AGENDA

Trust Board (Open)

Meeting held on Wednesday 8th January 2025 at 9.30 am to 12.15 pm
PLEASE NOTE CHANGE IN VENUE: to be held via MS Teams

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 6th November 2024	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
10 mins	**6.**	Chief Executive's Report –December 2024	Information	Dr S Constable	Enclosure	
10:05		**HIGH QUALITY**				
10 mins	**7.**	Care Quality Commission Action Plan	Assurance	Mrs AM Riley	Enclosure	1
10 mins	**8.**	Maternity and Neonatal PSIRF Investigation Report Q2	Assurance	Mrs AM Riley	Enclosure	1
10 mins	**9.**	NHS Resolution Maternity Incentive Scheme	Assurance	Mrs AM Riley	Enclosure	1
10:35		**RESPONSIVE**				
10 mins	**10.**	Urgent and Emergency Care Pressures, Ambulance Handover and Winter Update	Assurance	Mrs K Thorpe	Enclosure	1, 4
10:45 – 11:00 COMFORT BREAK						
11:00	**HIGH QUALITY**	**RESPONSIVE**	**PEOPLE**	**IMPROVING & INNOVATING**	**SYSTEM & PARTNERS**	**RESPONSIVE**
	11.	Integrated Performance Report – Month 8 and Committee Assurance Reports:				
15 mins	**11a**	• Quality Governance Committee Assurance Report (28-11-24 & 20-12-24) • High Quality Dashboard	Assurance	Prof A Hassall Mrs AM Riley Dr M Lewis	Enclosure	1
25 mins	**11b**	• Performance & Finance Committee Assurance Report (18-12-24) • Responsive Dashboard • Resources Dashboard	Assurance	Prof G Crowe Mrs K Thorpe Mr M Oldham	Enclosure	4 7, 8
15 mins	**11c**	• People, Culture & Inclusion Committee Assurance Report (18-12-24) • People Dashboard	Assurance	Prof G Crowe Mrs J Haire	Enclosure	2
10 mins	**11d**	• Improving & Innovating Dashboard • System & Partners Dashboard	Assurance	Dr M Lewis Ms H Ashley	Enclosure	9 3
12:05		**PEOPLE**				
10 mins	**12.**	Freedom to Speak Up Report	Assurance	Mrs C Cotton	Enclosure	
12:15	**CLOSING MATTERS**					
5 mins	**13.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
12:20	**DATE AND TIME OF NEXT MEETING**					
	14.	**Wednesday 12th March 2025, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**				

Questions from the Public - Please submit questions in relation to the agenda, by 9.00 am 6th January to nicola.hassall@uhnm.nhs.uk These questions will then be addressed and answered as part of the relevant item on the agenda

Trust Board (Open)

Meeting held on Wednesday 6th November 2024 at 9.30 am to 12.05 pm
Trust Boardroom, Third Floor, Springfield, Royal Stoke

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

Members:			A	M	J	J	J	A	O	N	J	M
Mr D Wakefield	DW	Chairman (Chair)										
Mrs L Bainbridge	LB	Non-Executive Director										
Mrs T Bowen	TBo	Non-Executive Director										
Prof G Crowe	GC	Non-Executive Director										
Dr L Griffin	LG	Non-Executive Director										
Ms A Gohil	AG	Non-Executive Director										
Prof A Hassell	AH	Associate Non-Executive Director										
Prof K Maddock	KM	Non-Executive Director										
Mrs M Monckton	MM	Non-Executive Director										
Mrs W Nicholson	WN	Associate Non-Executive Director										
Mrs A Rodwell	AR	Non-Executive Director										
Prof S Toor	ST	Non-Executive Director										
Dr S Constable	SC	Chief Executive	TB	TB	TB	TB						
Ms H Ashley	HA	Director of Strategy										
Mrs C Cotton	CC	Director of Governance					NH			NH		
Mrs A Freeman	AF	Chief Digital Information Officer										
Mrs J Haire	JH	Chief People Officer										
Dr M Lewis	ML	Chief Medical Officer										
Mr M Oldham	MO	Chief Finance Officer										
Mrs AM Riley	AR	Chief Nurse						JHo				
Mrs L Thomson	LT	Director of Communications										
Mrs K Thorpe	KT	Acting Chief Operating Officer	KT	SE	SE	SE	SE	SE				
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI	DR									

In Attendance:

Mrs N Hassall	Deputy Director of Governance (minutes)
Dr C Baker	Consultant Anaesthetist (item 1)
Mr J Dodds	Head of EPRR (item 9)

Members of Staff and Public: 4

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Staff Story**	
152/2024	Dr Baker provided a presentation to Board members following a visit to St Helena and highlighted the following: • The demographics of the remote island, its brief history and the healthcare system • A team of 4 members of staff had visited St Helena for a few weeks to help repatriate a patient from South Africa back to St Helena. The patient's	

	medical history was highlighted and Dr Baker explained the way in which the patient had been supported with his recovery Mr Wakefield queried whether there were any learnings from the visit and Dr Baker referred to the way in which the visit reaffirmed his appreciation of the facilities which were available in the UK. Dr Lewis queried if there was anything which was done differently in St Helena compared to the UK which could be undertaken at UHNM and Dr Baker stated that the members of staff had a wider scope of responsibility due to the limited number of staff available. In addition, due to the lack of facilities, problem solving required more creativity. Mrs Haire referred to the sense of teamwork and resourcefulness described by Dr Baker and queried how that could be utilised at UHNM. Dr Baker stated that this could be achieved by empowering staff to be able to work across their scope of practice within certain boundaries. Mr Wakefield summarised some of the similarities between St Helena and UHNM, in terms of the ability to provide sustainable healthcare and sustaining services and he noted the comment regarding creating greater flexibility between staff. **The Trust Board noted the story.** Dr Baker left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
153/2024	Mr Wakefield welcomed members to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate. Mr Wakefield welcomed Mrs Bainbridge to the meeting who joined the Trust on 1st November as Non-Executive Director.	
3.	**Declarations of Interest**	
154/2024	There were no declarations of interest raised.	
4.	**Minutes of the Meeting held 9th October 2024**	
155/2024	Mrs Riley highlighted that the sentence regarding vacancies on page 6 required amendment to read 0.2% rather than 0.2. With the exception of this amendment, the minutes of the meeting held 9th October 2024 were approved as a true and accurate record.	
5.	**Matters Arising via the Post Meeting Action Log**	
156/2024	PTB/607 – Mr Oldham stated that a wider piece of work was being undertaken in terms of the cost improvement programme (CIP), including the context of the CIP challenge and benchmarking rather than just focussing on performance from the past 3 to 4 years. It was agreed to close the action and to discuss the monitoring and effectiveness of CIPs through the Performance and Finance Committee (PAF). Professor Crowe suggested that a wider discussion was required to include development, delivery and ongoing sustainability of CIPs.	

6.	**Chief Executive's Report - October 2024**	
157/2024	Dr Constable highlighted three areas from his report: • Ambulance handovers and the current challenges of urgent care with renewed approaches being taken in respect of urgent and emergency care pathways • Challenges with iPortal and the risk this was posing to the Trust. He provided his thanks to Mrs Freeman and the IM&T team on the interim actions taken to improve stability and performance of the system. It was noted that this would continue to be a risk for the Trust in the absence of an integrated Electronic Patient Record • Legislation was expected to be changed in respect of sites being Smoke Free and actions had started to be taken in terms of the Trust's approach to this Professor Hassell queried whether the Trust was confident that the interim solution would prevent further disruption to iPortal and Mrs Freeman stated that although the associated infrastructure remained on a shared server, the interim solution had improved performance. She described the plan to move iPortal into its own environment which would help further, and there were additional plans to move all application servers onto their own environment which would provide a lot less interference from other systems. She stated that these actions were expected to take a further 12 weeks. Ms Bowen welcomed the statement on becoming Smoke Free and highlighted the improvement reported within maternity in terms of reducing the number of mothers smoking whilst pregnant. She queried how the Trust would be able to implement such a policy in practice and Dr Constable stated that a multitude of actions would be required, which would be different for staff compared to patients. He stated that the Trust's ambition was to become Smoke Free by January 2026 subject to the changes in legislation. Ms Bowen welcomed the inclusion of employee recognition within the report. Mrs Bainbridge referred to the anti-racist statement included within the report and welcomed the reference to the action which was being taken. She queried how the actions being taken were being publicised with staff. Dr Constable stated that the approach taken reiterated the actions stated within existing policies. Mrs Haire added that the Trust had signed up to the Race Code in addition to formal policies to manage inappropriate behaviours such as the resolution and disciplinary policies. Mrs Haire referred to both the corporate communications on this important subject but that on an individual basis it was difficult to communicate widely outcomes of formal processes. She stated that the Trust was also working on its approach to provide a clear commitment to staff in terms of the action being taken. Mr Wakefield queried, when people raise an issue of racism, whether they would be aware of the actions taken. Mrs Haire stated that the actions taken were shared in communications and Dr Constable stated that this applied to any issue raised by staff in terms of communicating the action being taken which was a challenge given the issues of confidentiality. Mrs Thomson added that the Trust also publicised the positive interventions taken. **The Trust Board received and noted the report.**	
7.	**Board Assurance Framework (BAF) – Quarter 2**	
158/2024	Mrs Hassall highlighted the following: • The summary version of the BAF was provided; the full version had been	

	considered by each of the Committees • The document had been updated by Executives and took into account the comments made at the Committee Deep Dives, in addition to strengthening the action plans to include specific actions to address areas of partial assurance • The most significant extreme risks related to financial in year delivery (BAF 7) and financial sustainability (BAF 8), in addition to digital transformation (BAF 5) which had increased in risk score • Two risks had slightly decreased in risk score although they remained at an extreme rating; delivering responsive patient care (BAF 4) and improving workforce sustainability and culture (BAF 2), and alongside the reduction, the date to achieve the target risk score for this had moved to March 2026. • Fit for purpose estate (BAF 6) remained the only risk in line with its risk tolerance with all other risks being above the tolerated score • Following discussion at Committees, actions for the next quarter would focus on reviewing the risk radar, ensuring the controls and actions identified were more explicit in terms of how they were expected to reduce the risk score towards the target, in addition to reviewing the target risk scores and dates to ensure these were realistic and achievable. Mr Wakefield referred to BAF 4 where the score was rated at Extreme 15 but was expected to rise to Extreme 20 in Quarter 4 and he queried the reason for this given the winter plan was in place. Mrs Thorpe stated that in the context of the BAF the issue was that the risk would remain, irrespective of the plan, with the potential for the risk to be higher due to the increased acuity of patients attending during winter. She agreed to further reflect on the actions identified within BAF 4 to ensure these were focussed at mitigating the key elements of the risk. Professor Crowe referred to financial sustainability and in year delivery which PAF felt were unlikely to reduce towards the target, given the current financial challenges both locally and within the system, and stated that this would be reviewed for Q3. Mr Oldham stated that whilst additional monies for the NHS were confirmed within the recent budget, this would only be able to be reflected within the BAF once any funding had been confirmed with NHS Trusts. **The Trust Board approved the Board Assurance Framework for Quarter 2.**	
8.	**Integrated Performance Report – Month and Committee Assurance Reports**	
	Quality Governance Committee Assurance Report (31-10-24)	
159/2024	Professor Hassell highlighted the following: • Following a peer review to major trauma, 4 areas had been identified as needing to be addressed. The Committee did not agree an assurance rating for the item, given the formal report had not yet been received • The update on infection prevention received partial assurance; while some metrics were on an improving trajectory, a number of areas remained higher than target such as c-difficile and e-coli in addition to improvements required in training compliance • Three annual reports were received for vulnerable patients, adult and children safeguarding and the Committee welcomed the update from the dedicated team, whilst noting the sobering data included within the reports. It was noted that partial assurance was provided, due to the gaps in training and a risk in relation to staffing due to the levels of activity. It was noted that an action had been agreed to confirm whether the increase in child attendances to the Emergency Department was correct and the reasons for this i.e. whether this	

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	was to be expected as a result of a service change • A formal review had been undertaken of wrong site surgery for skin lesions due to the number of never events in the past year whereby it was noted that the increase may be due to the increase in patients seen, in order to reduce waiting lists • Clinical effectiveness remained an extreme risk and whilst progress had been made, a further gap analysis was to be undertaken • Positive assurances included the successful implementation of patient safety investigations with clarity of learning points. Further action was to be taken to include the status of implementing the learning points in future reports • The bi-annual organ donation report received significant assurance and the Committee welcomed the benchmarking which demonstrated that the Trust continued to be one of the highest providers of organs, nationally. In addition, the Committee noted that the Trust had recently established an eye and tissue retrieval service • The Committee received the maternity and neonatal workforce report which had been appended to the Board papers with positive progress noted **The Committee received and noted the assurance report and received and noted the maternity and neonatal workforce report.**	
	High Quality Dashboard	
160/2024	Mrs Riley highlighted the following: • Stabilising the workforce had continued, whereby Registered General Nursing turnover in April 2022 was 7.2% which had since reduced to 5% with no vacancies • Midwife turnover in June 2022 was 7.6% and this had reduced to 2.2%; some of the best performance regionally and nationally • A similar structure had been created for allied health professionals, to strengthen their professional development and as such improvements in recruitment and retention were starting to be seen Professor Toor referred to the retention rates which were particularly positive and queried whether any learning could be duplicated across the organisation. Mrs Riley stated that similar approaches were being taken with Pharmacy Assistants and including them within clinical fellowships and work remained ongoing to transfer this approach to other staff groups. Mr Wakefield queried the chart within the maternity workforce paper and levels of acuity in midwifery. Mrs Riley stated that the chart related to a point in time and after each assessment, any risk would be escalated and mitigated in real time. Mr Wakefield referred to the case mix for category 1 / 2 births which was 23%, resulting in the remaining births being high risk. Mrs Riley stated that this case mix was representative of the local population, and she expected this to be further reflected in the next birth rate plus report.	
	Performance & Finance Committee Assurance Report (29-10-24)	
161/2024	Professor Crowe highlighted the following: • Whilst there remained continuing challenges in diagnostics and endoscopy the Committee received assurance that credible plans were in place for planned care and the impact on these of reducing long waits • The Committee welcomed the update on sustainability and progress towards net zero	

- Two business cases received approval
- The in year financial outlook continued to be challenged compared to the original plans and whilst progress with in year CIPs was being made, this was reliant on a number of non-recurrent schemes. In addition, the financial outlook for the system remained challenged and therefore a roadmap for the development of a tangible medium / long term plan had been requested
- Urgent care performance continued to be challenged, and a number of schemes had been commissioned. It had been agreed to hold a deep dive into the winter plan at next meeting to include the actions being taken to tackle emergency pressures

Mr Oldham referred to the investigation intervention (I&I) regime which had commenced with Deloitte. He stated that it was expected that a two week rapid diagnostic would take place with feedback subsequently provided to the system, of areas of key focus and opportunities. He added that the following 10 weeks would involve Deloitte assisting the system with implementation of any projects. It was noted that the focus of the regime was on the 2024/25 run rate and it was recognised that any improvement needed to ensure that this did not make the 2025/26 position untenable.

It was noted that the forecast outturn of £23 m deficit had not changed.

Mr Wakefield referred to the pharmacy delays and queried how these were being managed. Professor Crowe stated that there had been a number of challenges which included Lloyds Pharmacy giving the Trust notice of their intention to remove the on-site pharmacy, which was affecting other Trusts, and an alternative plan had been identified. He added that the plans to replace the robotic dispensing system had been delayed due to the supplier subsequently stating that they were not able to provide the system, therefore alternative arrangements were being considered.

The Trust Board received and noted the assurance report.

Responsive Dashboard

162/2024

Mrs Thorpe highlighted the following:

- The trajectory for October for urgent and emergency care was expected to follow similar performance, with the 4 hour target at approximately 66% for October, alongside a deterioration in category 2 handovers, whereby 57% of patients were being handed over within 45 minutes, notwithstanding that the 45 minute target was the maximum handover time and therefore should be quicker
- The frailty unit had opened at County Hospital, and work was ongoing with the frail elderly assessment unit, given the age profile of patients attending the Emergency Department. In addition, improvements to discharge facilities were being considered. In terms of community support, the beds at Haywood Hospital were due to come online in December
- Key areas of focus were on the consistent implementation of policies and as such capacity had been created for divisional teams to focus on key actions before 10 am such as enacting rapid handover, compliance with internal professional standards, ward standard work, your next patient and corridor care, whilst recognising that the latter was not ideal but helped to support the capacity requirements
- In terms of diagnostics, endoscopy performance had been brought back in line with the trajectory with further work to be taken on non-obstetric ultrasound

	Mr Wakefield referred to the actions identified which were not too dissimilar to those articulated in previous plans, and he queried how these would be enacted this winter. Mrs Thorpe stated that the issue was consistency and therefore teams were being supported and challenged on whether they were taking consistent action on a daily basis. Dr Lewis stated that he had agreed the approach with Mrs Thorpe and Mrs Riley in terms of the policies and processes to be enacted, and that the focus was on enabling divisions to implement these as well as holding them to account. He stated that engagement with staff had also taken place to ensure they understood the impact of their decisions, with the aim of ensuring that the Trust was treating patients in the right place, be that in hospital or at home. Mrs Riley added that the function of the site team had also been reviewed. Dr Constable stated that the Trust recognised that this was the main priority for the next few months and these were things which were within the Trust's gift to improve, in terms of robust trust-wide deployment with a clear patient safety and effectiveness benefit. Professor Hassell queried how the Integrated Care Board (ICB) demand management scheme was working in addition to call before convey. Ms Ashley stated that a clear urgent and emergency care structure was in place with the Integrated Care System (ICS) chaired by Dr Lewis and the ICB had a number of priorities which were intended to support operational and financial improvement including demand management. She stated that the main actions in respect of these were yet take place, therefore the impact was not yet known and Mrs Thorpe added that some actions required additional staff, therefore the impact was expected later in winter. Mrs Thorpe referred to call before convey which was being used but was not having an impact as this was not affecting the number of ambulances or predicted conveyances. She agreed to provide a further update on the impact of demand management and call before convey, to PAF as part of the discussion on the winter plan in November. It was agreed that this should include the context, the improvement plans which were already in place and whether these were working, the effectiveness of the winter plan as well as the outcomes and actions from the recent NHS England assurance visit. Dr Lewis referred to the urgent and emergency care board and the focus on residential home patients due to the number of presentations to acute providers, half of which were admitted. He referred to the need to avoid harm from admitting frail elderly patients which required advanced care planning and added that this would become part of the demand management programme.	
	People Dashboard	
163/2024	Mrs Haire highlighted the following: • Employee engagement remained static as the staff voice had stopped whilst the national staff survey was underway. In terms of the national staff survey, the Trust's response rate stood at 39% with 3 weeks left • Other metrics were showing an improvement, and a sickness absence deep dive had been held at People, Culture and Inclusion Committee (PCI) which looked at the interventions in place, and assurance was being obtained on adherence to policies before other interventions were considered • In terms of vacancies and turnover, these continued to track well with the number of staff in post having increased by 120, due to the newly qualified workforce. Increases in workforce were being regularly discussed with Divisions as to whether this correlated with reduced bank expenditure and agency utilisation	

	• There had been a small decline in the appraisal figures, of 0.5% and this continued to be an area of focus. A 'go, look, learn' had been undertaken in Women's, Children's and Support Services following their success with Personal Development Review (PDR) completion at 95%, with the aim of sharing good practice with other divisions Mrs Riley referred to the number of nursing vacancies within the report which utilised different numbers and calculations and therefore differed from her report.	
	Strategy & Transformation Committee Assurance Report (30-10-24)	
164/2024	Ms Bowen highlighted the following: • A robust discussion was held in terms of transformation and the way in which this was used to help to address areas of challenges within the Trust and it was recognised that metrics were required in order to evidence the impact transformation was having • An update on international commercial opportunities was provided outlining the main areas of focus • The risk in relation to BAF 5 had been widened to full digital transformation as opposed to focussing on cyber, following the deep dive, and there remained ongoing concerns with iPortal, as such the target risk score was to be reviewed and further assurance on iPortal was to be provided • The pilot of the Electronic Prescribing and Medicines Administration (EPMA) had been delayed to January Professor Maddock referred to improving together and that this seemed to have stalled. She stated that whilst it seemed to be well utilised at senior level, utilisation in areas which had received training seemed to have reduced and queried the reasons for this. Ms Ashley stated that improving together was one tool used to address the challenges of the Trust, and work was ongoing to consider the other approaches used which aided delivery of the Trust's strategy. She agreed that the improving together tools could be used more in terms of day to day deliverability. Mrs Riley stated that the roll out of training was on trajectory and divisional teams which had been trained had set their priorities and as such felt that they had an input in their services, however these did not always align to strategic metrics. She stated that the Trust was at a point where the Trust needed to consider how all teams could utilise the various improvement tools available, in order to get better outputs. Mr Wakefield referred to his walkabouts around the Trust whereby he had noted that some of the improving together boards were not being regularly used. Dr Constable suggested that this be discussed further as part of the Trust Board Time Out in November. **The Trust Board received and noted the assurance report.**	
	Improving & Innovating Dashboard	
165/2024	Dr Lewis highlighted the following: • Work remained ongoing to identify the number of clinical academics and research active employees • The Trust was halfway in reaching its annual target of research participants • Financial income for the year was £700,000 compared to £500,000 for the whole of 2023/24	

	System & Partners Dashboard	
166/2024	Ms Ashley highlighted the following: • Metrics had been included which would continue to be populated such as tobacco and alcohol dependency • In terms of the anchor maturity assessment this reflected the work being undertaken on the sustainability agenda and a self-assessment on this was undertaken every 6 months Mr Wakefield queried the level of confidence in the anchor maturity assessment and Ms Ashley stated that as this was a self-assessment, it was at a point in time and identified the areas which could be improved upon. Mrs Thomson added that when undertaking the self-assessment, she had utilised benchmarking from other organisations in addition to linking with Matthew Missen to identify the evidence for each area. Mr Wakefield noted the intention to provide a deep dive into health inequalities at a future Strategy and Transformation meeting.	
	Audit Committee Assurance Report (31-10-24)	
167/2024	Mrs Monckton highlighted the following: • Positive assurance was provided in terms of losses and special payments, single tender waivers and the process in place for the BAF • The nurse e-rostering report was brought to the meeting although it was noted that it had not yet been agreed and required final internal review • In terms of internal audit recommendations and problematic actions these related to actions where the target date had moved once and where these had been moved twice or more, the Audit Committee received an update on progress and the reasons for delay, from respective Executive Directors • The first cyber security assurance report was provided, and this was to be considered further in terms of the management of risk and the resource required to do so • In terms of job planning Dr Lewis had provided an update on the work required to identify whether the content of the job plans was being delivered, and the Committee supported the recommendation to identify an electronic solution to record this Dr Lewis referred to the job planning recommendation and stated that whilst completion of job plans had been improved, it was not clear whether the job plans were being worked as stated. He stated that a pilot study was to be undertaken within a few specialties to obtain information as to whether this would provide a benefit trust-wide. He added that he was due to attend a regional meeting on job planning, whereby he hoped to receive further information on how to tackle this issue. Dr Constable added that this would help to support clinical effectiveness as well as having a financial benefit but Mrs Freeman highlighted the difficulties in being able to confirm what activity was being delivered and by whom, due to using over 400 separate systems whereby the information could be on any one of the systems. **The Trust Board received and noted the assurance report.**	
	Resources Dashboard	
168/2024	Mr Oldham highlighted the following: • The income and expenditure position was highlighted within the PAF report	

	• Risks were emerging in relation to slippage on the Community Diagnostic Centre (CDC) and breast unit at County Hospital, funded by TIF monies, and the mitigation for these were to be discussed at PAF due to the potential impact on the 2025/26 capital programme. It was noted that part of the mitigation was expected to be the sale of the Royal Infirmary site and whether this could be brought forward Ms Ashley stated that the slippage on capital had been raised with regional colleagues although there was little capability for the position to be supported beyond the ICS, therefore the Trust was trying to explore options in which it was able to control. Mrs Whitehead added that the issues had also been raised nationally, in terms of the delays with the supply partner for the CDC. Mr Oldham added that there was an overcommitment of the capital programme for 2025/26 for all partners within the ICS which further compounded the risk and required further consideration.	
RESPONSIVE		
9.	**Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance**	
169/2024	Mr Dodds joined the meeting. Mrs Thorpe highlighted the following: • The annual core standards process had been undertaken which included a rigorous self-assessment which was subject to confirm and challenge from the ICB and NHS England • The process concluded with a rating of partial compliance at 78% compared to the 2023 position of non-compliance at 34% • A number of gaps in compliance remained the same as 2023 such as the mass casualty plan and pan flu plan and this was due to the work required across the system The process in place to test staff awareness of their role in the event of a mass casualty was queried and Mrs Thorpe stated that while staff were aware of the actions to be taken, this remained an area of partial compliance due to the need to test compliance against each policy, via live test incidents, in particular in relation to business continuity. Mr Dodds explained that there was good compliance in areas such as the 'front door', which had been confirmed following the live exercises undertaken in year. Mr Wakefield referred to the three areas of challenge; business continuity, continuous improvement and assurance from commissioners which were all partially compliant in 2023 and were not reliant on system and therefore queried what was stopping the Trust from moving these forwards. Mr Dodds stated that the main focus for 2024/25 was on business continuity with work required with all ward areas and departments to establish the number of plans required and the number in place. He stated that as such he was expecting to have to review 350 business impact analysis and Mrs Thorpe added that this also involved testing each of the plans which would take some time. **The Trust Board received and noted the outcome of the annual EPRR core standards assurance assessment.** Mr Dodds left the meeting.	

GOVERNANCE		
10.	**Board Development Programme Update**	
170/2024	The update was taken as read and Mr Wakefield suggested that areas such as productivity, financial sustainability and clinical effectiveness be included again on the 2025/26 programme. **The Trust Board received and noted the update.**	
11.	**Calendar of Business 2025/26**	
171/2024	**The Trust Board received and approved the calendar of business for 2025/26.**	
12.	**RM02 Handling Complaints and Concerns**	
172/2024	Mr Wakefield queried how the Trust tested the effectiveness of the complaints process and queried what assurance was available that verbal complaints were being logged. Mrs Riley stated that all complaints were logged whether verbal or written and the effectiveness of the process was reported to the Quality Governance Committee. This included monitoring the number of complaints which had breached the target response time, the number referred to the Ombudsman and the number coming back to the Trust with further comments. It was confirmed that reporting also included concerns raised as well as formal complaints. **The Trust Board approved the policy.**	
CLOSING MATTERS		
13.	**Review of Meeting Effectiveness and Review of Business Cycle**	
173/2024	No further comments were made.	
14.	**Questions from the Public**	
174/2024	Mr Syme referenced the winter surge plan and that it had not been presented in public. He referred to urgent care and ambulance handover delays and referenced the questions he had raised over the past few years. He referred to the 45 minute ambulance handover target and the number of ambulance handovers which exceeded the 45 minutes standard, as reported by West Midlands Ambulance Service (WMAS). He asked, given the number of ambulance handovers which were above 45 minutes, despite less ambulance conveyances to the Emergency Department portals, and despite the opening of additional capacity: (a) What new initiatives were being rapidly and consistently implemented to substantially and consistently decrease handover delays? (b) How and when will the Trust publicly report the efficacy or otherwise of initiatives to substantially decrease more than 45 minute ambulance handovers delays? (c) By what date does the Trust expect to achieve the standard of maximum handover delays not exceeding 40 minutes? Dr Constable stated that whilst performance across the metric was poor, it was a similar position across the country and not unique to the Trust. However, he recognised that this needed to improve and referred to the previous discussion	

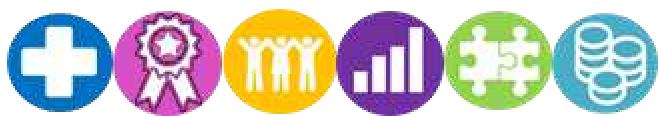
	which outlined some of the actions being taken to address the current challenges. He stated that this would continue to be reported to the Public Board meetings via existing metrics, which included the less than 45 minute ambulance handover target. Mr Wakefield added that all chairs were aware of this priority and that the Trust was the single largest A&E in the country, with issues in relation to its geography. He stated that he visited the A&E Department twice a week and the peaks in the numbers of ambulances arriving to the Trust at the same time was a challenge. He referred to the investment made within emergency medicine and stated that the situation would have been worse, if this investment had not been made. Dr Constable added that a trajectory for this would not be helpful therefore the Trust would continue to work to the less than 45 minutes handover metric, and this would be managed by spreading the risk across the organisation, not just within emergency medicine, in order to mitigate the worst excesses of patient safety. Mr Syme referred to maternity workforce and that July, August and September saw an increase where there were 2 or more midwives short for acuity requirements. He queried what the internal measures (as referenced in the report) were to address this situation? Mrs Riley reiterated the point made earlier in terms of the assessments completed every 4 hours which were mitigated and escalated in real time by moving staff around to the areas which required further support due to acuity.	
DATE AND TIME OF NEXT MEETING		
15.	**Wednesday 8th January 2025, 9.30 am, via MS Teams**	

Trust Board (Open)

Post meeting action log as at 02 January 2025

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/606	09/10/2024	Appraisal and Revalidation Annual Report	It was agreed to provide further information to the People, Culture and Inclusion (PCI) Committee, in terms of when the outstanding appraisals were due to be undertaken.	Matthew Lewis	18/12/2024		Immediate steps have been taken to appoint a new appraiser (Dr Andrew Brown) and work is underway to develop a plan to reduce the rate of missed appraisals. An early task for the lead appraiser will be to put this plan in writing and share it with the Responsible Officer Advisory Group for approval before it is shared with the PCIC.	GA
PTB/607	09/10/2024	Integrated Performance Report	To provide PAF with an update on data from the past 3 to 4 years, demonstrating the percentage of cost improvements delivered at this point in the year so that this could be used as a comparison.	Mark Oldham	26/11/2024	06/11/2024	Update provided to November's meeting. Mr Oldham stated that a wider piece of work was being undertaken in terms of the cost improvement programme (CIP), including the context of the CIP challenge and benchmarking rather than just focussing on performance from the past 3 to 4 years. It was agreed to close the action and to discuss the monitoring and effectiveness of CIPs through the Performance and Finance Committee (PAF). Professor Crowe suggested that a wider discussion was required to include development, delivery and ongoing sustainability of CIPs.	B
PTB/608	09/10/2024	Integrated Performance Report	To agree where to report the breakdown of long wait patients by ethnicity and demographic after discussion with the Executive	Helen Ashley	08/01/2025		Action not yet due.	GA



Chief Executive's Report to the Trust Board

January 2025

Part 1: Highlight Report

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last public meeting on 6 November 2024, some of which are not covered elsewhere on the agenda for this meeting.

1. National and Regional Context

Appendix 1 is a summary document that details the main areas covered in the ICB Board meeting that took place on 21 November 2024. This summary does not replace the formal minutes of the meeting; it is intended to support the briefing of colleagues within the Trust.

Similarly, the Briefing Paper for the Integrated Care Partnership Meeting in December 2024 is included as Appendix 2.

2. Operational Performance Overview

We have made huge progress over the last few months with our delivery of the COVID-recovery planned care backlog of patients waiting a very long time – 104 weeks, then 78 weeks and then 65 weeks. The combined efforts of all have meant we have made massive inroads into our collective waiting list, although clearly, we still have a long way to go. We learnt in November that we have been stepped down from the highest level of NHS England oversight (Tier 1) to a lower level (Tier 2), indicating confidence in our ability to deliver on our plans.

Ambulances are still being held for a far too long outside our hospitals, especially RSUH. This is unjustifiable at any time, but even more so as the temperatures drop outside. This is poor for everyone involved. We have declared two separate Critical Incidents in December 2024 (one was for the whole local NHS system) because of poor flow compromising patient care.

We are in a national programme aimed at improving our ambulance offload performance with a trajectory to get us to 85% within 45 minutes. We have been working with West Midlands Ambulance Service and our local Integrated Care Board to implement this, and there has been some improvement most recently (1794 lost WMAS hours in the week commencing 16 December 2024; 507 lost hours in the week commencing 23 December 2024).

However, this is still not good enough, and it remains to be seen whether any improvements are sustained.

To support sustained improvement, we have been working through our Your Next Patient, Rapid Handover and general flow actions. This includes renewed focus on moves to all inpatient and portal capacity in line with the Internal Professional Standards. We have engaged further support from the National NHSE Urgent Care Team to assist with our pathways and processes as we move into January 2025.

3. County Hospital CQC Rating

County Hospital has now been rated by the CQC as Good overall.

Following the publication of its official report into medical services at County Hospital, the CQC has confirmed that the overall rating for all services at County Hospital has now moved to good from requires improvement. This is a fabulous achievement, symbolic of so much over so many years. I am obviously delighted that the hard work and commitment of our staff at County has been recognised. To be rated as good overall is a true testimony to the dedication and compassion of all who have made significant effort to make the necessary improvements for patients in order to achieve this rating.

The whole Trust's rating remains as requires improvement overall.

4. Disruption to heating and hot water supply at RSUH

On Monday 16 December 2024 the Trust experienced a disruption to the heating and hot water supply from the Energy Centre in some areas at Royal Stoke Hospital due to several underground water leaks across the system. This event affected heating and hot water in the Maternity and Oncology building, the West Building and in two office buildings, B Block and Springfield. A Critical Incident was stood up and immediate temporary measures were put in place as part of our Business Continuity Plans to manage patient and staff comfort, which included providing temporary heaters where they were needed.

Heating and hot water was restored to both the Maternity and Oncology and West Buildings in under 24 hours (Tuesday 17 December 2024). The supply was re-established through the connection of temporary boiler facilities and work commenced with specialist contractors and the Trust's estates team to repair the water leaks. A temporary repair was completed for Maternity and Oncology and this building is now reconnected to the Energy Centre. The West Building remains on a temporary boiler, which is operating well, and work is progressing with specialist heating contractors in investigating and repairing the pipes that are leaking.

Attempts to reconnect the office buildings, B Block and Springfield, to the Energy Centre, without disrupting high priority clinical areas, have not been successful. As a result, temporary heaters have been issued for use in these two areas and those staff working in these buildings have been encouraged, where possible, to either work from other locations within the hospital, or from home, where appropriate.

The repair work remains in progress with the need to conclude investigations, identify the root cause of the water leaks experienced in pipes which are well within their expected life-span and carry out permanent repairs. Once completed, the findings from the investigations will be used to avoid a similar situation recurring in the future.

I would like to take this opportunity to thank estates team colleagues who have worked incredibly hard, often working long hours beyond their routine shifts, over the Christmas/New Year period to ensure that the Energy Centre remains stable, and that the temporary facilities have continued to operate successfully. I would also like to thank any teams affected by the event for their patience and understanding throughout.

5. Continued IT Challenges

We have continued to experience significant challenges with our digital clinical systems, with an excessive number of Priority 1 incidents having occurred over the last 24 months, and especially most recently. Whilst our Digital Services Team have worked tirelessly to troubleshoot and create short term fixes, our systems are highly complex and extremely fragile, with iPortal being over a decade old and running on deprecated and unsupported code. As a result, we have experienced ongoing disruption, numerous periods of working in business continuity and a loss of clinical confidence – all alongside significant winter pressures.

A virtual risk summit was held during December, where we sought feedback from many colleagues around the operational and clinical impact. Clinicians described cancelled appointments, delayed discharges, diagnosis and treatment, staff impact and potential harm. This is reflected in our risk register and Board Assurance Framework and we have escalated these risks to colleagues within the ICB and to NHS England.

The business case for a new Electronic Patient Record (EPR) has been updated to reflect the increased operational and clinical risk and whilst this comes with a significant cost, it is clear from the impact we are seeing, that we will have to work with all stakeholders on providing a satisfactory resolution to this particular challenge.

6. Worker Protection Act 2023

The Worker Protection Act 2023 (amending the Equality Act 2010) came into effect on 26 October 2024, introducing new duties for employers to take reasonable steps to prevent sexual harassment in the workplace. This highlights the critical importance of fostering a safe and respectful culture at UHNM.

To ensure compliance and uphold our commitment to workplace safety, we are focusing on eight key areas:

- Developing effective policies: Ensuring clear, robust policies are in place to address sexual harassment.
- Engaging staff: Actively involving colleagues in shaping a culture of respect and awareness.
- Assessing and reducing risk: Identifying and mitigating workplace risks related to harassment.
- Reporting mechanisms: Enhancing and promoting accessible channels for reporting concerns.
- Training: Delivering comprehensive training for all staff to understand their roles and responsibilities.
- Responding to disclosures: Establishing clear, fair, and timely processes for handling disclosures.
- Addressing third-party harassment: Taking steps to manage risks posed by third parties.
- Monitoring and evaluation: Continuously reviewing the effectiveness of our actions and making improvements.

UHNM has been actively engaged in this agenda since signing the NHS Sexual Safety Charter in October 2023 committing to a zero-tolerance approach toward any unwanted, inappropriate, or harmful sexual behaviours in the workplace. This requirement of the Worker Protection Act aligns with the ten core principles outlined in the Charter.

A dedicated working group has been established to advance this agenda, focusing on refining our policies, practices, and culture to meet the Charter's principles.

To strengthen our approach, we have commissioned an external national specialist partner with expertise in handling sexual violence and safeguarding. Their remit includes:

- Developing a new support model for staff who experience sexual misconduct.
- Conducting a comprehensive review of our progress against the NHS Sexual Safety Charter commitments.
- Identifying further actions required to meet the new duties under the Worker Protection Act.

This partnership demonstrates our commitment creating a safe and inclusive workplace where every colleague feels supported, respected, and protected.

7. Martha's Rule and Call for Concern

Earlier this year NHS England announced that we would become one of more than 100 trusts to pilot 'Martha's Rule' in hospitals, enabling patients and families to seek an urgent review if their condition deteriorates.

The patient safety initiative – Call for Concern – launched at UHNM in November and will give our adult inpatients, their families, and those working here at UHNM round-the-clock access to a review from our critical care outreach team if they are worried about a deterioration. This escalation process will be available 24/7 for adult inpatients initially and will be rolled out to Royal Stoke's emergency department and children's inpatients over the next few months.

Thirteen-year-old Martha Mills died from sepsis having been treated at King's College Hospital, London, in 2021. Martha tragically died due to a failure to escalate her to intensive care despite her family's concerns about her deteriorating condition, which were not responded to promptly.

Extensive campaigning by her parents Merope and Paul has seen widespread support for a single system that allows patients or their families to trigger an urgent clinical review from a different team in the hospital if the patient's condition is rapidly worsening and they feel they are not getting the care they need.

This is a hugely important step in empowering the voices of patients, families and carers, and ensuring their concerns are heard as well as also giving our people an opportunity to raise concerns.

8. PACS Refresh

Digital Services, Radiology and Estates & PFI are pleased to report that a major platform refresh to our Sectra PACS System has been completed.

Sectra PACS is used by the whole Trust (and in the wider health economy in the region) to view images and reports for Radiology, Dental, DEXA and Rheumatology Ultrasound. The completed works encompassed the replacement of the entire server infrastructure for the Live and Standby PACS environments and the migration of more than 10 million examinations over the last 15 years; it has also seen the replacement of approximately 100 highly specialist reporting workstations.

This was a highly technical and complex project on a business-critical system completed with minimal disruption to the organisation. It could not have happened without the combined input of PFI, Radiology and Digital Services colleagues and a great deal of attention to detail and planning.

By bringing UHNM up the latest version of Sectra radiologists can bring stronger attention to patient safety with improved tools for comparing previous and current images, lesion tracking and advanced "on-the-fly" fusion and subtraction. This in turn paves the way for the innovation of clinical reporting workflows via PACS-based reporting, due in the Spring as phase two of the project.

My thanks go to the PACS, Desktop, Network and Infrastructure Teams of Digital Services, Radiology Senior Management Team, and the Estates Capital/PFI Team for their hard work on this project.

9. Annual PFI Partnerships Day

We pride ourselves here at UHNM on the difference we make to our patient and colleague experience through our strategic partnerships. It has taken a great effort by all to develop the strong team culture we now enjoy with our PFI (Private Finance Initiative) private sector partners Healthcare Support (North Staffs) Project Co, Sodexo and Siemens Healthineers. We recognise that an important part of our success is our annual Partnership Days.

This year's partnership day, on 28 November 2024, proved another successful event with the day opening with a look back across the year.

We also turned our attention to the year ahead, thinking about the role of strategy and how as a partnership we would respond to the Trust's refreshed Strategy and key priorities. In terms of our delivery plans, we recognised the vital role of our partnerships as a critical ingredient for success as well as communication. We discussed collectively our proposed Partnership Plan and how we would ensure that this aligned to the Trust's main overarching priorities.

We are part of a national programme, run by the Cabinet Office, the Strategic Supplier Relationship Management (SSRM) Programme. This programme recognises the benefits that effective management of strategic supplier relationships brings in delivering improved outcomes for the public, added social value, reduction of costs and risks, and delivery of innovation. In conjunction with the Cabinet Office, we formally assess the maturity of our relationships across our PFI partnership on an annual basis. The findings from this year's relationship survey were shared on the day. The results were very positive with scores of 70%+

across all areas including commitment, mutuality, transparency, capability, performance, innovation and continuous improvement.

10. Defence Employer Recognition Scheme (Gold) Award

In November 2024, we received confirmation from the Defence Relationship Management (DRM) that we were one of 8 organisations across the West Midlands (88 across the UK) to have their Defence Employer Recognition Scheme (Gold) Award revalidated for a further five years. The gold award, which is the scheme's highest award, recognises UHNM for sustaining excellent levels of support, whilst continuing to implement and advocate forces-friendly initiatives for our workforce and local Armed Forces Community.

This reaccreditation also sits alongside our successful Veteran Aware reaccreditation that was attained in August 2024 by demonstrating compliance with set standards, including identifying service users from the armed forces community, ensuring they receive appropriate forces related support, linking in with local veteran and Armed forces community services and how staff are trained to understand the needs of veterans and Armed Forces personnel.

11. Commercial Research Delivery Centre

In December 2024, we were thrilled to be able to announce a ground-breaking milestone at UHNM. Thanks to an award of over £3.1 million from the National Institute for Health and Care Research (NIHR), UHNM is now home to one of the UK's 20 selected Commercial Research Delivery Centres (CRDCs).

This is a massive achievement, not only for UHNM Research and Innovation but for our entire research community. The CRDC will amplify our ability to conduct pioneering clinical trials, focusing on areas like cancer, diabetes, stroke, obesity, and infectious diseases such as flu and RSV (Respiratory Syncytial Virus). It will also accelerate patient access to cutting-edge treatments that are at the forefront of medical innovation.

This partnership with local community organisations places UHNM at the heart of NHS research and will help us build our capacity for research into the future, with this yet another important step along the way. This investment not only expands our commercial research but also builds a sustainable infrastructure for ongoing research opportunities.

It will help us especially in Staffordshire and Stoke-on-Trent as it will enable us to engage communities that historically have not participated in research, and offer access to treatments that are otherwise not available in the NHS.

By working together with our community partners, we aim to create a welcoming, patient-centred environment for all. Our goal is to ensure inclusive and accessible research for everyone.

12. Keele University QA Visit

The preliminary feedback from the Keele University School of Medicine panel at the Quality Assurance (QA) visit in November 2024 was overwhelmingly positive. As expected, there were a few recommendations in relation to support for Physician Associate and Paramedic students for which we will create an action plan. The panel particularly expressed their gratitude for the excellent turnout from clinical teachers and the very positive attitude from all who engaged on the day.

The next important date is the GMC assessment of the School of Medicine and UHNM as a placement provider which will take place in February 2025

13. Regional and National Award Winners

In November we proudly supported some of our UHNM colleagues at two important award ceremonies.

In London, at the 2024 Nursing Times Workforce Awards, we were announced as winners as Best UK Employer of the Year for Nursing Staff.

In Stoke, we saw three UHNM colleagues be announced winners in the 2024 Your Heroes Awards in the NHS Heroes category. Eric Dray, staff nurse, and Dr Sanjeev Nayak, Consultant Interventional Neuroradiologist, were both highly commended; Kirsty Lazenby, speciality organ donation nurse, was the overall category winner.

