can be found on the ICB website.

Quality Governance Committee Chair's Highlight Report to Board

28th September 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • The Get It Right First Time update highlighted a continued focus on elective recovery, with actions being taken to ensure the outputs were appropriately shared. The limited managerial capacity to fully realise all GIRFT opportunities was highlighted as was the need to regularly report the outcomes of reviews at the Clinical Effectiveness Group • The Care Excellence Framework (CEF) report highlighted that of 17 visits undertaken in the quarter, 10 areas had a drop in their rating, although this was in part due to a change in the way areas were assessed. The Committee recognised the positive way in which teams were provided with regular support following the reviews, which had been welcomed by staff as this helped them to address the areas for improvement • The County Hospital report highlighted that falls continued to be high and as such wards were taking an improving together approach in terms of identifying the root causes. In terms of timely observations this remained an area of focus for improvement in addition to undertaking investigations into avoidable c-difficile cases • The maternity dashboard highlighted a decline in friends and family responses and an improvement group had been established to focus on how more feedback could be obtained. There continued to be challenges in terms of training and whilst there remained 57 vacancies in midwifery, 36 midwives were due to commence in October with a future recruitment event planned. The Committee welcomed the work undertaken to retain staff in maternity • The gap in the lack of undertaking harm reviews due to the high number of long wait patients was highlighted, although actions had been put in place to streamline the process • The report arising from the Care Quality Commission (CQC) review of brachytherapy assessing compliance with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) was presented, which resulted in a Health and Safety Act Improvement Notice into 3 elements, and immediate actions had been taken to address the areas of non-compliance with a formal response provided to the CQC	• To ensure future recommendations and actions arising from GIRFT reviews are considered by the Clinical Effectiveness Group so that assurance could be provided to future Committee meetings • An update on the deep dive into sepsis management in the Emergency Department was provided which highlighted a focus on improving sepsis training and digitalisation of the CAS card and use of VitalPacs. The main causes of decreased compliance were associated with demand versus capacity and acuity of patients and other actions included the identification of sepsis champions and improvements to triage screening • Given the number of long wait patients, a change in the harm review process was being undertaken, in consultation with clinical leads prior to introduction. It was agreed to provide an update to the Committee in December on the number of reviews undertaken and outcomes
✓ Positive Assurances to Provide	**Decisions Made**
• The patient experience report highlighted results from the National Urgent and Emergency Care Survey; for the Emergency Department the Trust scored better in one question and the same for 35. For urgent care, the Trust scored better for two questions and the same for 35 • The Committee welcomed the introduction of a Carers Strategy and the roll out of associated actions • The CQUIN update highlighted challenges with 3 / 11 audits with actions being taken in terms of addressing the issues arising from these • The quarterly quality report for County Hospital highlighted no pressure ulcers with lapses of care in June, improvements around catheter care, no further increase in the number of VTEs following focussed work, and Ward 8 having received a Platinum CEF award • The maternity dashboard for August highlighted 100% of Perinatal Mortality Reviews having commenced within 2 months of death, and a reduction in the number patients smoking at booking over the past 12 months • The quality report highlighted reductions in the number of incidents associated with Your Next Patient in addition to an increase in reporting of incidents which resulted in no harm and near misses. In addition there had been a reduction in falls incidents as well as a reduction in falls with harm. There had also been a reduction in pressure ulcers with lapses in care.	• The Committee approved the revised Terms of Reference for respective Executive Groups
Comments on the Effectiveness of the Meeting	
• The Committee welcomed the hybrid approach to the meeting which worked well.	

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Q1 Patient Experience Report 2023/2024 & Carers Strategy	BAF 1	Ext 16	✓	Assurance	7.	Maternity Dashboard: August 2023	BAF 1	ID13420 ID11518 ID13419 ID15993 ID16432	! ✓	Assurance
2.	Get It Right First Time (GIRFT) Update	BAF 1	ID25470	!	Assurance	8.	Patient Waiting List Backlog	BAF 1	Ext 16	!	Assurance
3.	Commissioning for Quality and Innovation (CQUIN) scheme for 2023/24	BAF 1	Ext 16	✓	Assurance	9.	Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) CQC Inspection Report		-	!	Assurance
4.	Care Excellence Framework Summary Q1	BAF 1	Ext 16	!	Assurance	10.	Quality Performance Report – Month 5 23/24	BAF 1	Ext 16	✓	Assurance
5.	Sepsis Management – Emergency Department Royal Stoke	BAF 1	Ext 16	-	Assurance	11.	Quality & Safety Oversight Group Highlight Report	BAF 1	Ext 16	-	Assurance
6.	County Quality Report Q1 23/24	BAF 1	Ext 16	! ✓	Assurance	12.	Executive Groups Terms of Reference	-	-	-	Approval

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 S Evans	Chief Operating Officer	PB											
3.	Prof K Maddock	Non-Executive Director												
4.	Mr J Maxwell	Head of Quality, Safety & Compliance												
5.	Dr M Lewis	Medical Director				ZD		AMM						
6.	Mrs AM Riley	Chief Nurse	JHo			JHo	JHo							
7.	Mrs C Cotton	Associate Director of Corporate Governance			NH	NH		CC						
8.	Prof S Toor	Non-Executive Director												
9.	Mrs J Haire	Chief People Officer				KM								

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th October 2023
Report Title:	August Maternity Dashboard: 2023	**Agenda Item:**	
Author:	Sarah Jamieson - Director of Midwifery & Jill Whitaker – Deputy Director of Midwifery - Governance		
Executive Lead:	Ann-Marie Riley – Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

ID	Title	Risk level
13420	Lack of activity at Freestanding Midwifery Birth Unit (FMBU), County leading to suspension of intrapartum care	15
11518	No current operational Midwifery Continuity of Care team	15
13419	Midwifery safe staffing (entered following Birth Rate Plus establishment review 2019) Midwife to Birth ratio 2019 = 1:28 Midwife to Birth ratio 2021 = 1:26-1:25 due to fall in Birth Rate from 2019. Risk remained an item due to Covid related workforce challenges and acuity of patients 2020-2021 Risk details suspension of home births as an action	16
15993	Maternity Assessment Unit Triage	15
16432	COVID 19 & compliance with CNST maternity safety actions	15

Executive Summary

Situation

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

Background

The Maternity Dashboard provides a monthly and quarterly overview of Maternity performance against a defined set of targets alongside key performance standards and safety indicators.
Each month data is collated from K2 Maternity electronic records and other sources to monitor outcomes against key performance targets. Targets are regularly reviewed against local and national standards for example National Maternal and Perinatal Audit (NMPA), Saving Babies Lives Care Bundle (SBLCB) and the NHS Resolution CNST Maternity Incentive Scheme.

The dashboard enables clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement.

An Immediate and Essential safety action in the recently published Ockenden (2020) report recommends that clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMNS agendas at least every 3 months. A local Standard Operating Procedure (SOP) is in place which provides an outline of the governance process for the UHNM Maternity Dashboard. An organogram will be included as an appendix to the SOP.

The Local Maternity and Neonatal System (LMNS) have requested that the dashboard is shared so that data can be added from across Staffordshire to provide information reflecting the STP footprint.

Assessment

The key performance targets are measured using a RAG system.

- Green: performance within an expected range
- Amber: performing just below expected range, requiring close monitoring
- Red: performing below target, requiring monitoring and actions to address

The key points from the current August dashboard are as follows:

RED

Home birth and intra – partum care at FMBU:

- UHNM home birth services are currently suspended. Provision of home births will be revisited as and when minimum safe staffing levels allow. The maternity business case for minimum safe midwifery staffing levels in line with Birthrate Plus (2022) was approved in November 2022 and budgeted establishments have now been aligned. There is a recruitment campaign within maternity services and we are seeking to fill all remaining vacancies.

Smoking at time of delivery:

Smoking at booking and at birth remains above the national average. (9.50%)

Red Flags

There is a decrease in red flags this month to 436 though this number remains high. (31 of the red flags are attributable to the suspension of the home birth service)

AMBER

Smoking at time of booking:

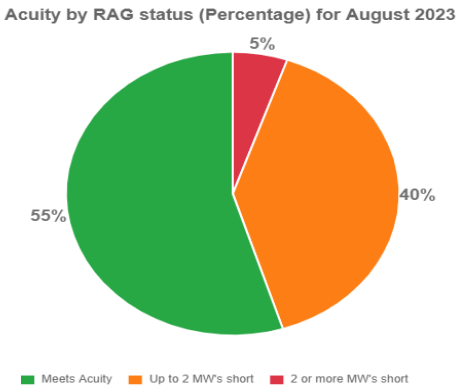
Though still below the national average there is a slight increase in August.

Green

- 100%t of PMRT was commenced within 2 months of death.

Midwifery staffing

The Birthrate plus data for August confirms that all women received one to one care in labour and there were no delays in pain relief.
Positive acuity was achieved for 55% of the month. 40% of the month was up to 2 midwives short to meet the acuity on the ward and 5 % of the month there were 2 or more midwives short.



This shows a slight improvement on last month where positive acuity was 50%.

One to one care in labour and supernumerary status of the coordinator was maintained at all times by using the escalation policy and moving midwives to cover areas of high acuity.

Smoking

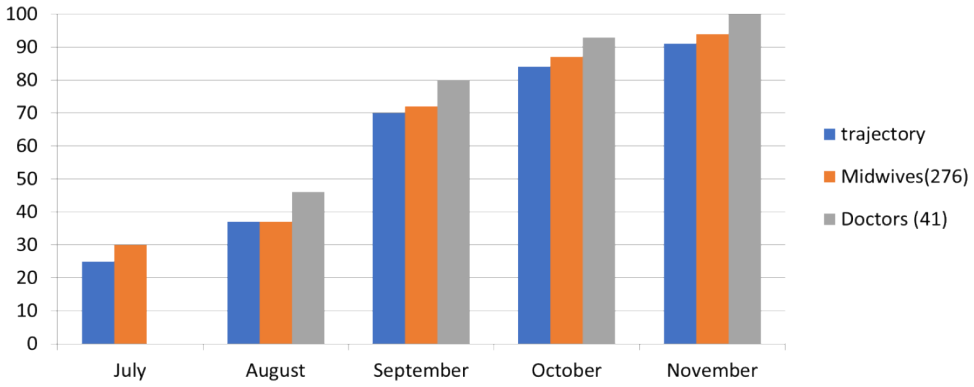
In August smoking at booking was 10.05%, this is below the target of 11% and at birth it was 9.50%%. The aim is to reach the target of 6% at birth. Great improvements have been made in the carbon monoxide testing of women with 92% tested at booking and 87% at 36 weeks pregnant. The opt out process of referral to help to quit services continues.

Training

Prompt training continues with 83% of midwives and 90% of medical staff now compliant. Anaesthetic staff is now at 73%. Support staff compliance has risen to 77%.

Fetal monitoring training is a priority; the current compliance has reduced because 2022 training is now due for renewal.
The current position is 37% of Midwives and Doctors are trained. Based on training booked for September the trajectory is 71% by month end.

Fetal heart monitoring training trajectory



Maternal Morbidity Measures:

UHNM remains below national average for:

- % of PPH >1500mls -0.79%
- % of ¾ degree tears-2.38%
- % of postnatal re admissions.3.76%

There were 2 stillbirths in August. Based on 505 births this gives a percentage of 0.39%

There were no maternal deaths and no maternal admissions to the Intensive Care Unit.

Term admissions to the NICU were 4.36% which is below the national target of 5%. All admissions are reviewed and reported within the ATAIN process.

Service user feedback

Friends and family feedback shows good levels of satisfaction on the delivery suite and the birthing unit.

Delivery suite

University Hospitals of North Midlands NHS
NHS Trust

		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
	Total Number of Responses via survey	30	18	33	29	15	40	30
	Response Rate							
1	How likely are you to recommend our ward to your family and friends if they needed similar care and treatment?	93%	100%	100%	97%	97%	88%	92%
2	During your labour, were you able to move around and choose the position that made you most comfortable?	83%	88%	96%	75%	95%	92%	88%
3	During your labour and birth, did the staff treating and examining you introduce themselves?	95%	100%	90%	98%	90%	96%	95%
4	If you needed attention during your labour and birth, were you able to get a member of staff to help you within a reasonable time?	92%	97%	97%	98%	100%	96%	91%
5	During your labour, were you involved enough in the decisions about your care?	98%	84%	95%	91%	97%	90%	88%

MBC

University Hospitals of North Midlands NHS
NHS Trust

		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
	Total Number of Responses via survey	40	18	12	23	11	40	20
1	How likely are you to recommend our ward to your family and friends if they needed similar care and treatment?	98%	100%	100%	97%	80%	99%	92%
2	During your labour, were you able to move around and choose the position that made you most comfortable?	92%	91%	100%	93%	83%	99%	100%
3	During your labour and birth, did the staff treating and examining you introduce themselves?	97%	100%	100%	94%	95%	99%	97%
4	If you needed attention during your labour and birth, were you able to get a member of staff to help you within a reasonable time?	96%	97%	100%	100%	90%	97%	93%
5	During your labour, were you involved enough in the decisions about your care?	94%	97%	100%	97%	91%	99%	94%

We have been able to identify that improvements can be made on our postnatal ward and an improvement group has been established. The aim of which is to focus on areas identified in the feedback and patient experience as a whole.

University Hospitals of North Midlands NHS
NHS Trust

		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
	Total Number of Responses via survey	48	27	21	30	25	28	19
1	Overall, how was your experience?	96%	96%	86%	88%	78%	71%	83%
2	Looking back did you think your stay in hospital, after the birth, was the right amount of time?	98%	81%	100%	96%	84%	64%	72%
3	If you needed attention in hospital after the birth, were you able to get a member of staff to help you within a reasonable time?	89%	87%	88%	77%	72%	61%	66%
4	Thinking about the care you received in hospital after the birth, were you given the information or explanations you needed?	93%	91%	83%	87%	70%	70%	68%
5	Thinking about the care you received in hospital after the birth, were you treated with kindness and understanding?	96%	92%	86%	88%	84%	74%	76%

Key Recommendations

The Trust Board is asked to receive this report.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th Oct 2023
Report Title:	SSOT System Surge Plan	**Agenda Item:**	8.
Author:	Oliver White: UHNM Deputy Chief Operating Officer, Delivery Joe Woodman: UHNM Head of Operations – Corporate Operation Bobby Miles: UHNM Head of Delivery & Improvement – Non-Elective Care Jonathan Tringham: UHNM Director of Operational Finance Ashleigh Shatford: ICB Associate Director of Delivery & Improvement – UEC Jack Butler: ICB Head of Delivery & Improvement – UEC Thomas Bailey: ICB Delivery & Improvement Lead – UEC Katy Thorpe: UHNM Deputy Chief Operating Officer, Planning and Performance		
Executive Lead:	Simon Evans: UHNM Chief Operating Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 1	*Delivering Positive Patient Outcomes*	*16 (extreme)*
BAF 5	*Delivering Responsive Patient Care*	*20 (extreme)*

Executive Summary

Situation

- The SSOT System Surge Plan (including internal UHNM schemes) is attached and describes both the anticipated capacity deficit against predicted demand, initiatives committed to in order to mitigate this deficit, and plans for managing escalation and risk across the SSOT ICS throughout the winter period.
- This presentation is part of a wider governance submission timeline (articulated within the SSOT System Surge Plan) which will encompass formal sign off from all ICS Trust Boards as well as the ICS Unitary Board itself. This approach to sign off is aligned to the principles of collaboration in which the single system plan has been produced.

Background

- Whilst it was noted last year that significant assurance was taken from the UHNM Winter Plan, winter pressures brought a historic level of challenge that resulted in an unprecedented number of patients outlying and patients with a DTA in the ED, the compromising of the Trust Elective Recovery Trajectory, and WMAS Category 2 mean responses times representing potentially catastrophic risk to patients in the SSOT community. It is therefore necessary to learn lessons, prepare, and deliver an even more robust plan this year in order to take all reasonably available measures to prevent a repeated level of system risk.
- The SSOT System Surge Plan has been produced in a more collaborative and integrated manner than has ever been achieved before. The UHNM internal elements have been produced and signed off by the UHNM Winter Planning Group and UHNM Non-Elective Improvement Group with system input managed through the SSOT System Surge Group and signed off by the SSOT UEC Board.

Assessment

- The SSOT System Surge Plan has been internally assessed as representing positive progress against historic winter planning and in light of current resource and capacity constraints. The SSOT System

Surge Plan clearly identifies an expected residual bed gap which has been substantially reduced during the peak of winter demand expected to occur during December and January. This assessment is however contingent on the delivery of mitigations outlined, particularly that of OPAT, Virtual Ward, and Golden View Manor.

- The SSOT System Surge Plan also focuses on the peak demand of winter predicted for December and January. Whilst the residual bed gap described has been mitigated to agreed manageable levels there is significant risk for October and November as some of the mitigating schemes are currently not planned to be available. Work is currently on going to determine which mitigating schemes may be able to be brought forward in order to manage this predicted escalation of risk across the system. In addition to this; work is progressing to further close the residual bed gap and the alignment of system escalation plans.

Key Recommendations

The Board is asked to accept the SSOT System Surge Plan and take positive assurance with regards to mitigations outlined in response to the expected capacity and demand deficit and note the risks described throughout.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

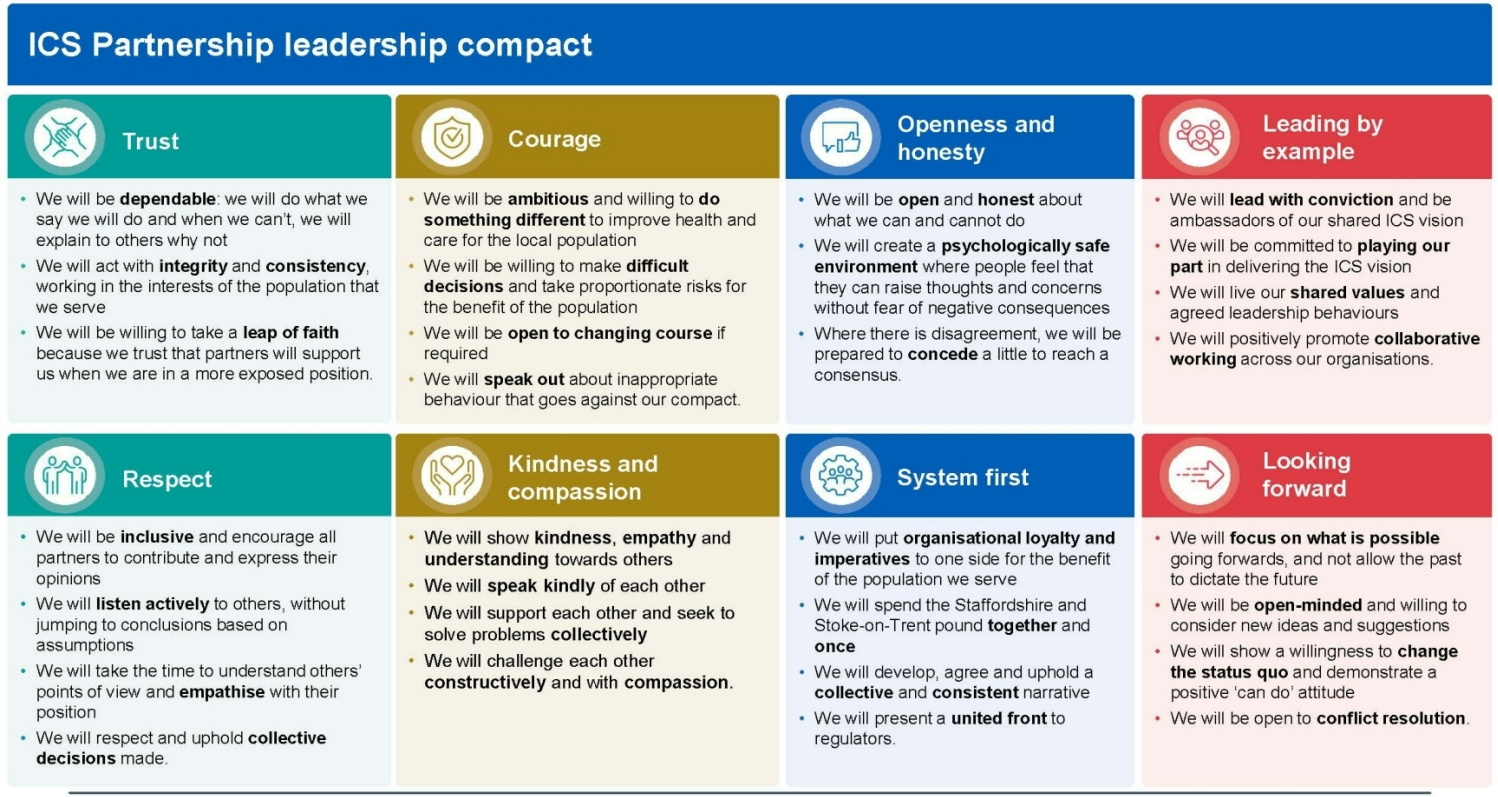
System Surge Plan 2023/24

Content

- Approach
- Lessons Learned
- Priorities
- Governance
- Scope
- Risk
- System Capacity Plan
- System Escalation Plan
- System Workforce Plan
- Finance

Approach:

The ICS Partnership leadership compact is at the forefront of the UEC Portfolio, it supports the entirety of the governance structure and progressive system development.



22/23 Lessons learned: Key learning points

What worked well?	What requires improvement?	Key priorities
Winter Planning development process (involvement of system partners)	Early mobilisation of workforce – role specificity and flexibility	System agreement re Funding. Utilising funding/resource more efficiently
CRIS – pull from WMAS 999 stack, admissions, conveyance & dispatch avoidance	Earlier mobilisation of Surge/Super Surge actions. Recalibrating plans	Continued development of System Escalation Plan/approach to Risk
Governance & system response to Critical Incident	Targeting resource to high impact schemes/initiatives (Focus on smaller number of schemes)	Proactive and collaborative Workforce recruitment approach. Expansion of System Workforce Hub
System partners felt system plan was system owned	Better definition of outcome measures (Wider focus beyond Bed numbers)	Early engagement with Primary Care
Development of System Escalation Plan – positive steps taken to develop, further work will build upon & refine plan	Longer term focus – aligned to System Planning processes	Agreed parameters/measures to facilitate improved responsiveness to pressures
Industrial Action response – SCC coordination	Agreed metrics/triggers re Early Warning Signs	Utilisation of alternative resources (e.g. VCS)
Utilisation of wider system partners (i.e. Staffs Fire Service – falls active response)	Staff engagement and comms	Investing in existing services/staff
Mutual Aid	Adherence to Leadership Compact	Building upon & further embedding the System Leadership Compact
	Supporting & empowering clinicians during periods of pressure	CEO support for EPRR leads to develop System Escalation Plan

22/23 Lessons Learned: Actions and outputs

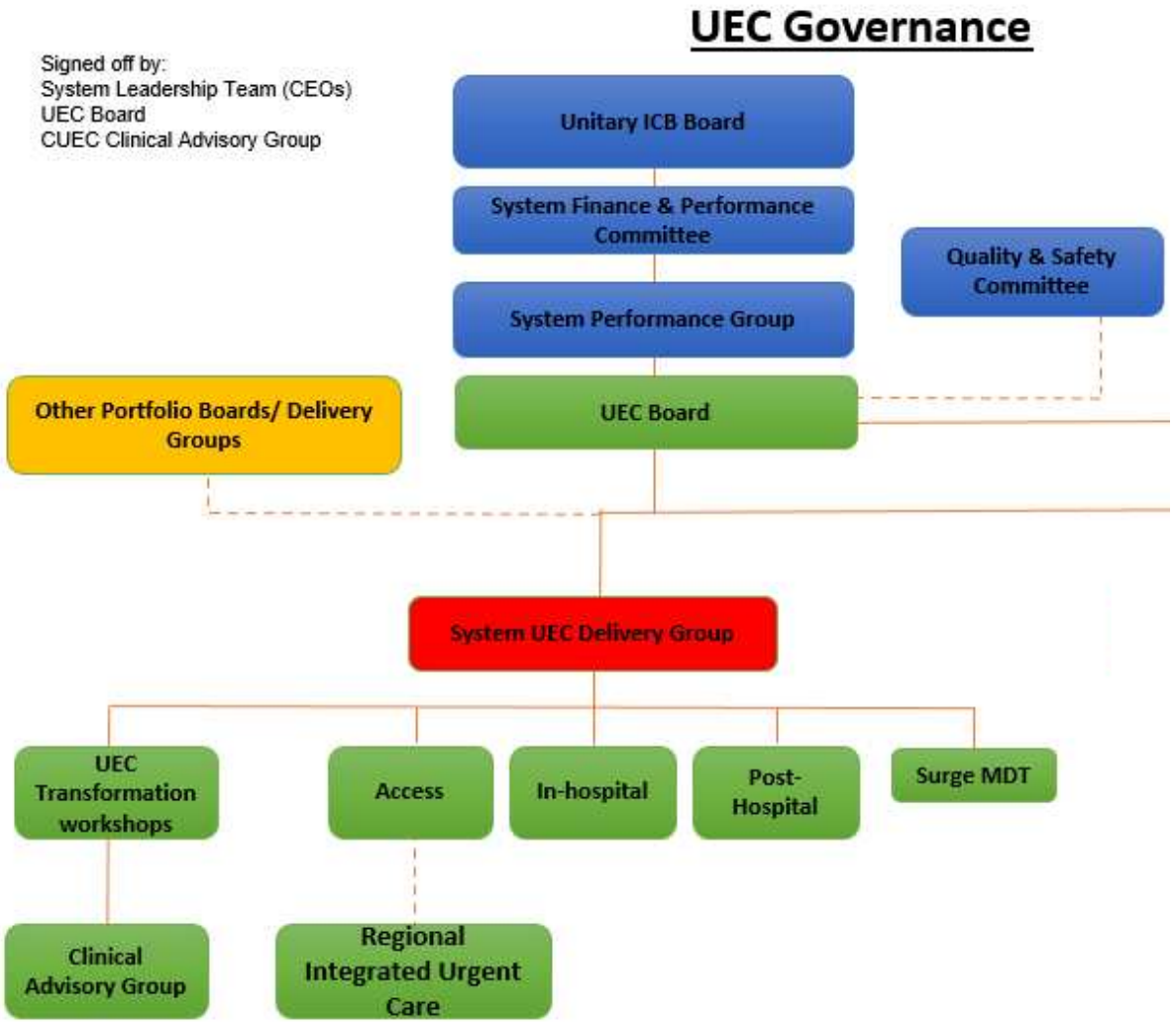
Behaviours & Approach	Escalation & Risk Sharing	Finance & Planning	Embedding Learning
Adherence to the System Leadership Compact & empowerment to speak up	Continued development of the System Escalation Plan and Risk sharing	System agreement re financial allocation for 2023/24 - to underpin development of Surge plans	Qualitative assessment of Winter/Surge plan
Surge/winter planning to commence in April 2023	CEOs to collectively support EPRR leads to further develop System Escalation Plan	Expansion of the System Workforce Hub – to include ASC	Feedback to be shared with attendees, evaluation of Workshop to be conducted
Engagement and advanced work with Primary Care	Development and definition of System Outcome and Early Warning metrics	Refresh of the System Bed Model with updated 2022/23 data	Utilising Lessons Learned event outputs to shape system planning
Greater involvement and input from voluntary care and other sectors	Wider sharing and acknowledgement of System Escalation plan to ensure partner buy-in	Prioritisation of resource/spend allocation	Defining outcome measures and metrics to evaluate future plans at the outset
Greater involvement of other system portfolios; e.g. End of Life, Frailty	Further development of Early Warning metrics and triggers	Prioritisation of future plans; doing more of what works and dedicating less resource to what does not	

Priorities

Six key areas of focus for SSOT Surge Plan:

1. Using our lessons learned to reflect and continue our improvement journey
2. Focus on reducing duplication with clear priorities
3. Admission avoidance
4. Teamwork and compassionate leadership is the culture needed across ICS to manage the challenges
5. Risk sharing across the system
6. Addressing harm as a system approach

Governance structure



System Surge MDT Membership

- ICB UEC Delivery and Improvement Lead - Chair
- Associate Director of UEC Delivery and Improvement ICB - Chair
- ICB UEC Clinical Director
- Deputy Chief Operating Officer - UHNM
- Deputy Chief Operating Officer - UHDB
- Associate Director of Urgent Care – MPFT
- Deputy Chief Operating Officer NSCHT
- Paramedic Practice & Patient Safety Director – WMAS
- Assistant Director, Care Commissioning Health and Care Staffordshire LA
- Assistant Director of Adult Social Care Stoke LA
- Head of Operations – CRIS & UCCC
- ICS Acute Care at Home Programme Manager
- ICB Primary Care Programme Lead
- Head of ICS People Team
- ICB Urgent Care Operations Manager
- ICB Head of Programme Finance – Acute and Community
- ICB Associate Director of Quality and Patient Safety
- ICB Associate Director – Mental Health, Learning Disability and Autism and Children and Young People
- ICB Senior Intelligence Analyst (UEC portfolio)
- ICB Planning and Assurance Manager
- TDU management lead

Surge governance timetable

Meeting	Anticipated Date (TBC)	Papers	Mtg date
UEC Board	August	14/08/23	24/08/23
NHS England Surge Plan Template	September	NHSE Template Return due for completion by September 6 2023	
NHS England Regional Assurance Visit	September	12/09/23	
CYP Programme Board	September	13/09/23	20/09/23
NHS England Surge Plan Template	September	Opportunity to resubmit NHSE Template following feedback September 25th	
System Performance Group	September	21/09/23	27/09/23
UEC Board	September	18/09/23	28/09/23
UEC Clinical Advisory Group	September	24/09/23	28/09/23
Finance & Performance Committee	October	25/09/23	3/10/23
UHNM Trust Board	October	27/09/23	4/10/23
ICS People Collaborative Board	October	4/10/23	11/10/23
System Quality Committee	October	2/10/23	11/10/23
NSCHT Trust Board	October	3/10/23	12/10/23
Clinical Senate	October	28/09/23	12/10/23
SOTCC Operational Business Meeting	October	5/10/23	12/10/23
MPFT Trust Board	October	19/10/23	26/10/23
SCC Health & Care SLT	October	TBC	TBC
Staffordshire Health OSC	October	5/10/23	16/10/23
ICS People, Culture and Inclusion Group	November	1/11/23	8/11/23
ICB Board (ratification)	November	6/11/23	16/11/23

Scope

- This is Staffordshire and Stoke on Trent (SSOT) ICS Surge Plan.
- SSOT ICB are the responsible ICS for UHNM.
- Given our flow we are linked with UHDB and RWT colleagues to understand their assumptions, however their acute bed plan is being managed by Derbyshire and Black Country ICBs respectively. It is recognised that we also have large volumes of flow to Walsall and Dudley which the plan supports.
    - The interdependency of the SSOT community offer is clear and is managed through the UEC System Surge MDT & System Delivery Group, reporting to UEC Board.
- The national £650m MSIF investment in Social Care will be included in the plan as the delivery mechanisms are known.

Note: the System Surge Plan is under continual review and detail may be subject to change through the system surge planning MDT and ratified through UEC Board.

Risk register

Risk Title	If (Cause)	Then (Event)	Resulting in (Effect)	Date of Update	Mitigations and Updates	Target date	Inherent Score	Residual Score	Target Score
UEC Workforce /Staffing	If we fail to improve on the current vacancy rates, or experience increased staff sickness	Then there may be an acute impact upon the system	Resulting in workforce constraints dictating that the system is forced to prioritise urgent services - with a negative impact upon patient flow/patient experience/safety and experience and may lead to negative publicity and increased scrutiny.	**15/09/2023**	15/09/2023 Update This was previously a winter risk and has been amended to reflect it is a year round risk. Update The System Workforce plan remains in place to try and mitigate workforce issues and ensure adequate staffing The plan has been updated as part of 2023/24 Surge Planning work. Workforce plan will once again be a key component of the UEC Surge Plan for 2023/24 and will be completed and shared with ICB and partner committees/boards in September/October. Discussions remain ongoing at Surge MDT and other forums to ensure Workforce considerations are forefront with regard to surge planning & underpin mitigatory planning and initiatives/schemes. HRDs and other senior system colleagues are sighted & involved in order to e.g. ensure mitigating actions are in place and reflect system-wide planning. Assessment of additional opportunities is underway. Agreement that prioritisation of initiatives/schemes/services with greatest impact is required. No change to risk score.	**01/06/2023**	**25 (5x5)**	**25 (5x5)**	**10 (5x2)**
Virtual Wards	If we are unable to recruit a sufficient workforce to staff the additional Virtual beds b due to workforce challenges, including recruitment to VW roles and sustainability of the number and capacity of clinical leads needed to manage remote care and virtual wards.	Then we will not be able to roll out the planned number of Virtual beds.	Resulting in a significant gap in UEC Plan	**18/09/2023**	18/09/2023 Update Recruitment initiatives continue across all roles with recruitment improving across the system into vacant role within VW. The ICS people function are supporting with initial understanding of workforce vacancies being collated as part of the winter planning workstreams. ICS workforce schemes are expanding the utilisation of reserves/bank staff as a system priority. The team have been expanding the utilisation of remote/digital monitored beds within lower acuity pathways to release additional workforce capacity. Joint working across MPFT has taken place, with the CIS teams in the South West supporting with some of the face to face visits within there skill mix and available capacity. A further meeting is held with Acute Care at Home clinical and operational leads on the 29th September to understand the required recruitment to expand the beds against the trajectory and support with mitigations.	**31/10/2023**	**15 (3x5)**	**12 (3x4)**	**6 (3x2)**
D2A Capacity	If the on-going challenges with flow from D2A capacity, due to capacity issues in the domiciliary care and care home markets, persist.	Then there will be reduced D2A capacity.	Resulting in a significant gap in the winter capacity plan.	**20/09/2023**	20/09/2023 - Wording updated following UEC Delivery group. Score remains the same. Currently reporting all delays within daily escalation calls to partners within CSU and LA and also reporting into the system coordination centre. Delays remain. Integrated Discharge Hub (IDH) to offer mitigation of risk.	**01/06/2023**	**15 (3x5)**	**15 (3x4)**	**3 (3x1)**

Risk register

Risk Title	If (Cause)	Then (Event)	Resulting in (Effect)	Date of Update	Mitigations and Updates	Target Date	Inherent Score	Residual Score	Target Score
Ambulance Handover Delays	If Continued delays to ambulance handovers are incurred, and sustained or levels increased	Then there will be significant pressures placed onto ED, ambulance crews and the wider UEC system	Resulting in increased instances of patient harm, increased system capacity issues, 'lost' ambulance time & associative issues including financial costs, whereby WMAS are requesting an addition £1.591m from SSOT.	**15/09/2023**	15/09/2023 Update Risk reviewed at UEC Board in August.. Signs of sustained improvement seen in late July/early August have continued, despite system pressures remaining. Agreement to monitor & review score based on ongoing performance. Ambulance hand over plan was mobilised and the UEC Improvement Plan (7 point plan) has replaced this which seeks to improve efficiency and performance across the UEC System. This remains in place and is monitored via System Delivery Group. System pressures in UEC dictate that score remains at 15 - ongoing assessment and review at UEC Board and UEC Delivery Group in place.	**01/09/2023**	**25 (5x5)**	**15 (5x3)**	**10 5x2**
Industrial Action	If Industrial action continues, with further days/periods of staff walk-outs	Then there will be periods of additional pressure placed upon the system due to staffing cover and contingency arrangements	Resulting in increased instances of patient harm, increased system capacity issues, compromised staffing ratios and the need for enhanced contingency measures.	**18/09/2023**	18/09/2023 - Reviewed and no change. Planned mitigations working and awaiting voting on offers by professional bodies. Due to no incident and managed well risk likelihood of harm reduced. Approach remains operational to enable optimum system response to further periods of action. No change to risk score.	**30/052023**	**16 (4x4)**	**12 (3x4)**	**4 4x1**

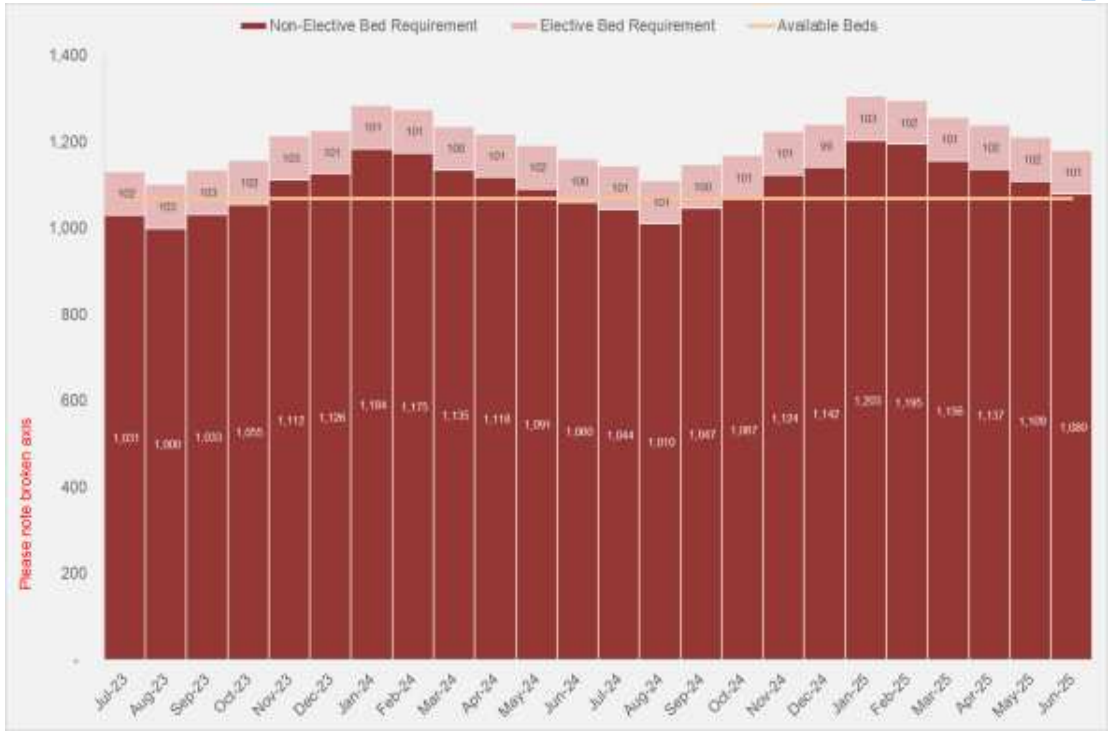
Risk register

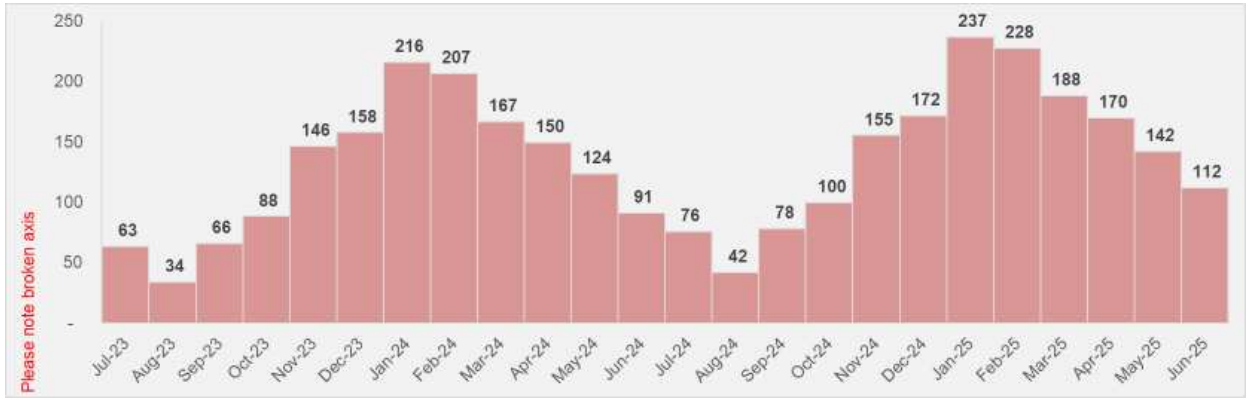
Risk Title	If (Cause)	Then (Event)	Resulting in (Effect)	Date of Update	Mitigations and Updates	Target Date	Inherent Score	Residual Score	Target Score
Mobilisation of System Surge Capacity	If the system is unable to implement sufficient system surge and escalation capacity during periods of increased UEC pressure and demand	Then there is a significant risk to system resilience due to insufficient capacity to meet periods of increased demand and surge, particularly during winter	Resulting in significant risk to patient safety, system performance, system delivery of the UEC improvement plan and overall system resilience	**15/09/2023**	System surge planning for 23/24will be finalised during September & aims to ensure that sufficient system capacity is available and scheduled for implementation during acute periods of increased pressure, utilising the system bed model to inform decision making and recalibrate plans accordingly. UHNM has been successful in application for NHSE capital to open additional beds by way of a new modular build and associative reconfiguration of bed capacity. The mobilisation of this capacity has slipped and is unlikely to be in place to mitigate winter escalation as planned. This is a significant risk to system capabilities to meet periods of surge. The refresh of the System Bed Model is complete and is underpinning and informing all planning discussions and actions. The bed model illustrates a significant unmitigated system bed deficit - peaking in January 2024. This has been escalated to UEC Board and to System SLT/CEOs. System Surge MDT continues to manage development of the Surge (and Winter) plans with regular reports to UEC Board & a full presentation of the System Surge Plan to Clinical Senate, SPG, F&PC, Quality Committee and all provider board meetings in due course. Regular reporting to System CEOs, CFOs and UEC Board is in place to ensure oversight and assessment of approach. NHSE has issued its Winter Resilience letter and supporting documentation. An initial return (both a narrative and numerical template) was submitted to provide assurance to NHSE. Feedback has been received and will be built into the final system plan. NHSE assurance visit took place on 12 September - further feedback and direction from NHSE regional team received and will be implemented as part of the system plan. These requirements have been built into surge planning timelines and is presently on track.	**30/09/2023**	**20 (4x5)**	**20 (4x5)**	**4 (4x1)**
Risk of financial failure at Stoke-on-Trent City Council	If the Council is unable to set a balanced budget	Then the Council failure regime would be enacted and local decision making would be restricted	Resulting in the removal of services, some of which could be essential to the delivery of health and social care to local residents	**18/09/2023**	The ICB continues to liaise with both SOTCC and SCC to ensure joint working to address financial pressures in all organisations. Both Local Authorities had representation at the System Workshop on 14 July. If either Local Authority receives a S114 notice, the impact on the health system will impact on health care in terms of Urgent Care delivery and financial sustainability. No change to risk score. UEC-specific issues to be addressed via UEC Board.	**31/03/2024**	**12 (4x3)**	**12 (4x3)**	**9 (3x3)**

Risk register

Risk Title	If (Cause)	Then (Event)	Resulting in (Effect)	Date of Update	Mitigations and Updates	Target Date	Inherent Score	Residual Score	Target Score
Totally PLC Sustainability	If totally not awarded the regional 111 contract (that is currently under evaluation)	This will impact on their operational delivery model within the SSOT system. Totally currently have two 111 contracts (SSOT and National resilience)	Resulting in the model potentially not being sustainable or viable for delivery. If this were the case, this would impact on the SSOT 111 and GP OOHs services.	**18/09/2023**	18/09/2023 Update To time the UEC team have undertaken the following actions. 1. ICB finance and contract representatives who are in receipt of the D&B credit reports are closely monitoring and filter into the UEC MDT for discussion of any concerns. 2. The ICB UEC representative as part of the regional procurement group has met with peers regarding mitigations to the outcome of the procurement, and have agreed that the current provider across the East and West Midlands would be a suitable mitigation to request if they could start the contract earlier if required. The provider can not be contacted until the procurement process has been completed and the outcome is known. 3. Current performance is under continual review for Totally services, managed via the CRM meetings, daily via the System Control Centre and escalated as required. A remedial notice for 111 has been issued to Totally for 111 performance for KPI's 1 - 6. The Remedial plan has being escalated to governing bodies due to non-agreement as per contract. A remedial notice has also been issued for GP OOH's contract due to performance and due to non-agreement has also been escalated to Governing Bodies as per contract. Both contracts are not experiencing quality impacts and are closely monitored through CQRM forums. 4. There is a national resilience platform that would support continual delivery of 111 services if required. 5. EPRR have been requested to support initiate Business Continuity Planning to support next steps in terms of resilience for our system and potential provider failure. 6. Partners from across the ICB and CSU are meeting weekly to discuss progress and planning to support monitor the performance and contract.	31/03/2024	**12 (4x3)**	**12 (4x3)**	**4 (2X2)**
Urgent And Emergency Clinical Assessment Service (CAS)	The inclusions within the regional 111 specification for clinical validation post initial health advisor contact are currently managed locally within our integrated CAS. There are some dispositions that are not included within the regional 111 procurement. The outcome of the regional 111 procurement may result in a cost	Then the Clinical Assessment service dispositions not included at a regional level may not be sustainable from April 2024 as currently offered	Then patients triage will be reliant on there Pathways assessment for some dispositions within 111. Pathways is a nationally mandated triage system and can be risk adverse. Therefore patients may not be directed to the right service, first time resulting in increased pressures on our system or patient journeys affected by multiple touchpoints.	**18/09/2023**	18/09/2023 Update The ICB have reviewed the initial data provided and have a meeting in place on 27th September to clinical review areas of the outcome dispositions. This will enable clinical rationale to support what is required post April 24. NHSE are reviewing the dispositions as recognised that Pathways was developed circa 15 years ago, and such dispositions may not be reflective and required moving forward. The UEC ICB team are working with respective partners to understand their workstreams to enable appropriate reflection on the DOS to support patient pathways. There are multiple system access points and service offers across the system that need review to ensure reduced duplication. A stock take of the Urgent Care Coordination Centre to improve and standardise its provision for UEC has commenced and in the initial stages of working towards this being our Single Point of Access as mandated through winter planning by NHSE. Further review of the Directory of services is ongoing to ensure wider services are accurately reflected to ensure patients are directed to the appropriate service, first time.	02.24	**6 (3x2)**	**6 (3x2)**	**4 (2X2)**

UHNM Whole Trust Capacity Modelling





Bed Modelling shows a 200+ unmitigated average bed gap in Jan 2024

- Peak Bed Gap is forecast as 231 beds (Mondays in Jan)
- Lower chart illustrates monthly average bed pressure
- This illustration is for All Divisions & across both County & RSUH sites

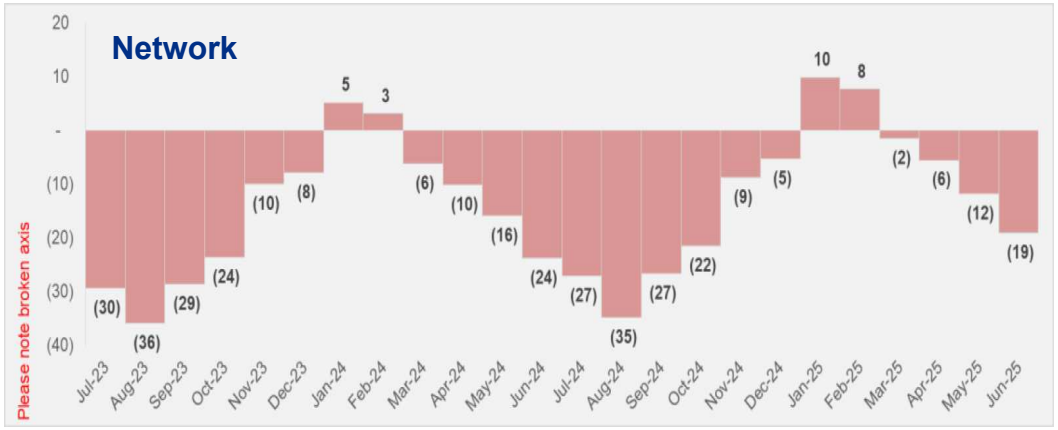
Inpatient IP implications require additional capacity circa. 20 beds

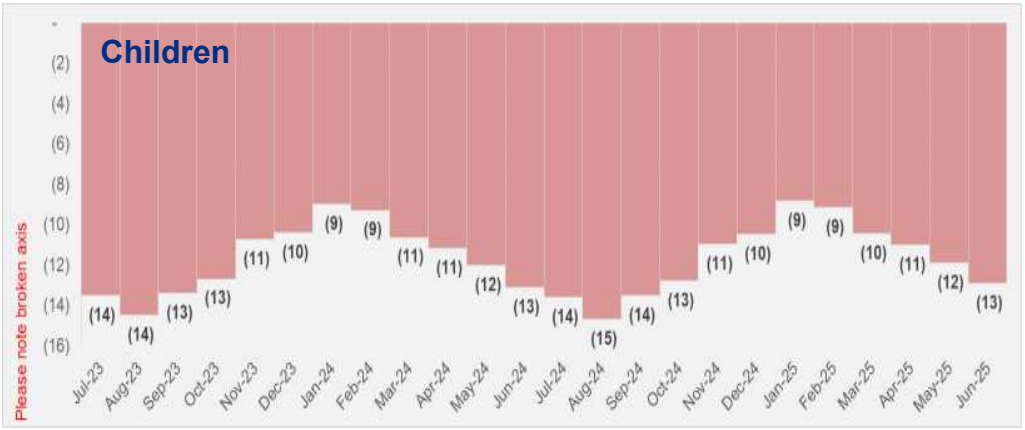
- Updated data (based upon last 12 months to end June 2023) resulted in significant increases in demand and bed utilisation.