14. Employee and Team Recognition

i) Chief Executive Award – Digital Services

I made my own award to the newly renamed Digital Services Team (formerly IM&T) in recognition of all that they have done, above and beyond, in response to the aforementioned digital system challenges.

ii) Appreciation of UHNM staff from patients, family, visitors and colleagues

I have also specifically and personally recognised the contribution of the following colleagues:

- Lieutenant Colonel David Cooper, Consultant in Emergency Medicine
- Steve Rushton, Head of UHNM Charity
- Lisa Thomson, Director of Communications & Charity
- Dr Simrat Gill, Consultant Cardiologist
- Nadine Opiniano, Head of Nursing - Medicine
- Lee-Ann Boardman, Matron - Older Adults
- Flora Okwuozu, Staff Nurse - Neurosciences (Ward 127)
- Gemma Burke, Senior Staff Nurse, Neurosciences (Ward 127)
- Moly John , Staff Nurse – AMU (RSUH)
- AMU Team, County Hospital
- Michael Weetman, Team Leader – MRU, County Hospital
- Professor Fidelma O'Mahony, UHNM Hospital Dean, Keele Medical School
- Emergency Department, County Hospital
- Emergency Department, RSUH
- Dr Alexandra Tabor, Consultant Paediatrician
- Dr Sukesh Mohta, Consultant Paediatrician
- Helen Wood, Clinical Nurse Specialist - Neurosciences
- Georgina Shenton, Directorate Manager - Trauma & Orthopaedics
- Mr Viany Jasani , Consultant Spinal Surgeon
- Eric Dray, Staff Nurse - PACU, RSUH
- Kirsty Lazenby, Organ Donation Specialist Nurse
- Dr Sanjeev Nayak, Consultant Interventional Neuroradiologist
- Dr Madhu Menon, Consultant Nephrologist/Clinical Lead
- Professor Kam Karunanithi, Director of Research and Innovation
- Sarah Jones, Head of Research and Innovation
- Heidi Poole, Deputy Director of IM&T
- Clare Bosanquet, Head of Service Development
- Matthew Gilbert , Software Development Consultant
- Phil Harrison, Software Development Consultant
- Julie Knall, EPR System Programme Manager
- Rod Marshall, Senior Technical Engineer
- Ian Massey, Database Administrator
- Nigel Parker, Software Development Consultant
- Simon Talbot, Senior Software Architect
- Robert Stedall, Deputy Head of Service Delivery
- David Tudor, Head of Service Delivery

- Bal Singh, Technical Architect
- Mohammed Waeed, Head of Infrastructure
- Tom Mercer, Technical Engineer
- Luke Masters, Senior Technical Engineer
- Andrew Fraser, Head of Business Intelligence
- Thomas Hill, Senior Systems Developer
- Digital Services Help Desk Team
- Mr Amit Patel, Consultant Orthopaedic Surgeon
- Dr Pritesh Pranay, Consultant Neurologist
- Dr Andrew Bennett , Specialty Doctor - Emergency Medicine
- Carol Lloyd-Bennett, Senior Nurse - Education & Workforce Development

Part 2: Consultant Appointments

The following table provides a summary of consultant medical staff interviews which have taken place during November and December 2024:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant GI & Urological Radiologist	Newly created post	Yes	16.12.24
Spinal Surgeon	Newly created post	Yes	TBC
Consultant Musculoskeletal Radiologist	Newly created post	TBC	TBC
Consultant in Adult Intensive Care Medicine	Newly created post	Yes	5.2.25
Consultant Obstetrician and Gynaecologist	Newly created post	Yes	TBC
Consultant Fetal Medicine Obstetrician	Newly created post	Yes	TBC

The following table provides a summary of medical staff who have taken up positions in the Trust during November and December 2024:

Post Title	Reason for advertising	Start Date
Consultant Histopathologist	Newly created post	11.11.24
Consultant in Oral & Maxillofacial Surgery	Vacant post	14.11.24
Respiratory Consultants with Specialist Interests	Vacant	1.11.24
PICU Consultant	Newly created	1.11.24
Consultant ENT and Body Radiologist	Newly created	16.12.24
Consultant GI and Urological Radiologist	Newly created	16.12.24

The following table provides a summary of medical vacancies which closed without applications / candidates during November and December 2024:

Post Title	Closing Date	Notes
Consultant Medical Oncologist - Gynae & Lung	1.11.24	No applicants
Consultant in Microbiology or Microbiology/Infectious Diseases	22.12.24	No applicants

Medical Management Appointments

The following table provides a summary of medical management interviews which have taken place during November and December 2024:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Deputy Chief Medical Officer (System)	Vacancy	No	N/A

The following table provides a summary of medical management who have taken up positions in the Trust during November and December 2024:

Post Title	Reason for advertising	Start Date
Acute Care at Home Clinical Director	Vacancy	1.12.24

No medical management vacancies closed without applications/candidates during November and December 2024.

Appendices:

- **Appendix 1: ICB Board Briefing Paper November 2024**
- **Appendix 2: Integrated Care Partnership Briefing December 2024**

Appendix 1

Integrated Care Board Briefing

Staffordshire and Stoke-on-Trent ICB Meeting

21 November 2024

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.

Community Story - Keep warm, keep well community energy scheme – transforming health and the environment

- Louise Stockdale, Head of Transformation and Sustainability at University Hospitals of North Midlands NHS Foundation Trust (UHNM), and Fiona Miller, Chief Executive Officer at Beat the Cold presented the scheme; Keep Warm, Keep Well.
- The scheme was first implemented in 2016. UHNM lease roof space at their two hospital sites to Staffordshire Community Energy and the money earnt from this is ringfenced for health improvement. This funding is provided to Beat the Cold who use this to help patients out of fuel poverty.
- Fiona shared a story about a local resident called Matthew, a 14-year-old, who was diagnosed with asthma at a young age. Following some tragic family circumstances, his asthma got worse, and he was hospitalised.
- Following treatment in hospital, Matthew was discharged, but his mother still worried about his condition and potential future flare-ups.
- The household was referred to Beat the Cold through a Childhood Asthma pilot. Since being referred, Beat the Cold have supported the family to provide several interventions such as advice on air quality, damp, condensation, mould and ventilation.

The Board thanked Louise and Fiona for their story. The Board commented that this was an excellent initiative and that it highlights the importance of the carbon neutral programme. The Board asked if the programme could support more patients and how soon this could be done. Fiona advised that she is hoping to develop the programme over the next 18 months to support additional patients. The Board commented that the scheme would benefit from a wider discussion with the Integrated Care Partnership (ICP) to roll this scheme out on a wider scale.

ICB Chair and Executive update

- David Pearson, Chair, and Peter Axon, Chief Executive Officer, presented the report.
- David advised that there have been some great initiatives from Primary Care that have taken place including the General Practice Long Service Award.
- David also highlighted that during October, ICS partners celebrated Black History Month.
- Peter advised that the medium-term plan sets out clear ambitions and expectations for the next five years. There is a lot of work to be achieved but the system is working together in a joined-up approach to achieve the targets set.
- Peter also advised that the Investigations and Implementation work is underway, and Deloitte and Kingsgate started to look through data and evidence a few weeks ago. Peter hopes to provide an update on this work in due course.

The Board thanked David and Peter for the report. The Board commented that some of the figures for the elective waits are unvalidated and asked when the Board will receive validated figures. Phil Smith, Chief Delivery Officer, provided an update on updated figures for the elective wait lists.

System Level Access Improvement Plan

- Sarah Jeffery, Portfolio Director for Primary Care, presented the report.
- Sarah advised the plan requires approval from NHS England in December.
- Sarah advised that over the last year appointments in General Practice have continued to increase. There have been an additional 200,000 appointments since 2023.

- All practices now have online registration completed, compared to 32% previously.
- Sarah explained there has been significant improvement in patient satisfaction rates across Staffordshire and Stoke-on-Trent. Nationally this has reduced.
- Other highlights of the plan include all practices are signed up for cloud-based telephony and 229 pharmacies are delivering Pharmacy First scheme across Staffordshire and Stoke-on-Trent.
- Digital technology is becoming more embedded and enhanced making it easier for patients to speak to practices on the phone and have their needs dealt with by a trained navigator who can direct them to the appropriate person for their needs.

The Board thanked Sarah for the report. The Board commented that this is excellent progress and asked if the information can be communicated to the public. The Board asked if there is much variation to the experiences patients across Staffordshire and Stoke-on-Trent will have. Sarah advised that there is a variation in data but there is a quality dashboard that highlights if any practices are struggling and therefore can be supported. The Board also asked if there was any health and wellbeing support available for practice staff. Sarah advised she would need to confirm this information and advised she would provide an update to the Board.

System Surge Plan for Winter

- Phil Smith, Chief Delivery Officer, Hayley Allison, Portfolio Director and Tom Bailey, Delivery and Improvement Lead, presented the report.
- Phil advised that the surge plan has been through various governance processes across the system and has been subject to an NHS England assurance visit.
- Phil advised that there has been a great deal of change on how partners come together to plan, deliver and learn from surge planning each year.
- Phil advised that it is recognised that there are challenges operationally and this year the plan delivered must be value for money.
- Tom advised that the approach for the plan this year is replicated from previous years. The plan is based on three elements:
  - A system capacity plan that is underpinned by the system capacity and bed modelling.
  - A system escalation plan designed to facilitate risk management.
  - A system workforce plan that ensures that there is the right level of staff to manage the plans that are put into place.
- Tom also advised that the plan is as resilient as possible and will be reviewed during weekly meetings.
- Hayley advised that during the process of creating the plan, data has been reviewed to determine what the capacity gap may look like.
- Work has also been done collaboratively across the system with acute and community partners to develop a plan that is fit for purpose.
- Hayley advised that demand might change but plans are in place to review this.
- Hayley also advised that we operate a System Coordination Centre (SCC) and this model aims to coordinate urgent care pathways efficiently. The SCC was recently commended by NHS England.

The Board thanked Phil, Hayley and Tom for the report. The Board commented that it was good to see that the plan had been through various assurance processes. The Board also asked if the plan is on track despite not being in the peak period of Winter yet. Hayley advised that urgent care has been challenged already and some of the schemes have been mobilised earlier than expected to mitigate these challenges. The Board also asked if we have the right things in the plan if we are not where we want to be at the moment. Phil advised that the last six weeks have

been challenging and demand has been higher earlier than expected. He also advised this isn't just about capacity, it's also about process.

Medium Term Plan

- Elizabeth Disney, Chief Transformation Officer and Paul Brown, Chief Finance Officer, presented the report.
- Elizabeth explained there is a system ambition for the next five years to get better outcomes, improve our performance, ensure we maintain quality and safety and to make sure we are a sustainable system for the future.
- This must be a whole system plan that is built and owned together. The plan also needs to be data led and this has underpinned the approach so far.
- The unmitigated model has been completed and this investigates how the population is going to change if nothing changes. Elizabeth highlighted that if the model is unchanged, by 2036 there will be an increase of 20% for the over 70's population. The unmitigated model highlights that the system can't continue to do what it is doing now.
- Paul advised that the underlying deficit for the system is £280m. He also stated that the over 70's population equates to additional costs in the system, for example, extra beds and extra staff. The costs would need to be mitigated to avoid a deficit of £340m.
- The financial model has three parts to it:
  - If we work together as a system with the new models of care this would mean significantly less patients in beds.
  - Being more efficient as a system and doing the same for less money.
  - Treating the remaining cohort in a productive way.
- Paul advised that it is being investigated that with these three options it would be enough to get the system into a financial balance over time.
- Elizabeth advised that the next step is to understand what opportunities the modelling work has told us about and discuss these across the system. It is critical to decide on creating these plans, how they will be delivered and manage the benefit that they will bring us.

The Board thanked Elizabeth and Paul for the report. The Board commented that the plan feels joined up between Transformation, Finance and Clinical and there is a focus on the outcomes. The Board asked considering the financial and capacity demands, will there be an ability to carry out the plan in its entirety. Peter Axon responded and advised that between now and 1 April 2025, there will be a discussion with NHS England about the plan for 2025/26.

Quality and Safety Report and System Quality and Safety Committee AAA Chairs Escalation Report

- Lynn Tolley, Assistant Chief Nursing and Therapies Officer, and Josie Spencer Non-Executive Chair of Quality and Safety Committee, presented the report.
- Lynn advised that there is increasing nursing demand in community services however, local authority have offered support.
- Lynn also advised that there is demand on paediatrics and dietetics and there will be a review in these areas.
- There are still some issues with waiting lists for wheelchair services but there has been improvements over the last five months.
- Lynn also advised that at a recent Local Maternity and Neonatal System Partnership Board, a patient whose son tragically passed away at 7 days old has petitioned for 'Rowan's Rule' to be implemented nationally. A video is also being promoted to encourage people to learn infant CPR.
- Lynn advised that a letter from the NHS England Executive team had been received asking for assurances and outlining actions required to maintain focus and oversight in

urgent care services. Unannounced visits had already been arranged at urgent care services at UHNM and University Hospitals of Derby and Burton in July, and the feedback from these were positive.

- Josie thanked the Governance team for helping to support the AAA report.
- There are some advisories in the report and Joise picked up the Intensive and Assertive Community Mental Health Review. Although there are some gaps in the process, there has been lots of positive work.
- Josie also advised that for the Gordon Street Surgery Quality Report that the group were impressed with how the quality impact of that change has been manged and that patients are receiving an improved service.

The Board thanked Lynn and Josie for the report. The Board received the report and ratified he decision of the Quality and Safety Committee with regards to assurance that the ICS are working in partnership to maintaining focus and oversight on quality of care and experience in pressurised services.

Staffordshire and Stoke-on-Trent Health and Care Senate Summary and Escalation Report

- Rachel Gallyott, Deputy Chief Medical Officer, presented the report.
- Rachel advised that the Senate are asking the Board for ratification of vitamin D testing which has come through the clinical values collaborative. This is to support the guidance for appropriate use of vitamin D testing, which we are benchmarking about 10% over our peers.
- The Senate have approved the Integrated Medicines Group decisions for migraine medications and anaesthetic gases. The Senate have also approved the adult asthma improvement project.

The Board thanked Rachel for the report. The Board received and noted the report.

Finance and Performance Report

- Paul Brown, Chief Finance Officer, Phil Smith, Chief Delivery Officer, and Megan Nurse, Non-Executive Chair of Finance and Performance Committee, presented the report.
- Paul advised that the month six position is a £30m variance from the plan.
- Paul advised that at month 4 the forecast outturn position was a £104m variance from the plan but after the recovery plan over the summer, this has reduced to £56m.
- Paul explained that regulators have advised we must break even. The Investigations and Implementation scheme is ongoing and the ICB is waiting for a report from the first phase of that programme that will augment the work done to date within the system.
- Phil advised that nationally the NHS saw it's busiest October and there is a 7% increase compared to last year locally.
- There has been deterioration for Category 2 calls and for the first time this year it has gone beyond the 30minute target.
- Phil also advised that there are some patients who have presented at Emergency Departments who could have received care elsewhere. Their patient journey is being investigated to see if anything else can be done.
- At UHNM there is a focus to apply and hold to account processes in hospital including ward standards, promoting home care is best care and efficient ambulance handovers.
- A multidisciplinary team is visiting Royal Stoke hospital every week to support identification for discharge. NHS England have also visited to look at this discharged process and said it was exemplar.
- Phil also advised that UHNM have been de-escalated from Tier One for cancer and diagnostics. However, there is still a long way to go for acceptable wait times.

- Megan advised that the committee is focusing on the key performance challenges, especially around emergency care.
- There are established clear reporting processes through the Recovery director, and this will continue to include reports from the Investigations and Implementation process.
- The capital plan is compliant for 2024/25 but there is potential slippage on national programmes. However, there are mitigations being developed.

The Board thanked Paul, Phil and Megan for the report. The Board accepted the recommendations:
1. Acknowledge the high-level performance against the five priorities.
2. Acknowledge the high-level key programme deliverables update.
3. Acknowledge the financial position.

People, Culture and Inclusion Report and People Culture and Inclusion Committee Report

- Mish Irvine, Chief People Officer, and Shokat Lal, Non-Executive Chair of People, Culture and Organisational Development Committee, presented the report.
- Mish advised that in terms of workforce the total workforce levels, as of September 2024 equated to 24,250 Whole Time Equivalent (WTE) which is currently +364 WTE (+1.5%) above the 2024-25 operational workforce plan. Work is ongoing with Deloitte, and the organisations concerned, to reduce this whilst maintaining safe staffing.
- Mish confirmed that the total agency spend is 2.6% which is below the cap of 3.2%. The turnover is 8.7% and the vacancy rate is 9%.
- However, sickness is starting to rise, and this is being looked at from a staff Health and Wellbeing perspective.
- Shokat confirmed there are no escalations from the People, Culture and Inclusion Committee report other than the sickness rates rising.

The Board thanked Mish for the report. The Board accepted the recommendations to note the workforce position, operating plan, risks and mitigations in place to address.

Staffordshire and Stoke-on-Trent ICB Remuneration Committee Summary and Escalation Report

- Shokat Lal, Non-Executive Chair of People, Culture and Organisational Development Committee, presented the report.
- Shokat advised that recruitment is ongoing for the vacant Non-Executive Member role.
- There is also consideration for the Very Senior Management (VSM) pay strategy and there is a recommendation of 5% pay rise from the 1 April 2024.

The Board thanked Shokat for the report and approved the recommendation.

Date and time of next meeting in public: 19th December 2024 at 1:00pm held in Public via MS Teams.

Appendix 2

Integrated Care Partnership Briefing

Staffordshire and Stoke-on-Trent Integrated Care Partnership (ICP) Meeting

December 2024

This briefing aims to keep partners and members of the public informed of the discussions at the NHS Integrated Care Partnership (ICP) meeting.

Ending Well: ICP Strategy

Our priority

We will maximise health and wellbeing in the last years of life by supporting people and carers with personalised care when needed. To achieve this, we will focus on:

- Offering personalised, high-quality end-of-life care for people and carers.
- Reducing preventable emergency hospital admissions at the end of life.

There is a national ambitions document for Palliative and End of Life Care (PEoLC) which all of our work is pointed at in the Palliative and End of Life portfolio. There are six key headings:

1) Each person is seen as an individual
2) Each person gets fair access to care
3) Maximising comfort and wellbeing
4) Care is coordinated
5) All staff are prepared to care
6) Each community is prepared to help

Foundations for these ambitions:

- Personalised care planning
- Shared records
- Education and training
- 24/7 access
- Evidence and information
- Those important to the dying person
- Co-design
- Leadership

Work programme

Action	Progress
Development of an all-age strategy for palliative care and end of life with a supporting delivery plan. Led by Dr Hannah Missen, Paul Garner and David Fletcher.	• Palliative and End of Life Care Needs Assessment completed • Communications and engagement (professional stakeholders) sessions undertaken • Public engagement online survey undertaken • Draft Strategy written and going through Governance process (Palliative and End of Life Care Programme Board, Staffordshire and Stoke-on-Trent Health and Care Senate) • Due for publication January 2025
Increase usage of Palliative Care Registers	• Performance has maintained at 0.84% (increased from 0.5% in July 2023) • Quality Improvement Framework (QIF) has been implemented which focusses on incentivising practices at lower end of performance
Review and assess benefits of a 24/7 Advice Line identifying the case for sustainable delivery	• The Staffordshire hospices, as the regional specialists in palliative care, committed to funding this project during the implementation phase, providing a single point of contact for specialist palliative advice and support across the region. • Support matches the existing day services.

	• Delivery of 24/7 advice line from December 2023 • Review of existing service and future investment included in business case for review December 2024.
Increase access and availability of palliative care medication	• Access to palliative care medication Task and Finish Group programme of work has included identifying Tier 1 and 2 pharmacy provision • Obtaining licences for Haywood hospital, St Georges and Redwoods and development of a policy for informal carers.
Increase the number of people identified in the last year of life and the number, and quality, of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT). Plans in place and co-ordinated	• QIF in place which focusses on improving performance in terms of completion of ReSPECT. • Communications Plan rolled out to include ReSPECT including GP Forums/GP Newsletter and GP 365 Web page • Palliative Care co-ordination Centre set up providing access to training for Primary Care through Staffordshire Training Hub on Identification and ReSPECT.
Enhance existing training for system workforce in response to the six National Ambitions	• Ambition 5 (National Ambitions for end-of-life care): 'All Staff are Prepared to care' is being led by Paul Garner - Transformation Clinical Lead for Palliative and End of Life Care Midlands Partnership NHS Foundation Trust (MPFT). • Audit against End-of-Life Care Core Skills Education and Training Framework undertaken summer 2024 • Response to audit being reviewed and training plan in place through Staffordshire Training Hub
Undertake work to respond to the recommendations of the all-parliamentary group report in relation to commissioning of specialist palliative care services	• Hospice Grants currently in place for 2024/25 • NHS Contract specifications in development • ICB must meet statutory requirements under the Health Care Services (Provider Selection Regime) Regulations 2023.

End of Life Home Care Pathway

The End-of-Life Home Care Pathway helps people to be looked after in their home or in a care home. This video created by MPFT explains the End-of-Life Home Care Pathway: https://youtu.be/Fho4ter33yQ

The End-of-Life Home Care Pathway has been developed and managed by the Palliative Care Coordination Centre (PCCC) based at Bradwell Hospital. The following update was given on the End-of-Life Home Care Pathway and how systems work together:

- Delivery of daily PCCC Multi-disciplinary Team which supports collaborative decision making, this is open to any professionals.
- On a daily basis there are meetings with Marie Curie/Crossroads/St Giles/Katherine House and Douglas Macmillan Hospice to coordinate all of the supportive care capacity to ensure best use of resources.
- Agreements with Staffordshire County Council and Stoke-on-Trent City Council regarding time scales and escalation process. There is good day to day working relations with front line staff.
- We work closely with the Integrated Discharge Hub, bed hubs and Discharge to Assess (D2A) pathways and beds (day to day and via monthly supervision) and have close relations with the Palliative Care Teams at Queens Hospital, Burton and University Hospitals of North Midlands (UHNM).
- We work closely with our providers Care Homes/Care agency's offering free education (soon to be hosted with Staffordshire County Council's new Social Care Academy). We interact with them regularly and offer a supportive approach to quality improvement via the established processes such as Quality Assurance Form's /Safeguarding's etc. Staff from PCCC are often visiting the homes via our assessment process, so relationships are strong.
- Midlands and Lancashire Commissioning Support Unit (MLCSU) are partners in delivery supporting with back-office functions of the Pathway.
- MPFT resources, particularly community nursing, remain at the heart of delivery of the Pathway.
- PCCC has access to and good relations across the wide range of expertise within MPFT particularly around Mental Health, Learning Disabilities and Autism and Children and Young People.

The Strategic Picture

There is an increased demand as:

- The overall population in Staffordshire and Stoke-on-Trent is set to increase by 6% by 2035, from 1.13m in 2018 to 1.2m in 2035.
- Our population is ageing.
- We also have one of the largest gaps in life expectancy and healthy life expectancy in the region.

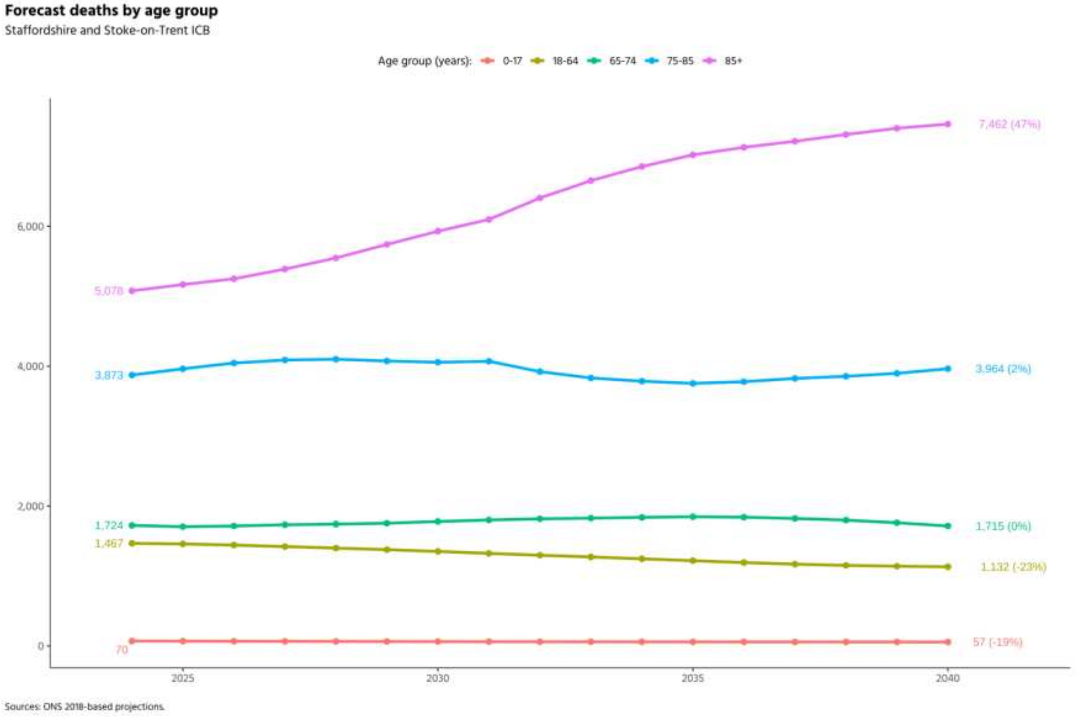
We must also recognise that the system is under pressure and the finance and workforce constraints that we have.

What do we know?

A group led by Dr Hannah Misson undertook a comprehensive Strategic Needs Assessment and patient, public and stakeholder engagement over the summer. Some of the key elements that have come out of that work are:

- In Staffordshire and Stoke-on-Trent in 2022, 47.1% of deaths occurred in hospital, significantly higher than the England average (43.4%)
- Men and ethnic minority groups are less likely to access palliative care services
- The majority (69%) of patients who have died will have experienced an emergency admission up to one year before death and sometimes there are multiple admissions.
- For patients who died in during 2023/24, nearly half had some sort of referral to a community service.
- The demand on services will increase and the graph below shows that over the next few years our 85+ age group will be the biggest increase in death.

How many deaths are there likely to be in the next 3, 5 and 10 years?



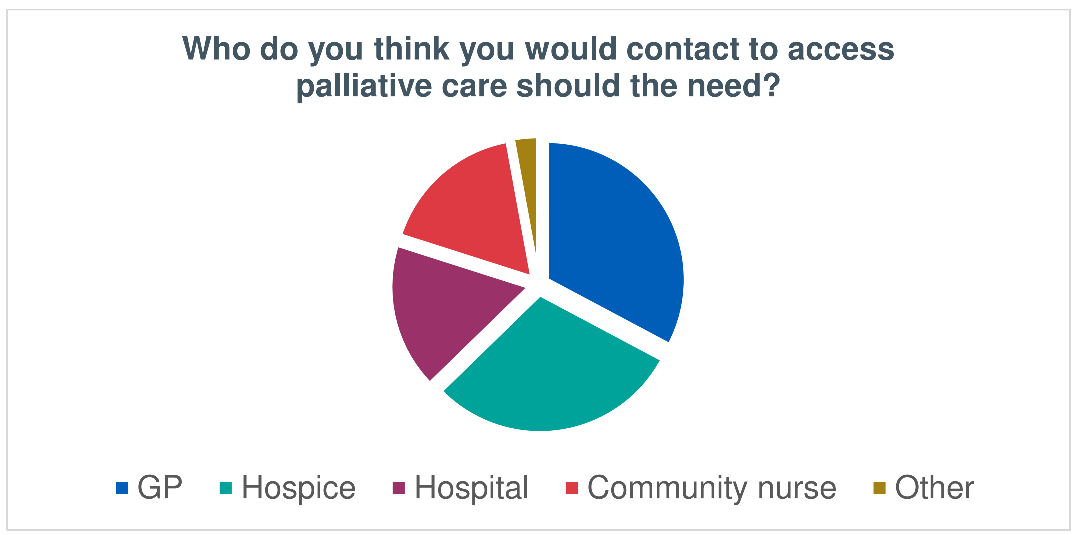
- This data is based on forecasted data
- The 85+ year old age group are forecast to see the biggest increase in deaths

- If patterns of care do not change, the current growth in deaths per annum suggests that over 270 additional beds will be needed in Staffordshire and Stoke-on-Trent ICS by 2040.
- More detail is available in the Strategic Needs Assessment.

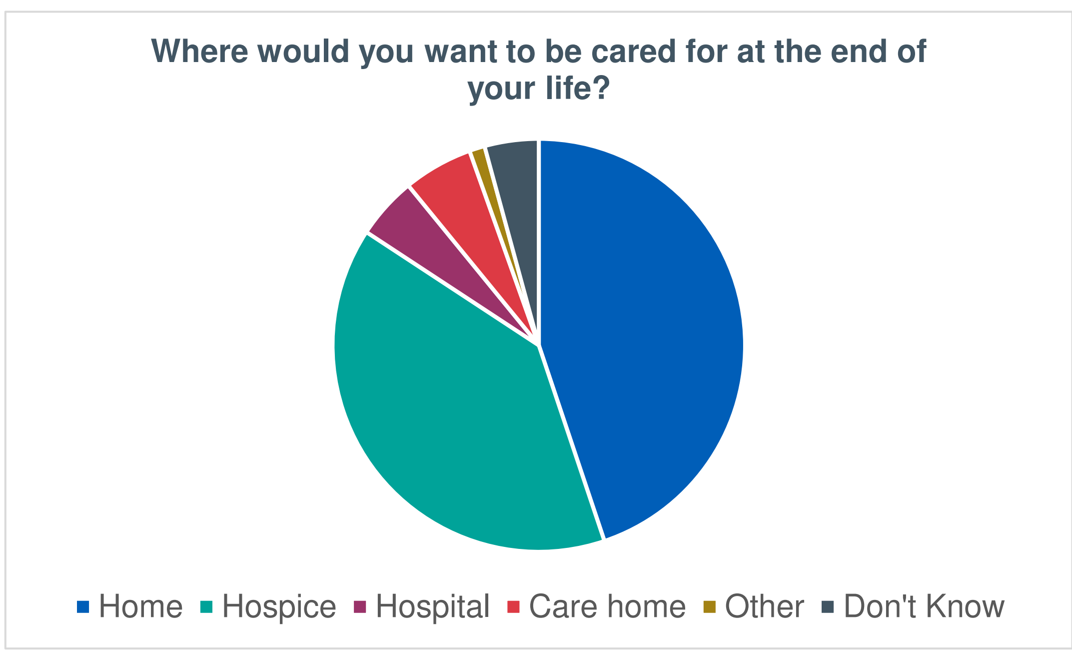
What does the public say?

An online survey in 2024 attracting 248 responses from Staffordshire and Stoke-on-Trent residents showed:

- **67%** of people felt that their experience of Palliative End of Life Care (PEoLC) was **good** or **very good**.
- **42%** would go to hospital to access PEoLC services. Many patients also felt that they would contact a hospice or their GP.



- **82%** of respondents valued dying in the place that they have chosen
- As a community, 88% gelt that we talk about dying too little
- Only **8%** of people want to die in hospital. The majority of people would want to die in their own home or in a hospice setting.



What do people working in the system tell us?

- They want radical change
- Better communication with the public, between providers, and normalising discussion about dying
- Better co-ordination of care, and use of digital technology to support this
- More collaboration within and between organisations

Staffordshire and Stoke-on-Trent Integrated Care System

- Empowering communities to support one another, with better use of voluntary organisations
- A directory of services so that the public and providers can see what we have to offer as a system.

What next?

An All Age Palliative and End of Life Care Strategy is in development, and due for publication in early 2025. Areas of focus will include:

- Integrated care to support people to die at home, including out of hours provision
- Development of Electronic Palliative Care Coordinating Systems (EPaCCS) to improve communication and co-ordination
- Reduce silo working and improving networking between system providers
- The development of a toolkit for both the public and system providers to include a robust education offer and a directory of services.

Compassionate and Resilient Communities

- There will also be a focus on ambition six of the National Ambitions Framework; **'each community is prepared to help'**
- Dying is not a 'health' or 'social care' event; it is a part of each and every one of our lives in every aspect - it should be treated as such
- End of life care should be at the heart of community health and wellbeing across all of Staffordshire and Stoke-on-Trent
- Cannock Chase have developed an extensive network including individuals from the NHS, Voluntary and Community Sector and Local District and County Council
- They have mapped community resources to identify levels of support and any gaps
- Some things they have achieved include:
  - Two bereavement charities for children, young people and parents and bereavement training for schools
  - Drop-in cafes where people can feel safe, belong and contribute
  - Sports, outdoor recreation and creative activities to support physical health and wellbeing
  - Memorials, memorial services and gardens, which give people a space to reflect and grieve
  - Fiveways Ramblers, a group which encourages friendship and reduces isolation by meeting weekly for walks and social activities
- There are many other great examples of compassionate and resilient communities across Staffordshire and Stoke-on-Trent
- We have a real opportunity to work together as a system to develop a public health approach to Palliative End of Life Care (PEoLC) and equip our communities with what they need to help one another.

Feedback

The partnership split into groups to discuss and capture feedback on the following topics of discussion:

- How do your 24/25 organisational plans support key life course points in the pack?
- What do you need to do to ensure that 25/26 emerging organisational plans better support the key points?

The following points were fed back to the group:

- The 24/25 organisational plans didn't support it very well as they were medicalised, business as usual and didn't address what we needed in terms of that full shift to move to a completely different way of supporting people to end their life.

- It comes down to education for the various groups of people involved in a person's end of life. The people coming to the end of their life need to know what to expect and what options are available to them and their families. Education is needed for clinicians to know when to stop medical intervention and what would be best for the persons happiness. Families may panic and call and ambulance when one isn't actually needed, and what is happening to their loved one is a natural part of the process. There needs to be an information line available for people at this stage.
- Capture collective stories of people who have been through these experiences of losing loved ones at the end of their life – both the good and bad experiences.
- Conversations between local authorities, police and fire with health which gave a really valuable insight in distinguishing between the planned deaths in health and unplanned unexpected deaths that their professionals and officers deal with.
- We need to have better conversations with our communities about death and dying and people's wishes as it's not a topic that people want to talk about.
- We spoke about the impact of death on children and that need for better education and support from a child's perspective.
- We need to think about the impact of dealing with death. What impact does this have on our staff, particularly the sudden deaths experienced by firefighter and police officer?
- We need to think about the hospices and secondary carers who are that last port of call – there needs to be behaviour change more upstream.
- The huge role that the VCSE in the hospice sector has – we need to strengthen it.
- Giving people choices and empowerment to determine their destiny.
- Housing and social care work really well together around living well and giving people autonomy around making their choices around their own home.
- People might want different things at the end of life so we need to listen to patients and not put our own views on to them.
- Portfolios need to work together and really think about neighbourhoods and communities.
- We need to be flexible and adaptable – put the patient first.
- We have too many looked after children and too many people in residential care and not enough people dying in their place of choice.
- Special priorities for people with special needs – where we can personalise plans.
- Make sure we capture the stories of people who've been through the journey with their loved one and get a sense for what looks good like.
- Families need a good experience to ensure they don't go through psychological problems after losing a loved one if it was a bad experience in terms of care.
- Integrated care plans in place so families don't call an ambulance when they panic or feel they're out of control.

Date and time of next meeting: Monday 3rd March 2025, 3.00pm – 5.00 pm, via MS Teams.

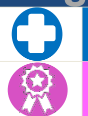
Executive Summary

Meeting:	Trust Board (Open)	Date:	8th January 2025
Report Title:	Care Quality Commission Action Plan Update	Agenda Item:	7.
Author:	Fiona Hibberts DCNO		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities



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

Risk Register Mapping

ID24028	Lack of flow across the Trust leading to congestion of ED (both sites) and UEC standards unable to be met	Ext 20 ↑	ID15788	Delivery of RTT Performance	High 12 ↓
ID23842	RTT Outpatient Capacity / Wait Times	High 12↓	ID25682	Unstructured records management	High 12 →
ID9738	Nursing Training - Medicine	High 12 →	ID23361	Number of open adverse incidents and root cause analysis investigations	High 12 →
ID8580	Medical staffing for the Emergency Department	High 10 ↑	ID13419	Midwifery safe staffing	High 9 →
ID9782	Reporting of Patient Safety Incidents	High 8 →	ID9783	Incident Investigation	High 8 →
ID15993	Maternity Assessment Unite Triage	Mod 6 →	ID8543	Lack of facilities for storage of patient records in ED	Mod 4 →

Situation

Following the previous Care Quality Commission (CQC) inspections, actions for improvement were identified. This report provides assurance to the Trust Board on the progress made to date against the must do and should do recommendations.

Background

The CQC inspected UHNM in August 2021, visiting and rating Urgent and Emergency Care (Requires Improvement) and Medicine (Good) at Royal Stoke and Medicine (Requires Improvement) and Surgery (Good) at County Hospital. A Well Led inspection took place in October 2021.

Following the initial inspection, the Trust was served a Section 29A Warning Notice under the Health and Social Care Act 2008, notifying the Trust that the CQC had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health need in medicine at County Hospital required significant improvement. Remedial actions were required to be completed by the end of November 2021 and evidence to support the completed actions have been submitted to the CQC.

In October 2022, the CQC conducted an unannounced visit to UHNM to review immediate actions taken. Although the CQC were satisfied that the Trust had made significant improvements in relation to medical staffing in urgent and emergency care at Royal Stoke, they continued to have serious concerns about the assessment, recording and mitigation of risks associated with acute mental health concerns in medicine at County Hospital and subsequently issued a further Section 29A Warning Notice under the Health and

Social Care Act 2008. The Trust was required to provide evidence of significant improvement in relation to the Section 29A warning notice by 26th January 2023, which was submitted to the CQC, followed by a further portfolio of evidence to demonstrate sustained improvements at County Hospital, which was submitted in November 2023.

The CQC have since visited County Hospital on 4th July 2024. Positive feedback was received both verbally and written. An extensive number of data requests were submitted to the CQC by the deadline of 15th July 2024. The Trust has been informed that the CQC are removing the section 29A warning notice and is the final report has been published along with an improved rating to 'Good'.

The CQC also conducted a focussed visit to Maternity Services in November 2024 to review the Section 29A Warning Notice under the Health and Social Care Act 2008. Data requests and Evidence has been submitted and we await the first draft of the report.
The inspection of Maternity Service currently has the following ratings:

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

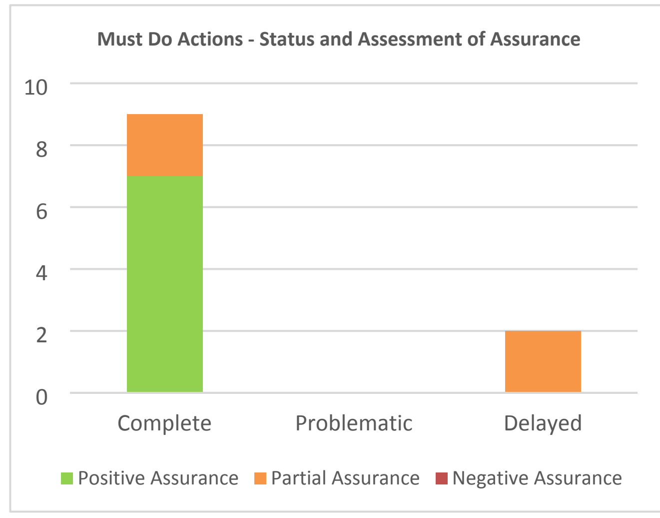
Assessment

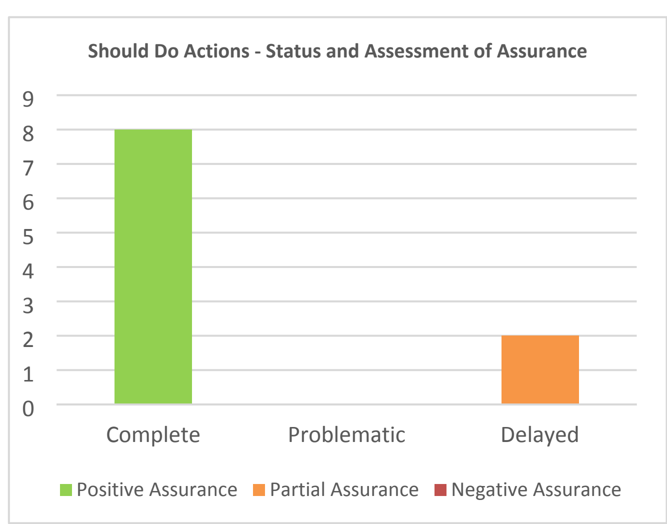
Following feedback from the Quality Governance Committee (QGC) and Internal Audit during early 2023, work was undertaken to review all completed actions and ensure that they addressed the concerns raised by the CQC. As a result, some duplicate actions were removed, and additional columns were added to capture ongoing assurance of sustained improvement against the completed actions including any additional actions required to provide positive assurance.

In August 2023, the QGC also agreed to archive 15 actions, which had either been fully completed, had a clearly defined monitoring process or had been progressed as far as possible. All archived actions have been mapped to a Risk on the Risk Register, where appropriate.

In June 2024, Internal Audit reported reasonable assurance with regards to the CQC action plan. Three management actions were assigned.

Current status of open actions are as follows:





On review of the updated action plan in July 2024, agreement was given by QGC for two additional actions that have no outstanding actions and a clearly defined monitoring process, which is Business as Usual through UHNM governance processes, to be archived. Outstanding risks will be monitored via the Risk Register:

A4: Medicine-Urgent and Emergency The Trust MUST ensure patients are kept safe from infection and avoidable harm and staff receive appropriate guidance and support to enable them to do this.

A5: Medicine-Urgent and Emergency The Trust MUST ensure all risks are appropriately identified, assessed and mitigation put in place where possible. Regulation 17 (1)

Of the remaining open actions, those relating to the following issues have made positive progress since the previous update:

Speech and Language Therapy (SLT) provision at County Hospital
Recruitment to 2.0WTE SLT posts at County Hospital has taken place and one of these members of staff commenced 30th December 2024.

Section 29A the risk management of patients with mental health needs in medicine at County Hospital
Internal audit reported reasonable assurance (June 2024) for Mental Capacity Assessment Framework at County Hospital. A CQC inspection at County Hospital took place on 4th July 2024 -very positive feedback verbally and written; data requests returned to CQC on 15th July 2024. The Trust has been informed that the CQC are removing the section 29A warning notice and the final report and outcome of their review of the County Hospital has been published confirming that the overall rating for all services at the hospital had moved up to 'good' from 'requires improvement'.

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	
No Assurance	No confidence in delivery	

Rationale

Internal Audit into the CQC Action Outcomes Framework concluded in June 2024 with an opinion of 'reasonable assurance' that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied and effective. However, there were some issues identified which need to be addressed in order to ensure that the control framework is effective in managing the identified risks.

Key Recommendations

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

CQC Action Plan - Must Do's

As at 2-Jan-25

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

Date of Visit	Action Number	Site	Division	Core Service	Observation / Issue	Outstanding Actions and Progress	Executive Lead	Operational Lead	Initial Target Date for Completion	Revised Target Date	Number of Times Target Date has Changed	Current Progress Rating (Against Target Date for Completion not Revised Target Date)	Actions Completed	Assurance Statement Against Completed Actions (Green = positive assurance / Amber =Partial assurance or awaiting sign-off Red = negative assurance)	If Negative or Partial Assurance Identified, what further actions are being taken?	Target Date for Further Actions
Aug-21	A4	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust MUST ensure patients are kept safe from infection and avoidable harm and staff receive appropriate guidance and support to enable them to do this. **Regulation 12 (1) (2) (h)**	No actions outstanding	Chief Nurse	Danielle Beech, Matron	NA	NA	NA	**Actions Complete**	• Infection Prevention poster describing correct PPE for red and green areas displayed through ED. Original target date April 2022 and completed June 2022 • Staff receive updates in PPE training/mask fit training, according to latest National Guidance. Original target date April 2022 and completed October 2022 • Weekly CEF reviews include equipment cleaning checks. Original target date March 2022 and completed June 2022	• Segregation of Emergency Department now discontinued post Covid-19 Pandemic - evidence available in EPRR meeting logs •Infection Prevention Level One training compliance available and monitored via Governance Meetings and PRM process.. • Monitoring of Stat/Mandatory Training and support for compliance is now deemed Business as Usual within Performance Review Meeting (PRM) process •4* Environmental audits sustained • Action plans in place in response to IPC audits. Matron has regular meetings with the IP Team to ensure all actions are completed Silver CEF award for Royal Stoke ED •Nov 2024 - Plan for spot check to be conducted by IPC team to give final approval to close action.	•Nov 2024 - Spot check conducted by IPC team to give final approval to close action.	Dec-24
Aug-21	A5	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust MUST ensure all risks are appropriately identified, assessed and mitigation put in place where possible. **Regulation 17 (1)**	No actions outstanding	Chief Nurse / Medical Director	Richard Hall, Clinical Director Danielle Beech, Matron	NA	NA	NA	**Actions Complete**	• Risk register updated to include all current risks relating to the ED Department. Original target date March 2022 and completed June 2022 • Harm review process identified and in place to review harm for patients who have been subject to a long wait (i.e. 12 hour breaches, ambulance handover delay, Your Next Patient and Corridor Care). Original target date May 2022 and completed August 2023	Risk Register process in place to capture risks to patient safety in ED	•Head of Nursing to undertake review of all current risks to patient safety in ED to ensure they are captured on the Risk Register, in order to close this action.	Dec-24
Aug-21	A6	**County**	**Medicine**	**Medical Care**	The Trust must ensure that risks associated with acute mental health needs are assessed, recorded and mitigated. **Regulation 12 (1) (2) (a) (b)**	No actions outstanding	Chief Nurse	Melanie McNair, Matron Vulnerable Patients	NA	NA	NA	**Actions Complete**	•ED Mental Health Assessment Tool revised in June 2022 (original target date June 2022) to accompany the patient on admission and facilitate ongoing mental health assessment in assessment and ward areas. This included review of the ward risk assessment booklet undertaken and all of the checklists relating to Mental Health, Dementia, Learning Disability and Autism have been simplified and amalgamated and sit under the Vulnerable patient banner, at the front of the booklet. This includes Vulnerable Patient trigger questions and a nursing risk assessment related to mental health. This assessment supports the Registrant to make a judgement regarding whether the patient will require close supervision due to harm to themselves or potential harm to others. • The Trust report and monitor the number of mental health referrals via the Mental Health & Learning Disability Trust Group, which has representation from all clinical divisions, the mental health liaison team and psychiatric liaison team. Areas of escalation and assurance provided to the Trust Quality and Safety Oversight group. Original target date May 2022 and completed June 2022. • Trust-Wide Harm Free Care Alert developed February 2022 (original target date November 2021). • Corporate audit process in place • Head of Nursing - County Hospital recruited in order to continue to embed significant improvements in the assessment, recording and mitigation of risks associated with acute mental health concerns. The post holder will be responsible for conducting spot checks and initiating relevant actions to improve practice with regard caring for patients with acute mental health concerns, vulnerabilities and requirements for an interpreter.	internal audit reported reasonable assurance (June 2024) for Mental Capacity Assessment Framework at County Hospital A CQC inspection at County Hospital took place on 4th July 2024 -very positive feedback verbally and written; data requests returned to CQC on 15th July 2024 and we have been informed that the S29a has been removed. 30th Sept 24 - monthly assurance audits continued until September and due to compliance of 100% these have now been stood down to quarterly. Nov 2024 Plan to close this action		
Aug-21	A7	**County**	**Medicine**	**Medical Care**	The Trust MUST ensure nutritional risk assessments and care plans are completed in line with their policy. **Regulation 12 (1) (2) (b)**	No actions outstanding	Chief Nurse	Ann Griffiths, Chief Dietician	NA	NA	NA	**Actions Complete**	• In January 2023 the Trust relaunched a training programme emphasising key learning around assessing, managing and monitoring patients nutrition (original target date May 2022) • Nutrition and Hydration awareness training delivered within new NA programme. • Update training delivered at County by dietetics team. • Ward based training targeted to AMU and FEAU at Royal Stoke. Now complete and will be offered refresher training • Training programme delivered in key admission areas, presentation added to Dietetics section of intranet • Focus Group convened in October 2022 to review the current Nutrition bundle (original target date April 2022) • Nutrition bundle updated and in place, including nutrition care plans • Process for sharing Vital Pac reports detailing MUST compliance identified with Ward teams in October 2022 (original target date May 2022) and Nutrition Dashboard live within UHNM Report Centre • Tendable roll-out to County with first audit submitted by 31st December 2022 (original target date July 2022) • Tendable rolled out to Royal Stoke January / February 2023 •Over 800 MUST training contacts have been completed since April 2023	• Senior Nursing team/Dietetic Team continue to monitor compliance of timely MUST Assessments via Vitals Dashboard and Tendable Audits • A Training Video is now available on Trust Intranet •Compliance with MUST assessment and reassessment now part of MUST DO actions in the CEF award criteria (>95% Platinum, >85% Gold, >75% Silver)	*Plan to close this action and monitor via the CEF process	Nov-24
Aug-21	A8	**County**	**Medicine**	**Medical Care**	The Trust MUST ensure patients receive timely swallow assessments. **Regulation 12 (1) (2) (a) (b)**	•MNP/ANP nurse swallow screening training to be implemented at RSUH to support service provision. Consider rollout at County Hospital. •Training has not been offered to County ANP's to date due to ongoing limited SLT resources over at County. There has been recent recruitment within SLT which will support this development. Target date amended to reflect the delay in providing the training at County. •Due to ongoing concerns about delay in achieving this action, a Deep Dive into SLT services was presented at QSOG in July 2023	Chief Nurse	Lois Dale, Head of Speech and Language Therapy Alan Bethell, Divisional Nurse Director Network Services	Jun-22	Mar-25	6	**Delayed Actions - due date moved more than once**	Position paper presented at the Acute Patient Flow Group in April 2022 highlighting the shortfalls in the service provision to inpatient medical wards, across both sites • Education programme to support ward teams developed in October 2022 (original target date June 2022) regarding 'what makes a good referral' and how to escalate referrals • SLT presence at County has increased from twice weekly to three times per week. • Following presentation of the SLT Deep Dive at QSOG in July 2023, further work has been commissioned to gather data on the current levels of incidents reported in relation to insufficient referrals, the number of rejected referrals and delays in responding to referrals in order to define solutions, which will be presented to the Executive CQC action plan panel, chaired by the Chief Nurse. * Junior workforce are in their development stage and will be upskilled by June 2024. * Prioritisation has been agreed within the Division of Network Services as part of executive submission 24/25. * Development of service specification has commenced. * Head of SLT in place to support service developments and transformation.	* Recruitment to 2.0WTE SLT posts at County Hospital has taken place and one of these members of staff has started week commencing 30th December 2024.. * Workforce is flexed according to workload demand across County and RSUH. * Service specification written and presented at NMAHP forum. * Data capture now available and referral to review times to be monitored via Network Services Divisional Board	Data to be reviewed in December 2024 to determine impact of recruitment to County Hospital and consideration as to whether to close this action on CQC action plan and monitor as Business as Usual	Dec-24
						•To explore the options available to obtain data from Onderkos, so that assurance can be provided that timely swallowing assessments are being undertaken. • Due to ongoing concerns about delay in achieving this action, a Deep Dive into SLT services was presented at QSOG in July 2023	Chief Nurse	Lois Dale, Head of Speech and Language Therapy Alan Bethell, Divisional Nurse Director Network Services	Mar-23	Mar-25	5	**Delayed Actions - due date moved more than once**				
Aug-21	A9	**County**	**Medicine**	**Medical Care**	The Trust MUST ensure Mental Capacity Act Assessments are consistently completed in a timely and responsive manner. **Regulation 11 (1) (2) (3)**	No actions outstanding	Medical Director / Chief Nurse	Sarah Curran, Lead for Vulnerable Patients Zia Din, Deputy Medical Director	NA	NA	NA	**Actions Complete**	• Clinical Audit Programme reviewed in June 2022 to ensure that all audits relating to the delivery of care include questions around whether mental capacity should have/was assessed (original target date April 2022) • Audit of the Mental Capacity Act and Deprivation of Liberty prioritised on the Trust Clinical Audit programme to monitor compliance with Trust Policy. Original target date April 2022 and completed June 2022. • Template to remind / guide staff through the MCA assessment process introduced in October 2022 (original target date May 2022) • A structured note re MCA assessments went live on iportal in April 2023 • The Trust has undertaken a baseline review of current training compliance in relation to consent and a trajectory of improvement developed. Original target date April 2022, completed June 2024. • A review of the current training packages will be undertaken to ensure that any training around the provision of care to vulnerable patients, includes MCA information	internal audit reported reasonable assurance (June 2024) for Mental Capacity Assessment Framework at County Hospital A CQC inspection at County Hospital took place on 4th July 2024 -very positive feedback verbally and written; data requests returned to CQC on 15th July 2024 and we have been informed that the S29a has been removed. 30th Sept 24 - monthly assurance audits continued until September and due to compliance of 100% these have now been stood down to quarterly		

Date of Visit	Action Number	Site	Division	Core Service	Observation / Issue	Outstanding Actions and Progress	Executive Lead	Operational Lead	Initial Target Date for Completion	Revised Target Date	Number of Times Target Date has Changed	Current Progress Rating (Against Target Date for Completion not Revised Target Date)	Actions Completed	Assurance Statement Against Completed Actions (Green = positive assurance / Amber =Partial assurance or awaiting sign-off Red = negative assurance)	If Negative or Partial Assurance Identified, what further actions are being taken?	Target Date for Further Actions
Oct 2022	A10	**County**	**Medicine**	**Medical Care**	The Trust MUST ensure that where required, mental capacity assessments and Deprivation of Liberty Safeguards applications are made in line with the trust policy and legal frameworks. **Regulation 11 Need for Consent)**	No actions outstanding	Chief Nurse/Medical Director	Rebecca Ferneyhough, Head of Nursing Stacey Boyjoo, Matron	NA	NA	NA	**Actions Complete**	•A weekly status exchange has been introduced to gain assurance of compliance with completion of MCA, DoLS applications and MH proforma. In addition, Safeguarding team are completing monthly audits on the wards at County. Audit outcomes are shared with HON for County and Medicine Division (original target date June 2023, completed June 2024). •Monthly audit programme in place •A3 under development to drive improvements	due to compliance of 100% these have now been stood down to quarterly. Nov 2024 Plan to close this action		
Oct 2022	A11	**County**	**Medicine**	**Medical Care**	The Trust MUST ensure that all required assessments including the mental health proforma and within 'seven-day patient risk assessment booklet' are completed as per trust processes. **Regulation 12 Safe Care and Treatment**	No actions outstanding	Chief Nurse	Kirsty Smith, Matron for Vulnerable Patients Rebecca Ferneyhough, Head of Nursing Stacey Boyjoo, Matron	NA	NA	NA	**Actions Complete**	•The Patient Risk Assessment booklet has been reformatted to clarify the required assessments and move them to the front of the booklet for ease of use. Original target date June 2023 and completed June 2023	•Redesigned booklet is now in use •Audits completed by the Lead for Vulnerable adults have been positive. Audits in May and June demonstrated 100% with the Mental Health questions on page 4 of the risk assessment book. •A CQC inspection at County Hospital took place on 4th July 2024 -very positive feedback verbally and written; data requests returned to CQC on 15th July 2024 and we have been informed that the S29a has been removed. 30th Sept 24 - monthly assurance audits continued until September and due to compliance of 100% these have now been stood down to quarterly. Nov 2024 Plan to close this action	.	
Oct 2022	A12	**County**	**Medicine**	**Medical Care**	The Trust MUST ensure that where enhanced or therapeutic observations have been identified as necessary within patient care plans, staff are sourced to cover these. **Regulation 18 Staffing**	No actions outstanding	Chief Nurse	Stacey Boyjoo, Matron Rebecca Ferneyhough, Head of Nursing	NA	NA	NA	**Actions Complete**	• The Trust will ensure that shifts with patients requiring enhanced observations are red flagged on Safe Care (E-Roster) and that additional staffing is requested by the Nurse Bank. Unfilled shifts will be escalated to relevant matron - action completed October 2024 •Data collated on staffing template to support redistribution of staff and measure improvement	•A red flag for patients requiring enhanced observations is not available. Patients requiring enhanced observations are escalated to matron and additional staffing is requested. Although staff are asked to support the extra shifts and bank shifts are advertised these are not always covered. For unfulfilled shifts, staff are moved to ensure the patients at highest risks are cohorted. For patients in side rooms or where cover cannot be sourced within day hours family support could be requested. A CQC inspection at County Hospital took place on 4th July 2024 -very positive feedback verbally and written; data requests returned to CQC on 15th July 2024 and we have been informed that the S29a has been removed. 30th September 24 - daily staffing status exchange takes place and enhanced observations are highlighted in the staffing book. This is reviewed by Matrons and staff moves are prioritised as /when required.		
Oct 2022	A13	**County**	**Medicine**	**Medical Care**	The Trust MUST ensure they maintain oversight of performance and risks in relation to the medicine core service when supporting patients with acute mental health needs or cognitive impairment. In particular, the Trust MUST ensure that all risks relating to the care of patients with mental health conditions or symptoms are captured on the risk register for the service and staff follow trust policies and processes. The service must also ensure that learning from serious case reviews, audits and incidents is shared and embedded across the Trust. **Regulation 17 Good Governance.**	No actions outstanding	Chief Nurse	Stacey Boyjoo, Matron Lisa Underwood, Head of Nursing Jill Ayres, Divisional Nurse Director	NA	NA	NA	**Actions Complete**	•Monthly audits undertaken since October 2023 • Risks associated with supporting patients with acute mental health needs or cognitive impairment are discussed on a monthly basis at Directorate/Divisional Governance Meetings. Original target date May 2023 and completed June 2024	Internal audit reported reasonable assurance (June 2024) for Mental Capacity Assessment Framework at County Hospital A CQC inspection at County Hospital took place on 4th July 2024 -very positive feedback verbally and written; data requests returned to CQC on 15th July 2024 and we have been informed that the S29A has been removed 30th Sept 24 - all Medicine Division governance highlight reports now have a section included to record any CQC/safeguarding updates to ensure it is discussed in governance meetings (directorate and divisional). Minutes from meetings are available to evidence that this is being discussed		

CQC Action Plan - Should Do's

As at 02-Jan-25

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

Date of Visit	Action Number	Domain	Site	Division	Core Service	Observation / Issue	Outstanding Actions and Progress	Executive Lead	Operational Lead	Target Date for Completion	Revised Target Date	Number of Times Target Date has Changed	Current Progress Rating (Against Target Date for Completion not Revised Target Date)	Actions Completed	Assurance Statement Against Completed Actions (Green = positive assurance / Amber =Partial assurance or awaiting sign-off /Red = negative assurance)	If Negative Assurance Identified, what further actions are being taken?	Target Date for Future Actions
Aug-21	B2	Responsive	Trust wide	Corporate	Trust wide	The Trust SHOULD ensure all complaints are reviewed, investigated and responses are managed in a timely manner and in line with Trust policy	•The Trust are reviewing the current formal complaints process to improve the quality and timeliness of reports and to streamline the sign off process • Electronic sign off process under development •Pilot of Matron early involvement in formal complaint process commencing in Network Services Division in May 2023	Chief Nurse	Rebecca Pilling Head of Patient Experience	Oct-22	Mar-25	5	Delayed Actions - due date moved more than once	• Complaint triage process in place •Electronic process in place for corporate nurse sign off •Pilot project with matrons to promote early engagement with complainants •Consideration of alternative ways to resolve complaints such as co-production communication project with vulnerable patients	• The average time taken to resolve formal complaints, remains above the Trust's 40 day target for all clinical divisions. •UHNM Complaints Policy is currently under review to include stratified response times according to complexity of complaint and formal escalation process to expedite complaint responses in a timely manner Clinical Divisions discussed their Trajectory for improvement in complaint response times at Executive CQC action plan panel with the Chief Nurse on 14th November 2024	Plan to monitor Divisional performance with complaint response times at Executive PRM , as business as usual	Mar-25
Aug-21	B5	Safe	Royal Stoke	Medicine	Urgent and Emergency	The Trust SHOULD ensure all staff follow best practice when completing care records to ensure they are an accurate record of care and treatment provided	No outstanding actions	Chief Digital Information Officer	Richard Hall, Consultant Danielle Beech, Matron	NA	NA	NA	Actions Complete	• Combined work with digitalisation of ED Records as part of EPR programme. Original target date March 2023 and completed in terms of linking in with EPR business case April 2024. •Weekly Tendable Documentation reviews •ED Focus weeks for staff education and development •Monitored through Directorate Governance Meetings as Business as Usual	•Digital ED records in place on both sites regular review of digital rollout completed. Vital implementation October 2024. EPMA planned for early 2025		
Aug-21	B6	Responsive	Royal Stoke	Medicine	Urgent and Emergency	The Trust SHOULD consider how they can improve information management for certain patient groups	No outstanding actions	Chief Nurse	Richard Hall, Consultant Danielle Beech, Matron	NA	NA	NA	Actions Complete	•Tendable Documentation audit results will identify themes for improvement and communicated as required •ED Cas card updated to support accurate/relevant documentation •IPS process embedded well within the department - any relevant learning completed • A review of current documentation undertaken to ensure the provision of standardised templates for electronic referrals and Medical/Nursing handovers. Original target date October 2023 and completed April 2024	•Digital ED records in place on both sites tendable review and action plan ongoing via senior nursing team.		
Aug-21	B9	Effective	Royal Stoke	Medicine	Medical Care	The Trust SHOULD ensure that all wards display up to date audit results such as results from hand hygiene audits	No outstanding actions	Chief Nurse	Jill Ayres, Divisional Nurse Director/Rebecca Ferneyhough Head of Nursing - Quality, Safety & Compliance	NA	NA	NA	Actions Complete	• Tendable has been rolled out to County. First audit submitted by 31st December 2022 • Tendable rolled out to Royal Stoke January / February 2023 - actions completed October 2024	•Tendable roll out now complete • Hand hygiene audits incorporated into Tendable. Standard templates issued to all wards for display of audit results on Quality Boards		
Aug-21	B16	Safe	County	Medicine	Medical Care	The Trust SHOULD consider taking action to ensure key information about patients care in consistently recorded. For example, ensuring clear wound care plans are in place for all patients with a wound	No outstanding actions	Medical Director / Chief Nurse	Victoria Lewis, Quality Assurance Manager Katie Leek, Lead Nurse: Tissue Viability	NA	NA	NA	Actions Complete	• Clinical Audit programme reviewed in June 2022 to ensure that appropriate documentation audits are in place to review the standards of patient documentation and identify areas for improvement (original target date April 2022) • Wound Care Document finalised in January 2023 (original target date May 2022)	• Clinical Audit Programme in Place • Wound Care Document being rolled out		
Aug-21	B17	Safe	County	Medicine	Medicine Care	The Trust SHOULD consider making the speech and language therapy service provision equitable across County Hospital	MNP/ANP nurse swallow screening training will be implemented at RSUH to support service provision. Consider rollout at County Hospital • ANP training for Respiratory ANP's was completed by SLT. A meeting is being arranged to discuss competency assessment process. •Training has not been offered to County ANP's to date due to ongoing limited SLT resources over at County. There has been recent recruitment within SLT which will support this development. •Due to ongoing concerns about delay in achieving this action, a Deep Dive into SLT services to be presented at QSOG in May 2023	Chief Nurse	Lois Dale, Head of Speech and Language Therapy Alan Bethell, Divisional Nurse Director	Sep-22	Mar-25	6	Delayed Actions - due date moved more than once	• Position paper presented at the Acute Patient Flow Group in April 2022 highlighting the shortfalls in the service provision to inpatient medical wards, across both sites (original target date May 2022) • Education programme to support ward teams developed in October 2022 regarding 'what makes a good referral' and how to escalate referrals (original target date June 2022) • SLT presence at County has increased from twice weekly to three times per week. • Following presentation of the SLT Deep Dive at QSOG in July 2023, further work has been commissioned to gather data on the current levels of incidents reported in relation to insufficient referrals, the number of rejected referrals and delays in responding to referrals in order to define solutions, which will be presented to the Executive CQC action plan panel, chaired by the Chief Nurse. * Junior workforce are in their development stage and will be upskilled by June 2024. * Prioritisation has been agreed within the Division of Network Services as part of executive submission 24/25. * Development of service specification has commenced. * Head of SLT in place to support service developments and transformation.	* Recruitment to 2.0WTE SLT posts at County Hospital has taken place and one of these members of staff has started week commencing 30th December 2024.. * Workforce is flexed according to workload demand across County and RSUH. * Service specification written and presented at NMAHP forum. * Data capture now available and referral to review times to be monitored via Network Services Divisional Board	Data to be reviewed in December 2024 to determine impact of recruitment to County Hospital and consideration as to whether to close this action on CQC action plan and monitor as Business as Usual	Dec-24
Oct-22	B20	Effective	Royal Stoke	Medicine	Medical Care	The Trust SHOULD consider reviewing the mental health training needs of staff so that they are assured they have the skills to meet the needs of patients.	No outstanding actions	Chief Nurse	Mel McNair, Matron for Vulnerable Patients Nadine Opiniano, Head of Nursing	NA	NA	NA	Actions Complete	• Trust wide mental health ambassador training launched January 23 (original target date December 2022) • Trust wide TEAS enhanced and therapeutic observation Training launched January 23 (original target date December 2022) • Trust wide Dementia Tier 2 face to face training launched January 23 (original target date December 2022)	• Training provision in place and compliance monitored on a monthly basis • internal audit reported reasonable assurance (June 2024) for Mental Capacity Assessment Framework at County Hospital A CQC inspection at County Hospital took place on 4th July 2024 -very positive feedback verbally and written; data requests returned to CQC on 15th July 2024 and we have been informed that the S29a has been removed.		
Oct-22	B25	Effective	County	Medicine	Medical Care	The Trust SHOULD ensure they consistently check and record where a person has a power of attorney for health and welfare on behalf of the patient if that patient lacks capacity to consent for their own care and treatment.	No outstanding actions	Chief Nurse	Sarah Curran, Lead for Vulnerable Patients Rebecca Ferneyhough, Head of Nursing Andrew Vernon, Associate Director of Legal Services	NA	NA	NA	Actions Complete	• Trust Policy in Place and training programme in place. Original target date September 2023 and completed March 2024	• internal audit reported reasonable assurance (June 2024) for Mental Capacity Assessment Framework at County Hospital A CQC inspection at County Hospital took place on 4th July 2024 -very positive feedback verbally and written; data requests returned to CQC on 15th July 2024 and we have been informed that the S29a has been removed.		
Oct-22	B26	Effective	County	Medicine	Medical Care	The Trust SHOULD ensure that all patients requiring an interpreter are provided with one as soon as is reasonably practical prior to undertaking care and treatment.	No outstanding actions	Chief Nurse	Rebecca Pilling, Head of Patient Experience	NA	NA	NA	Actions Complete	•Monthly meetings undertaken Capita Contracts Manager to discuss performance • Communications issued to ward teams • The Trust is promoting available Interpreter services available and monitor provider performance. Original target date September 2023 and completed March 2024	• Translator on Wheels introduced on both Hospital Sites • Awareness and education shared with all County staff on location and availability of interpreter on wheels devices. Following Datix reports of opportunities that were not taken to access the devices further updates have been shared with staff. During a CQC preparation visit on 4/6/2024 no patients were seen to have not been provided with an interpreter if one was required. Recent Datix incidents re: interpreter have been reviewed and actions shared with teams to prevent reoccurrence. A CQC inspection at County Hospital took place on 4th July 2024 -very positive feedback verbally and written; data requests returned to CQC on 15th July 2024 and we have been informed that the S29a has been removed.		
Oct-22	B27	Well Led	County	Medicine	Medical Care	The Trust SHOULD ensure staff are consistently supported following incidents of violence and/or aggression.	No outstanding actions	Chief Nurse	Lisa Underwood, Head of Nursing Stacey Boyjoo, Matron	NA	NA	NA	Actions Complete	• Training Programmes available for CISM (original target date September 2023 and completed July 2024) • Staff formally supported regarding the incident which the CQC were referring to	• Training provision in place and compliance monitored on a monthly basis 30th Sept 24 - Increase in qualified PNAs on the wards, increase in qualified CISM practitioners on the wards, 2 x inhouse clinical holds trainers now in place with agreed trajectory to train all staff.		

CQC Action Plan - Maternity

As at 22 0ctober 2024

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

Date of Visit	Action Number	Division	Core Service	Observation / Issue	Outstanding Actions and Progress	Executive Lead	Target Date for Completion	Revised Target Date	Number of Times Target Date has Changed	Current Progress Rating (Against Target Date for Completion not Revised Target Date)	Actions Completed	Assurance Statement Against Completed Actions (Green = positive assurance / Red = negative assurance)	If Negative Assurance Identified, what further actions are being taken?	Target Date for Further Actions
Mar-23	A1	**W,C & CSS**	**MATERNITY**	The service must ensure that systems are in place to ensure effective triage and escalation processes are in place to reduce risk of patient harm **Regulation (12) (2) (b)**	No outstanding actions.	Chief Nurse	N/A	N/A	N/A	**Actions Complete**	Feb 2023 A3 completed, monthly review at PRM, currently not meeting trajectory. With effect from 14th March 2023, prioritization of inductions of labour takes place daily prior to 09:00hrs Safety Huddle, so the risks can be discussed by the MDT at the Safety Huddle. This process previously took place after the safety huddle. Safety huddle SOP revised. UHNM Escalation guideline and Induction of labour guideline updated in line with regional midlands escalation policy , which includes trigger point for divisional and regional escalation and mutual aid request. Induction of labour breach SOP completed. Monthly monitoring of compliance of prioritisation prior to Safety huddle. Monthly monitoring of compliance of daily safety netting call to deferred inductions of labour. MAU 15 minute triage assessment and medical review in line with BSOTS is a directorate driver metric - monitored monthly at Trust Performance Review. Business Case for increased obstetric medical workforce approved.	MAU Triage has achieved above the trajectory of 85% for the last 9 months, on track to remain compliant. IOL Breach has achieved trajectory for the last 9 months , on track to maintain compliance.	Business Continuity Plan completed.	Nov-24
Mar-23	A2	**W,C & CSS**	**MATERNITY**	The service must ensure staff are up to date with maternity mandatory training modules, including safeguarding adults and child protection training. **Regulation (12) (1) (c)**	Reach target trajectory for Level 3 adult safeguarding and Level 3 child safeguarding.	Chief Nurse	Nov-23	Dec-24	2	**Problematic actions - due date moved once**	Feb 2023 Establish compliance for safeguarding adults and child protection training for medical staff. Training Plan in place for adult and child protection training. Revised date set. Implementation of Bi-monthly Maternity Education Team Meeting. Monthly monitoring of compliance by directorate and LMNS.	90 % of all staff groups are trained on PROMPT skills drills and the fetal monitoring day. Child safeguarding (3) - Midwifery 72.64 % Medical staffing 61.54% % All midwifery and medical staff booked on for level 3 child safeguarding	Target Trajectory set for all relevant staff groups. All midwifery and medical staff booked on for Level 3 child safeguarding level 3. Evidence to be submitted to CQC by end November 2024	Nov-24
Mar-23	A3	**W,C & CSS**	**MATERNITY**	The service must ensure that staff complete regular skills and drills training **Regulation 12 (1) (2) (c)**	No outstanding actions.	Chief Nurse	N/A	N/A	N/A	**Actions Complete**	Nov 2023 Monthly monitoring of compliance by directorate and LMNS. Trajectory target set for 90% by 26.11.23. Further training days arranged to reach target.	90% of all staff groups are trained on PROMPT skills drills and the fetal monitoring day.		
Mar-23	A4	**W,C & CSS**	**MATERNITY**	The service must ensure the environment used to care for and treat service users is adequate for the needs the women and birthing people using them and that any identified risks are mitigated **Regulation 12 (2) (b)**	No outstanding actions.	Chief Nurse	N/A	N/A	N/A	**Actions Complete**	Nov 2023 -New waiting room and triage room built enabling clinical supervision of patients waiting to be reviewed. Immediate relocation of Maternity Assessment Unit (MAU) waiting area in order to increase visibility.	Increased budget establishment for additional 3.1 WTE Ward clerk and 5.6 WTE Maternity Support worker approved for 24/7 support for the new triage and waiting area.		
Mar-23	A5	**W,C & CSS**	**MATERNITY**	The service must ensure systems or processes in place operating effectively in that they enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular risks identified with current maternity triage processes and effective oversight such as emergency equipment checks. **Regulation 17 (2) (b)**	No outstanding actions.	Chief Nurse	N/A	N/A	N/A	**Actions Complete**	Nov 2023 Elective Daycare Clinic relocated to Ante-natal Clinic. 2 ACP's commenced September 2023. Increased midwifery budgeted establishment allocated to MAU. A3 completed, monthly review at PRM. Currently not on trajectory. UHNM MAU Triage guidance changed from 30 minutes initial assessment to 15 minutes. Full team safety huddle at 09:00 hrs now extended to 7 days a week rather than 5 days, with effect from 11th March 2023. New MAU safety huddle introduced at 15:00hrs daily 7 days a week, attended by MAU midwife in charge, flow co-ordinator and inpatient matron. The huddle now includes breach of triage assessment and the breach of medical review by priority rating tool. 2 hourly oversight walkabouts/assurance audit on MAU by the flow-coordinator daily, 7 days a week. Clinical Education team allocated to deliver re enforcement of BSOTS training (delivered to MAU core staff, consultant Obstetricians, intra partum band 7s) Implementation of A-I-D - clinical situation and escalation communication tool. Implementation of central electronic fetal monitoring Review of MAU patient waiting board Monthly monitoring of MAU targets through divisional driver metric - 15 minute triage assessment / medical review in line with BSOTS priority rating			
Mar-23	A6	**W,C & CSS**	**MATERNITY**	The service must ensure persons employed in the provision of a regulated activity received training, professional development, supervision, and appraisal as was necessary to enable them to carry out their duties they were employed to perform. **Regulation 18 (2) (a)**	No outstanding actions.	Chief Nurse	N/A	N/A	N/A	**Actions Complete**	A3 completed, reviewed monthly at divisional PRM. ESR hierarchies checked and corrected Refresher training for all managers Trajectory developed to reach target of 95 % (completed Dec 2024)	Current PDR compliance reached 95 % , target now to maintain compliance		
Mar-23	A7	**W,C & CSS**	**MATERNITY**	The service should ensure the correct level of harm is reported and reviewed when incidents are reported in line with national guidance **Regulation 17 (2) (b)**	No outstanding actions.	Chief Nurse	N/A	N/A	N/A	**Actions Complete**	Spot check completed, all harm recorded in line with Trust Guidance.			
Mar-23	A8	**W,C & CSS**	**MATERNITY**	The service should review current safeguarding processes in place to ensure staff complete safeguarding risk assessments at every appointment **Regulation 12 (2) (a) (b)**	No outstanding actions.	Chief Nurse	N/A	N/A	N/A	**Actions Complete**	Existing safeguarding pathways reviewed and fit for purpose (completed Dec 2024)	Risk Assessment performed at each antenatal contact.		

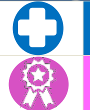
Executive Summary

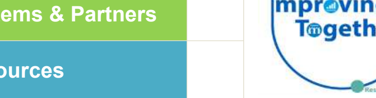
Meeting:	Trust Board (Open)	Date:	8th January 2025
Report Title:	Maternity and Neonatal PSIRF Investigation Report: Quarter 2 (1st July 2024 – 30th September 2024)	Agenda Item:	8.
Author:	Catherine Hegarty, Quality & Risk manager		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities





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

Risk Register Mapping

Executive Summary

Situation

At the start of December 2023, UHNM ceased to report incidents under the national Serious Incident Framework as the new national Patient safety Incident response Framework for learning from incidents was formally adopted following development of new incident response templates. The Trust's approach and local Patient Safety Incident Response Plan (PSIRP) was approved at Trust Board in October and then approved by the ICB in November 2023. The ICS agreed for 3 main providers to all formally adopt the PSIRF approaches and not report incidents as serious incidents under the Serious Incident Framework.

Maternity & Neonatal incidents are a national priority within the PSIRF framework. National systems capture certain maternity and neonatal incidents that require a standardised approach, these systems are:

PMRT:
The standardised perinatal mortality review tool supports high quality standardised perinatal reviews on the principle of 'review once, review well'.

The tool is used to review the Maternity care, neonatal care and bereavement care for all families who have:

- A Late fetal loss (between from 22-23+6 gestation)
- A Stillbirth (24 weeks and beyond)
- A Neonatal Death (deaths up to 28 days of age)

The care is graded (A-D) according to quality of care in relation to influence on outcome.

MNSI (formerly HSIB):
MNSI (Maternity & Newborn Safety Investigations) is a national programme to improve maternity safety across the NHS in England. An independent investigation is conducted for maternity incidents that meet the current MNSI criteria and safety recommendations are fed back to trusts to improve services. The incidents investigated under the MNSI criteria are:

- Intrapartum stillbirth
- Early neonatal death (0-6 days of life)
- Potential severe brain injury
- Maternal death (within 42 days of the end of pregnancy)

All incidents that meet MNSI criteria or are considered to grade as C or D on the PMRT will be reported through UHNM governance processes as PSII's. The report also provides assurance that incidents are being investigated timely and appropriately. Lessons are learned from these investigations and actions taken to address any patient safety concerns.

This report provides a summary of the patient safety incidents that are being reviewed under the new PSIRF framework to provide oversight and assurance that issues are identified, learning is disseminated and actions are formulated to improve patient safety and experience.

No of open maternity and neonatal Serious Incidents (under the former SI framework):	2
Investigation in progress:	0
Investigations completed/awaiting to be presented and closed by Risk Management Panel and ICB SI Group:	2
No of open maternity and neonatal PSIRF reviews:	
PMRT (Not reportable as PSII) PMRT (Reportable as PSII)	40 5
MNSI	3
AAR	7
Thematic Review	1
Case Record Review	1

Background
Ockenden recommendations and CNST requirements state that Trust Boards and ICB's must have oversight of Maternity serious incidents on a quarterly basis.

Assessment
In Quarter 2 there were 2 new incidents that met the criteria for PSII's; 1 in July and 1 in September 2024. One incident was PMRT (Potentially score C or above) and the other an MNSI (Intrapartum Stillbirth)

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	
No Assurance	No confidence in delivery	
Rationale		
All incidents are reviewed weekly at the Obstetric and Neonatal risk meeting to identify any immediate learning or themes. A rapid review of care is completed for incidents that meet the national reporting criteria or are considered of moderate harm or above. *Incidents that meet the criteria for PMRT or MNSI will follow a robust review process and any immediate actions or local reviews will be implemented as a result of a rapid review or a PSIRF response review.*		

Key Recommendations
The Trust Board is asked to receive and note the report.

Executive Summary

Meeting:	Trust Board (Open)	Date:	8th January 2025
Report Title:	NHS Resolution Maternity Incentive Scheme Year 6	Agenda Item:	9.
Author:	Rebecca Irons, Project Lead Midwife for Ockenden and Clinical Negligence Scheme for Trusts (CNST) Donna Brayford, Deputy Director of Midwifery - Governance		
Executive Lead:	Ann-Marie Riley, Chief Nurse and Executive Maternity Safety Champion		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Executive Summary

Situation

NHS Resolution is operating year six of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. In April 2024, a revised set of standards was released.

Background

The Maternity Incentive Scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Assessment

UHNM Maternity Service can demonstrate that they have met all the 10 safety actions:

Safety Action:	RAG	Comments
1 Perinatal Mortality Review Tool		All eligible deaths notified to MBRRACE-UK within seven working days. 100% of all deaths of babies has had a review using the Perinatal Mortality Review Tool.

		100% of all deaths of babies parents perspectives were sought. 100% reports published within 6 months of death. All standards met.
2 Maternity Services Data Set (MSDS)		UHNM has passed all MSDS linked CNST requirements.
3 Transitional Care and Avoiding Term Admissions Into Neonatal Care (ATAIN)		UHNM Transitional Care Pathway of care is fully operational in alignment with British Association of Perinatal Medicine (BAPM). A successful Quality improvement initiative was implemented. In the first 2 months the improvement have demonstrated a 53% decrease in term admissions to the NNU with hypoglycaemia.
4 Clinical Workforce		The Trust have ensured all short-term locums have a Royal College of Obstetrics and Gynaecology certificate of eligibility and have implemented RCOG guidance on long term locums. Consultant attendance at Clinical attendance monitored and discussed with agreed strategies and action plans. A duty anaesthetist is available 24 hours a day. The neonatal medical workforce meets BAPM standards. The neonatal nursing workforce does not meet BAPM standards- approved action plan in place to achieve Qualified in speciality (QIS) ratio by December 2025.
5 Midwifery Workforce		Midwifery staffing budget reflects BirthRate assessment. 1:1 care in labour and supernumerary status of the labour ward co-ordinator have been maintained.
6 Saving Babies' Lives Care Bundle Version Three		The Local Maternity and Neonatal System (LMNS) are satisfied with the progress that has been made and the targets achieved with each individual element of SBL for CNST. Quarter 2 compliance was 89%.
7 Listen to women and families		Evidence of Maternity and Neonatal Voice Partnership (MNVP) engagement with those experiencing worst outcomes. Evidence of MNVP infrastructure being in place.
8 Training		All standards met for: Fetal wellbeing training PROMPT (including live drills) – obstetric emergency training Newborn Life support training
9 Maternity and Neonatal Safety and Quality Issues and Board assurance		UHNM is able to demonstrate clear oversight to provide assurance to Board on maternity and neonatal, safety and quality issues.
10 Maternity and Neonatal Safety Investigation Programme (MNSI)		All qualifying cases for MNSI and Early notification scheme (ENS) reported. Compliance maintained with duty of candour, role of MNSI and NHS Resolutions ENS.

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	
No Assurance	No confidence in delivery	
Rationale		

Our Maternity and Neonatal teams have been committed to meeting all 10 safety actions to provide assurance to the Trust Board that the safety and wellbeing of the women, babies and families in our care remain our top priority.

We are pleased to report that, thanks to the dedication and hard work of our teams, we will be able to declare full compliance with all safety actions for Year 6.

Key Recommendations

- The Trust Board are asked to note that they satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions.
- If satisfied with the evidence the Board are asked to give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution.

NHS Resolution
Maternity Incentive Scheme
Year 6 Compliance

Public Trust Board
8th January 2025

Rebecca Irons Project Lead for Maternity Incentive Scheme and Ockenden
Donna Brayford Deputy Director of Midwifery

Delivering Exceptional Care with Exceptional People

What is the MIS?

Trusts pay an additional 10% maternity CNST contribution.

All 10 safety actions are met: Trusts receive initial maternity contribution back, plus a share of any unallocated funds.

All 10 safety actions not met: Trusts supported to develop action plan and apply for smaller amount of discretionary funding.

All monies paid into the Maternity Incentive Scheme will be paid back out to participating Trusts.

NHS Resolution operates the MIS **on behalf of Secretary of State for Health and Social Care.**

- Trusts self-declare their progress against the 10 safety actions at the end of each year of the scheme.
- Safety actions are evidence based and supported by a safety action lead
- The Trust Board (CEO) and Integrated Care Board (ICB) Accountable Officer must be assured of this progress before signing the Board declaration form.
- Only the declaration form which has been signed off is submitted to NHS Resolution and not the evidence.
- Evidence used to support the position and assure the Board should be retained. In the event that the declaration is later called into question, this evidence may be reviewed by the NHS Resolution Team.

Delivering Exceptional Care with Exceptional People

Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

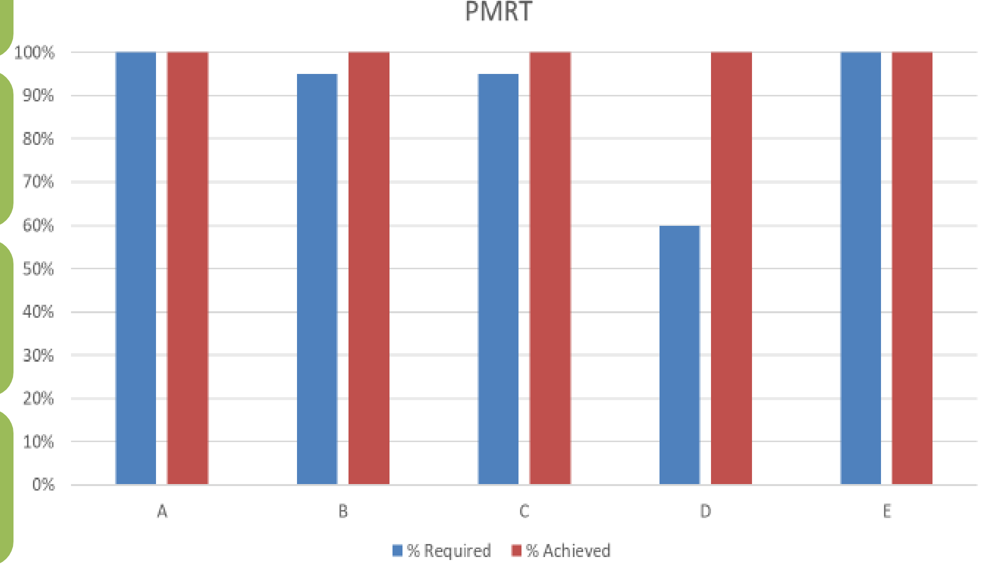
a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 2nd April 2024

b) For 95% of all the deaths of babies in your Trust from 8th December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?

c) Has a review using the PMRT of 95% of all deaths of babies suitable for review using the PMRT, from 2nd April 2024 been started within 2 months of each death?

d) Were 60% of the reports published within 6 months of death?

e) Quarterly reports should be submitted to the Trust Executive Board from 8th December 2023 and discussed with the Trust maternity safety and Board level safety champions.



Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

UHNM are compliant with Safety Action 2 for the reporting period of July 2024:

Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024?

UHNM can confirm that all 11 Clinical Quality Improvement Metrics (CQIMS) have passed the associated data quality criteria.

Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)

In July 2024, UHNM achieved 98.4%.

Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Reporting Period
July 2024

Notes: The final results for the CNST MIS Y6 SA2 assessment, using July 2024 data, are now available in this scorecard.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	460	515	89.3		Passed
CQIMDQ15	455	455	100.0		Passed
CQIMDQ16	415	455	91.2		Passed
CQIMDQ24	415	415	100.0		Passed
CQIMApgar	10	415		22	Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	290	445	65.2	Passed
CQIMDQ08	445	465	95.7	Passed
CQIMDQ09	460	515	89.3	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	460	515	89.3		Passed
CQIMDQ11	10	460	2.2		Passed
CQIMDQ12	10	460	2.2		Passed
CQIMPPH	10	460		22	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	460	515	89.3		Passed
CQIMDQ22	455	455	100.0		Passed
CQIMDQ23	415	455	91.2		Passed
CQIMPreterm	40	455		84	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	460	515	89.3		Passed
CQIMDQ15	455	455	100.0		Passed
CQIMDQ16	415	455	91.2		Passed
CQIMDQ18	230	455	50.5		Passed
CQIMDQ20	10	215	4.7		Passed
CQIMTears	10	215		42	Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	460	515	89.3	Passed
CQIMDQ15	455	455	100.0	Passed
CQIMDQ16	415	455	91.2	Passed
CQIMDQ18	230	455	50.5	Passed
CQIMDQ26	455	455	100.0	Passed
CQIMDQ27	615	615	100.0	Passed
CQIMDQ28	290	615	47.2	Passed
CQIMVBAC	5	45	11.1	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	460	515	89.3	Passed
CQIMDQ31	465	465	100.0	Passed
CQIMDQ32	420	465	90.3	Passed
CQIMDQ33	465	465	100.0	Passed
CQIMDQ34	230	465	49.5	Passed
CQIMDQ36	460	460	100.0	Passed
CQIMDQ37	225	460	48.9	Passed
CQIMDQ38	460	465	98.9	Passed
CQIMDQ39	425	460	92.4	Passed
CQIMRobson01	5	50	10.0	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	65	110	59.1	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	70	75	93.3	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	615	515	119.4	Passed
CQIMDQ04	590	615	95.9	Passed
CQIMDQ05	60	590	10.2	Passed
CQIMSmokingBooking	60	590	10.2	Passed

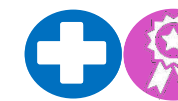
CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	385	460	83.7	Passed
CQIMSmokingDelivery	15	385	3.9	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	605	615	98.4	Passed



Safety Action 3: Can you demonstrate that you have transitional care services in place and undertaking quality improvement to minimise separation of parents and their babies?