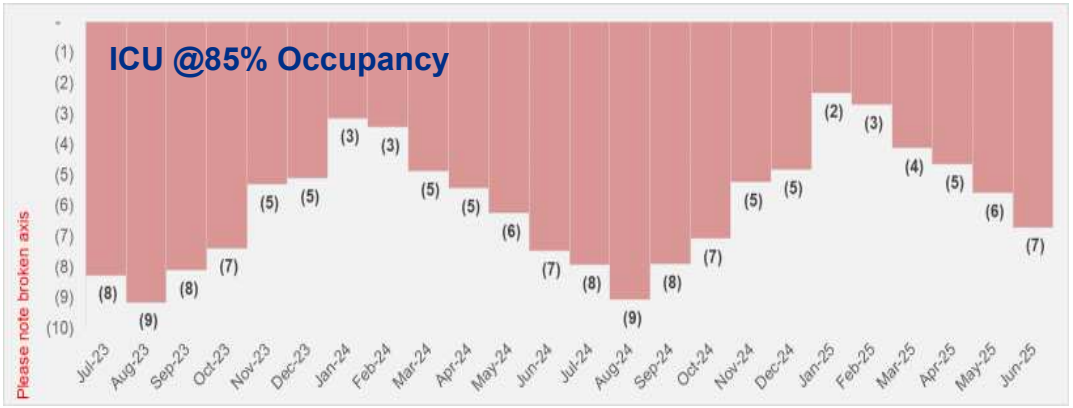
Flu prevalence and impact peaked in 2022/23 earlier (in December)

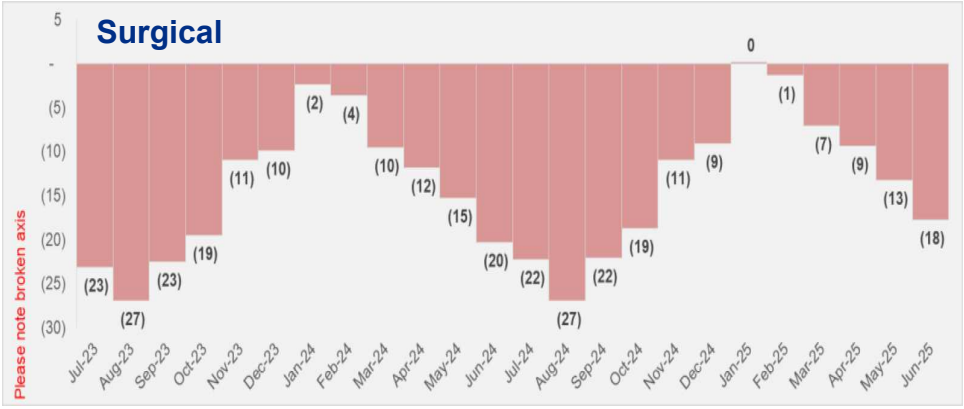
- To mitigate this planning will seek to mobilise mitigations in Dec

Capacity modelling – Network, Surgical, Children, and ICU



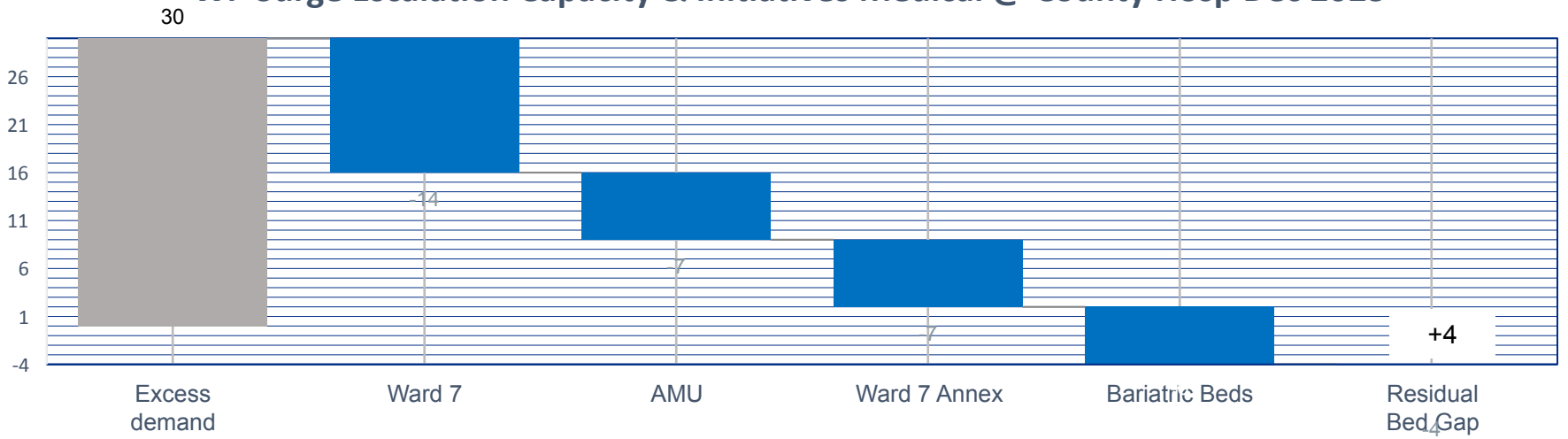






County Hospital Bed Modelling – Residual Gap

Enabling Schemes: Primary Care Add. Appts, Empowered HALO model, NEPTs, Falls Service, Mental Health initiatives

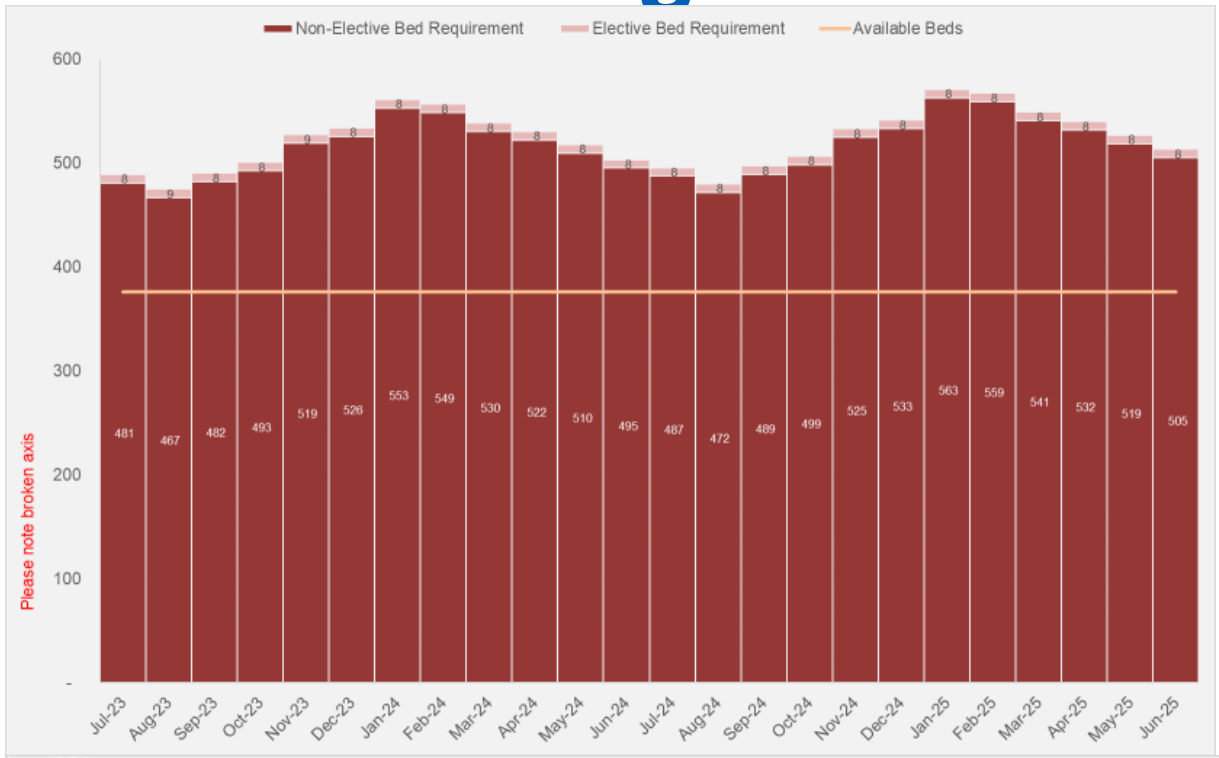


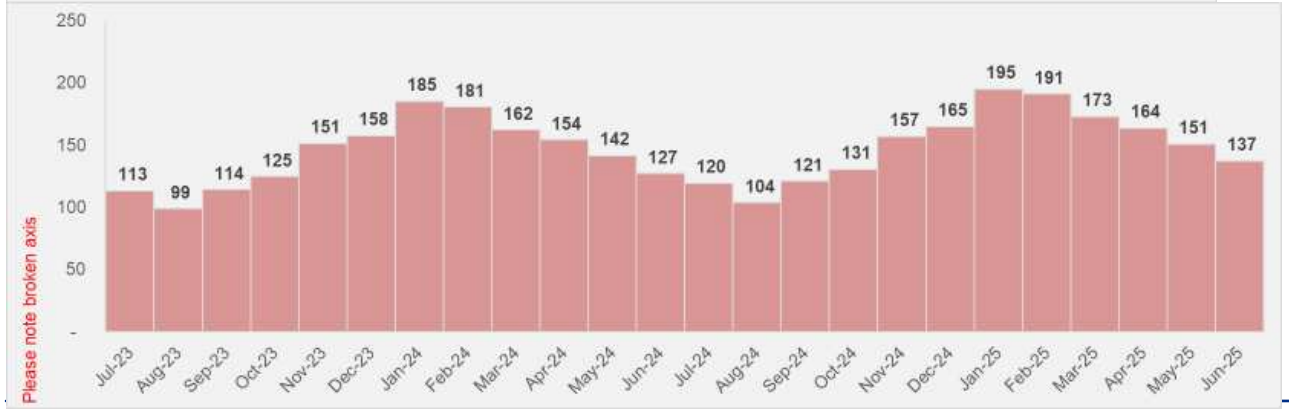
- Residual Bed Gap for Medical Beds at County Hospital = +4 beds currently (equates to 4 bed County Repat. value on RSUH slide)

NOTE

- Peak demand is brought forward to December to anticipate early seasonal spike as experienced in 22/23 and in Southern hemisphere 23 winter.
- Illustration is for County beds and demand only
- LOS efficiencies are netted off by stretched staffing ratios to support additional capacity

Bed Modelling – RSUH Medical

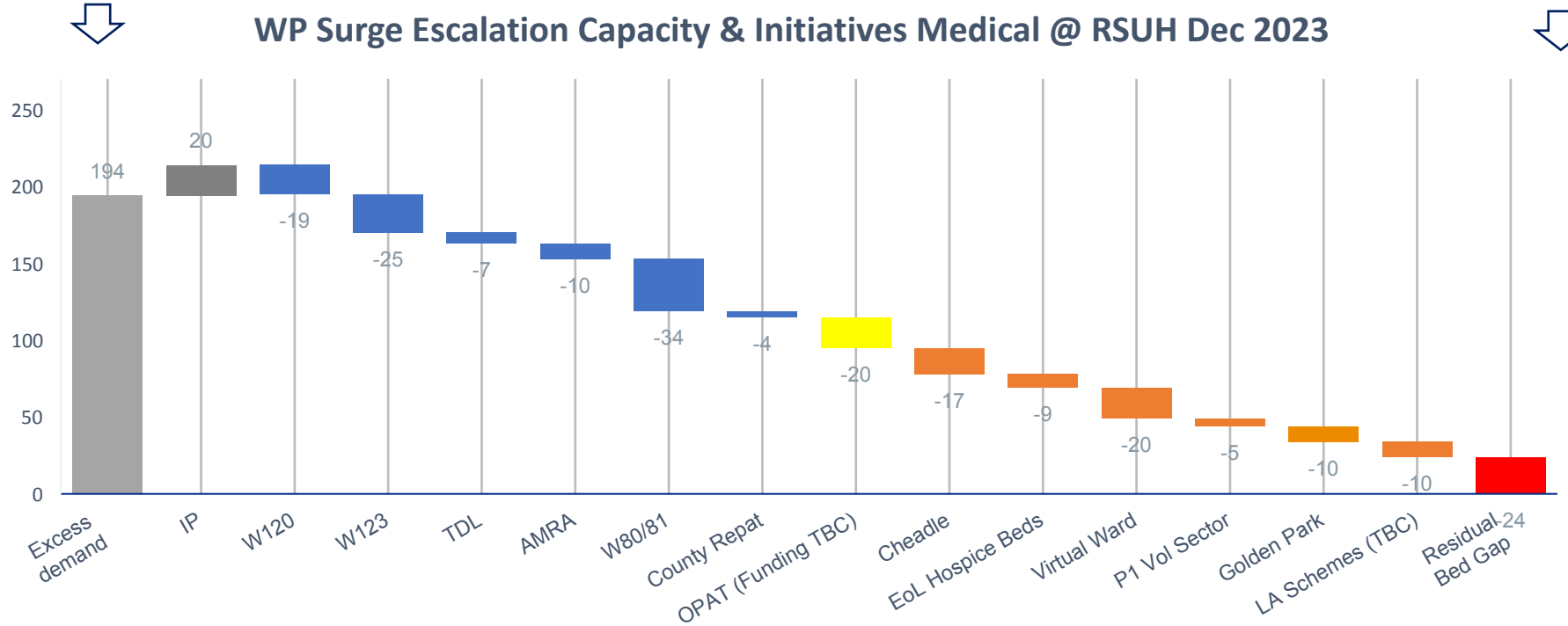




- Approach for 23/24 will be to focus on mitigation of medicine bed gap. The plan will demonstrate that non-medicine beds can be mitigated through internal divisional actions
- Medical Beds at RSUH represents greatest area of concern and highest forecast bed gap
- Peak Bed Gap is 194 Medical Beds at RSUH
  - Mondays in Jan '24
- IP considerations and anticipated earlier Flu peak need to be considered in addition

RSUH Bed Modelling – Residual Gap

Enabling Schemes: Primary Care Add. Appts, Empowered HALO model, NEPTs, Falls Service, Mental Health initiatives



Primary Care: 4,974 additional F2F apts. per week

Cheadle 2.4:1 ratio
VW 3:1 ratio
EOL beds + dom care additionality + advice = 1:1
Pathway 0.5 Indicative

UHNM additional capacity

- Residual Bed Gap for Medical Beds at RSUH = ~24 beds
- 'Acute Bed Equivalent' calculations for community & other supporting schemes represented

NOTE

- Peak demand is brought forward to Dec-23 to anticipate early seasonal spike as experienced in 22/23 and in Southern hemisphere 23 winter.
- Escalation Wards at County (AMU, Ward 7) not included in Mitigations – utilised to address bed gap at County site
- Additional monies for Modular Solution will not be online until March 2024
- LOS efficiencies are netted off by stretched staffing ratios to support additional capacity

Indicative Medical Bed Count

Initial winter plan positin	Lead provider	Position	NHSE funding (£M)	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Bed gap (Inc IP impact)		**-214**		**-153**	**-180**	**-214**	**-214**	**-209**	**-191**	**-162**	**-150**	**-136**
Mitigated by												
W120	UHNM	19		19	19	19	19	19	19	19	19	19
W123	UHNM	25		25	25	25	25	25	25	25	25	25
TDL	UHNM	7		7	7	7	7	7	7	7	7	7
AMRA	UHNM	10		10	10	10	10	10	10	10	10	
W80/81	UHNM	34		34	34	34	34	34	34	34	34	
County repatriation	UHNM	4			4	4	4	4	4			
OPAT	UHNM	20				20	20	20	20	20	20	20
Cheadle	MPFT	17		-	-	17	17	17	17	17	17	
Hospice	Various	9				9	9	9	9	9	9	
Virtual Ward		20		15	17	20	20	20	20	20	20	20
P1 Voluntary Sector		5		5	5	5	5	5	5	5	5	5
Golden Park/Manor - EOL		7			7	7	7	7	7			
Golden Park/Manor - Step up		3			3	3	3	3	3			
Local Authority Schemes (TBC)		10			10	10	10	10	10			
Modular										30	30	30
Balance		-24		-38	-39	-24	-24	-19	-1	34	46	-10

Managing the peak

- The planned interventions described leave an expected peak deficit of -24 across Medicine in RSUH.
- This will be further mitigated by the impact of enabling schemes as above although this has not been quantified.
- The remaining deficit will be managed through a combination of outlying patients, maintaining occupancy in excess of 92%, and the holding of patients with a DTA in the RSUH ED. This will be supplemented by the clinical risk share approach across system partners.
- Should these final actions fail to satisfactorily reduce risk across the System a Business Continuity Incident will be declared and a Command and Control structure established.

Enabling Schemes

Title	Summary	Impact	Timescale	Funding Source
Primary Care	MDT Acute Primary Care Access Hubs – 1 per locality. Providing same day access Additional appointment capacity – 4,974 appts p/week	Admission avoidance Greater Prim. Care provision during surge	November – April	System Funding Total £3.7m rqrd Awaiting CFO sign off
Enhanced UCCC	Increasing 111 referrals Embedding WMAS 3 x approaches Increased utilisation of 2hr UCR Recruitment of Triage Nurse/Nurse Co-ordinators	Admission avoidance	October onwards	Baseline
CRIS	Targeted Care Home Work – identification of high A&E referrals ACP Alignment & Education Programme Docobo introduction – improve GP capacity & admission avoidance Falls Service – strengthening existing 'pick up' service & introducing Enhanced Falls Service	Reduced wait time for WMAS response. Reduced variation and gaps in service provision.	November - March	Baseline
Staffordshire Fire Service – Falls Response Service	Falls response service to calls in Staffordshire and Stoke for patients who have had a fall requiring no medical intervention but require being lifted.	Responses within 2 hours	November - March	BCF
WMAS	Empowered Hospital Ambulance Liaison Officer (HALO) cover at RSUH	Reduce extended ED waits	November – March	Winter monies
EMED (NEPTS)	Increase capacity across acute sites that service SSoT patients with clear outcomes for delivery. Priority for ED and emergency portals to support admission avoidance.	Reduce failed discharges, support increased flow.	Oct – March 23	Clarification re No. Crews & Funding
D2A Additional Hours	1300 additional hours of Home First D2A activity	Facilitated discharges. Improved patient flow	Dec-March	Baseline

Enabling Schemes

Title	Summary	Impact	Timescale	Funding Source
Primary Care	- Seasonal Vaccination Programme - Increase 111 Direct Booking - Proactive QIF prioritisation - Community Pharmacy Provision - Dentistry access	Admission avoidance Increased Prim. Care Access	Specific to each aspect	Baseline
Totally (111)	Seasonal increase in Call Handlers	Increased 111 access	November onwards	Baseline
UCCC/CRIS Care Home Education	Suite of initiatives designed to educate and support Care Homes and CH staff	Increased support for Care Homes Admission avoidance	November onwards	Baseline
Deteriorating Patients Network	Supporting Care Homes with managing extreme frailty	Admission avoidance	Ongoing	Baseline
End of Life	Hospice collaborative offer - 18 System Hospice beds, 24/7 advice line and dom care support	Admission avoidance and discharge support Support OoH admissions	November onwards	System
Mental Health	111 ‘soft launch’ for Option 2 Crisis plans for service users known to services WMAS liaison, education and Crisis Service linkage Police Street Triage MH liaison & High Volume Users team work with ED Health Facilitator work in Primary Care (supporting vacs & imms)	Mental Health admission avoidance Parity of esteem	October onwards	Baseline/ MH funding streams

Elective Protection

- Elective operating will continue and be protected where possible through winter.
- This will be facilitated through:
  - Movement of orthopaedic operating to county site with an enhanced recovery model,
  - Day case arthroplasty on the royal Stoke Site
  - Support of the virtual ward for IV in orthopaedic patients (est. reduced LOS)
  - Use of the day case ward overnight and weekend to support plus 24hour stays in elective operating
  - Weekend operating to spread the bed flow

- The impact on the patient flow and bed requirement is currently being worked up

End of Life further detail

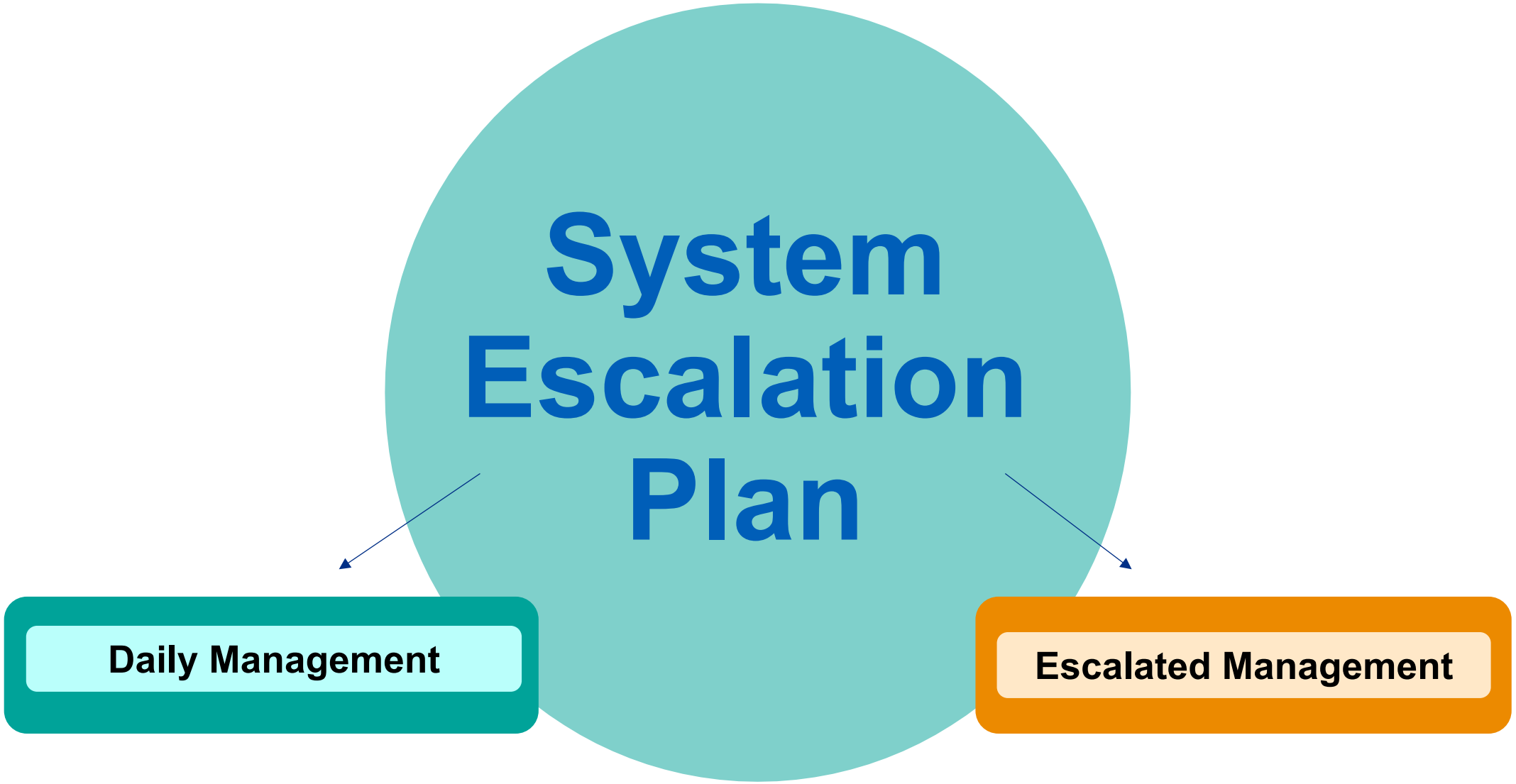
- 4 hospices have formed a provider collaborative to deliver 24/7 advice for patients and professionals which will be up and running by November. It will particularly support admissions out of hours when we know most EOL admissions happen.

- Streamlined CHC EOL pathway, phase 1 will go live 1st November will impact on CHC LOS but also referral to decision times – currently on average 48 hours, aim to reduce to within 24 hours.

- 18 Additional hospice beds will be made available subject to funding agreement . Admission criteria and referral criteria TBC by end September.

- EOL integration workshop – 3rd October to bring this all together with partners.

System Escalation Plan



Note: this is continually evolving, updates may be available following paper submission dates.

System Control Centre – Daily management

- Senior daily operational cover 8-8 x7 days, supported OOH by On-Call Teams, ability to step up if needed.
- Clear escalation process for the SCC within the ICS.
- System support from all partners, effective system calls, bed meetings etc.
- Regular feedback into Regional Team.
- Operational support to providers with a system view.
- Battle Rhythm to ensure consistent approach.
- Various IT systems used for data collection and live position, e.g. NACC, CAD, SHREWD etc.
- Physical room available to step up for Control & Command/EPRR.

Escalated Management

1. Introduction

This document sets out the Plan for Staffordshire and Stoke on Trent based populations and describes how partners across the health and social care economy are planning to ensure that our services can best meet the anticipated emergency demands.

The key driver behind this document is ensuring patients across our systems remain safe, patient safety risks are escalated and mitigated across all partners within the ICS. The system response will be led by senior leaders, both clinical and operational across all organisation ensuring our aims and leadership compact is adhered to at all times.

The success of this plan requires a continuation of a whole system approach and effective partnership working.

It will be crucial that all partners understand their role in supporting and delivering this plan. Planning is led through the System Control Centre (SCC) with emphasis placed on whole system collaborative planning processes rather than individual organisations undertaking planning in isolation.

2. Purpose of the Plan

To provide a single, centralised point of reference for all organisations across our system to assess actions and triggers required through periods of surge and escalation.

To give visibility and offer deliverable solutions to operational pressures.

To provide a structure and mechanism for safely and methodically escalating and de-escalating.

To provide the outline and structure to ensure risk is facilitated across the system.

The Plan has been formed via the employment of best practice and lessons learned from recent winter periods. Representatives from all key stakeholders have been engaged in the formation of the plan and compliance will be the responsibility of all SSOT ICS members, in collaboration with their respective organisation.

3. Approach to Escalation

Operational Pressures Escalation Levels (OPEL) Framework has been revised for 23/24 This review has resulted in a significant change in the measurement of the ICS OPEL levels, moving from a multi-provider scoring to an acute provider position. Under the revised framework it is expected that the ICS OPEL level mirrors that of its acute providers. Organisations may be at different levels of escalation in line with their view on pressures that may be individual to their organisation. However, there is agreement that armed with knowledge about the pressure of the system and using principles of mutual aid – the system will be in a better position to be able to cope.

OPEL	Definition
OPEL 1	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources..
OPEL 2	The local health and social care system is starting to show signs of pressure. The local ICS will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible.
OPEL 3	Further urgent actions are now required across the system by all ICS partners, and increased external support may be required. Regional teams in NHSE will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally
OPEL 4	There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the ICS to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHSE will be aware of rising system pressure, and will be actively involved in conversations with the system.
BUSINESS CONTINUITY	These actions have been developed locally to support responding to sustained pressure, where the system has remained at level 4 for a trigger period agreed by system. All level 4 actions will have been undertaken and there is a potential, for services to be overwhelmed leading to the potential of serious patient harm because of service failure or inability to respond.
CRITICAL/MAJOR INCIDENT	Defined through EPRR processes, defined as the use of extraordinary measures.

3. Approach to Escalation continued….

- System Escalation Action cards set out the procedures across the ICS to manage day to day variations in demand and significant surge – these include both escalation and de-escalation actions based on the OPEL level
- To support exceptional levels of pressure an ‘System Critical Incident’ trigger and action card has been developed.
- During periods of surge, escalation quickly reaches level 3/4. The response is then to focus on specific issues to de-escalate and manage the surge. The escalation cards have been tested as a system and have subsequently been revised to assure that the correct actions are taken by the correct organisations to produce a measurable output. This will enable the system leadership to monitor effectiveness and address any inadequacies or shortfalls in response.
- The SSOT ICS System Escalation Plan, on call arrangements and Emergency Preparedness Resilience and Response (EPRR) mechanisms all enhance the resilience of the system by means of detailing the responsibilities and key actions for partners to enact and return the system to a stable position.
- Partners will be asked to confirm that they have fully enacted their actions included in the SSOT ICS Escalation Plan and if there are any residual risks or issues associated to them

System Workforce plan

Workforce Planning Approach

- The ICS Health & Care People Team has taken responsibility as ICS lead in workforce planning and assurance of additional workforce to support Winter Schemes.
- ICS Workforce Leads work in collaboration with NHS, Local Authority, Social Care, Independent providers and ICB to understand the workforce required to deliver the schemes, explore alternative workforce models and skill mix required, and availability of current workforce to determine any gaps.
- Regular communication and involvement of Partners ensures that plans for workforce scheme activity are monitored and reviewed regularly.
- Providers continue assess and review their workforce models and additional capacity required for anticipated scenarios and surge.
- Providers are modelling their workforce internally, utilising a range of roles and skills across the schemes, adopting flexible workforce models which respond to demand accordingly. Providers have plans in place to deliver the additional capacity utilising their internal available workforce through skill mix, redeployment and additional hours.

Risks and mitigation

Main **risks associated with the supply of workforce** in the short and medium term currently include:

- Continued Industrial Action, low morale among workforce, sickness (rising COVID instances), turnover, vacancies, availability of registered workforce

In order to **mitigate** risks, Providers and leads implementing a number of actions including:

- Targeted recruitment campaigns, focussing on ‘new to care’ wherever possible so as not to destabilise (*what is our Employee Value Proposition*?)
- System wide and local retention programme activities including flexible working and retirement offers, HWB offer, career development opportunities, support for new starters and improved on boarding, 5 high impact actions for nursing & midwifery
- Introduction of competitive and consistent internal bank rates, to provide viable alternative to agency
- Mutual Aid Support and robust process for mobilisation of workforce across System as required
- Growth of Reserves via People Hub, including reaching out to private and volunteer sector. Particular focus on imams boarding and training Reserves in readiness for supporting wards and care homes.
- Vaccination programme for staff

Surge 2023/24 Workforce Initiatives

Reserves

- Continue to grow bank of **Reserves** via **People HUB** – new Hub and Spoke model. Increase numbers of **New to Care HCAs** in readiness for supporting wards. Programme of induction and shadowing already underway in collaboration with UHNM.
- **Corporate Reserves** – expansion of programme to include NHSE colleagues
- Expansion of **volunteer Companion role** for UHNM
- **Scoping extension of Companion role to local businesses –** corporate responsibility

Internal Banks / Flexible Workforce

- System wide approach to escalated bank rates, **creation of bank offer to reduce agency usage and support substantive staff to pick up more shifts,** including HCAs? Split out Band 5 / 6 roles?
- Higher rates for set hotspot areas?
- Scope additional incentives for existing staff

Recruitment

- Take learning from previous Winter campaigns
- Scope **large scale training and induction for New to Care HCAs** (collaboration between UHNM / MPFT)
- Support from Health and Care team for large scale campaigns – including **'Refer a Friend' for New to Care**
- **What is our EVP??**
- **Scope offers of flexible working** – permanent, fixed term working, bank roles, **flexible hours including school hour shifts?**
- Scope 'insourcing' for entire ward (MS speak to Kate Farrow)
- **EDI lens** / seldom heard communities / public health

Retention Programme

- Focus on HWB of existing staff – particularly in light of surge / I A
- **Flexibility / WLB**
- **Flex retirement options**
- Support for **new starters** – buddy systems
- 5 HIAs for nursing & midwifery including menopause support, legacy mentoring, pension awareness, preceptorship framework

Mutual Aid processes

- Ensure robust processes in place for workforce requests / mutual aid support via People Hub

Next phase : Sept – Oct

- Confirmation of additional workforce requirements and numbers from Providers and Partners
- Confirmation of workforce deficit, following provider/partner workforce mobilisation and schemes
- Agree and commence activities to address the deficit / mitigate supply risks
- Agreement on alternative workforce schemes and escalated bank rates
- Ongoing collaboration with CPOs and partners to develop and deliver the system plan

FINANCE

System Surge Finance as at 21 September 2023

Winter/Surge Allocations

	Funding:	£'000	
ICS	Allocation winter and virtual wards	7,678	
	Virtual Wards	-3,919	
	Residual Winter funding	**3,759**	
	Additional submission	2,850	*not confirmed*
	SDEC revenue funding	1,484	*not confirmed*
	Remaining funding	**8,093**	

- Primary Care Respiratory Hubs and additional appointments from December 2023, costs exclude reinstatement of AVS services
- Care home solution for additional Beds is an indicative cost and has not been approved
- Both UHNM and MPFT have confirmed that the identified costs have been included in their respective M5 Forecasts
- The primary care winter schemes can no longer be funded through anticipated slippage and the care home solution has not been included the forecast of any organisation resulting in a risk to the M5 system forecast of circa £3m.

Winter Schemes

	Scheme	Baseline	Forecast Expenditure	Pressure	Expected Additional Funding	Surplus (+) / Risk (-)
ICB	Respiratory Access Hubs	0	1,394	-1,394	0	-1,394
	Additional Appointments	0	1,568	-1,568	0	-1,568
	HALO Support	0	466	-466	350	-116
	Non-Emergency Patient Transport	0	797	-797	700	-97
	Primary Care in ED	0	100	-100	650	550
	Hospice EOL Support Line	0		0	0	0
	Additional beds (Care home solution)	0	1,500	-1,500	0	-1,500
	Unallocated allocation				1,293	1,293
	ICB	-	5,825	**-5,825**	**2,993**	**-2,832**

	Scheme	Baseline	Forecast Expenditure	Pressure	Expected Additional Funding	Shorfall / Risk
MPFT	Cheadle D2A capacity	1,426	3,007	-1,581	435	-1,146
	Home First Reablement Winter Surge	800	800	0	0	0
	MPFT Total	2,226	3,807	**-1,581**	**435**	**-1,146**

	Scheme	Baseline	Forecast Expenditure	Pressure	Expected Additional Funding	Shorfall / Risk
UHNM	Ward 80 / 81 - Acute bedded provision	-	4,135	-4,135	859	-3,276
	Cohorting / Corridor	-	1,423	-1,423	369	-1,054
	Virtual Wards	3,919	3,206	713	-206	507
	County - Ward 1	624	882	-258	66	-192
	Ward 120/123	2,225	5,321	-3,096	943	-2,153
	FDU / TDL		750	-750	750	0
	IDH - Discharge Facilitators		400	-400	400	0
	Other Schemes; internal capacity	951	1,520	-569	0	-569
	SDEC Revenue costs		tbc	tbc	1,484	1,484
	UHNM Total	7,719	17,637	**-9,918**	**4,665**	**-5,253**

Total Winter Schemes	**9,945**	**27,269**	**-17,324**	**8,093**	**-9,231**

*Full year position shown, subject to full sign off

UHNM Finance Position as at 19.09.2023

Funding	£m
UHNM Funding	
Trust Winter Budget	3.8
Tier 2 Funding	
Frailty Decision Unit	0.8
Integrated Discharge Hub	0.4
Other Funding	
SDEC Modular	1.5
Total Funding	**6.5**
Planned Expenditure	
UHNM Winter Plan Approved	4.5
UHNM Winter Plan External Funding	0.9
UHNM Winter Plan Unfunded	0.8
County Hospital Ward 1	0.8
Total Planned Expenditure	**6.9**
Affordability	**(0.4)**

*Winter uplift costs only

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th October 2023
Report Title:	UHNM Patient Safety Incident Response Plan (PSIRP)	**Agenda no.**	9.
Author:	Head of Quality, Safety and Compliance & Quality Assurance Manager		
Executive Lead:	Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

High Quality		People		Systems & Partners	
Responsive		Improving & Innovating		Resources	

Risk Register Mapping

	No associated risks	

Executive Summary

Situation

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

This paper introduces the University Hospitals of the North Midlands (UHNM) patient safety incident response plan (PSIRP) which sets out how the Trust will respond to the new national requirements by seeking to learn from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide. The PSIRP has been reviewed and approved previously at Quality Governance Committee and following approval at Trust Board will be formally shared with the Integrated Care Board for agreement as per national requirements.

Background

In March 2020, NHS England launched the concept of a new Patient Safety Incident Response Framework (PSIRF) to replace the existing Serious Incident Framework (SIF), from which it differs in the following key aspects:

- **Broader scope:** the PSIRF moves away from reactive and hard-to-define thresholds for 'Serious Incident' investigation and towards a proactive approach to learning from incidents. It promotes a range of proportionate safety management responses.
- **Investigation approach:** safety investigation is now tightly defined. Quality of investigation is the priority with the selection of incidents for safety investigation based on opportunity for learning and need to cover the range of incident outcomes.
- **Experience for those affected:** expectations are clearly set for informing, engaging and supporting patients, families, carers and staff involved in patient safety incidents and investigations. In accordance with a just culture, 5 staff involved in incidents are treated with equity and fairness.
- **Investigator expertise, experience, time and authority**: the framework clarifies that investigations must be led by those trained and experienced in patient safety incident investigation (PSII), with the

authority to act autonomously and with dedicated time and resource.
- **Investigation timeframe:** timeframes are more flexible and set in consultation with the patient and/or family.
- **Terminology:** 'systems-based6 PSII' replaces the term root cause analysis
- **Governance and oversight:** this is strengthened, with commissioners and local system leaders assuring plans and co-ordinating investigations spanning multiple settings. Provider boards now sign off PSII quality and safety improvements.

The national implementation of the new framework has been significantly delayed due to the pandemic and the receipt of feedback from the early adopter sights. As such, NHS Trusts have been given a deadline of Autumn 2023 to prepare for, implement and adopt PSIRF.

As part of the move towards the new approach, Organisations are required to apply this framework in the development and maintenance of their patient safety incident response plan (PSIRP).

An organisation's PSIRP specifies the methods it intends to use to maximise learning and improvement and how these will be applied to different patient safety incidents. It is based on a thorough understanding of the organisation's patient safety incident profile, on-going improvement priorities, available resources and the priorities of stakeholders including patients and local economy.

Assessment

The UHNM PSIRP describes the local strategic and operational arrangements for proportionate and co-ordinated response to patient safety incidents. It describes:

- the local situational analysis in relation to patient safety incidents
- selection of incidents for patient safety incident investigation (PSII) or review, based on national and local priorities
- the approach to the different types of patient safety incidents that normally fall outside the scope of the PSII
- roles and responsibilities
- incident reporting arrangements
- procedures to support patients, families and carers affected by patient safety
- incidents
- procedures to support staff affected by patient safety incidents
- mechanisms to develop and support improvements following incidents
- evaluating and monitoring outcomes following PSIIs and reviews
- complaints and appeals.

In relation to the above, the following should be noted:

Patient Safety Incident Investigation (PSII)

A PSII looks back at what happened and why, so that action can be taken to help prevent or significantly reduce the likelihood of a similar incident in the future. As part of the PSIRP, organisations are required to declare under what circumstances a PSII will be initiated. PSII's will be carried out for all nationally defined incidents including:
- Maternal and neonatal incidents which meet the e 'Each Baby Counts' and maternal deaths criteria.
- Child deaths
- Deaths of persons with learning disabilities
- Safeguarding incidents
- Deaths of patients in custody, in prison or on probation
- Incidents meeting the Never Events criteria
- Incidents meeting the Learning from Death criteria

In addition to the above, Organisations are required to identify locally-defined incidents requiring PSII. It is anticipated that between 3 – 6 locally defined PSIIs will be completed each year and should be detailed in the PSIRP accordingly.

In order to inform which locally –defined PSIIs should be undertaken, the patient safety incident risks for

UHNM have been profiled using organisational data from a number of qualitative and quantitative sources including; patient safety incident, legal claims, Coroners findings, complaints, clinical reviews of services, mortality thematic reviews, staff and service user survey results, Care Excellence Framework feedback and safeguarding reviews.

A review of the data has been undertaken and 5 safety priorities have been selected for locally-defined PSII. Prioritisation was based on the following:

- actual and potential impact of incident
- likelihood of recurrence
- potential for learning.
- the provision of existing patient quality improvement initiatives and projects currently underway.

As such, for the period 2023 – 2025 the following locally defined PSIIs have been proposed:

- Deteriorating patient with identified omissions of care causing actual impact of 4 severe or 5 death
- Delayed diagnosis where procedures were not undertaken / delayed causing actual impact of 4 severe or 5 death
- Delayed diagnosis where results were not acted upon causing actual impact of 4 severe or 5 death
- Omissions of critical medications causing actual impact of 4 severe or 5 death
- Unplanned maternal readmissions

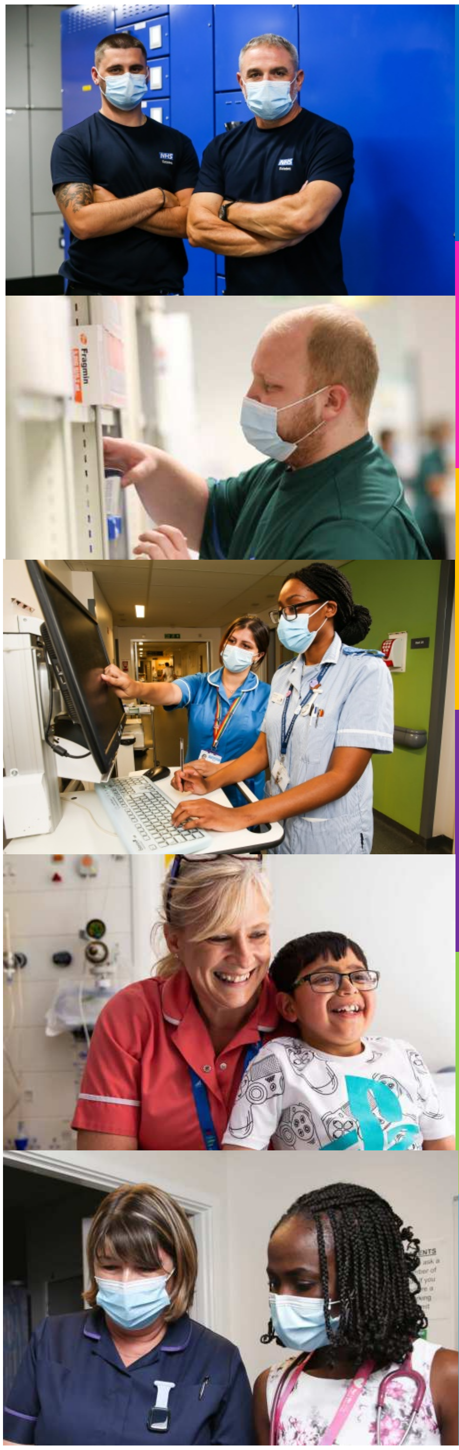
In accordance with the national PSIRF requirements, the contents and key messages from the PSIRP have been condensed to a 'plan on a page', which sets out, at a glance, the organisation's patient safety incident and issue profile and details the methods it will use to respond in a way that maximises learning and improvement.

Key Recommendations

The Trust Board is asked to review and approve the Patient Safety Incident Response Plan and the Plan on a Page.

Patient Safety Incident Response Plan

2023 / 2025



Contents

1. Purpose, scope, aims and objectives

1.1 Purpose

1.1.1 This patient safety incident response plan (PSIRP) sets out how the **University Hospitals of North Midlands NHS Trust** will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide.

1.1.2 This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

a. refocusing PSII towards a systems approach[1] and the rigorous identification of interconnected causal factors and systems issues
b. focusing on addressing these causal factors and the use of improvement science[2] to prevent or continuously and measurably reduce repeat patient safety risks and incidents
c. transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents
d. demonstrating the added value from the above approach.

1.2 Scope

1.2.1 There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of system learning and improvement.

1.2.2 This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed.

1.2.3 We have developed the planning aspects of this PSIRP with the assistance and approval of the organisation's local commissioner(s).

1.2.4 The aim of this approach is to continually improve. As such this document will be reviewed annually to start with.

1.3 Strategic aims

1.3.1 Improve the safety of the care we provide to our patients, and improve our patients', their families' and carers' experience of it.

1.3.2 Further develop systems of care to continually improve their quality and efficiency.

1.3.3 Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified.

1.3.4 Improve the use of valuable healthcare resources.

1.3.5 Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.

1.4 Strategic objectives

1.4.1 Act on feedback from patients, families, carers and staff about the current problems with patient safety incident response and PSIIs in the NHS.

1.4.2 Develop a climate that supports a just culture and an effective learning response to patient safety incidents.

1.4.3 Develop a local board-led and commissioner and integrated care system (ICS)/sustainability and transformation partnership (STP)-assured architecture around PSII and alternative responses to patient safety incidents, which promotes ownership, rigour, expertise and efficacy.

1.4.4 Make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents, as a whole. The aim is to:

- make PSIIs more rigorous and, with this, identify causal factors and system-based improvements
- engage patients, families, carers and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors
- develop and implement improvements more effectively
- explore means of effective and sustainable spread of improvements which have proved demonstrably effective locally.

2. Situation Analysis – National

2.1.1 Many millions of people are treated safely and successfully each year by the NHS in England, but evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff.

2.1.2 When things go wrong, patients are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatment and litigation. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

2.1.3 Historically, the NHS has required organisations to investigate each incident report that meets a certain outcome threshold or 'trigger list'. When this approach was developed it was not clear that:

a. Luck often determines whether an undesired circumstance translates into a near miss or a severe harm incident. As a result, focusing most patient safety investigation efforts on incidents with the most severe outcome does not necessarily provide the most effective route to 'organisational learning'.[3]

b. There is no clear need to investigate every incident report to identify the common causes and improvement actions required to reduce the risk of similar incidents occurring. To emphasise this point, it has been highlighted that in-depth analysis of a small number of incidents brings greater dividends than a cursory examination of a large number.

2.1.4 An increased openness to report patient safety issues has also led to an ever-growing number of incidents being referred for investigation. NHS organisations are now struggling to meet the number of requests for investigation into similar types of incident with the level of rigour and quality required. Available resources have become inundated by the investigation process itself – leaving little capacity to carry out the very safety improvement work the NHS originally set out to achieve.

2.1.5 In addition, the remit for patient safety incident investigation (PSII) has become unhelpfully broad and mixed over time. This originates from an attempt to be more efficient by addressing the many and varied needs of different types of investigation in a

single approach. Sadly, the very nature and needs of some types of investigation (eg professional conduct or fitness to practise; establishing liability or avoidability; or establishing cause of death) have frustrated the original patient safety aim and blocked the system learning the NHS set out to achieve.

2.1.6 Many other high-profile organisations now identify and describe their rationale for deciding which incidents to investigate from a learning and improvement perspective. While some industry leaders describe taking a risk-based approach to safety investigation (eg the Rail Accident Investigation Branch and Air Transport Safety Board), others list the parameters that help their decision-making processes (the police, Parliamentary Health Service Ombudsman and Healthcare Safety Investigation Branch).

2.1.7 We need to remove the barriers in healthcare that have frustrated the success of learning and improvement following a PSII (eg mixed investigation remits, lack of dedicated time, limited investigation skills). We also need to increase the opportunity for continuous improvement by:

a. improving the quality of future PSIIs

b. conducting PSIIs purely from a patient safety perspective

c. reducing the number of PSIIs into the same type of incident

d. aggregating and confirming the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents.

2.1.8 This approach will allow NHS organisations to consider the safety issues that are common to similar types of incident and, on the basis of the risk and learning opportunities they present, demonstrate that these are:

a. being explored and addressed as a priority in current PSII work or

b. the subject of current improvement work that can be shown to result in progress or

c. listed for PSII work to be scheduled in the future.

2.1.9 In some cases where a PSII for system learning is not indicated, another response may be required. Options that meet the needs of the situation more appropriately should be considered; these are listed in Section 5.

3. Situational analysis – local

3.1 Results of a review of activity and resources

3.1.1 Patient safety incident investigation activity based on the current Serious Incident Framework, January 2018 to December 2022:

		Definition	2020	2021	2022
National Priorities	Incident resulting in death	Serious incident requiring investigation which met the standard investigation timeframe and resulted in patient's death	13	18	25
	Never Events	Incident meeting criteria for never events framework and reported to STEIS	2	2	7
Local Patient Priorities	Serious Incidents Requiring Investigation	Serious incident requiring investigation which met the standard investigation timeframe	103	115	126
	Patient Safety Incident Reviews	Including moderate harm incidents meeting the requirement for Duty of Candour; not meeting SI criteria	106	116	246
	Patient Safety Incident Validation	Patient safety incidents of low / no harm requiring validation at department / ward level	18,127	19,994	20,914

3.1.2 The patient safety incident risks for this organisation have been profiled using organisational data from recent; patient safety incident, legal claims, Coroners findings, complaints, clinical reviews of services, mortality thematic reviews, staff and service user survey results, Care Excellence Framework feedback and safeguarding reviews

3.1.3 A review of the resource and activity associated with the current Serious Incident Framework for the period 2019 to 2023 has been undertaken to determine how many PSIIs can be supported during 2023/2024. This review was carried out alongside the NHS

National standards for patient safety investigation to ensure that all future PSIIs are compliant with these standards.

3.1.4 In addition, a review has been completed to determine the current level of resource for Patient Safety Reviews, including pressure ulcers and falls. This supports planning of appropriate responses – using different review techniques – where PSII is not indicated.

3.1.5 In order to meet the requirements of the new NHS National Standards for Patient Safety Investigation we will:

- Develop a gap analysis based on the national PSII Standards to identify potential shortfalls in dedicated PSII personnel, seniority, PSII skills etc.
- Assign an appropriately trained member of the Executive Team to oversee delivery of the PSII standards and support the sign off of all PSIIs.
- Provide Being Open training for all board members.
- Provide access to update training for current staff who provide the incident investigation oversight function on use of updated response tools, use of improvement approaches and utilisation of the national report template.
- Identify an appropriate training provider for training new investigators of PSII's in the Trust to the standard required by PSIRF.
- Use a targeted approach to identify a number of investigators from a range of professional backgrounds i.e. medical, nursing, AHP.
- Produce new documentation for patients, families and staff members involved in patient safety incidents and ensure they are available on a public-facing area of our website
- Negotiate time in job plans for a core group of senior clinical staff to undertake PSII investigations every year.

3.2 Conclusions from review of the local patient safety incident profile

3.2.1 The current top 10 local priorities/risk register for PSII are:

	Incident type	Specialty
1	Falls	Trust Wide
2	Hospital Acquired Pressure Ulcers	Trust Wide
3	Identification and Escalation of the Deteriorating Patient	Trust Wide
4	Diagnosis failed / delayed	Trust Wide
5	Omission of critical medicines	Trust Wide
6	Patient Flow	Trust Wide
7	Handover of Care	Trust Wide
8	Failure to act upon / interpret results	Trust Wide
9	Maternal Readmission	Obstetrics
10	Medication error – DOAC / Insulin	Trust Wide

3.3 Strategic Plan

3.3.1

a. Based on the gap analysis and current resources the Trust has planned to undertake up to 30 patient safety incident investigations during the 12 months running October 2023 to September 2024.

b. Based on historic incident reporting data it is anticipated that of the 30, 25 will be 'national priority' patient safety incident investigations during the 12 month period.

c. The Trust has therefore identified 5 priority areas for "local priority" patient safety incident investigations for the next 12 months. The 5 priority areas are outlined within section 4.6.1 of this document.

d. All subsequent incidents falling outside each priority area will be reviewed by one of the alternate incident responses outlined in Section 5. However, it should be noted

that if it is felt that there is potential for significant new learning then a full patient safety incident investigation will be undertaken.

e. Clinical effectiveness processes such as clinical audits, national reviews and Learning from Death data will continue to be monitored to ensure any new patient safety risks are identified and acted upon in a timely manner.

f. The summary PSIRP will be available on the Trust's website making it accessible to patients, relatives, carers and wider stakeholders.

3.3.2 For each comprehensive PSII the Trust will:

a. Ensure each PSII is conducted separately, in full and to a high standard, by a team whose lead investigator is an experienced Band 7 / 8 and has received a minimum of two days' training.
b. Refer to training and the national PSII standards and conduct PSIIs as per the plan and in line with national good practice for PSII.
c. Use the national standard template to report the findings of the PSIIs.
d. Identify common, interconnected, deep-seated causal factors (not high-level themes or problems).

3.3.3 For each group of PSIIs dedicated to a similar/narrow focus incident type the Trust will:

a. Design strong/effective improvements to sustainably address common interconnected causal factors.
b. Develop an action plan for implementation of the planned improvements.
c. Monitor implementation of the improvements.
d. Monitor effectiveness of the improvements over time.

3.5.3 The Trust will introduce a system to monitor the quality of PSII findings and progress against this PSIRP, ensuring that the following questions are routinely considered:

a. Are the actions likely to achieve improvement?

b. Is there evidence of improvement?

4. Patient safety incident investigations

4.1 PSII Overview

4.1.1 PSIIs are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

4.1.2 There is no remit in PSII to apportion blame or determine liability, preventability or cause of death.

4.1.3 There are several other types of investigation which, unlike PSIIs, may be conducted for or around individuals. Examples include complaints, claims, human resource, professional regulation, coronial or criminal investigations. As the aims of each of these investigations differ, they need to continue to be conducted as separate entities to be effective in meeting their specific intended purposes.

4.2 Selection of patient safety incidents for PSII

4.2.1 In view of the above, the selection of incidents for PSII is based on the:

A. Actual and potential impact of the incident's outcome (harm to people, service quality, public confidence, products, funds, etc)

B. Likelihood of recurrence (including scale, scope and spread)

C. Potential for new learning in terms of:

- Enhanced knowledge and understanding of the underlying factors
- Improved efficiency and effectiveness (control potential)
- Opportunity to influence wider system improvement.

4.3 Timescales for patient safety PSII

4.3.1 Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified.

4.3.2 PSIIs should ordinarily be completed within one to three months of their start date.

4.3.3 In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the healthcare organisation with the patient/family/carer.

4.3.4 No local PSII should take longer than six months. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. (Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.)

4.4 Nationally-defined priorities to be referred for PSII or review by another team

4.4.1 The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) for the period 2023 to 2024 are:

a. **maternity and neonatal incidents:**

- incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation (https://www.hsib.org.uk/maternity/)
- all cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme
- all perinatal and maternal deaths must be referred to MBRRACE

b. **mental health-related homicides by persons in receipt of mental health services or within six months of their discharge** must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)

c. **child deaths** (*Child death review statutory and operational guidance*):

- incidents must be referred to child death panels for investigation

d. **deaths of persons with learning disabilities:**

- incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

e. **safeguarding incidents:**

- incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multiprofessional investigation

f. **incidents in screening programmes:**

- incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

g. **deaths of patients in custody, in prison or on probation** where healthcare is/was NHS funded and delivered through an NHS contract:

- incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

4.5 Nationally-defined incidents requiring local PSII

4.5.1 Nationally-defined incidents for local PSII are set by the PSIRF and other national initiatives for the period 2020 to 2022. These are:

a. **Incidents that meet the criteria set in the** Never Events list 2018

b. **Incidents that meet the** 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan, or following reported concerns about care or service delivery. Further, specific examples of deaths where a PSII must take place include:

i. **Deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's** mortality review tool and which have been determined by case record review to be more likely than not due to problems in care

ii. **Deaths of persons with learning disabilities** where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the leder review

iii. **Deaths of patients in custody, in prison or on probation** where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS

c. **Suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.**

4.6 Locally-defined incidents requiring local PSII

4.6.1 Based on the local situational analysis and review of the local incident reporting profile, local priorities for PSII have been set by this organisation for the period 2023-2024.

a. **Locally-defined emergent patient safety incidents requiring PSII.** An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.

b. **Locally-predefined patient safety incidents requiring investigation.** Key patient safety incidents for PSII have been identified by this organisation (through analysis of local data and intelligence from the past three years), and agreed with the commissioning organisation(s) as a local priority in line with the following guidance:

- **Criteria for selection of incidents for PSII:**

  a. Actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)
  b. Likelihood of recurrence (including scale, scope and spread)
  c. Potential for learning in terms of:

     – Enhanced knowledge and understanding
     – Improved efficiency and effectiveness (control potential)

– Opportunity for influence on wider systems improvement.

For the period 2023- 2024 local priorities for PSII have been agreed as follows:-

	Incident type	Specialty	Quantity
1	Deteriorating patient with identified omissions of care causing actual impact of 4 severe or 5 death	Trust Wide	1
2	Delayed diagnosis where procedures were not undertaken / delayed causing actual impact of 4 severe or 5 death	Trust Wide	1
3	Delayed diagnosis where results were not acted upon causing actual impact of 4 severe or 5 death	Trust Wide	1
4	Omissions of critical medications causing actual impact of 4 severe or 5 death	Trust Wide	1
5	Unplanned maternal readmissions causing actual impact of 4 severe or 5 death	Obstetrics	1

4.7 Thematic analysis following the completion of a small number individual investigations of similar patient safety incidents

4.7.1 A valuable and thorough way of accomplishing thematic analysis is to select a few (three to six) recent and very similar incidents and **investigate each individually** with skill and rigour to determine the interconnected contributory and causal factors.

4.7.2 The findings from each individual investigation are then collated, compared and contrasted to identify common **causal factors** and any common interconnections or associations upon which effective improvements can be designed.

4.7.3 Importantly, investigation of recent incidents allows more accurate information gathering from properly specified, good quality PSIIs, and detailed analysis of the system as it currently stands.

4.8 Patient safety improvement plans underway

4.8.1 The findings from incident reviews, PSIIs or other related activities must be translated into effective and sustainable action that reduces the risk to patients. For this to happen, organisations must be able to apply knowledge of the science of patient safety and improvement to identify:

- where improvements are needed
- what changes need to be made
- how changes will be implemented
- how to determine if those changes have the desired impact (and if they do not, how they could be adapted).

4.8.2 The Trust has developed a Safety Action Development Tool, based on a nationally recognised template to ensure staff have a mechanism to use to embed and sustain improvement.

4.8.3 A number of quality improvement initiatives and projects, as well as locally designed patient safety improvement plans are underway across the Trust.

4.8.4 The table below details an overview of the Trust's programmes, projects and quality improvement plans

	National patient safety incident improvement plan / scheme title	**Specialty**	**Monitoring Committee / Group**
1	LoCSSIPs / NaTSIPs	Trust Wide	Clinical Effectiveness Working Group
2	Sepsis compliance	Trust Wide	Sepsis Group / Patient Safety Group

	Local patient safety incident improvement plan / scheme title	Specialty	Monitoring Committee / Group
3	Hospital acquired pressure ulcers	Trust Wide	Tissue Viability Steering Group
4	Diabetes / Insulin safety	Trust Wide	Medicines Optimisation Steering Group
5	Failure / delay to administration	Trust Wide	Medicines Optimisation Steering Group
6	Oxygen Prescription	Trust Wide	Medicines Optimisation Steering Group
7	Anticoagulation Prescription	Trust Wide	Medicines Optimisation Steering Group
8	Antibiotics Prescription and Review	Trust Wide	Medicines Optimisation Steering Group
9	Increase of Incident Reporting	Trust Wide	Risk Management Panel
10	Inpatient falls	Trust Wide	Falls Steering Group
11	NG Tube insertion and management	Trust Wide	Nutritional Steering Group
12	Discharge Planning / Patient Flow	Trust Wide	-
13	Induction of Labour	Obstetrics	-
14	Time to Triage	Obstetrics	-

5. Selection of incidents for review

5.1 Some patient safety incidents will not require PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff.

5.2 A clear distinction is made between the activity, aims and outputs from reviews and those from PSIIs.

5.3 Different review techniques can be adopted, depending on the intended aim and required outcome. The most commonly used are:

Technique	Method	When?
After Action Review	Incident recovery	An AAR should be used at any point where there has been an unexpected outcome – whether it is positive or negative. It is usually focused on task-based events during a project
'Being open' conversations	Open disclosure	A Being Open Conversation should be used for incidents that are prevented ('near miss') or no harm. Consideration should be given to local circumstances and what is in the best interest of the patient.
Case record/note review	Clinical documentation review	Clinical record reviews are recommended for the following: • Complaints made by the patient and/or their relatives • Specific serious incident(s) and/or aspects organisational care • Concerns raised by colleagues and or members of the wider medical team.
Hot debrief	Debriefing	Hot debriefing is a form of debriefing which takes place 'there and then' following a clinical event. Hot debriefing has the advantage of earlier intervention, improved participation and improved recall of events.
Safety huddle	Briefing	Immediately after an incident, staff visit the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. Safety huddles enable insights and reflections to be quickly sought and generate prompt learning
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.

Technique	Method	When?
Thematic review	Team review	Useful in understanding common links, themes or issues within a cluster of investigations or incidents. It will seek to understand key barriers or facilitators to safety using incidents
Link Analysis	Team Review	Link analysis can be used to highlight the frequently used paths taken in an environment and those that are critical for safety. This can inform the design of a healthcare environment by co-locating those items or areas used to complete the most frequent tasks.
Observation	Specialist review	To reduce risk we must understand how work is actually performed, rather than what is documented in training, procedures or equipment operating manuals (work as prescribed), how we imagine work is conducted (work as imagined) or how people tell us work is performed (work as described)
Mortality / MDT review	Specialist Review	Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each death.
Transaction audit	Audit	To check a trail of activity through a department, etc, from input to output. This could include: • Tracking patient pathway from admission to discharge • Tracking a process i.e. receiving medication / stock onto a ward • Tracking receipt and distribution of equipment i.e. oxygen cylinders
Process audit	Audit	To Process audits look at specific processes, activities or functions performed by Ward or Department. i.e. a process audit can be used to look at practice following a medication error or none adherence with a LoCSSIP.
Outcome audit	Audit	Outcomes are the end results of care; the changes in the patients' health status and can be attributed to delivery of health care services. Outcome audits determine what results if any occurred as result of specific intervention. These audits assume the outcome accurately and demonstrate the quality of care that was provided. Example of outcomes traditionally used to measure quality

Technique	Method	When?
		of hospital care include mortality, its morbidity, and length of hospital stay.
Clinical audit	Outcome audit	A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes.
Walkthrough Analysis	Proactive hazard identification and risk analysis	To determine the likelihood of an identified risk and its potential severity (eg clinical, safety, business).

6. Patient Safety Incident reporting arrangements

6.1 The reporting of all incidents is essential so that, when things go wrong or could have gone wrong, we can learn and take action to reduce the risk of harm to patients and staff, and improve the quality of our services.

Notifying others and recording and sharing relevant information are crucial to an effective and co-ordinated response to patient safety incidents. The following must happen as soon as possible:

- All members of staff must report (or ensure that a colleague has reported) all incidents in which they are involved or become aware of.

- Staff who identified the incident should also inform their Line Managers and the Divisional Quality & Safety Manager team so they can: –

    - Ensure clinical staff involved in or responsible for the patient's care are given relevant information
    - Liaise with Corporate Clinical Governance who will inform other care providers who need to know about the incident, particularly of any implications for care and how they can support patients and families emotionally and practically as required
    - Liaise with Corporate Clinical Governance to inform other healthcare providers and commissioners where a cross-system response may be required.

- The Quality, Safety & Compliance Department and Divisional Management Teams will liaise to ensure internal and external notification and recording procedures are followed. Communication channels may also need to be established between providers and relevant regulatory and/or oversight bodies to ensure a co-ordinated response to the incident.

- A clear record of what happened should be documented in the patient's clinical record and the organisation's local risk management system, Datix. (This should be a factual account based on what is known at the time. Records should then be updated as required.)

- Information (such as staff accounts of what happened) and physical evidence (such as equipment, pictures of the area) likely to be useful in any subsequent review or PSII should be obtained and stored securely.
- Incidents subject to a PSII (selected as per the organisation's patient safety incident response plan; PSIRP) should be reported to the Strategic Executive Information System (StEIS and its successor when this becomes available).

7. Mechanisms to develop and support improvements following PSIIs

The national and local mechanisms to develop and support improvements are:

- Sharing the knowledge gained from activities associated with patient safety incident management – the 'lessons learned' – of itself may not achieve the desired outcome: that is, a lower risk of the same incident happening again or its prevention.
- The importance of being clear about what has been learned and how 'lessons' in the form of proposed improvements/solutions should be tested to see if they achieve the intended change and improvement.
- There are multiple opportunities through the incident management process to extract and share information, and this information can be used in different ways to support safety improvement. Information can be used at a team, department, organisation or system level to identify the most commonly reported incident types and insight about the nature of these incidents; triangulation with information from other sources (eg complaints, claims and coroner inquests) can provide further insight into the level of risk and potential opportunity for improvement.
- The Trust will be reporting themes and trends from all modules of Datix including incident reporting data with 'curiosity' and to use the intelligence it provides to identify the areas in most need of improvement. The Quality & Safety Oversight Group and Risk Management Panel will be receiving this data and establishing work flows for service improvement, monitoring progress of these projects until completion.

Implementing improvements/solutions to prevent harm and monitor impact

Once a PSII has been finalised, recommendations can be formulated and actions developed to reduce the risk of an incident happening again by addressing the key underlying causal factors. This is where the improvement journey starts.

People with relevant skills, experience and time to design and support technical aspects of improvement efforts are required, led by those skilled in supporting these efforts. The Learning Group will support the service improvement projects as well as member of the Quality and Safety team.

Measurement is fundamental to any improvement programme. Without it, organisations may invest time and effort implementing changes that have little or no impact or, in the worst case, increase the risk of further harm. From the start those responsible for implementing

improvements/solutions must establish procedures to monitor actions and determine whether they are having the desired effect. Both outcome and process measures should be used to interpret the impact of actions and to inform how actions should be adapted if they fail to have the desired effect.

Organisational escalation processes must be developed to manage situations where resources are insufficient to robustly implement actions or influence improvement, eg where an investment in technology or a widespread/systemic change may be the better option.

8. Evaluating and monitoring outcomes of PSIIs, Reviews

8.1 Robust findings from PSIIs and reviews provide key insights and learning opportunities, but they are not the end of the story.

8.2 Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

8.3 Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents.

8.4 Reports to the QSOG and QGC will be monthly and will include aggregated data on:

- Patient safety incident reporting
- Audit and review findings
- Findings from PSIIS
- Progress against the PSIRP
- Results from monitoring of improvement plans from an implementation and an efficacy point of view. Service Improvement plans will be monitored as an agenda item through the Trust Lead groups, eg Trust Falls Group, Tissue Viability Group and the Risk Management Panel
- Results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- Results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents.

9. Complaints and appeals

9.1 Local and national arrangements for complaints and appeals relating to the organisation's response to patient safety incidents are:

The Trust fully upholds the NHS Constitution, aspiring to put the patient at the heart of everything it does. It also aims to deliver first-class complaint handling to all complainants.

The Trust has taken these recommendations on board and wants to make sure that it is easy for anyone to make a complaint. The Trust also wants it to be easy for anyone to give feedback about how improvements can be made and to feel confident that making a complaint will not affect the care/service they receive. Complaints will be treated positively and, where possible, leave the person raising the complaint feeling satisfied with the way their complaint has been handled and confident that the Trust has learned from their experience.

The level and nature of complaints received by the Trust are important indicators of the Trust's performance and the quality of service it is providing. Listening and learning from feedback and complaints can help the Trust to deliver real improvements in quality of service and safe care. The Trust Concerns and Complaints Handling – Trust Policy and Procedure takes on board all changes and good practice regarding complaints handling which is available on Net-i.

The purpose of the policy is to: -

- Offer an open, honest, equitable and fair system, accessible to people who are dissatisfied with the service received from the Trust
- Provide staff with a framework to enable the Trust to comply with the NHS Constitution, Complaints Regulations and good practice standards
- Help people using the Trust's services, their relatives and carers and the general public to understand how the Trust handles complaints and concerns
- Ensure the concerns and complaints system is accessible and inclusive to all communities, that reasonable adjustments are made for people with disabilities and for those whose first language is other than English
- To ensure that the concerns and complaints service offered by the Trust is consistent with all relevant legislation and best practice guidance

- To ensure that complaints and concerns are analysed effectively to provide high quality information indicating Trust achievement of CARE values including dignity and compassion to patients and relatives

The policy applies to all groups of staff and anyone using the Trust's services. Anyone who uses the Trust's services may complain, including:

- The patient
- Someone acting on behalf of the patient, and with their written consent (e.g. an advocate, relative, carer, or Member of Parliament)
- Parents or legal guardians of children
- Someone acting on behalf of a patient who is unable to represent his or her own interests, provided this does not conflict with the patient's right to confidentiality, or a previously expressed wish of the patient

The **objective** of this policy is to make sure that when people are dissatisfied they are able to express concerns about the services and/or facilities provided by the Trust:

The Trust has three key objectives for handling complaints:

- To ensure complainants are satisfied that their complaint has been listened to and action has been taken if necessary
- To ensure that we learn from mistakes
- To ensure that the complaints process is timely, efficient and effective

The complainant can expect to:

- Receive an acknowledgement within two working days
- Be treated fairly with respect and courtesy and kept informed
- Have their complaint investigated and receive a true and factual response
- Be informed of independent support available through advocacy services
- Receive an apology where appropriate and be informed of any learning outcomes, actions/changes in service to improve the patient experience
- Be signposted to the PHSO to request an independent review of their complaint if they remain dissatisfied with the trust's response

Patient Safety Incident Response Plan

Purpose: This patient safety incident response plan (PSIRP) sets out how the University Hospitals of North Midlands NHS Trust will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide.

Local Situational Analysis:
In the last 3 years, more than 59,000 patient safety incidents have been reported in UHNM with <0.7% of these being investigated as a Serious Incident as per the Serious Incident Framework.
A key part of implementing the new Patient Safety Incident Response Framework (PSIRF) is to understand the amount of patient safety activity the Trust has undertaken over the last few years. This will ensure that we have the people, systems and processes available to support the new approach.
The patient safety PSIRF related activity undertaken prior to PSIRF was as follows:

	Activity	2020	2021	2022
National Priorities	Incident resulting in death	13	18	25
	Never Event	2	2	7
Local Patient Safety Priorities	Serious Incident requiring investigation	103	115	126
	Patient safety incident reviews	106	116	246
	Patient safety incident validation	18,127	19,994	20,914

A review of the resource and activity associated with the current Serious Incident Framework for the period 2019 to 2023 has been undertaken to determine how many PSIIs can be supported during 2023/2024. This review was carried out alongside the NHS National standards for patient safety investigation to ensure that all future PSIIs are compliant with these standards.

Strategic Plan:
Based on the historic reporting data presented above, it is anticipated that the Trust will undertake up to 30 patient safety incident investigations during the 12 months running October 2023 to September 2024:

- 25 will be 'national priority' patient safety incident investigations
- The Trust will also identify 5 priority areas for "local priority" patient safety incident investigations for the next 12 months.
- All subsequent incidents falling outside each priority area will be reviewed by one an alternate incident response.

PSII Overview: PSIIs are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

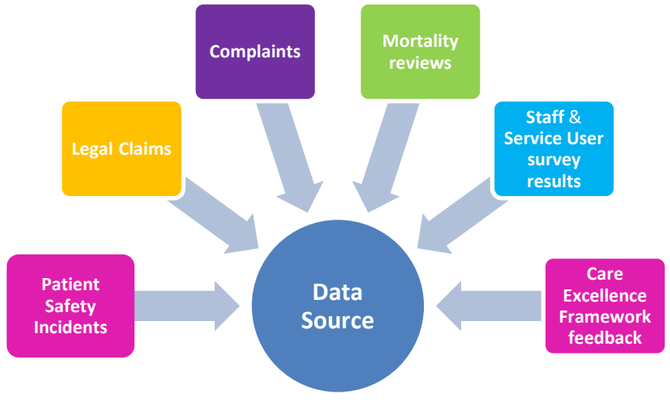
Nationally Defined Priorities to be referred for PSII or review by another team:

- Maternity and neonatal incidents
- Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge
- Child Deaths
- Deaths of persons with learning disabilities
- Safeguarding incidents
- Incidents in screening programmes
- Deaths of patients in custody

Nationally defined incidents requiring PSII:

- Incident that meet the Never Event Criteria
- Incidents that meet the Learning from Death Criteria
- Deaths of persons with mental illness
- Suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.

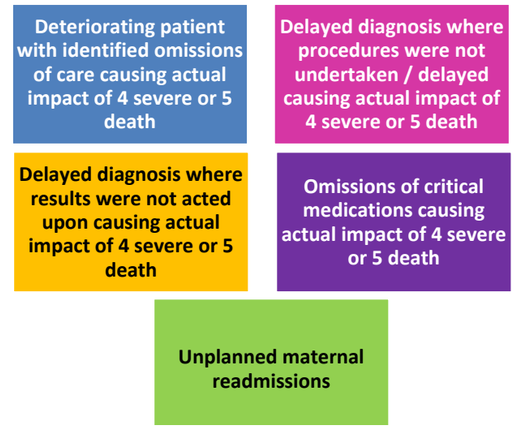
Locally defined incidents requiring PSII:
The patient safety incident risks for this organisation have been profiled using organisational data from the following qualitative & quantitative sources:



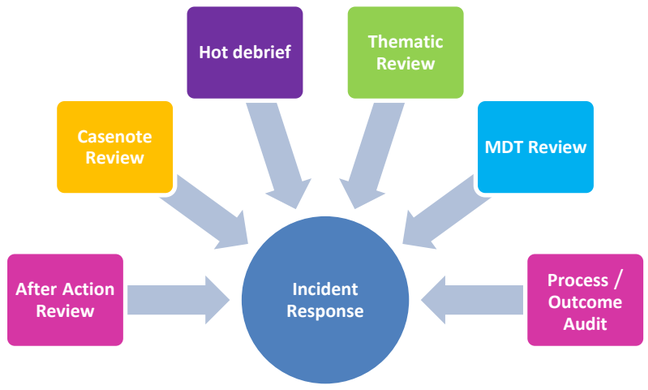
Key patient safety incidents for PSII have been identified by this organisation (through analysis of local data and intelligence from the past3 years in line with the following guidance:

- Actual and potential impact of outcome of the incident
- Likelihood of recurrence Potential for learning in terms

For the period 2023- 2024 local priorities for PSII have been agreed as follows:-



Other patient safety incident responses:



Involving Patients, Relatives and Staff in PSI

Getting involvement right with patient and relatives in how we respond to incidents is crucial, particularly to support improvement.

Patients & Carers → Being Open

The Trust will ensure that it is a safe & fair place to work, where everyone's voice is encouraged, valued and listened to

Staff → Just Culture

Performance and Finance Committee Chair's Highlight Report to Board

26th September 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • The Committee considered the 6 / 8 areas rated as Amber and Red identified within Sustainability and Net Zero Carbon Bi-Annual Report, and noted the actions being taken in respect of these areas and reflected on the potential implications of not achieving the plan • The Committee received the review of the UHNM/SATH Urology Alliance and Expansion of Robotic Operating business case which demonstrated under delivery of prostatectomies but over delivery of nephrectomy and cystectomy. This was due to referrals from SATH being lower than anticipated due to backlogs although these were expected to increase in 2023/24 • The Committee welcomed receipt of the joint system surge plan whereby the main risks related to demand for medical inpatient beds and the gap between capacity and demand with further work being done on the plan for escalation. The Committee robustly discussed the risks, assumptions, fragility of the Local Authority, GP capacity and utilisation and affordability • The challenge in relation to the system financial position was queried and reassurance was provided in relation to the forecast and the ongoing actions being taken to identify mitigation	• Executive consideration to be given as to post-implementation reviews, in particular the review of the Speech Recognition Business Case • To update the overseas nurses business case review with up to date financial figures, updated information in terms of measurable benefits, and an updated sustainability impact assessment • Future sustainability updates to consider the available capital for the identified schemes as well as considering the potential impact if any projects were delayed • A further summary of the Urology Alliance and Expansion of Robotic Operating business case was to be provided to highlight the initial KPIs and what was delivered • To update the Colorectal and General Surgery Capacity - Route to 65 Weeks Business case to reflect the comments made during the meeting, prior to being taken to Trust Board • To provide additional information on the unit costs associated with e-REAF 11241 as well as the additional annual cost for e-REAF 11453 • To provide additional narrative regarding the controls in place to mitigate the risks identified within the surge plan
✓ Positive Assurances to Provide	**Decisions Made**
• The Committee received the review of the overseas nurses business case whereby 131 nurses were recruited, with positive retention rates. The case supported the ability to reduce the number of registered nurse vacancies to 40 by October 2023 • The update in relation to the Trust's trajectory to net zero highlighted the current projects underway to reduce carbon emissions and the progress made against the Green Plan since April 2023	• The Committee agreed to further consider the proposal to extend insourcing in order to address the high volume of upper and lower GI and general surgery patients waiting for surgery, at Octobers Trust Board meeting • The Committee approved eREAFs 11241 (subject to clarification of costs), 11407, 11453 (subject to clarification), 11448, 11515, 11502, 11313, 11529, 1163 and 11568 • It was agreed to consider any questions arising from the Operational Performance Report and Finance Report at the Non-Executive Director's meeting prior to being considered by the Trust Board
Comments on the Effectiveness of the Meeting	
• It was recognised that due to the discussion held on the surge plan as well as considering the business cases and sustainability update, that the Committee were not able to consider the performance and finance report, and it was agreed to discuss these outside of the meeting, prior to discussion at the Trust Board	

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Business Case Review: BC-0448 Overseas Nurses	BAF 1, 2	Ext 16	✓	Assurance	7.	Performance Report – Month 5 2023/24	BAF 1 BAF 5	16 20	-	Assurance
2.	Sustainability and Net Zero Carbon Bi-Annual Report	BAF 7	High 12	! ✓	Assurance	8.	Planned Care Improvement Group Highlight Report	BAF 5	Ext 20	-	Assurance
3.	Business Case Review: BC-0330 UHNM/SATH Urology Alliance and Expansion of Robotic Operating	BAF 5	Ext 20	!	Assurance	9.	Finance Report – Month 5 2023/24	BAF 8	High 9	!	Assurance
4.	Colorectal and General Surgery Capacity - Route to 65 Weeks	BAF 5	Ext 20	-	Approval	10.	Executive Business Intelligence Group Highlight Report	BAF 8	-	-	Assurance
5.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	-	Approval	11.	Executive Groups Terms of Reference	-	-	-	Approval
6.	SSOT System Surge Plan	BAF 1 BAF 5	16 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 S Evans	Interim Chief Operating Officer	PB	KT	KT/OW	KT								
7.	Mrs C Cotton	Associate Director of Corporate Governance		NH	NH	NH		NH						
8.	Mr M Oldham	Chief Finance Officer												
9.	Mrs S Preston	Strategic Director of Finance												
10.	Mrs A Rodwell	Associate Non-Executive Director												
11.	Mr J Tringham	Director of Operational Finance												

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

Transformation and People Committee Chair's Highlight Report to Board

27th September 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate

- The Transformation update highlighted that further work was required on identifying metrics and deliverables for the system and partners priority. However, a separate update on improving population health had been provided which demonstrated the work planned to be undertaken on health inequalities, prevention and UHNM as an anchor institution, with revised target dates identified.
- The cyber security report highlighted that in terms of current cyber security performance, there were 4 critical elements within the yearly penetration test, although two of these would be mitigated by March 2024. In addition, data security and protection training continued to be a challenge with consequences of not completing the training being considered by the Executive Digital and Data Security Protection Group and it was agreed to consider whether the target date could be brought forward to November 2023 given winter pressures
- The update on the strategic workforce plan highlighted progress against the plan and in terms of nursing and midwifery, vacancies were expected to reduce to circa 44 WTE by November 2023. In terms of medical and dental staff it was anticipated that there would be 75 WTE vacancies by year end, with actions being taken to close the gap such as flexible retirement and change in the workforce model.
- Compliance with essential to role training had been identified as an additional watch metric due to being below target

Major Actions Commissioned / Work Underway

- Further clarity to be provided in identifying specific targets and milestones for the clinical strategy, via the Annual Planning process. Future updates would also highlight the linkages with other enabling strategies.
- Future updates to be provided on key transformational projects to provide additional information on progress, deliverables and any areas of risk
- To consider the options to digitise the process for obtaining patient feedback for revalidation
- Further assurance was requested to be provided within the next update of the strategic workforce plan in terms of use of temporary staffing and the areas of highest risk as well as expanding on assurance provided in relation to other areas of the workforce such as non-clinical
- To provide assurance as to whether the revised target dates within the people delivery plan were realistic and achievable
- To include information in relation to emerging technologies within future Digital Strategy updates

✓ Positive Assurances to Provide

- An update was provided on the progress made with the Clinical Strategy, in particular highlighting the changed pathways and investment in both workforce and estate
- The Committee noted that the current adoption of Improving Together tools within trained teams had increased to 44%, following work undertaken by the Quality Improvement team in addition to the introduction of the leadership development forum. Training figures were on trajectory, with a focus being made on clinical leadership
- Progress had been made with the Electronic Prescribing and Medicines Administration Project with User Acceptance Testing being undertaken.
- Positive progress had been made against the clinical areas identified within the system strategic transformation and service change programmes
- The Guardian of Safe Working report did not highlight any issues in relation to missed educational opportunities and more exception reports being completed. Work was ongoing to stress the importance of Consultants needing to support junior doctors in terms of their workload
- No issues were highlighted within the appraisal and revalidation report, although there were 42 deferrals which related to requiring multi-source feedback. Some improvements were required in terms of educational supervision and mentorship in addition to recruiting additional appraisers
- The equality, diversity and inclusion report highlighted the progress made against the seven objectives within the strategy and the steps taken to fulfil the Trust's obligations under the Public Sector Equality Duty. The work in terms of Being Kind and the increase in colleagues in senior roles with protected characteristics were particularly highlighted.
- The Chief People Officer report highlighted a slight decrease in engagement score for the month, although this demonstrated an overall upward trend. There continue to be an improvement in turnover as well as positive progress in reducing vacancies

Decisions Made

- The Committee approved the recommendations within the appraisal and revalidation report which was to be considered by the Trust Board
- The Committee approved the Terms of Reference for the respective Executive Groups

Comments on the Effectiveness of the Meeting

- Members recognised the quality of papers provided and felt a positive meeting was held, with good levels of engagement and constructive challenge

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Clinical Strategy Progress Report	BAF 5	Ext 20	✓	Approval	8.	Guardian of Safe Working Report Q1	BAF 2	High 12	✓	Assurance
2.	Transformation Programme Update	BAF 4	Ext 20	!	Assurance	9.	Appraisal & Revalidation Annual Report	BAF 3	High 12	✓	Approval
3.	Improving Together Countermeasure Summary	-		✓	Assurance	10.	Equality, Diversity & Inclusion Annual Report 2022-23	BAF 3	High 12	✓	Assurance
4.	Cyber Security Assurance Report	BAF 6	Ext 16	!	Assurance	11.	Strategic Workforce Plan - Progress	BAF 2	Ext 16	!	Assurance
5.	Executive Digital and Data Security & Protection Group Highlight Report	BAF 6	Ext 16	! ✓	Assurance	12.	Chief People Officer Report M5 & M6	BAF 2/3	Ext 16 High 12	! ✓	Assurance
6.	Improving Population Health A3 Strategic Priority Update	BAF 4	Ext 20	!	Assurance	13.	Executive Groups Terms of Reference	-		-	Approval
7.	ICS Transformation Update	BAF 4	Ext 20	✓	Assurance						

3. 2022 / 23 Attendance Matrix

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

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th October 2023
Report Title:	2023 Workforce Disability Equality Standard Report and Action Plan	**Agenda Item:**	12
Author:	OD, Culture & Inclusion Business Partner		
Executive Lead:	Chief People Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

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

Executive Summary:

Situation The Workforce Disability Equality Standard (WDES) is mandated through the NHS Contract. The WDES is a set of 10 specific metrics that enable NHS organisations to compare the workplace and career experiences of Disabled staff compared to their non-disabled colleagues, using the information to develop and publish an action plan. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality. The ambition of the WDES is to increase the representation of Disabled people in the NHS workforce and see the disparities between Disabled and non-disabled staff reduce year on year; supported by an inclusive culture, through the realisation of the vision set out in the NHS People Promise.

The assurance questions this paper is seeking to respond to are set out below:

- Do the disability equality actions and work programmes being delivered help us to deliver a sustainable workforce at the required levels reducing the burden on premium costs? (BAF2 : Sustainable Workforce)
- Do the disability equality actions and work programmes being delivered help us to improve the culture of the organisation to make UHNM a place where all staff are treated with respect and have the opportunity to build a fulfilling career? (BAF3 : Leadership, Culture and Delivery of Values/Aspirations)
- Are the actions and work programmes delivering a positive impact in order to reduce the Risks as set out in the Board Assurance Framework?

Background National evidence tells us that:

- Disabled job applicants are less likely to be appointed through shortlisting
- Are more likely to go through performance management capability processes
- Are more likely to experience harassment, bullying or abuse
- Are less likely to feel that they have equal opportunities for career progress or promotion
- Are more likely to feel pressured to attend work when feeling unwell
- Are less likely to feel valued for their contribution to the organisation and less likely to feel engaged
- Disabled people also continue to be under represented in middle to senior pay bands and boards

Assessment

This is the 5th year of reporting the WDES and there has been positive improvement in the majority of metrics including:

- 0.9% increase in disability representation across the organisation as recorded on ESR
- Improvement of 0.08 in the likelihood metric of applicants with a disability being appointed from shortlisting compared to applicants without a disability
- 2.5% reduction in the percentage of colleagues with a disability reporting experience of bullying, harassment or abuse from managers
- Improvement of 4.4%, and better than the peer average percentage of colleagues that stated that the last time they experienced bullying, harassment or abuse that they reported it
- Improvement of 3.5% in the percentage of colleagues with a disability that believe that the Trust offers equal opportunities for career progression or promotion, which is also better than the peer average
- 0.5% improvement in colleagues with a disability reporting feeling pressured by their manager to come into work, despite not feeling well enough to perform their duties
- 2% increase in the percentage of colleagues with a disability who are satisfied with the extent to which the organisation values their work
- An improvement in disability board representation and better than the WDES national average
- No change in the staff engagement score

The differential between the experiences of colleagues with a Disability and those without has also narrowed for the majority of metrics.

Metrics that have deteriorated are:

- 0.8% increase in the percentage of colleagues with a disability reporting experiencing harassment, bullying or abuse from patients/service users, their relatives or the public. This figure has also deteriorated for colleagues without a disability, which as increased by 4.1%.
- 0.5% increase in the percentage of colleagues experiencing harassment, bullying or abuse from other colleagues. This metric has also deteriorated for colleagues without a disability, which increased by 1.4%
- 6.5% deterioration in the percentage of disabled colleagues who reported that the organisation put reasonable adjustments in place to enable them to carry out their work

We have identified a number of actions, informed by our Disability and Long Term Conditions Staff Network that we will focus on during 2023-24:

1. Formally launch the reasonable adjustments procedure with the aim of increasing knowledge of the importance of equity and meeting individual needs
2. Continued focus on our Being Kind approach
3. Spotlight Neurodiversity in the workplace
4. Continue to grow the membership, influence and empowerment of the Disability & Long Term Conditions Staff Network
5. Review the Trust Sickness Absence Management Policy and the Capability Policy

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

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

Our September 2023 Disability & Long Term Conditions Staff Network meeting will be a workshop about how the Network can assist the organisation in the delivery of the action plan. Progress will be measured by improved metric results in the 2023 Staff Survey, 2024 WDES submission, divisional EDI dashboards and the monitoring of other relevant metrics including the lived experiences of our Disability and Long Term Conditions staff network membership.

Key Recommendations:

This report and action plan has been presented at Executive Workforce Assurance Group and Transformation and People Committee. Trust Board is asked to review this report and the associated action plan, which identifies actions against each metric to improve the workplace experiences of our disabled colleagues and reduce the disparity between those that have a disability or long term condition and those that do not.

Workforce Disability Equality Standard (WDES)
2023 Report

1. Introduction

The Workforce Disability Equality Standard (WDES) is an evidence-based standard that aims to help improve the experiences of Disabled staff in the NHS. The ten WDES metrics enable NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff. The WDES is mandated for provider trusts by the NHS Standard Contract. Provider trusts are required to publish a WDES annual report, which contains:

- A report that sets out the organisation's data for each metric
- A WDES action plan, which should set out how they will address the differences highlighted by each of the metrics data in the forthcoming 12 months
- A narrative on what progress has been made in delivering the objectives detailed in their WDES action plan.

The purpose of the WDES is to improve the workplace and career experiences of Disabled people working in and seeking employment in the NHS. The WDES Data Analysis Report provides key findings highlighting inequalities between the experiences of Disabled and non-disabled staff across all 10 metrics. This demonstrates the case for trusts to continue in 2023 to take urgent action to create an inclusive and diverse leadership; reduce bullying and harassment; improve recruitment of a diverse workforce; and improve the retention of Disabled staff.

The WDES will help foster a better understanding of the issues faced by Disabled staff and the inequalities they experience compared to non-disabled colleagues. Trusts will be able to look at key areas highlighted by their metrics data and will enable them to compare performance on a national, regional, trust type and size basis. The WDES will aid trusts to consider Disabled staff representation at all levels throughout the organisation and identify any barriers that stand in the way of career progression.

2. WDES Metrics and UHNM Performance

The WDES comprises of 10 Metrics that incorporate data from the following primary sources: the NHS Electronic Staff Record (ESR), the NHS Staff Survey and local HR and recruitment systems. Six of the WDES metrics are drawn from the national NHS Annual Staff Survey. The UHNM response rate for the 2022 staff survey was 33.2% with 24.3% of respondents (888 people) stating that they had a physical or mental health condition or illness lasting or expected to last 12 months or more. This compares to the peer average of 22.9%.

Metric1: Percentage of Disabled staff compared with the wider organisation

In last year's WDES Action Plan, we set ourselves an organisation-wide target of disability declaration. In line with the national recommendation that this should be at least 4% in 2022 and in the longer term, be closer to 20% (the proportion of staff that have declared a disability or long-term condition in the NHS Staff Survey). We are currently at 3.7% of our workforce sharing that they have a disability on ESR, and this is an improvement from last year's position of 2.8%.

The WDES presents workforce data in 4 Agenda for Change clusters, and Medical & Dental professional group. The percentage of employees with a disability has increased in all clinical and non-clinical pay clusters compared to the previous year with a reduction in the number of disability unknown status.

Pay Cluster	Disabled Headcount	Disabled %	Non-disabled Headcount	Non-disabled %	Unknown Headcount	Unknown %	Total
AfC Bands 1 (& under) 2,3 & 4	235	4.8%	3,560	72.8%	1,096	22.4%	4,891
AfC Bands 5,6 & 7	159	3.2%	3,645	74.2%	1,106	22.5%	4,910
AfC Bands 8a and 8b	22	4.2%	375	70.8%	132	25.0%	529
AfC Bands 8c, 8d, 9 and VSM	3	3.8%	58	72.5%	19	23.7%	80
Medical & Dental	14	1%	1,110	79.6%	271	19.4%	1,395
Totals	**433**	**3.7%**	**8,748**	**74.1%**	**2,624**	**22.2%**	**11,805**

UHNM uses recruitment monitoring and the ESR system to capture and record employee disability status. The Trust regularly encourages our workforce to update their ESR record and the number of records where colleagues have not disclosed their disability status has improved from 41% in 2020 to 22% at 31st March 2023. Nationally it is recognised that there is a significant under reporting across the country of the numbers of staff who disclose a disability on ESR, compared to those sharing this information when completing the anonymous NHS Staff Survey.

Positively, the percentage of UHNM colleagues that have declared their disability status on ESR has continued to improve year on year, with 77.8% of employees sharing their status compared to 59% in 2020. The percentage of staff that have shared they have a disability has increased from 2.8% last year to 3.7% (representing an additional 114 staff). Nationally, across England 3.7% of the NHS workforce is recorded as having a disability.

Disability Status	Headcount	%
Disabled	433	3.7
Not Disabled	8,748	74.1
Unknown	2,624	22.2
Total	**11,805**	**100%**

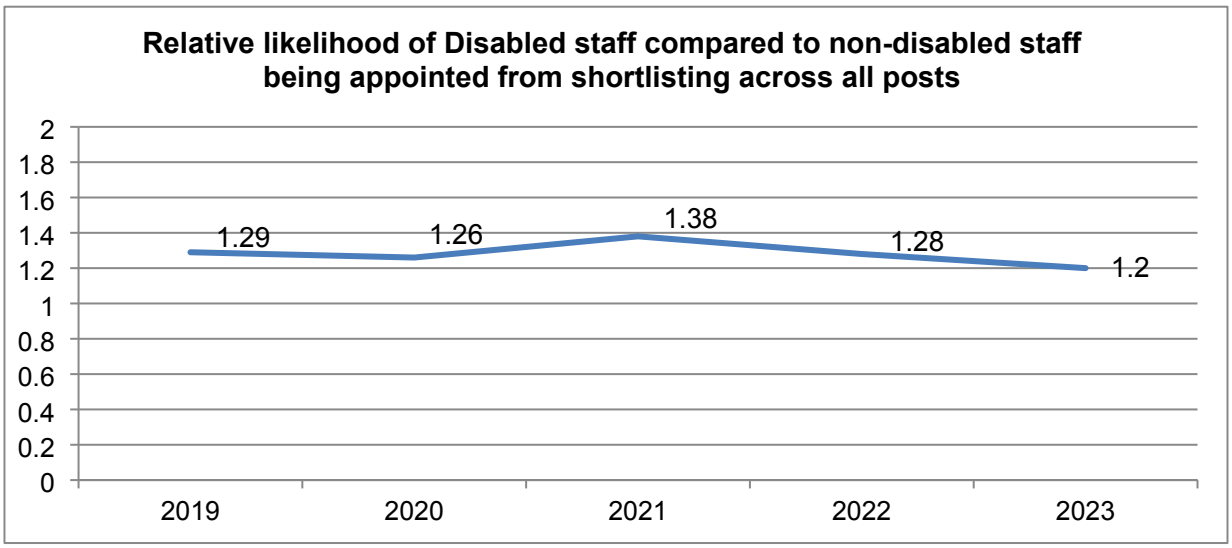
6.4% of non-clinical and 3.2% of the clinical workforce (excluding Medical and Dental) have declared a disability on ESR. This compares to the most recent national picture of 4.3% of non-clinical and 3.9% of clinical staff in 2019. Nationally it is recognised that Medical and Dental staff are less likely to declare a disability (1.1 %) compared to other clinical and non-clinical staff, and this is reflected at UHNM.

Staff Group	Disabled %
Non-clinical	6.4%
Clinical (excluding Medical & Dental)	3.2%
Medical & Dental	1%

The following table lists the health conditions declared on ESR:

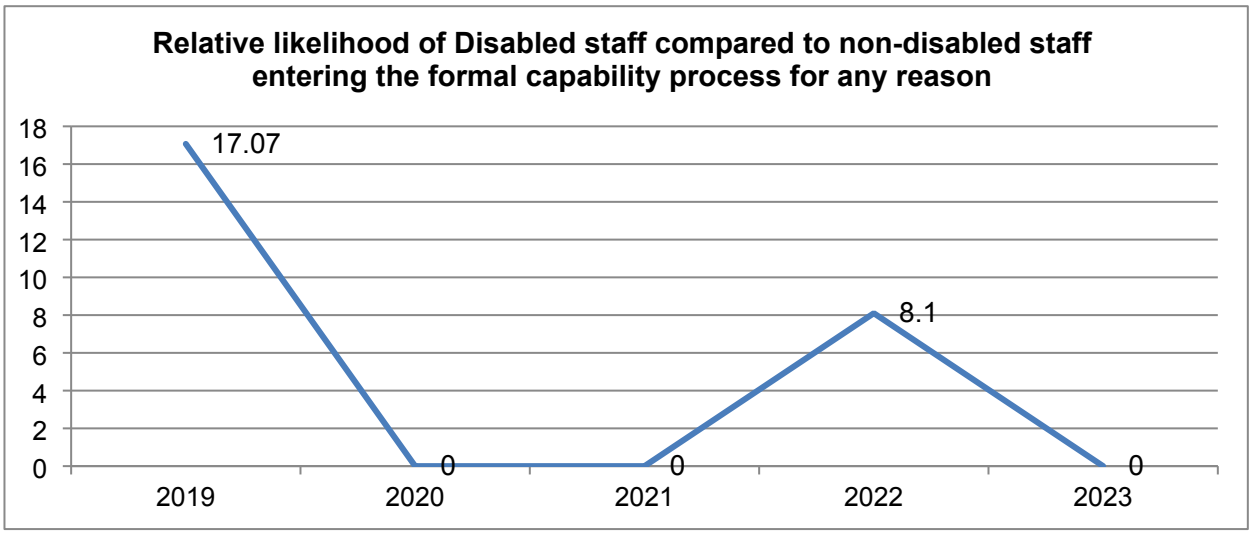
Disability Category	Headcount		
Learning disability/difficulty	107	Physical Impairment	46
Long-standing illness	142	Sensory Impairment	44
Mental Health Condition	48	Other	46

Metric 2: Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts



Analysis of recruitment activity recorded on the TRAC recruitment system shows that non-disabled applicants are 1.2 times more likely to be appointed from shortlisting compared to Disabled applicants (a metric of 1.0 represents equal likelihood of disabled and non-disabled applicants being appointed from shortlisting). A continued downward (positive) trajectory in our recruitment data compares with the most recent national average metric from 2021, which was 1.11.

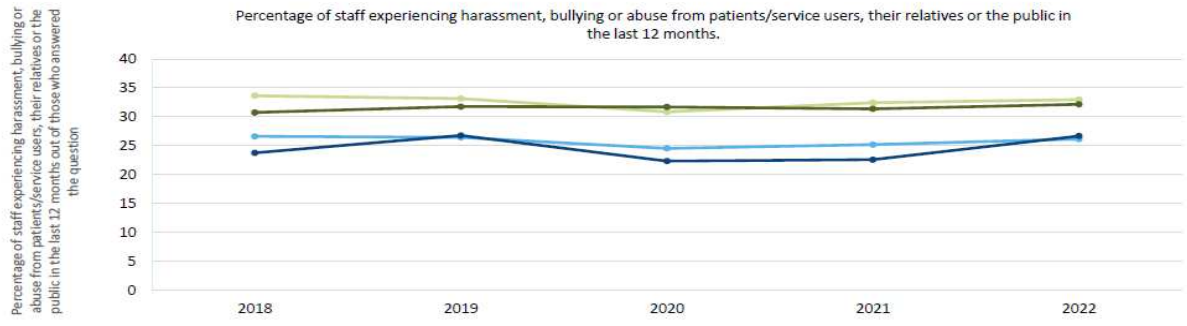
Metric 3: Relative likelihood of Disabled staff compared to non-disabled staff entering into the formal capability process



This metric is based on data from a two year rolling average of the current year and the previous year of entry into a formal capability process as recorded on the HR Case Tracker. From 2022 this metric is related to entry into the formal capability process for all reasons (previously the metric measured entry into the capability process due to performance issues only). Our Capability Policy is designed to be supportive and encouraging to enable our employees to reach the desired performance level through informal processes and hence very small numbers of staff enter the formal stage of the Policy.

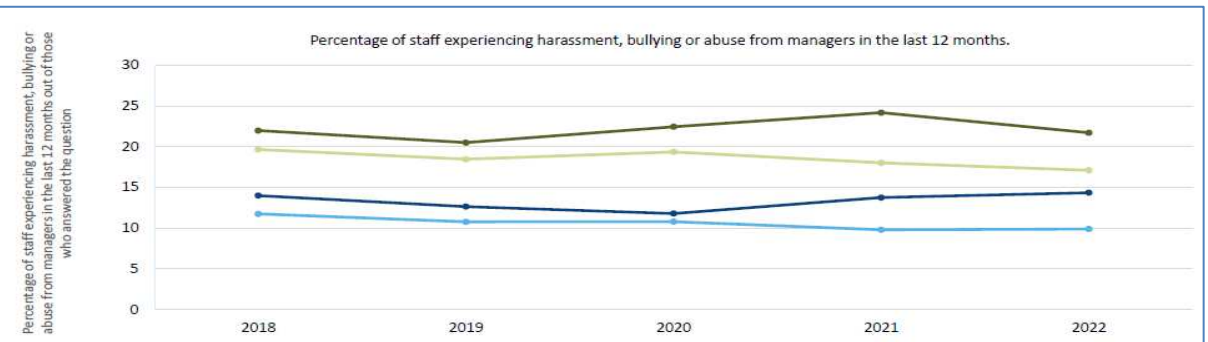
Our data for the last two years tells us that on average only 2 disabled colleagues have entered the formal capability procedure compared to 23 non-disabled colleagues, and 13.5 colleagues with unknown disability status. This result gives a relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff score of 0.0.