1) Is there a pathway of care into transitional care (TC) which includes babies between 34+0 and 36+6 weeks in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?

The Neonatal Transitional Care Unit at UHNM was re-opened to 6 beds in November 2023 after a period of being closed since January 2023.This has now been increased to 10 beds. Neonatal Transitional Care is about keeping mothers and babies together and should be the cornerstone of newborn care.

The on-going review of term infant admissions to the NNU has demonstrated that rates remain low at UHNM:

- Q1 (Apr- June 2024) **= 4.3%**
- Q2 (July-Sept 2024) **= 4.4%**
- We remain below the **National benchmark of 6%** for term admissions into the Neonatal Unit (NNU) and under **UHNM local stretch target of less than 5%**.
- This clearly demonstrates that UHNM minimises separation of mothers and their babies in line with National Guidance.

2) Drawing on insights from themes identified from any term admissions to the NNU, one quality improvement initiative must be undertaken to decrease admissions and/or length of stay

- Our QI project launched in August 2024 to use 40% Glucose gel to avoid admissions to the NNU due to hypoglycaemia- a leading cause of term admissions to the NNU.
- In 2023- 39 babies were admitted to NNU due to hypoglycaemia (average = 3.25 babies per month), 36 of these admissions potentially could have been avoided with the use of Glucose Gel 40%.
- Recent audit results (Sept- Oct 2024) have demonstrated an average of 53.8% reduction in admissions- promising results thus far
- The LMNS and Safety Champions have been presented with an update of its progress.

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Obstetric Medical Workforce

a) Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: Currently work in their unit on the tier 2 or 3 rota or have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums. Compliance is demonstrated by completion of the audit.

An audit of 6 months activity has been carried out. During this time, the Obstetrics and Gynaecology department employed 1 locum who met the compliance criteria above.

b) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance.

An audit of 6 months activity has been carried out. During this time, the Obstetrics and Gynaecology department did not employ any long-term locums.

c) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careerstraining/workplace-workforce-issues/rolesresponsibilities-consultant-report/ when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

Compliance of consultant attendance for the clinical situations is listed as part of UHNM Audit Programme. UHNM has developed an action plan where it has highlighted non-compliance of consultant attendance. This is also shared with Trust Board and Board level safety champions, and LMNS meetings. Quarterly audits are undertaken against Consultant attendance at situations where they must attend, Consultant attendance at situations where the consultant must attend unless the most senior doctor present has documented evidence as being signed off as competent

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Anaesthetic Medical Workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1).

UHNM is compliant with this standard. Rotas are provided as evidence of UHNM position and duty anaesthetist available 24/7

Neonatal Medical Workforce

Does the neonatal unit meet the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing?

UHNM is compliant with this standard and this is formally recorded in Trust Board minutes. UHNM is in line with British Association of Perinatal Medicine (BAPM) national standards for medical staffing

Neonatal Nursing Workforce

Does the neonatal unit meet the BAPM neonatal nursing standards. If the requirements have not been met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies and share with the LMNS and ODN.

The BAPM standard for qualified in speciality nurses (QiS) is 70%. UHNM currently sit at 52% therefore an education and action plan has been devised and we are on target to achieve 70% QiS nurses by December 2025. An action plan has been completed and shared with the LMNS and ODN.

Table to illustrate current training schedule

Intake	Pass date	Head Count	WTE
June 2023	March 2024	5	3.55
January 2024	October 2024	5	4.84
June 2024	March 2025	4	3.38
January 2025	October 2025	Proposed 4	To be calculated
June 2025	March 2026	Proposed 4	To be calculated

- This will deliver the BAPM standard of 70% QIS by December 2025.

Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

NHS
University Hospitals of North Midlands
NHS Trust

1) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months that includes the following points:

a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years?

Evidence should include:

A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.

b) Can the Trust Board evidence midwifery staffing budget reflect establishment as calculated?

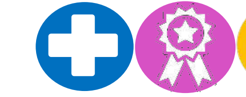
Evidence should include:

- **Meeting midwifery staffing recommendations from Ockenden and evidence of the funded establishment being compliant with outcomes of birthrate+ or equivalent calculations.**
- **Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.**
- **Where deficits in staffing levels have been identified, the plan to address these findings must be shared with the local commissioners.**
- **Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall.**
- **The midwife to birth ratio**
- **The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives." Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.**

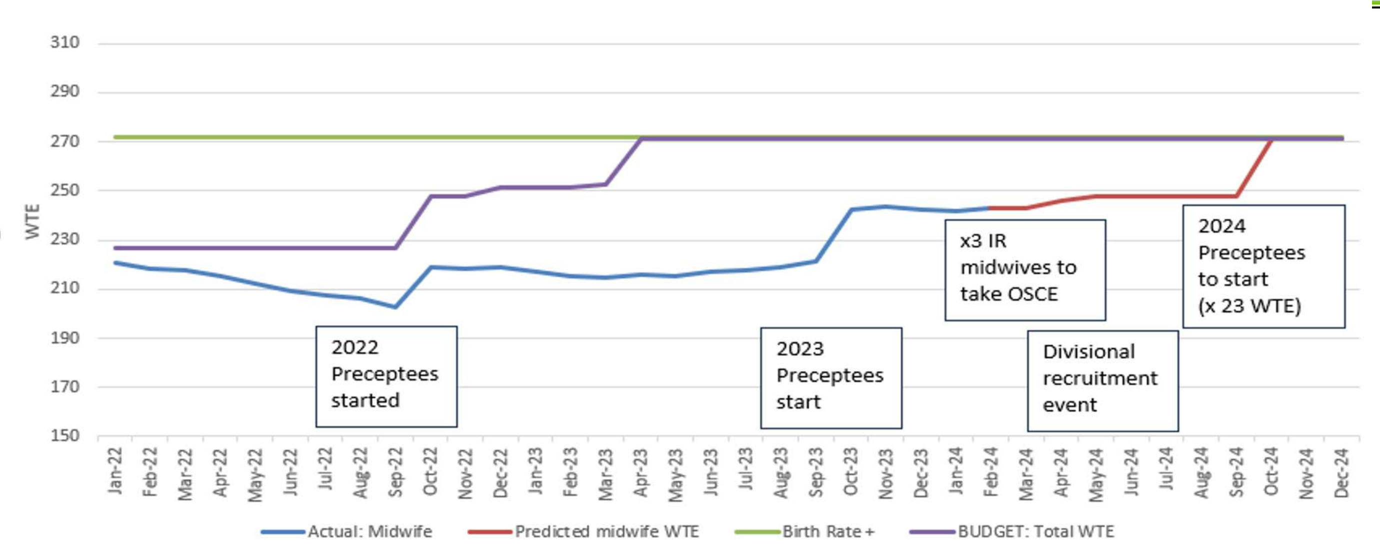
Birthrate Plus review undertaken in June 2022, next due 2025 in line with Ockenden. Based on 25.99% Uplift the workforce requirements are as shown in the table below.

Total Clinical WTE (including band B4 MSW's)	271.88
Non-Clinical	29.91
Clinical, Specialist, Management Total	**301.79**

- 6 monthly staffing report submitted to provide evidence to the Board that the midwifery establishment is set to the Birthrate Plus recommendations from June 2022.
- Direct Support Offer & Workforce Plan (Recruitment & Retention Plan.)
- Maternity and Neonatal Recruitment campaigns along with offers of employment, to all our students, has led to the drop in vacancies from 68.23 WTE midwife posts to the current position of 0 vacancies.
- UHNM is in the lowest quartile of Trusts for midwifery attrition at 2.4% (vs 4.4% regionally and 4.7% nationally.)
- 1:1 care in labour and supernumerary status of Delivery Suite Co-Ordinator has been maintained.



Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?



2) Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

The midwifery coordinator has been supernumerary 100% of the time. This is reported daily via the maternity Sitrep and recorded within the monthly dashboards. UHNM also have an escalation policy in place.

3) Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour.

All women in active labour have received one to one care. This is reported daily via the maternity Sitrep and recorded within the monthly dashboard reports.

Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Midwifery Recruitment Update

We worked hard to increase funding to match Birth Rate +.

This used locally calculated data for annual leave, sickness, maternity leave and training

Since the increase in establishment in September 2022 we have advertised over 65 times for midwife roles

To attract midwives to work at UHNM we have held 3 recruitment events attracting over 250 people

Over 50 people interviewed
13 midwives appointed

UHNM took the opportunity to recruit internationally supporting 8 midwives to join the team

UHNM are one of the only regional Trusts offering a midwifery apprenticeship

11 appointed over 2 years

To retain staff we have implemented several development opportunities including:

Advanced practitioner
Secondment opportunities
Apprenticeships
Vitality
Training courses
Funded educational spaces
Shadowing

By supporting our NQM's we have retained 100% of the 2022 & 2023 cohorts

We have worked with our partner universities to appoint all the students you have passed over the previous 2 years

You told us we were missing the opportunity to appoint our own students so we changed our recruitment

Regionally UHNM have the lowest midwifery leaver rate and 5th lowest nationally

Safety Action 6: Can you demonstrate that you are on track for compliance with all elements of the Saving Babies' Lives Care Bundle Version 3?

1) Have you agreed with the ICB that Saving Babies' Lives Care Bundle, version 3, is fully in place or will be in place and can you evidence the Trust Board has had oversight of this progress?

(Where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours, and sufficient progress, have been made towards full implementation, in line with the locally agreed improvement trajectory.)

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	60%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	93%	Partially implemented	93%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	89%	Partially implemented	89%	CNST Met

- Where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours, and sufficient progress, have been made towards full implementation, in line with the locally agreed improvement trajectory.
- UHNM have achieved **89% compliance.**

Have you continued quarterly discussions between the Trust and the LMNS/ICB from year 5 and be able to demonstrate that at least 2 quarterly discussions have taken place in year 6 to track compliance with the care bundle?

AND

- **These quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.**
- **There is a regular review of local themes and trends with regard to potential harms in each of the six elements.**
- **Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**
- **Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?**

UHNM continue with quarterly meetings to track compliance for year 6 that include all of the above. Element specific improvement work continues to be undertaken. Staffordshire and Stoke on Trent LMNS are continuing to use the national SBLCBv3 implementation tool for the quarterly assessments which provides a robust framework to work towards.

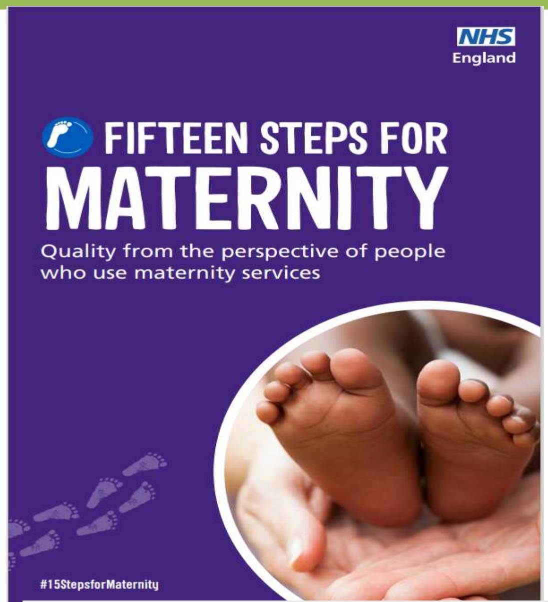
Safety Action 7: Listen to women, parents and families using Maternity and Neonatal services and coproduce services with users

1) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.

- ✓ The MNVP Chair has protected time for engagement with women and families, with specific time each month dedicated to reaching seldom heard groups.
- ✓ Demographic questions are asked on the online feedback survey.
- ✓ Demographic forms are requested at engagement visits.
- ✓ Continued outreach and linking in with third party and voluntary sector trusted partners.
- ✓ Inclusivity visits to UHNM maternity unit planned, to track progress from 2022 reports.
- ✓ Embedded agenda item on bi-monthly MNVP Forum meetings.
- ✓ Progress and challenges reported on to the MNVP Forum and the LMNS Quality and Safety Oversight Forum.

Additional work required;

- Continue to strengthen and use existing contacts and relationships.
- Build new relationships to increase engagement opportunities with women and families that have the worst outcomes.
- Continue to work with LMNS and providers to highlight this area.
- Continue to feed into the LMNS Equity & Equality plan.
- Work collaboratively with the new EDI Midwife post.
- Continue to work with MNISA colleague to develop feedback pathways for all families.
- Ensure literature and information is available in the family's language, and translation facilities are available.



The MNVP have been in to complete 15 steps and given some great feedback.

The Fifteen Steps for Maternity is a a framework used to drive quality from the perspective of people who use maternity services.

Our feedback included:

- How friendly, inviting and considerate staff were to each other and patients
- They really liked the thankyou cards displayed around the building
- How there has been a considerable improvement in the MAU waiting area
- There was a positive culture and that people were willing to talk openly
- How many positive changes there had been since their last visit

Well done to everyone.

Safety Action 7: Listen to women, parents and families using Maternity and Neonatal services and coproduce services with users

2) Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member)

3) Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as:

- Job description for MNVP Lead
- Contracts for service or grant agreements
- Budget with allocated funds for IT, comms, engagement, training and administrative support
- Local service user volunteer expenses policy including out of pocket expenses and childcare cost

4) Show evidence of a review of annual CQC Maternity Survey data, such as the documentation of actions arising from CQC survey and, if available, free text analysis, such as an action plan.

Evidence of the co-produced action plan being shared with Safety Champions and LMNS.

- ✓ **MNVP are listed within Terms of Reference for Maternity forums, safety champion meetings, guidelines meetings, maternity education team meetings and induction of labour / MAU improvement groups and all relevant MNVP infrastructure evidence stored centrally.**
- ✓ **A report and action plan has been devised by our PMA and shared with the LMNS and Safety Champions detailing the maternity survey feedback.**

Maternity Survey 2023

Published 9 February 2024

This survey looks at the experiences of 25,515 women and pregnant people, across 121 NHS trusts, who gave birth in February 2023 (and January 2023 for smaller trusts).

Questionnaires were sent out between April and August 2023, responses were received from 214 people at University Hospitals of North Midlands NHS Trust.

	Patient Response	Compared with other trusts
Labour and birth	7.7 / 10	About the same
Staff caring for you	8.2 / 10	About the same
Care in hospital after the birth	6.9 / 10	About the same

Delivering Exceptional Care with Exceptional People

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house' one day multi professional training?

Fetal monitoring training:

90% of staff groups

December 2023- November 2024 inclusive

	DOCTORS	OBS CONSULTANTS	OBS TRAINEES	MIDWIVES/BANK	TOTAL
TOTAL NUMBER OF STAFF	54	15	39	353	407
STAFF TRAINED	52	14	38	328	380
COMPLIANCE 30th NOV 2024	**96%**	**93%**	**97%**	**92%**	**93%**

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house' one day multi professional training?

Maternity emergencies and multidisciplinary training (PROMPT)

90% of staff groups

December 2023- November 2024 inclusive

	DOCTORS	OBS CONSULTANTS	OBS TRAINEES	ANAESTHETISTS	ANAESTHETIC CONSULTANTS	ANAESTHETIC TRAINEES	MIDWIVES/BANK	CSW	TOTAL (THEATRE NOT INC)	THEATRE	HDU NURSES
TOTAL NUMBER OF STAFF	67	17	50	64	30	34	353	99	583	6	3
STAFF TRAINED	65	16	49	59	28	31	331	95	550	6	3
COMPLIANCE 30th NOV 2024	**97%**	**94%**	**98%**	**92%**	**93%**	**91%**	**93%**	**95%**	**94%**	**100%**	**100%**

At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff. **The clinical education team run live drills on a regular basis therefore achieving this standard.**

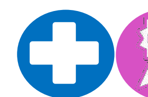
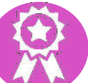
Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house' one day multi professional training?

Neonatal Basic Life Support:

90% of staff groups

December 2023- November 2024 inclusive

	MIDWIVES	NEONATAL NURSES	ANNP	NEONATAL CONSULTANTS	NEONATAL DOCTORS
TOTAL NUMBER OF STAFF	353	91	7	10	18
STAFF TRAINED	331	85	7	9	18
COMPLIANCE 30th NOV 2024	**93%**	**93%**	**100%**	**90%**	**100%**

Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Requirement	Response
Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded?	Reported in monthly maternity dashboard
Has a non-executive director (NED) has been appointed and is visibly working with the Board Safety Champion (BSC)?	Sunita Toor, Non-Executive Director Board Safety Champion works with the Board Safety Champions and attends quarterly meetings along with monthly visits to Maternity.
Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set and presented by a member of the perinatal leadership team to provide supporting context? Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback. Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	A review of maternity and neonatal quality is undertaken and reported to the Quality Governance Committee. UHNM Maternity and Neonatal Services have a clear assurance map which is in line with the Perinatal Quality Surveillance Model. Trust level intelligence is shared in collaboration with the LMNS for areas of early action and support for areas of concern.
Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Staff engagement sessions held monthly. Improving together projects. SCORE survey
Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	The Trust scorecard is reviewed and presented quarterly.
Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Quarterly meetings between the Maternity and Neonatal Board Safety Champions and the QUAD. A report of concerns identified, improvement plans, and any support required of the Board is presented quarterly to the directorate and division.
Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	UHNM Perinatal Culture and Leadership Programme published with feedback and themes from SCORE survey. Actions are contained within the report. External engagement with staff continues.

Safety Action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8th December 2023 to 30th November 2024

University Hospitals of North Midlands NHS Trust

Incidents investigated under the MNSI criteria are:

Intrapartum stillbirth
Early neonatal death (0-6 days of life)
Potential severe brain injury diagnosed in the first 7 days of life
Maternal death (within 42 days of the end of pregnancy)

All incidents that meet MNSI criteria or are considered to grade as C or D on the PMRT will be reported through UHNM governance process as PSII's.

During this reporting time period:

- UHNM referred 10 cases to MNSI during this reporting period. 4 cases rejected.
- MNSI referral has been offered to parents when cases met the criteria
- The national Badger Net electronic neonatal records have been cross checked to identify all babies born at UHNM above 37 weeks' gestation who required therapeutic cooling for the reporting time period.
- All eligible families received information on the role of MNSI and NHS Resolution's and EN scheme (where relevant) as part of the duty of candour process.
- The UHNM legal team have confirmed that there were no claims as a result of reporting to the Early Notification Scheme for the reporting time period.
- UHNM is fully compliant with safety action 10

Safety Action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8th December 2023 to 30th November 2024

Early Notification Scheme process

Up to 6 months

Baby born and meets MNSI criteria for serious brain injury → Trust reports incident to MNSI for investigation → MNSI creates reference number and starts investigation → Trust reports incident to NHS Resolution → NHS Resolution acknowledges incident to Trust → MNSI completes investigation → MNSI give family information on NHS Resolution and the EN Scheme → NHS Resolution send introduction letter to family

Up to 1 month

Trust shares MNSI report with NHS Resolution

You have three months to reach your decision from the date the letter is sent. We will contact you two weeks later to confirm you have received the letter and then four weeks later to confirm if you have made a decision about the legal investigation

Up to 1 month

NHS Resolution reviews MRI information within MNSI report and/or MRI report → EN MRI criteria met → NHS Resolution undertakes an initial clinical review → Early indication of substandard care which may / reasonably expected to have made a difference to the outcome → NHS Resolution sends letter to family notifying them of the legal investigation

Up to 3 months

Permission received → NHS Resolution commence legal investigation → NHS Resolution sends letter to Trust and family → Move to legal investigation process

Up to 2 months

See legal investigation flowchart

Once you give us your permission, we can start our liability investigation

EN MRI criteria not met → No investigation takes place

Early indication of no substandard care or the care would not have made a difference to the outcome → No investigation takes place

Permission not received → No investigation takes place

If you do not give permission for an investigation to take place or we do not hear back from you, no investigation will take place

No investigation takes place → NHS Resolution sends letter to Trust and family → Clinical Negligence Scheme for Trusts route

Up to 6 weeks

We will signpost you to legal advice and support organisations

You have the option of pursuing a claim where the EN investigation isn't taking place. More details can be found on our website

Process from 1 April 2024

NHS Resolution

Maternity incentive scheme - Year 6 Guidance

Trust Name	**University Hospitals of North Midlands NHS Trust**
Trust Code	**T016**

This document must be used to submit your trust self-certification for the year 6 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D which is the board declaration form.

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in.
This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the Board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact **nhsr.mis@nhs.net**

Tab D - Board declaration form - This is where you can view your overall reported compliance with all of the maternity incentive scheme safety actions. This sheet will be protected and compliance fields cannot be altered manually.
If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the Trust Board, ICB and before submission to NHS Resolution.

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are 'for and on behalf of' the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering either 2023/24 financial year or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2025

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**

Technical guidance and frequently asked questions can be accessed in the year 6 MIS document:
MIS-Year-6-v1.1-20240716.pdf (resolution.nhs.uk)

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.

Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 8 December 2023 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 2 April 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose NA)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 2 April 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 60% of the reports published within 6 months of death?	Yes
5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews, any themes identified, and consequent action plans.	Yes
6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024?	Yes
2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?	Yes
2	Or Is there a Transitional Care (TC) action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	N/A
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.		
3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	Yes
4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	Yes

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity: Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance	Yes
3	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person.	Yes
4	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	Yes
Do you have evidence that the Trust position regarding question 3 & 4 has been shared:		
5	At Trust Board?	Yes
6	With Board level safety champions?	Yes
7	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		

8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? And is this formally recorded in Trust Board minutes?	Yes
10	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	N/A
11	Was the above workforce action plan shared with the LMNS?	N/A
12	Was the above workforce action plan shared with the ODN?	N/A
d) Neonatal nursing workforce		
13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	No
14	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
15	Was the above workforce action plan shared with the LMNS?	Yes
16	Was the above workforce action plan shared with the ODN?	Yes

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.	Yes
2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. If this process has not been completed due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.	Yes
3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Meeting midwifery staffing recommendations from Ockenden and evidence of the funded establishment being compliant with outcomes of birthrate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● Where deficits in staffing levels have been identified, the plan to address these findings must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift.** An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
5	A workforce action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will NOT enable the Trust to declare compliance with this sub-requirement.**	N/A
6	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
7	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will enable the Trust to declare compliance with this sub-requirement.**	N/A

Safety action No. 6

Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)	Yes
2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**	Yes
3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	Yes
4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.	Yes
5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**	Yes
6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	Yes

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes
2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as:** •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	Yes
3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: •Job description for MNVP Lead •Contracts for service or grant agreements •Budget with allocated funds for IT, comms, engagement, training and administrative support •Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	N/A
5	Show evidence of a review of annual CQC Maternity Survey data, such as the documentation of actions arising from CQC survey and, if available, free text analysis, such as an action plan.	Yes
6	Has progress on the coproduced action above been shared with Safety Champions?	Yes
7	Has progress on the coproduced action above been shared with the LMNS?	Yes

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2024?		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants	Yes
6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota	Yes
7	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	Yes
9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.	Yes

12	For rotational anaesthetic staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
13	At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff	Yes
	Neonatal basic life support (NBLS)	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births	Yes
16	For rotational medical staff that commenced work in neonatology on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
17	90% of Neonatal nurses (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
19	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes

Safety action No. 9

Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded?	Yes
2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Yes
6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Yes
7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Yes
2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Yes
4	Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	Yes
6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Yes
7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes

Maternity Incentive Scheme - Year 6 Board declaration form

Trust name	**University Hospitals of North Midlands NHS Trust**
Trust code	**T016**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	**Action plan**	**Funds requested**	**Validations**
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2024/25) or the previous financial year (2023/24)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	University Hospitals of North Midlands NHS Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	University Hospitals of North Midlands NHS Trust
Name:	
Position:	
Date:	

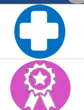
Executive Summary

Meeting:	Trust Board (Open)	Date:	8th January 2025
Report Title:	Urgent and Emergency Care Pressures, Ambulance Handover and Winter Update	Agenda Item:	10.
Author:	Katy Thorpe, Chief Operating Officer		
Executive Lead:	Katy Thorpe, Chief Operating Officer / Matthew Lewis, Chief Medical Officer / Ann Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF4	Delivering Responsive Patient Care	Extreme 15
BAF 1	Delivering Positive Patient Outcomes	High 12

Executive Summary

This paper aims to update board members on the progress of the winter plan along with UEC pressures and ambulance handover delays.

Winter Update

Our attendances and admissions remain high, with an over predicted bed occupancy, high discharge to assess (DTA)'s in ED for both Stoke and County sites, above expected numbers of medically fit patients and a significant impact of IPC restrictions during the reported period.

The schemes due for implementation as part of the winter plan are largely on track although the discharge lounges at County and Stoke were delayed. Since the previous report the County lounge has now opened and Stoke is due at the beginning of January and is being mitigated through use of alternative space.

UEC Pressures, Ambulance Handover

The following information highlights that while actual attendance is not outside normal variation, the attendance by ambulance is a cause for concern.

This is coupled with the higher than expected medical bed occupancy as demonstrated in the chart below.

Attendances to Royal Stoke ED

Ambulance Arrivals - Royal Stoke

Medical Beds Occupied at Midnight

Occupied — Threshold (92%) — 100% Occupancy

Mitigating Actions

There are a number of mitigating actions in place which include:

At Hospital

- Command and control remains in place across divisions with enhanced actions within medicine.
- Additional Emergency Department (ED)/Ward improvement team now in place led by Deputy Chief Medical Officer focussing on both ED processing, and ward standard work.
- Integrated Discharge Hub (IDH) in reach support to ED and Same Day Emergency Care (SDEC) portals – 270 patients discharged direct from portals.

- Cohort wards established for Flu
- Elective Orthopaedic Onit (14 beds) at County flipped to support Medicine – Reviewing potential for additional winter ward. Since the report was published this has been increased to all 26 beds.

Discharge

System Health Integration Team (HIT) supporting 20-30 extra discharges a week (both simple and complex). Additional reviews of patients with a NEWS 3 and under to support discharge identification.
Home for Christmas campaign across the acute and community bed base:

- Command and Control style approach support to Division of the Day
- Daily walk round of all wards within Division of the Day
- Proactive tracking of patients
- Transfer of Care (TOC) Quality Enhancement
- Confirm and Challenge across all wards around exit plans / Expected Discharge Date's
- Risk assessment management of exit plans
- Additional Local Authority brokerage capacity in place.
- 40 Additional community hospital/D2A beds operational in-line with plan. Supported by additional spot purchase beds above plan as required.

Your Next Patient / ED Corridor Care

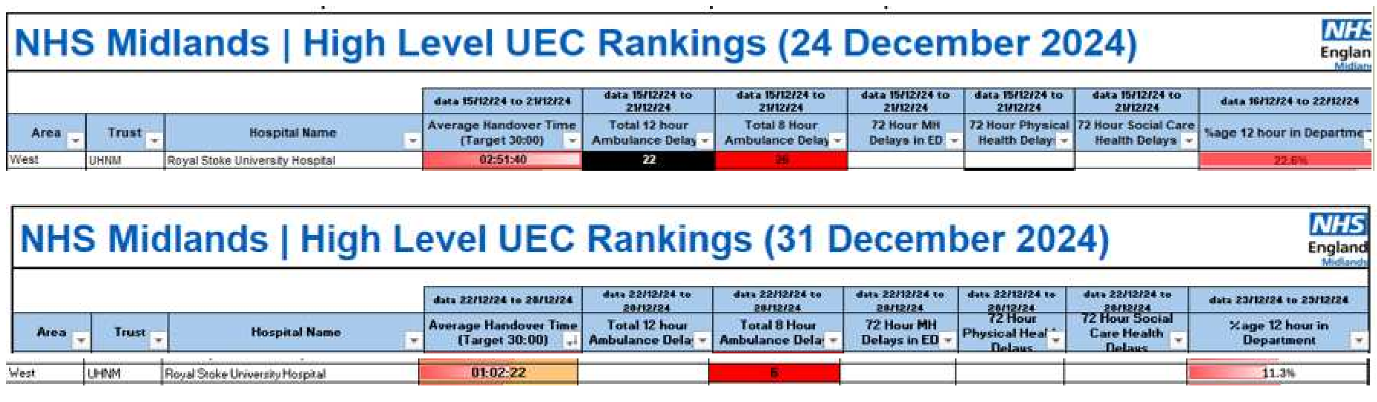
We continue to make use of 15 risk assessed spaces in ED to support ambulance offload. We also continue to use a 'Your Next Patient' (YNP) model where wards have been risk assessed and suitable spaces are used to care for additional patients in ward areas – this Standard Operating Procedure is currently under review. A review of the YNP model is currently being undertaken to consider expanding the number of spaces that patients are held in both during the day and, during periods of pressure, overnight.

ED Space

During extreme pressure in critical incident the paediatric ED has been moved to co-locate with the paediatric assessment unit to create additional space for adult ED.

Regional Position

When reviewing the UEC regional rankings as at 28th December 2024, this shows a marked improvement for UHNM since the two week period (15/12/24 – 21/12/24).



NHS Midlands | High Level UEC Rankings (24 December 2024)

NHS England Midlands

Area	Trust	Hospital Name	Average Handover Time (Target 30:00)	Total 12 hour Ambulance Delay	Total 8 Hour Ambulance Delay	72 Hour MH Delays in ED	72 Hour Physical Health Delay	72 Hour Social Care Health Delays	%age 12 hour in Departme
			data 15/12/24 to 21/12/24	data 15/12/24 to 21/12/24	data 15/12/24 to 21/12/24	data 15/12/24 to 21/12/24	data 15/12/24 to 21/12/24	data 15/12/24 to 21/12/24	data 16/12/24 to 22/12/24
West	UHNM	Royal Stoke University Hospital	02:51:40	22	26				22.6%

NHS Midlands | High Level UEC Rankings (31 December 2024)

NHS England Midlands

Area	Trust	Hospital Name	Average Handover Time (Target 30:00)	Total 12 hour Ambulance Delay	Total 8 Hour Ambulance Delay	72 Hour MH Delays in ED	72 Hour Physical Health Delays	72 Hour Social Care Health Delays	%age 12 hour in Department
			data 22/12/24 to 28/12/24	data 22/12/24 to 28/12/24	data 22/12/24 to 28/12/24	data 22/12/24 to 28/12/24	data 22/12/24 to 28/12/24	data 22/12/24 to 28/12/24	data 23/12/24 to 29/12/24
West	UHNM	Royal Stoke University Hospital	01:02:22		6				11.3%

Key Recommendations

- *The Board is asked to receive the update re Winter*
- *The Board is asked to note the actions being taken*

Integrated Performance Report (IPR)

Month 8 Performance 2024/2025

Contents

No.	Title	Page
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Data Quality & Statistical Process Control

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

Explaining Each Domain:

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

Sign Off & Validation

Timely & Complete

S T A R

Audit & Accuracy

Robust Systems & Data Capture

RAG Rating Key:

Colour	Meaning
Green	Good level of assurance for the domain
Amber	Reasonable Assurance with an action plan to move into Good
Red	Limited or No Assurance for the domain with an action plan to move into Good

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

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

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

Assurance Grid

Strategic Priority Domain Metrics Key

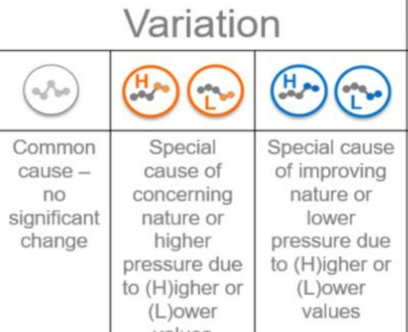
Aiming Here

Failing

Assurance / Variation Key

Assurance

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



Worsening

ASSURANCE / VARIATION

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

Overview from the Chief Nurse and Chief Medical Officer

How are we doing against our trajectories and expected standards?

We continue to see continual improvements across a range of metrics and the progress made to stabilise the NMAHP workforce is being maintained.

We have met the required targets across a range of metrics including induction of labour, MW triage, falls with harm, medication incidents with moderate harm or above, pressure ulcer with lapses in care, DOC verbal, MRSA bacteraemia, e-coli, c-diff, FFT inpatients, hospital acquired thrombosis, sepsis inpatients, sepsis IVAB ED, sepsis IVAB maternity, and HSMR/SHMI. There are no never events reported this month.

Some metrics, whilst not at target, are seeing continual improvement including sepsis screening ED, compliants response times, FFT maternity and ED, and timely observations.

We failed to meet the required target for DOC written, VTE assessments, sepsis screening in maternity and children, single sex accommodation breaches (all in critical care), . Due to this inconsistency there is limited assurance.

Maternity Sepsis is now a Directorate Driver metric and progress will be monitored via MNQSOG/QSOG.

We had a CQC inspection in relation to the S29a at County on 4th July. We have met the S29a requirements, the medicine service has improved from Inadequate to Good, and the County Hospital site has improved from Requires Improvement to Good.

What is driving this?

Falls with harm reducing overall since peak in April 2022 and in month we were below the threshold of 1.5.

Pressure Ulcers with lapses in care continues on a downward trajectory since peak in Oct 2022 and was below target in month.

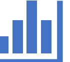
We were below target in month for both e-Coli and C-Diff.

VTE assessment performance is predominantly poor due to the date and time not being recorded on the assessment form by the prescribers who carry out the assessment. This is required so we can demonstrate that an assessment has been done within 12 hrs of admission which is the metric we are required to report nationally. DOC continues to fail to meet the target.

Single sex breaches were all in critical care and caused by an inability to transfer patients to wards due to capacity constraints.

High Quality | Overview

Provide safe, effective and caring services



Overview from the Chief Nurse and Chief Medical Officer

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

We are continuing to work with all services across the Trust to implement PSIRF methodologies and principles for incident responses and learning. This is planned to improve the identification of system-based learning and recommendations to support our wider learning for improving the quality of care provided.

The patient experience team are constantly working with clinical teams to promote and increase completion rates for patients and assessing new approaches to try and increase completion of the FFT questions including efficacy of text messaging in Maternity, improving access to paper questionnaires in Emergency Departments along with greater visibility of QR codes. Surgery have FFT as a Divisional Driver metric and report countermeasures and progress through PRM. We are also scoping an avenue for women and families to provide feedback 3 months plus post delivery directly to the maternity safety champions.

Timely observations continues to be a driver metric discussed at Divisional PRM and Medicine Division continue to have the biggest impact in overall performance.

UHNM are participating in regional work focusing on C-Diff and e-Coli f to consider root causes of increased rates and any learning for organisations. We awaiting any learning to be disseminated form these workstreams.

Intensive corporate support to Bronze CEF wards continues.

What can we expect in future reports?

Focus on Timely Observations of indwelling devices a focus for IPCC and progress updates will be provided to QGC via this report in due course. Consideration of the reports available from VITALS to support QI being reviewed by CNIO.

We will share the learning from the thematic review and infection prevention work as the information is shared.

UHNM are in the first wave of Trusts implementing Martha's Rule. This is expected to be implemented across adults and Children at RSUH within the next 12 months. By Q3 provider sites are expected to be moving to implementation of parts 1,2 and 3 of Martha's Rule with a data being collated (metrics TBC). We will be participating in a regional T+F group to consider component 3 and an update can be provided as that work progresses

UHNM are also now part of a national person-centred practice improvement collaborative and hope to become an exemplar site.

The CN is SRO to develop a regional nursing and midwifery excellence accreditation framework – more information will be shared with the committee as that work progresses.

High Quality

High Quality | Dashboard

Provide safe, effective and caring services

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Induction of Labour	95.0%	97.1%	97.9%						
Maternity Triage	85.0%	92.0%	90.3%						
Patient Safety Incidents rate per 1000 bed days	50.7	53.9	48.7						
Patient Safety Incidents with moderate harm and above per 1000 bed days	0.6	0.6	0.8						
Patient falls with harm per 1000 bed days	1.5	1.8	1.4						
Medication Incidents per 1000 bed days	6.0	6.9	6.6						
Medication Incidents % with moderate harm or above	0.50%	0.34%	0.36%						
Patient Safety Incident Investigation (PSII's) instigated	0.0	1.0	1.0						
Never Events per month	0.0	0.0	0.0						
Pressure ulcers developed under UHNM per 1000 bed days	1.6	1.5	1.9						
Family & Friends Test - Inpatient	95.0%	95.5%	95.2%						
Family & Friends Test - ED	85.0%	60.1%	61.1%						
Family & Friends Test - Maternity	95.0%	83.1%	87.6%						
Sepsis - Adult Inpatient Screening	90.0%	91.8%	98.0%						
Sepsis - Adult Inpatient IVAB	90.0%	93.1%	100.0%						
Sepsis - ED Portals Screening	90.0%	83.8%	87.5%						
Sepsis - ED Portals IVAB	90.0%	88.9%	93.5%						
Sepsis - Childrens Screening	90.0%	82.7%	83.3%						
Sepsis - Childrens IVAB	90.0%	n/a	n/a						
Sepsis - Maternity Screening	90.0%	80.0%	66.7%						
Sepsis - Maternity IVAB	90.0%	66.7%	100.0%						

The Assurance icons refers to when we are consistently passing or falling short of our target and our data has been within or outside our agreed target range.

The icon will remain grey as long as we remain within the target range set (e.g. between the upper and lower limits) even if we have consistently exceed the target and the variability icon is

The icon will change to blue only when we are consistently passing the target and the target is also outside the process limits.

The icon will change to orange when we consistently fail to achieve the target and the target is outside the process limits.

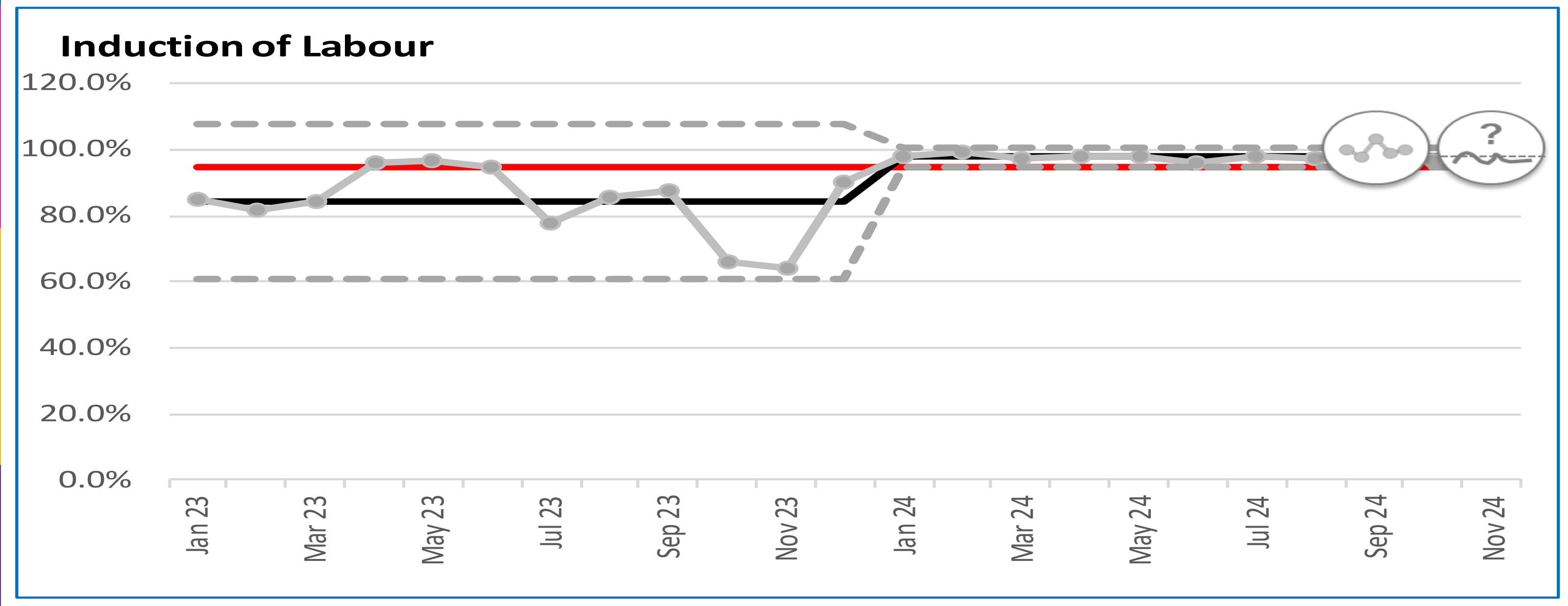
The Assurance icon is not an assurance statement on quality & safety of the service/care but on statistical confidence.

Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 1: Delivering Positive Patient Outcomes	High 12	Partial	High 12	Partial			High 12	Acceptable

High Quality | [Induction of Labour]

Provide safe, effective and caring services



What is the data telling us?

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

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

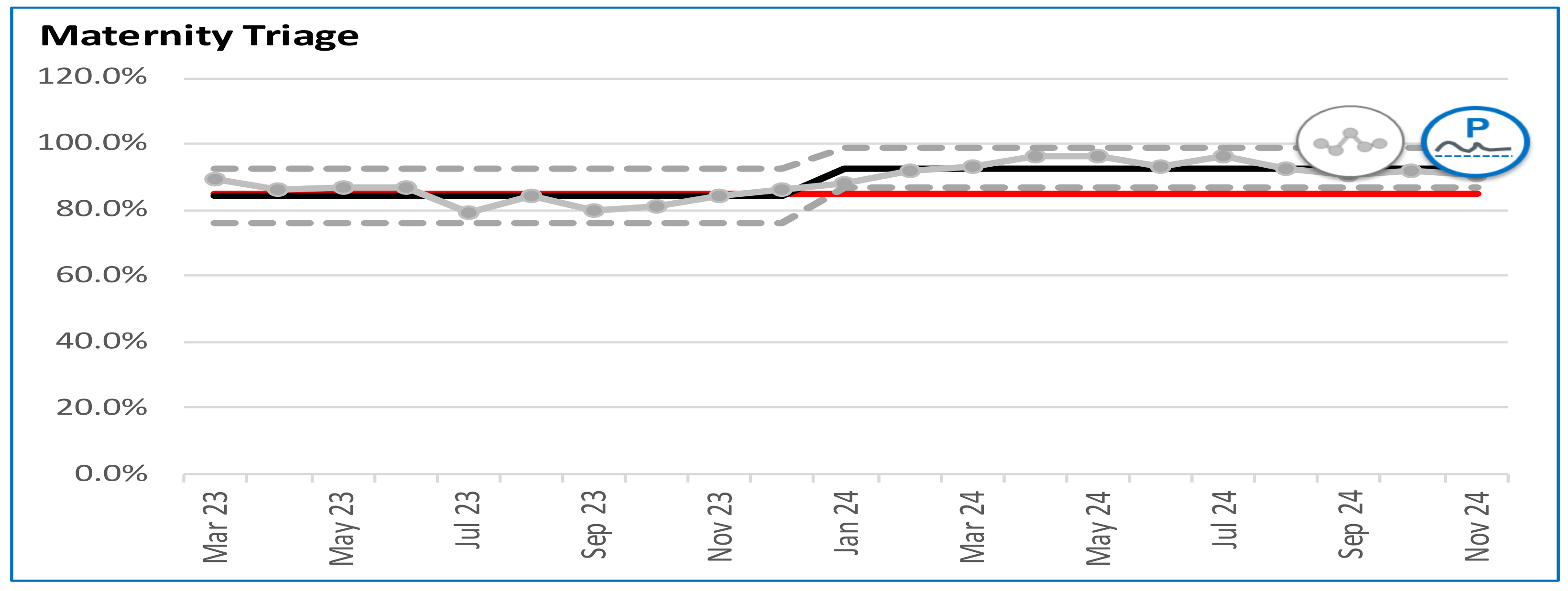
The introduction of the opening of 8 beds for IOL on the MBC in December 2023 and the development of the IOL improvement project have contributed to this improvement

What are we doing about it?

Any IOL breaches are safety netted, and incident reported for full review through the internal governance process.
IOL Datix are grouped into an IOL Improvement group tab, allowing a refined audit & review with focus on IOL themes.
Any IOL breaches are discussed daily at the patient safety huddle and escalated.
Any IOL breaches will have a wellbeing appointment with a medical review and if necessary, admitted for observation (admission will be offered prior to breaching when this is forecast)
Prioritisation occurs daily by the on-call Consultant Obstetrician for all IOL's booked for that day- this will include any deferred IOL.
All midwifery induction core vacancies now recruited. Additional recruited trained midwives will commence post in the unit from October sustaining progress made and keeping timely flow during the IOL process.
Dilapan , mechanical IOL method introduced since May 2024. When accepted as an IOL method it gives certainty of cervical changes aiding planning and flow in the unit along with patient satisfaction.