Metric 4a: Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months



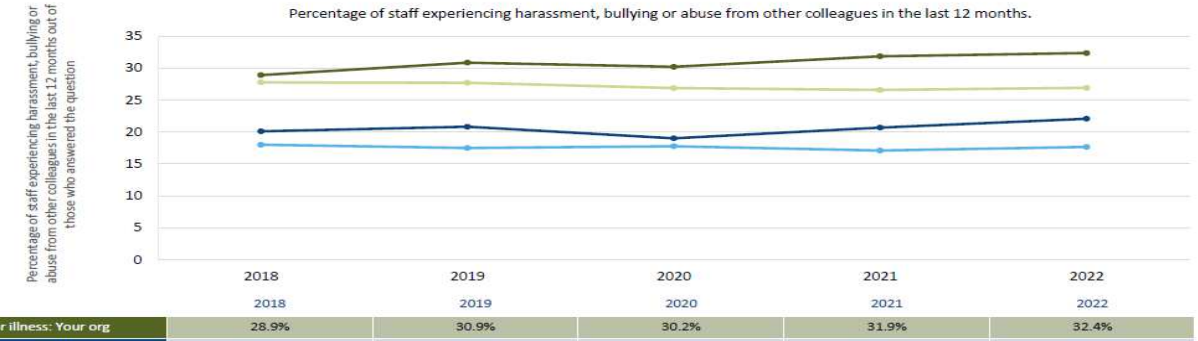
	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	30.7%	31.8%	31.7%	31.4%	32.2%
Staff without a LTC or illness: Your org	23.8%	26.8%	22.3%	22.6%	26.7%
Staff with a LTC or illness: Average	33.6%	33.2%	30.9%	32.4%	33.0%
Staff without a LTC or illness: Average	26.6%	26.5%	24.5%	25.2%	26.2%
Staff with a LTC or illness: Responses	735	853	883	1055	883
Staff without a LTC or illness: Responses	3228	3527	3434	3291	2751

Metric 4a: Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months



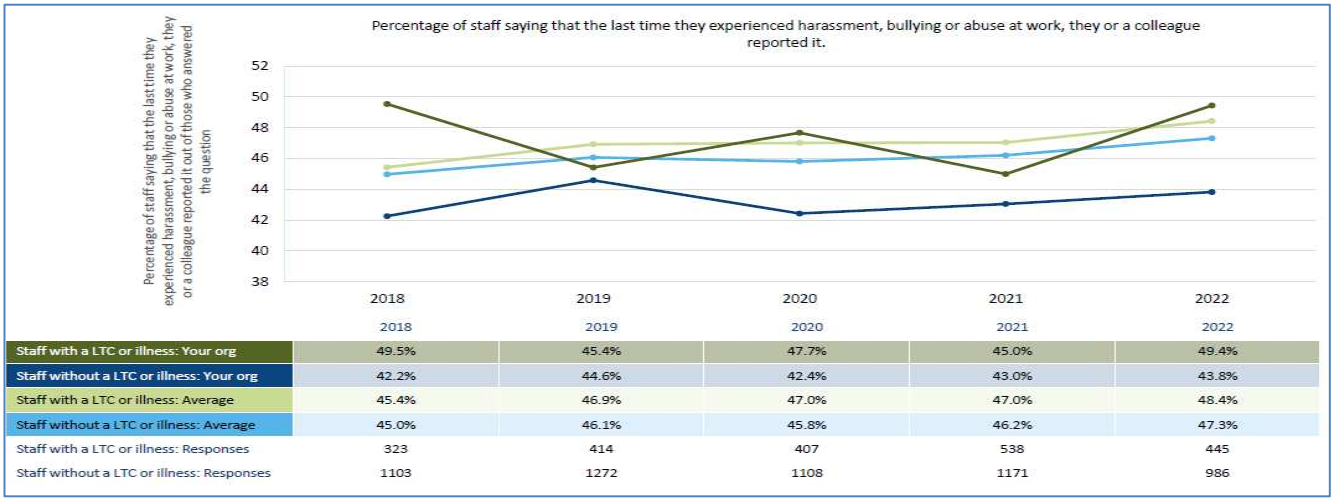
	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	22.0%	20.5%	22.4%	24.2%	21.7%
Staff without a LTC or illness: Your org	14.0%	12.6%	11.8%	13.7%	14.3%
Staff with a LTC or illness: Average	19.6%	18.4%	19.3%	18.0%	17.1%
Staff without a LTC or illness: Average	11.7%	10.8%	10.8%	9.8%	9.9%
Staff with a LTC or illness: Responses	724	854	878	1051	871
Staff without a LTC or illness: Responses	3177	3515	3421	3275	2734

Metric 4a: Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	28.9%	30.9%	30.2%	31.9%	32.4%
Staff without a LTC or illness: Your org	20.1%	20.8%	19.0%	20.7%	22.1%
Staff with a LTC or illness: Average	27.8%	27.7%	26.9%	26.6%	26.9%
Staff without a LTC or illness: Average	18.0%	17.5%	17.8%	17.1%	17.7%
Staff with a LTC or illness: Responses	719	855	880	1051	880
Staff without a LTC or illness: Responses	3171	3523	3416	3270	2716

Metric 4b: Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	49.5%	45.4%	47.7%	45.0%	49.4%
Staff without a LTC or illness: Your org	42.2%	44.6%	42.4%	43.0%	43.8%
Staff with a LTC or illness: Average	45.4%	46.9%	47.0%	47.0%	48.4%
Staff without a LTC or illness: Average	45.0%	46.1%	45.8%	46.2%	47.3%
Staff with a LTC or illness: Responses	323	414	407	538	445
Staff without a LTC or illness: Responses	1103	1272	1108	1171	986

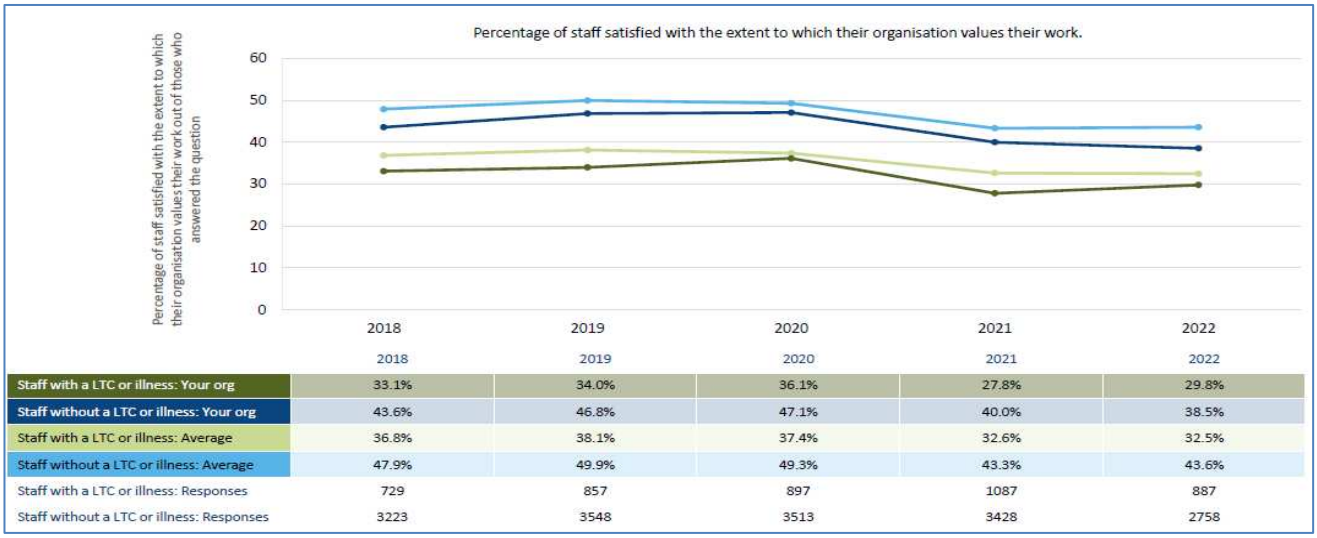
Metric 5: Percentage of staff who believe that the organisation provides equal opportunities for career progression or promotion

	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	50.9%	53.5%	54.9%	48.2%	51.7%
Staff without a LTC or illness: Your org	57.2%	58.8%	60.8%	57.4%	57.0%
Staff with a LTC or illness: Average	51.3%	51.9%	51.6%	51.4%	51.4%
Staff without a LTC or illness: Average	57.4%	58.4%	57.4%	56.8%	57.3%
Staff with a LTC or illness: Responses	731	854	894	1075	882
Staff without a LTC or illness: Responses	3220	3533	3489	3393	2730

Metric 6: Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

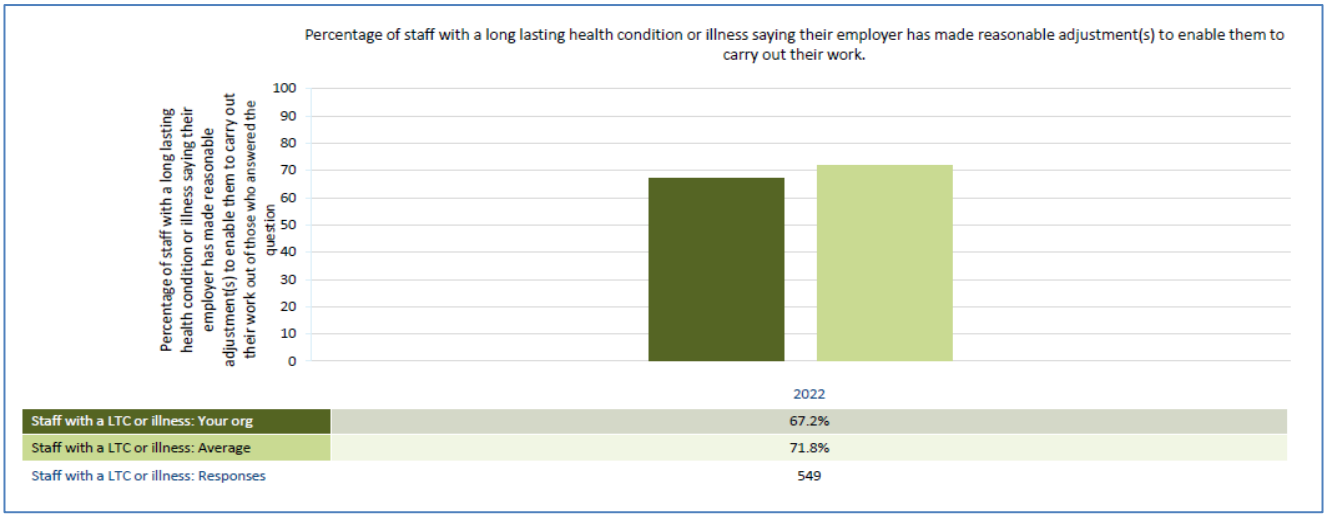
	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	38.9%	34.7%	36.9%	35.8%	35.3%
Staff without a LTC or illness: Your org	28.3%	25.7%	22.9%	26.0%	24.0%
Staff with a LTC or illness: Average	33.3%	32.7%	33.0%	32.2%	30.0%
Staff without a LTC or illness: Average	22.8%	21.8%	23.4%	23.7%	20.8%
Staff with a LTC or illness: Responses	576	659	615	800	645
Staff without a LTC or illness: Responses	1756	1902	1517	1664	1422

Metric 7: Percentage of staff satisfied with the extent to which the organisation values their work



	2018	2019	2020	2021	2022
Staff with a LTC or illness: Your org	33.1%	34.0%	36.1%	27.8%	29.8%
Staff without a LTC or illness: Your org	43.6%	46.8%	47.1%	40.0%	38.5%
Staff with a LTC or illness: Average	36.8%	38.1%	37.4%	32.6%	32.5%
Staff without a LTC or illness: Average	47.9%	49.9%	49.3%	43.3%	43.6%
Staff with a LTC or illness: Responses	729	857	897	1087	887
Staff without a LTC or illness: Responses	3223	3548	3513	3428	2758

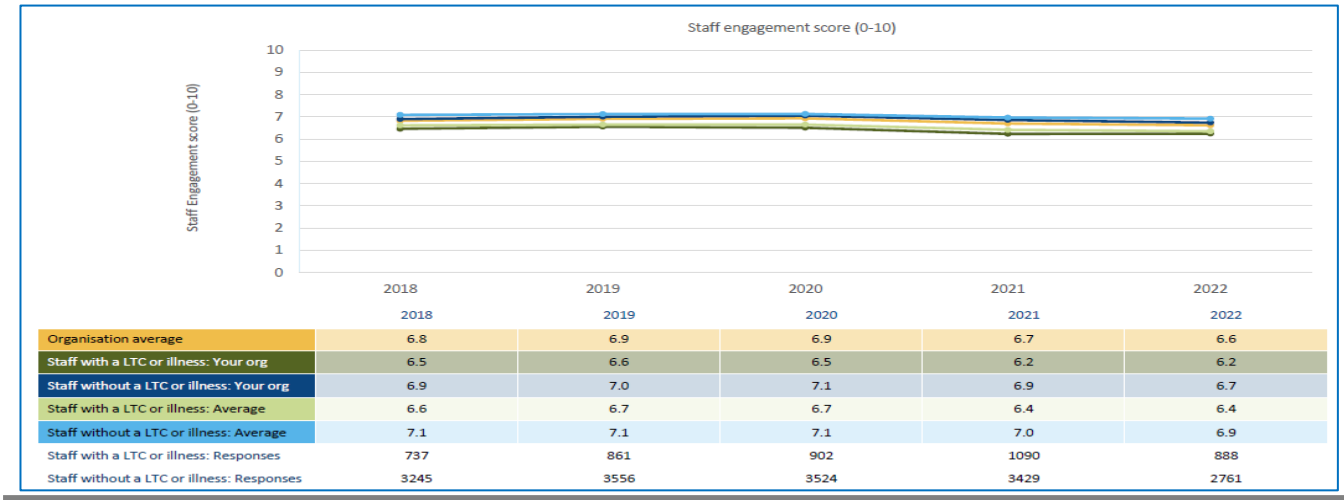
Metric 8: Percentage of staff with a long lasting health condition or illness saying the organisation has made reasonable adjustments to enable them to carry out their work



	2022
Staff with a LTC or illness: Your org	67.2%
Staff with a LTC or illness: Average	71.8%
Staff with a LTC or illness: Responses	549

There has been a notable reduction in the number of colleagues who report that the organisation has made reasonable adjustments to enable them to carry out their work. This metric was 74.0% last year.

Metric 9: Staff engagement score



	2018	2019	2020	2021	2022
Organisation average	6.8	6.9	6.9	6.7	6.6
Staff with a LTC or illness: Your org	6.5	6.6	6.5	6.2	6.2
Staff without a LTC or illness: Your org	6.9	7.0	7.1	6.9	6.7
Staff with a LTC or illness: Average	6.6	6.7	6.7	6.4	6.4
Staff without a LTC or illness: Average	7.1	7.1	7.1	7.0	6.9
Staff with a LTC or illness: Responses	737	861	902	1090	888
Staff without a LTC or illness: Responses	3245	3556	3524	3429	2761

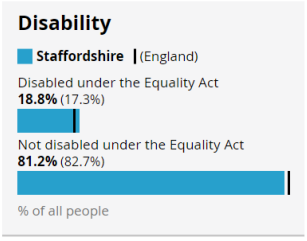
Metric 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by the voting membership of the Board and executive membership of the Board

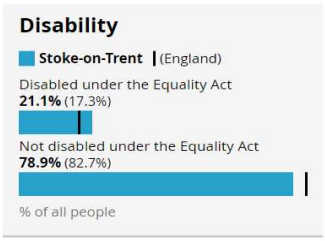
Disability Representation	2023
Difference Total Board : Overall Organisation	7.44%
Difference Voting Membership : Overall Organisation	4.66%
Difference Executive Membership : Overall Organisation	6.33%

Boards are expected to be broadly representative of their workforce. The percentage difference between the organisation's Board membership and its organisation's overall workforce is a positive 7.44% and an improvement on last year. The national WDES average board representation is 3.7%.

Disability in our local communities:

The 2021 census shows the prevalence of disability within our local populations. Both Staffordshire and Stoke on Trent demonstrate a higher proportion of people stating that they have a disability under the Equality Act compared to the population of England.





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

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

1) Introduce 'Disability Champions' across the organisation
2) Introduce a reasonable adjustments procedure
3) Launch the Sunflower Lanyard Scheme for hidden disabilities
4) Embed equality, diversity and inclusion into divisions, directorates and departments
5) Continue to grow the membership and influence of the Disability & Long Term Conditions Staff Network

UHNM Disability Champions

Disability Champions are UHNM colleagues and members of the Trust's Disability & Long Term Conditions Staff Network who are passionate about supporting staff with disabilities/LTC. Champions have undertaken specialist disability training and can support other colleagues and new starters at by:

- Being a confidential listening ear for colleagues with a disability or long term health condition
- Provide an informal and friendly 'buddy' role to colleagues who may be newly diagnosed or new to the organisation with a disability or long term health condition
- Raise awareness of the Tailored Adjustments Plan and Trust requirements to put in place reasonable adjustments as outlined in our Reasonable Adjustments Procedure
- Signpost colleagues to additional staff support and resources
- Support colleagues with a disability, neurodiversity or long term condition whether seen or hidden to have a voice

- Support the organisation to improve workplace experiences for colleagues with disabilities and long term health conditions

A list of our Disability Champions is available on our Disability Champions intranet page.

Themes from contacts to our Disability Champions are discussed at Network meetings, to help us identify issues and topics that are important to our colleagues.

Georgia Fox, Senior Recruitment and Retention Officer

My reasoning for becoming a 'Disability Champion' is that I am passionate about creating a kind and respectful culture across the Trust as well as a fair Recruitment process with equality and without discrimination. I hope I can play my part by supporting staff with disabilities and long term health conditions. Whether you need a listening ear or require some further staff support, please reach out as I would be more than happy to help.

UHNM Reasonable Adjustments Procedure

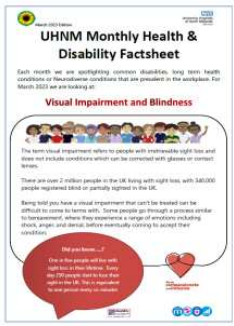
Our Staff Network has been involved in the creation of our Reasonable Adjustments Procedure, to be launched shortly. It is important to demonstrate our commitment to equity and inclusion with a formal process that will help our disabled colleagues to feel supported, engaged and able to deliver their full potential, as well as being clear about our responsibilities as an employer and expectations for line managers. It is also designed to support talent attraction and retention, productivity, and performance. Evidence shows that trusts that have a reasonable adjustment policy perform better across all the metrics derived from the NHS Staff Survey.

The procedure provides clear guidance about reasonable adjustments and outlines processes, the support available and the role of different functions such as HR, Occupational Health and IT.

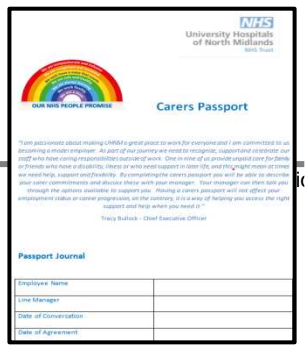
Focus on Hidden Disabilities

We introduced the Sunflower lanyards during Disability History Month. The Hidden Disabilities Sunflower is a discreet sign that the wearer has a hidden disability and may need additional support. Lanyards are available for colleagues that request one free of charge. An awareness campaign and promotion for patients and service users will continue throughout 2023-24.

We have produced monthly factsheets on particular long term conditions, and below are some examples of our range of factsheets covering hidden disabilities**:**



UHNM Carers Passport



Our new Carers Passport has been launched for UHNM staff who care for family or friends who have a disability, illness or who need support in later life. The passport has been designed with the intent of offering assistance to colleagues who have caring responsibilities which may affect their work now or may do in the future.

It is a 'live' document offering the assistance to carry out an open conversation with colleagues/line managers which relates to relevant Trust policies and allows access to the right support and help when it is needed.

Enable Leadership Programme

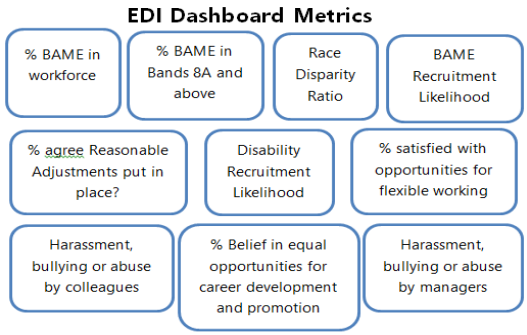
A key strand of our cultural development programme has been the introduction of a new leadership programme for line managers that has been designed to embed appreciative, compassionate and inclusive leadership within UHNM, entitled Enable. The programme was successfully launched at the beginning of April 2022. In the first year of activity we have trained over 600 staff. The programme has a focus on increasing awareness and understanding of diversity and inclusion, and creating a culture where everyone who works at UHNM feels valued and included.

Being Kind

Our Being Kind approach to creating a kind, respectful and inclusive culture was launched in October 2022 at the UHNM Leadership Conference. The Being Kind approach includes our Being Kind Behaviour Compact, created with our staff, and includes guides for colleagues and managers. The Being Kind approach complements our new Resolution Policy, also launched in 2022.

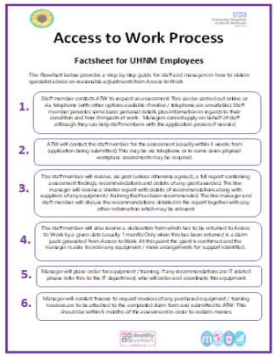
EDI Dashboard

Effective from April 2023 we have created EDI dashboards for each of our Divisions so that they can monitor key EDI metrics, and use these to identify EDI priorities in their areas. Metrics within the dashboard are correlated with areas identified for improvement from the WDES and other staff experience feedback. This includes metrics relating to disability recruitment, access to reasonable adjustments and experience of bullying and harassment by disability status.



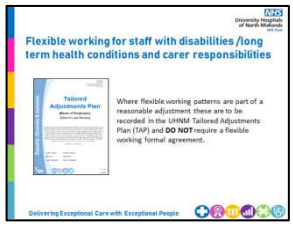
Disability History Month 2022

In November 2022, the focus was on creating a diability positive and inclusive workplace, promoting our support for colleagues with a disability or long term health condition, as well as launching our Disability Champions initiative.



Flexible Working

We marked International Women's Day with a webinar about the options available to all colleagues within our flexible and agile policies, recognising the benefits of a healthy work-life balance for our colleagues, and how this in turn supports attraction and retention of our workforce. Within the webinar we took the opportunity to clarify the difference between agile and flexible working as a reasonable adjustment for colleagues with a disability, and how the Tailored Adjustments Plan is the process rather than the Trust formal flexible and agile working policies.



Reciprocal Mentoring

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

4. Conclusions

The WDES has been developed and continues to be underpinned by the ethos of 'nothing about us without us'. Through their lived experiences, our colleagues with disabilities or long term health conditions have crucial insight and expertise about how they will be affected by actions and decisions. We are committed to ensuring that our disabled colleagues are involved in shaping our equality, diversity and inclusion priorities and have opportunities to contribute and influence our activities to improve disability equality at UHNM. This year's WDES metrics show some positive improvements:

- 0.9% increase in disability representation across the organisation recorded on ESR
- Improvement of 0.08 in the likelihood ratio of applicants with a disability being appointed from shortlisting compared to applicants without a disability
- No difference between the likelihood of colleagues with a disability entering the formal capability process compared to colleagues without a disability
- 2.5% reduction in the percentage of colleagues with a disability reporting experience of bullying, harassment or abuse from managers

- Improvement of 4.4%, and better than the peer average percentage of colleagues that stated that the last time they experienced bullying, harassment or abuse that they reported it

- Improvement of 3.5% in the percentage of colleagues with a disability that believe that the Trust offers equal opportunities for career progression or promotion, which is also better than the average

- 0.5% improvement in colleagues with a disability reporting feeling pressured by their manager to come into work, despite not feeling well enough to perform their duties

- 2% increase in the percentage of colleagues with a disability who are satisfied with the extent to which the organisation values their work

- An improvement in disability board representation and better than the WDES national average

- No change in the staff engagement score

Metrics that have deteriorated are:

- 0.8% increase in the percentage of colleagues with a disability reporting experiencing harassment, bullying or abuse from patients/service users, their relatives or the public. This metric has also deteriorated for colleagues without a disability, which as increased by 4.1%

- 0.5% increase in the percentage of colleagues experiencing harassment, bullying or abuse from other colleagues. This metric has also deteriorated for colleagues without a disability, which increased by 1.4%

- 6.5% deterioration in the percentage of disabled colleagues who reported that the organisation put reasonable adjustments in place to enable them to carry out their work

We have identified a number of actions, informed by our Disability and Long Term Conditions Staff Network that we will focus on during 2023-24.

- Launch the reasonable adjustments procedure with the aim of increasing knowledge of the importance of equity and meeting individual needs
- Continued focus on our Being Kind approach
- Spotlight Neurodiversity in the workplace
- Continue to grow the membership, influence and empowerment of the Disability & Long Term Conditions Staff Network
- Review the Trust Sickness Absence Management Policy and the Capability Policy

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

	UHNM WDES Action Plan 2023-24		
WDES Metric	**Action / Recommendation**	**Timescale**	**Progress Rating**
Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce	• Continue to act upon the under representation of staff sharing their disability status by regularly encouraging all staff to update their disability status, or updating 'unknown' status via ESR and other communications. Aim for a 4.0% target, as recommended by WDES and incremental increases over coming years	Q4	B
Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts	• Use the EDI Dashboard to present Divisional data on the diversity of their recruitment and the likelihood of disabled applicants being appointed from shortlisting compared to non-disabled applicants • Submit a bid, with system provider organisations for a bespoke positive action leadership programme, Calibre, designed for disabled staff in the NHS and wider public sector. It is unique because it addresses the problems disabled staff face in the workplace as well as enables organisations to better support them. The second part of the programme will be a system peer mentor programme to create a legacy of disability mentors • Continue system wide implementation of the 6 High Impact Changes to recruitment practice and work with the UHNM Recruitment Team ensuring that disability inclusion is an attraction tool for recruitment campaigns	In place Q2 On-going	B GB
Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	• Launch the reasonable adjustments procedure with the aim of increasing knowledge of the importance of equity and meeting individual needs to enable people to reach their potential • Review of the Sickness Absence Management and Capability Policies, using lived experience feedback from colleagues to inform changes • Continue to work closely with our Staff Side colleagues to ensure that all reasonable adjustments have been put in place for disabled staff and that the capability policy has been applied in a consistent and supportive manner	Q3 Q4 In place	GB GA B

Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from • patients /service users, their relatives or other members of the public • Managers • Other colleagues	• Continue to embed our Being Kind approach with: - Being Kind Training roll out plan and focus on creating a culture of giving and receiving respectful feedback - ENABLE leadership programme for all line managers - Our NHS People Masterclass • Refreshed EDI statutory and mandatory training with enhanced focus on disability inclusion	On-going Q2	B GA
Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	• Continue to work closely with Trust FTSU Guardians in raising awareness of safe speaking up channels for our disabled workforce and build confidence to speak up • Continue with the second cohort of the Reciprocal Mentorship Programme including colleagues with a disability • Discuss experiences of harassment, bullying or abuse with Disabled staff, through the safe space protected time within staff network meetings	In place Q1 In place	B
Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	• Implement the refreshed Performance Development Review (PDR) process, linking the review with the Tailored Adjustments Plan to ensure colleagues have the right support and adjustments in place to reach performance objectives and career aspirations using Scope for Growth • Introduction of our new inclusive talent management approach for career progression • Submit a bid, with system provider organisations for a bespoke positive action leadership programme, Calibre, designed for disabled staff in the NHS and wider public sector. It is unique because it addresses the problems disabled staff face in the workplace as well as enables organisations to better support them. The second part of the programme will be a system peer mentor programme to create a legacy of disability mentors	Q2 Q4 Q2	GA
Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	• Review of Sickness Absence Management Policy • Promote the need to review the Tailored Adjustments Plan during return to work interviews, following periods of disability related sickness, ensuring that reasonable adjustments, including disability leave and/or referrals to Access to Work are in place.	Q4 Q3	GS

Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	• Promote the UHNM Disability and Long Term Conditions staff network and increase membership and ensure NHS best practice for staff networks is implemented with a new Network Vision • Use national campaigns such as Disability History Month to drive engagement and raise understanding and awareness across the organisation and positive value of employing disabled people through our work creating a sense of belonging for all • Creation of the Employee Experience Network, bringing together all of the voluntary peer support roles including Disability Champions	Q3 On-going Q2	GA B
Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	• Raise awareness of the Workplace Reasonable Adjustments Procedure and line manager responsibilities. Promote the Tailored Adjustments Plan, Reasonable Adjustments Procedure and Disability Champions during recruitment, induction and on boarding • Share positive stories and scenarios that highlight the difference adjustments can make and that the majority of adjustments have no cost or cost than £100 • Promote our commitment and expectations in supporting colleagues with the right adjustments within the revised EDI mandatory training, and, • Launch the refreshed PDR process, which includes prompts to review the Tailored Adjustments Plan during the conversation • Revision of Sickness Absence Management Policy and Capability Policy • Launch of accredited Mental Health First Aid training • Focus on supporting colleagues with Neurodiversity with a range of resources and awareness for line managers	Q3 Q3 Q2 Q2 Q4 Q1 Q4	GA GS B GS
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce	• Encourage all Board members to share their disability status • Disability Network Executive Sponsor to continue to champion disability issues with the Trust Board and be a member of the Disabled NHS Directors Network	On-going In place	B

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th October 2023
Report Title:	Appraisal and Revalidation Annual Report	**Agenda Item:**	13.
Author:	N Coleman, Deputy Medical Director		
Executive Lead:	Matthew Lewis, Medical Director		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Executive Summary

The Responsible Officer (RO) is obliged, according to the RO regulations, to submit an annual board report and statement of compliance and then forward this to NHS England. This contains details of revalidation information, appraisal compliance, and any issues relating to RO responsibilities within the organisation.

- Arrangements for appraisal and revalidation are of high quality and in line with the Responsible Officer regulations.
- Appraisals are conducted in accordance with national standards and a detailed quality assurance exercise has demonstrated that appraisals are of high quality.
- The Trust needs to recruit additional appraisers to provide resilience to an increase in medical recruitment and losing appraisers to retirement.
- Attempts since last year to improve the collection of patient feedback to improve compliance and reduce unnecessary revalidation deferrals has only been partially successful due to flaws in the Allocate system design that make it difficult for patients and doctors to complete the electronic forms.
- Educational supervision and mentorship of locally employed doctors and, in particular international medical graduates, could be improved and we are planning to implement some changes in this area in the coming year.
- Effective systems are in place for monitoring the conduct and performance of all doctors and, where escalation is required, an appropriate consensus is reached to ensure that action is timely appropriate, and free from bias.
- The process of appointing a new Responsible Officer has started.

Key Recommendations

To note the report and approve the findings.

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Dr N Coleman in the current Responsible Officer. He intends to step down from the role on the 30th September 2023 and the appointments process has been commenced.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes. Sufficient resources are in place to carry out the responsibilities of the role.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   The list of licensed medical practitioners is regularly reviewed on GMC connect and updated to ensure it is accurate.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

   Relevant policies are updated as part of the Trust business cycle.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

No recent peer review has been undertaken but the RO has performed a peer review for University Hospitals of Derby and Burton and their RO has indicated he would be happy to do this for UHNM in the coming year.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

All doctors are supported with appraisal and their revalidation process. It is acknowledged that the process for educational supervision of short term appointments and in particular oversees medical graduates new to the NHS could be improved, and the RO has been working with the Medical Director and the Medical Workforce Group to develop options for expanding the supervision of this group of doctors. We have also been working with neighbouring organisations who have been concentrating on this area and plan to put options before the Trust Board in the near future.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Appraisers are allocated to all new appointments and rotated every 3 years for existing colleagues. The appraisal format is consistent with the current GMC guidance , and is a more streamlined process that puts a greater focus on wellbeing. We have emphasised a reduction in pre-appraisal paperwork requirements to reduce the burden on doctors. The RO expects the information presented to be limited to that which directly supports the doctor's clinical practice and should concentrate on clinical effectiveness,

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

complaints and adverse events, and have a strong emphasis on personal development and a doctor's wellbeing.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

There are regular electronic reminders regarding appraisal and additional contact if deadlines are missed. All doctors non compliant with the appraisal process are approached by the Lead Appraiser in order for him to understand the reason for non-compliance.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

There is an agreed and approved medical appraisal policy in place

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The number of medical appraisers is currently satisfactory but it is acknowledged that there are a number of older appraisers who may retire in the near future and would leave a gap in appraisal provision. The Lead Appraiser is keen to expand the number further in the next 12 months

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

The Lead Appraiser is responsible for ongoing training of the appraiser team and puts on regular training events for them.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

This year there has been a detailed review of the appraisers performance over the previous appraisal year . Each of the 114 appraisers had one of their appraisals scored by the Lead Appraiser using a quality assurance tool.76% of reviewed appraisals scored 75% or more and the results are to be fed back to appraisers.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	**909**
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**838**
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	**71**
Total number of agreed exceptions	**1**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Recommendations to the GMC are made on time for doctors with a prescribed connection to UHNM. There were 133 recommendations made to the GMC between the 1st April 2022 and 31st March 2023.

of these 42 were deferrals and 91 were positive recommendations. There were no non-engagement recommendations.

The vast majority of deferrals were due to a failure to complete the multi-source feedback exercise that is required by the GMC for successful revalidation.. This is despite regular reminders by the Revalidation Office and in all cases personal email communication from the RO

We now give doctors the option of either a paper-based or completely online system but due to the poor design of the electronic system linked to Allocate , compliance in this area has not improved in the last year as patients and doctors find the system difficult to use. A change to an alternative provider would be a considerable expense and the team are working at improving performance in this area using the existing system.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Positive recommendations are not communicated to the doctor in advance, but in the event that a deferral recommendation is made (or very rarely a statement of non-compliance) this is always communicated to the doctor in advance. This is always a result of multiple communications directly between the RO and the doctor as all recommendations are made by the RO personally.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

UHNM has a strong framework for clinical governance with a tightly organised reporting infrastructure and effective implementation of agreed actions.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

There are multiple sources of information used by the Responsible Officer and Medical Director and these include participation in national and local audit, data from the Risk Management Panel, clinical governance forums, data from mortality reviews and structured judgement review , never events etc. Any concerns about conduct come from a variety of sources including local concerns, grievances, complaints, and the Freedom to Speak Up Guardian, and these are all taken seriously and acted upon appropriately

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Any concerns regarding a doctor's fitness to practice are discussed by the MD and RO and a decision made regarding further investigation, escalation , or in rare cases exclusion.

After an initial fact-finding exercise and where escalation is thought to be appropriate , this is progressed in according with the local disciplinary policy for Medical Staff (MHPS)

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

All concerns regarding a doctor's practice and referred to the Professional Standards and Clinical Conduct Forum where they are discussed in detail and appropriate actions agreed. This committee has wide representation to ensure that the RO and MD establish a broad consensus on action. A highlight report

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

is prepared and escalated to the Executive Workforce Assurance Group which is turn reports to the Transformation and People Committee.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Requests for information from other organisations are reviewed by the Revalidation admin team and information regarding complaints or concerns are sought from Governance and from the RO directly. These are processed quickly and efficiently.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Any concerns raised from a variety of sources are initially discussed between the RO and the MD. Where further action is taken this is managed according to our local disciplinary policy for Medical and Dental Staff which is consistent with the national MHPS process. We now have sufficient trained case investigators to ensure formal processes are not unnecessarily prolonged and all concerns are discussed in detail at the Trust's Professional Standards and Clinical Conduct Forum where there is appropriate representation to ensure freedom from bias and discrimination.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

All doctors employed by UHNM are subject to the mandatory NHS pre-employment checks. In addition , a medical practitioner information template form (MPIT) is used for all doctors who have had prior NHS employment.

Section 6 – Summary of comments, and overall conclusion

Arrangements for appraisal and revalidation are of high quality and in line with the Responsible Officer regulations. Appraisals are conducted in line with the latest standards and the burden on doctors has been appropriately reduced. A detailed quality assurance exercise has demonstrated that appraisers are working at a high standard.

Attempts since last year to improve the collection of patient feedback to improve compliance and reduce unnecessary revalidation deferrals has only been partially successful due to flaws in the Allocate system design that make it difficult for patients to complete the electronic forms. This is an area we need to concentrate further on in the coming year to prevent unnecessary deferrals.

We consider that educational supervision and mentorship of locally employed doctors and in particular international medical graduates could be improved and are planning to implement some changes in this area in the coming year.

The Trust needs to recruit additional appraisers to provide resilience to an increase in medical recruitment and losing appraisers to retirement.

Effective systems are in place for monitoring the conduct and performance of all doctors and where escalation is required an appropriate consensus if reached to ensure that action is timely appropriate, and free from bias.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication reference: PR1844

Executive Summary

Meeting:	Trust Board	**Date:**	4th October 2023
Report Title:	Integrated Performance Report, Month 05 2023/24	**Agenda Item:**	
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & Safety; Operational Performance: Warren Shaw, Strategic Director of Performance & Information; Matt Hadfield, Associate Director of Performance & Information. Workforce: Jason Ahern, Assistant Director of Workforce Information; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Simon Evans: Chief Operating Officer Jane Haire: Chief People Officer Mark Oldham: Chief Finance Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Executive Summary

Situation

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

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

Quality & Safety

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

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

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

Assessment

Friends & Family Test for A&E remains below the 85% target of patients recommending the service. The August figure remains above the mean recommending rate. There has however been a reduced response rate with 10% compared to 14% in July. UHNM is 37th out of 124 Trusts nationally for response rate. Feedback from patient experience of using 111First and the kiosks continues to be monitored. 22% of respondents in August 2023 reported to have used 111First prior to attending ED, which is an increase on previous months. Key themes from August 2023 remain the same: poor communication, long waits, pain relief especially related to Royal Stoke; cleanliness and patient's feeling dismissed.

Inpatient FFT results remain above the 95% target. The response rate has remained steady at 21% in August 2023. There were 2376 responses returned in August 2023 from 66 different inpatient and day case areas across UHNM. The response rate equates to 21% and lower than outr internal 30% target. UHNM remains 15th our of 124 acute trusts for inpatient response rates. 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 in month improvement for Maternity FFT but remains below the 95% target at 89.8%. August 2023 saw 108 completed surveys returned (154 in July and 111 in June 2023) and 49 (78 in July and 46 in June) completed from the Birth touchpoint.

Complaints rate is below the target/benchmark rate of 35 and remains within normal variation.

The number of reported patient safety incidents remain above the long term mean but has decreased very slightly this month although the rate per 1000 bed days has continued to remain relatively stable and is within normal variation limits but above the NRLS mean rate

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers are Patient Flow, Medication, Patient Falls, Clinical Assessment and Treatment related incidents. Patient Flow and Medication related incidents were higher than Patient falls during July 2023 but otherwise no significant changes in these categories compared to previous months.

There have been 76 incidents identified as relating to Your Next Patient which is continued reduction compared to previous months (110 in July, 102 in June, 97 in May, 117 in April, 157 in March, 170 in February and 228 in January 2023) which accounts for 3.6% (5.1% in July, 4.8% in June and May, 6.21% in April, 7.4%in March, 9.8% in February and 12% in January 2023) of total patient safety incidents. 30.4% (28.2% previous month) were Tissue viability. However, 68% 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 August 2023 but remain within normal variation and continues on a longer term reducing trend since December 2022. It is key to note that during August 2023 there have been 0 'Your Next Patient' / patient flow related incidents reported. The main category for these moderate harm or above incident are medication (8), tissue viability (7), falls (5), clinical assessment (3) and treatment related (4).

Patient falls rate has continued to show positive trend, not yet statistically significant, with monthly reductions in both total falls rate and falls with harm.

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

Pressure Ulcer developed under UHNM care with lapses in care have seen continued improvement and is within normal variation. There are number of ongoing actions noted for imrpving pressure area car including strategic work with A3 on urethral erosions is on-going with associated actions identified as well as a Task and Finish Group set up

with the ICB to improve continuity of care and reduce harm

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

There was 0 new Never Event reported during August 2023.

Duty of Candour compliance for evidence in written notification has declined in August and relates to 1 case. 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.

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

Hospital Associated Thrombosis rate remains below the long term mean in August 2023 with 17 cases and a rate of 0.85 per 10,000 admissions.

The current position for received patient Safety Alerts shows that there was 2 new Patient Safety Alerts issued during July 2023 and 1 is closed and 1 remains under. There remains 2 overdue alerts but both and due to be fully actioned and closed in August 2023.

Sepsis screening and IV Antibiotics continue to be below targets within Royal Stoke Emergency Department. Other emergency portals are achieving these targets. Sepsis Team continue to work with RSUH ED Teams to try and improve compliance and staff are following correct sepsis guidance.

All data used in this report is as recorded on 5th September 2023 and figures may change following further review/investigation/update

Operational Performance

Situation

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

In addition to this, UHNM have been issued draft proposed Undertakings (for Board approval October 2023) by NHS England, outlining steps that must be taken across UEC, Elective Care, Cancer, Maternity and Governance.

The proposed UHNM Undertakings require the Trust Board to receive and approve a highlight report that describes progress against agreed action plans on key performance domains. This report will satisfy that requirement by describing the activities undertaken to improve performance against four areas of National Constitutional Standards. Those four areas are:

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

Assessment

1. Urgent and Emergency Care

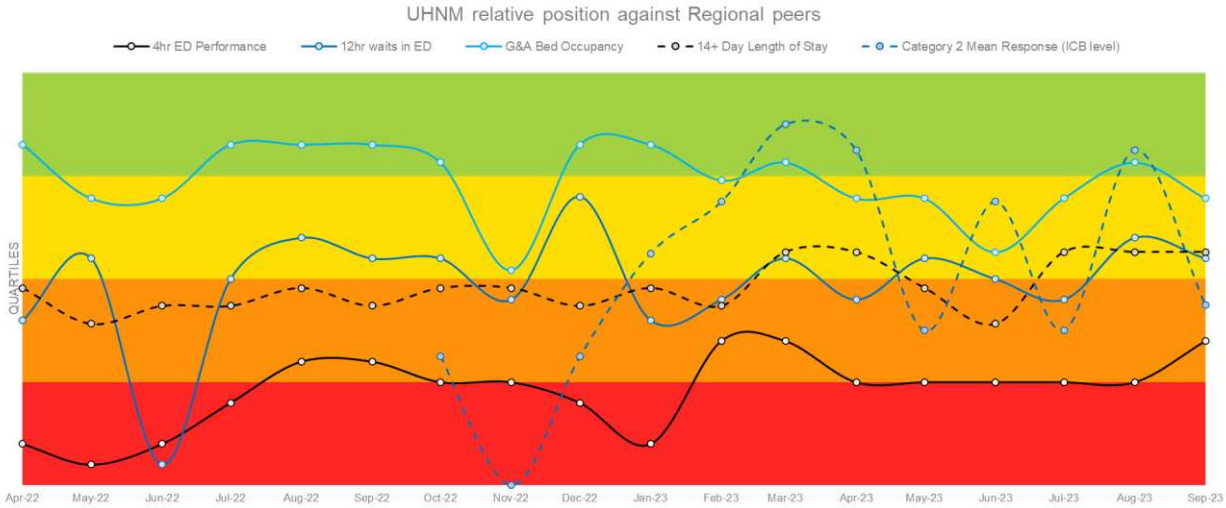
- UEC required actions set out within the draft Undertakings centre around the production and delivery of an NHS England approved SSOT UEC Improvement Plan focussing on A&E 4 Hour, 12 Hour Wait, and Ambulance Handover performance including evidence based narrative of current drivers, planned actions, KPI, timelines, trajectories, and a robust reporting framework.

- August saw a slight improvement against 12 Hour Wait and 1 Hour Ambulance Handover performance with maintenance of A&E 4 Hour performance. While there are variations in performance the overall position has been relatively static since April. It is important to note that the current driving factors behind 4 and 12 Hour performance are distinct. The A&E 4 Hour target is primarily driven by RSUH non-admitted (NAD) performance and County Hospital overall performance while 12 Hour Wait are influenced by Trust capacity,

demand, and discharges as a result of system flow.

- WMAS SSOT Category 2 Response Times performed comparatively well in August with all weeks below the 30minute target achieving an average of 27minutes6seconds. This brings our year to date performance to approximately 30minute which will need to be improved upon further in anticipation of increased pressure over winter. This recent performance placed UHNM in the top quartile regionally for this metric in August making it one of the strongest relative performing KPI for UHNM. This is positive given national scrutiny on this metric as part of the national UEC Recovery Plan.

- Whilst Ambulance Category 2 Response Time performance has been broadly positive and 12 Hour performance responded well to improved hospital flow in August (placing in the second quartile regionally) A&E 4 Hour performance remains flat. This represents the greatest challenge to UEC delivery and is the only UEC metric under national scrutiny remaining consistently in the bottom quartile of regional performance.



- In response to this stagnation of performance improvement meetings with the Divisional and Departmental leadership teams continue focus on a small number of high impact actions. These include the development and utilisation of a tactical Capacity & Demand dashboard to identify optimum performance based on daily capacity (22-Sep), the expansion of Progress Chasers to cover the Ambulatory and CED areas 24/7 (18-Sep), and the introduction of Standard Work (15-Sep). These are expected to show benefits in October against a revised trajectory to be agreed demonstrating a path to 80% NAD performance. The final significant initiative to be targeted is the extension of Senior Decision Maker presence past midnight. This has however not yet been agreed and the ED Clinical Director is progressing options with the Consultant body.

- NHSE Regional Executive Triumvirate completed a pre-winter assurance visit in early September. This visit was constructive and well received noting the articulated known bed deficit of approximately 65 beds ahead of the winter period. There is a provisional plan to bring this to 20 beds which reflects a much lower risk of bed occupancy restricting UEC access. The winter plan will be presented separately for sign off to board, as part of the wider system preparations for increased demand over winter months.

2. Diagnostic Standard:

- During August Diagnostic activity slipped to below 2019/20 levels. This was impacted particularly by the Bank holiday week at the end of the month, this has happened once previously and the last time this was over the Easter period. This was predicated and mitigated by performance generally being over 110%.
- Diagnostic performance against the 6 week standard was 67% un-validated overall which is below the validated July performance of 73% (this improved from 69% pre validated position reported last month). The post validation position for DM01 always shows an improved position. Endoscopy performance is the main contributor to this performance. It has a large programme of work and improvement teams are designing an intensive improvement cycle in addition to extra Independent Sector capacity to ensure that trajectories for improvement are met and standard reached by March 2024.

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

As part of the Undertakings issued to the Trust the commitment for Elective services is to develop a single, comprehensive recovery plan for elective recovery. This must include:

- Maintaining zero 104-week in line with trajectories and this is maintained in line with plan
- Achieving zero 78-week waiters in line with trajectories and this is maintained in line with plan
- Eliminating waits of over 65-week by end March 2024 in line with an agreed system/NHSE trajectory and this is maintained in line with plan.

At the end of August the number of patients waiting more than 104 weeks was 3. The current prediction for the end of September is 0.

The validated number of 78 week breaches for end of July was 186, un-validated 78 week breaches for August is 183. This is predicted to be 178 for September, and takes into account the impact of industrial action (IA). Without IA the prediction for recovery would have been only 98 patients waiting.

National focus has now moved to patients waiting 65 weeks or more with an expectation to reduce them to below 200 patients by end of March 2024. In addition to this, there is a further expectation nationally that all patients waiting for their first outpatient appointment for more than 65 weeks are seen by the end of October. There are a number of specialties as part of our recovery plan that have substantial challenges in achieving this including Spines, Ophthalmology, MaxFac, Plastics, Paediatric Orthopaedics, Gastroenterology, Respiratory and Neurology. The number of patients waiting for more than 65 weeks position for August was 1340, down from July's 1352.

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

Theatres:

- Day Case activity and Elective Activity have moved from delivering 80% and 84% respectively for July to 82% and 81% for August. The Trust has now launched the national standard booking 6-4-2 process within theatres with support from the regional theatres team. Day case as a % of all elective work is currently 87.4%. Both of these schemes seek to increase the number of patients being treated within existing resources and thereby reduce waiting lists.
- UnCapped utilisation in August was 80.6%, this is in normal variation, however national reporting focuses on capped utilisation and the Trust will move to this metric which gives greater scope for benchmarking. The first workstream in improving utilisation has been identified as starting lists on time. 58% of lists started within 15mins of the scheduled time and this is the first action on the theatres A3 programme. On the day cancellations for August were 9.5%, and this is within normal variation.

Outpatients:

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

4. Cancer

Undertakings for the Trust set out the requirement for a single comprehensive Cancer services recovery plan for Cancer. It will set out sustained improvement in the reduction of the 62-day backlog, and improvement in the Faster Diagnosis Standard (28-day FDS), in line with an agreed system trajectory for a period of a least two consecutive quarters. Whilst current plans are refreshed and adapted into this single comprehensive format, existing trajectories will be maintained. In agreement with NHSE the submission of the full plan will be in November 2023.

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

- The trajectory which has been agreed through the tier 1 meetings with NHSE is included on slide 23 of the performance pack.
- In July the backlog of patients ended at 500, a reduction of 13. This position has now started to show signs of improvement, but affects the over all 62 day target. The backlog position is of

particular issue in Colorectal, with some slippage in Skin, Urology and Head and Neck.

- Most recent submitted Cancer Waiting Times position is June which was 55% for 62 day performance. July is currently predicted to be 47% although this will improve post validation, this is due to the number of treatments for our longest waiting patients increasing.

The 28 Day Faster Diagnosis Standard;

- This achieved 72.6% for all referral routes combined in July. The August position is currently incomplete and will be validated once Pathology confirms cancer or non cancer on high volume pathways such as Skin.
- Areas of best practice consistently achieving the standard are Breast and Upper GI and Skin.

This achieved the regional ask of >70% and is improving towards the 75%target.

Workforce

Key messages

- The 12m turnover rate in August 2023 decreased to 8.3% (0.9% in July) which remains below the trust target of 11%.
- M5 vacancies decreased to 9.43% (10.20% in July). Divisions are reporting good progress on their recruitment pipeline to close the gap on vacancies which is supported by the August presentation on progress made against the annual Workforce Plan.
- For M5, the in-month sickness rate decreased by 0.13% to 5.08% (5.21% in July 2023). The 12-month cumulative rate decreased to 5.31% (5.32% in July 2023).
- Stress and anxiety continues to be the top reason for sickness in August, which saw a decrease of 0.4% in the last month to 24.9% (25.3% in July). Chest & respiratory problems saw a decrease of 0.6% in the last month to 14.8% (15.4% in July 2023).
- August 2023's covid-related absences dramatically reduced to 5 (79 in July 2023), which was 0.24% of the 2,091 open absences. This is a 3.84% decrease on the previous month.
- August 2023's PDR Rate decreased by 0.9% to 82.0% (82.9% in July 2023). Work is progressing on refreshed PDR paperwork to support colleagues in achieving their potential.
- Statutory and Mandatory training rate on 30th August was 94.2% (94.1% on 31 July 2023) showing a very slight increase. This compliance rate is for the 6 'Core for All' subjects only.
- The Staff Voice trust survey, for August 2023, received a total of 1,403 submissions providing an overall colleague engagement score of 6.63.
- The Being Kind sessions continued in August with over 3,500 colleagues in attendance. The events continue to evaluate extremely well including lots of positive feedback on social media.
- Next week is National inclusion Week, where work colleagues are invited to bring in a dish which represents their heritage and also create diversity displays, highlighting all team members and why inclusion is important to them.
- Divisions are continuing to focus discussions on flexible working, with big conversations and in some areas piloting of self rostering.
- Junior doctors took industrial action in August which required extensive coordination and cover from across the whole organisation.
- UHNM response to the NHS Long Term Workforce Plan continues to be developed to shape collective understanding of the opportunities and challenges.

Finance

Key elements of the financial performance year to date are:

- For Month 5 the Trust has delivered a year to date deficit of £8.8m against a planned surplus of £2.9m; this adverse variance of £11.7m is primarily driven by underperformance against the Trust's in year CIP target, the impact of industrial action and unfunded additional winter escalation capacity that remains open.
- The Trust has incurred £3.6m of costs relating to winter escalation capacity remaining open to Month 5; the Month 5 position includes £1.5m of additional funding from the local ICB.
- The industrial action (IA) by medical staff has cost the Trust £3.4m in backfill arrangements. Whilst this cost is unfunded the ERF target for the year has been reduced by 2% in relation to the April IA with further guidance expected for subsequent IA.
- To date the Trust has validated £18.1m of CIP savings to Month 5 against a plan of £22.9m. The Trust has recognised £2.1m of CIP due to an assumed reduction in the annual leave provision; this delivers 50% of the NR ICB stretch CIP target. Schemes of £47m have been identified for delivery in 2023/24. The PMO is

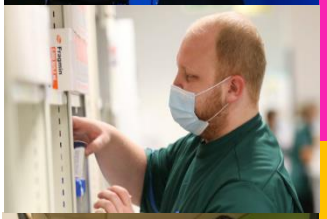
currently working with scheme leads to develop robust plan to deliver these savings. The £8.0m divisional schemes remain unidentified.

- There has been £20.4m of Capital expenditure which is £3.4m above plan.
- The cash balance at Month 5 is £84.4m which is £1.6m lower than plan

Key Recommendations

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

NHS
University Hospitals of North Midlands
NHS Trust



Integrated Performance Report

Month 05 2023/24

Delivering Exceptional Care with Exceptional People

Contents

A note on SPC

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

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

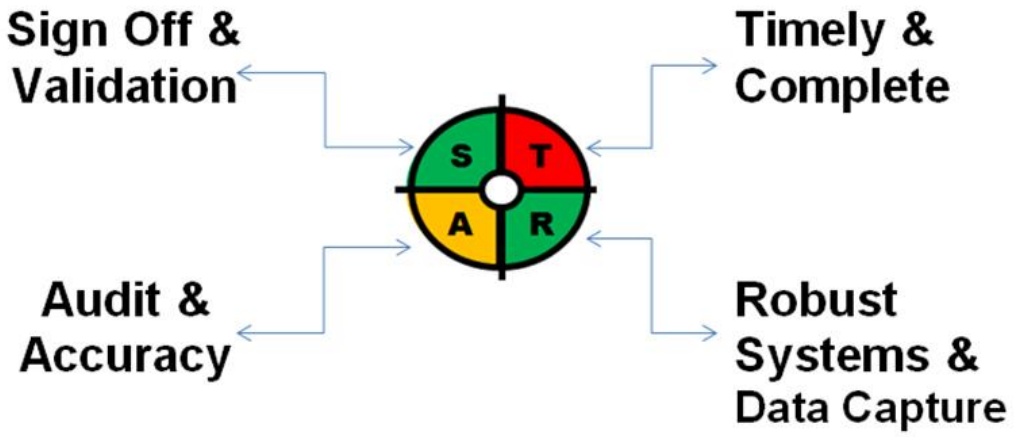
Assurance - how assured of consistently meeting the target can we be?