High Quality | [Maternity Triage]

Provide safe, effective and caring services



What is the data telling us?

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

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

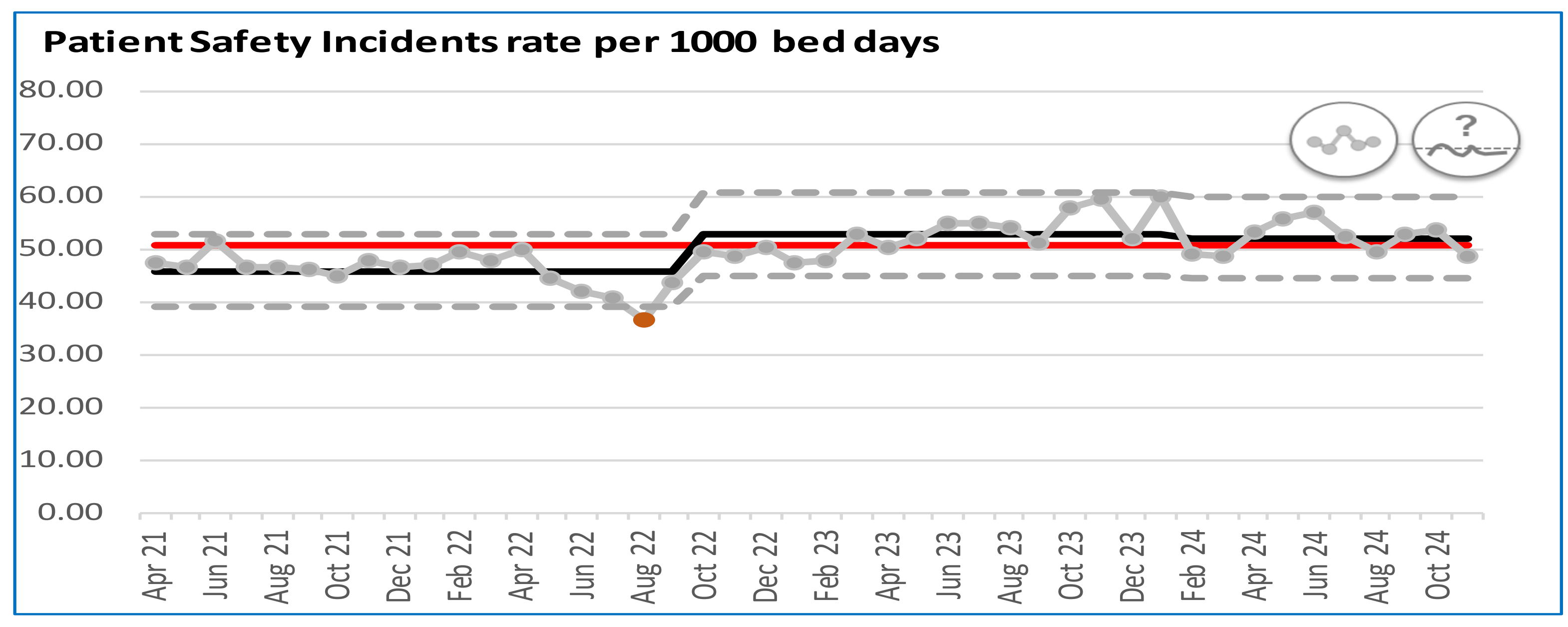
The development of the MAU improvement group in December 2023 and implementation of actions have contributed to the improvement and sustained reduction in MAU breaches

What are we doing about it?

The MAU improvement group meet weekly to continue to discuss and sustain the driver metrics.
All MAU timing breaches are incident reported and reviewed daily via audit and Datix in relation to impact and outcome.
MAU triage breaches are included in daily patient safety huddle and reported via the daily sitrep
This metric has met the Improving Together parameters to move from a driver to a watch metric. The A3 will be refreshed to focus on sustainability of current performance. The watch metric will be reviewed at the Executive Performance Review Meeting with the Division.
New recruits commence employment in October, this will aid flow through the unit sustaining our improvement.

High Quality | [PSIs per 1000bed days]

Provide safe, effective and caring services



What is the data telling us?

There have been consistent levels of reporting across the Trust and maintaining the improvements and higher mean rate since October 2022. LFPSE reporting and additional NHSE mandated questions introduced in February 2024 and the reporting rate remained consistent with the same months during 2023.

There is currently no significant variation in reporting rates and the average rate is just above the previously published NRLS average for Acute Trusts (new national LFPSE data publication is awaited)

What are we doing about it?

Currently reviewing the near miss and low harm data to identify potential trends for future improvement projects.

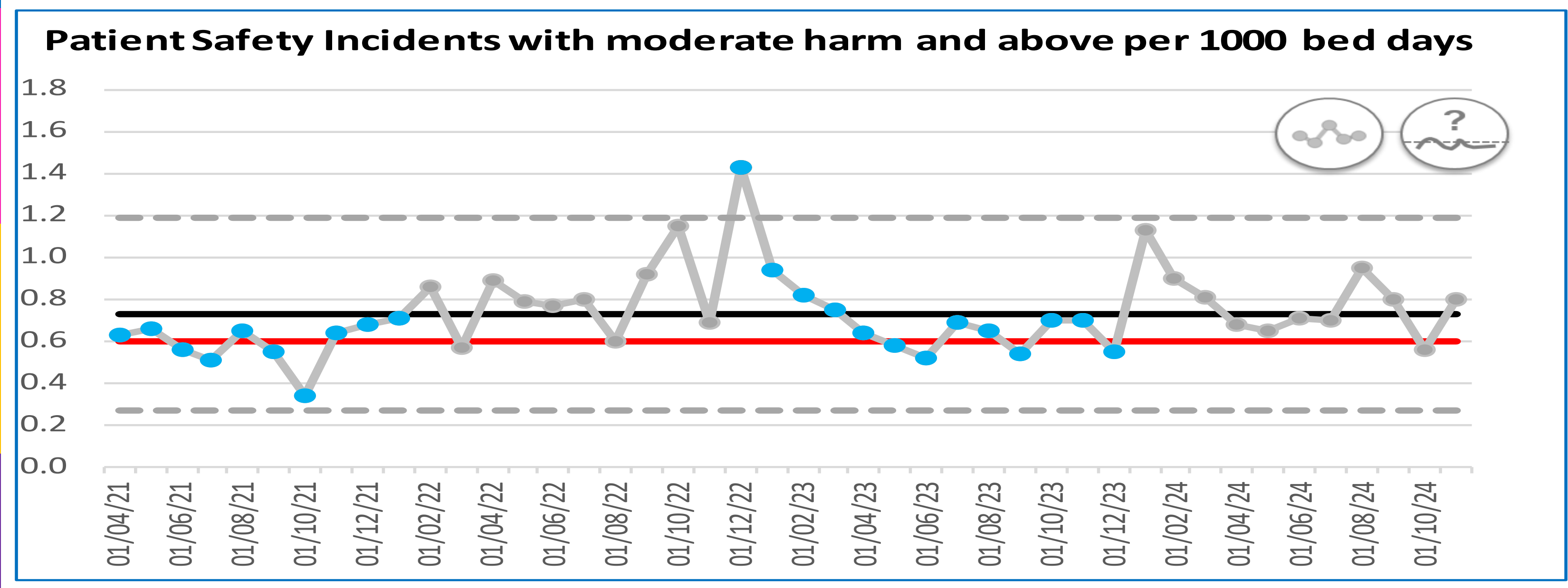
Will continue to monitor the internal reporting rates and identify if there are any specific reasons for reduced rate per 1000 bed days.

To utilise LFPSE data published to assess/benchmark our reporting and outcomes as soon as this is available. Noted that 99% of all NHS providers are now utilising LFPSE.

High Quality

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

Provide safe, effective and caring services



What is the data telling us?

The rate of PSIs reported with moderate harm or above has remained within normal variation since January 2024.

What are we doing about it?

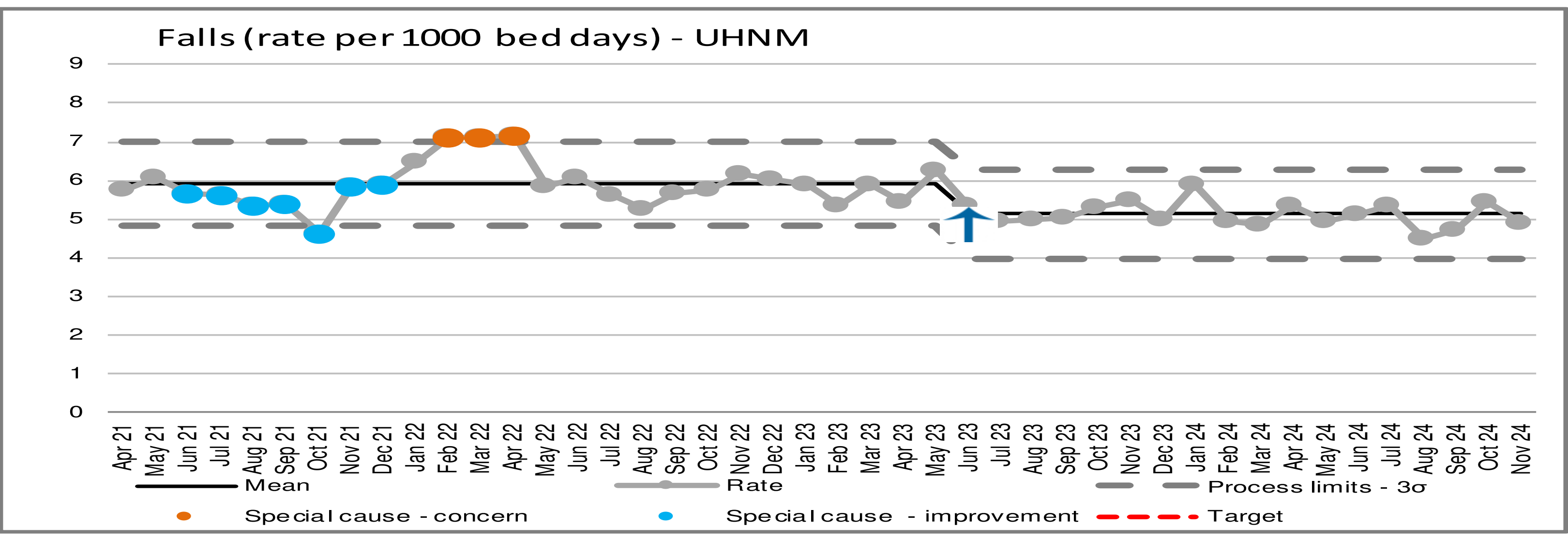
Reviewing harm profile and locations / categories for moderate harm and above incidents.

To support PSIRF principles we are reviewing learning and proportionate responses to incident reviews with formal review held in October 2024.

We are completing thematic reviews to ensure wider learning is captured and actions to improve the quality and safety of care delivered are in place.

High Quality | [Patient Falls per 1000 bed days]

Provide safe, effective and caring services



Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
N/A	4.7	5.4	4.9

Background

The number of falls per 1000 occupied bed days

What is the data telling us?

The average rate of reported patient falls per 1000 bed days has been stable since June 2023. The rate for November 2024 was within expected limits.

The areas reporting the highest numbers of falls in Nov 2024 were:
Royal Stoke ECC – 12 falls, Royal Stoke AMU – 11 falls, Ward 126 – 10 falls, Ward 14 – 10 falls

What are we doing about it?

From the 43 falls across the 4 areas there was 1 injury reported.

The injury was a scapula fracture, the patient has since been discharged. The patient had appeared on the multiple faller data and therefore preventative measures had already been discussed with the ward. It was found that although it had been documented that the patient could press the call bell, the patient would not have had the cognition required to request assistance.

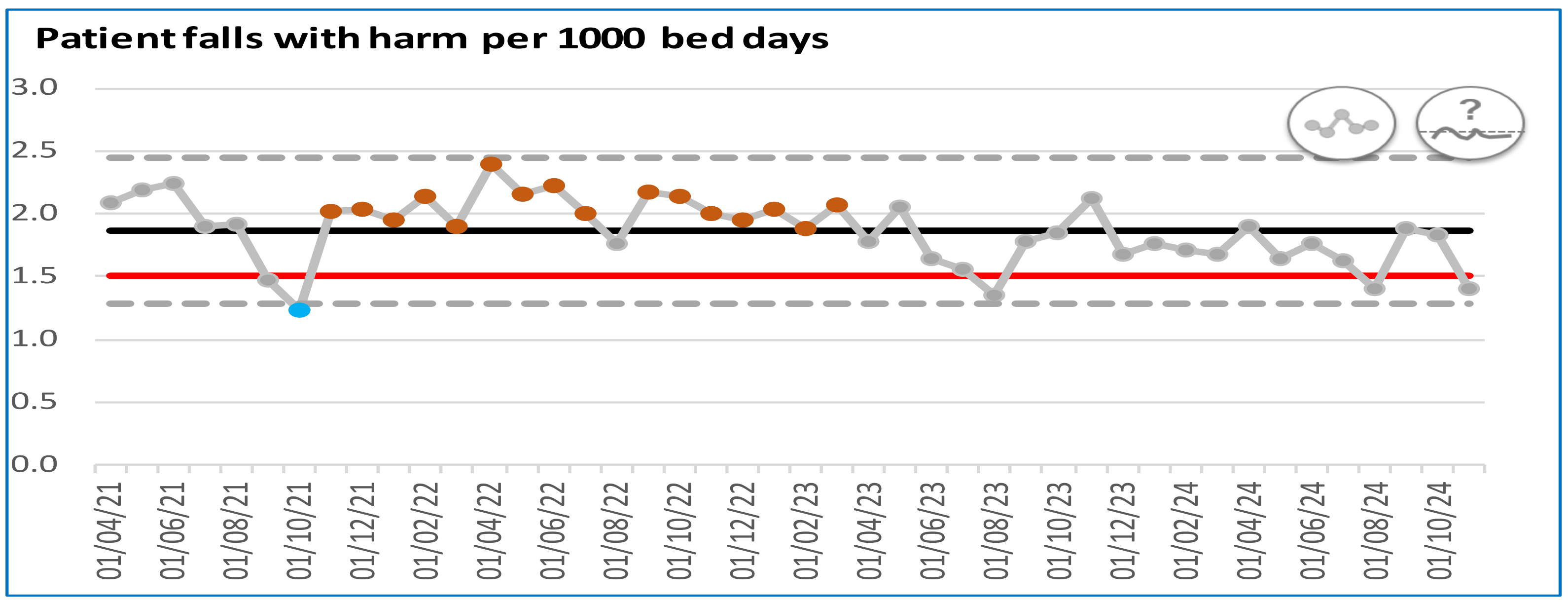
Although falls have reduced from the previous month the number of multiple falls have remained high, 1 patient had sustained 7 falls. The patients who had suffered multiple falls were discussed with the individual areas to identify if anything further could be put into place for these patients.

Audits and discussions have been undertaken in these areas to improve compliance with fall interventions.

Falls audits have been completed on the top reporting areas and feedback has been provided to the teams to support changes in practice to support falls reduction.

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

Provide safe, effective and caring services



What is the data telling us?

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

Wards with falls reported as resulting in serious injuries in November (5 incidents):
County AMU, Ward 1, Ward 12, Ward 14 , Ward 111

What are we doing about it?

The wards listed have been visited and the falls toolkits have been completed with the staff.

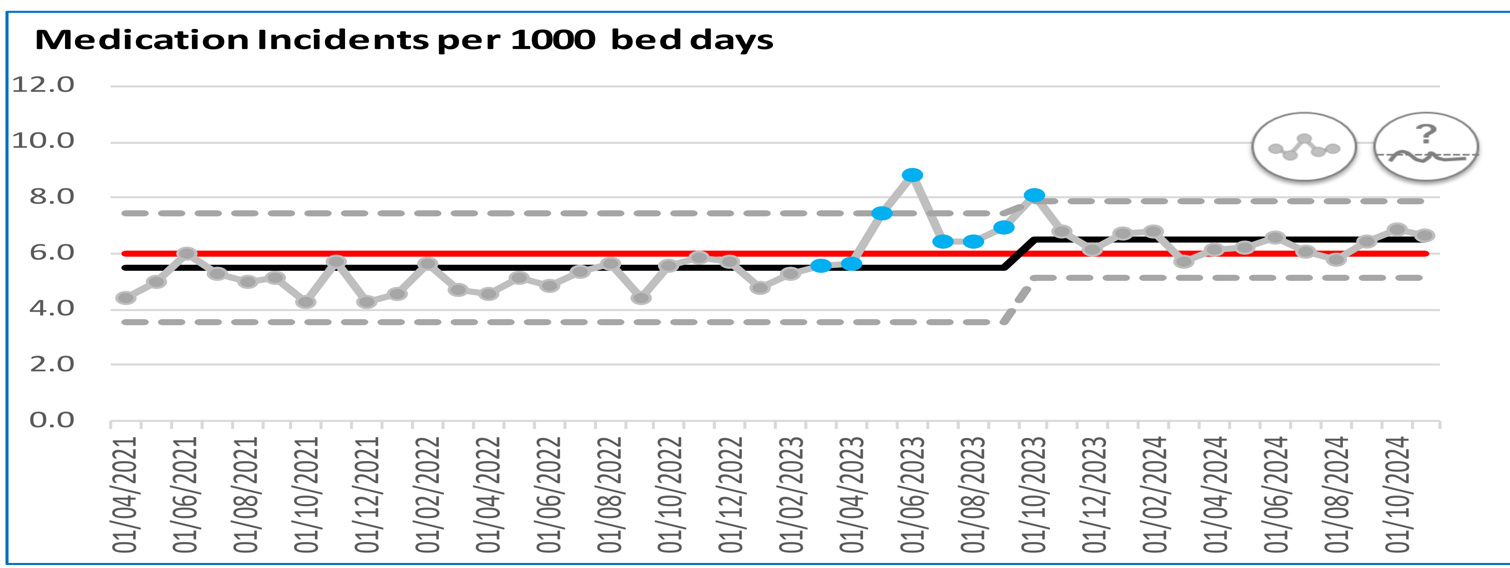
Investigations to the 5 injuries showed that call bells remained to be a concern.

The new call don't fall posters ask for the patients "to ask for our assistance" before mobilising. The team are currently taking these to the wards and discussing tables in bays, before I go, falls champion training and other falls related initiatives.

Wards have been supported to improve all facets of the fall's agenda

High Quality | [Medication Incidents per 1000 bed days]

Provide safe, effective and caring services



What is the data telling us?

The rate of reported medication related incidents has shown only normal variation since December 2023, with the average slightly above the NRLS mean.

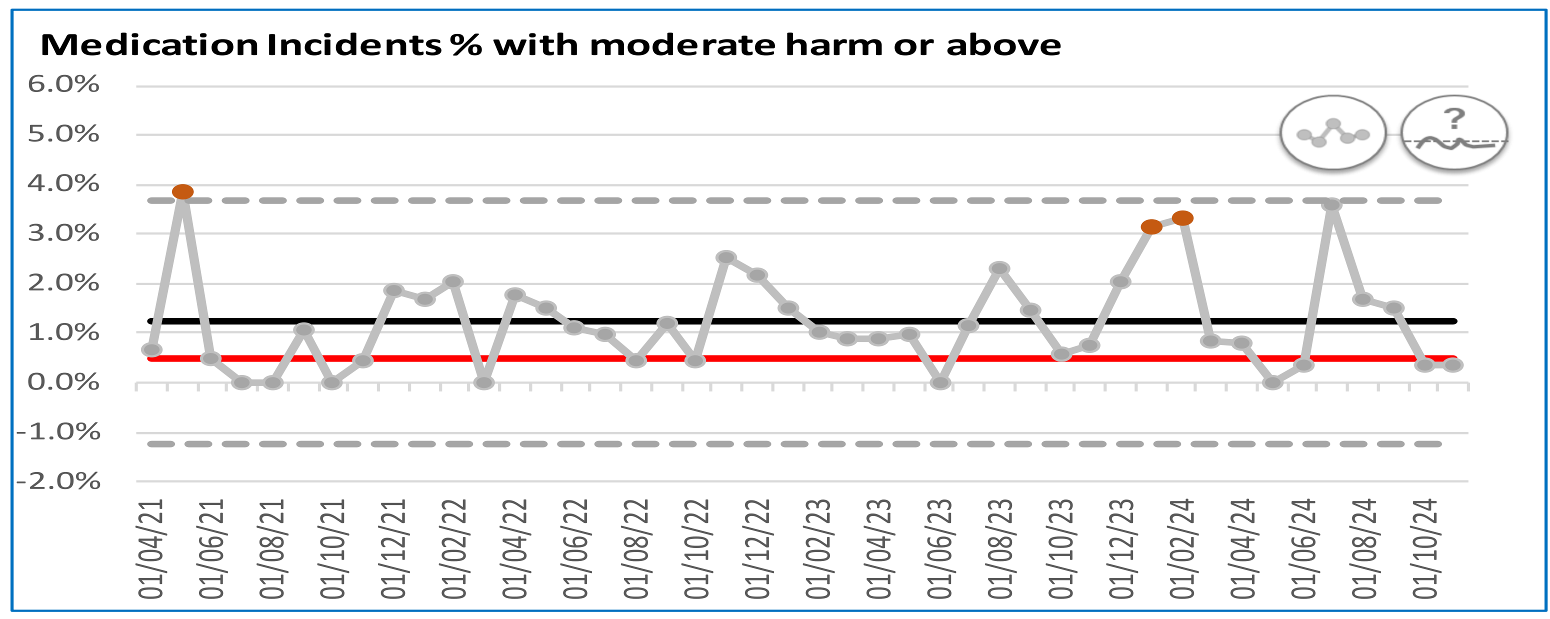
The highest theme from the CEF inspections relating to bronze wards is medicine storage non-compliances.

What are we doing about it?

- CEF self-assessment tool for Medicines Safety has been approved & ward managers / matrons have been encouraged to complete this before the 23/9/24. Tool for wards to self-assess and improve in preparation for audits / CEF / CQC inspections – move from reactive approach. The Medicine Safety Team have completed this as part of collaborative work with bronze review improving together project, expected this will take some time to embed and the next step would be digitalisation if Tendable continues.
- Insulin themed review group has started led by Q & S Team with MDT attendance, data analysis first step. To work with Insulin Safety Group as a number of workstreams in progress.
- Ward CD Audit (Q1 & 2) has been completed – results to be discussed at Meds Opt & Safety next week & shared via nursing / equivalent forums.
- Annual Medicine Storage Audit starts 23/9/24
- Safety Alert for SGLT2 inhibitors to be approved and shared via Meds Opt group.
- Yellow Card Report for Q1 shows sustained improved reporting figures for UHNM. We are the top reporter for the number of yellow cards and the top reporting acute trust. We are second highest reporter for yellow cards per finished consultant episode. Lag time on national data so still awaiting Q2.

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

Provide safe, effective and caring services



What is the data telling us?

1 incident reported in November 2024 with moderate harm

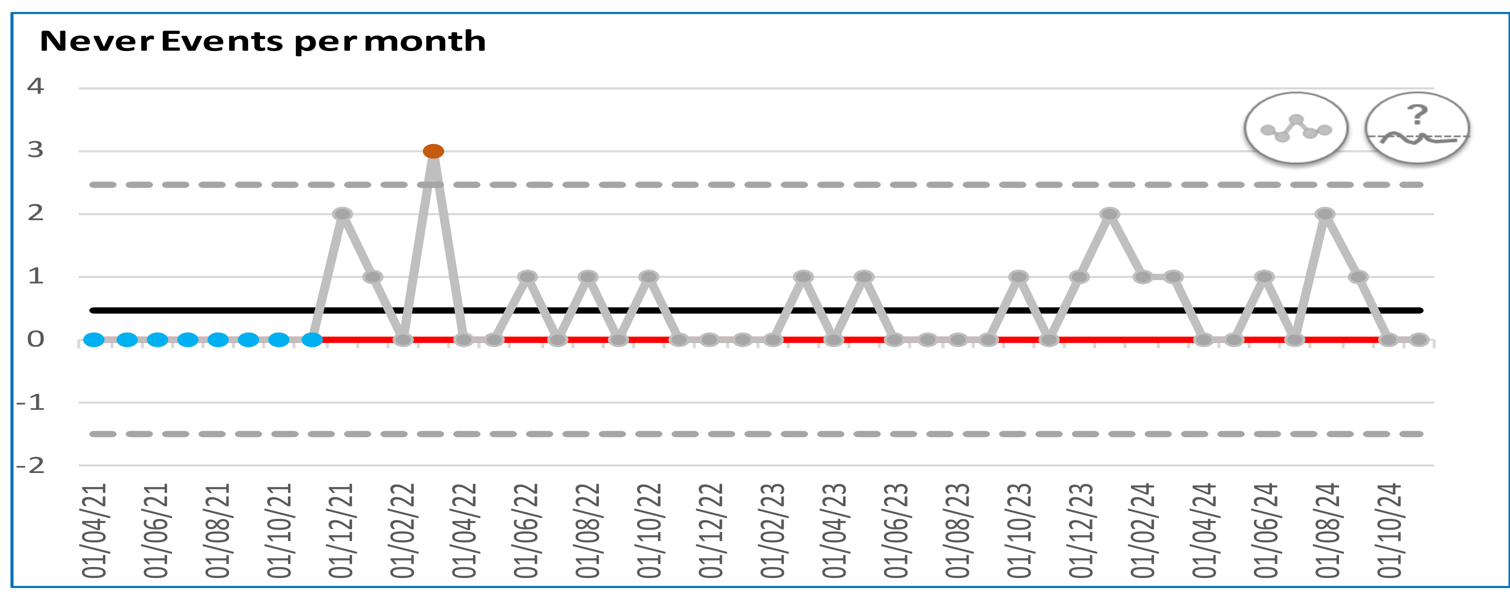
ID	Directorate	Location (exact)	Sub category	Codes	Description	Actual Impact
353591	External	GP	Prescribing	Contraindication due to medical condition	GP did not action TTO and continued to prescribe Omeprazole rather than Famotide	Moderate Harm

What are we doing about it?

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

High Quality | [Never Events per month]

Provide safe, effective and caring services



What is the data telling us?

There has been 0 reported Never Events during November 2024.

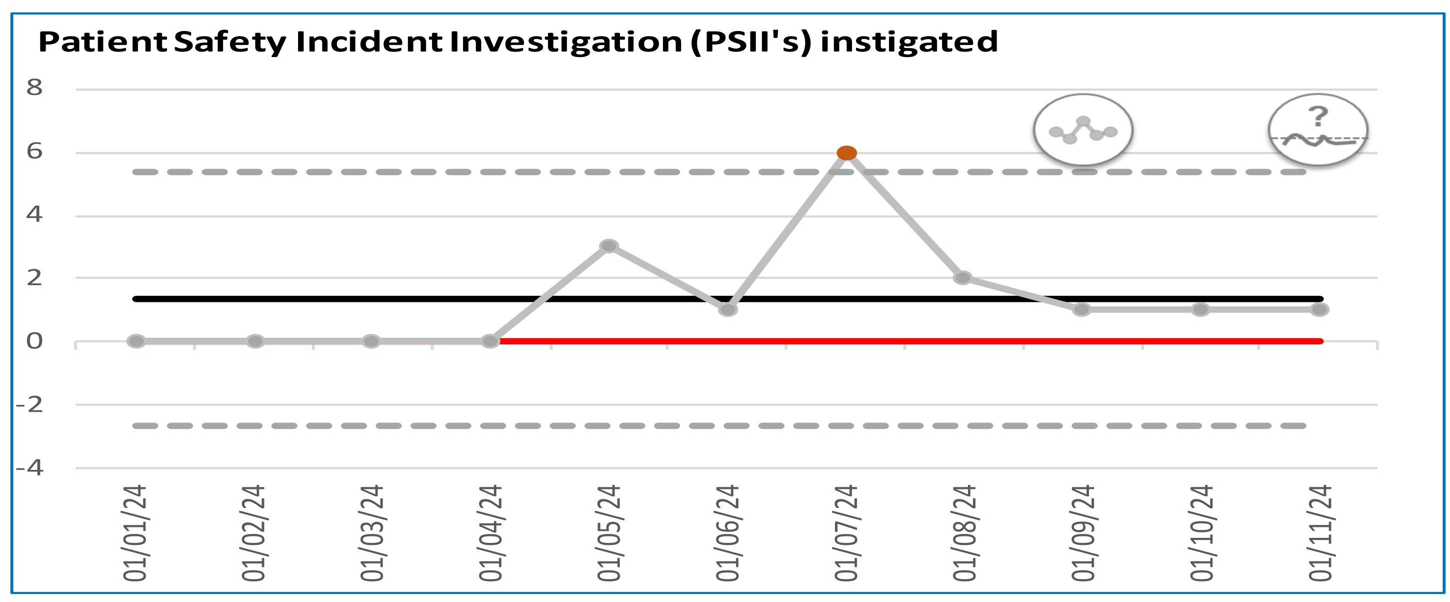
What are we doing about it?

The Never Events reported during 2024 which relate to Wrong site surgery (incorrect lesions removed or biopsy) reviewed within Specialised Surgery services utilising PSIRF Patient Safety Incident Investigation along with thematic review of these new incidents and previously reported wrong site surgery / incorrect lesion removed from previous years. Review identified that in opinion of reviewers the newly agreed and implemented actions would have mitigated against these incidents occurring.

For further assurance the new processes introduced have already resulted in patients having surgery cancelled as the images were not available in new agreed format to confirm the correct lesion/site in Central Treatment Suite.

High Quality | [PSIIs per month]

Provide safe, effective and caring services



What is the data telling us?

We have agreed 1 new PSII being undertaken, and reported on STEIS as agreed with ICB, during October 2024. This PSII is following Maternal Death and referral to MNSI which triggers national PSII response.

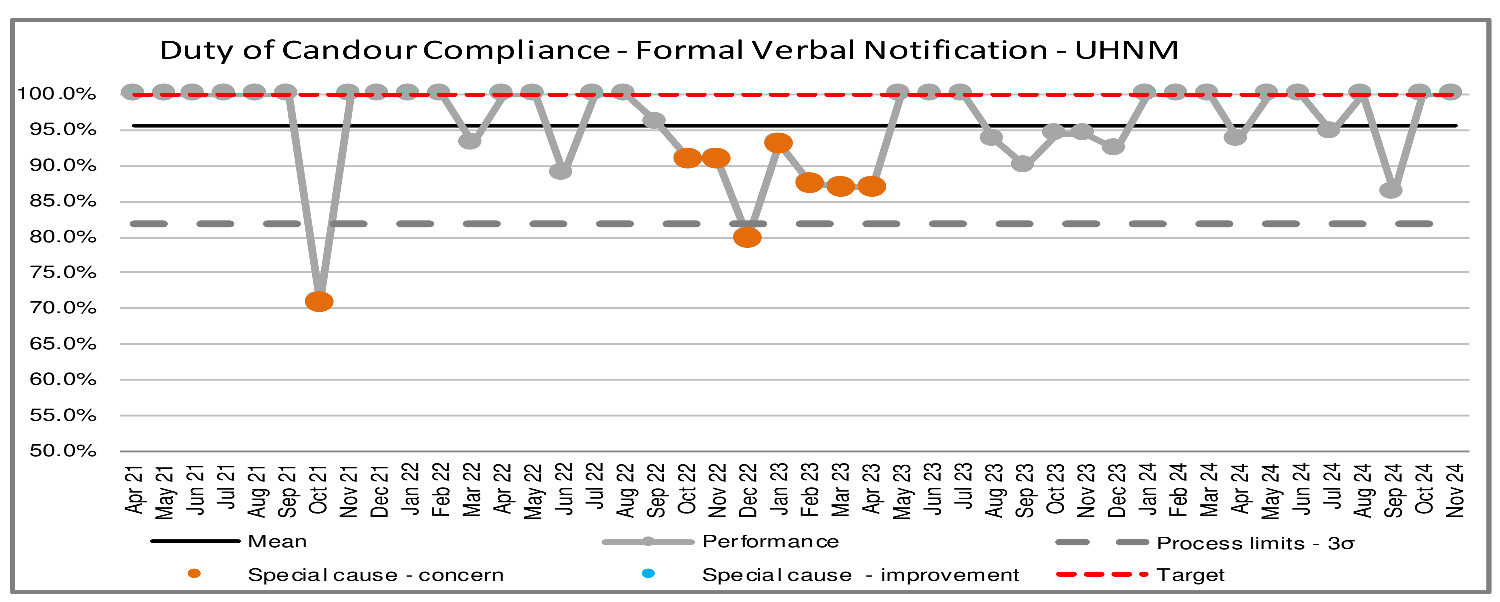
What are we doing about it?

Immediate local review as per MNSI referral.

Patient Safety Huddle undertaken and local After-Action Review to be completed. Family provided with support.

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

Provide safe, effective and caring services



Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
100%	86.2%	100.0%	100.0%

Background

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

What is the data telling us?

The achievement of verbal duty of Candour has been inconsistent with the recording of the completion of this in Datix. During November 2024, there are 0 cases where verbal completion has not been formally recorded on Datix.

What are we doing about it?

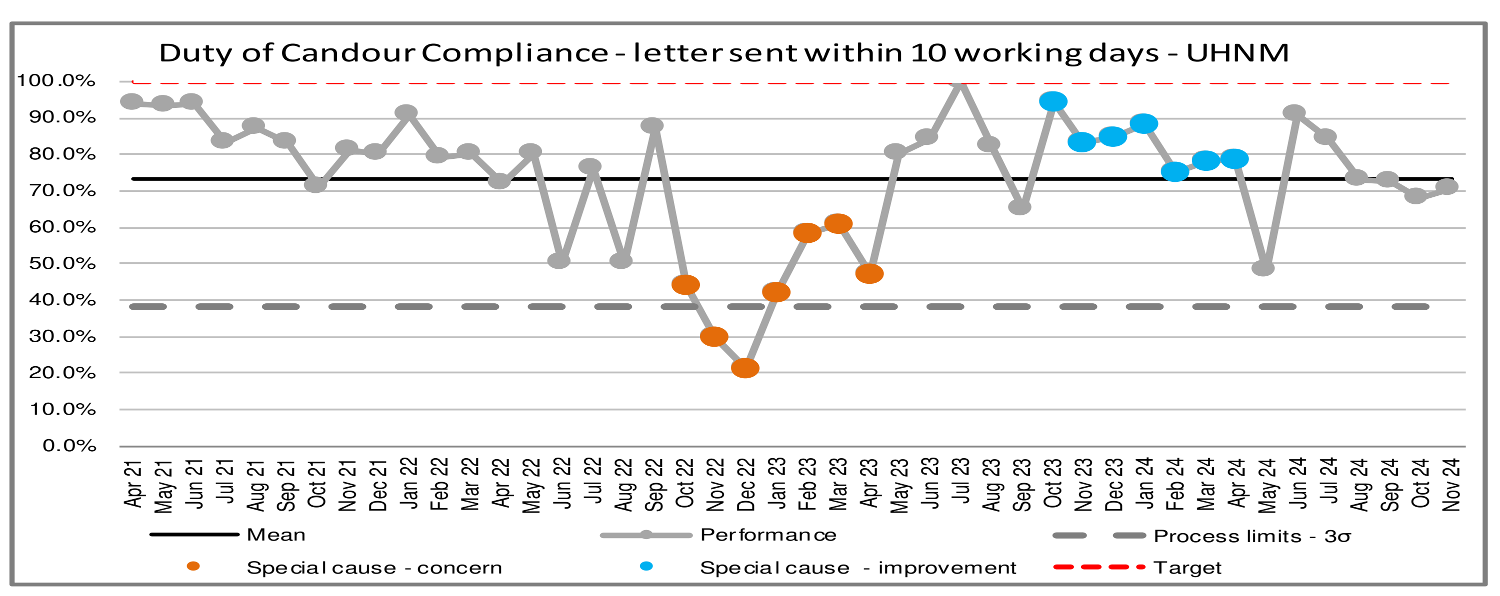
We are continuing to work with individual areas and with Divisional Teams to continue to raise the importance of undertaking Duty of Candour and being open with patients and their relatives when things go wrong.

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

We are monitoring compliance to ensure actions taken continue to be effective in maintaining timely compliance with duty of candour completion.

High Quality | [Duty of Candour – written notification]

Provide safe, effective and caring services



Variation		Assurance	
Target	Sep 24	Oct 24	Nov 24
100%	72.4%	68.0%	70.6%

Background

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

What is the data telling us?

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

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

There were 5 out of 17 cases that were not completed with 10 working day target within Medicine and WCCSS Divisions

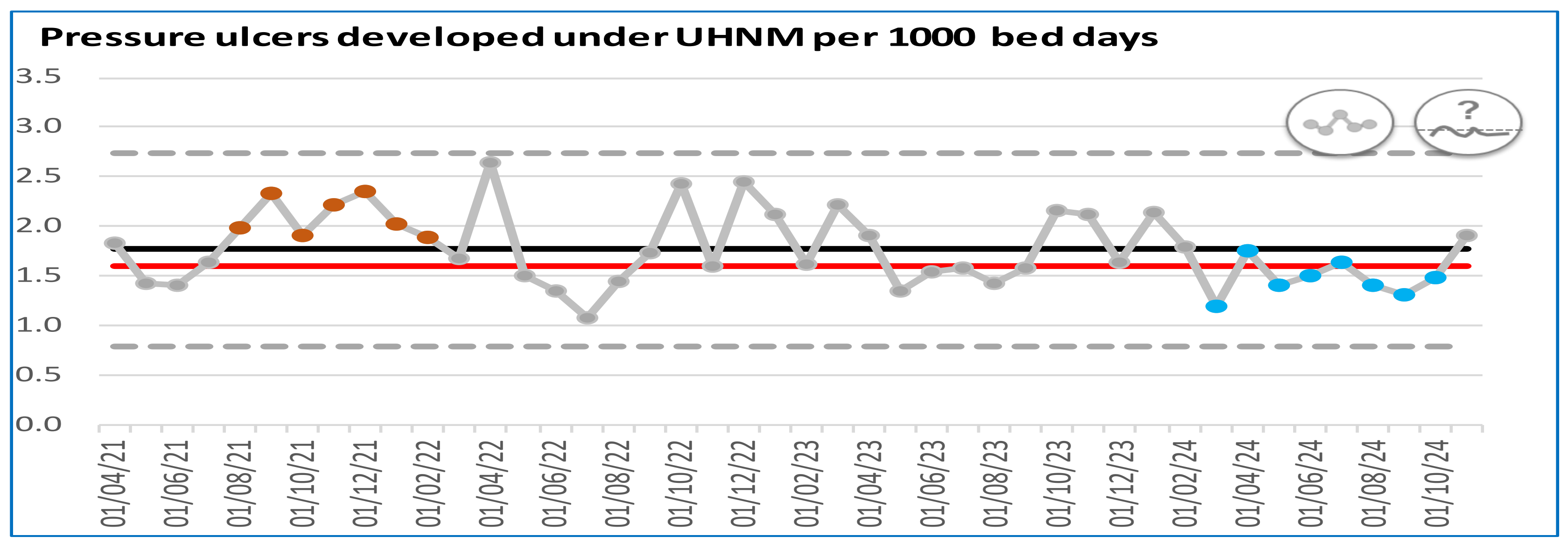
What are we doing about it?

Divisions are reviewing the cases of non compliance and following up with respective areas to work on improving the timely completion and evidencing that letters have been sent out.

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

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

Provide safe, effective and caring services



What is the data telling us?

The rate of pressures ulcers reported as developed under UHNM care was within expected limits in November 2024.

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

As well as pressure ulcers, 4 urethral splits were reported in November 2 with lapses identified. This is below the average for the 9th consecutive month which may indicate significant improvement.

What are we doing about it?

Education available for pressure prevention, continence, wound assessment, and lower limb. ESR package to be completed and presented at steering group at end of August. (delayed due to sickness in the team)

Tissue Viability champions and Skin Care champions to be Launched as part of Stop The Pressure week in November.

The implementation of Purpose T in the new risk assessment booklet is now in circulation. Education has been shared with departments. Drop-in session booked for November to offer further support.

Next Focus Of The Month newsletter to look at surfaces (mattresses / chairs / heel offloading)

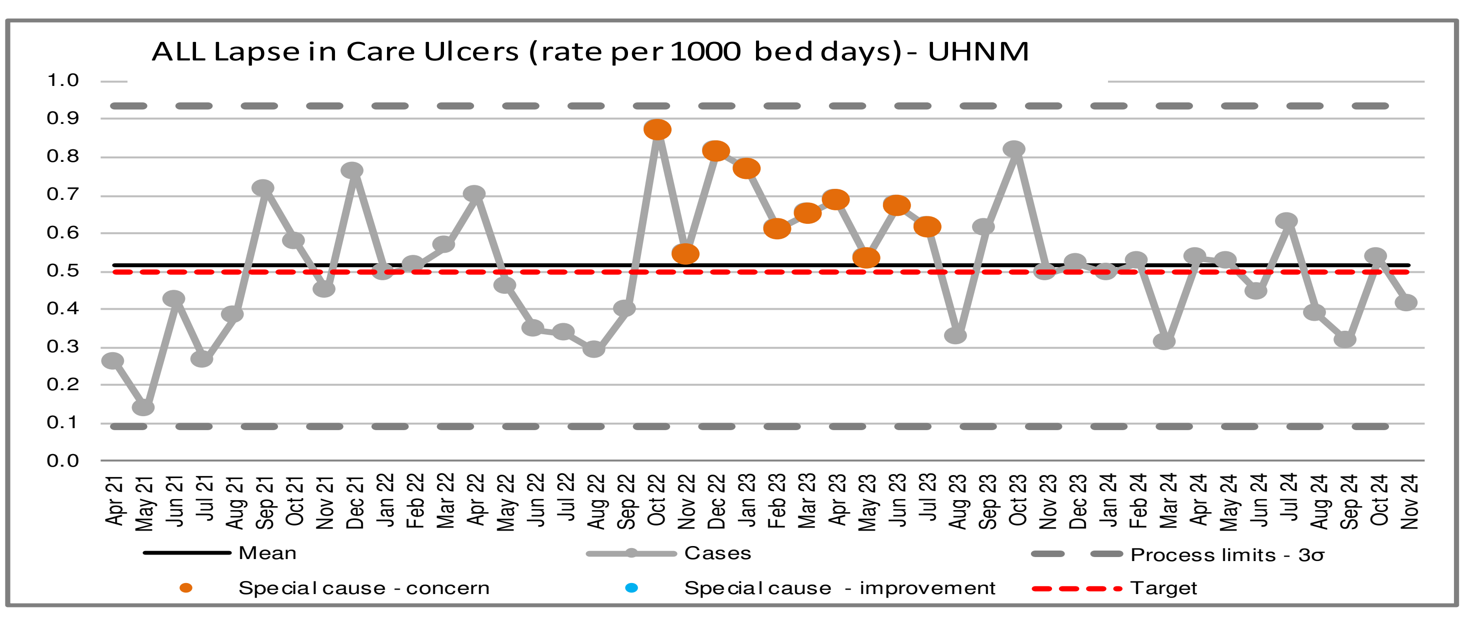
Prompt cards being developed to include QR codes for prevention, categorisation, and appropriate pathways. Looking at funding to get these printed.

Consultant connects to be implemented in AMU on 11/11/24.

Approved furniture list to have contact finalised. Request to charities to support in with purchasing chairs in ED.

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

Provide safe, effective and caring services



Variation	Assurance		
Target	**Sep 24**	**Oct 24**	**Nov 24**
0.5	0.31	0.53	0.41

Background

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

Root Cause(s) of damage - Lapses - Nov 2024	Total
Management of repositioning	13
Management of heel offloading	5
Management of non-concordance	3

What is the data telling us?

The rate of pressure ulcers with lapses in care identified was within expected range in November (based on cases validated as of 3rd of the current month). The most common lapses in care identified are shown in the table above right.

Wards with more than case with a one lapse in care identified to date for November are: Stoke ED (7)

The average percentage of pressure ulcers reported as developing under UHNM care where lapses in care are identified has been around 31% on average (based on data since Apr-22).

What are we doing about it?

PSIRF toolkit and action plan completed to gain assurances of improvements.