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

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

A note on Data Quality

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



Explaining each domain

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

RAG rating key

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

NHS
University Hospitals of North Midlands
NHS Trust

Quality

Caring and Safety

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

Quality Spotlight Report

University Hospitals of North Midlands NHS Trust

The Trust achieved the following standards in August 2023:

- Friend & Family (Inpatients) 96.3% and exceeds 95% target.
- The rate of complaints per 10,000 spells is 27.64 and is below the target of 35 but within normal variation
- Falls rate was 5.0 per 1000 bed days for July 2023
- Rate of falls reported that have resulted in harm to patients currently at 1.4 per 1000 bed days. The rate of patient falls with harm continues to be within the control limits and normal variation.
- Pressure Ulcers per 1000 bed days with lapses in care developed under UHNM care is now 0.33 in and below the target rate 0.5
- Hospital Associated Thrombosis has continued to decrease and is within normal variation and cases are under review.
- 0 Never Events
- Trust rolling 12 month HSMR continue to be below expected range.
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- VTE Risk Assessment completed during admission above 95% target with 98.5% (via Tendable)
- Inpatient sepsis Screening and Sepsis IVAB within 1 hour achieved 97.9% and 90% respectively and meeting the 90% target rate
- Children's Sepsis Screening compliance achieved 91% and above the 90% target.
- Maternity IVAB compliance 100% and below the 90% target for audited patients

The Trust did not achieve the set standards for:

- Friend & Family (A&E) has improved but remains below 85% target at 77.1%
- Friend & Family (Maternity) 85.7% and below 95% target
- 93.8% verbal Duty of Candour compliance recorded in Datix
- 82.4% compliance with Duty of Candour 10 working day letter performance following formal verbal notification and under review for completion and upload of letter on Datix
- There were 27 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- Timely Observations remain below the 90% target but has seen improvement during recent months
- E. Coli Bacteraemia cases above trajectory with 23 in June compared to target of 16.
- C Diff YTD figures above trajectory with 19 against a target of 8.
- Sepsis Screening compliance in Emergency Portals decreased to 75.3% below the target 90%.
- Emergency Portals Sepsis IVAB in 1 hour improved to 81% but remains below the 90% target for audited patients
- Maternity Sepsis Screening compliance declined to 71.38% against 90% target
- 2 overdue and open Patient Safety Alerts

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

- Majority of complaints in August 2023 continue to relate to clinical treatment.
- Total number and rate of Patient Safety Incidents decreased in month
- Total incidents with moderate harm or above and the rate of these incidents have exceeded normal variation levels during August 2023.
- Medication related incidents rate per 1000 bed days is 6.3 which is same as previous month but patient related 5.3 is lower than previous month. The monthly variation is within the normal expected variation and in line with NRLS national rates. The % of medication incidents reported with moderate harm or above has increased for August 2023 and increase from previous 9 months.
- 10 Serious Incidents reported during with 7 falls related.
- SHMI 101.78 and is Band 2 – as expected. There has been improvement in SHMI

Quality Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Benchmark	Previous	Latest	Variation	Assurance
Patient Safety Incidents	1900	2222	2082	H	?
Patient Safety Incidents per 1000 bed days	50.70	54.71	52.10	H	?
Patient Safety Incidents per 1000 bed days with no harm	32	38.51	35.43	H	?
Patient Safety Incidents per 1000 bed days with low harm	13	13.10	13.39		?
Patient Safety Incidents per 1000 bed days reported as Near Miss	2	2.44	2.28	H	?
Patient Safety Incidents with moderate harm +	20	25	37		?
Patient Safety Incidents with moderate harm + per 1000 bed days	0.60	0.62	0.93		?
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		?
Patient Falls per 1000 bed days	5.6	4.9	5.0		?
Patient Falls with harm per 1000 bed days	1.5	1.8	1.5		?
Medication Incidents per 1000 bed days	6	6.3	6.3	H	?
Medication Incidents % with moderate harm or above	0.50%	1.18%	3.59%	H	?
Patient Medication Incidents per 1000 bed days	6	5.5	5.3	H	F
Patient Medication Incidents % with moderate harm or above	0.50%	1.34%	4.23%	H	?

Metric	Benchmark	Previous	Latest	Variation	Assurance
Serious Incidents reported per month	0	6	10		F
Serious Incidents Rate per 1000 bed days	0	0.15	0.00	L	F
Never Events reported per month	0	0	0		?
Duty of Candour - Verbal/Formal Notification	100%	100.0%	93.8%		?
Duty of Candour - Written	100%	100%	82.4%		?
All Pressure ulcers developed under UHNM Care	60	66	63		?
All Pressure ulcers developed under UHNM Care per 1000 bed days	1.6	1.63	2.10		?
All Pressure ulcers developed under UHNM Care lapses in care	12	25	13		?
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.62	0.33		?
Category 2 Pressure Ulcers with lapses in Care	8	6	7	H	?
Category 3 Pressure Ulcers with lapse in care	4	3	2		?
Deep Tissue Injury with lapses in care	0	13	5		?
Unstageable Pressure Ulcers with lapses in care	0	3	1		?

Delivering Exceptional Care with Exceptional People

Quality Dashboard

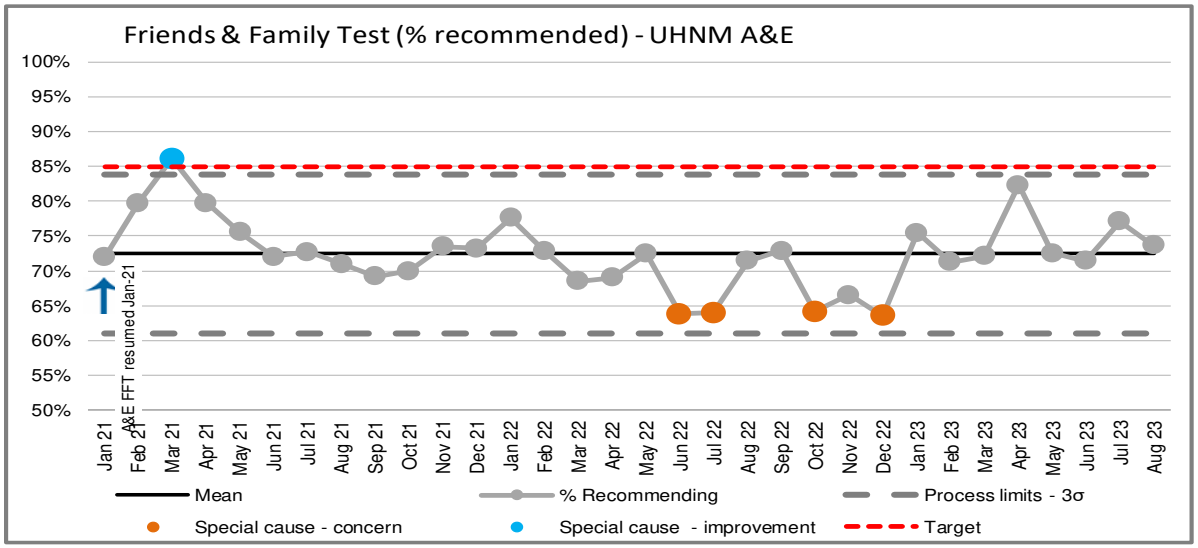
University Hospitals of North Midlands NHS Trust

Metric	Benchmark	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	77.1%	73.7%	L	F
Friends & Family Test - Inpatient	95%	96.5%	96.3%		?
Friends & Family Test - Maternity	95%	86%	89.8%		
Written Complaints per 10,000 spells	35	35.10	27.64		?
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	98.13	100.00	H	P
Rolling 12 Month SHMI (4 month time lag)	100	102.78	101.78		F
VTE Risk Assessment Compliance	95%	98.0%	98.5%		P
Timely Observations	90%	71.0%	72.8%	H	F
Reported C Diff Cases per month	8	19	17	H	?
Avoidable MRSA Bacteraemia Cases per month	0	0	0		?
HAI E. Coli Bacteraemia Cases per month	16	19	20	H	?

Metric	Benchmark	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	97.9%	91.7%	H	?
Inpatient IVAB within 1hr (Contracted)	90%	100%	90.0%	L	P
Children Sepsis Screening Compliance (All)	90%	91%	86.4%		?
Children IVAB within 1hr (All)	90%	N/A	N/A	H	P
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	85.3%	75.3%	L	?
Emergency Portals IVAB within 1 hr (Contracted)	90%	75.61%	81.0%		?
Maternity Sepsis Screening (All)	90%	83%	71.8%	L	F
Maternity IVAB within 1 hr (All)	90%	86%	100.0%	H	F

Delivering Exceptional Care with Exceptional People

Friends & Family Test (FFT) – A&E



Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
85%	71.4%	77.1%	73.7%

Background

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

- The overall satisfaction rate for our EDs remains somewhat below our internal target at 73.7% for August 2023.
- The Trust received 904 responses which is a decrease on the previous month with a 10% response rate for overall. The Trust's overall satisfaction rate is lower than the national average of 80% (NHS England June) at 74%. UHNM is 37th out of 124 Trusts for number of responses in ED (NHS England June 2023).
- Feedback from patient experience of using 111First and the kiosks continues to be monitored. 22% of respondents in August 2023 reported to have used 111First prior to attending ED, which is an increase on previous months. Key themes from August 2023 remain the same: poor communication, long waits, pain relief especially related to Royal Stoke; cleanliness and patient's feeling dismissed.

Actions :

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

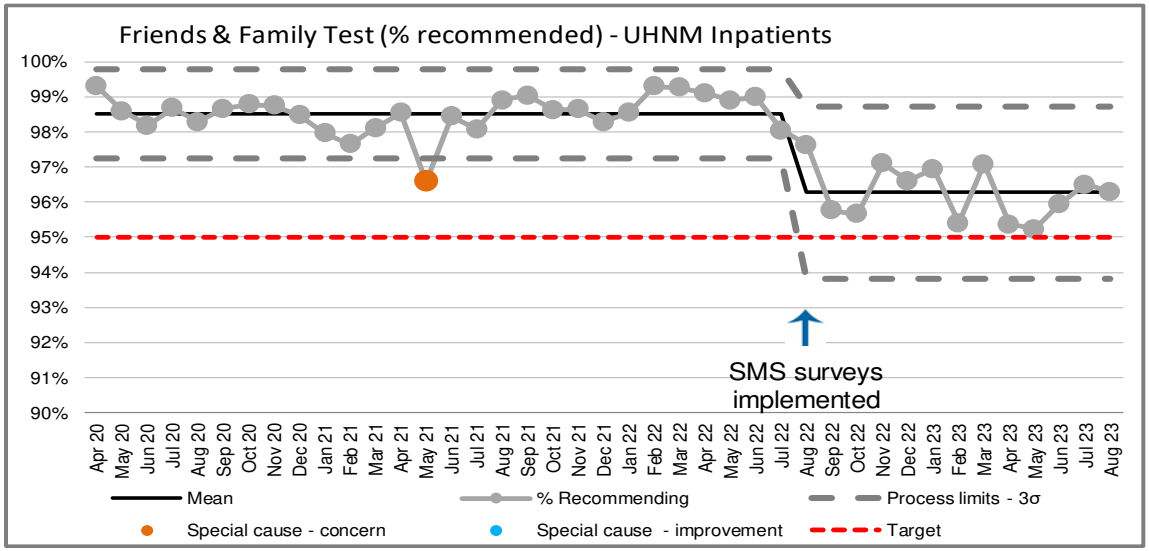
QR code made visible throughout the department.

QR code put onto all future FFTs.

You said we did board in waiting room.

Friends & Family Test (FFT) - Inpatient

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
95%	96.0%	96.5%	96.3%

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 95% (June 2023 NHS England) at 96.3% for August 2023.
- In August 2023 a total of 2376 responses were collected from 66 inpatient and day case areas (11383 discharges) equating to a 21% return rate which is a slightly lower than the previous month and remains lower than the internal target of 30%. UHNM remain the 15th highest response rate for all reporting Trusts in the country (154) NHS England June 2023.

Actions:

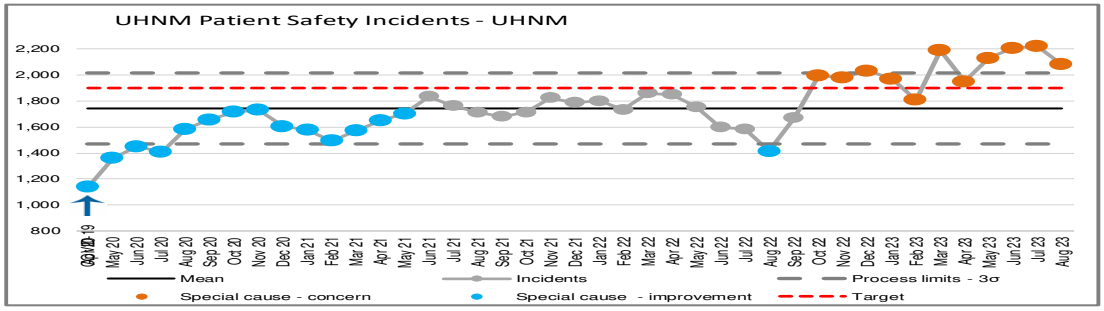
- Continue to ensure that FFT surveys are available in multiple formats to ensure accessibility for all patients.
- Focus on Medicine and Surgery to increase response rate.

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

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

Reported Patient Safety Incidents

University Hospitals of North Midlands NHS Trust

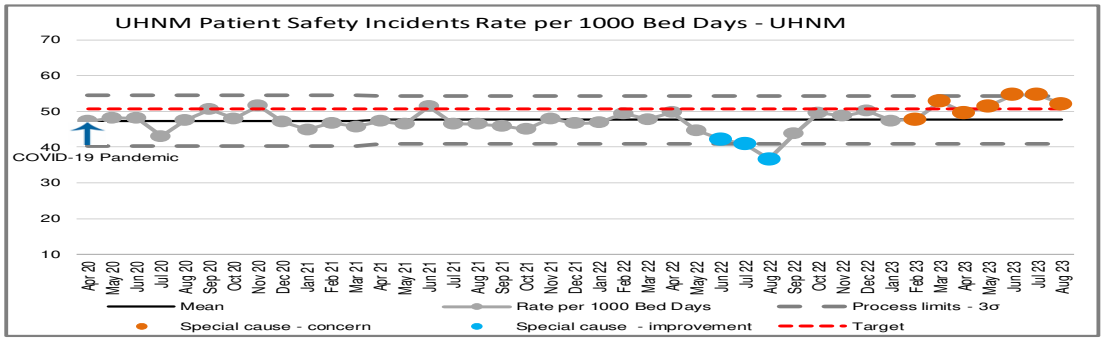


Variation	Assurance
H	?

Target	Jun 23	Jul 23	Aug 23
1900	2207	2222	2082

Background

Total Reported patient safety incidents



Variation	Assurance
H	?

NRLS Mean	Jun 23	Jul 23	Aug 23
50.70	54.70	54.71	52.10

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The July 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 increase in total numbers remain relatively stable and is slightly above the NRLS rate.

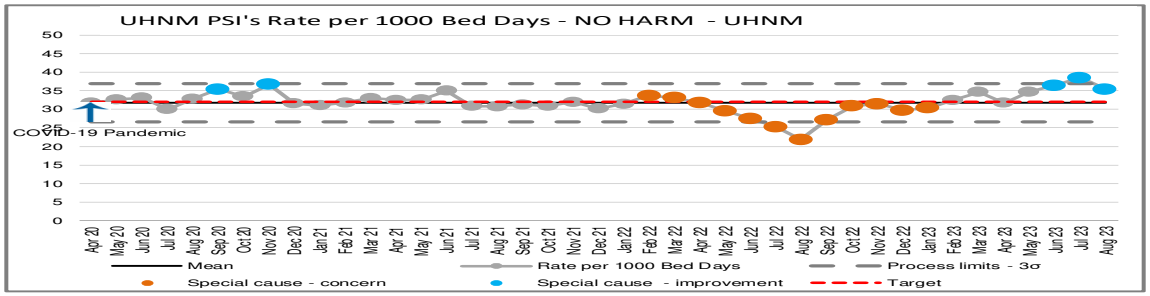
However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers are Medication, Patient Falls, Patient Flow, Clinical Assessment and Documentation related incidents. Medication related incidents were the largest category after Tissue Viability in august 2023 but were slightly lower than numbers reported in July 2023.

There have been 76 (110 in July, 102 in June, 97 in May but reductions compared to previous months 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 3.6% (5.1% in august, 4.8% in June and May, 6.21% in April, 7.4% in March, 9.8% in February and 12% in January 2023) of total patient safety incidents. 30.4% (28.2% previous month) were Tissue viability. However, 60% of these were **NOT** hospital acquired but recording pressure damage on admission/attendance at UHNM.

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

NHS University Hospitals of North Midlands NHS Trust

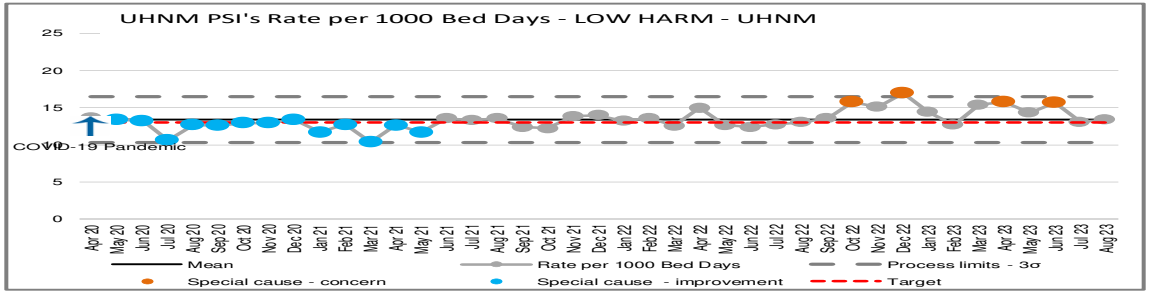


Variation	Assurance
H	?

Target	Jun 23	Jul 23	Aug 23
32	36.48	38.51	35.43

Background

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

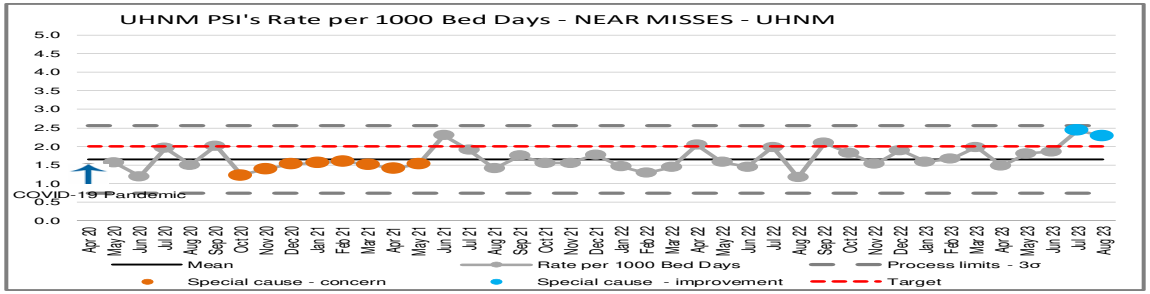


Variation	Assurance
	?

Target	Jun 23	Jul 23	Aug 23
13	15.71	13.10	13.39

Background

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



Variation	Assurance
H	?

Target	Jun 23	Jul 23	Aug 23
2.0	1.86	2.44	2.28

Background

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

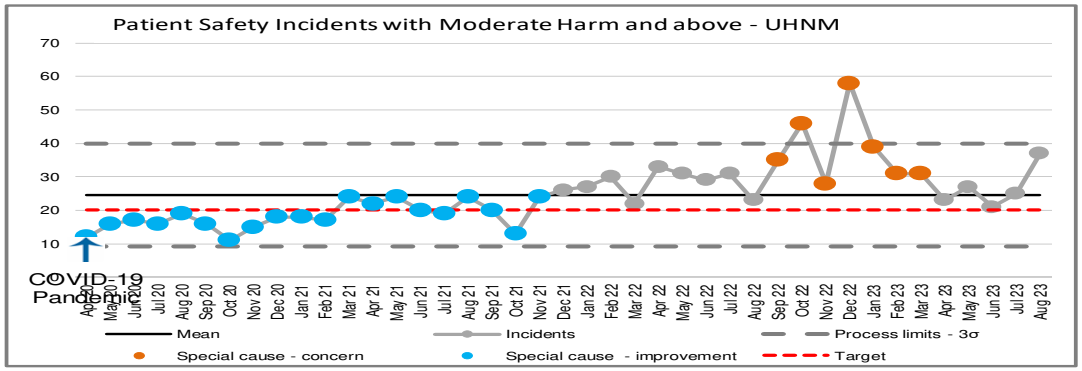
What is the data telling us:

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

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

Reported Patient Safety Incidents with Moderate Harm or above

NHS University Hospitals of North Midlands NHS Trust

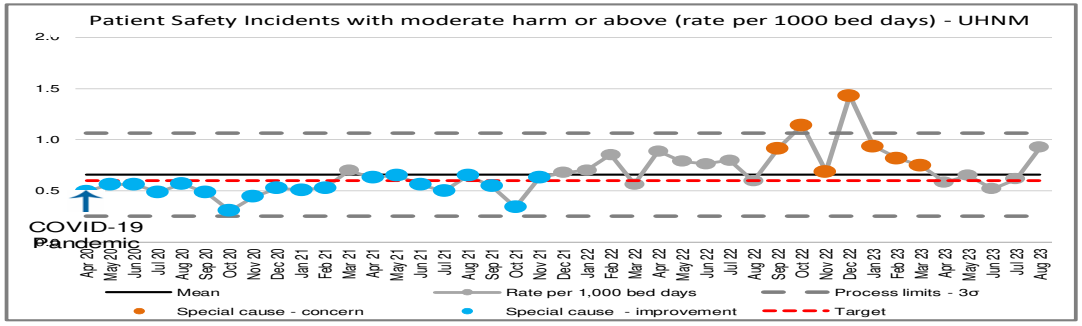


Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
20	21	25	37

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
0.60	0.52	0.62	0.93

What is the data telling us:

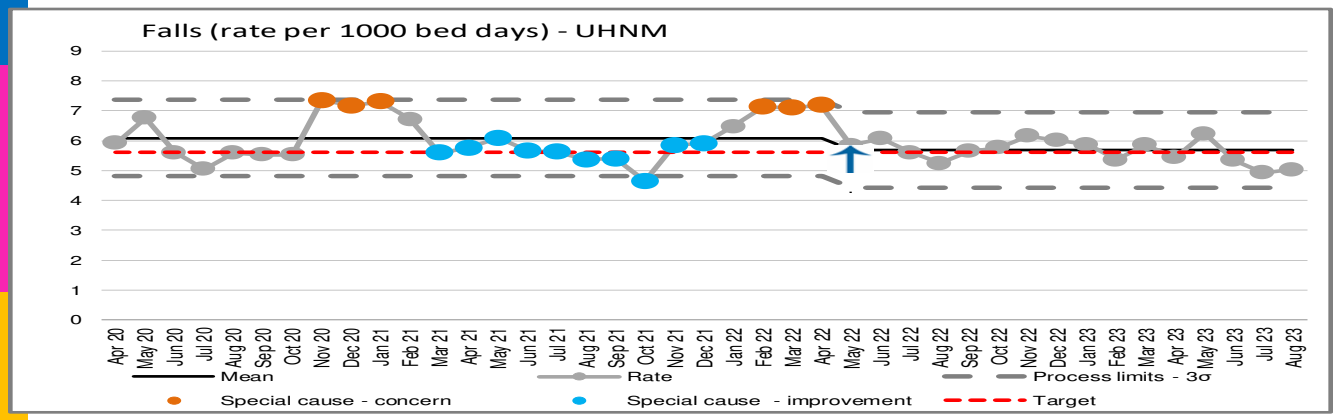
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within control limit but has shown decreasing total numbers and rate for the past 8 months.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 8 Medication, 7 Tissue Viability, 5 Falls, 4 Treatment/procedure related, 3 Clinical assessment

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

Patient Falls Rate per 1000 bed days

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
5.6	5.4	4.9	5.0

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

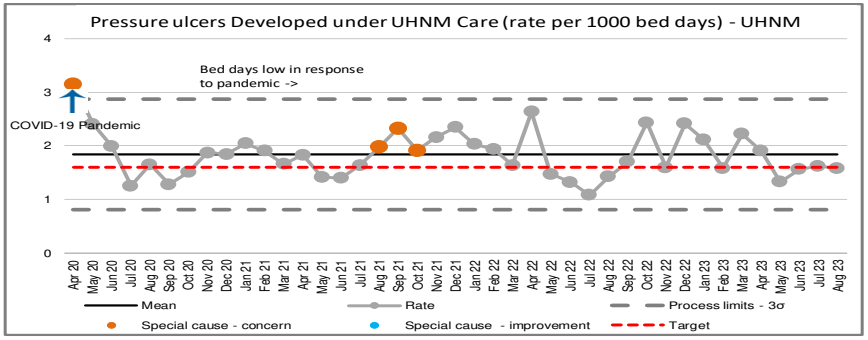
The Trust's rate of reported patient falls per 1000 bed days was within the normal range in August.

The areas reporting the highest numbers of falls in August 2023 were:
Royal Stoke AMU – 15 falls, Royal Stoke ECC – 12 falls, Ward 230 – 12 falls, Ward 14 – 9 falls
ED falls numbers per month have doubled since Autumn 2020, however, the rate per 1000 attendances has also been 77% higher since Autumn 2020 indicating that increased activity may not be the only factor behind increased falls. The number of ED falls reported for August (12) is a 13 month low, but it is not yet clear that a sustained reduction has been achieved.

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

- Audits/spot checks have taken place in all of the above areas.
- 1:1 education has been delivered by Q&S to ECC and AMU staff. The staff have been educated about documentation, interventions to prevent falls and discussions around deconditioning. This will continue weekly by Q&S.
- ECC monthly topic for improvement is lying and standing blood pressures.
- AMU have trained a third of the staff on how to complete the new risk assessment booklet correctly (new book holds more risk assessments than previous).
- AMU have improved nurse to patient ratio and the team have been asked if it would be possible to have tables in the bays to allow staff to carry out documentation whilst being visible to patients who have falls risk factors.
- All of the areas above have had new falls champions trained recently in order to cascade training to their teams.
- AMU and ECC have had recent SI's and remain in the Top 5 falling wards therefore focus of improvement is constant.
- Ward 230 are frequently in the Top 5 falling wards and this is possibly due to their group of patients, however last SI was in March 2023.
- Ward 14 are seen in the Top 5 falling wards occasionally and their last SI was in July last year.

Pressure Ulcers developed under care of UHNM per 1000 bed days

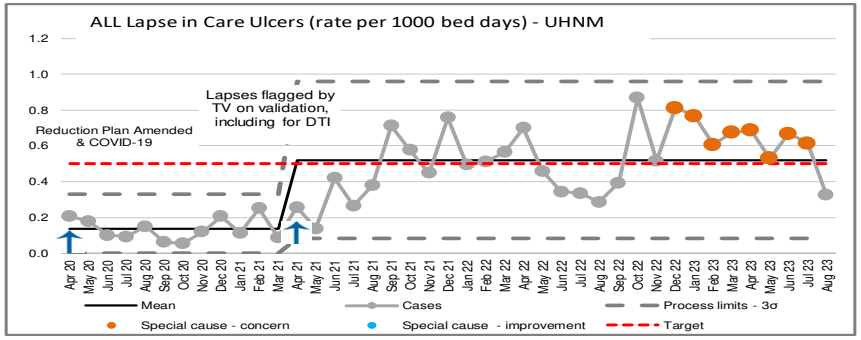


Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
1.6	1.56	1.63	1.58

Background

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



Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
0.5	0.67	0.62	0.33

Background

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

What the data is telling us

The rate of pressures ulcers reported as developed under UHNM care was within expected limits in July. The rate of cases with lapses in care identified was below the average in August after 10 consecutive months above the average.

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

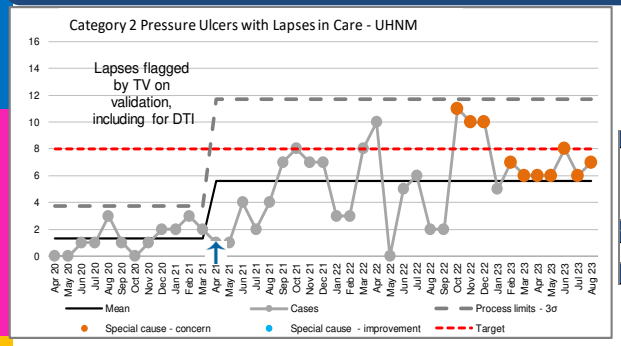
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.

Actions

- Training continues for NA induction, Preceptorship days, overseas nurses, and ED agency paramedics .
- Education is being delivered in pressure prevention, continence, categorisation, and wound assessments. Ad hoc education requests are mad by clinical areas.
- ESR approved by Stat & Mand Training group has been approved – moving forward with the new categorisation recommendations from NWCSP
- Skin health booklet has been approved – moving forward with the new categorisation recommendations from NWCSP
- Stakeholder group created for patient seating. To update the chair and mattress audit with IP and visits to areas have recommenced. Company reps will be supporting with auditing surfaces
- A3 on urethral erosions is on-going work, actions identified. Catheter audits have been completed, currently awaiting continence audits
- Task and finish group has been set up with the ICB to improve continuity of care and reduce harm

Pressure Ulcers with lapses in care

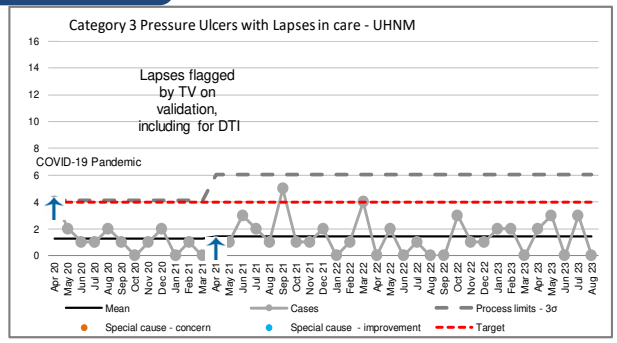
NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	?

Target	Jun 23	Jul 23	Aug 23
8	8	6	7

Background

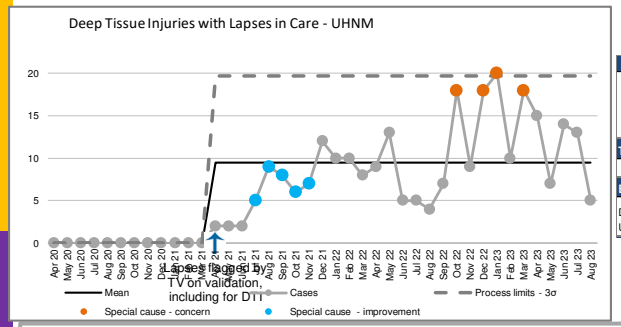


Variation	Assurance
	?

Target	Jun 23	Jul 23	Aug 23
4	0	3	0

Background

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

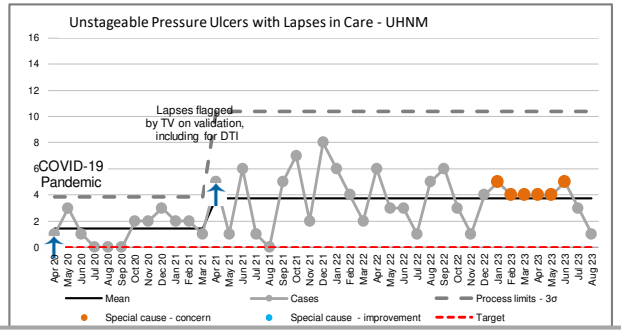


Variation	Assurance
	?

Target	Jun 23	Jul 23	Aug 23
0	14	13	5

Background

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



Variation	Assurance
	?

Target	Jun 23	Jul 23	Aug 23
0	5	3	1

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., although the number of Category 2 ulcers with lapses in care has been above average for 10 of the past 11 months. This correlates with the higher numbers of total lapses seen in recent months, and offers some reassurance that the higher numbers have been associated with Category 2's rather than numbers in the more serious categories.

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

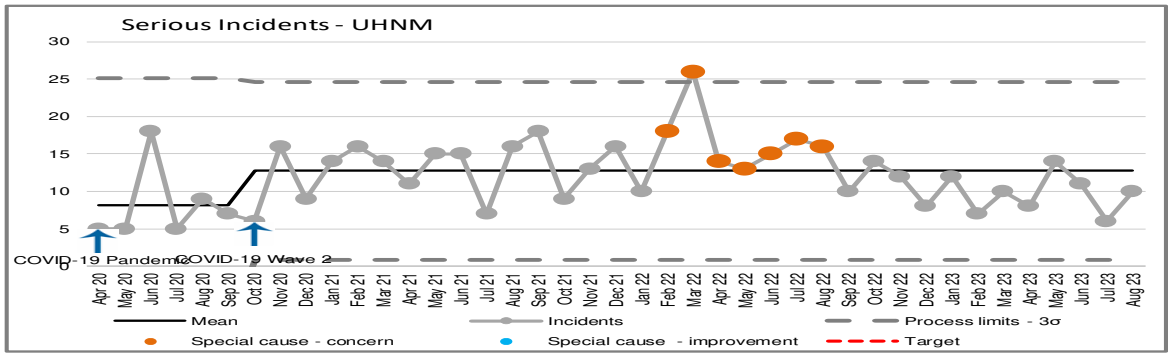
Locations with more than 1 lapse in August 2023 were: **ED Stoke (3), AMU Stoke (2)**

Root Cause(s) of damage - Lapses - Aug 2023	Total
Management of repositioning	6
Management of device	4
Management of heel offloading	2

Actions:

- PSIRF AAR are being completed and learning identified more timely. RCA panels will continue until a established process is in place
- High reporting wards and wards of concern are visited by Quality and Safety and Tissue Viability to complete audits and deliver education
- ED CAS card has been updated and in circulation to focus on pressure prevention improvements
- Tendable questions have been updated to focus on root causes. Support for completion of Tendable audit with high reporting areas
- 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 to evidence care and prevention of damage

Serious Incidents per month

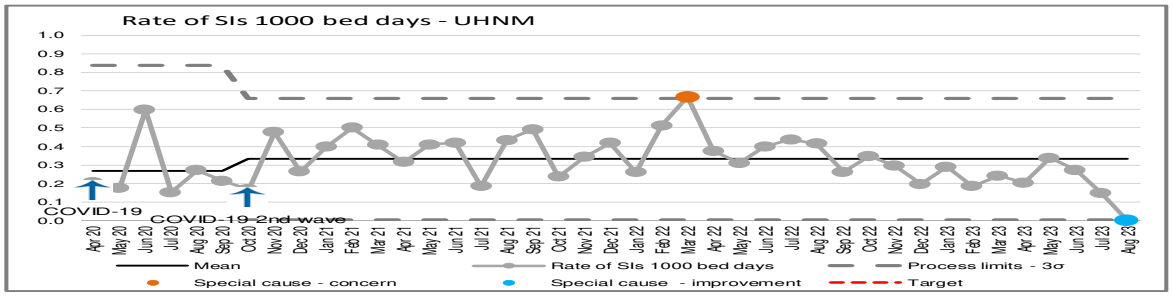


Variation	Assurance
	F

Threshold	Jun 23	Jul 23	Aug 23
0	11	6	10

Background

The number of reported Serious Incidents per month



Variation	Assurance
L	F

Target	Jun 23	Jul 23	Aug 23
0	0.27	0.15	0.00

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. August 2023* saw 10 incidents reported:

- 7 Falls related incidents
- 1 Diagnostic related including delay making diagnosis
- 1 MRSA
- 1 Maternity/Obstetric related (baby only)

The rate of SIs per 1000 bed days has varied consistently within confidence limits but the past 10 months have shown significant improvement with rate below the long term mean of 0.4. The current rate is 0.25.

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

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

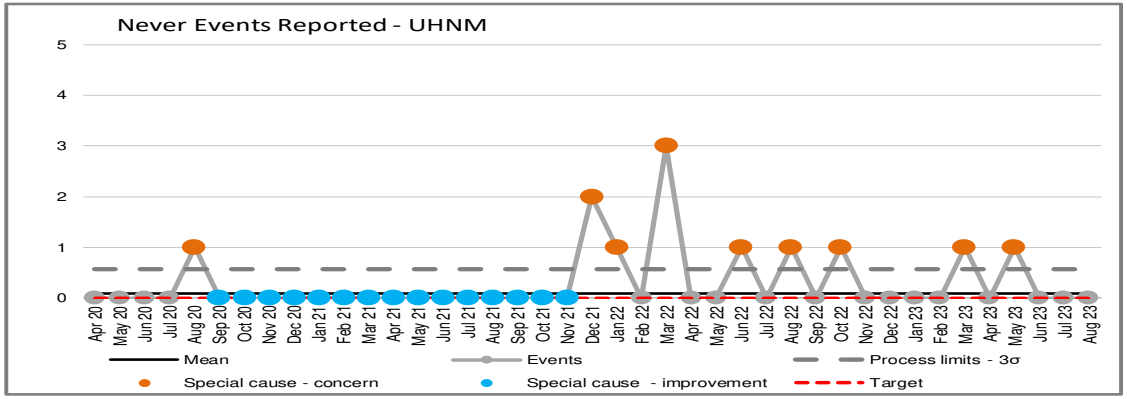
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during August 2023. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

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

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2023/15335	White - British	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	02.11.2023	baby born in poor condition. Category 2 caesarean section performed

Never Events



Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
0	0	0	0

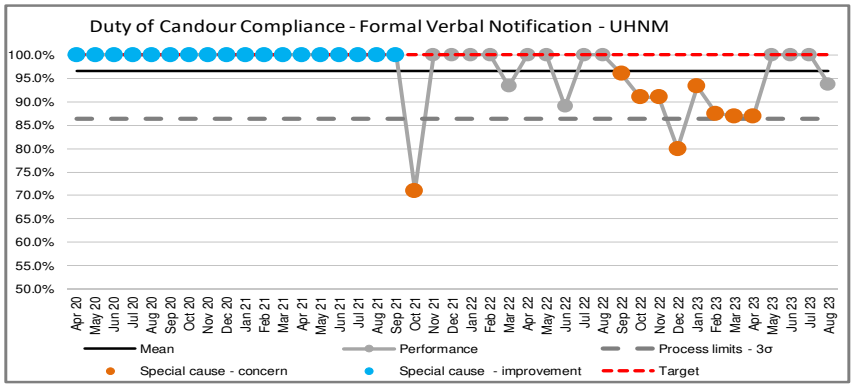
Background

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

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

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

Duty of Candour Compliance

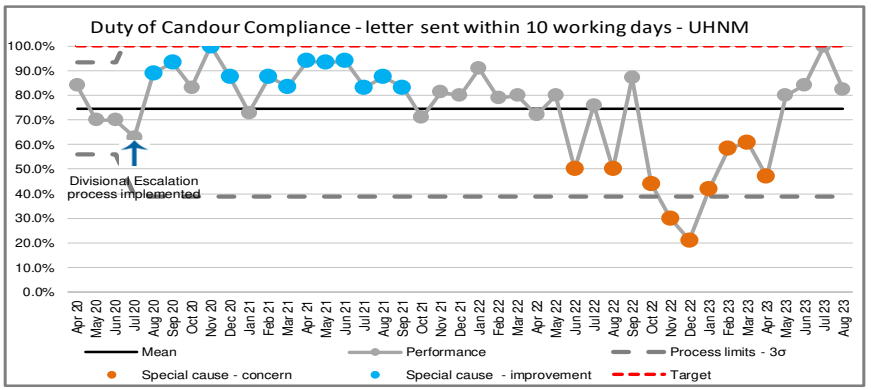


Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
100%	100.0%	100.0%	93.8%

Background

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



Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
100%	84.2%	100.0%	82.4%

Background

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

What is the data telling us:

During August there were 17 incidents reported and identified that have formally triggered the Duty of Candour. 93.8% (16 out of 17) 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 August 2023 was 82.4% as at 5th September 2023 including those letters that are completed within timescale and not yet exceeded the timeframe.

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

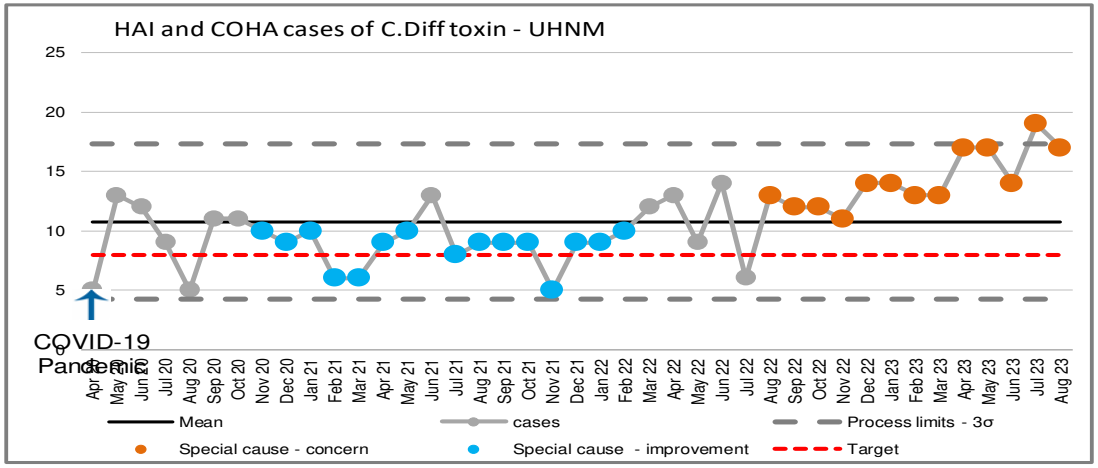
Actions taken:

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

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

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

Reported C Diff Cases per month



Variation	Assurance
	

Target	Jun 23	Jul 23	Aug 23
8	14	19	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 August 2023

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

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

There has been three clinical areas with more than one Clostridium *difficile* case within in a 28 day period. Ward 78 2 x toxin HAI , Critical Care pods 1-2 2x toxin HAI , Ward 124 1 x HAI and 1 x COHA

The top 3 areas for C Diff toxin during August were Ward 124 , Ward 78, Critical Care pods 1-2

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)

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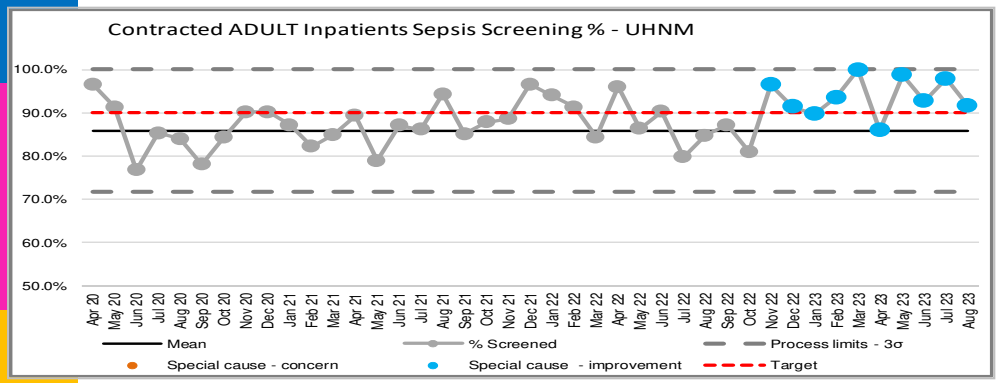

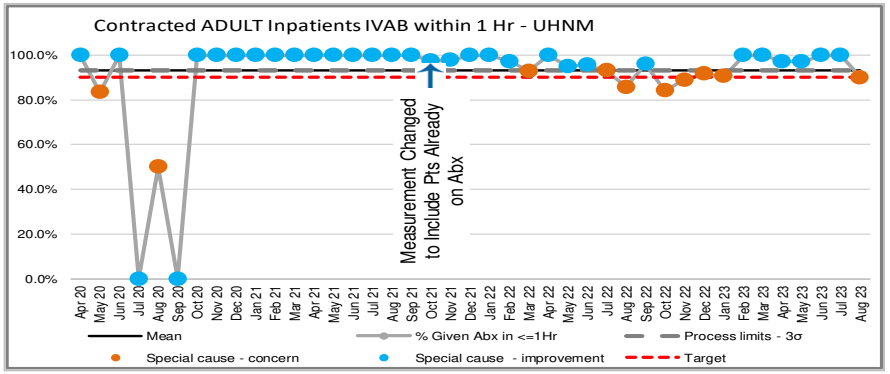

Variation	Assurance
H	?

Target	Jun 23	Jul 23	Aug 23
90%	92.8%	97.9%	91.7%

Background

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

Variation	Assurance
L	P

Target	Jun 23	Jul 23	Aug 23
90%	100.0%	100.0%	90.0%

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 August 2023. There were 72 cases audited with 6 missed screening from different ward areas or divisions. Out of 72 cases audited, 46 cases were identified as red flags sepsis with 26 cases having alternative diagnosis and 20 cases were true red flags. 15 were already on IVAB treatment.

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
- World Sepsis day 13th September 2023 events and awareness planned for both sites on 13th and 14th September 2023

Sepsis Screening Compliance (Emergency Portals Contract)

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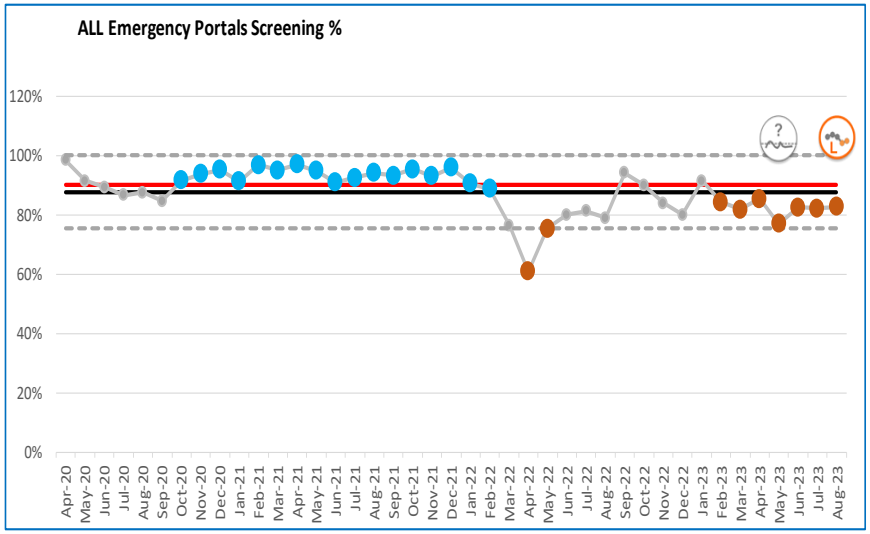

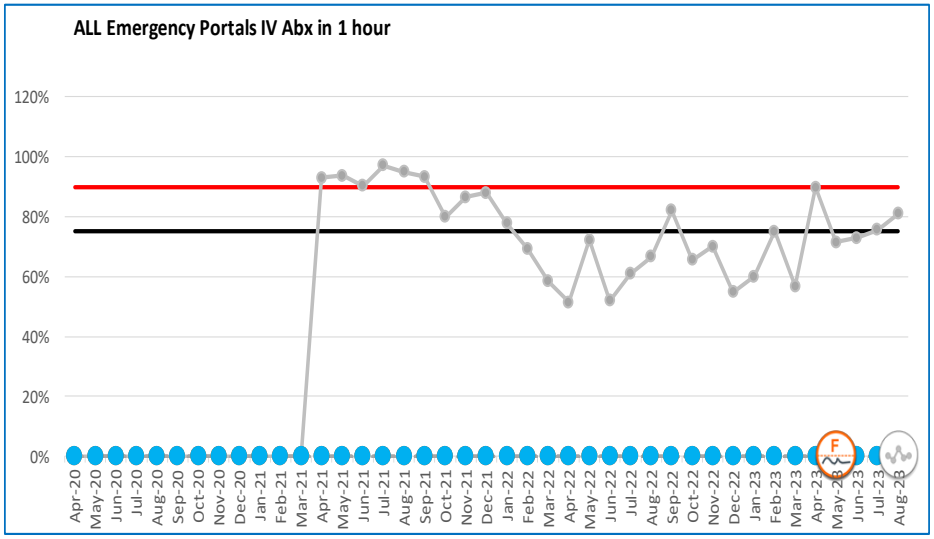

What is the data telling us:

Adult Emergency Portals screening did not meet the target rate for August 2023. There were 69 cases audited with 12 missed screening in total from the emergency portals. The performance for IVAB within 1 hour achieved 81 %. Out of 69 cases, there were 42 red flags sepsis in which the 13 cases already on IVAB, 29 cases were newly identified sepsis and 17 cases have alternative diagnosis. There were 7 delayed IVAB within 1 hour and 2 within 2 hours. Missed screening contributed at ED stoke and FEAU

Actions:

- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E daily. Provide sepsis session when staffing and acuity allows.
- Face to face A&E sepsis induction/ training for new nursing staff, nursing assistant and medical staff already recommenced.
- Further training planned for FEAU and other emergency portals
- Monitoring impact of long ambulance waits on timely assessment and treatment of sepsis; on-going
- World Sepsis Day 13th September 2023 events planned

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

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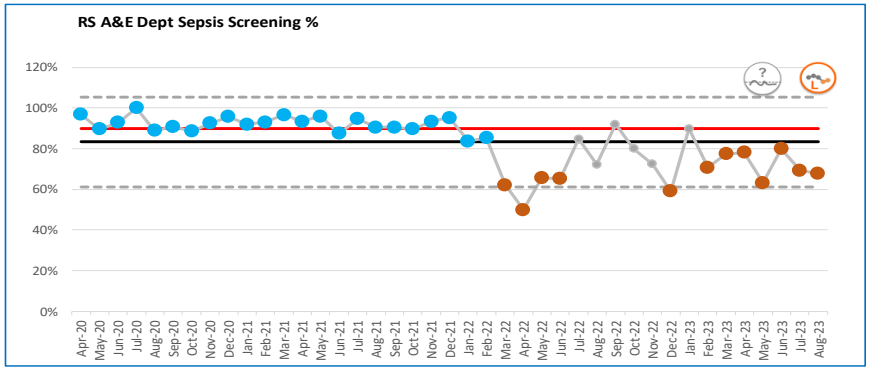

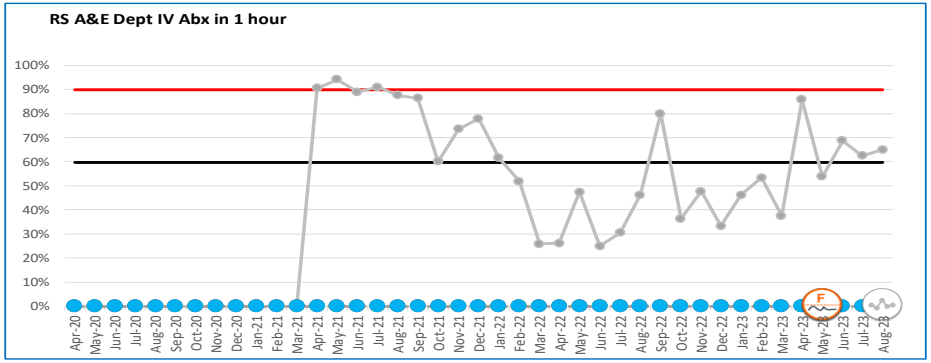

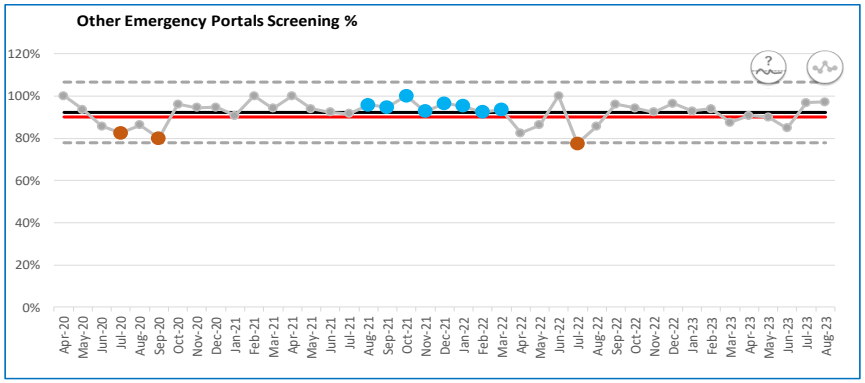

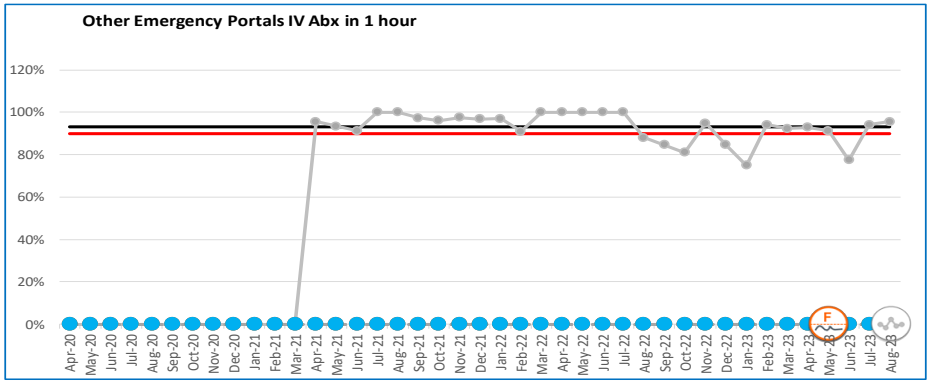

What is the data telling us:

RSUH Emergency Department performance in August 2023 remains below target rate for both screening and IVAB within the 1 hour. A improvement for County Hospital can be seen this month as they achieved screening compliance.