Tendable audit updated with increased sample size to reflect the new risk assessment booklet. Expert audits to be completed to support assurances.

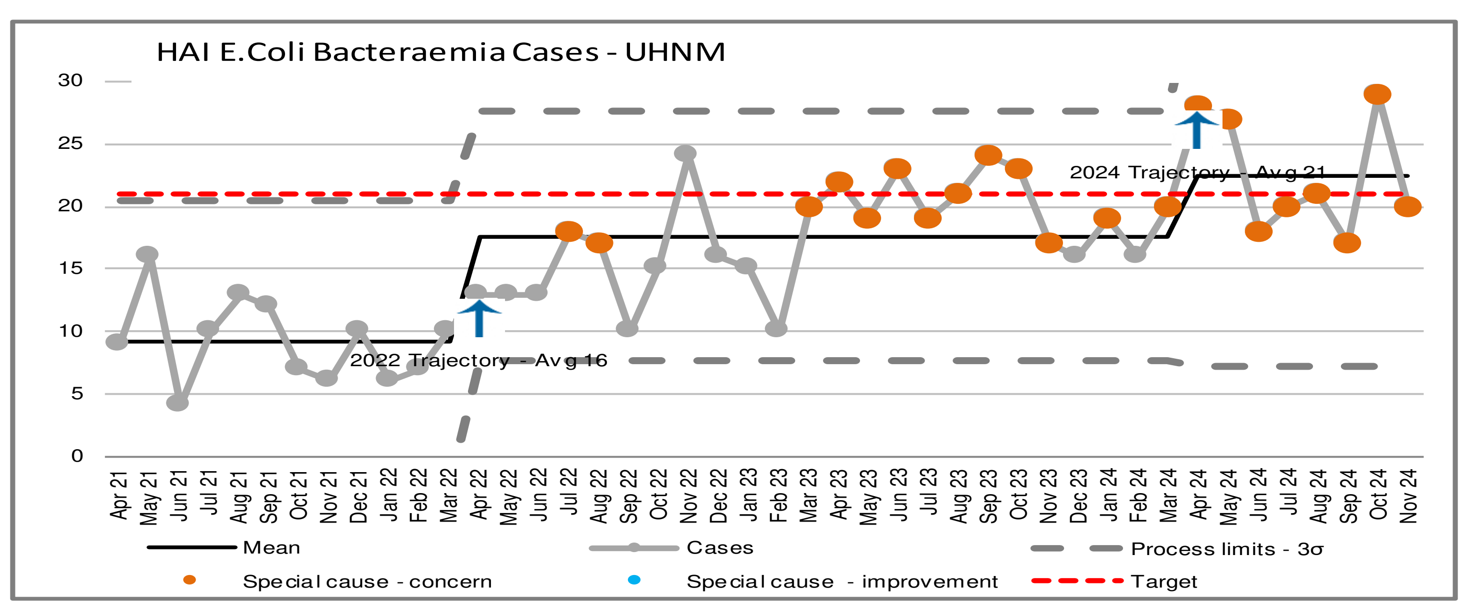
Multiple reporting areas are invited to an assurance panel to present learning and assurances from incidents.

Weekly visits from Quality and safety team to multiple reporting areas to support improvements.

Harm Free Care educators to visit wards for 2-3 week periods where data suggests increase in harms reported.

High Quality | [HAI E.Coli Bacteraemia cases per month]

Provide safe, effective and caring services



Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
21	17	29	20

Background

Number of HAI E.Coli cases reported by month Re: IPCC E.Coli reduction plan

What is the data telling us?

EThe number of E.coli cases has been significantly higher since March 2023, significantly exceeding the target most months.

The 2024/25 target trajectory has been received from NHSE and the monthly average is maximum of 21 cases per month. As in previous years this includes both Hospital (HAI) and Community onset healthcare associated (COHA).

What are we doing about it?

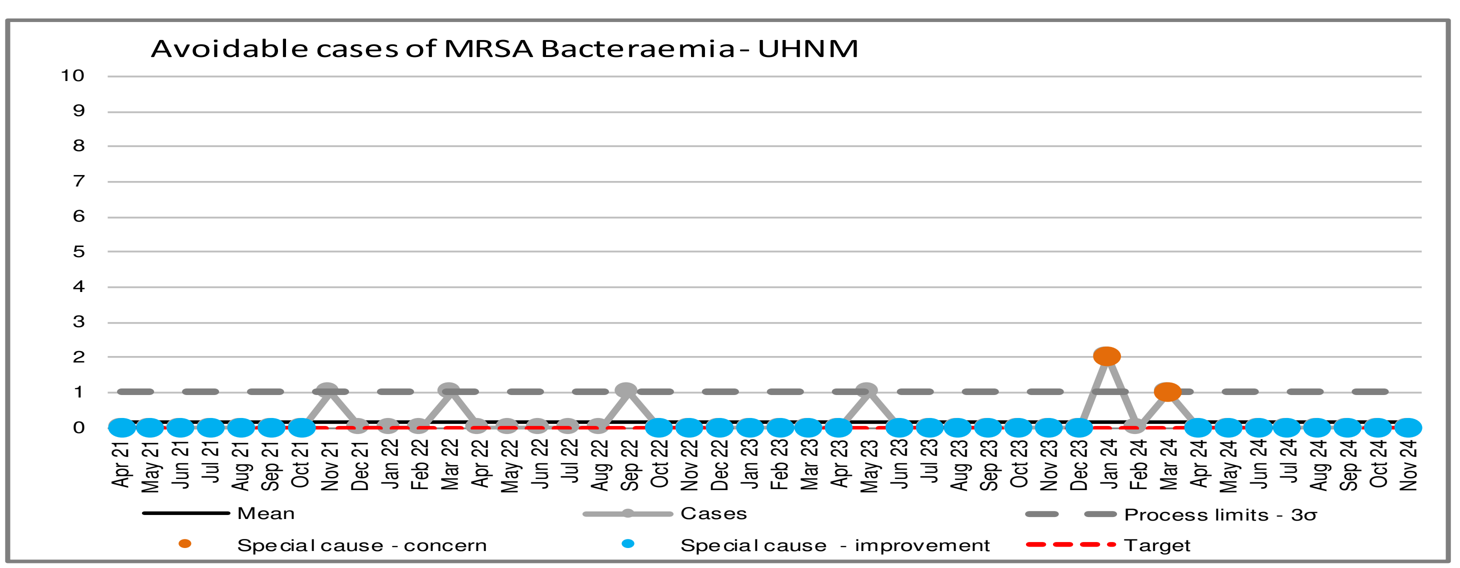
ICB-wide E.coli rates are also high and have been awarded a grant to look into potential reasons for these higher than expected rates. There is now a Health Economy stream for e coli work to identify what our root causes are and if they match national themes.

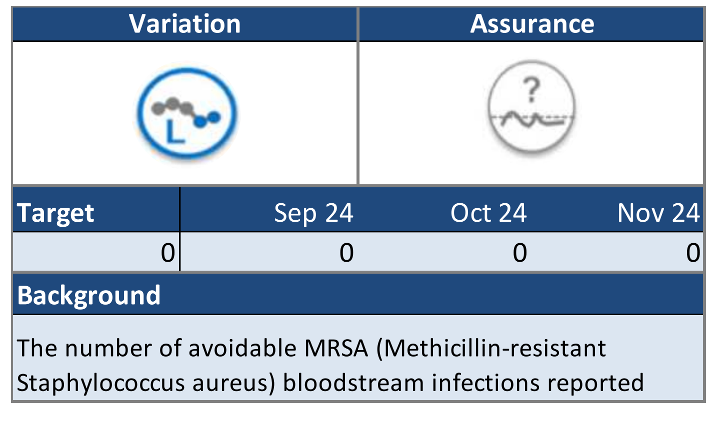
Additionally the ICB have established a T&F group to look at urinary tract infections.

We are also reviewing patient blood results to check for indications of dehydration.

High Quality | [Avoidable MRSA Bacteraemia cases per month]

Provide safe, effective and caring services





Variation		Assurance	
Target	Sep 24	Oct 24	Nov 24
0	0	0	0

Background

The number of avoidable MRSA (Methicillin-resistant Staphylococcus aureus) bloodstream infections reported

What is the data telling us?

Zero avoidable cases during September 2024

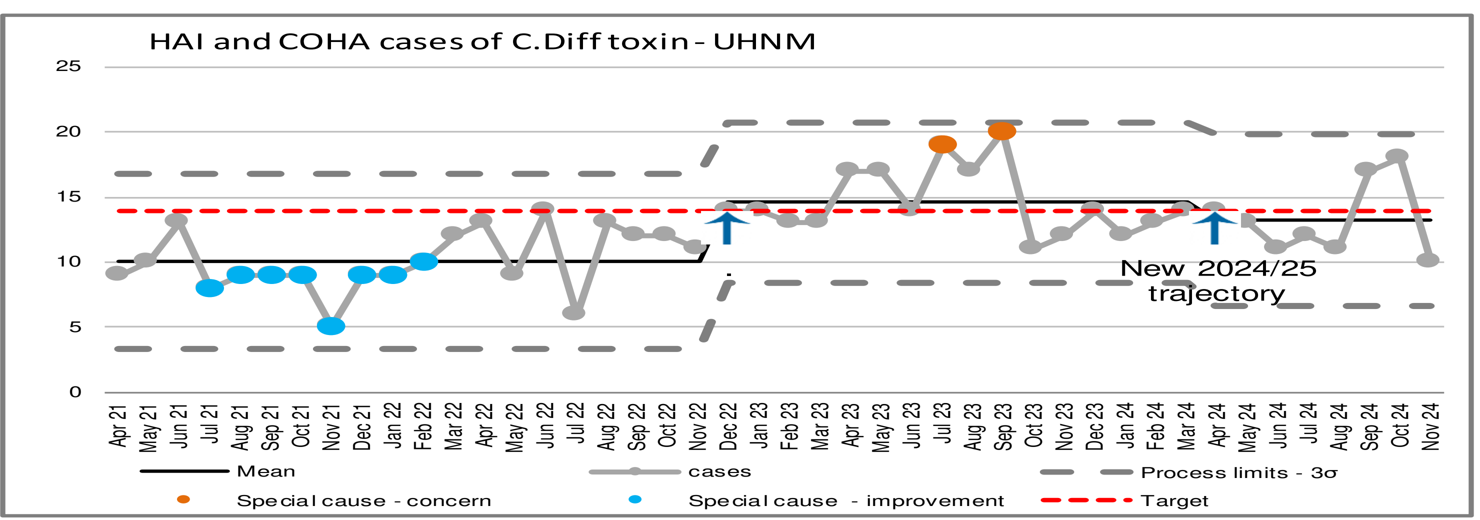
What are we doing about it?

MRSA screening education continues.

Continued surveillance for MRSA with immediate implementation of control measures to prevent transmission

High Quality | [Reported C Diff cases per month]

Provide safe, effective and caring services



Variation		Assurance	
Target	Sep 24	Oct 24	Nov 24
14	17	18	10
Background			
Number of HAI + COHA cases reported by month			

What is the data telling us?

There have been 10 reported C diff cases in November 2024. 7 x HAI and 3 x COHA

The new thresholds from NHSE/UKHSA for 24/25 have now been received and the 24/25 objective for C-Diff is 179 cases or less. the AMR Core Contract metrics have been provided for Q1 24/25.
We are one of only 17% of Trust regionally (22% nationally) achieving a reduction in line with the target reduction in Watch and Reserve Antimicrobials

Two clinical areas have reported a period of increased incidence triggered during November
- 76A 2 X HAI – different ribotypes
- 122 2x HAI - different ribotypes

What are we doing about it?

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- Task and Finish Group for West Building is in place
- CURB -95 score added to CAP antimicrobial Microguide .
- Antimicrobial working group to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- Additional oversight of C-Diff cases is being implemented where there is potential learning in terms of antibiotic use
- Big bed clean completed in June
- PSIRF process and monthly themes report
- Weekly AMS presence at County to support antimicrobial prescribing
- Continuing to develop a penicillin history questionnaire for inpatients and Pre Amms

High Quality | [NPSA Alerts received and overdue]

Provide safe, effective and caring services

New Alerts received:

Year	Alert Type	CAS Status	Alert Reference Number	Alert Title	Date Issued	Date Completed	Deadline Date

Overdue Alerts:

Year	Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Date Issued	Deadline Date	Comments	Actions
2023	NHS Patient Safety Alert	Open	Nat/PSA 2023 010 MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.	31/08/23	01/03/24	Delay in progressing bed rail assessment in maternity and child health. A risk has been added to the risk register to cover the gap identified in bed rail safety training. This will remain in place for the next 12 months as the transition from a standalone package to a package linked with manual handling training happens. To note - wider funding/capital bids planned for the future investment of appropriate beds/trolleys and the trial of a tracking system to ensure robust maintenance and servicing.	Escalated to QSOG and to receive updates on progress
2024	Nat/PSA	**Open**	Nat/PSA 2024 004 MHRA	Reducing risks for transfusion-associated circulatory overload	04/04/24	04/10/24	Dr Graham and Louise Rogers reviewing with the Hospital Transfusion Committee. Dr Zia Din – exec lead Discussed at PSG on 18.11.2024 and noted new TACO Prescription Chart. Awaiting confirmation of actions by HTT	HTT reviewing and finalising action plan update. Noted as partially compliant

What is the data telling us?

UHNM have received 0 new alerts during November 2024. We currently have 4 other CAS alerts open, 2 of which remains overdue. The overdue alerts has been fully actioned and progress is continuing to ensure that the requirements of the alert are being implemented.

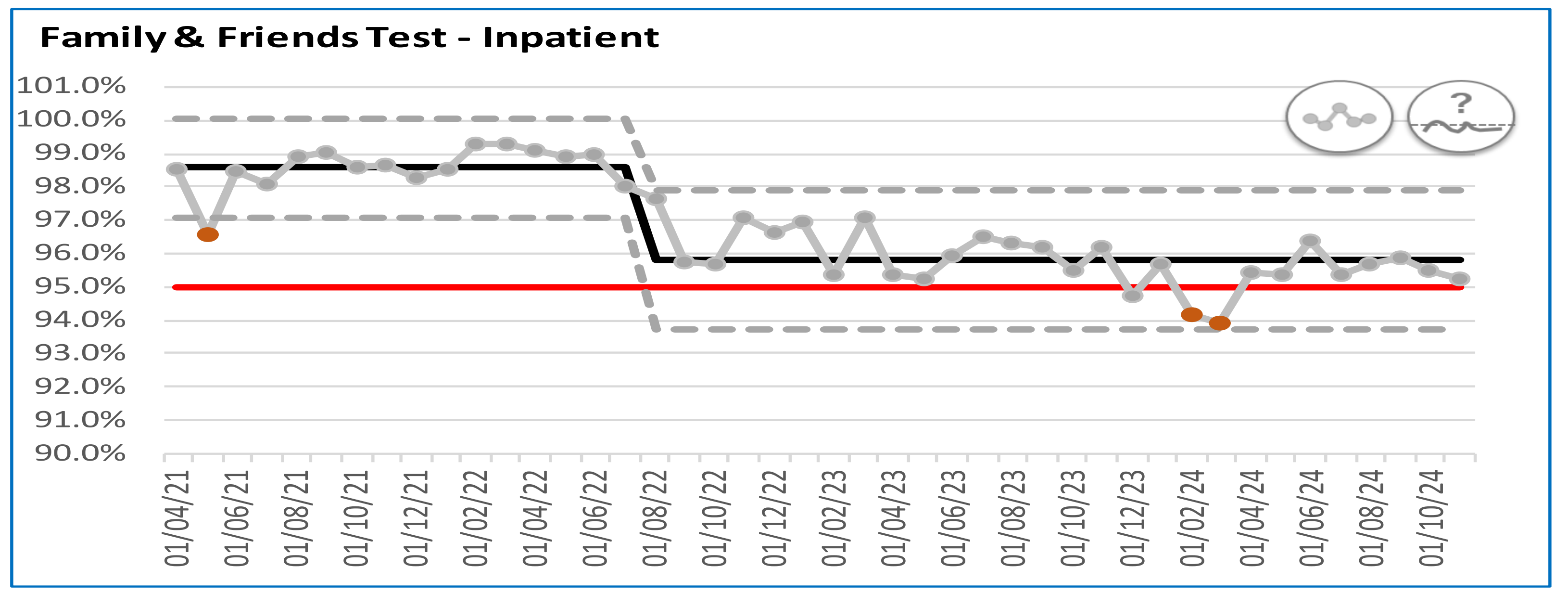
What are we doing about it?

The alerts are all allocated operational/subject matter expert leads and Executive leads as per alert requirements. Relevant specialist forums provide support for leads to agree and monitor actions.
The overdue alerts have agreed action plans in place and assurances have been received that actions are being taken. CAS / MHRA website are updated with progress

High Quality

High Quality | [Friends & Family Test - Inpatients]

Provide safe, effective and caring services



What is the data telling us?

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

In November 2024, a total of 2596 responses were collected from 67 inpatient and day case areas equating to a 24% return rate which is close to the 23% average since text messaging was implemented in August 2022. NHS England data has not been updated since April 2024 therefore UHNM remain the 16th highest response rate for all reporting Trusts in the country (152) and are 81st for percentage positive responses (NHS England April 24 latest data).

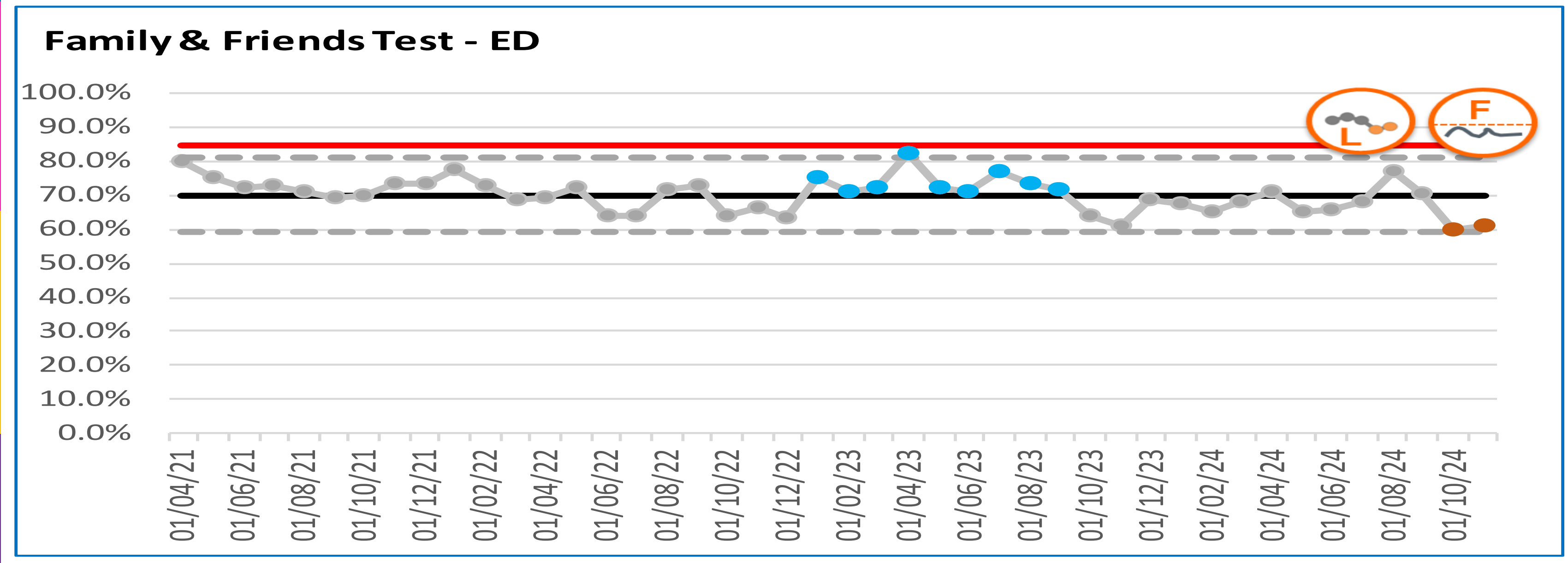
- Scores split by Division for November 2024:
- Network- 28% response rate 96% satisfaction score
- Surgery- 30% response rate 94% satisfaction score
- Medicine- 22% response rate 94% satisfaction score

What are we doing about it?

Continue to focus on Medicine and Surgery to increase response rate.
Work continues around a suite of patient priorities based on patient feedback:
Timely medications- a new task & finish group has been started to include Patient Rep and PSP
Pain management
Involvement in care and decision making
Improving the experience of our oncology patients
CQC National Inpatient Survey 2023 results to be published August 2024 and will provide further focus for improvements

High Quality | [Friends & Family Test - ED]

Provide safe, effective and caring services



What is the data telling us?

The overall satisfaction rate for our EDs was significantly below average in October & November 2024, some way below the target.
The Trust received 697 responses in November 2024 which was 8% and remains the same as the previous few months. The satisfaction rate for November was 61% while the national average is 79% UHNM is 39th out of 124 Trusts for the number of responses in ED (NHS England April 24), and 87th out of 124 Trusts for the percentage positive results (NHS England April 24- latest figures)

Feedback from patient experience of using 111First and the kiosks continues to be monitored with 22% of respondents in August 2024 reported to have used 111First prior to attending ED, which is an increase on the previous few months. Key themes from August 2024 continue to be long waits for both sites. Feeling dismissed was a common theme from County Site, while communication around results and environment (how busy and sometimes intimidating) were key themes at Royal Stoke.

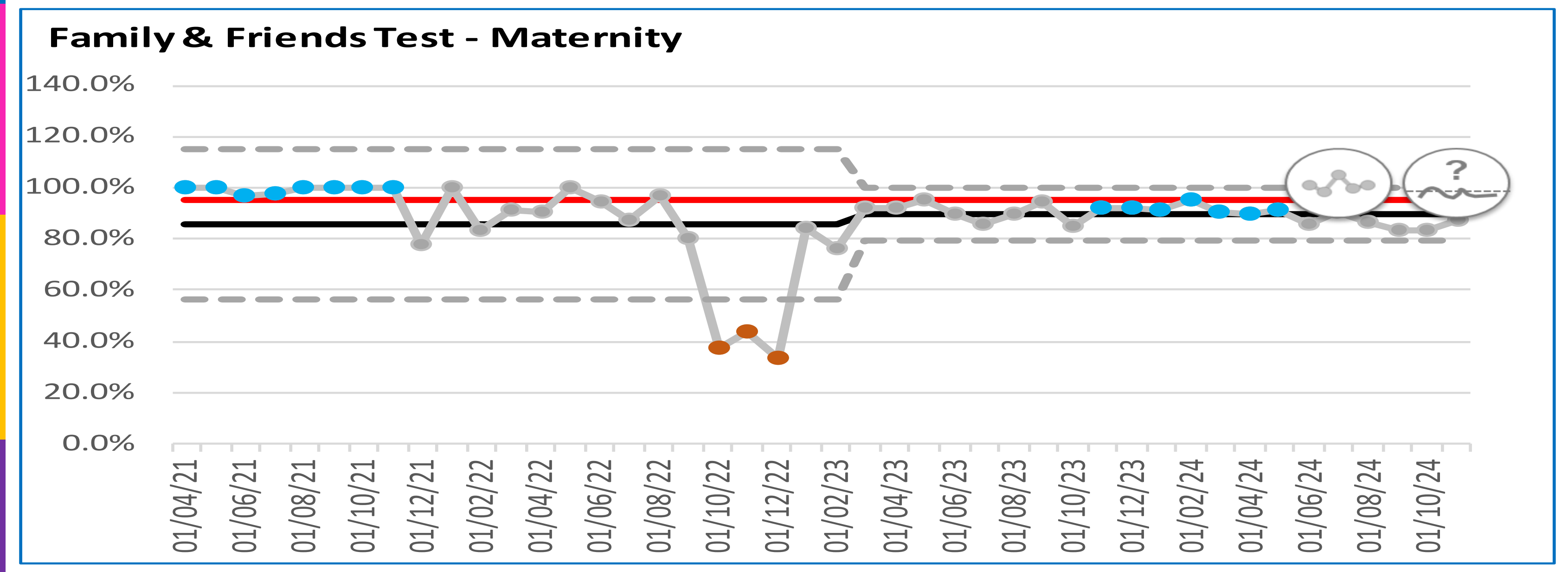
What are we doing about it?

QR code made visible throughout the department.
Consideration to alternative methods of sharing QR code such as “business cards” available on reception and throughout the department.
Discuss with Dept Leads regarding ensuring mobile phone numbers are recorded in the "mobile" phone part of Iportal (not just "contact number") to ensure Netcall can pick up for text.

‘You said we did’ board in waiting room.
Patient Experience is a Driver Metric on both sites

High Quality | [Friends & Family Test - Maternity]

Provide safe, effective and caring services



What is the data telling us?

The average % recommending has been stable at around 90% since 2023, a little below the 95% target.
There were a total of 194 surveys were received in November 2024 across all 4 touch-points (ante-natal, birth, post-natal ward; post-natal community) with 82 of these being collected for the "Birth" touch-point, providing a 17% response rate (based on number of live births- significant increase on previous month) and a 96% satisfaction score.
The Antenatal touch point scored 71% recommendation (51 surveys). The post-natal ward touch point scored 95% satisfaction rate (60 surveys).
Compared to the latest national data available (April 24) out of 112 reporting Trusts, UHNM were 64th for number of responses for antenatal & 79th for percentage positive; 54th for number of responses for birth & 83rd for percentage positive, 50th for post-natal ward & 48th for percentage positive; and 36th for post-natal community & 33rd for percentage positive.

What are we doing about it?

Continue to monitor the efficacy of collecting feedback via text message
Proposal put forward for "business cards" with QR code. Waiting confirmation from Management team.

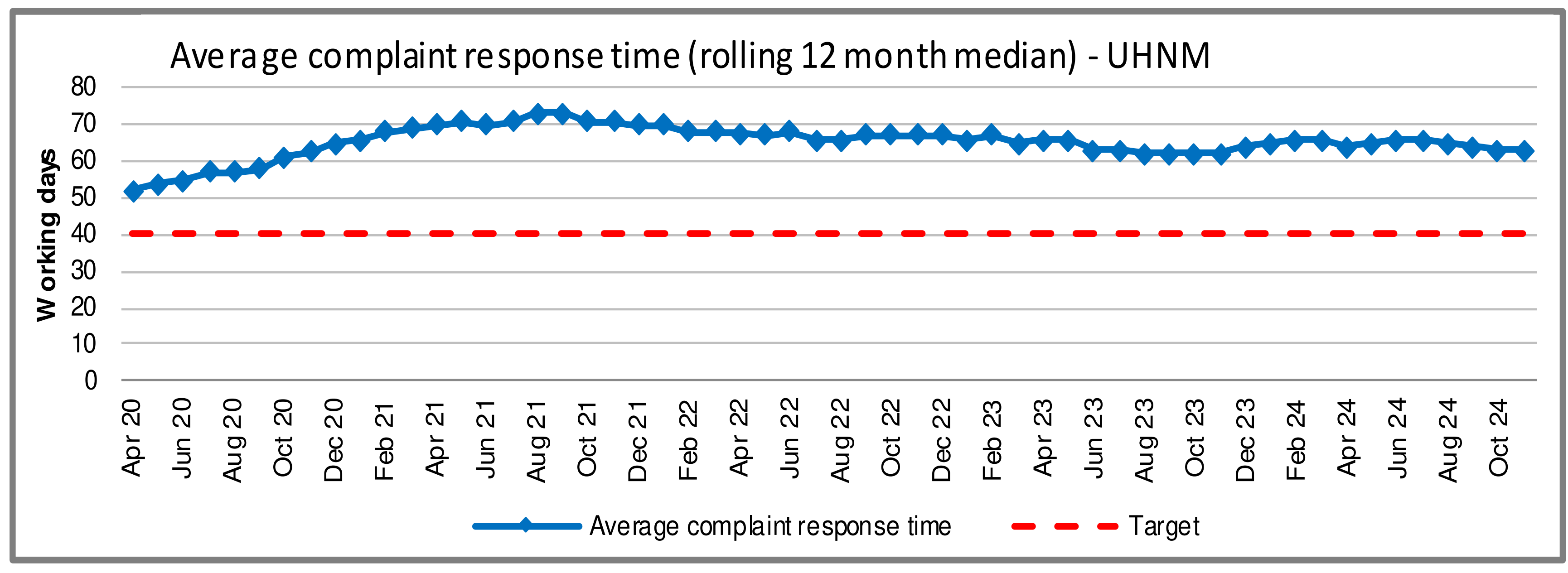
Look at incorporating the questions from the National Maternity Survey which requires the most improvement into the FFT survey.

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

High Quality

High Quality | [Complaints Response Time]

Provide safe, effective and caring services



What is the data telling us?

45 complaints were closed in November 2024, with a median average response time of 68 working days.

The chart shows the average complaint response time peaked in 2021 but remains some way above the 40 working day target.

202 complaints were open at the end of November 2024, of which:

- 1 had been open longer than 12 months
- 18 had been open 6 – 12 months
- 24 had been open 3 – 6 months

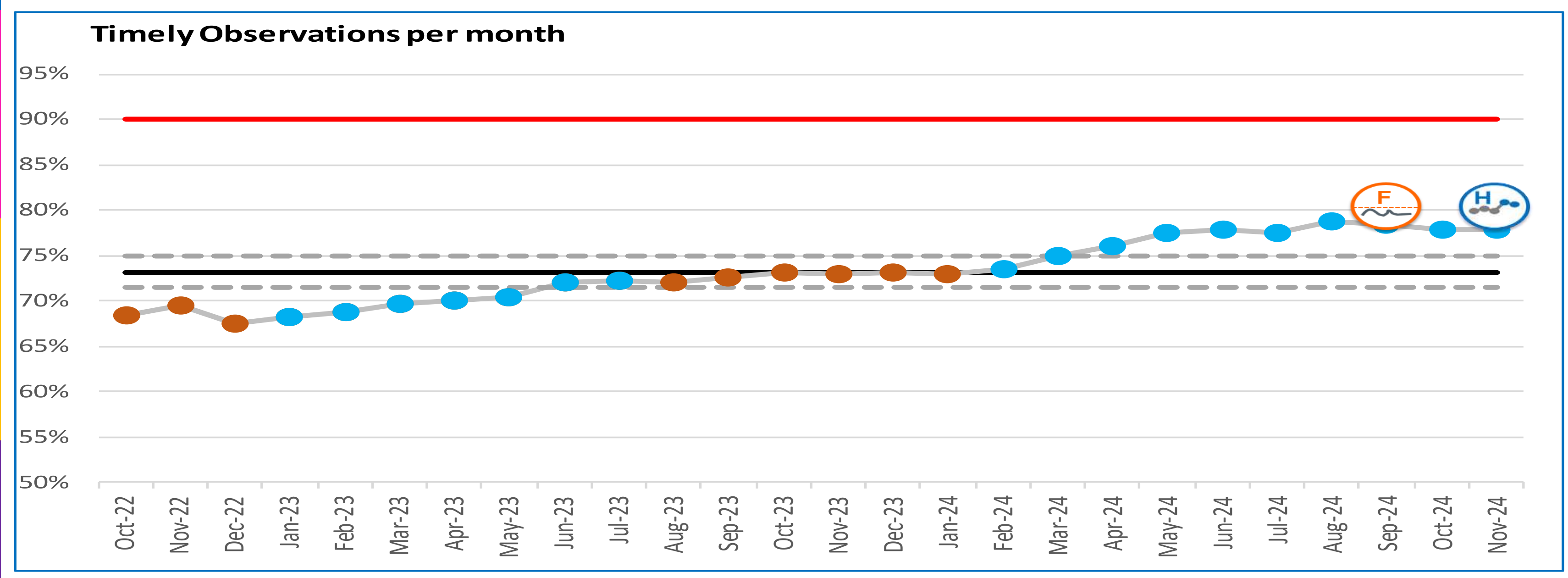
What are we doing about it?

An updated reporting structure has been implemented to more accurately capture at what stage open complaints are within the formal process.

New Complaints Policy drafted to include complaint response times triage.
Formal Escalation process to be included in the new policy and implemented.

High Quality | [Timely Observations]

Provide safe, effective and caring services



What is the data telling us?

The proportion of observations recorded as timely in November 2024 was 77.9%. Compliance appears to have plateaued since August and remains some way below the 90% target.

What are we doing about it?

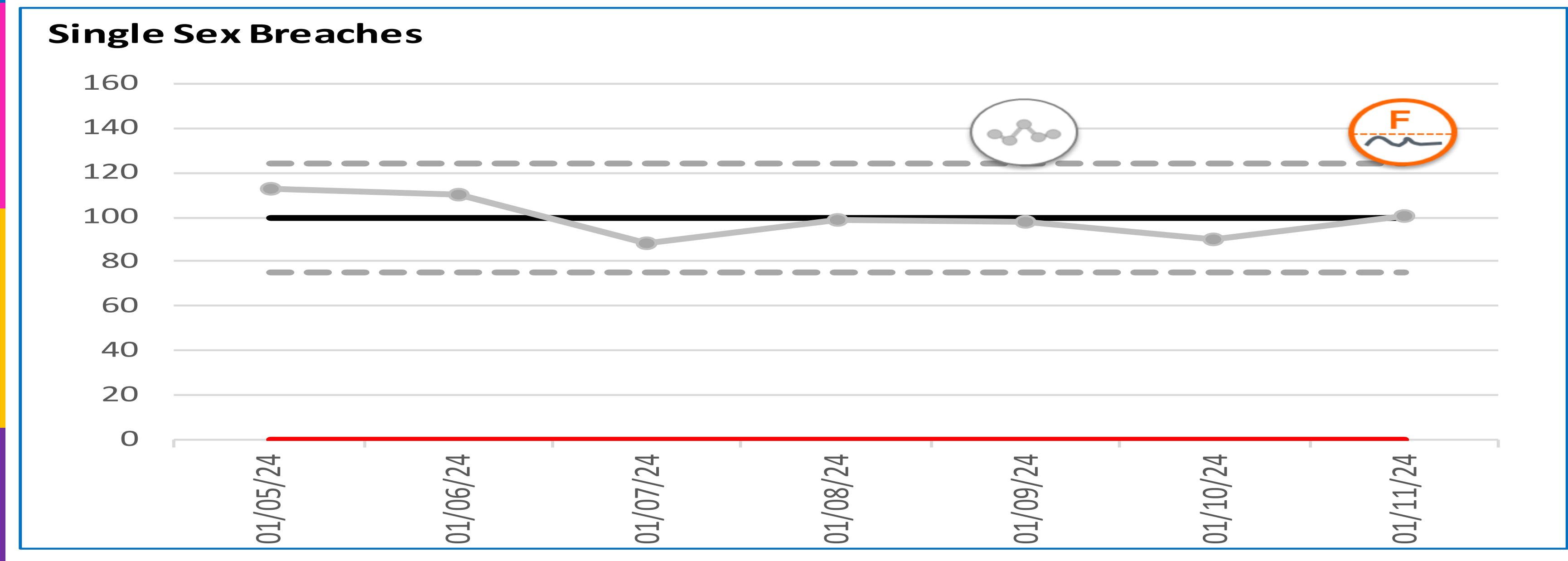
Individual Wards and Departments continue to be reviewed and monitored as part of the monthly Performance Review process and actions are identified to improve compliance.

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

Compliance with timely completion of observations is an essential element within the SAFE domain of the Care Excellence Framework (CEF) award criteria.

High Quality | [Single Sex Breaches]

Provide safe, effective and caring services



What is the data telling us?

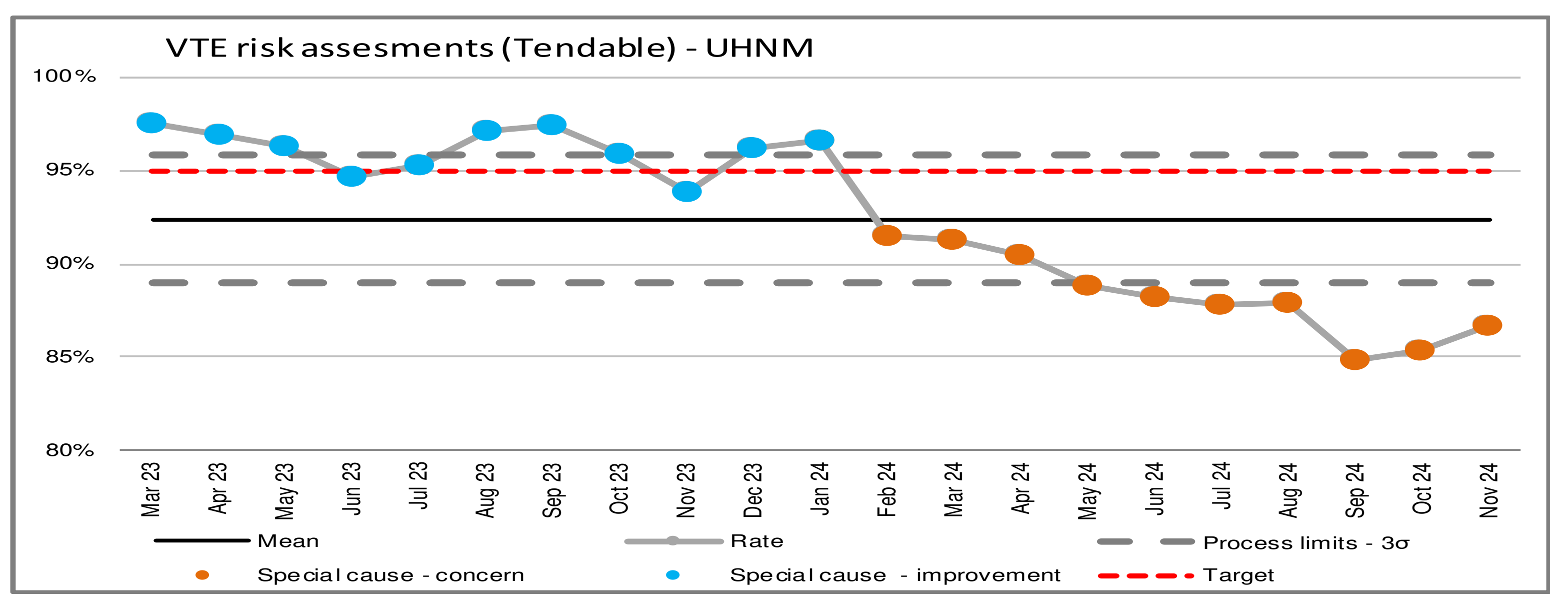
November 2024 is the first month where have SPC trend available with 7 consecutive data points. There has been slight trend reduction from May 2024 but the variation at the initial reporting point is normal variation.

What are we doing about it?

The patients waiting to be transferred from critical care are discussed at the relevant site/operational meetings however there is an assessment of the overall capacity deficit when making decisions to transfer patients to ward beds.

High Quality | [VTE Risk Assessment Completion]

Provide safe, effective and caring services



Variation	Assurance		
Target	**Sep 24**	**Oct 24**	**Nov 24**
95%	84.9%	85.4%	86.7%

Background

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

What is the data telling us?

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

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

Performance attributed predominantly to missing date and time of assessment.

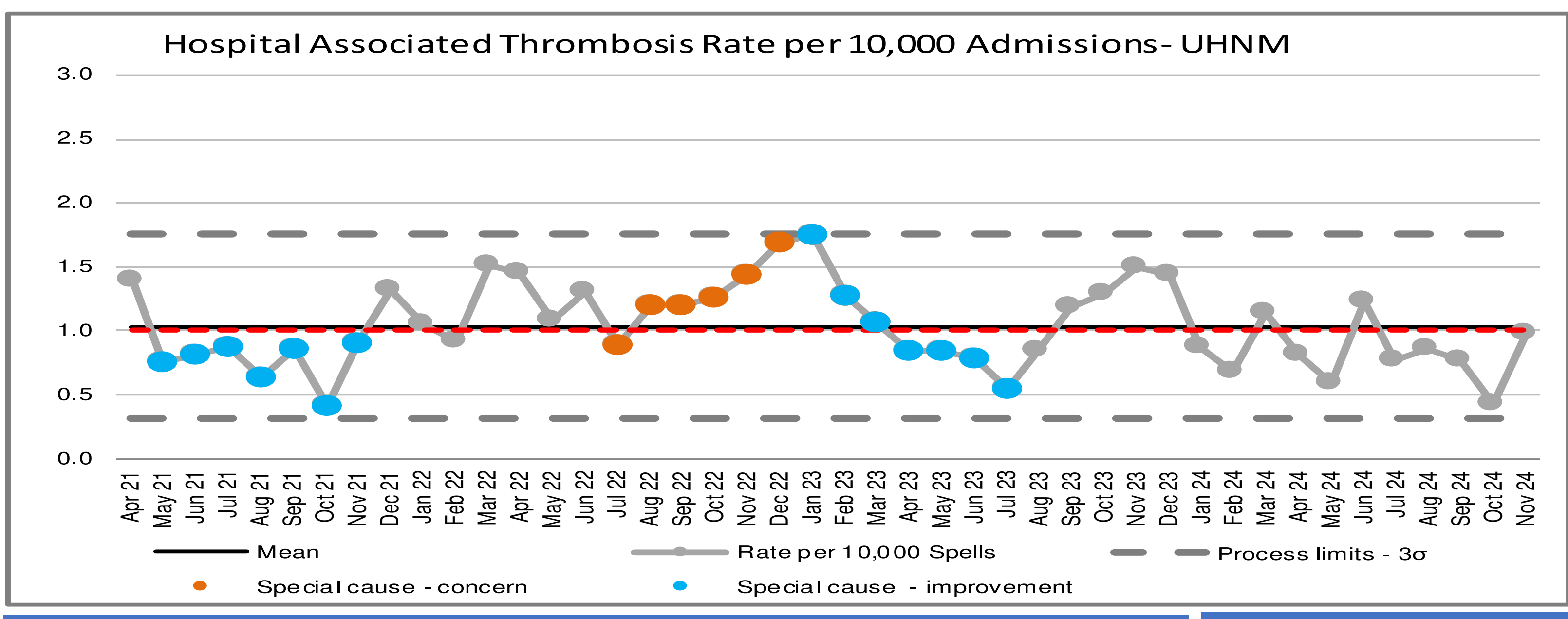
In spite failing the VTE target, we do not have excessive HATs (see next slide)

What are we doing about it?

All Divisions discussed work to improve VTE performance within Performance Review Meetings with Executives
ePMA once introduced will provide accurate assurance of VTE risk assessment completion.
Communications have been sent via all Clinical leads and Ward managers, within the UHNM Bulletin, Current news and the Quality & Safety Newsletter to raise awareness of the importance of recording an accurate a date and time, areas with the lowest compliance are also being visited by SSR Quality & Safety
Q1 data from NHS England has not yet been published; previously no specification had been made from NHS England for 'on admission' which now refers to within 14hours from the Decision to admit. Feedback from National VTE forum is that many organisations are submitted data from 24 hours and not 14 hours as specified by NHS England, which will not be reflected in the submissions.

High Quality | [Hospital Associated Thrombosis rate]

Provide safe, effective and caring services



Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
1	0.77	0.43	0.98

Background

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

What is the data telling us?

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

What are we doing about it?