Actions:

- CAS card has been further updated to reflect the sepsis pathway and to ensure all staff are following the correct guidance.
- 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: on-going
- 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

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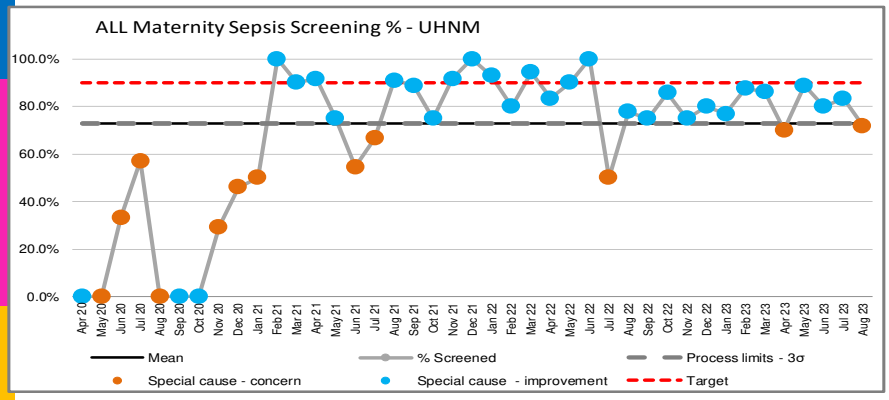

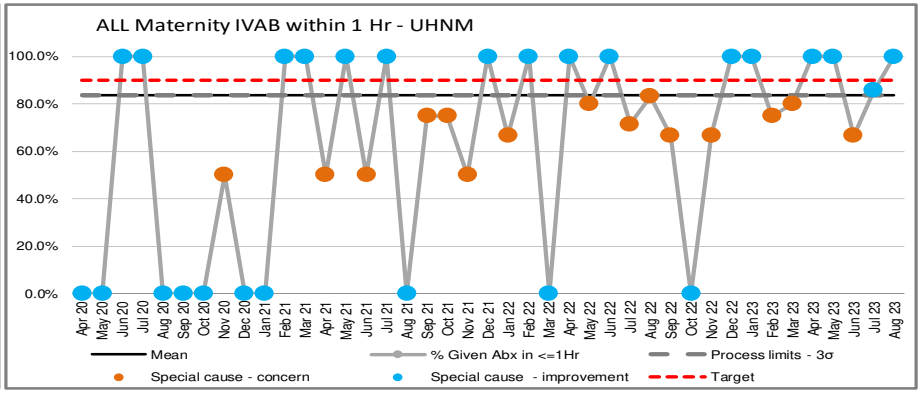

Variation	Assurance
L	F

Target	Jun 23	Jul 23	Aug 23
90%	80.0%	83.3%	71.8%

Background

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

Variation	Assurance
H	F

Target	Jun 23	Jul 23	Aug 23
90%	67%	86%	100%

Background

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

What is the data telling us:

Maternity audits in screening compliance is below target this month achieving 81% for emergency portals. However they achieved 100 % for IVAB within the 1 hour. Inpatient areas is below target for screening at 70% however achieved 100% for IVAB within 1 hour. This compliance score is based on a small number, however a regular spot checks audit is being conducted monthly.

There were 16 cases audited from emergency portal (MAU) and inpatients with 3 missed screening. There were 2 true red flags identified from the randomise audits, and both 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; on-going
- 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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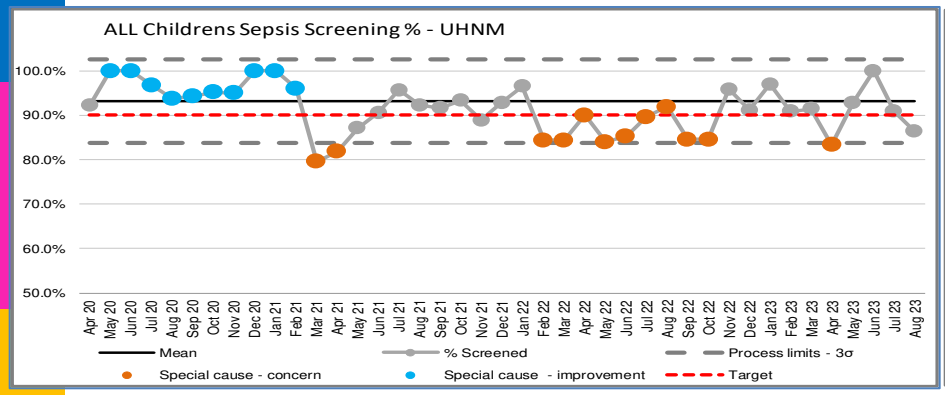

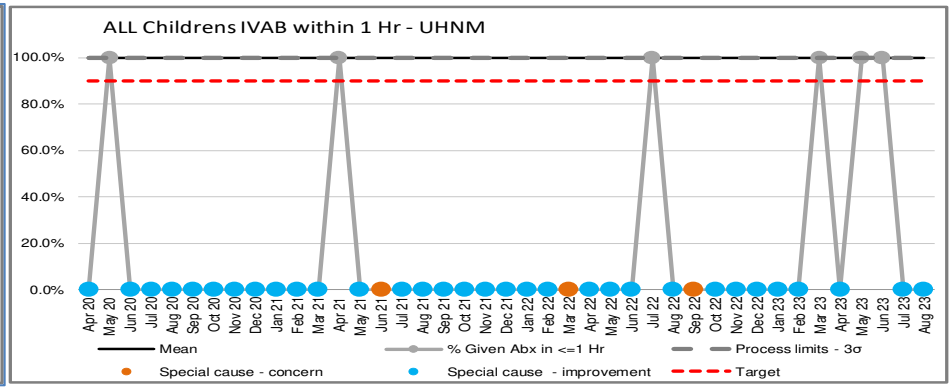

Variation	Assurance
	?

Target	Jun 23	Jul 23	Aug 23
90%	100.0%	90.9%	86.4%

Background

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

Variation	Assurance
H	P

Target	Jun 23	Jul 23	Aug 23
90%	100.0%	N/A	N/A

Background

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

What is the data telling us:

Children's Services target rate of > 90% was not achieved for August. 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 21 cases audited for emergency portals and inpatients areas with 2 missed screening. No true red flag sepsis was identified from the randomise audits in inpatients and emergency portals.

Actions:

- The Sepsis Team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective; on-going
- Plan of collaborative work with Children education lead and aiming to deliver Induction training and ward based sessions in the next few weeks
- Create sepsis awareness on the 13th September 2023 World Sepsis Day events

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Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS
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Non-Elective Care

- Context
  - ED Conversion increased slightly from 30.9% in July to 32.0% in August
  - 12 Hour Trolley Waits improved from 692 in July to 456 in August
  - Type 1 A&E Attendances decreased slightly from 14117 in July to 13634 in August

- Driver Metrics
  - 12+ Hours In ED improved again from 1772 in July 1398 in August
  - Ambulance Handovers <60 Minutes slightly improved from 88.2 in July to 91.6% in August
  - Four Hour performance remained static at 68.6% in August from 69.0% in July

Cancer

- Trust overall 2WW Performance achieved 94.6% in July 23 – un-validated 95.3% for August.
- The Trust also predicted to achieve the 2WW in August. This sustained improvement is as a result of schemes such as the Lower GI Community Referral hub and Community Tele-dermatology pathways being successfully implemented.
- Breast symptomatic (where cancer is not suspected) achieved at 94.1% in July and is predicted to achieve the target again in August.
- The 62 Day Standard achieved better than predicted in July at 51.8%. The current provisional position for August is 45.8%. This is an un-validated and incomplete position that is expected to change as pathology confirms or excludes cancer for treated patients. Contributing factors include treatment and diagnostic capacity, with robust plans in place to tackle the most challenged specialties (LGI) over the next quarter.
- The 31 Day Standard achieved 87.8% for July. It is predicted to land at 86.9% in August.
- The 31 day Subsequent Radiotherapy achieved 99.1% in July and is expected to achieve 88.6% in August.
- The 28 Day Faster Diagnosis Standard achieved 72.6% for all referral routes combined in July. The August position is currently incomplete and will be validated once Pathology confirms cancer or non cancer on high volume pathways such as Skin. Areas of best practice consistently achieving the standard are Breast and Upper GI and Skin.
- In August last year the PTL was over 6000 – this has now reduced to around 4600 in total.
- The number of patients waiting over 62 days on an open pathway at the month end was 455 – a reduction of 45 since last month.
- UHNM has received record 2WW referral volumes moving into the summer months, more than usual seasonal demand plus the predicted growth, with some weeks exceeding 1000 referrals received.

Spotlight Report from Chief Operating Officer

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Planned Care

- At the end of August the validated numbers of >104 patients was 3. The current prediction for end of September is 0.
- The validated number of 78 week breaches for end of July was 186, un-validated 78 week breaches for August is 183. This is predicted to be 178 for September, this takes into account the impact of industrial action – without IA the prediction was 98.
- The focus has moved to 65 week waiters with an Annual Plan to reduce them to below 200 patients by end of March 2024 but National ask of 0. The National ask is to see all first non-admitted pathways by the end of October. There are a number of specialties which are challenged with this including Spines, Ophthalmology, MaxFac, Plastics, Paeds Orthopaedics, Gastro, Respiratory and Neurology. The un-validated 65 week position for August was 1340, down from July's 1352.
- Day Case activity and Elective Activity have moved from delivering 80% and 84% respectively for July to 82% and 81% for August. The Trust has now launched the national standard 6-4-2 process within theatres with support from the regional theatres team. Day case as a % of all elective work is currently 87.4%.

RTT

- The overall Referral To Treatment (RTT) Waiting has increased again from 78,866 in June to 80,109 in July and 81,237 (un-validated) in August.
- The number of patients > 52 weeks has increased, currently standing at 4676 up from 4,266 in July.

Diagnostics Summary

- During August the Diagnostic activity slipped to below 1920 levels.
- DM01 performance was 67% un-validated overall which was below the validated July performance of 73% (this improved from 69% pre validated position reported last month). Endoscopy performance is the main contributor to this performance

Histology Position – as at 22nd August 2023:

- **Urgent** (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day **18** (No Change), with 80% of cases reported by Day **12** (Previously Day 11)
- **Accelerated** (include all Cancer Resections): 95% reported at Day **32** (Previously Day 31) with 80% of cases reported by Day **22** (Previously Day 24)
- **Routine** (all Specimens not in above categories): 95% Day reported at **35** (Previously Day 33) 80% of cases reported by Day **22** (Previously Day 27)

Our 7 day reporting turnaround time (TAT) for Urgent cases is at 51.27% against the Royal College of Pathologists' target of 80% within 7 days (59.4% previously)

Radiology reporting backlog:

- High risk relating to 'routine /non cancer reporting' due to reporting capacity and delays in diagnosis. The risk register has separate risks for each reporting sub group. The highest risk currently 12 relates to MSK however this is an improving position with 7 phases outsourced to Medica – with a total of 3,700 scans being reported by Medica, the longest waits have reduced; fortnightly backlog meetings with the clinical lead and divisional team are continuing. Paediatric reporting backlog – the focus is on the longest waiters. AAC panel arranged for mid December to recruit to a 1wte substantive Paediatric Radiologist.

Endoscopy:

- In-sourcing extended for 1 month until end September; further extension being considered
- Service team reviewing demand management and productivity measures to improve utilisation and appropriateness
- Outsourced booking service approved and contracting arrangements in place; due to commence mid-September
- Booking Team skills bank continues to be developed, on-going recruitment programme to fill all temporary and substantive posts
- Successfully recruited 2 x Trainee Clinical Nurse Scopists (1 x HEE training commencing September; one is relocating to SOT and will be trained in-house)

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Section 1: Non-Elective Care

Headline Metrics

Non-Elective Care – monthly *(context)*

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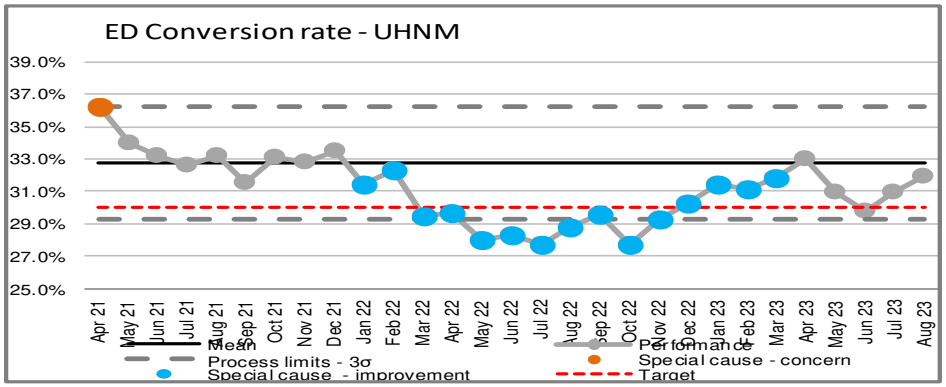
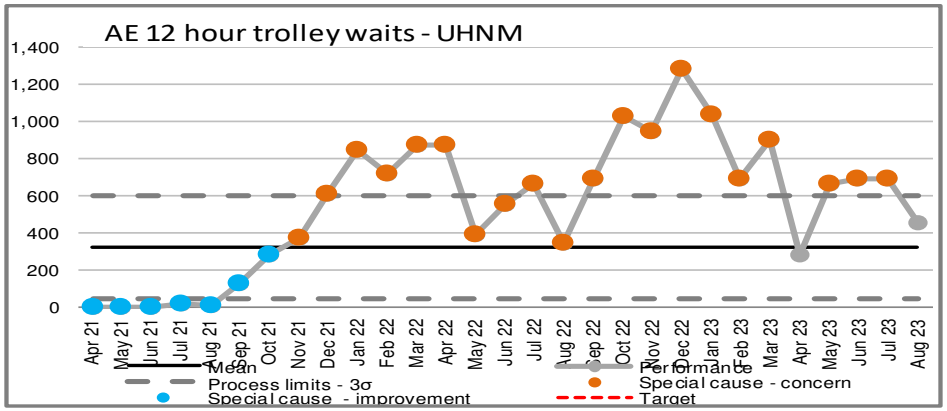


Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
30%	29.8%	30.9%	32.0%

Background

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

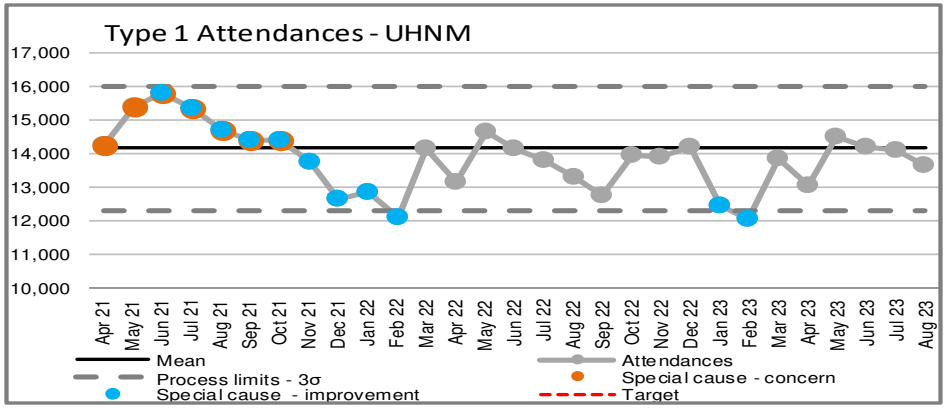


Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
0	690	692	456

Background

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



Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
N/A	14202	14117	13634

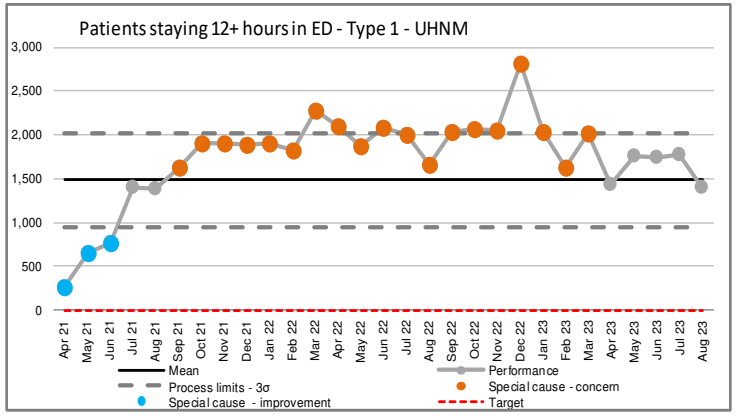
Background

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

Delivering Exceptional Care with Exceptional People

Non-Elective Care – Headline Metrics

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

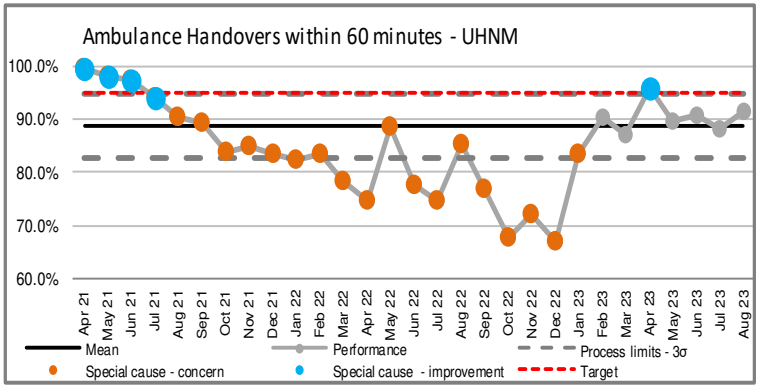
Target	Jun 23	Jul 23	Aug 23
0	1734	1772	1398

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 reduced by 21% in August compared to July.



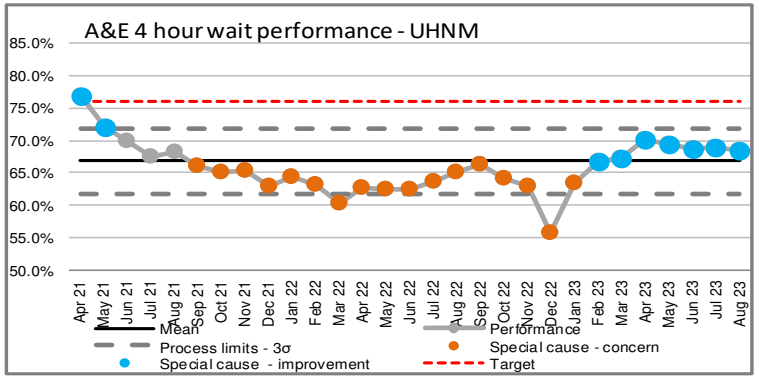
Variation	Assurance
	F

Target	Jun 23	Jul 23	Aug 23
95.0%	90.9%	88.2%	91.6%

Background

The percentage of ambulance handovers completed within 60 minutes.

Ambulance handovers within 60 minutes performance improved last month to 91.6% against the 95% target.



Variation	Assurance
H	F

Target	Jun 23	Jul 23	Aug 23
76%	68.8%	69.0%	68.6%

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 has been consistently above the two year average during 2023.

Urgent Care - 4 hour standard

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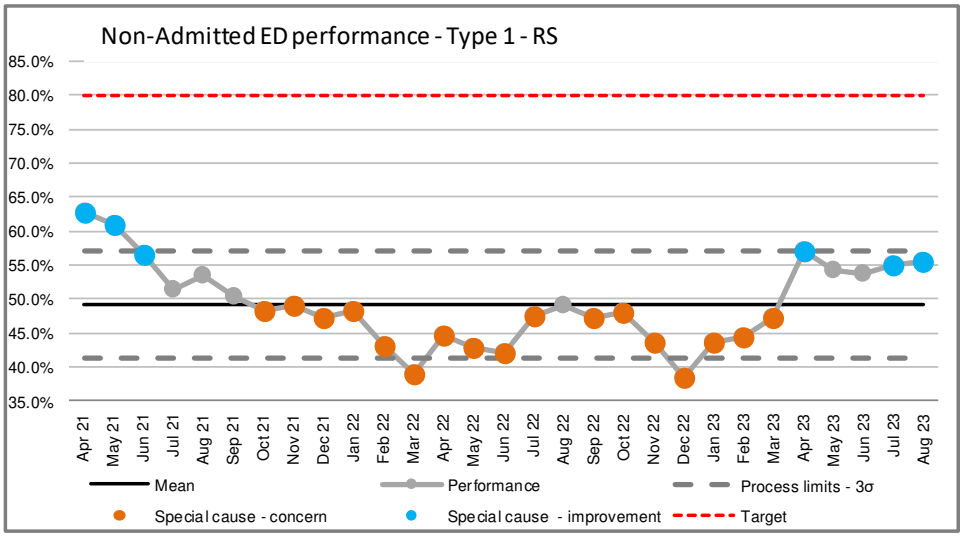
Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Jul 23	76.00%	69.6%			34

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 12 Hour Standard	Jul 23	1.0%	12.5%			14
A&E - 4 Hour Standard	Jul 23	76.00%	69.6%			34
A&E - 4 Hour Standard (Type 1)	Jul 23	76.0%	51.8%			19
A&E - 4 Hour Standard (Type 2 or 3)	Jul 23	95.0%	98.2%			51
A&E - Conversion Rate	Jul 23	25.0%	26.5%			17
A&E - DTA to Admission >12 Hours	Jul 23	0.0%	11.7%			20
A&E - DTA to Admission >12 Hours#	Jul 23	0.0	692.0			6
A&E - DTA to Admission >4 Hours	Jul 23	10.00%	29.4%			42
A&E - Left Without Being Seen	Jun 23	5.00%	5.8%			33
A&E - Reattendance Rate	Jun 23	5.0%	9.0%			36
A&E - Time to Initial Assessment	Jun 23	15.0	7.0			66
A&E - Time to Treatment	Jun 23	60.0	74.0			50
A&E - Total Time in A&E	Jun 23	160.0	171.0			63
A&E - Total Time in A&E (Admitted)	Jun 23	180.0	378.0			36
A&E - Total Time in A&E (Non-Admitted)	Jun 23	140.0	150.0			65

- UHNM 4 hour performance over the last four months has sustained c.70% against a 76% target.
- This is remained in line with other peer groups, but at a lower rate.
- UHNM remain in the 3rd quartile.

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

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Jun 23	Jul 23	Aug 23
80%	53.8%	55.1%	55.6%

Summary

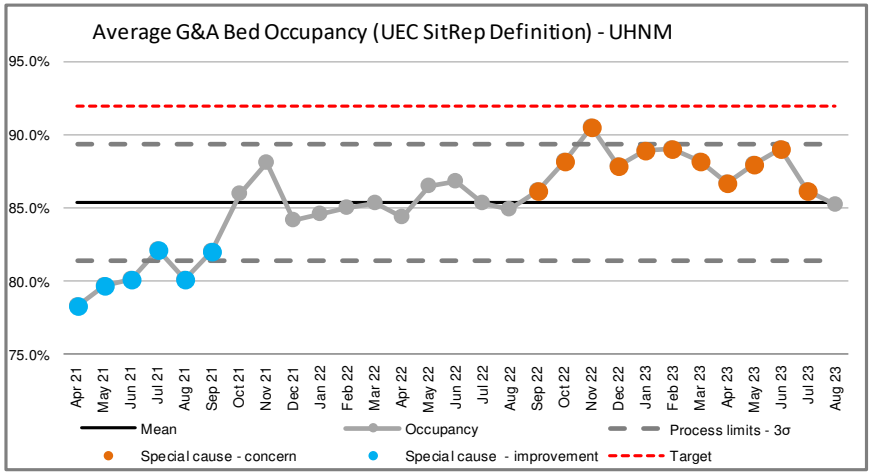
- RSUH ED Non-Admitted Four Hour Performance is significantly off track with a performance of 55.6% against a target of 80% for August. Despite weekly meetings continuing with the Divisional and Department Senior Leadership Teams supported by the Deputy Chief Operating Officer and Deputy Medical Director to monitor progress against an Improvement Plan delivery has been slow as a result of reported lack of capacity.
- There are a number of initiatives that are expected to support delivery scheduled for mid-September with the Directorate confident this will deliver a degree of improved performance.

Actions

- The ED Clinical Director has developed an SOP to support standard work across the Ambulatory and CED area. This is to be implemented from 18 September in order to improve non-admitted performance.
- Implementation of a 24/7 Progress Chaser in the Ambulatory and CED area is to commence 18 September to further support improvement of non-admitted performance.
- The Ambulatory and CED SDM late or twilight shift trial is being explored with a focus on delivering improvements in the known area of poorest performance and greatest congestion.
- The Ambulatory and CED C&D tool is now in production with the support of the UHNM Performance Team with a target delivery date of 29 September. This will allow a day-to-day tactical view of whether the area has sufficient staffing to succeed.
- Cubicle standardisation as per lean principles is now in its final stages with standard photos to be shared, final small works escalated, and equipment orders made. This will drive clinical productivity in the area.
- Options are being explored to define how the F2S area could be utilised as an Ambulatory CDU which would have the potential to bring about incremental performance improvements with a conclusion expected by 22 September.

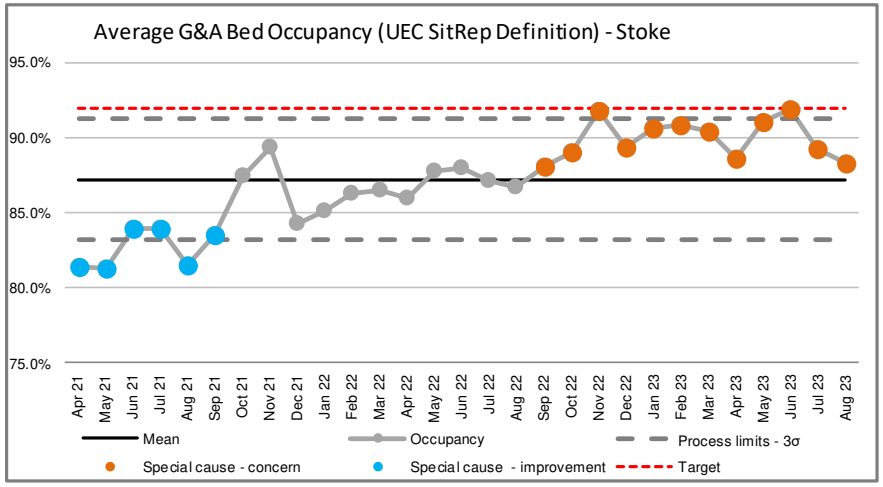
Workstream 2; Acute Patient Flow
UHNM G&A Bed Occupancy

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jun 23	Jul 23	Aug 23
92%	89.0%	86.2%	85.3%



Actions

- The LOS Improvement Working Group has developed a standard work evaluation and LOS review process questionnaire which has been sent out to Divisions to complete. This review will be used to identify focus areas as well as local best practice to inform the next wave of improvements. This will include a focus on pre-noon discharges for patients with no criteria to reside as well as ensuring the maximum proportion possible of all discharges happen before 17:00.

- The Digital Tools Working Group has now confirmed a reporting mechanism for a %EDD Completion KPI. This will support scrutiny against the objective of every patient in the Trust having an EDD that is up to date and accurate. Next steps are to launch an improvement project which will ultimately support C&D analysis, patient flow through the hospital on a daily basis, and financial efficiency driven by greater utilisation of technology.

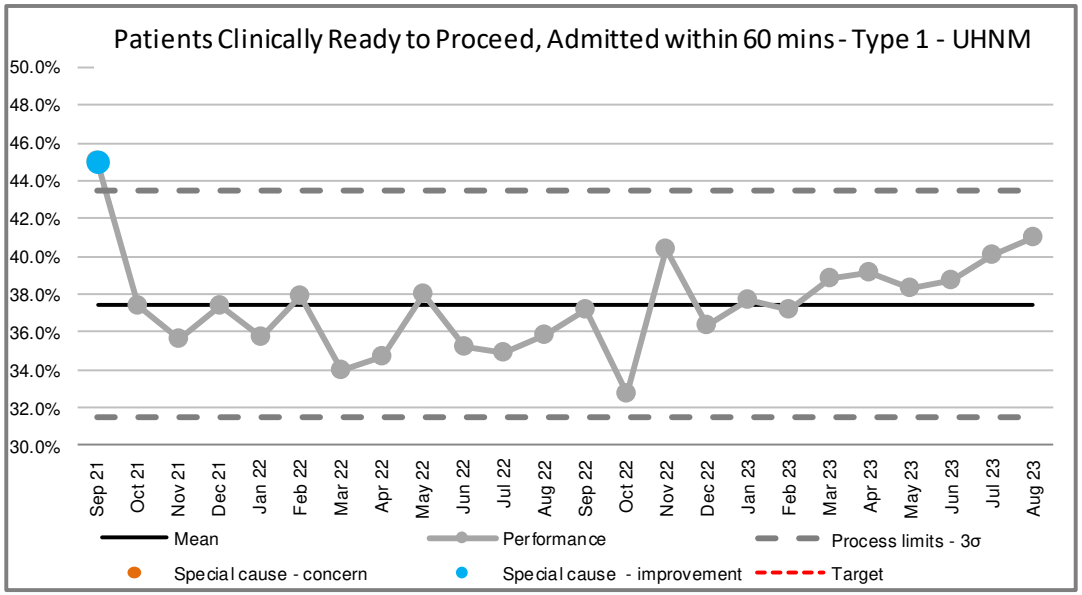
Summary

- G&A Bed Occupancy decreased again in August to 85.3%, this meant that target performance was not achieved against the Annual Plan trajectory of 84.8% for August. This places UHNM at the bottom of the first quartile for the midlands in August and is broadly consistent with our position historically.

- One of the key pieces of stratified data for Workstream 2 is the percentage of patients occupying acute beds with a LOS of 14 days or more. This has seen a sustained step change over August to an approximate average of 22.5% from 25% and now ranks in the second quartile regionally which is an improvement from long standing third quartile performance.

Workstream 3; Acute Portals & Navigation
CRTP+1

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jun 23	Jul 23	Aug 23
90%	38.7%	40.0%	41.0%

Actions

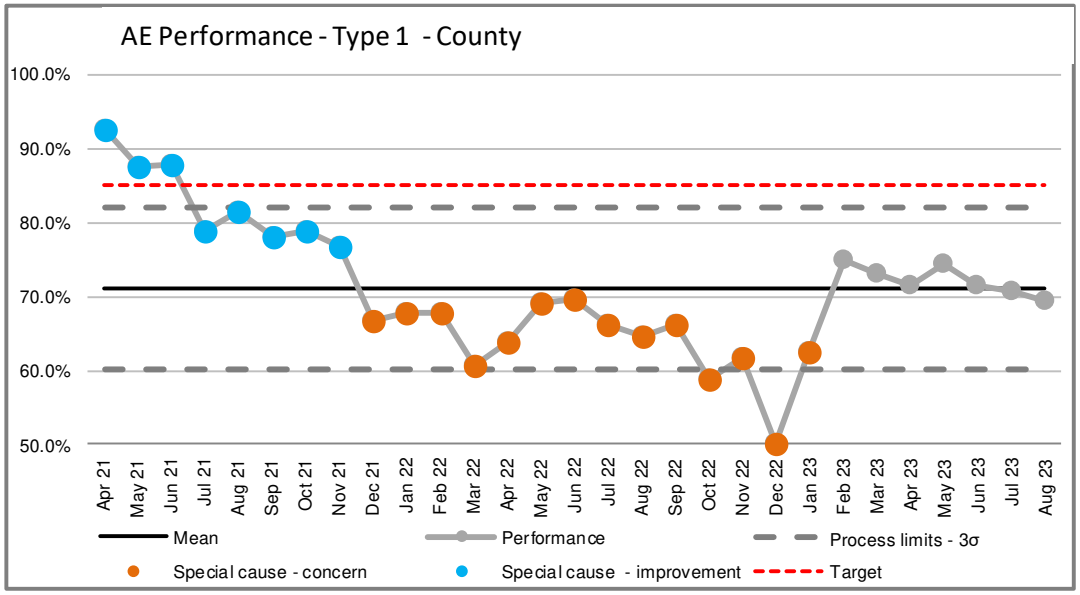
- In anticipation of winter and seeking to reduce the number of elderly admissions the implementation of a four pronged Frailty Strategy will now become a key focus of this workstream. In the first instance this will seek to release senior geriatric physician capacity through a proposed variation to existing pathways in order to support more SDEC and FEAU activities.
- Develop and implement standard work for AMU and the Short Stay Unit aligned to the introduction of the new AMRAU modular build with an aim to reduce extended lengths of stay and ensure early and proactive specialty input. This will allow the medical portal to 'churn' in a more consistent and reliable fashion.
- Final actions to be completed on data quality improvements will mean that this KPI will be reported more accurately next month following the removal of patients with no specialty tag.

Summary

- CRTP+1 performance reached 41.0% for August, continuing an overall improvement trend since December 2022 and representing the highest performing month since September 2021. While this is positive this KPI remains largely adrift from its 90% target primarily driven by flow challenges across the Medicine Division. Delivery of the overall target will require significant alignments in C&D at a system level supported by improvements in medical models across AMU, Frailty, and ACAH.

Workstream 4; County Hospital UEC
County Hospital Four Hour Performance

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
	F

Target	Jun 23	Jul 23	Aug 23
85%	71.5%	70.6%	69.4%

Actions

- While the Quality Improvement methodology has been robustly followed Four Hour Performance has not seen expected improvements. Therefore a refresh of the A3 has been undertaken in order to drive improvement aligned to the Annual Plan trajectory.
- The A3 refresh will include a focus on both medical and nursing workforce. This is because they were not included in the original A3 and it is hypothesised this has contributed to the lack of performance improvements.
- The ED is participating in a 111 trial implementation to support maximising streaming potential of patients and therefore improve Four Hour Performance.
- Long LOS reviews continue for long stay patients as part of wider LOS improvement standard work on the County Hospital site focussing on EDD compliance, Frailty, and patients with no Criteria To Reside.

Summary

- The County Hospital UEC workstream driver metric was not achieved in August with a performance of 69.4% against a trajectory of 85.0%. The refresh of the workstream A3 has been initiated in order to address this deficit and will be supported by actions and trajectories against a subset of metrics including triage and per-noon discharges.

Section 2: ELECTIVE CARE

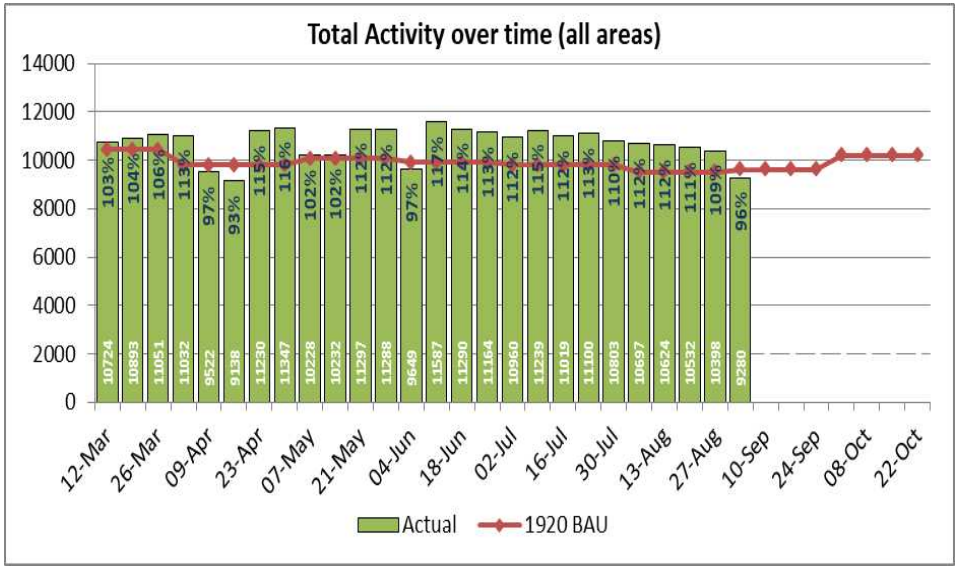
Planned Care - *Diagnostics*

NHS University Hospitals of North Midlands NHS Trust

		2019 Method For Imaging Activity				2019 Method For Imaging Activity				Under Validation			
		Jun-23				Jul-23				Aug-23			
Area	DM01 Test	Total WL	6+	%	Activity	Total WL	6+	%	Activity	Total WL	6+	%	Activity
Imaging	Magnetic Resonance Imaging	3,097	40	98.7%	7,360	3,277	56	98.3%	6,616	3,172	62	98.0%	6,868
	Computed Tomography	3,824	11	99.7%	14,994	3,589	12	99.7%	15,018	3,242	32	99.0%	15,189
	Non-obstetric ultrasound	7,911	2,793	64.7%	5,941	6,531	1,634	75.0%	7,146	5,823	1,347	76.9%	6,982
	Barium Enema	0	0		0	0	0		0				
	DEXA Scan												
Physiological Measurement	Audiology - Audiology Assessments	442	9	98.0%	432	394	45	88.6%	326	433	77	82.2%	
	Cardiology - echocardiography	3,822	2,054	46.3%	1,228	3,709	1,974	46.8%	1,144	3,358	2,029	39.6%	
	Cardiology - electrophysiology	1	0	100.0%	0	2	1	50.0%	2	2	1	50.0%	
	Neurophysiology - peripheral neurophys	297	0	100.0%	235	255	0	100.0%	268	282	1	99.6%	
	Respiratory physiology - sleep studies	575	83	85.6%	309	534	61	88.6%	315	519	80	84.6%	
	Urodynamics - pressures & flows	0	0		0	1	0	100.0%	1	0	0		
Endoscopy	Colonoscopy	1,286	1,019	20.8%	198	1,460	935	36.0%	334	1,832	1,294	29.4%	
	Flexi sigmoidoscopy	923	733	20.6%	139	1,033	717	30.6%	221	1,315	1,003	23.7%	
	Cystoscopy	190	15	92.1%	182	164	17	89.6%	206	192	63	67.2%	
	Gastroscopy	1,013	556	45.1%	675	1,053	585	44.4%	867	1,527	1,113	27.1%	
	Totals	23,381	7,313	69%	31,693	22,002	6,037	73%	32,464	21,697	7,102	67%	29,039

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

Area	DM01 Modality	13+	Total	% 13+
Imaging	Magnetic Resonance Imaging	3	3,058	0.1%
	Computed Tomography	3	3,137	0.1%
	Non-obstetric ultrasound	1	5,700	0.0%
	Barium Enema	0	0	
	DEXA Scan			
Physiological Measurement	Audiology - Audiology Assessments	16	429	3.7%
	Cardiology - echocardiography	445	3,305	13.5%
	Cardiology - electrophysiology	0	3	0.0%
	Neurophysiology - peripheral neurophysiology	0	288	0.0%
	Respiratory physiology - sleep studies	16	545	2.9%
	Urodynamics - pressures & flows	0	0	
Endoscopy	Colonoscopy	964	1,843	52.3%
	Flexi sigmoidoscopy	733	1,326	55.3%
	Cystoscopy	47	200	23.5%
	Gastroscopy	748	1,539	48.6%
	Total	2,976	21,373	13.9%



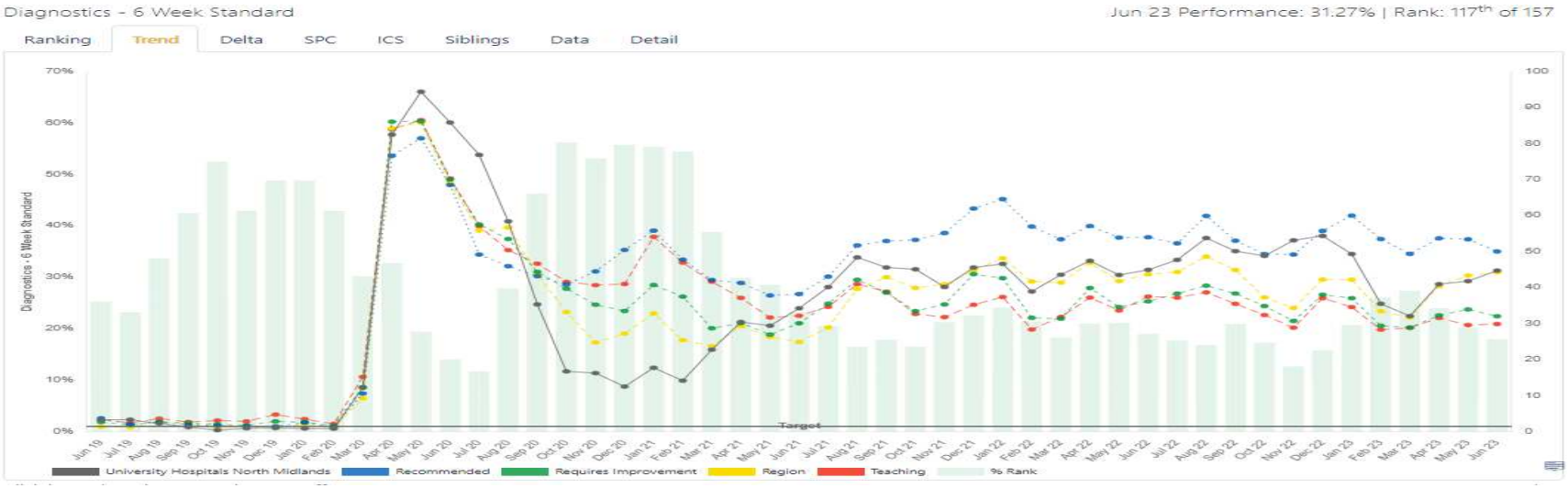
Pathology:

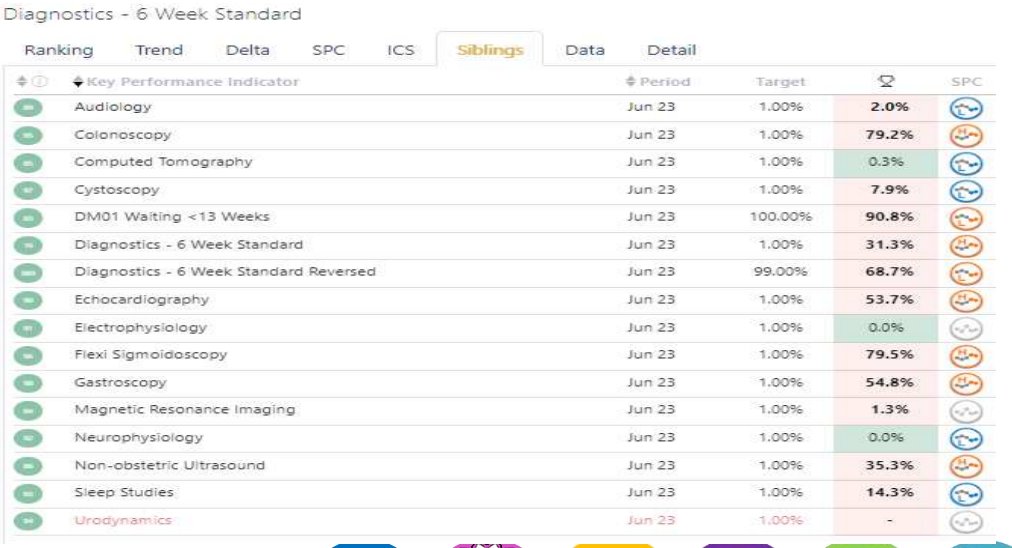
The following represents performance as at 22nd August 2023:

- **Urgent** (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day **18** (No Change), with 80% of cases reported by Day **12** (Previously Day 11)
- **Accelerated** (include all Cancer Resections): 95% reported at Day **32** (Previously Day 31) with 80% of cases reported by Day **22** (Previously Day 24)
- **Routine** (all Specimens not in above categories): 95% Day reported at **35** (Previously Day 33) 80% of cases reported by Day **22** (Previously Day 27)

Our 7 day reporting turnaround time (TAT) for Urgent cases is at 51.27% against the Royal College of Pathologists' target of 80% within 7 days (59.4% previously)

Diagnostics





Key Performance Indicator	Period	Target		SPC
Audiology	Jun 23	1.00%	2.0%	
Colonoscopy	Jun 23	1.00%	79.2%	
Computed Tomography	Jun 23	1.00%	0.3%	
Cystoscopy	Jun 23	1.00%	7.9%	
DM01 Waiting <13 Weeks	Jun 23	100.00%	90.8%	
Diagnostics - 6 Week Standard	Jun 23	1.00%	31.3%	
Diagnostics - 6 Week Standard Reversed	Jun 23	99.00%	68.7%	
Echocardiography	Jun 23	1.00%	53.7%	
Electrophysiology	Jun 23	1.00%	0.0%	
Flexi Sigmoidoscopy	Jun 23	1.00%	79.5%	
Gastroscopy	Jun 23	1.00%	54.8%	
Magnetic Resonance Imaging	Jun 23	1.00%	1.3%	
Neurophysiology	Jun 23	1.00%	0.0%	
Non-obstetric Ultrasound	Jun 23	1.00%	35.3%	
Sleep Studies	Jun 23	1.00%	14.3%	
Urodynamics	Jun 23	1.00%	-	

- UHNM had seen an improvement in performance against the 1% target during Q4 22/23.
- Since then performance to target has deteriorated for UHNM despite a slow reducing trend in the overall waiting list and an increase in activity levels.
- UHNM remain in the third Quartile.

Planned care - *Diagnostics*

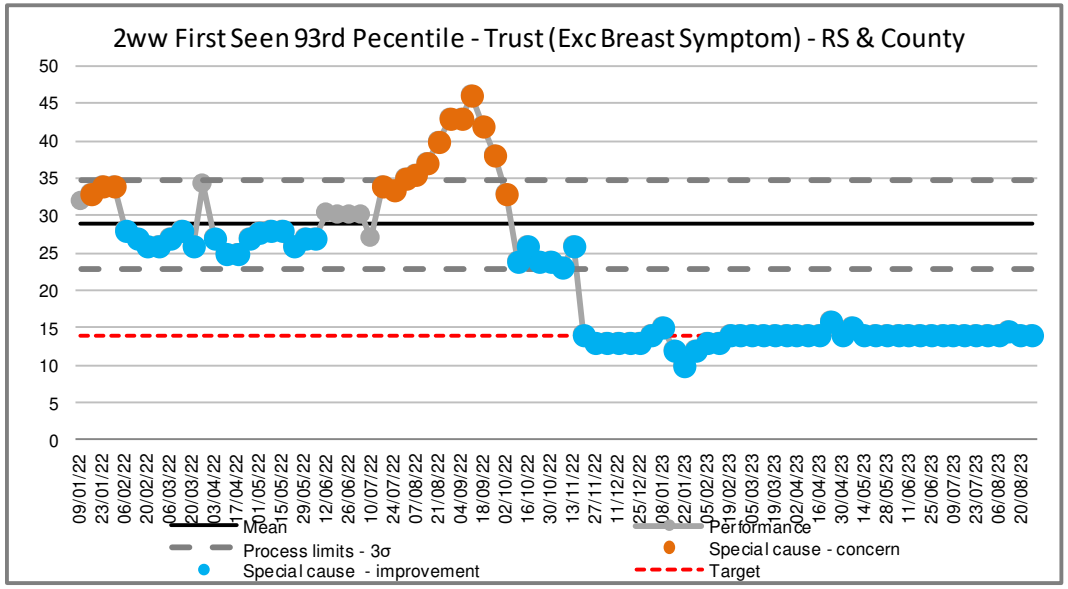
University Hospitals of North Midlands NHS Trust

Diagnostics Summary

- During August the Diagnostic activity slipped to below 1920 levels.
- DM01 performance was 67% un-validated overall which was below the validated July performance of 73% (this improved from 69% pre validated position reported last month). Endoscopy performance is the main contributor to this performance
- Histology 7 day reporting turnaround time (TAT) for Urgent cases is at 51.27% against the Royal College of Pathologists' target of 80% within 7 days (59.4% previously.
- Radiology reporting remains a high risk relating to 'routine /non cancer reporting' due to reporting capacity and delays in diagnosis. Outsourcing to Medica remains and the longest waits have reduced; fortnightly backlog meetings with the clinical lead and divisional team are continuing.
- Non-obs ultrasound capacity for routine patients: The DM01 position for non obs ultrasound has improved further to 76.9%. The plan aims to achieve DM01 trajectory by November 2023
- Endoscopy remains the highest impact on diagnostic pathways. The specialty has now been taken into internal special measures with a turnaround lead being allocated and a number of actions in place:
    - In-sourcing extended for 1 month until end September; further extension being considered
    - Service team reviewing demand management and productivity measures to improve utilisation and appropriateness
    - Outsourced booking service approved and contracting arrangements in place; due to commence mid-September
    - Booking Team skills bank continues to be developed, on-going recruitment programme to fill all temporary and substantive posts
    - Successfully recruited 2 x Trainee Clinical Nurse Scopists (1 x HEE training commencing September; one is relocating to SOT and will be trained in-house)

Cancer – Headline metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

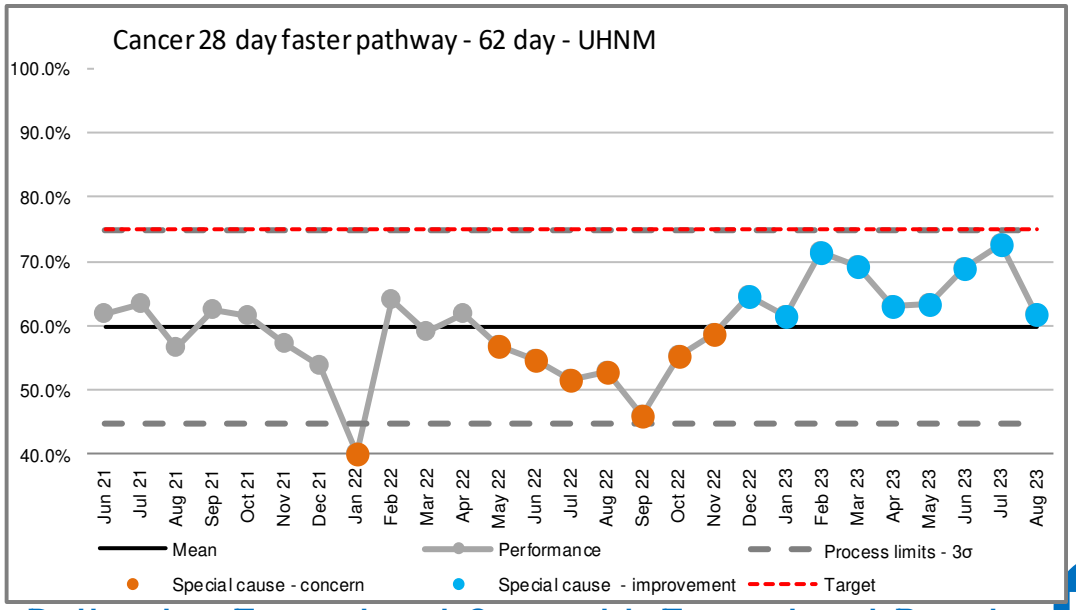
Target	13/08/2023	20/08/2023	27/08/2023
14	14	14	14

Background

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

What is the data telling us?