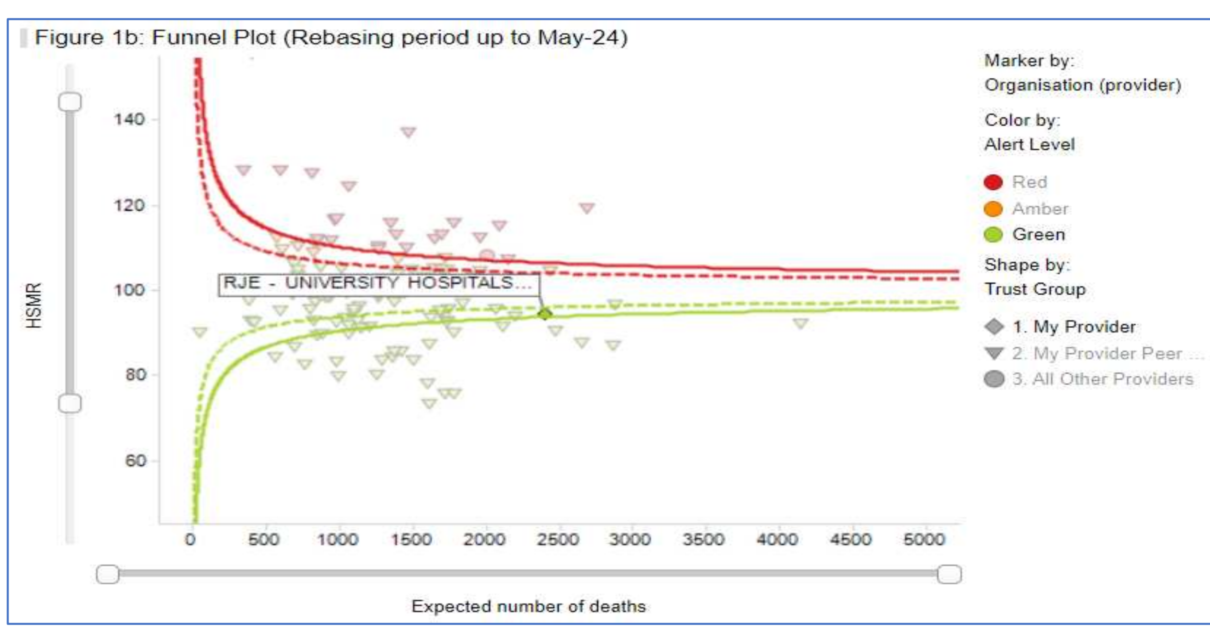
21 cases of Hospital Associated Thrombosis (HAT) were identified November 2024 and investigations are in progress.

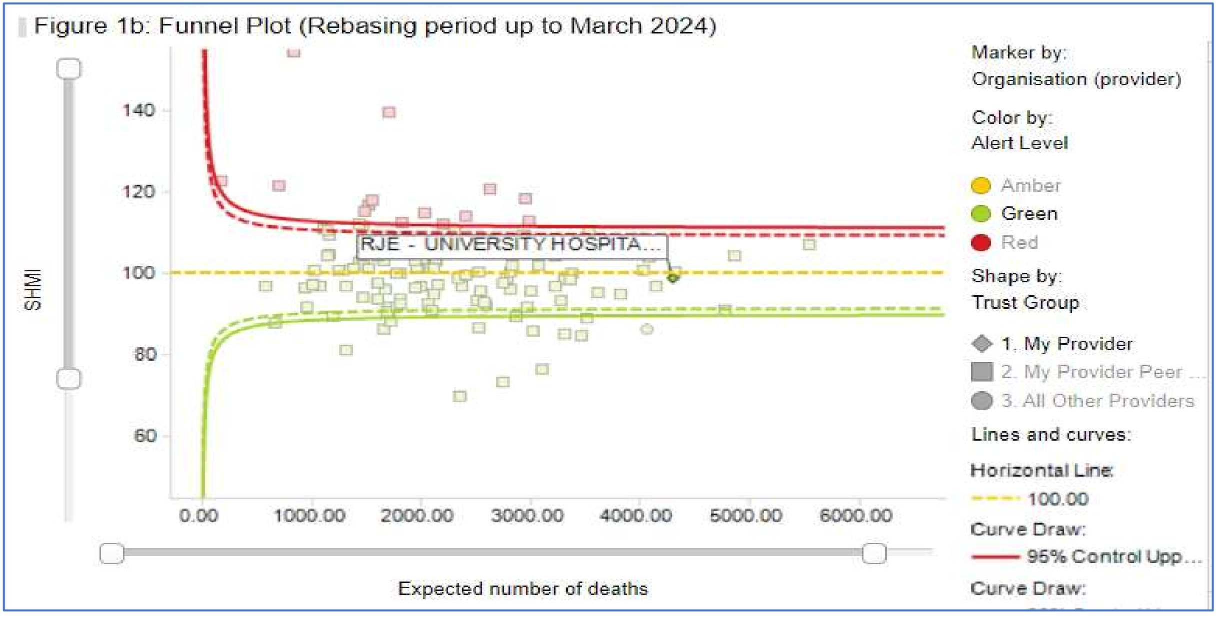
Key Themes identified from HAT Investigations; Missed doses of Prophylactic Dalteparin with no clear rationale recorded and inconsistent daily recording of mechanical thromboprophylaxis.

The VTE Steering Group are reviewing a number of potential QI projects for next year which will aim to reduce harm and raise awareness

High Quality | [HSMR / SHMI]

Provide safe, effective and caring services





What is the data telling us?

UHNM HSMR is significantly better than expected based on case mix and standardisation for current 12-month period (June 2023 – May 2024). The current 12-month HSMR is 94.60.

UHNM SHMI is within expected ranges at 98.80 for current 12-month period (May 2023 – April 2024)

What are we doing about it?

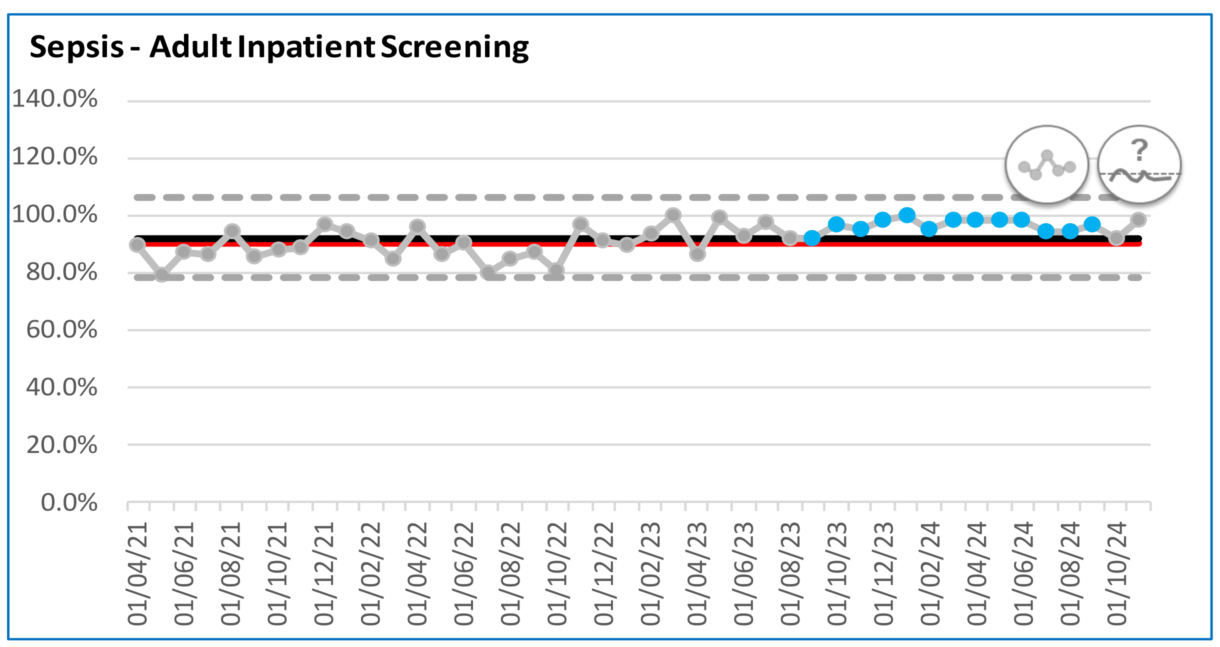
We are continuing to monitor and review any specific diagnosis codes and groups to identify any further potential improvements.

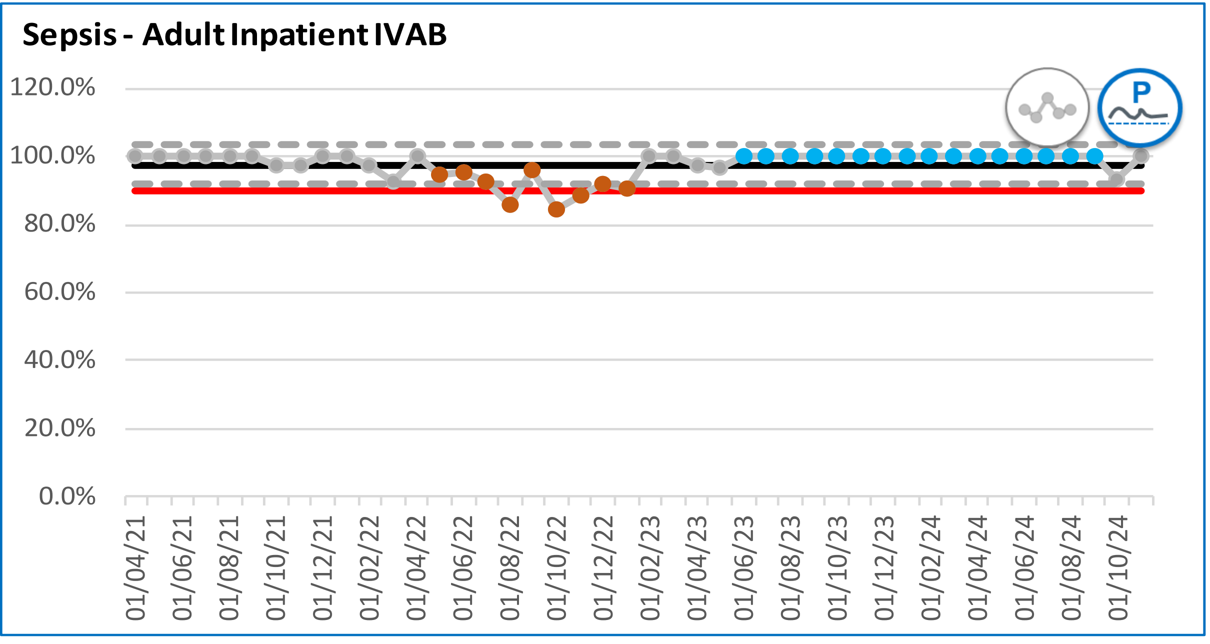
CuSum Alerts for diagnostic groups are reviewed and triangulated with outcomes of completed mortality reviews and mortality indicators.

High Quality

High Quality | [Sepsis – Adult Inpatient]

Provide safe, effective and caring services





What is the data telling us?

Inpatient areas achieved the screening and IVAB within the 1-hour target for October 2024, though 2 patients were found to have not had IVAB within 1 hour for the first time since May 2023.

There were 100 cases audited with 2 missed screening. Out of 100 cases audited 66 were identified as red flag sepsis with 40 having alternative diagnosis. 25 patients were already on IVAB treatment.

All true red flag sepsis patients received IVAB within 1 hour

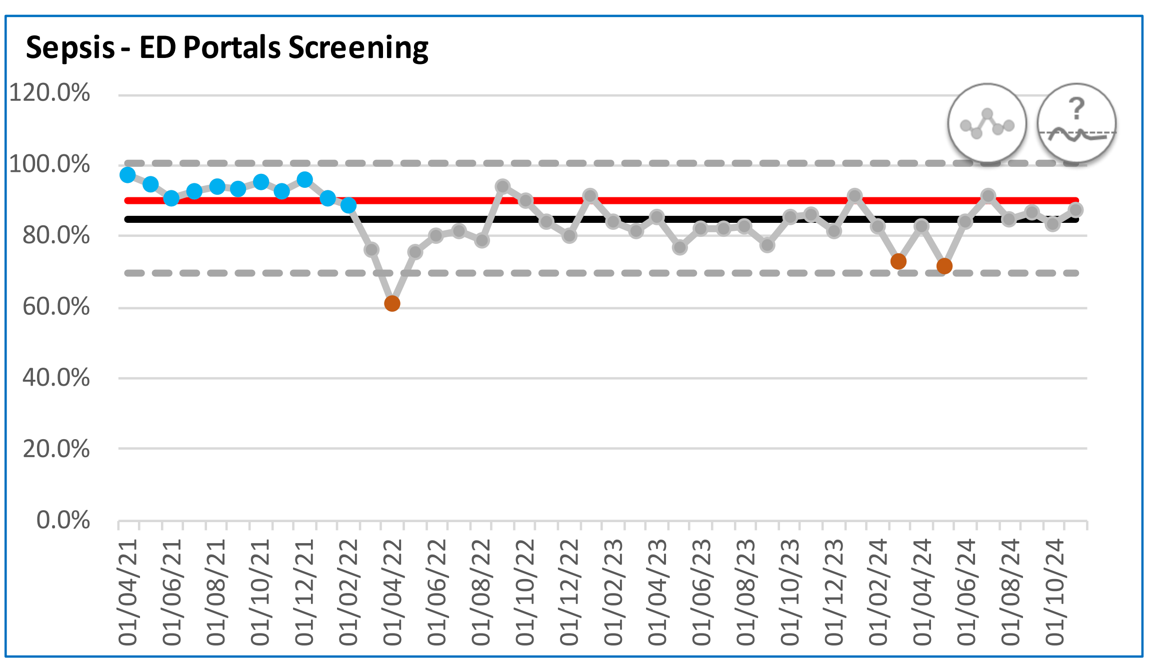
What are we doing about it?

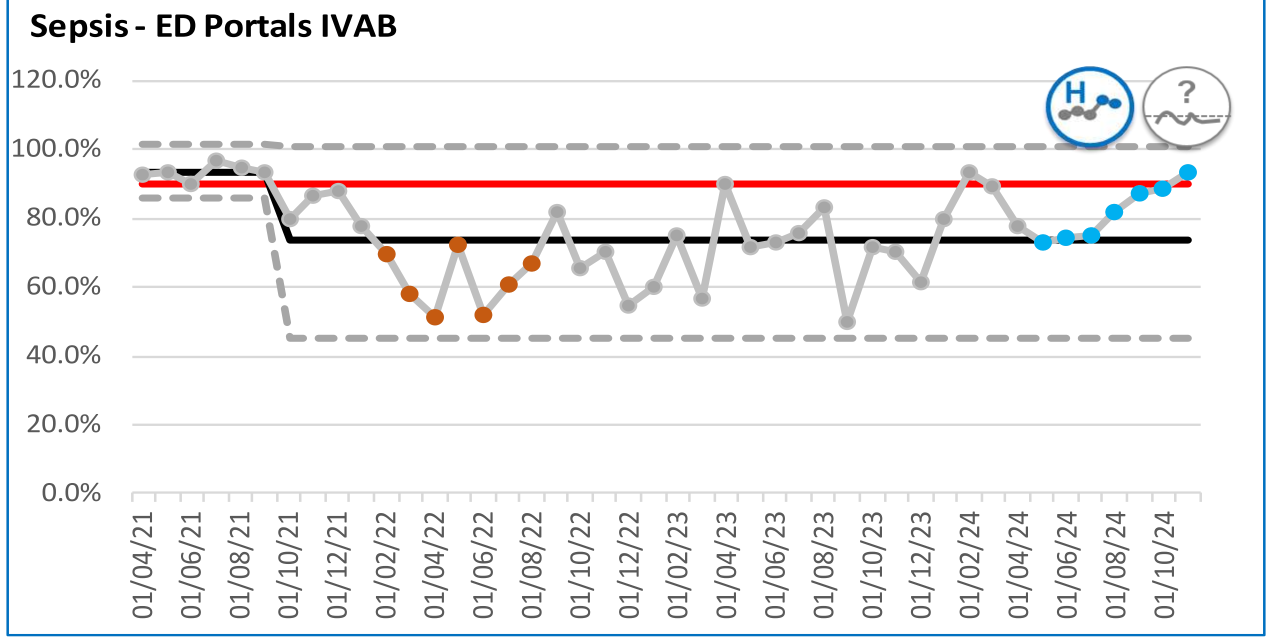
Sepsis sessions / kiosks continue to all levels of staff in the clinical areas that require immediate support.

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

High Quality | [Sepsis – Emergency Portals]

Provide safe, effective and caring services





What is the data telling us?

Adult Emergency portals screening has failed to meet the target most months since February 2022. Contributed to ED at Royal Stoke, FEAU and AMU at both sites. 88 cases were audited in November and 11 had not been screened.

IVAB within 1 Hr has been significantly better since January 2024 and has recorded 7 consecutive months of sustained improvement with November 2024 exceeding the 90% target with 93.5%.

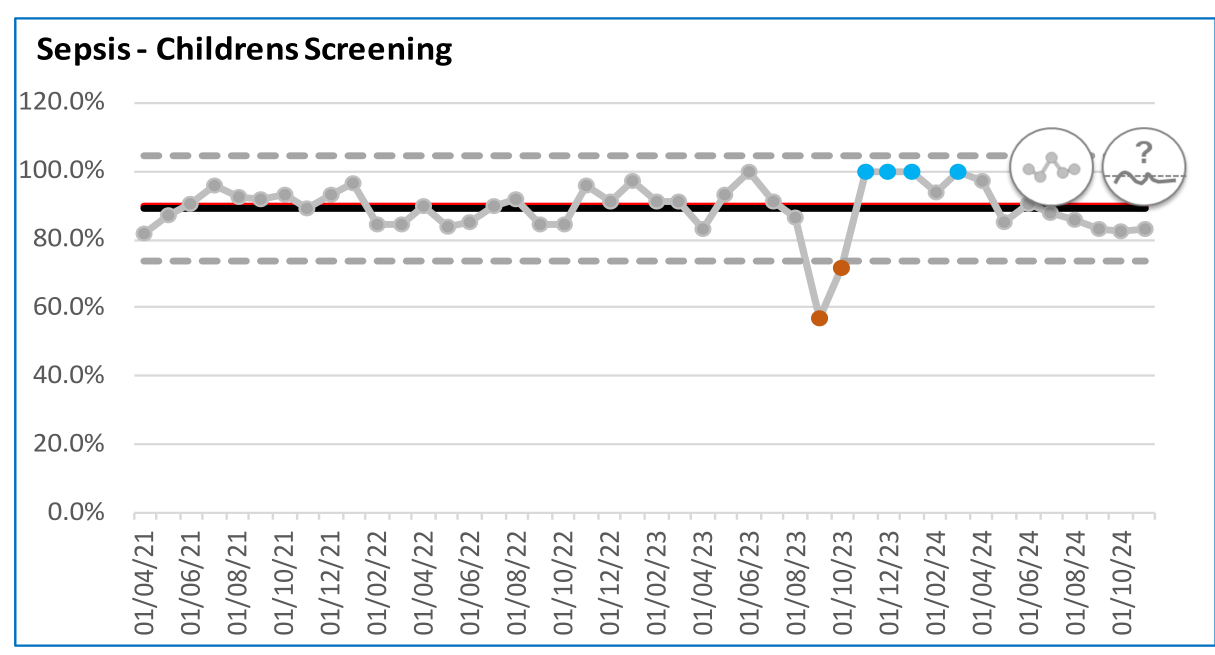
Out of 88 cases there were 67 red flag sepsis in which 22 patients were already on IVAB. 36 patients had an alternative diagnosis leaving 9 newly identified sepsis 2 patients received IVAB outside the target 1 hour window however both received IVAB within 2 hours.

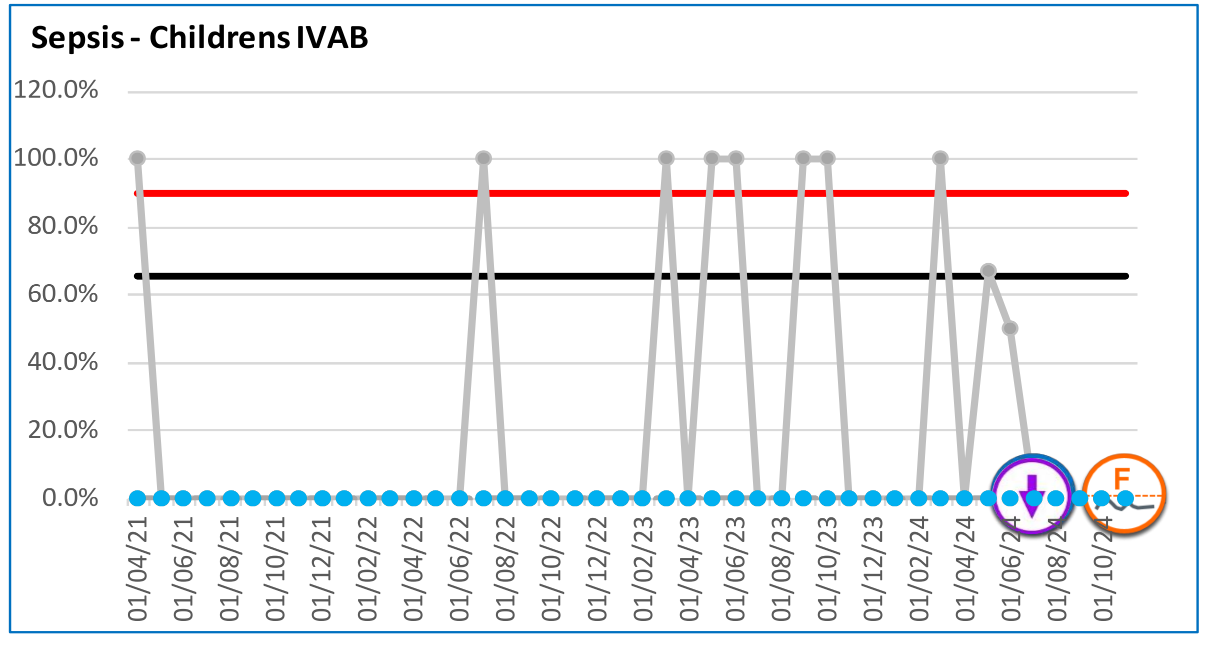
What are we doing about it?

- The sepsis team continue by closely monitor compliance by visiting and auditing ED regularly.
- Regular meetings with ED senior team with robust actions in place.
- Face to face sepsis induction / training for new nursing staff, nursing assistant and medical staff continue.
- Introduced Deteriorating Patient Vocera devices and assigned clinician role (Tier 3) in resus to review patients and make timely decisions re: sepsis or other significant condition. Reviewing usage following introduction and outcomes are awaited.

High Quality | [Sepsis – Children]

Provide safe, effective and caring services





What is the data telling us?

We are still seeing a small number of children trigger with PEWS >5 and above inpatient areas. Most inpatient paediatrics are already on oral or IV antibiotics prior to trigger of PEWS >5

There were 27 cases audited for emergency portals with 1 missed screening.
No true red flag sepsis was identified from the randomised audits in the emergency portals or inpatients.

What are we doing about it?

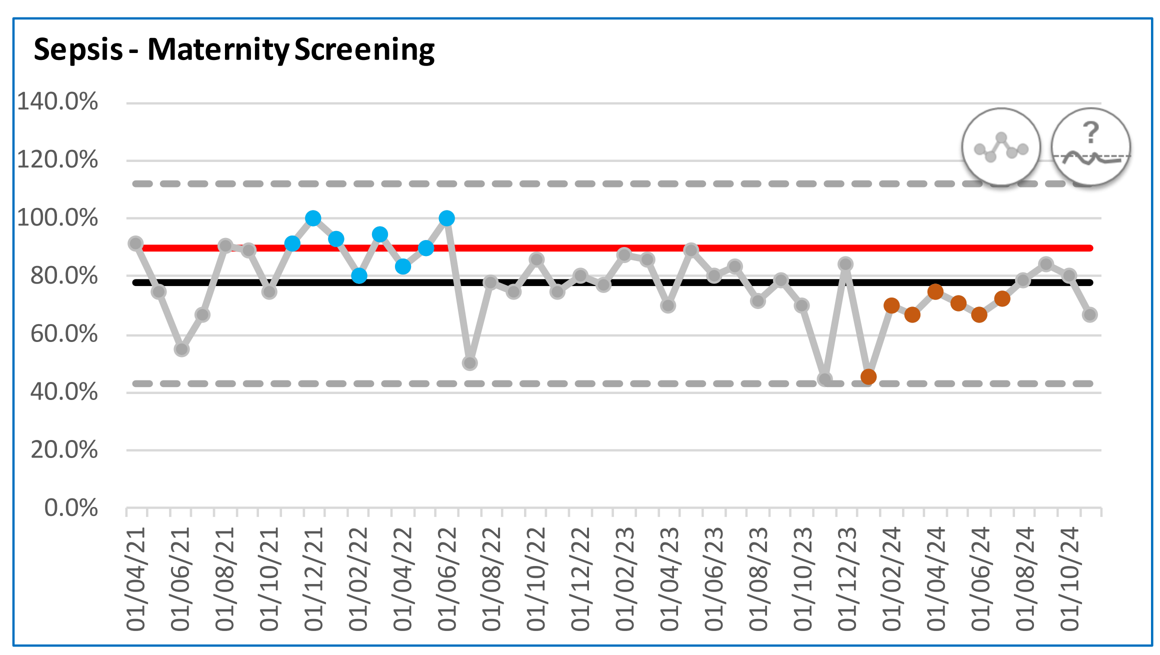
The sepsis team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective.

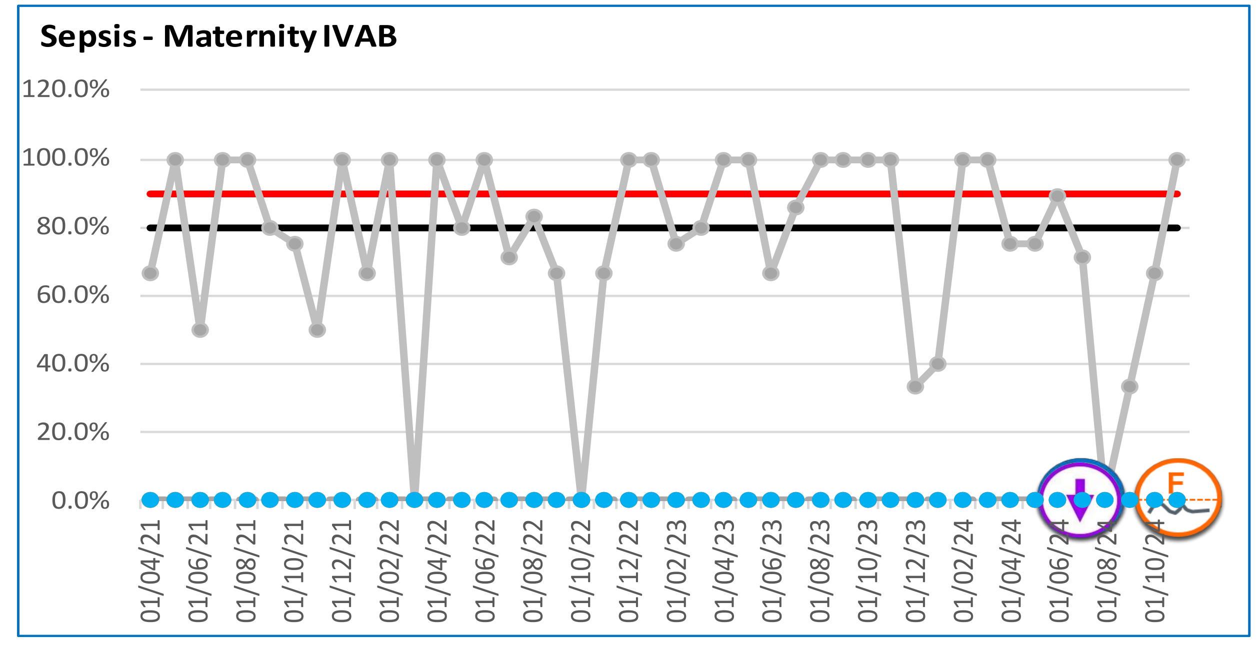
The children department has now implemented the national PEWS chart and sepsis screening tool guidelines.

High Quality

High Quality | [Sepsis – Maternity]

Provide safe, effective and caring services





What is the data telling us?

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

There were 8 cases audited from emergency portal MAU with 3 missed screenings. Inpatient had 7 cases audited with 2 missed screenings.

What are we doing about it?

Monthly maternity skills drill is now replaced with ad hoc sepsis sessions in each clinical area.

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

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

Responsive | Overview

Provide efficient and responsive services

Responsive

Overview from the Chief Operating Officer

How are we doing against our trajectories and expected standards?

Non-Elective

The 4-hr performance standard is 76% climbing to 78% in March 2025. Validated Performance is 64.8% for November which has decreased since last month by 1.4% and noting the average over the last 3 months has reduced slightly to 66.87%.
The submitted improvement trajectory against the 4hr standard set for November has not been met (70.6% vs 64.8%) and is 11.1% lower than the national target of 76% until February 2025. This is the third time in 9 months that we have not achieved greater than 70%.This however, this is still higher than 2020. Our relative performance is now in the lower 3rdquartile of Trusts regionally and nationally. We have seen slight improvement in our 12hour performance with 82 patients less since October, a decrease of 3.22%

The data provided by West Midlands Ambulance Service (WMAS) is provided a month in arrears. Ambulance Cat 2 mean time has continued to reduce since January 2024, January saw an average Cat 2 mean of 43.34 minutes compared with 35mins 48secs for November. The Trust went live with a new 45 minutes handover delay process on 11th November and has an agreed trajectory for 90% compliance by the end of March 2025. The Trajectory agree for November was 60% and the Trust achieved 54.99%.

To note that on 26th November, as a Trust and as a System, we declared a Critical Incident based on extreme pressures and loss of critical UEC pathways. Both UHNM and System behaviours changed at that point. The Critical incident was formally stood down on Friday 6th December 2024.

Elective

The Trust was de-escalated into Tier 2 for Planned Care, Cancer and Diagnostics in November. Our planned care teams are working closely with regional colleagues to maintain and improve our tiering position.

Recent operational pressures and period of critical incident have resulted in the need to cancel some planned care activity including a small number of cancer treatments. To date we have avoided long scale impact on our elective work however the additional seasonal pressures from our Urgent and Emergency Care pathways presents a significant risk through the remainder of quarter 3 and 4.

The combined faster diagnosis standard performance has demonstrated a special cause improvement over the past year. Our performance in October overachieved against the national standard of 75% recovering from a dip in September. Performance in November is not yet finalised and will be published in early January, our current position is at 75.8% providing a good degree of confidence that we will achieve our trajectory of 76.76% for the month. The 31-day combined cancer treatment standard achieved 93.1% in October. November is currently incomplete and unvalidated, however is at 88% currently. The combined 62-day performance was reported at 63% in October, short of our trajectory, November is currently incomplete and still being validated, the current position of 57% is predicted to improve as diagnostics continue to be reported. The combined faster diagnosis standard performance continues to demonstrate special cause improvement over the past year.

November DM01 data is unvalidated at time of writing this report however current performance was at 61% against the 95% six week standard, a 2% improvement on previous month and a show of 2 months back to back improvement on performance.

The number of patients waiting over 65 weeks for their treatment reduced from 206 in September to 143 in October and 121 breaches of the 65-week standard in November against the national zero target, which continues to be driven by the position in ENT which is in common with several other Trusts regionally. The number of patients waiting between 78 weeks or more for their treatment ended at 8 for November which included 2 reportable 104-week breaches, which were again related to data quality errors within the patient's pathway. As a Tier 1 (now Tier 2) Trust, NHSE national and regional teams have regular oversight of improvement trajectories and associated actions.

The number of patients over 52 weeks reduced slightly in November to 2373, a reduction of 148 patients from previous month. At the end of November 83% of patients on a 52-week pathway had their 1st contact booked (OP or diagnostic test), against the 100% end of December standard set by NHSE.

Validation of 10,000 high risk patient pathways was completed in October. Divisional teams have ensured that all patients identified as a result were treated within 4 weeks in line with updated NHSE DQ guidance. There are currently 3 patients remaining at the time of writing this report and teams are working to ensure that all patients will be treated, and a legitimate clock stop applied by the end of December.

Responsive | Overview

Provide efficient and responsive services

Overview from the Chief Operating Officer

What is driving this?

Non-Elective

4-hour performance is out with the trajectory and with deterioration both at Royal Stoke and County Hospital.

We remain within our expected trajectory for Emergency Department attendances Type 1 and Type 3- activity out turned at 23,213 in November verses 24,078 attendances which equates to a 3.6% reduction. Flow for our patients in our Emergency Departments requiring inpatient treatment has also deteriorated and is still below the daily requirement to hit the end of year standard. Both admitted and non-admitted pathway, during September, has been problematic in core hours and out of hours due to a continues cycle of 'doing yesterday's work today'.

The number of patients waiting an aggregated time of arrival greater than 12 hours decreased slightly in November. November demonstrated a decrease of 82 patients. An overall decrease of 3,.22%% compared with September. The availability of medical inpatient beds and timeliness of accessing has continued to be the primary issue even with the new AMRAU. The expectation and standard associated with Clinically Ready to Proceed is within 60 minutes of final intervention by the emergency department and is set at 95%. October achieved 42.86% of our patients accessing their onward pathway. This is a 3.19% improvement on September (39.67%).

Both the capacity of Emergency Departments (overcrowding) and the profile of ambulance arrivals (variation can be up to 22 ambulances/hours) has impacted on the ability to offload in a timely manner. There are improvement opportunities identified where handover reporting, and release process can reduce the amount of time patients wait to be handed over and ambulance crews wait in our departments. We have completed a detailed planning phase to enable an infrastructure whereby no crews breach a 45-minute handover against the compliance trajectory agreed. This process went live on 11th November 2024 and as of 30th November the compliance was 54.99% against a trajectory of 60%.

Elective

The improvements in cancer performance have been achieved due to an increase in capacity using West Midlands Cancer Alliance funding to support faster turnaround times in diagnostics, particularly in Endoscopy and Radiology along with a focus on lower performing pathways (Gynae, Colorectal and Urology) with associated improvement plans now in place.

The reduction in patients waiting >65weeks to be treated has been possible due to an increase in capacity funded through ERF, NHSE and Cancer Alliance bids, OP, IP/DC and diagnostic capacity has increased further from November as plans to achieve 52 weeks come into place.

The surveillance and planned backlog has been cleared in line with NHSE ask. The 3rd element of the business cases for endoscopy recurrent staffing is currently progressing through Executives and on to PAF in December. The mobile unit at County hospital remain operational providing additional capacity to support diagnostic recovery in line with trajectory.

Non obstetric ultrasound performance has plateaued at 39% with no further deterioration in performance seen. Additional insourced capacity is now in place and our team are currently finalising the processes to support the transfer of patients to the Cannock CDC. We are also progressing with demand management action to support improvement in performance through gathering of additional clinical information to ensure scans are clinically appropriate.

Responsive

Overview from the Chief Operating Officer

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

Non-Elective

Work continues within workstreams 1, 2, 3 and 4 to improve our non-elective flow and responsiveness to meet demand, improve patient experience and safety.
There are a number of immediate actions which are currently being undertaken, and onward monitoring is in place with daily check and challenge.
At Hospital:

- Consistent application, & accountability monitoring of 5 key organisational policies (Rapid Handover/IPS/Ward Standard Work/YNP/Home Care is Best Care)
- Implementation of 24/7 Strategic Ops On Site Leadership model
- Internal escalation process in place for all excessive ambulance waits
- Frailty ACP going into ambulances at RSUH to support early identification alternative pathways
- Scoping an additional senior medic based in Ambulance assessment to support RAT function 24/7
- Collating evidence / examples of inappropriate conveyances/attends to inform pre-hospital development
- Medical Director communications with consultant workforce in relation to risk assessed discharge.
- External support engaged –NHSE ED Pathway Mapping & Regional Care Pathway Audit during November

Pre-Hospital Actions:
HCP conveyance review. Call before convey levels remain low at 2.1% of dispatches calling through to ICC. NHS 111 ED SMS issue –NHSE supporting resolution / linking with Black Country. ICC –Strong progress with building referrals (over 3000 per month), with more pathways coming on line. Focus on Frailty. Boost CRIS resource to improve UCR capacity –Introduce a greater skill mix
Discharge Actions:
15 additional community beds this week (10 spots and 5 winter ward brought forward) –bringing forward further winter schemes. Multi-disciplinary HIT teamworking through base wards to support both simple and complex discharge identification >20 patients identified 07/11.-repeating whilst ward standards embedding
The Trust had agreed to go live in the first wave of Trusts for the Midlands with early handover of ambulances. This commenced on 11th November. All Standard Operating Procedures (SOP) have been reviewed and revised where appropriate.

Elective

Improvement plans in cancer with associated trajectories by tumour site to reduce the diagnosed and undiagnosed backlog of patient 62 days will continue to be monitored and developed. Delays due to histopathology (in line with other centres regionally) will need to be offset by further improvements in patients pathways. The Cancer Services Team have increased their validation of pathways from September which continues.

Divisional plans to achieve a maximum 52 week wait at the end of March have, in the main, been developed and approved. We intend to make sure that all patients on a 52 w pathways receive their first contact (OP or diagnostic test), by the end of December. The planned NOUS activity with Hassan has started to deliver from the end of November as well as the additional scrutiny of referrals to ensure that scans are clinically appropriate. The transfer of patients to the CDC at Cannock will start in December.

The digital and operational teams are working with external partners to develop a process to validate the majority of our c700,000 patients on our waiting lists. Meetings continue to happen through December. There will continue to be a high risk of patients who have waited >104 weeks until this exercise is completed. There has been an improved approach to RTT training with currently c61% of staff trained. Any member of staff not trained by the end of December will have their rights removed from Trust systems, up until the point that they are trained.

Responsive | Overview

Provide efficient and responsive services

Overview from the Chief Operating Officer

What can we expect in future reports?

Non-Elective

We expected our performance to follow our trajectory which considers the pressures over the summer months translating into the Autumn and winter months alongside the incremental improvement as part of our Non-Elective Improvement Programme. We expected November to be challenged as we continue to feel the impact of an earlier than planned for winter pressure. We will provide updates in terms of the 'winter' schemes funding internally and externally both for effectiveness and impact. We are also revisiting our original bed/capacity modelling assumptions based on an earlier than expected infectious decease profile which has impacted on bed restrictions and increase length of stay.

Going forward, improvements in 4-hour performance, 12 hour and ambulance handover delays will be tracked and monitored daily. We have seen the correlation between improvements in flow and these indicators. The impact of the implementation of the new HALO model is still being analysed and a proposed hybrid solution is now being explored.

Going forward this pack will include information on ambulance handover data. While this is ambulance data the oversight of this and harm reviews for the patient's awaiting handover is vital to support our UEC pathway.

The HRD Tool (High Risk Discharge Tool) was launched at Royals Stoke on 2nd December and will also feature in onward reporting.

Elective

For RTT/Planned Care we should expect to see a further reduction in the number of patients >65 weeks in December with a forecast of 85 patients breaching at month end and 57 at the end of January. The most significant risk to the continued delivery of improvement of elective performance is the additional seasonal UEC pressures associated with winter. We are aiming for all patients on a 52w pathway at end of March to have their 1st OPA by end of December. At the end of November 83% of patients were booked leaving 1017 yet to book.

NOUS performance has stabilised in November however and it is hoped that from December start to improve.

With the increased focus on improving cancer pathways through improvement plans along with a sustained increase in validation, we would expect to see continued improvements in cancer performance.

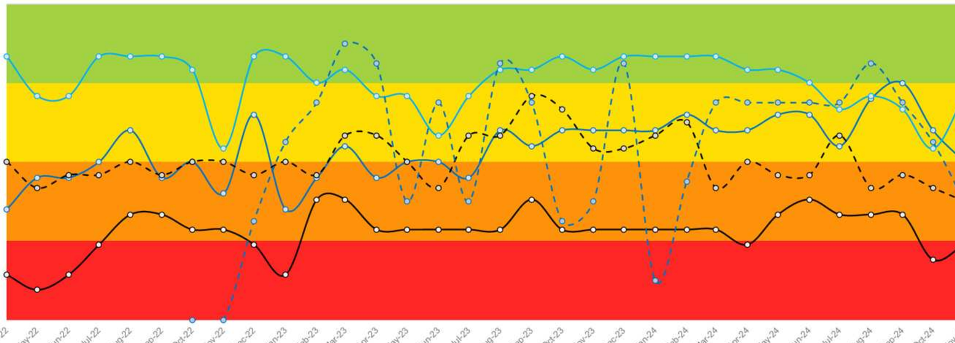
The Elective Improvement Program, developed in 2022/23 has been refreshed and outstanding or ongoing actions are being delivered through the Data Quality Group.

Responsive

Responsive | Dashboard

Provide efficient and responsive services

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
UEC 4 Hour Target	76%	66.2%	64.8%						
Over 12 hours in ED	0	2,549	2,467						
UEC Cat 2 Handover Average Time	00:18:00	00:26:19	00:34:44						
Cancer 28 Day FDS	75%	75.2%	73.9%						
Cancer 31 Day Combined	96%	93.1%	88.6%						
Cancer 62 Day Combined	85%	63.0%	57.4%						
Diagnostics DM01 Performance	99%	59.9%	61.0%						
RTT No. of Patients Waiting >52 Weeks	0	2,521	2,373						
RTT No. of Patients Waiting >65 Weeks	0	143	124						
RTT No. of Patients Waiting >78 Weeks	0	13	8						
RTT No. of Patients Waiting >104 Weeks	0	3	2						
Treating patients in a timely manner (Hospital Combined Performance Score)	7,000	4,019							



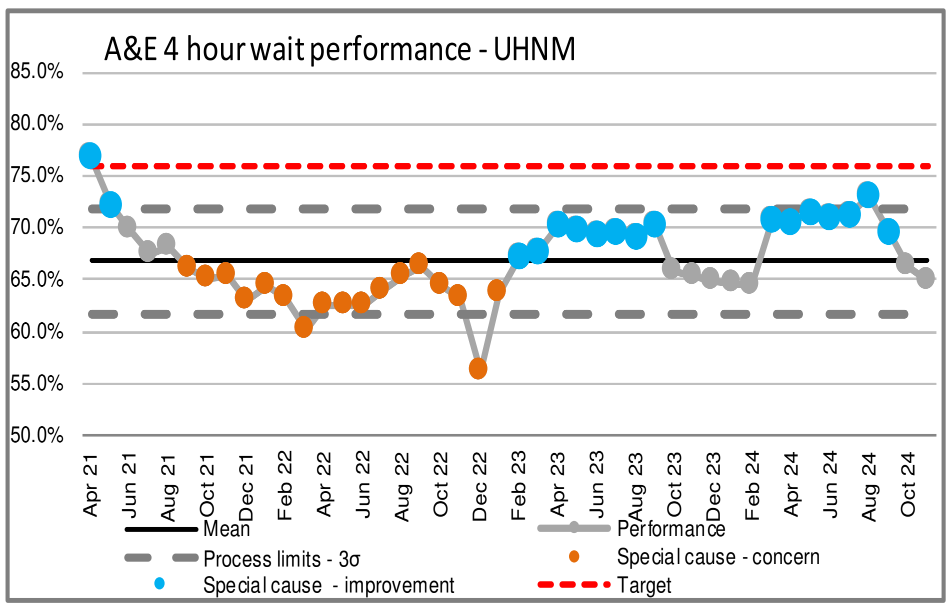
Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 4: Delivering Responsive Patient Care	Ext 20	Partial	Ext 15	Partial			Ext 20	Partial

Responsive | UEC 4 hour Target

Provide efficient and responsive services

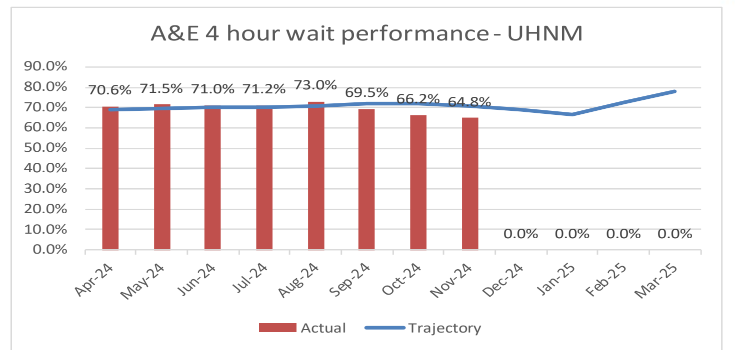
Responsive



Variation		Assurance	
Target	**Sep 24**	**Oct 24**	**Nov 24**
76%	69.5%	66.2%	64.8%

Background

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



What is the data telling us?