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



Variation	Assurance
H	F

Target	Jun 23	Jul 23	Aug 23
75%	68.9%	72.6%	62.0%

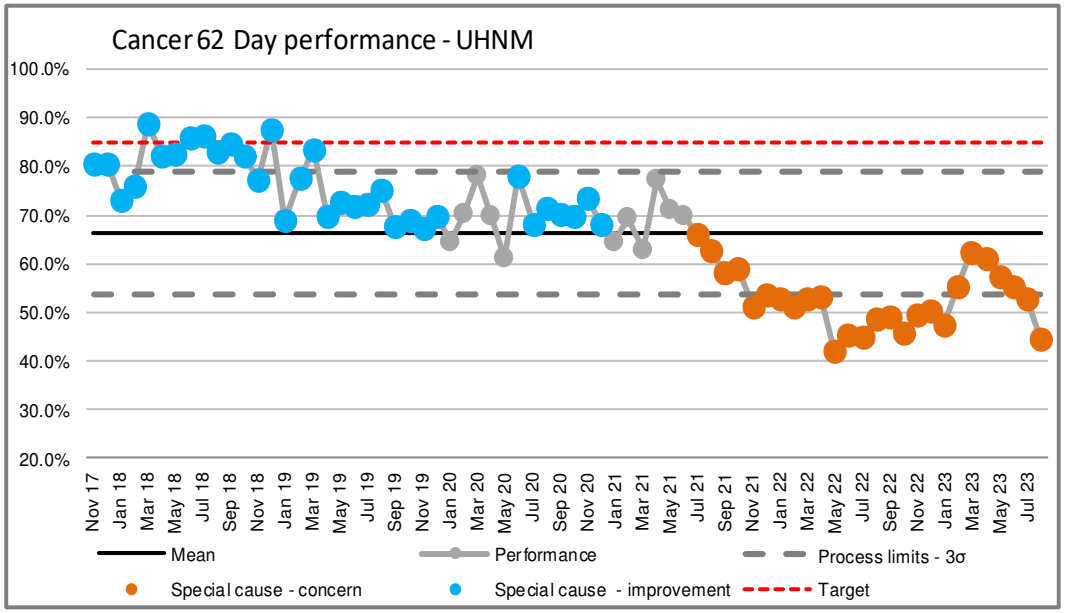
Background

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

What is the data telling us?

The FDS performance remains stable with pockets of good practice. E.g. Breast, Lung and Upper GI all achieve the standard . The June position landed at 69% - a special cause improvement on the SPC chart. July is currently incomplete.

Cancer – Headline metrics



Variation	Assurance
L	F

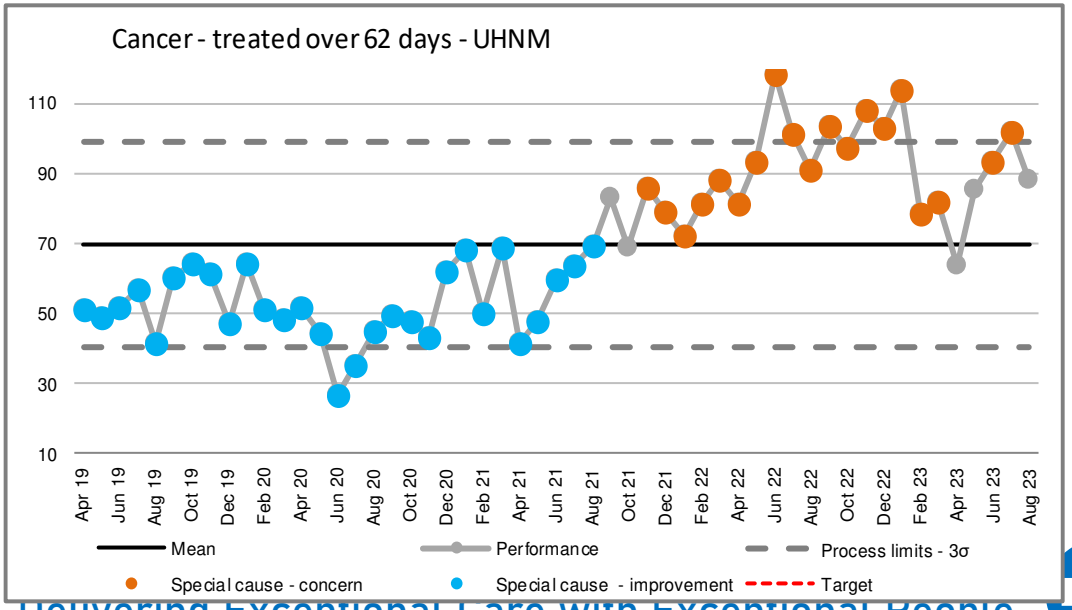
Target	Jun 23	Jul 23	Aug 23
85%	55.3%	52.7%	44.7%

Background

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

What is the data telling us?

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



Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
N/A	93.0	102.0	88.0

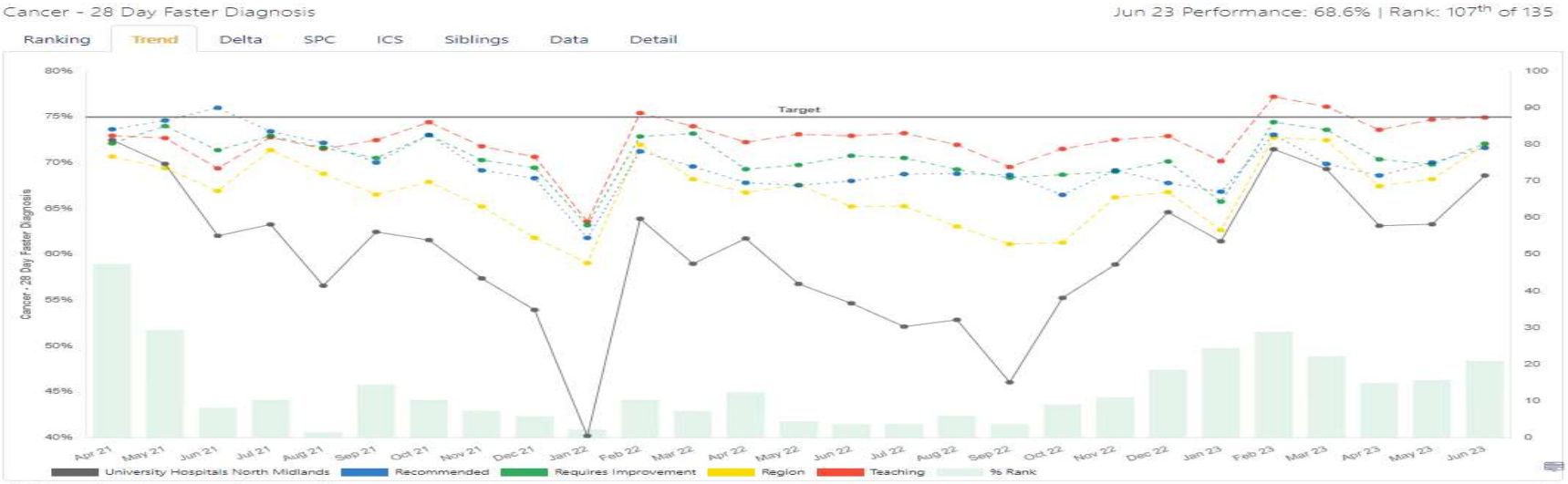
Background

The number of patients treated over 62 days

What is the data telling us?

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

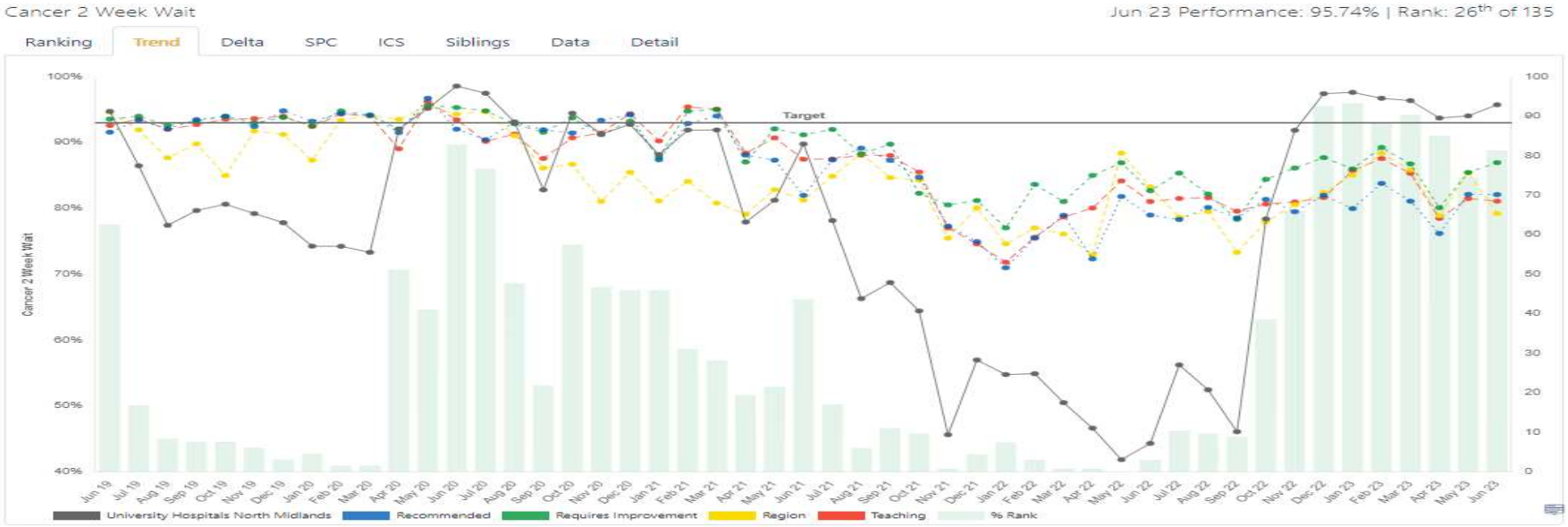
Cancer



	Cancer - 28 Day Faster Diagnosis	Jun 23	75.0%	68.6%	
	Key Performance Indicator	Period	Target		SPC
403	Cancer - 28 Day Faster Diagnosis	Jun 23	75.0%	68.6%	
406	FDS Acute Leukaemia	Jun 23	75.0%	-	
407	FDS Brain Tumours	Jun 23	75.0%	-	
408	FDS Breast Cancer	Jun 23	75.0%	90.2%	
404	FDS Breast Symptoms	Jun 23	75.0%	93.0%	
409	FDS Children's Cancer	Jun 23	75.0%	100%	
410	FDS Gynaecological Cancer	Jun 23	75.0%	60.6%	
411	FDS Haematological Malignancies	Jun 23	75.0%	54.8%	
412	FDS Head & Neck Cancer	Jun 23	75.0%	64.0%	
413	FDS Lower Gastrointestinal Cancer	Jun 23	75.0%	39.7%	
414	FDS Lung Cancer	Jun 23	75.0%	89.5%	
405	FDS Missing or Invalid	Jun 23	75.0%	-	
415	FDS Other Cancer	Jun 23	75.0%	-	
416	FDS Sarcoma	Jun 23	75.0%	40.0%	
417	FDS Skin Cancer	Jun 23	75.0%	79.3%	
418	FDS Testicular Cancer	Jun 23	75.0%	91.7%	
419	FDS Upper Gastrointestinal Cancer	Jun 23	75.0%	85.8%	
420	FDS Urological Malignancies	Jun 23	75.0%	47.0%	

- The 28 Day Faster Diagnosis position for UHNM has been lower than all peer groups since May 2021.
- During Q2 to Q4 2022/23 UHNM improved significantly, aligning to other peer groups.
- Whilst all peer groups performance dropped in April and May 2023, UHNM dropped more significantly.
- Lower GI and Sarcoma are the lowest performing cancer sites.
- UHNM remain in the bottom quartile.

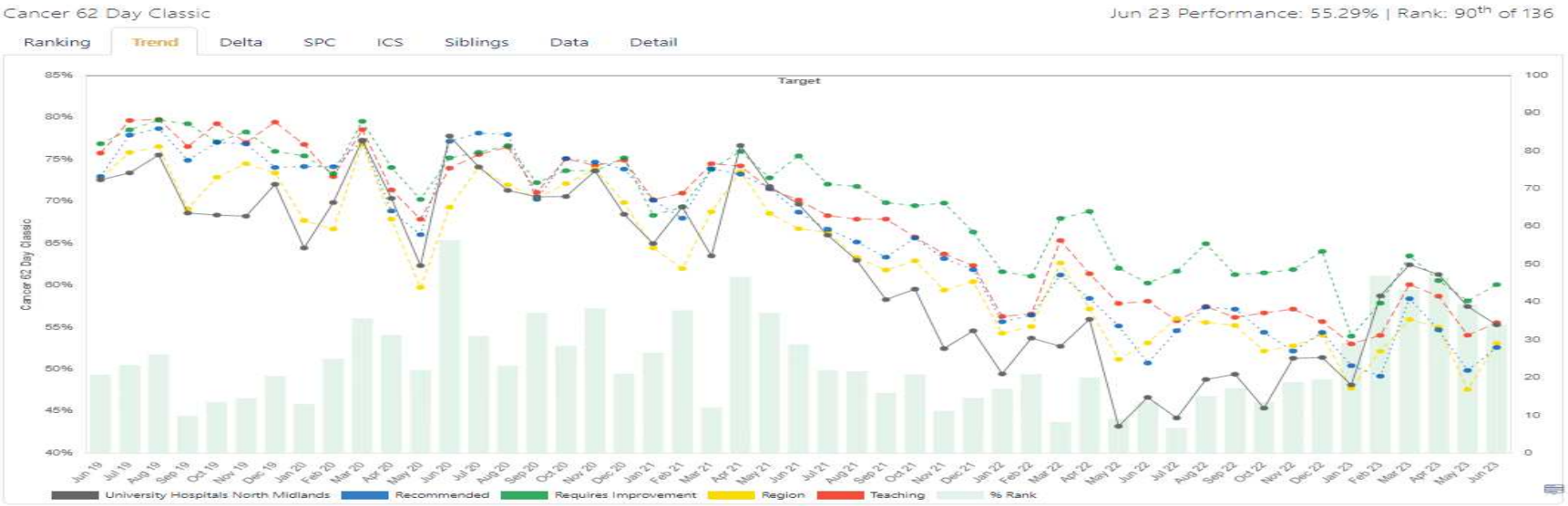
Cancer



- 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 26th against all Trusts and in the top quartile.

	Cancer 2 Week Wait	Jun 23	93.00%	95.7%	
	Key Performance Indicator	Period	Target		SPC
45	Cancer 2 Week Wait	Jun 23	93.00%	95.7%	
99	Cancer 2 Week Wait Breast Symptomatic	Jun 23	93.0%	98.3%	
46	Cancer 31 Day First Treatment	Jun 23	96.00%	83.9%	
120	Cancer 31 Day Subsequent Treatment	Jun 23	96.0%	88.6%	
51	Cancer 62 Day All Sources	Jun 23	85.00%	61.1%	
100	Cancer 62 Day Consultant Upgrade	Jun 23	85.0%	75.2%	
35	Cancer 62 Day Screening	Jun 23	90.0%	47.4%	
118	Cancer Sub Treat Drugs	Jun 23	96.0%	95.6%	
119	Cancer Sub Treat Radiotherapy	Jun 23	96.0%	96.0%	

Cancer



- UHNM have seen an improvement since May 22, where other peer groups have either seen no improvement or seen a deterioration.
- Since March 2023, UHNM performance has been reducing and following a similar trend to other peers.
- Lower GI and Lung are the lowest performers.
- UHNM remain in the 3rd quartile.

	Cancer 62 Day Classic	Jun 23	85.00%	55.3%	
	Key Performance Indicator	Period	Target		SPC
161	Breast Cancer	Jun 23	85.00%	78.6%	
15	Cancer 62 Day Classic	Jun 23	85.00%	55.3%	
162	Lower Gastrointestinal Cancer	Jun 23	85.00%	29.4%	
163	Lung Cancer	Jun 23	85.00%	25.0%	
164	Other Cancer	Jun 23	85.00%	46.4%	
165	Skin Cancer	Jun 23	85.00%	75.9%	
166	Urological Cancer	Jun 23	85.00%	38.5%	

Cancer Actions

NHS
University Hospitals of North Midlands
NHS Trust

For the month of August 2023, the weekending backlog position was 455 – which is a reduction of over 500 patients since August 22. This position includes patients with a decision to treat and a future treatment date scheduled. The majority of the backlog is attributable to Colorectal. A high proportion of patients waiting over 62 days in both tumour sites have future scheduled treatment dates. Moving into September however, the position is challenged by increasing turn around times in diagnostic services, and additional capacity schemes being sustained, plus the impact of industrial action. 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 funded additional Endoscopy activity.

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.

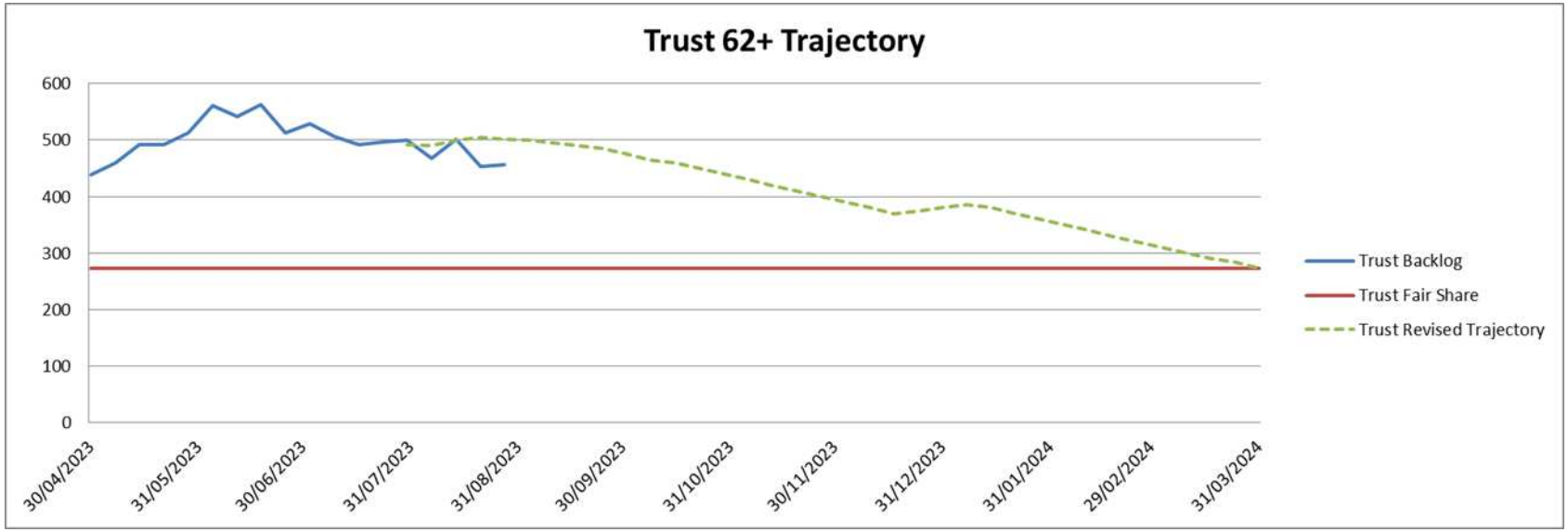
UHNM have implemented a number of best practice initiatives to streamline cancer pathways. The cancer team have developed tumour site specific heat map analysis of the Best Practice Timed Pathways, to identify pinch points on pathways an inform targeted improvement efforts. UHNM now also chair the West Midlands Cancer Alliance Expert Advisory Group which shares best practice and have presented the AccuRx text messaging service for patients who have received an all clear from suspected cancer investigations as a quality improvement and a performance improvement initiative – supporting patients with a better experience and the 28 day FDS standard.

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.

The Cancer Delivery plan has been agreed with ICB colleagues and prioritises 28 Day faster diagnosis improvement plans, such as GP direct access to diagnostics, releasing capacity schemes such as Breast Pain clinics in the community, and increasing referrals on to the Non Site Specific pathway.

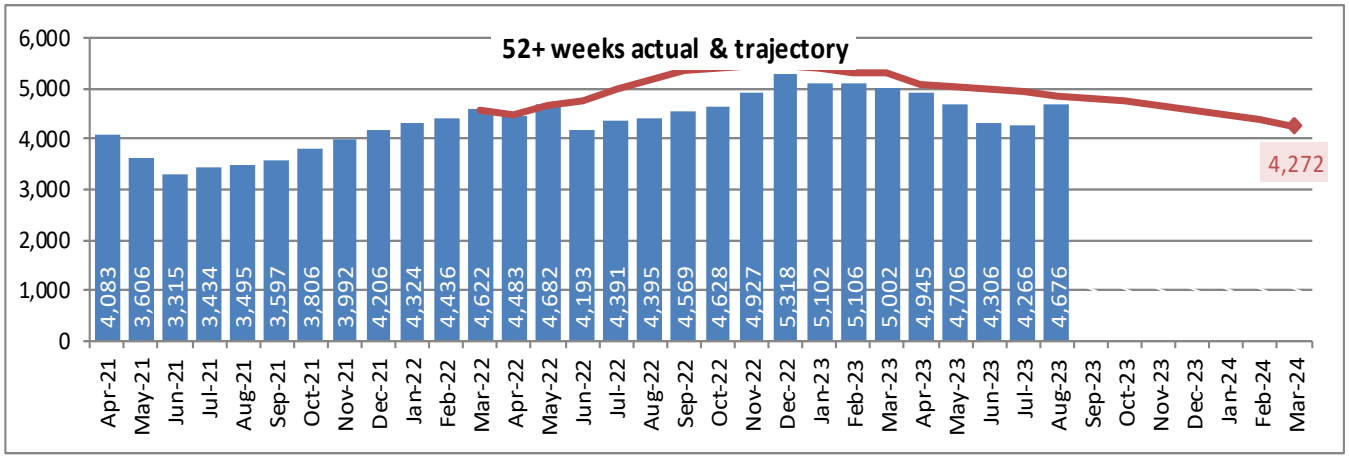
Cancer Trajectories

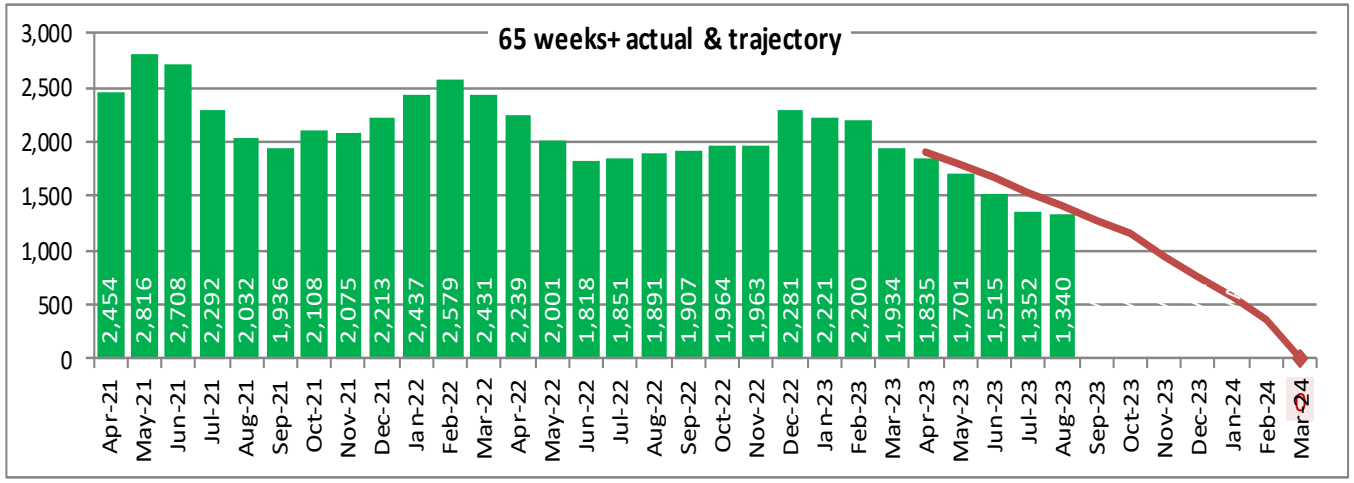
- National planning guidance 23/ 24 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. This was based on a fair share total allocated to Trusts, shown in red on the graph below. An internal PTL Backlog trajectory for UHNM is shown by the green dotted line below, which was revised and modelled to bring us back in line with the fair share target by March 24, taking into account the unpredicted workforce challenges in Endoscopy.
- The actual total of patient waiting over 62 days on a 2WW pathway are shown in blue below, and are a snap shot in time of the PTL position. This is for the week ending 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 22.
    - The number of days waited for 1st OPA (93rd Percentile) has reduced by 35 days since August 22.
    - The total PTL has reduced by around 2300 since August. 22
    - The number of patients waiting over 104+ has halved.
    - The Faster Diagnosis Standard has improved from 46% in September22 to a final July 23 position of 70%



- 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 agreed to fund additional capacity schemes, such as insourcing Endoscopy booking functions, which is contributing to the significant recovery of the Cancer position.

Planned Care – *RTT*



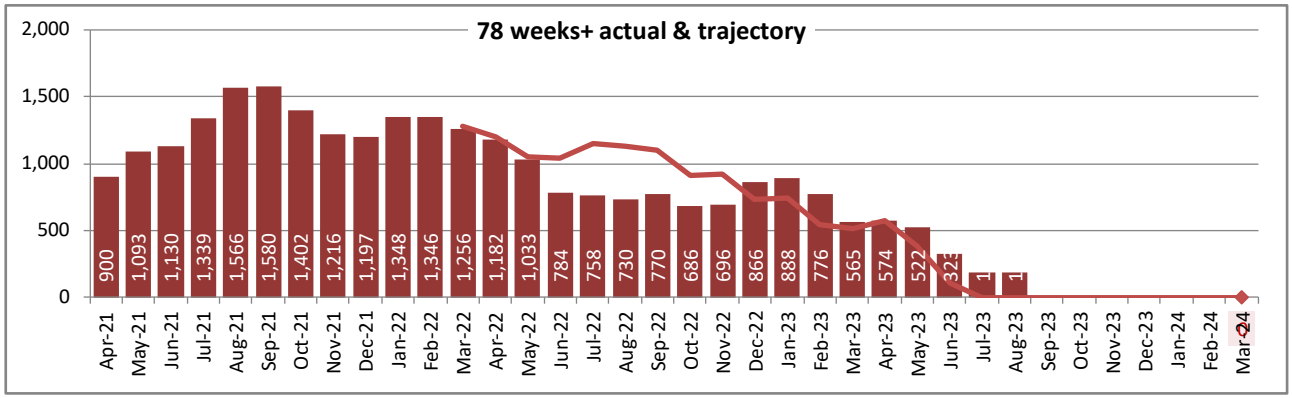


Despite the volume of 52+ week waiters remains within trajectory, August say an increase of 10%.

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

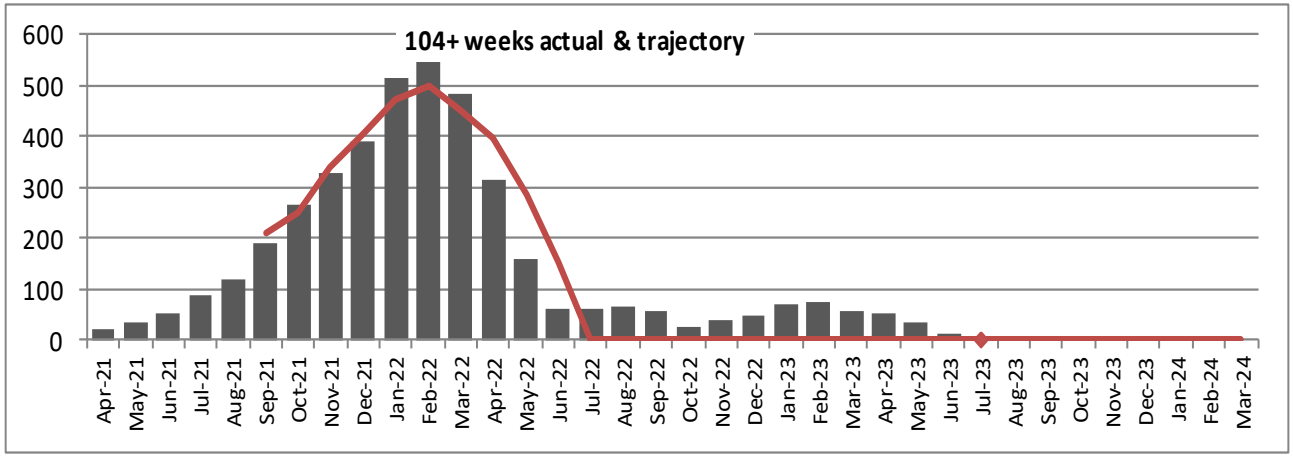
Planned Care – *RTT Long Waiters*

NHS University Hospitals of North Midlands NHS Trust



The number of patients waiting over 78 weeks continues to reduce gradually, with August currently at 183.

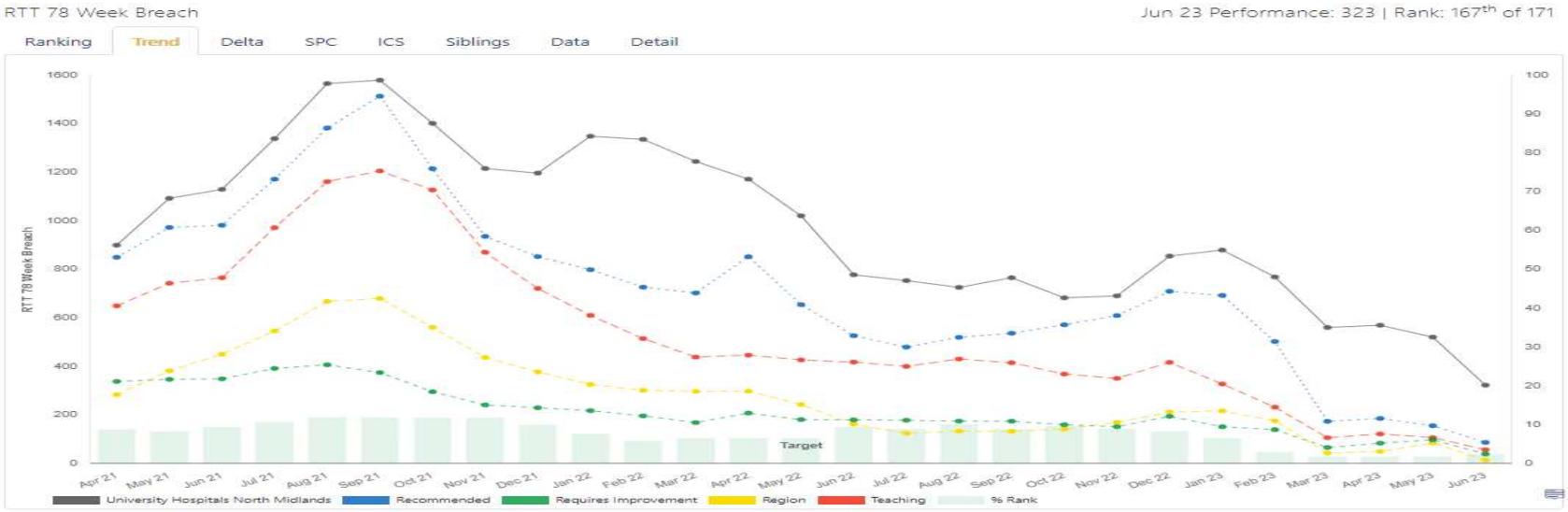
August data is unvalidated.



The number of patients waiting 104+ weeks continues to reduce.

There are 3 patients in August, which is made up of patient choice, patients presenting unwell or complex pathways.

RTT



	RTT 78 Week Breach	Jun 23	0	323	
	Key Performance Indicator	Period	Target		SPC
850	RTT 104 Week Breach	Jun 23	0	10	
55	RTT 52 Week Breach	May 23	0	4,696	
1202	RTT 65 Week Breach	Jun 23	-	1,511	
949	RTT 78 Week Breach	Jun 23	0	323	
142	RTT 95th Percentile Admitted Waiting Time	May 23	18.0	78.6	
144	RTT 95th Percentile Non-Admitted Waiting Time	May 23	18.0	62.2	
135	RTT Admitted Treatment Within 18 Weeks	Jun 23	90.0%	52.2%	
141	RTT Average (Median) Admitted Waiting Time	May 23	9.0	14.9	
143	RTT Average (Median) Non-Admitted Waiting Time	May 23	5.0	8.6	
65	RTT Average Wait for Incomplete	May 23	7.00	15.7	
133	RTT Incomplete 92nd Percentile	May 23	-	47.9	
134	RTT Incomplete Pathways With a DTA	Jun 23	25.0%	14.7%	
136	RTT Non-Admitted Treatment Within 18 Weeks	Jun 23	95.0%	67.7%	
138	RTT Total Clock Starts	Jun 23	-	17,049	
137	RTT Total Clock Stops	Jun 23	-	15,022	
132	RTT Total Incompletes	Jun 23	-	78,640	

- Since the latest increase during Dec 22/Jan 23, volumes at UHNM have since reduced, with all peers and UHNM following a similar trend.
- UHNM remain significantly above all peer groups and remain in the bottom quartile.

Planned care - *RTT*

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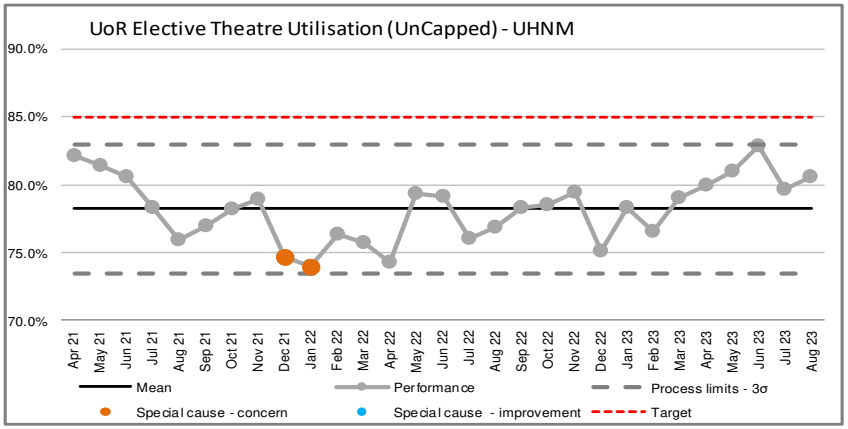
Summary

- 52+ week patients increased during August to 5,266 (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, 522 for May, 323 for June, 186 for July (and projected to be around 183 for August as yet un-validated).
- The trust did not achieve the national ask of eliminating 78 weeks waits by end of March 2023. Plans are in place to minimise the number of breaches, so that only patients who choose not to be treated before end of March or who have a highly complex case are still waiting at 78+ weeks. Trajectories have been updated, and are predicting end of September for delivering 0 78 week breaches. This however has been impacted by industrial action which has caused a standstill in the reduction.
- The overall Referral To Treatment (RTT) Waiting list now sits 81,237 end of August (un-validated).
- The focus continues 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 August the number of > 104 weeks was 3 a due to an unexpected pop-up returning from an ISP untreated . There is a challenge for some specific directorates in treating some of our long waiting complex patients within timeframe due to the size of the backlog.
- The IS have taken over 400 patients from Orthopaedics & Spinal (out of over 500 considered), with a further 60 patients being worked through to contact & transfer.

RTT

- Validation has increased slightly with some additional resource in the short term. The team are currently looking at validation capacity to provide an accurate picture of the resource required in the medium term to reduce the list, this includes electronic solutions.
- RTT Performance sits at 52.82%, a slight deterioration from 54.81% for June.
- 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 77.8% of all pathways over 52 weeks having been validated within the last 12 weeks. This is a reduction from 98.4% in June. The next national ask was to have all patients waiting longer than 12 weeks validated by 28th April 2023. The number currently not validated in the last 12 weeks in May was is 37,400, June, 38,028, 40,890 in July and has risen to 42,216.
- Trust wide revamp of validation & training underway, the IST are supporting the Trust with events in September to train all admin staff working with RTT.
- NHSE's RTT training lead to deliver lecture style training and engagement sessions with specialty groups to enhance shared knowledge and address issues where national rules are not always followed. Sessions to commence September 18th.
- 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 at RSUH, modular theatre at County and improvement in theatre utilisation and booking.
- Increased focus on non-admitted patients and increasing outpatient & diagnostic capacity, improving utilisation and business processes to move patients to a decision to admit.
- Roll-out of Palantir's Foundry platform underway, with working group to be up and running.
- External validation support sought from MBI, due to commence 18th September

Planned Care – *Theatres*

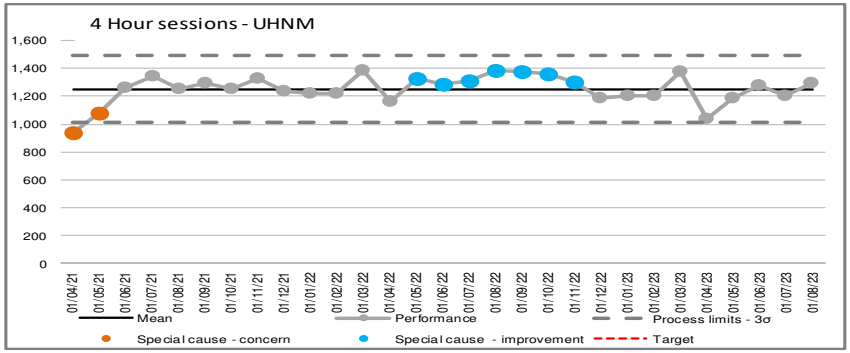


Variation	Assurance
	F

Target	Jun 23	Jul 23	Aug 23
85%	82.9%	79.6%	80.6%

Background

The percentage of theatre time used (capped).

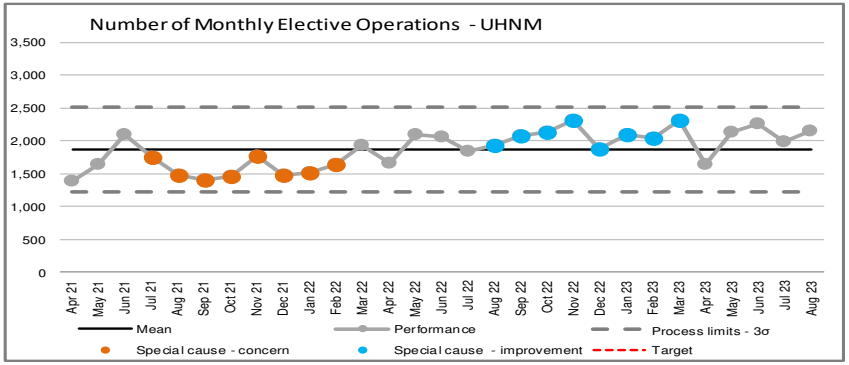


Variation	Assurance

Target	01/06/23	01/07/23	01/08/23
N/A	1274	1206	1294

Background

The number of 4 hour sessions during the month.



Variation	Assurance

Target	01/06/23	01/07/23	01/08/23
N/A	2265	1978	2151

Background

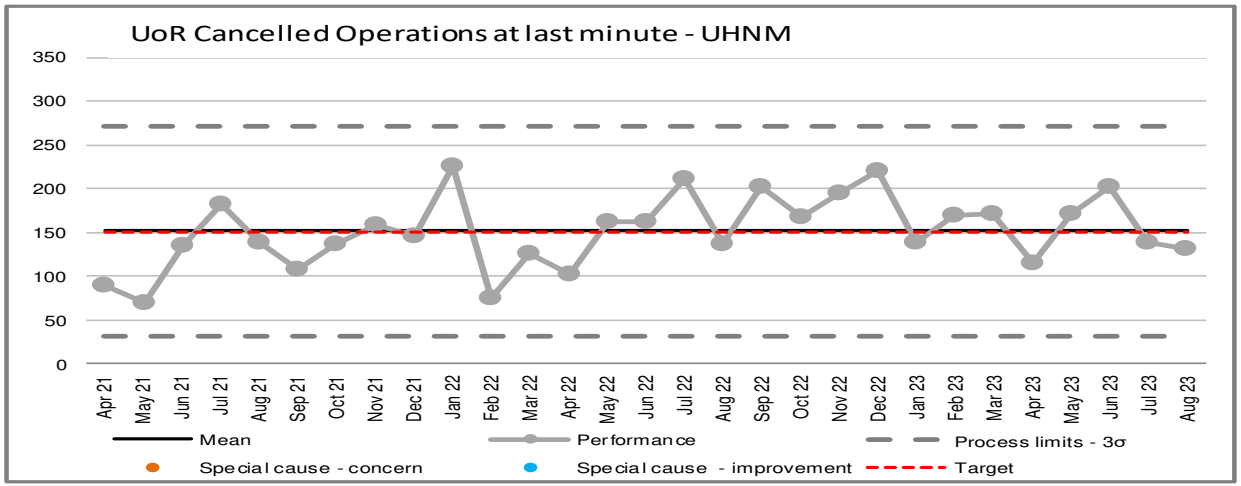
The total number of elective operations during the month.

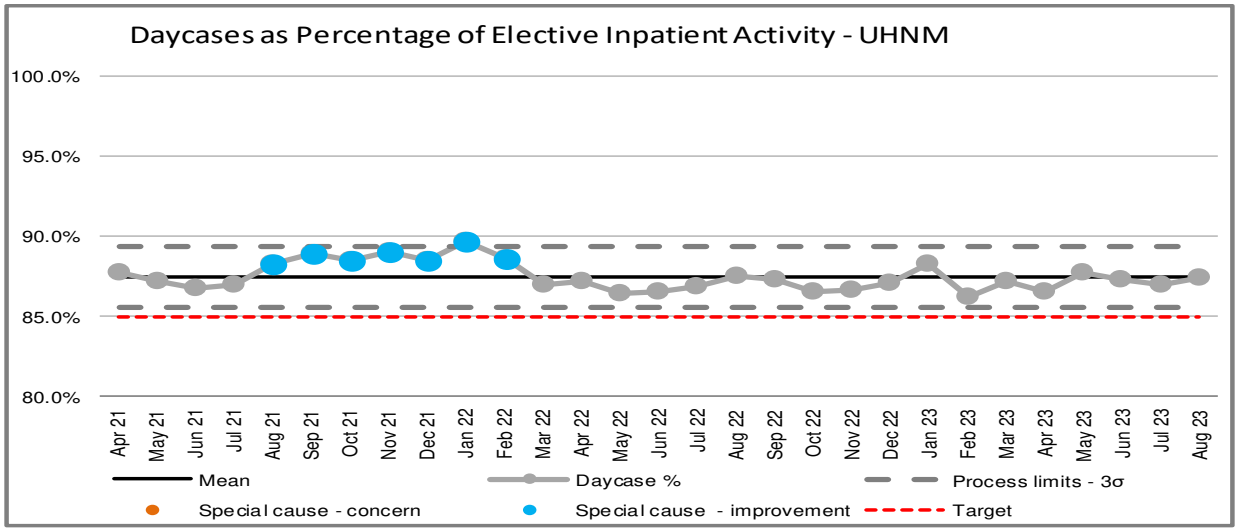
Following the dip in performance in July, August improved slightly to 80.6% against an 85% target.

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

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

Planned Care – *Theatres*

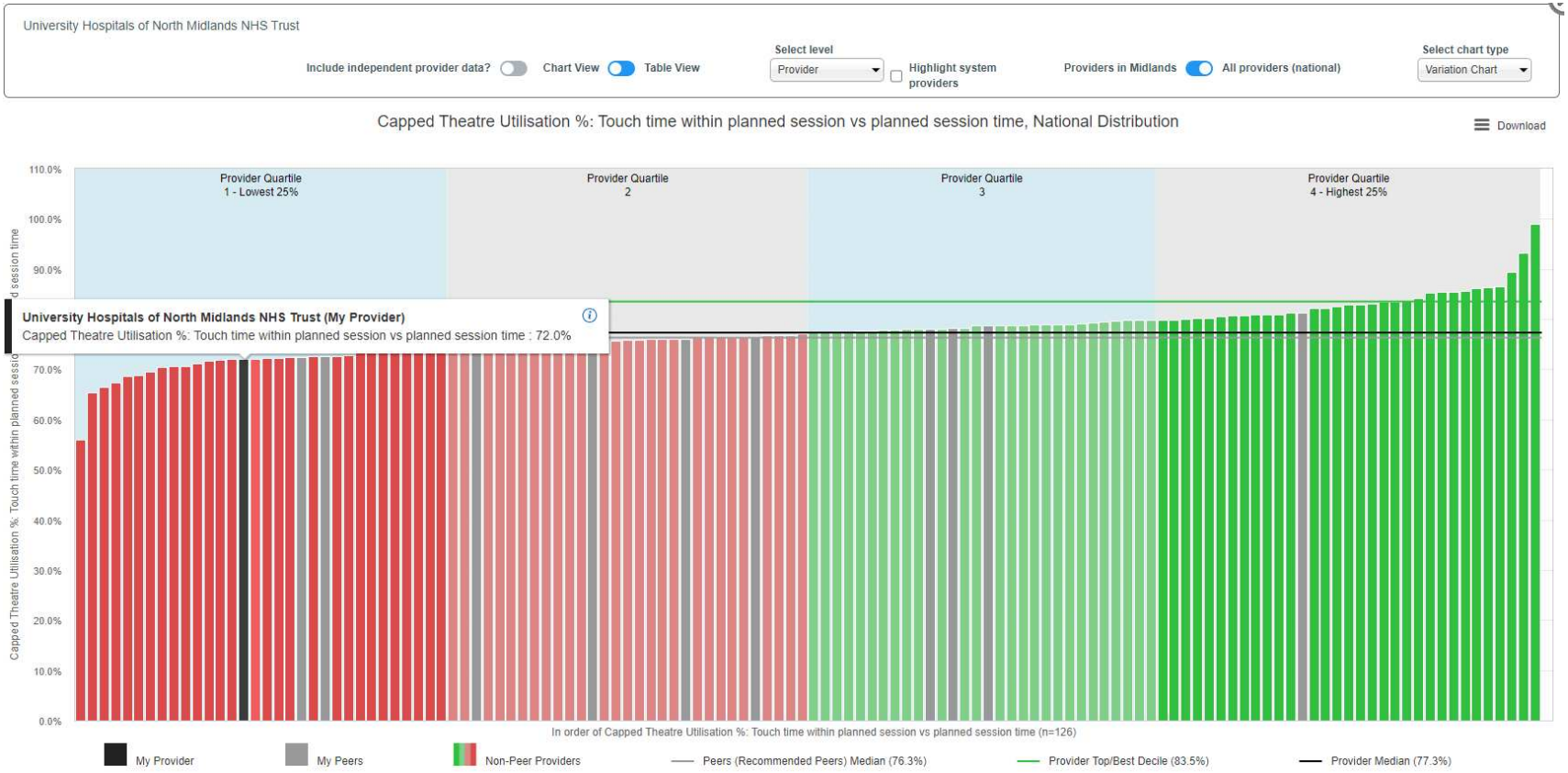




The number of patients cancelled at the last minute remains below the two year average.

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

Theatres - Benchmarked



- UHNM have improved since last month from 70% to 72%.
- They continue to remain in the bottom quartile.

Source data: Model Hospital 30/07/23

Planned Care - *Theatres*

Elective inpatients Summary

- Uncapped utilisation & Case numbers have improved after a decline in July, attributable to more stable period of capacity and focused actions through Theatre Performance Group. Adverse impact of Consultant & Jr Dr IA being assessed in order to define underlying productivity.
- Data submission anomaly to MHS has adversely impacted this periods Benchmarking. Work underway to explore a shift in the methodology for reporting Productivity to align with MHS methodology.
- Request from NHSE to shift focus to reporting Capped Utilisation - August 75.21%, Start times 58% (within 15mins), OTD cancellations 9.5%. (August data)

Actions

- NHSE/UHNM combined Theatre Productivity Action plan created from collaboration with NHSE region lead. Sharing of summary report planned for w/c 11th Sept. Areas of focus include timetabling and scheduling process, Pre-Ams, APOM, Data Quality and Late starts
- Meeting arranged between UHNM & MHS performance leads in order to assess the gap between each systems reported performance KPI's – 21st September
- Revised Timetable and scheduling process to be implemented in line with widely used national 6-4-2 framework from 11th September.
- NMHU activity continues to increase, some outstanding operational issues to be addressed, meeting with estates and transport teams arranged.
- Statutory Maintenance programme across PFI Theatres and CCU now complete
- Recruitment: Appointment of 7 x Specialist Grade anaesthetists
- Theatre Staff workforce plan comprehensive review/update commenced, peer review site visits arranged in order to assist benchmark and generate innovative approaches.
- MoC for introduction of Night team for Cardiothoracic theatres commenced in line with approved BC
- Feasibility study commissioned for County Theatre Holding Bay
- Workforce recruitment projections drafted for staff required to support County Day Case Business Case
- APOM Gateway review arranged for 26th September – pre meet questionnaire completed

Planned Care – *Outpatients*

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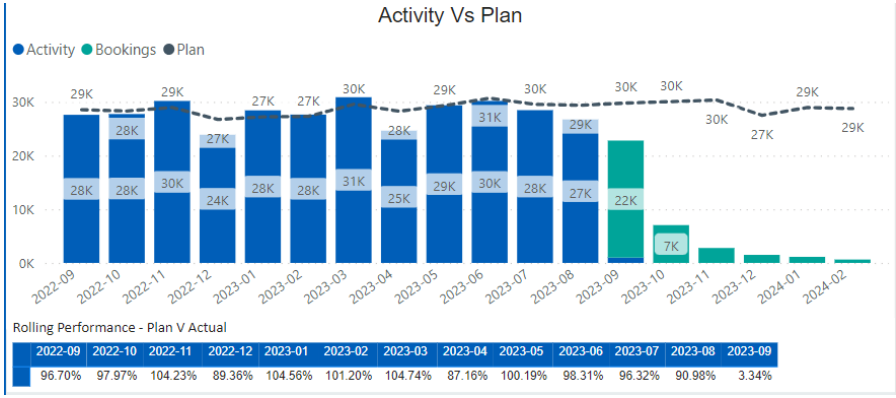
New Outpatient Performance to Plan



	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09
	96.70%	97.97%	104.23%	89.36%	104.56%	101.20%	104.74%	87.16%	100.19%	98.31%	96.32%	90.98%	3.34%

Follow Up Outpatient Performance to Plan

	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09
	103.75%	105.65%	113.36%	95.62%	108.56%	102.95%	104.23%	97.72%	111.48%	104.12%	98.07%	96.80%	2.95%

New Outpatient activity performance was 91% of plan in August and 95% YTD.
Outpatient Follow Up performance was 97% in August with YTD at 102%.

The Follow Up Backlog waiting list continues to see growth since early July.

Planned care – *Outpatients*

NHS University Hospitals of North Midlands

Actions

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

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

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

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

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

- **Referral Management / Variation**

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

- **Activity Management / Variation**

  Patient Initiated Follow up (PIFU) - Benchmarking vs national median July - UHNM: 30th of 143 providers (4.4% vs 2.6%). Dip to 4.4% continues for Aug 2023; this relates to delays in outcoming patients from 2 specialties, internal estimate of post-reporting PIFU % requested. Clarifying reporting requirements for new CDS during 23/24 (will be OP only). Additional PIFU pathway opportunities from OP GIRFT guidance & specialties to target from 'Action On' Data Pack. Increasing PIFU initiative with NHSE support; 4 priority specialties identified, plan to be drafted, to include facilitating specific clinical pathways discussion.

  Outcomes; DQ leading remedial actions, escalating to Divisions. Tail broadly cleared, but still high volume of respiratory device pts (known temporary issue where cohort not high risk) and cardiology pacing patients. New iportal Outcomes form live 25th July 2023, supporting capturing of Outpatient Procedures. Deputy Medical Director has issued directive to clinicians for completion of all clinic outpatient outcomes via iportal by October unless agreed exception.

  OP Productivity; OP Cell Dashboard revised, alongside booking & DNA Divisional / UHNM target & trajectories. Utilisation Aug 89.4% vs 90.0% plan. Focussed utilisation review at session code level with each specialty continues, plus review of clinic flag process. From NHSE 'Action on DNAs' initiative, 2 Way Messaging (see risks).

- **Key Enablers**

  OP GIRFT: issued Nov/Dec, aimed at clinicians & operational teams. 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 12/15 specialties. Working vs timeline for further Specialty Meetings & Reviews to challenge ongoing progress. Identifying clinical lead for OP GIRFT to support clinical conversations & challenge.

  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. 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), controlled go-live in Urology in August as pilot, good progress, principles & approach to be carried forward for specialty-by-specialty rollout. Robot-funding discussions with IM&T for RPA approaches. **Patient Portal (PKB)**; IM&T included at OP Cell for updates. Digital letters live from June 2023 with patient letter to encourage enrolment.

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	10.72%	9.44%	9.17%	7.48%	7.62%	11.44%	12.68%	10.22%	13.79%	6.70%	0.75%
Weeks Waited- 78-104	13.01%	11.34%	8.36%	10.04%	6.41%	11.15%	10.32%	9.57%	11.80%	7.25%	0.74%
Weeks Waited- 52-77	12.87%	11.64%	10.18%	10.01%	7.56%	11.51%	10.35%	9.16%	10.96%	4.53%	1.23%
Weeks Waited- Under 52	13.66%	11.32%	10.27%	8.88%	7.73%	10.97%	10.14%	8.89%	11.29%	5.53%	1.32%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	10.88%	9.83%	9.22%	9.01%	7.82%	10.94%	11.52%	10.21%	13.01%	6.53%	1.03%
Weeks Waited- 78-104	11.72%	10.74%	8.98%	8.97%	7.60%	10.86%	10.87%	9.81%	12.37%	6.78%	1.29%
Weeks Waited- 52-77	12.82%	11.26%	9.97%	8.64%	7.58%	10.74%	10.92%	8.96%	11.67%	6.06%	1.37%
Weeks Waited- Under 52	13.33%	11.34%	10.13%	8.86%	7.51%	10.50%	10.60%	9.11%	11.32%	5.94%	1.36%

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%	0.36%	0.30%	0.66%	0.06%	0.11%	0.25%	0.36%	0.42%	0.25%	0.03%	#N/A	93.13%	0.39%	0.89%	1.88%	0.28%
Weeks Waited- 78-104	0.19%	0.74%	0.09%	0.65%	0.46%	0.46%	#N/A	0.19%	0.19%	0.56%	0.93%	0.09%	#N/A	0.09%	91.08%	0.46%	1.67%	1.39%	0.74%
Weeks Waited- 52-77	0.44%	0.34%	0.31%	0.78%	0.54%	1.50%	0.07%	0.14%	0.10%	0.58%	1.46%	0.37%	0.03%	0.31%	87.20%	0.17%	2.08%	1.70%	#N/A
Weeks Waited- Under 52	0.48%	0.69%	0.32%	0.75%	0.59%	1.45%	0.12%	0.20%	0.16%	0.50%	1.64%	0.34%	0.11%	0.22%	84.04%	0.32%	2.69%	2.33%	3.05%

Outpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.30%	0.56%	0.23%	0.36%	0.46%	0.83%	0.08%	0.13%	0.12%	0.53%	1.33%	0.30%	0.11%	0.14%	88.02%	0.38%	2.61%	2.15%	1.37%
Weeks Waited- 78-104	0.41%	0.56%	0.27%	0.66%	0.52%	1.20%	0.11%	0.17%	0.21%	0.57%	1.58%	0.33%	0.16%	0.21%	86.20%	0.29%	2.80%	1.86%	1.87%
Weeks Waited- 52-77	0.48%	0.66%	0.17%	0.64%	0.58%	1.15%	0.14%	0.13%	0.13%	0.57%	1.67%	0.33%	0.15%	0.25%	84.38%	0.27%	2.90%	2.49%	2.92%
Weeks Waited- Under 52	0.54%	0.67%	0.22%	0.65%	0.60%	1.32%	0.16%	0.17%	0.15%	0.64%	1.79%	0.34%	0.17%	0.24%	82.57%	0.31%	3.24%	2.66%	#N/A

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APPENDIX 1

Operational Performance

Constitutional standards

NHS University Hospitals of North Midlands NHS Trust

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	Percentage of Ambulance Handovers within 15 minutes	0%	67.32%	H		
	Ambulance handovers greater than 60 minutes	1	1		F	
	Time to Initial Assessment - percentage within 15 minutes	85%	65.34%	H	F	
	Average (mean) time in Department - non-admitted patients	180	256		F	
	Average (mean) time in Department - admitted patients	180	352		F	
	Clinically Ready to Proceed	90	388	H	F	
	12 Hour Trolley Waits	0	456		F	
	Patients spending more than 12 hours in A&E	0	1398		F	
	Median Wait to be seen - Type 1	60	96		F	
	Bed Occupancy	92%	85.25%			
Cancer Care	Cancer 28 day faster pathway	75%	61.96%	H	F	
	Cancer 62 GP ref	85%	44.65%	L	F	
	Cancer 62 day Screening	90%	55.56%		?	
	31 day First Treatment	96%	86.42%	L	?	
	2WW First Seen (exc Breast Symptom)	93%	95.25%	H	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.1%	L	?	
	Cancelled Ops	150	131		?	
	Theatre Utilisation	85%	80.6%			
Inpatient / Discharge	Same Day Emergency Care	30%	36%	H	?	
	Super Stranded	183	170	L	?	
	MFFD	100	94	L	?	
	Discharges before Midday	25%	17.8%	L	F	
	Emergency Readmission rate	8%	0.0%		P	
Elective waits	RTT incomplete performance	92%	50.78%	L	F	
	RTT 52+ week waits	0	4676	H	F	
	Diagnostics	99%	67.27%		F	

Delivering Exceptional Care with Exceptional People

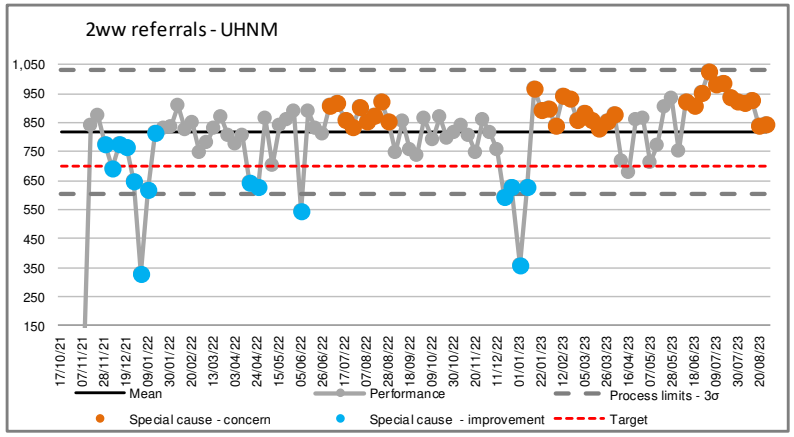
Cancer – 62 Day

NHS University Hospitals of North Midlands NHS Trust

Target	Jun 23	Jul 23	Aug 23
700	930	838	847

Background

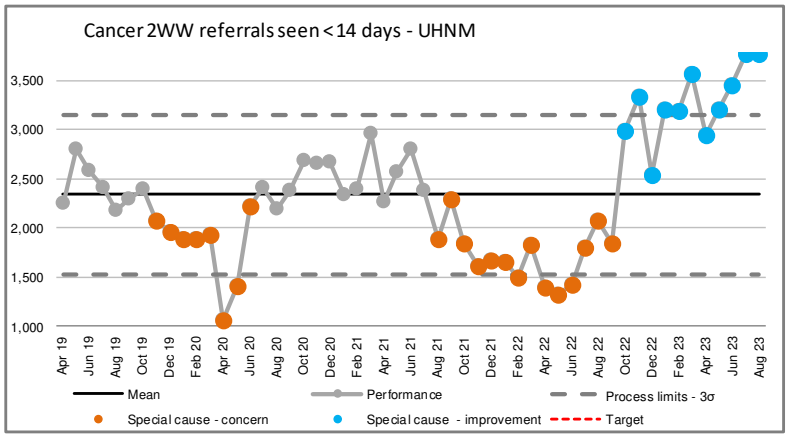
The number of patients referred on a cancer 2ww pathway.



Target	Jun 23	Jul 23	Aug 23
N/A	3449.0	3766.0	3770.0

Background

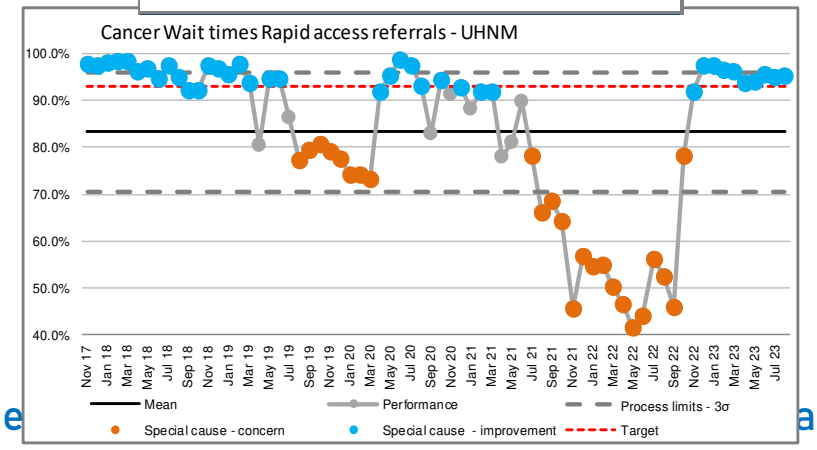
The percentage of patients waiting over 18 weeks for treatment since their referral.



Target	Jun 23	Jul 23	Aug 23
93%	95.6%	94.9%	95.3%

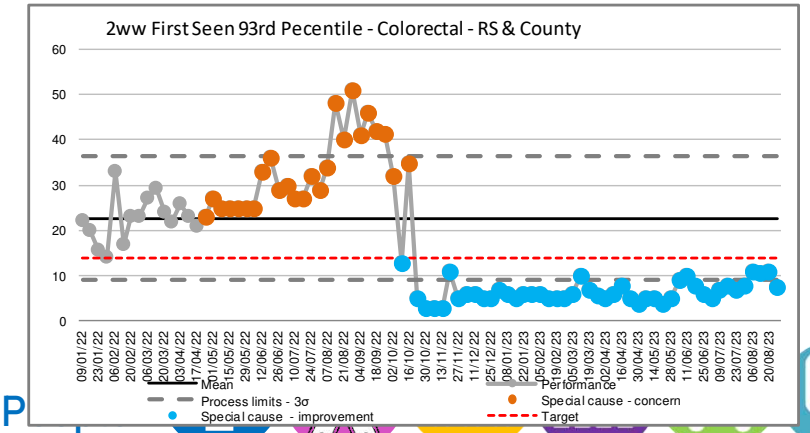
Background

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



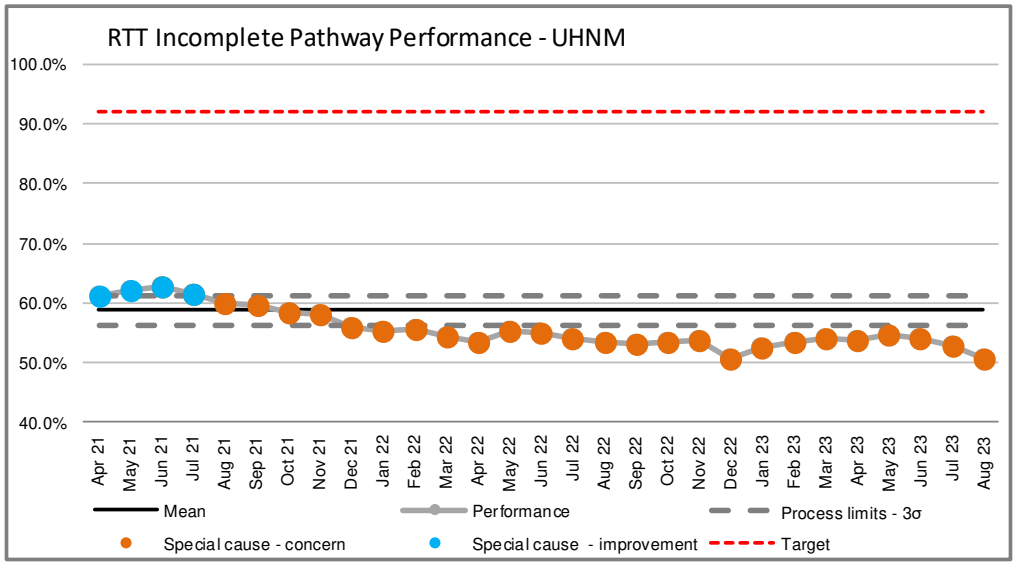
Variation	Assurance
L	?

Target	Aug 23	Aug 23	Aug 23
14	11	11	7



Referral To Treatment

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

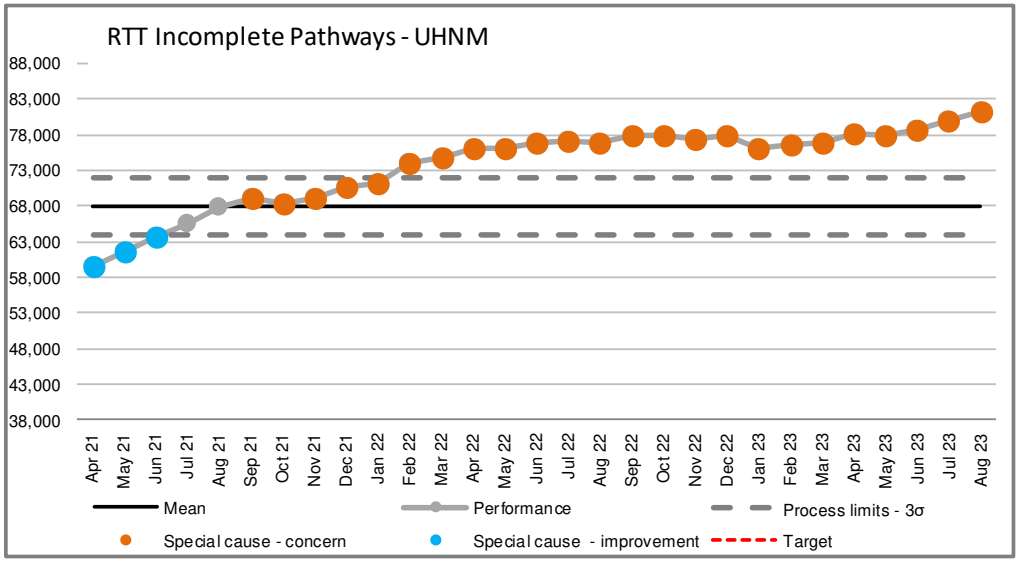
Target	Jun 23	Jul 23	Aug 23
92%	54.2%	52.8%	50.8%

Background

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

What is the data telling us?

Following performance at c.54% each month this year, July and August is seeing a downward trend to 51% in August.



Variation	Assurance
H	

Target	Jun 23	Jul 23	Aug 23
N/A	78771	80109	81186

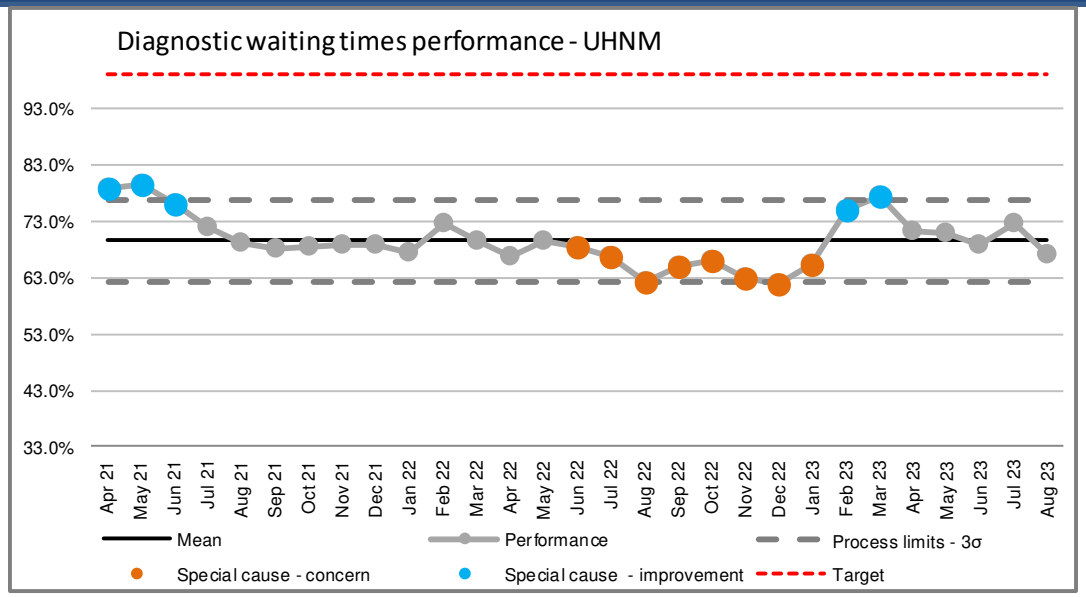
Background

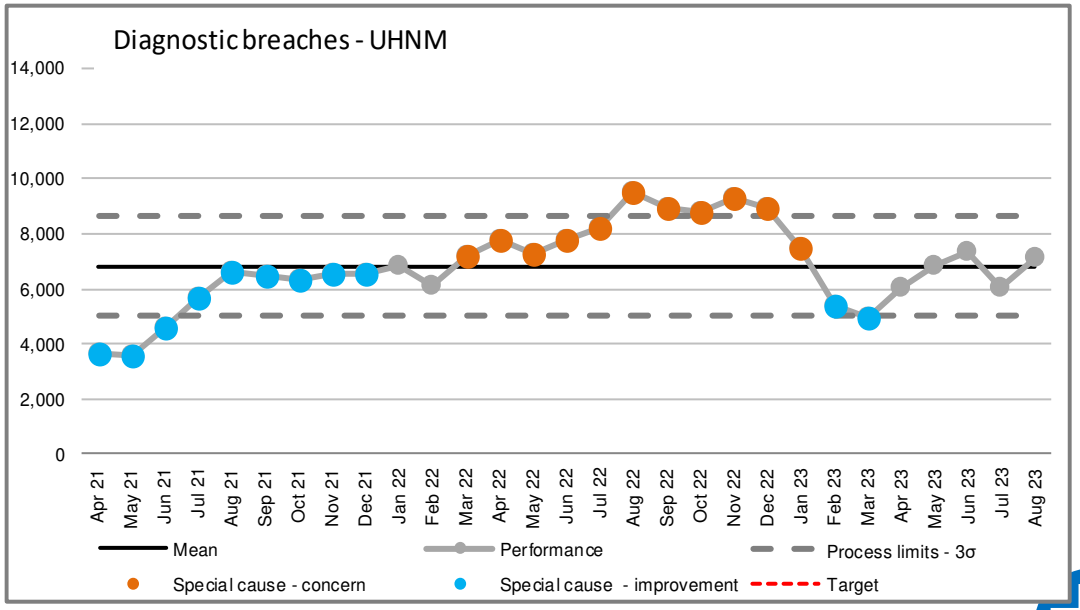
The number of patients waiting over 18 weeks for treatment since their referral.

What is the data telling us?

Despite the number of open pathways remaining stable since June 2022, this has started to see growth since May 2023.

Diagnostic Standards





Variation	Assurance

Target	Jun 23	Jul 23	Aug 23
99%	68.7%	72.6%	67.3%

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, predominantly due to Echo and Endo modalities.

The volume of breaches has seen an increasing trend since March 2023.

Workforce

University Hospitals of North Midlands NHS Trust

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

Delivering Exceptional Care with Exceptional People

Workforce Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key messages

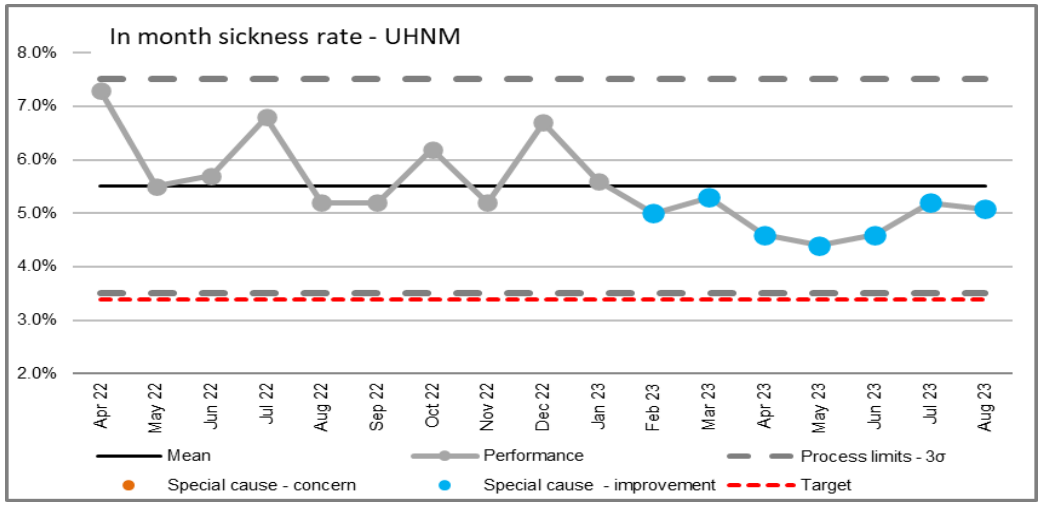
- The 12m turnover rate in August 2023 decreased to 8.3% (0.9% in July) which remains below the trust target of 11%.
- M5 vacancies decreased to 9.43% (10.20% in July). Divisions are reporting good progress on their recruitment pipeline to close the gap on vacancies which is supported by the August presentation on progress made against the annual Workforce Plan.
- For M5, the in-month sickness rate decreased by 0.13% to 5.08% (5.21% in July 2023). The 12-month cumulative rate decreased to 5.31% (5.32% in July 2023).
- Stress and anxiety continues to be the top reason for sickness in August, which saw a decrease of 0.4% in the last month to 24.9% (25.3% in July). Chest & respiratory problems saw a decrease of 0.6% in the last month to 14.8% (15.4% in July 2023).
- August 2023's covid-related absences dramatically reduced to 5 (79 in July 2023), which was 0.24% of the 2,091 open absences. This is a 3.84% decrease on the previous month.
- August 2023's PDR Rate decreased by 0.9% to 82.0% (82.9% in July 2023). Work is progressing on refreshed PDR paperwork to support colleagues in achieving their potential.
- Statutory and Mandatory training rate on 30th August was 94.2% (94.1% on 31 July 2023) showing a very slight increase. This compliance rate is for the 6 'Core for All' subjects only.
- The Staff Voice trust survey, for August 2023, received a total of 1,403 submissions providing an overall colleague engagement score of 6.63.
- The Being Kind sessions continued in August with over 3,500 colleagues in attendance. The events continue to evaluate extremely well including lots of positive feedback on social media.
- Next week is National inclusion Week, where work colleagues are invited to bring in a dish which represents their heritage and also create diversity displays, highlighting all team members and why inclusion is important to them.
- Divisions are continuing to focus discussions on flexible working, with big conversations and in some areas piloting of self rostering.
- Junior doctors took industrial action in August which required extensive coordination and cover from across the whole organisation.
- UHNM response to the NHS Long Term Workforce Plan continues to be developed to shape collective understanding of the opportunities and challenges.

Workforce Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.08%		
Staff Turnover	11%	8.30%		
Statutory and Mandatory Training rate	95%	94.21%		
Appraisal rate	95%	81.95%		
Agency Cost	N/A	5.17%		

Sickness Absence



University Hospitals of North Midlands NHS Trust

Variation	Assurance
L	F

Target	Jun 23	Jul 23	Aug 23
3.4%	4.6%	5.2%	5.1%

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	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Trajectory
205 Central Functions	3.39%	4.20%	3.74%	3.71%	3.85%	3.79%	3.90%	3.88%	3.73%	3.66%	3.59%	3.56%	3.60%	↑
205 Women's, Children's & Clinical Support Services	5.25%	6.25%	6.35%	6.29%	6.32%	6.22%	6.19%	6.01%	5.72%	5.68%	5.62%	5.44%	4.65%	↓
205 Estates, Facilities and PFI Division	5.25%	6.04%	6.20%	6.22%	6.15%	6.02%	6.00%	5.75%	6.02%	6.07%	5.99%	5.86%	6.09%	↑
205 Medicine and Urgent Care	5.25%	6.85%	6.94%	6.86%	6.90%	6.55%	6.41%	6.22%	5.98%	5.87%	5.76%	5.62%	5.83%	↑
205 Division of Network Services	5.25%	5.78%	5.73%	5.75%	5.80%	5.59%	5.48%	5.34%	5.06%	4.96%	4.82%	4.63%	5.58%	↑
205 Division of Surgery, Theatres and Critical Care	4.50%	7.31%	7.30%	7.20%	7.12%	6.94%	6.81%	6.73%	6.53%	6.37%	6.23%	6.12%	5.31%	↓
205 North Midlands & Cheshire Pathology Service (NMCPS)	5.25%	N/A	5.57%	5.61%	5.64%	5.65%	5.68%	5.56%	5.37%	5.34%	5.36%	5.29%	5.40%	↑

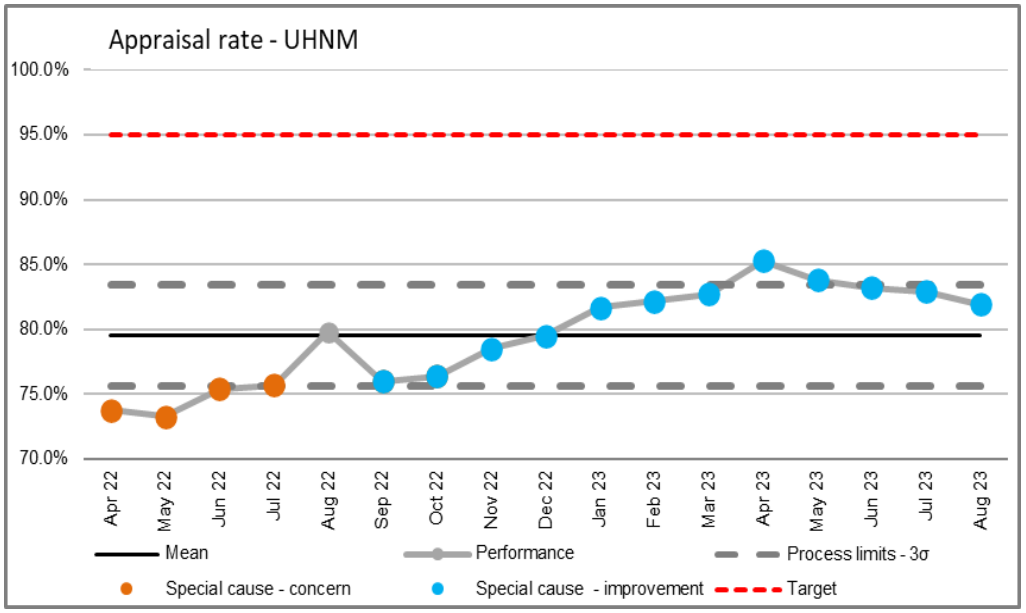
- For M5, the in-month sickness rate decreased by 0.13% to 5.08% (5.21% in July 2023).
- The 12-month cumulative rate decreased to 5.31% (5.32% in July 2023).
- Stress and Anxiety continues to be the top reason for sickness in August, which saw a decrease of 0.4% in the last month to 24.9% (25.3% in June).
- Most divisions saw an increase in sickness against the previous month, except for the Women's, Children's & Clinical Support Services and NMCPS divisions.

Actions

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

Appraisal/Performance Development Review (PDR)

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Jun 23	Jul 23	Aug 23
95%	83.2%	82.9%	82.0%

Background

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

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

Summary

- On 31st August 2023, the PDR Rate decreased by 0.9% to 82.0% (82.9% for July 2023).
- This is the fourth consecutive, month-on-month decrease, 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 - All out of date PDR's to be scheduled with line managers, and ESR hierarchy changes and training gaps to be identified.

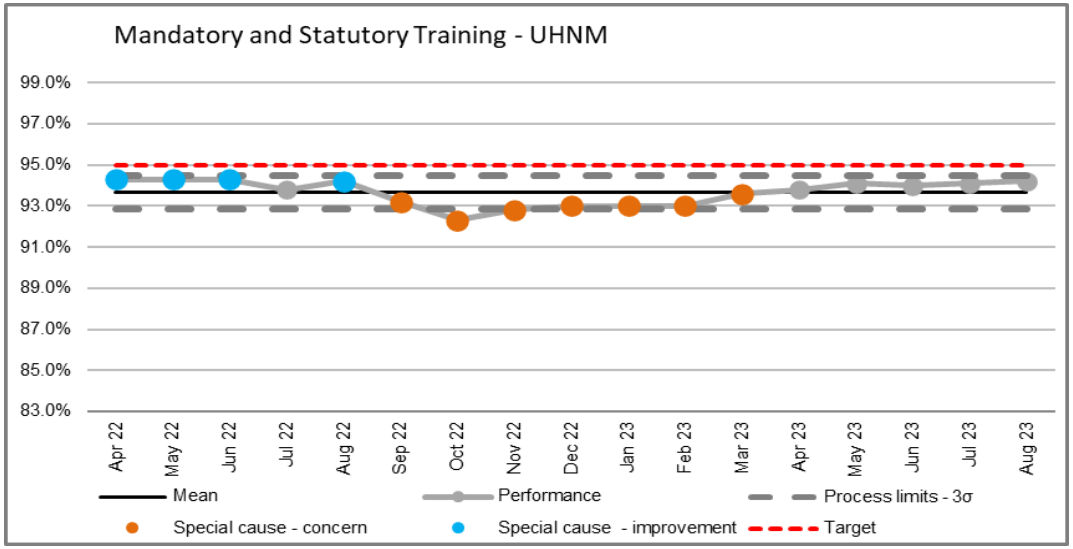
Network Division - Hold a dedicated weekly PDR compliance hotspot and assurance meetings

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

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

Statutory and Mandatory Training

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Jun 23	Jul 23	Aug 23
95%	94.0%	94.1%	94.2%

Background

Training compliance.

At 94.2%, the Statutory and Mandatory Training rate remains just below the Trust target for the core training modules

Summary

Statutory and Mandatory training rate on 31 August 2023 was 94.2% (94.1% on 31 July 2023) showing a very slight increase. This compliance rate is for the 6 'Core for All' subjects only.

Name	Assignment Count	Required	Achieved	Compliance %
205|LOCAL|Security Awareness - 3 Years|	11545	11545	10845	93.94%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	11545	11545	10937	94.73%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	11545	11545	10854	94.01%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	11545	11545	10929	94.66%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	11545	11545	10976	95.07%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	11545	11545	10719	92.85%

Compliance rates for the Annual competence requirements were as follows:

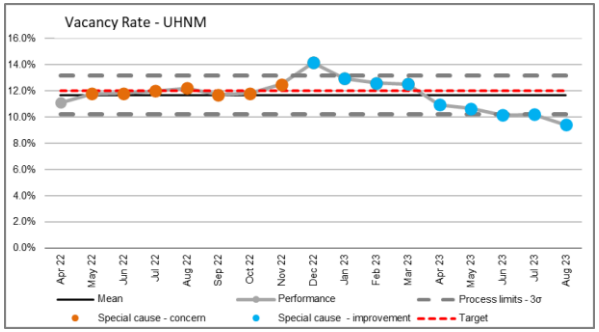
Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	11521	11521	10319	89.57%
NHS|CSTF|Information Governance and Data Security - 1 Year|	11521	11521	10371	90.02%

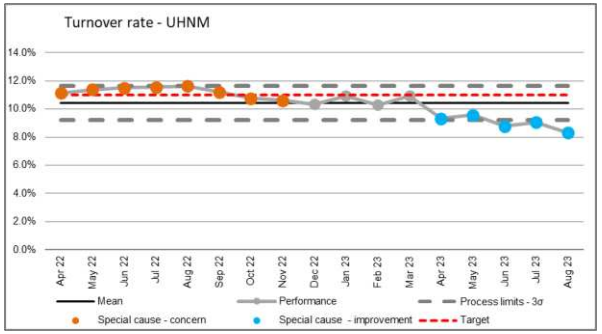
Actions

- We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.
- Compliance is monitored and raised via the Divisional performance review process.
- The Being Kind e-learning is now mandated from 1 April 2023 and face-to face sessions started from June 2023, with a total of 6,450 individuals who have already attended, of which 3,551 attended in August 2023.

Workforce Vacancies and Turnover

University Hospitals of North Midlands NHS Trust





Variation	Assurance
L	?

Target	Jun 23	Jul 23	Aug 23
11.0%	8.8%	9.0%	8.3%

Background

Turnover rate

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 August 2023 remains below the trust target of 11%.

Vacancy rate has decreased from 9.0% last month to 8.3%

Summary

- The 12m Turnover rate in August 2023 sat at 8.3% which remains below the trust target of 11%.
- The summary of vacancies by staff groupings highlights a 0.77%decrease in the vacancy rate over the previous month.
- M5 vacancies decreased to 9.43% (10.20% in July). Colleagues in post increased in August 2023 by 94.09 FTE, budgeted establishment increased by 4.39 FTE, which decreased the vacancy FTE by -89.70 FTE overall [*Note: the Staff in Post FTE is a snapshot at a point in time, so may not be the final figure for 31/08/23]

Vacancies at 31-08-23	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,562.29	1,388.77	173.52	11.11%	14.38%
Registered Nursing	3603.64	3149.79	453.85	12.59%	12.88%
All other Staff Groups	6594.54	6112.79	481.75	7.31%	7.74%
Total	11,760.47	10,651.34	1,109.13	9.43%	10.20%

Actions

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

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key elements of the financial performance year to date are:

- For Month 5 the Trust has delivered a year to date deficit of £8.8m against a planned surplus of £2.9m; this adverse variance of £11.7m is primarily driven by underperformance against the Trust's in year CIP target, the impact of industrial action and unfunded additional winter escalation capacity that remains open.
- The Trust has incurred £3.6m of costs relating to winter escalation capacity remaining open to Month 5; the Month 5 position includes £1.5m of additional funding from the local ICB.
- The industrial action (IA) by medical staff has cost the Trust £3.4m in backfill arrangements. Whilst this cost is unfunded the ERF target for the year has been reduced by 2% in relation to the April IA with further guidance expected for subsequent IA.
- To date the Trust has validated £18.1m of CIP savings to Month 5 against a plan of £22.9m. The Trust has recognised £2.1m of CIP due to an assumed reduction in the annual leave provision; this delivers 50% of the NR ICB stretch CIP target. 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 £20.4m of Capital expenditure which is £3.4m above plan.
- The cash balance at Month 5 is £84.4m which is £1.6m lower than plan

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	90.5		
	Expenditure - Pay	variable	53.7		
	Expenditure - Non Pay	variable	32.3		
Activity	Daycase/Elective Activity	variable	8,831		
	Non Elective Activity	variable	10,910		
	Outpatients 1st	variable	27,587		
	Outpatients Follow Up	variable	39,860		

Income & Expenditure

Income & Expenditure Summary Month 05 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	992.5	85.9	86.0	0.2	413.9	413.7	(0.3)
Other Operating Income	84.3	7.4	8.3	0.9	36.1	36.2	0.1
Total Income	1,076.8	93.3	94.3	1.1	450.0	449.9	(0.1)
Pay Expenditure	(657.3)	(57.6)	(58.3)	(0.8)	(271.7)	(273.9)	(2.2)
Non Pay Expenditure	(393.0)	(33.3)	(36.7)	(3.3)	(164.4)	(175.0)	(10.5)
Total Operational Costs	(1,050.4)	(90.9)	(95.0)	(4.1)	(436.1)	(448.8)	(12.7)
EBITDA	26.4	2.4	(0.6)	(3.0)	13.9	1.1	(12.9)
Interest Receivable	2.8	0.2	0.6	0.3	1.2	2.3	1.1
PDC	(10.3)	(0.9)	(0.9)	0.0	(4.3)	(4.3)	0.0
Finance Cost	(19.0)	(1.6)	(1.6)	0.0	(7.9)	(7.9)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Total	0.0	0.2	(2.5)	(2.7)	2.9	(8.8)	(11.7)

Key issues to note within the Month 5 position include the following

- The overspend of £11.7m is mainly driven by
  - an under delivery of CIP by £4.8m
  - additional capacity costs of £3.6m have been incurred to Month 5; additional funding of £2.0m has been agreed with the Staffordshire and Stoke on Trent ICB and £1.5m of this has been reflected in the Month 5 position.
  - costs relating to industrial actions of £3.4m
- The two main CIP schemes behind plan at Month 5 are the ICB non-recurrent stretch of £2.1m and the recurrent divisional schemes of £3.4m.

Capital Spend

NHS University Hospitals of North Midlands NHS Trust

UHNM Capital Expenditure Plan	2023/24 Plan/forecast £000	YTD Plan M05 £000	YTD Actual M05 £000	YTD Variance M05 £000
Total PFI & Loan Commitments	(19.6)	(7.1)	(7.1)	-
Pre-committed investment items (ICB allocation)				
PFI enabling costs	(0.2)	-	-	-
Project Star	(20.7)	(7.4)	(8.5)	(1.1)
Emergency Department (restatement costs)	(0.2)	(0.1)	(0.1)	(0.0)
Air heat boiler replacement Trust Contribution	(0.7)	-	-	-
Wave 4b Funding - Lower Trent Wards	(0.2)	-	-	-
EPMA (Electronic Prescribing) BC	(0.7)	(0.2)	(0.2)	0.0
Pathology LIMS BC	(0.6)	(0.4)	(0.3)	0.1
Pathology MSC Siemens refresh	(0.1)	-	-	-
Patient Portal roll out costs (BC 462)	(0.4)	(0.1)	(0.1)	0.0
Bi plane enabling (BC 425)	(0.2)	(0.2)	(0.0)	0.2
CT8 enabling works	(0.6)	(0.4)	(0.6)	(0.2)
Network and Communications (BC 510)	(1.2)	-	-	-
Pharmacy Robot BC487 - equipment	(0.5)	-	-	-
Pharmacy Robot BC487 - enabling and other	(0.8)	(0.0)	(0.0)	(0.0)
Electronic Patients records BC/specification	(0.8)	(0.2)	(0.0)	0.2
ED ambulance off - enabling ward moves	(0.7)	(0.2)	(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)	-	(0.1)	(0.1)
Required NHSE plan re-phasing adjustment	7.2	4.2	-	(4.2)
Endoscopy works - 22/23 PDC ICB allocation	(0.4)	(0.1)	(0.0)	0.1
Remaining 2022/23 commitments	(0.3)	(0.2)	(0.2)	0.0
Total Pre committed Investment items	(22.7)	(5.7)	(10.3)	(4.7)
UHNM Capital Expenditure Plan	**2023/24 Plan/forecast £000**	**YTD Plan M05 £000**	**YTD Actual M05 £000**	**YTD Variance M05 £000**
IMT Sub Group Total Funding	(2.3)	(1.1)	(0.2)	0.9
Medical Devices Sub Group Total Funding	(2.4)	(0.7)	(0.4)	0.2
Estates Sub Group Total Funding	(3.6)	(0.6)	(0.3)	0.2
Health & Safety compliance	(0.2)	(0.0)	(0.0)	0.0
Net zero carbon initiatives	(0.1)	(0.0)	-	0.0
Central funding beds, mattresses, hoists	(0.1)	-	-	-
Total Sub Groups	(8.7)	(2.3)	(1.0)	1.4
New IFRS16 leases (previously classified as operating leases and charged to revenue)				
Lease liability re-measurement	(0.2)	(0.2)	(0.3)	(0.1)
IFRS 16 leases	(0.9)	(0.2)	(0.2)	-
Total Internal Capital Expenditure programme	(52.1)	(15.3)	(18.9)	(3.3)
Additional CRL / Externally Funded PDC				
Wave 4b Funding - Lower Trent Wards	(1.6)	(0.1)	(0.0)	0.0
TIF 2 PDC CTS phase 1 - enabling slippage	(0.4)	(0.4)	(0.2)	0.2
TIF 2 PDC (Day Case Unit)	(2.7)	(0.1)	(0.1)	(0.0)
TIF 2 PDC (Women's Hospital)	(1.2)	(0.0)	(0.0)	-
PDC - additional General & Acute beds	(13.4)	(0.1)	(0.1)	-
PDC - Community diagnostic centre phase 1	(1.4)	(0.0)	(0.0)	-
PDC - Pathology LIMS	(1.2)	-	-	-
PDC - CDC phase 2 endoscopy	(2.7)	-	-	-
Air heat boiler replacement PSDS Grant BC 510	(2.9)	(0.1)	(0.1)	-
Charitable funded expenditure	(2.1)	(0.9)	(0.9)	-
Total Additional CRL / PDC Funded expenditure	(29.5)	(1.7)	(1.5)	0.2
Total Capital Expenditure	(81.6)	(16.9)	(20.4)	(3.4)
Planned (under)/over spend	5.9			

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 5 capital expenditure was £20.4m against a plan of £16.9m, an overspend of £3.4m. Of the £20.4m expenditure, £7.1m is related to pre-committed items for the repayment of PFI and IFRS16 lease liabilities and PFI lifecycle expenditure.

The main reason for the overspend is the £4.2m of the re-phasing / reduction in expenditure to Month 5 included in the NHSE plan in order to submit a balanced capital plan. The main other variances to plan relate to the following schemes:

- Project Star is £1.1m ahead of plan and reflects the costs from the latest statement of works;
- Bi-plane enabling works are £0.2m behind plan, this is expected to be completed by the end of the calendar year;
- CT8 enabling works are £0.2m ahead of plan and reflect completion of the work in August;
- Electronic Patient Records business case is £0.2m behind plan due to contractual delays with the scheme and 2 months of the expenditure will slip in to 2024/25; and
- County CTS phase 1 is £0.2m behind plan due to delays in the construction of items for the treatment rooms; this is expected to be completed shortly.

The IM&T sub-group is showing an underspend of £0.9m at Month 5, which is mainly due to delays in the radiation oncology equipment scheme (£0.75m) forecast with expenditure now expected in Month 6.

Balance sheet

Balance sheet as at Month 5	31/03/2023	31/08/2023			
	Actual £m	Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment *	627.6	627.7	629.3	1.6	Note 1
Right of Use Assets	18.8	17.3	17.6	0.2	
Intangible Assets	18.4	17.0	16.7	(0.3)	
Trade and other Receivables	1.4	1.4	1.4	0.0	
Total Non Current Assets	666.1	663.4	664.9	1.5	
Inventories	16.8	16.8	16.9	0.0	
Trade and other Receivables **	57.9	41.7	47.3	5.7	Note 2
Cash and Cash Equivalents **	84.0	86.0	84.4	(1.6)	Note 3
Total Current Assets	158.7	144.5	148.6	4.1	
Trade and other payables **	(134.0)	(121.0)	(136.9)	(15.8)	Note 4
Borrowings	(14.0)	(14.0)	(13.8)	0.1	
Provisions	(5.6)	(5.6)	(5.6)	-	
Total Current Liabilities	(153.5)	(140.6)	(156.3)	(15.7)	
Borrowings	(256.8)	(250.7)	(251.4)	(0.7)	
Provisions	(2.7)	(2.7)	(2.6)	0.0	
Total Non Current Liabilities	(259.5)	(253.4)	(254.0)	(0.6)	
Total Assets Employed	411.7	413.9	403.2	(10.7)	
Financed By:				-	
Public Dividend Capital	665.0	665.0	665.0	-	
Retained Earnings *	(427.5)	(425.3)	(436.0)	(10.7)	Note 5
Revaluation Reserve *	174.2	174.2	174.2	(0.0)	
Total Taxpayers Equity	411.7	413.9	403.2	(10.7)	

Accruals have increased by £4m in Month 5. This increase is partly due to an increase in capital creditors and reflects the reported position against the capital plan, particularly in relation to the car park construction. Accruals have also increased in relation to NHS Supply Chain and revenue accruals reflecting the impact of the current revenue position at Month 5.

Note 5. Retained earnings are showing a £10.7m variance from plan which reflects the revenue variance from plan of £11.7m at Month 5, which is partly mitigated by higher than planned capital donated income of £1m (relating to donated capital expenditure).

Variances to the plan at Month 4 are explained below:

Note 1. Variance mainly due to the phasing of capital expenditure in relation to Project Star required in the capital plan submitted to NHSE. The spend is in line with the Trust's internal plan.

Note 2. Trade and other receivables are £5.7m higher than plan at Month 5. NHS receivables includes accruals of £5.3m with ICBs in relation to inflation and escalation income at Month 5.

Note 3. The variance is mainly due to capital payments being higher than plan by £1.3m, which reflects the position against the capital plan and progress on the construction of new car park. Income is £1.9m higher than plan and payments not relating to capital are £2.2m higher than plan and reflect the impact of the current revenue position at Month 5.

Note 4. Payables are £15.8m higher than plan mainly due to increases in deferred income and accruals at Month 5.

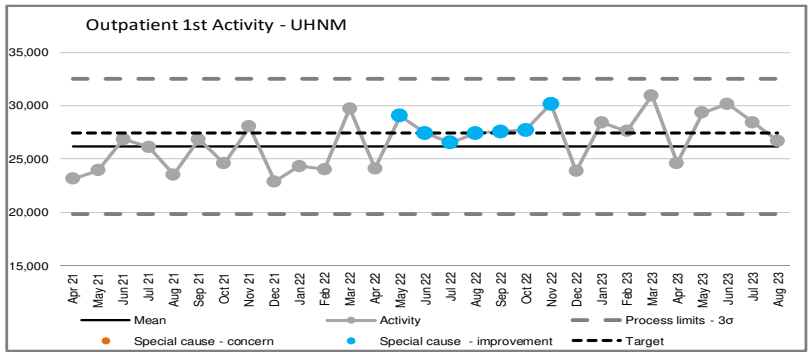
In comparison to Month 12, deferred income has increased by £19.5m to £33.9m. The main increase in deferred income compared to Month 12 relates to Stoke and Staffordshire ICB where the Trust has a deferred income balance at month 5 of £17.8m. This mainly relates to 23/24 non-recurrent income for Elective Recovery Fund, ERF Marginal Gains Transfer where the income for the entire financial year has been received.

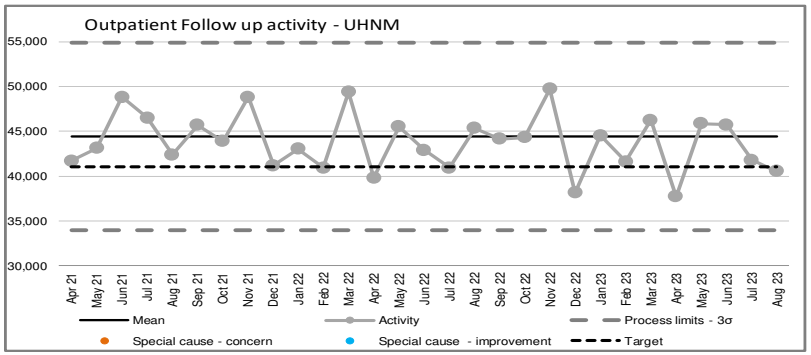
The deferred income balance also includes significant balances relating to cash received from Health Education England for a number of schemes (£3.8m); digital pathology (£1.8m); and high cost devices (£5.7m).

Activity

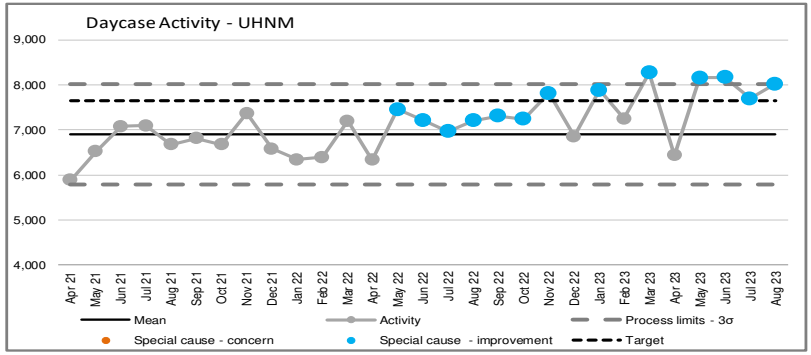
NHS
University Hospitals of North Midlands
NHS Trust

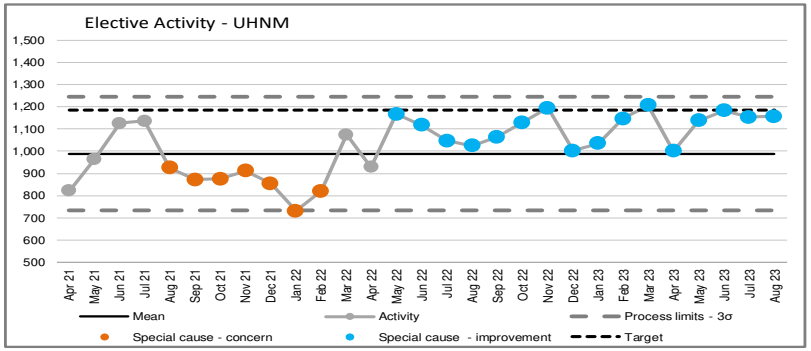
Planned care Outpatient



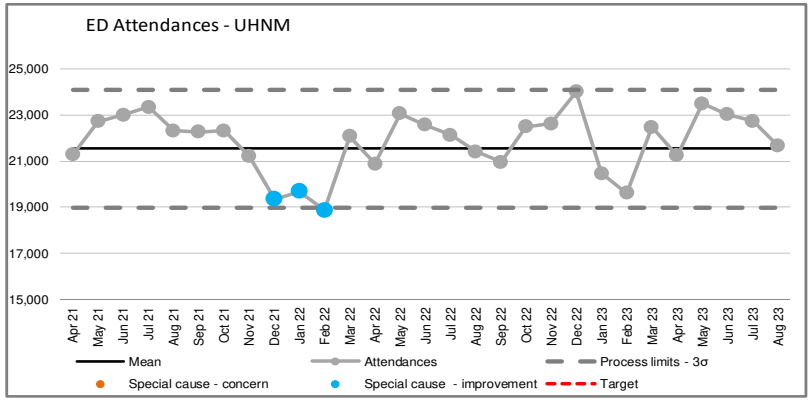


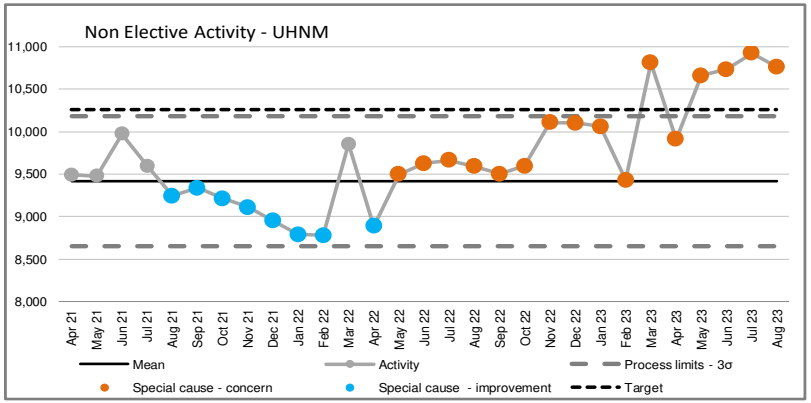
Planned care Inpatient





Urgent Care





Trust Board

2023/24 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		5	3	7	5	2	6	4	8	6	3	7	6	
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse		Staff		Staff				Staff			Staff		
Quality Governance Committee Assurance Report	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 £1,500,001 and above	Director of Strategy	N/A	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	3	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 considered at Trust Board Seminar in July
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													
Well-Led Self Assessment	Associate Director of Corporate Governance													
Risk Management Policy	Associate Director of Corporate Governance													
Complaints Policy	Chief Nurse													Next due for review June 2024