Validated Performance is 64.8% for November which has decreased since last month by 1.4% and noting the average over the last 3 months has reduced further to 66.83% (last month 3 month average 69.57%).
The submitted improvement trajectory against the 4hr standard set for November has not been met (70.6% vs 64.9%) and is 11.1% lower than the national target of 76% until February 2025 and then 78% for March 2025 onward.
The teams ongoing work to improve this performance metric is still evidenced in maintaining and demonstrating an increasing trend since March albeit it a reduction over the last 4 month's performance.
Type 1 4hr performance for Royal Stoke was 36.9% which is 1.2% lower than last month at 38.1%, however of note performance since March there has been an average of 43.63% compared to the preceding 6 months at 39.68%. The average has dipped due to the last couple of months performance however this still demonstrates an improvement of 3.95% during the 9-month period.
Type 1 4hr performance for County was 64.5% which has increased by 3.6% from last month's performance of 60.9%,
As a trust, there were zero days in November where we achieved greater than 78%, The highest recorded type 1 performance for October was 72.6% on 4th November. This was supported by a 78.3% performance at County Hospital.
No Trust ranking information is available currently.

What are we doing about it?

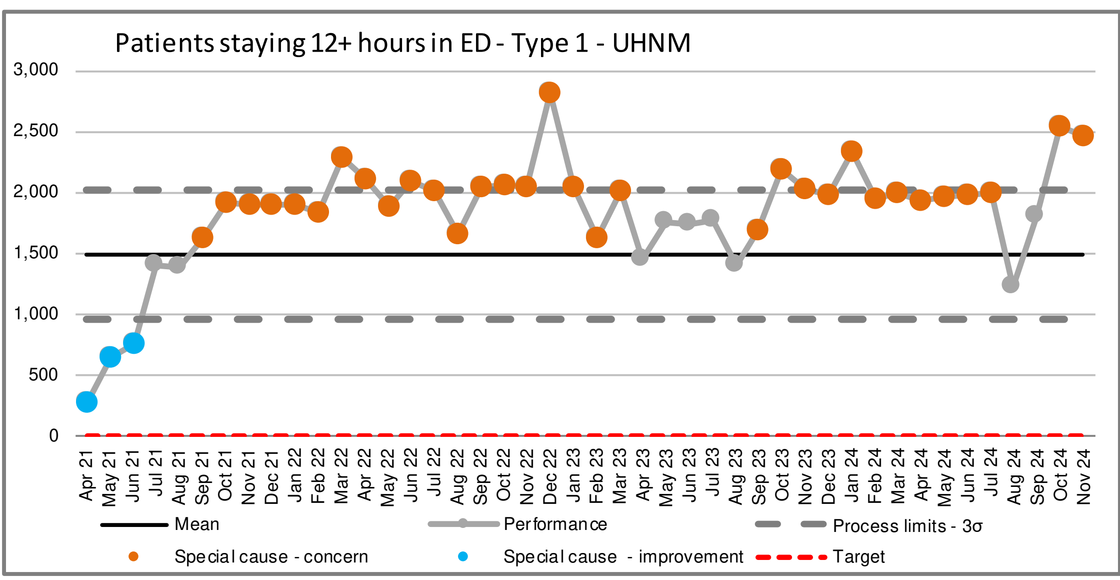
- Focus continues on streaming from ED to alternative pathways to support patient care.
- Review of escalation and triggers to support reduction in ambulance handover delays.
- CDU utilisation work continues on both sites to ensure consistent processes.
- EhPC chest pain pathway agreed, and trial date is being scheduled.
- High Risk of Delayed Transfer of Care prediction tool trial commenced on 2nd December to support deflections from the ED.
- SDEC: AEC task and finish in place to work through potential opportunities

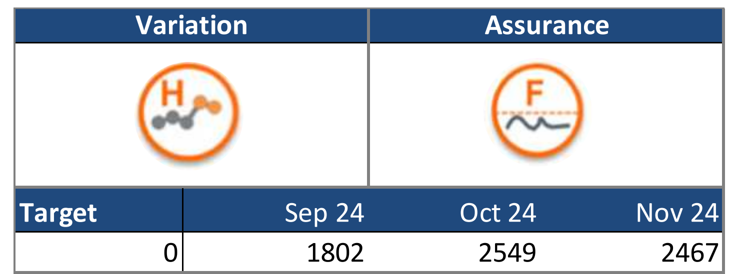
Responsive | Over 12 hours in ED From Arrival

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive





Variation	Assurance
H	F

Target	Sep 24	Oct 24	Nov 24
0	1802	2549	2467

What is the data telling us?

Note this metric is not "12-hour trolley waits" but the new aggregated time of arrival greater than 12 hours.

November experienced 2467 patients (82 a day) with a greater than 12-hour length of stay compared with 2549 patients (82 per day) in October.

After a significant improvement in performance seen in August coinciding with the opening of AMRAU, both October and November 2024 saw high numbers of patients waiting over 12 hours. With both data points outside the upper control limit and both seeing around 500 more breaches each month than seen the year prior.

Overall mean time in the Emergency Department for November, Type 1 only, increased from 6.71hrs in October to 7.67hrs in November.

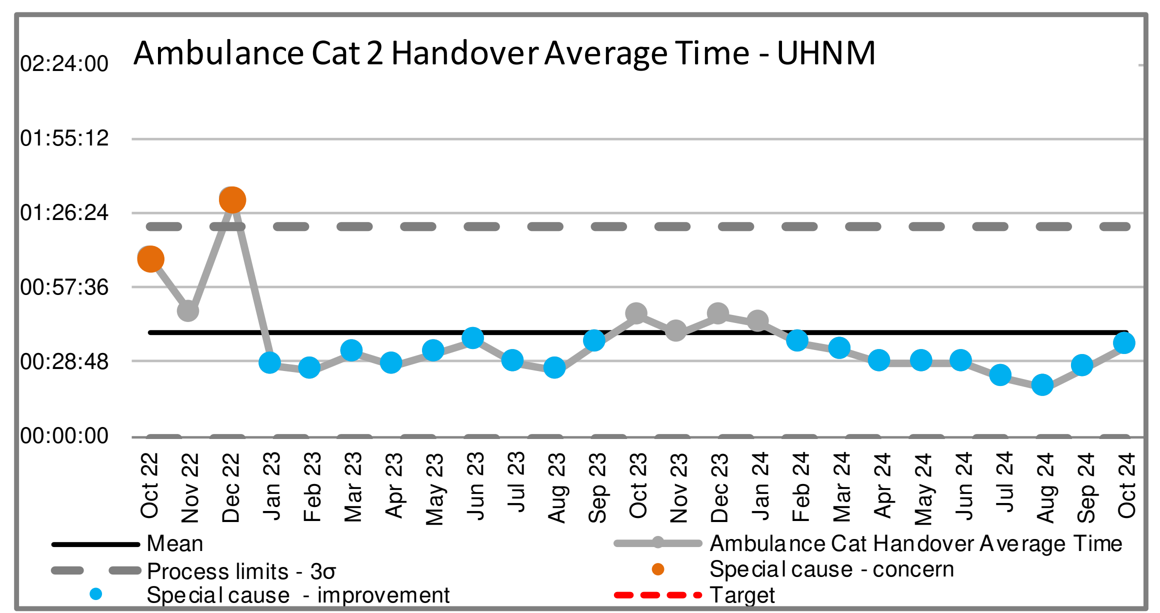
The latest benchmarking data available (up to September 2024) shows UHNM following the same trend as close peer groups, albeit at a slightly higher level.

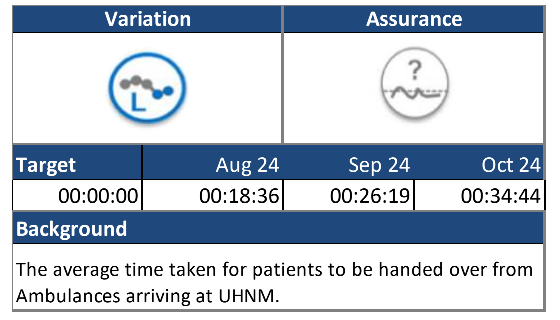
What are we doing about it?

- Rollout of standard work is planned to include a trial of a new prediction tool that is aimed to decrease overall LoS and deflections from the ED.
- Trial of a Frailty Assessment Unit (FAU) at the County site over winter.
- Task and finish groups continue to work through actions to address the issues identified including TTO's, Transport, Diagnostic Delays and Discharge processes to support earlier in the day discharges.
- Frailty >75, single document for CGA & admissions agreed and planned for trial in mid-November.
- Test of change completed for IDH in-reach to ED and support to FEAU demonstrated a positive impact and continues to remains in place with increased support through winter for the weekends.
- Frailty >75, End of life pathway – draft audit tool trialled across 2 wards which is aimed to support earlier decision making, impact currently being reviewed.
- AMRAU unit which created additional capacity in AMRAU & SSU continues to support flow out of the Emergency Department.

Responsive | UEC Cat 2 Handover Average

Provide efficient and responsive services

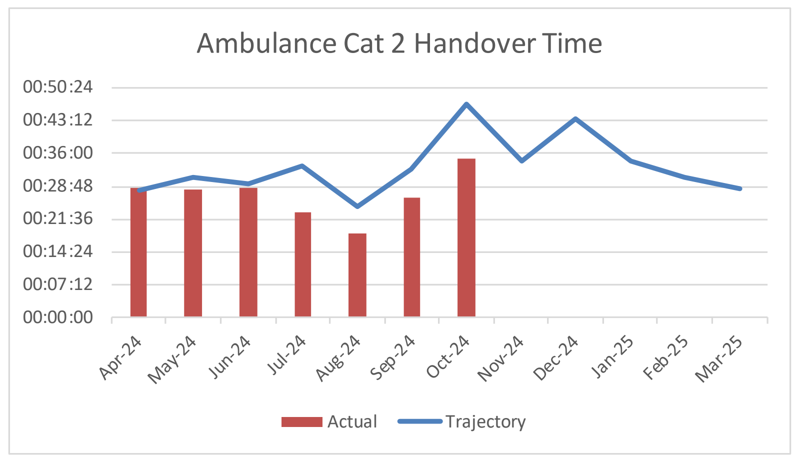




Variation	Assurance		
Target	Aug 24	Sep 24	Oct 24
00:00:00	00:18:36	00:26:19	00:34:44

Background

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



What is the data telling us?

The data provided by West Midlands Ambulance Service (WMAS) is provided a month in arrears. Ambulance Cat 2 mean time has continued to reduce since January 2024.

Handover within 15 minutes of arrivals in October was recorded at 34mins 44seconds (validated position). On November 11th, 2024. The Trust moved to a 45min handover delay threshold in partnership with WMAS, even though overall handover delays saw a reduction, the Cat 2 mean does not reflect this. A new SPC chart will be added to allow sperate reporting of this new metric.

Work remains ongoing with WMAS to provide more timely data going forward.

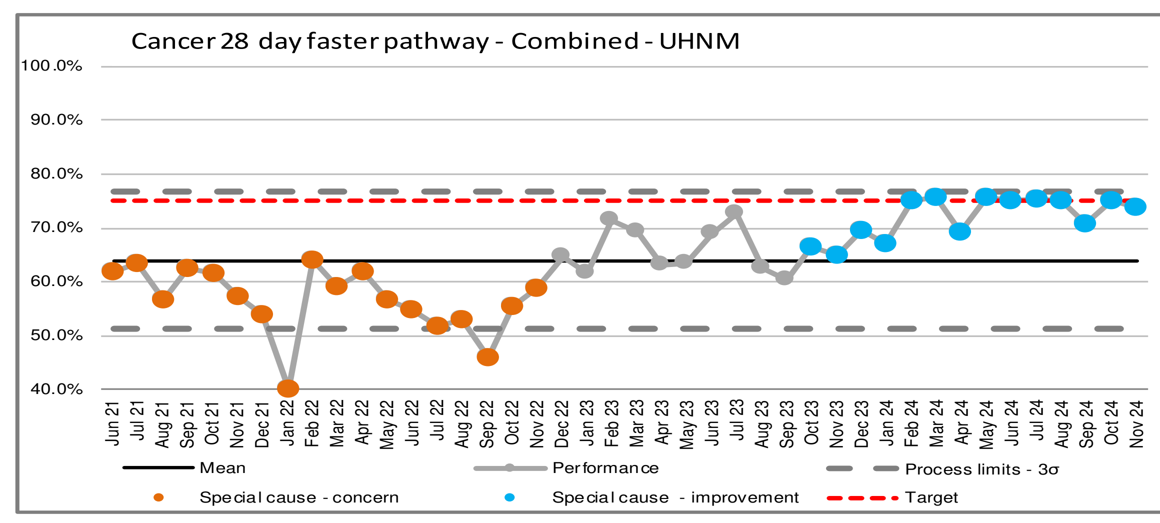
What are we doing about it?

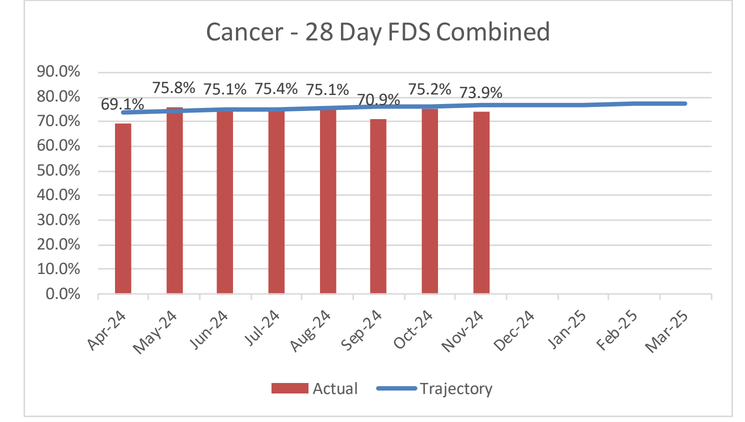
We have instigated an internal rapid handover process, which when triggered and enacted, drives the off load of 2 ambulances every 30 minutes until the pressure is reduced and the risk removed.
A review of escalation and triggers to support reduction in ambulance handover delays in partnership with WMAS is in train to replicate the London Ambulance Service model of no greater than 45minutes to offload. .
The 'corridor' in the emergency department is utilised to support the risk of reducing the waiting ambulances.
A revised HALO provision to cover 24/7 has been approved by The Urgent and Emergency Care Board and a 12-week test of change is now complete. A formal report is be ng presented at the December UEC Board to discuss onward steps.
'Your Next Patient' protocol is enacted to decompress the emergency department to further support flow and off load capability. This process is currently under review.
Regular daily contact with WMAS is in place to ensure confidence in actions taken and where possible deflects or diverts to County or Burton are agreed to support timely ambulance release.

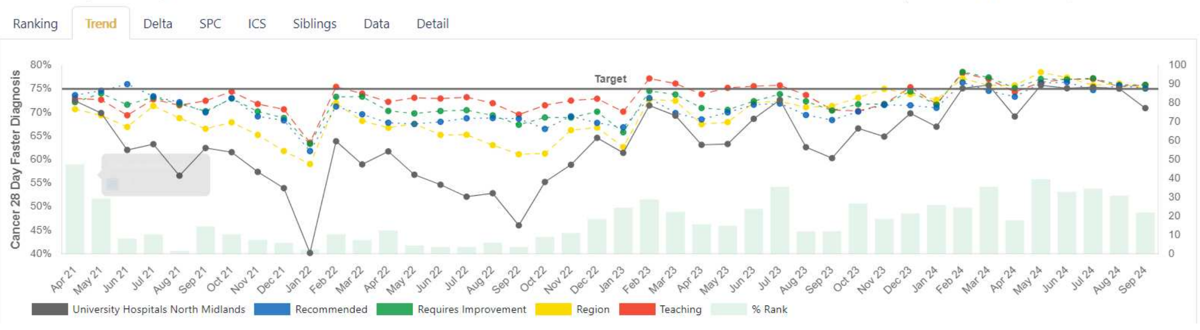
Responsive | Cancer 28 Day FDS

Provide efficient and responsive services

Responsive







What is the data telling us?

- The combined faster diagnosis standard performance has demonstrated a special cause improvement over the past year. UHNM has achieved the 75% national standard in October.
- When broken down at tumour site level, some pathways perform better than others; Upper GI, Skin and Breast being consistent and high achievers.
- Pathways that require a higher number of investigations such as Gynaecology and Urology perform lower than the standard.
- Pathology is a major delay factor in being able to tell patients they have cancer within 28 days.

What are we doing about it?

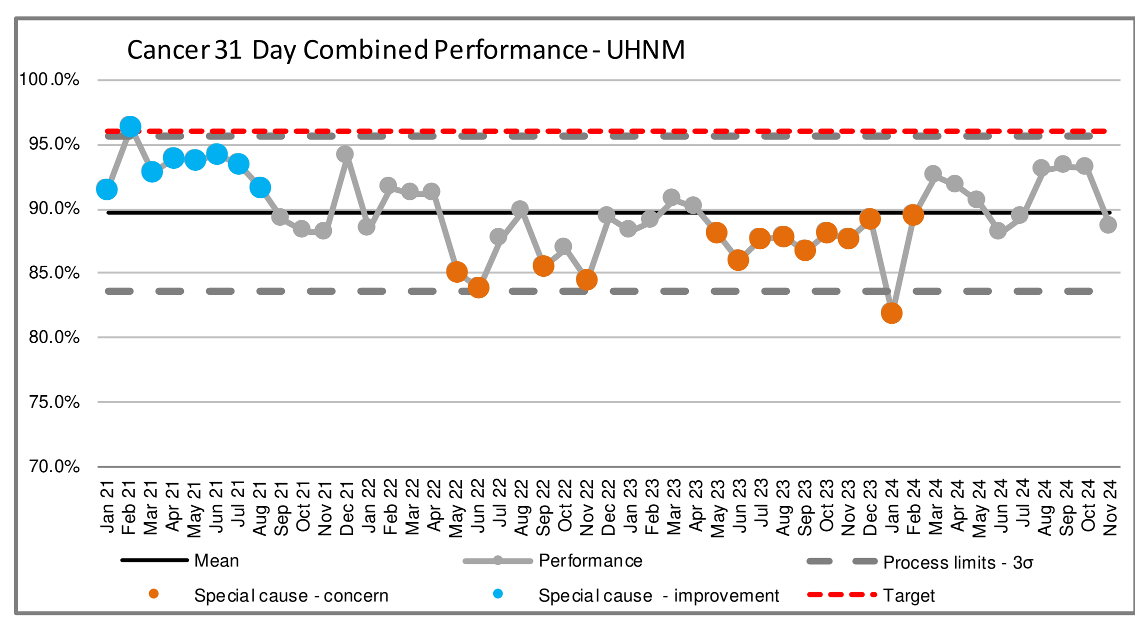
- Improvement plans for lower performing pathways are in place; Gynae, Colorectal and Urology. Best practice from better performing providers is being implemented, such as referral vetting and speedy booking of 1st OPAs. Teams have implemented national priorities such as Cancer Navigators who expedite patient pathways. Referral optimisation plans will support faster timelines for patients receiving diagnosis or all clear for cancer.
- West Midlands Cancer Alliance funding is being used to support faster turnaround times in diagnostics, particularly in Endoscopy, Radiology and Pathology.

Responsive

Responsive | Cancer 31 Day Combined

Provide efficient and responsive services

NHS
University Hospitals of North Midlands
NHS Trust



What is the data telling us?

- The 31-day combined cancer treatment standard achieved 93.1% in October. November is currently incomplete and unvalidated, however is at 88% currently.
- There is varying performance when broken down by tumour site. Consistent and high achievers are Breast, Skin and Upper GI. However, the most challenged tumour sites are Urology and Colorectal.
- Urology reported the longest waits due to access to surgical capacity. The longer waits on the Colorectal pathway were either due to access to surgery or therapeutic endoscopy procedures.

What are we doing about it?

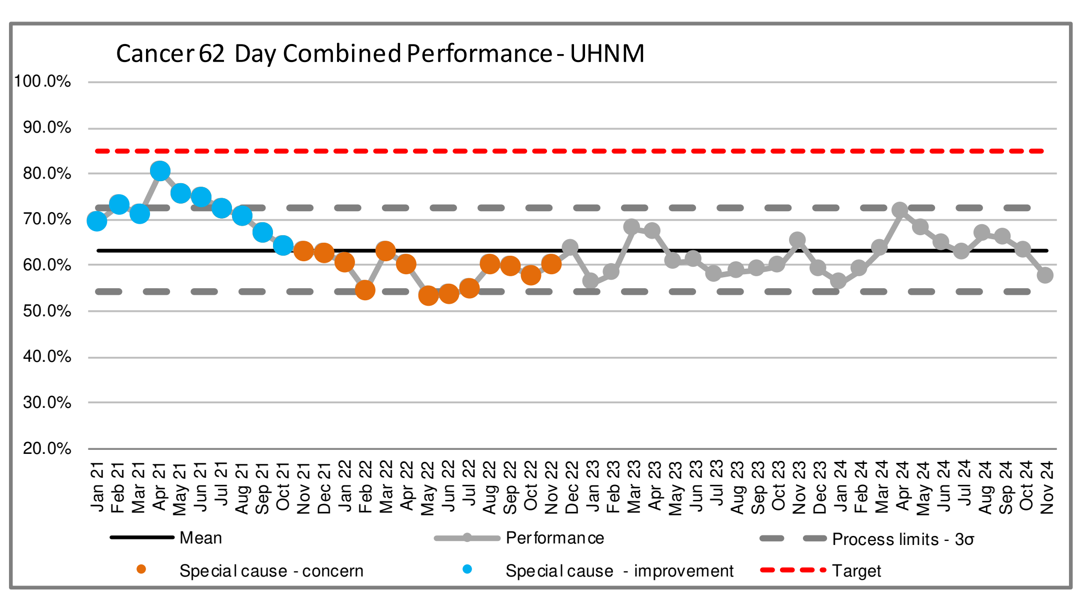
- Access to robotic procedures are prioritised through the oversight group.
- Partial Nephrectomy capacity has been escalated through the Tier 1 route with a request for mutual aid.
- The endoscopy improvement plan is being enacted that will clear backlog and create sufficient capacity to meet therapeutic demand. 31-day treatment capacity is inherent to 62-day improvement plans.
- Cancer services have engaged with the national cancer team and recommended providers through the Tier 1 route to ensure optimal application of the Cancer Waiting Times rules.

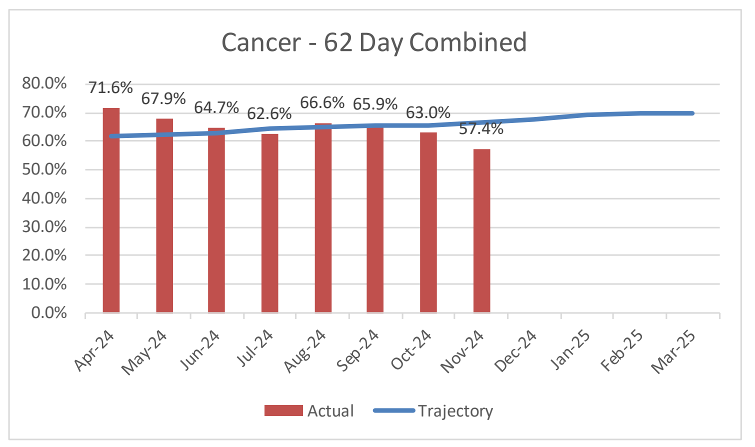
Responsive | Cancer 62 Day Combined

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive





What is the data telling us?

- The combined 62-day performance was reported at 63% in October. UHNM have met the trajectory for 5 out of 7 months of the year. November is currently incomplete and still being validated, the current position of 57% is predicted to improve as resections are reported by Pathology. NMCPS currently report 95% of resections by 24 days.
- When broken down by tumour site, there are no consistent achievers however pathways with better performance than most include Breast and Skin.
- Pathways with the most challenged performance are Gynae, H&N, Lung and Colorectal. Contributing factors include delay to diagnostics particularly pathology reporting which impacts significantly for Gynae and Lung. Oncology capacity also impacts timely treatment.

What are we doing about it?

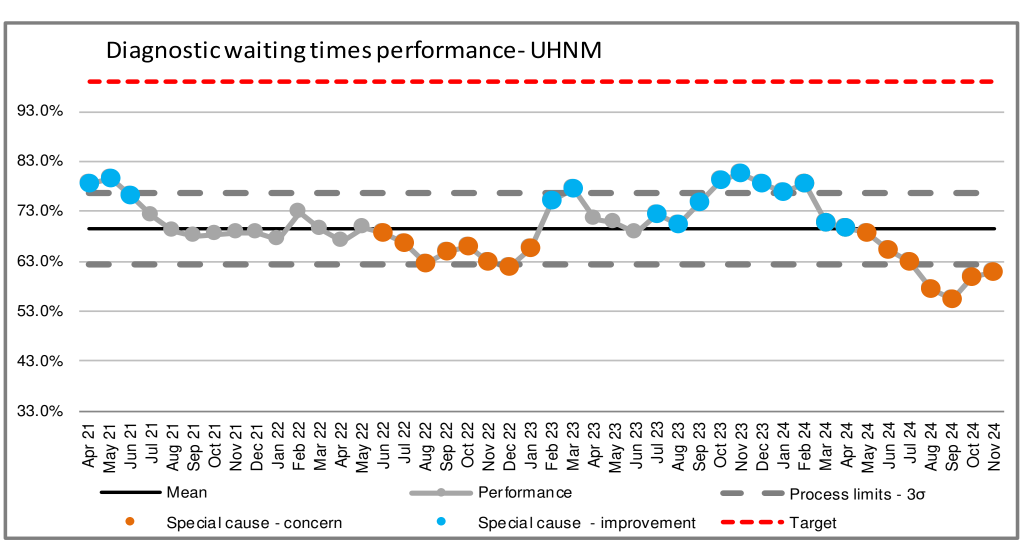
- 62-day treatment improvement plans have been worked up to include most challenged treatment modalities; surgery and oncology. Longest breaching pathways are being analysed with clinical input. The 104+ breach analysis governance process has been enacted to ensure oversight of long waiters. The annual peer review report has been through governance routes, which highlights tumour site treatment challenges to ensure visibility and escalation through the trust.
- Validation to ensure Cancer Waiting Times guidance is being applied appropriately is planned 4 weeks ahead of upload to ensure an accurate position is reported.
- National cancer team providing guidance on recording of complex pathways.

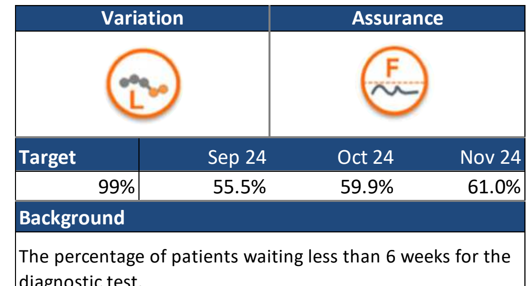
Responsive | Diagnostics DM01 Performance

NHS University Hospitals of North Midlands NHS Trust

Provide efficient and responsive services

Responsive

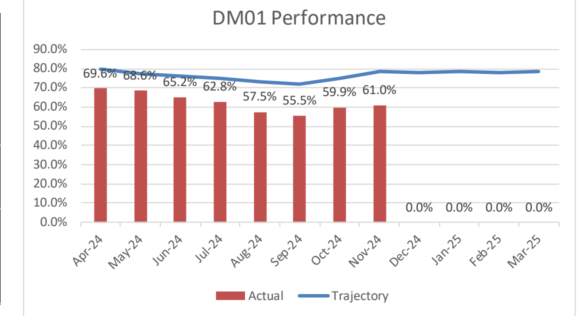




Variation		Assurance	
Target	Sep 24	Oct 24	Nov 24
99%	55.5%	59.9%	61.0%

Background

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



What is the data telling us?

November DM01 data is unvalidated at time of writing this report however current performance was at 61% against the 95% six week standard, a 2% improvement on previous month and a show of 2 months back to back improvement on performance.

The main contributing modalities are

- Endoscopy: October validated Performance for Endoscopy at is 53.73%. Performance has increased 8.4% from September. Total WL size has reduced by 229 patients. Awaiting November validated data at the time of writing,
- Non obstetric ultrasound performance has plateaued at 39% with no deterioration compared to previous month.
- Echocardiogram performance has improved to 62.7% for November . A particular focus was given for 13 week patients and this has improved performance further against the 13 week DM01 raising performance to 99.5%.

What are we doing about it?

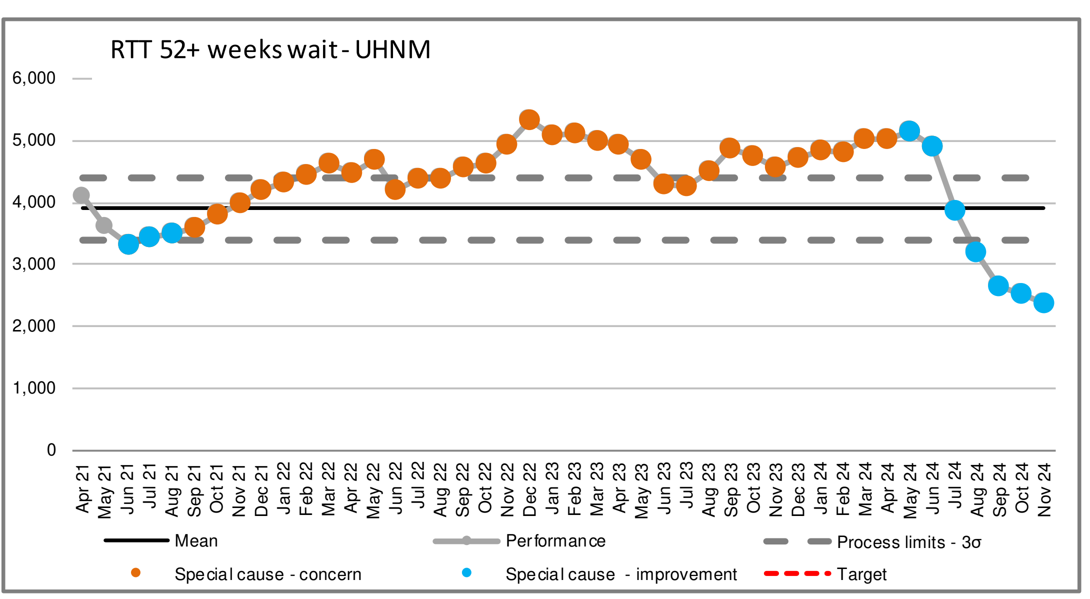
- Endoscopy: Q2-4 ERF funding in place enabling the service to continue to insource to cover all vacant sessions to increase capacity. The mobile unit is operational and scoping an average of 29 patients per day, 7 days per week. All additional capacity is supporting diagnostic recovery in line with trajectory.
- The surveillance and planned backlog has been cleared in line with NHSE ask.
- The 3rd element of the business cases for endoscopy recurrent staffing is currently progressing through Executives and on to PAF in December
- Non obstetric Ultrasound: Insourcing now fully in place at c300 scans pw. We are currently finalising the process with Cannock CDC to transfer 100 patients pw. Radiographer triaging of referrals has been implemented, admin triage is now in place and we are considering implementing partial booking to improve compliance, reduce cancellations and DNA rates. Additional alignment to new best practice pathways and additional registrar list validation in progress which will reduce the backlog based on appropriateness of the scan and additional clinical information gathered from other imaging procedures.
- Echo: Capacity continues to be supported by an external agency whilst we await recruitment to posts expected to commence in December and Jan 24. The additional locum secured from Mid September has supported the team to maintain to 99.5% against the 13 week wait DM01 (patient choice for x 10 pts to delay appt beyond 13 week date).

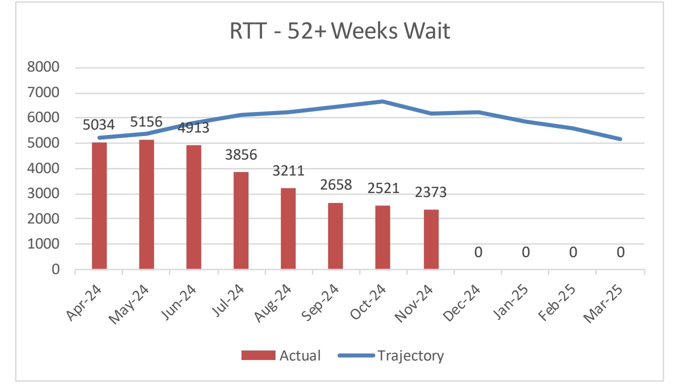
Responsive | RTT No. of Patients Waiting Over 52 Weeks

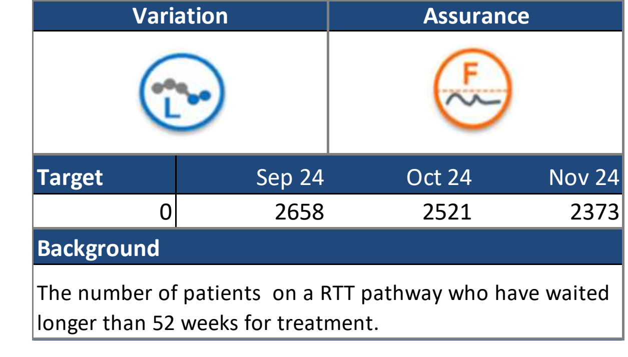
Provide efficient and responsive services

Responsive

NHS University Hospitals of North Midlands NHS Trust







Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
0	2658	2521	2373

Background

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

What is the data telling us?

- There has been a significant reduction in 52+ week waits due to a targeted validation exercise undertaken largely by the Trust Patient Access Team. The largest reductions have been seen in Respiratory & Gastroenterology.
- 17% of patients that will breach 52w at end of March currently have yet to have their first contact; of these 1,017 do not have that contact booked in December.

What are we doing about it?

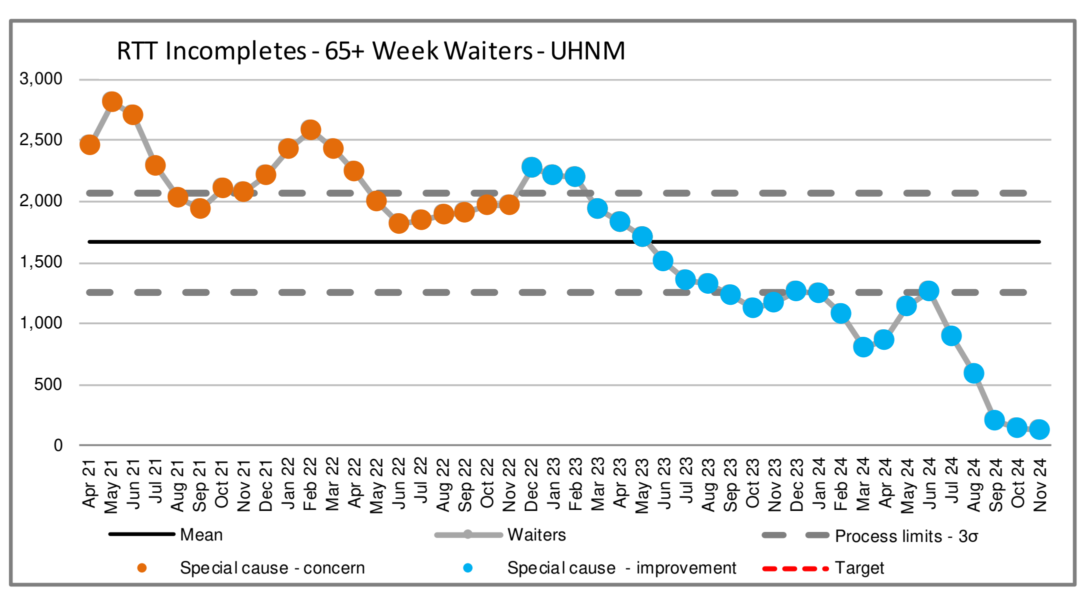
- Revamped RTT & Planned Care training offering now available, including Intermediate Training. RTT training performance will be monitored through Planned Care Board
- Further Patient Validation Texts have been sent, with 66% response rate and 9,069 patients overall wishing to be removed from the waiting list.
- Divisions supported with tracking and admin process improvements where resource allows.
- All patients on a 52w pathway at end of March will have their 1st OPA by end of Dec (currently 83%)
- ERF bids to achieve 52w standard have now been approved (in the main) and will provide additional capacity across a number of specialties from November

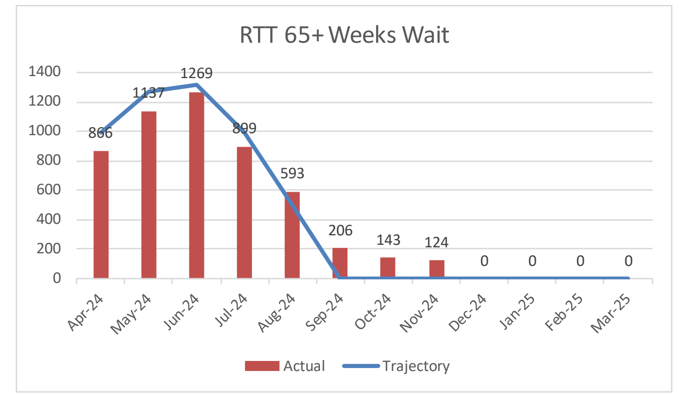
Responsive | RTT No. of Patients Waiting Over 65 Weeks

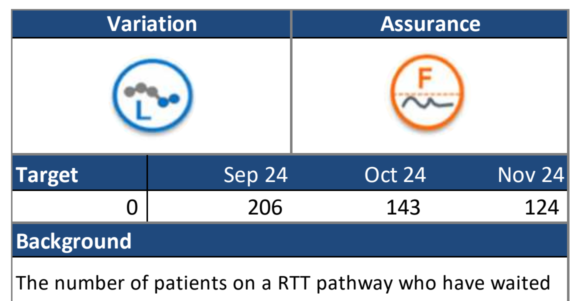
Provide efficient and responsive services

NHS University Hospitals of North Midlands NHS Trust

Responsive



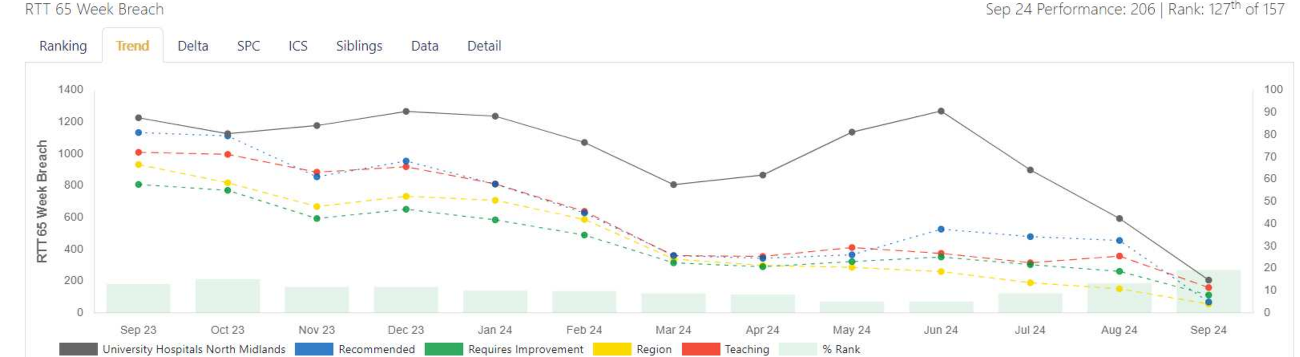




Variation		Assurance	
Target	Sep 24	Oct 24	Nov 24
0	206	143	124

Background

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



What is the data telling us?

- The volume of patients waiting 65 weeks reduced to 124 in November, a reduction of 19 patients compared to October. This is due to an increase in capacity in particular in Endoscopy, Gastro, ENT and Respiratory funded through a variety of cancer alliance, ERF and NHSE funds along with an increased focus on validation.

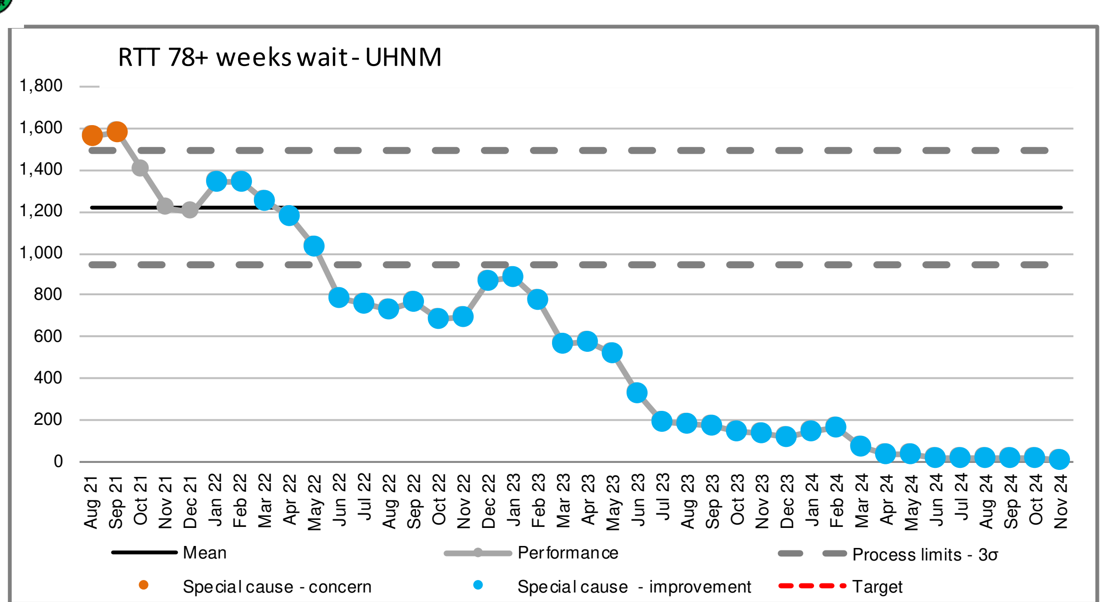
What are we doing about it?

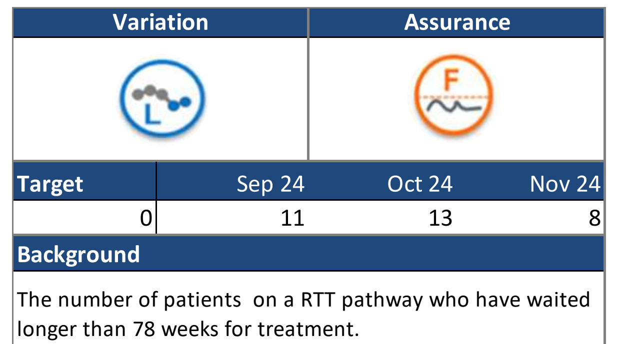
- ERF business cases for extra capacity through insourcing & WLIs approved
- Focus on utilisation and productivity in theatres and outpatients
- Targeted validation on Respiratory, Gastro & ENT pathways
- Detailed plans and trajectories to illustrate the route to 65weeks have been developed and are formally monitored weekly through Elective Oversight Group and PTL meetings
- Aiming for 85 patients >65w at end of December
- Forecasting of Q4V position is currently underway to scope impact of potential cancellations of surgery due to winter pressures, based on historical position.

Responsive | RTT No. of Patients Waiting Over 78 Weeks

Provide efficient and responsive services

Responsive



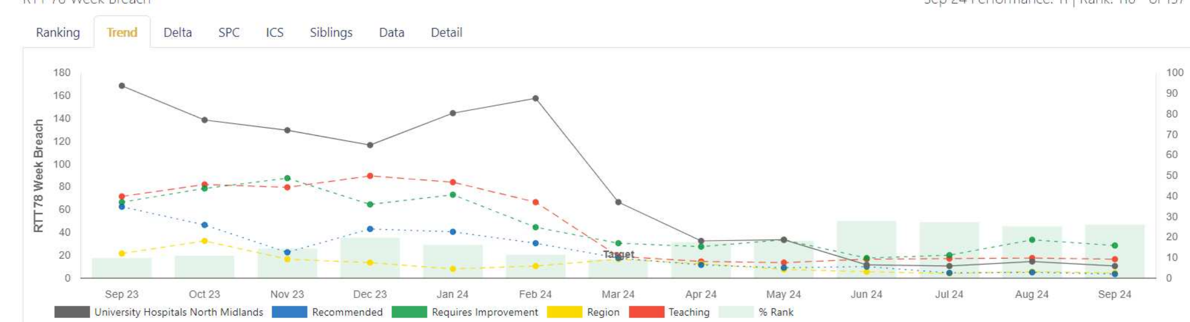


Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
0	11	13	8

Background

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



What is the data telling us?

- There were eight patients that waited >78weeks in November across Surgery, Medicine and Network Divisions, this included two breaches of the 104w standard.
- These breaches were a result of validation of the patients' RTT pathways where issues were identified and corrected

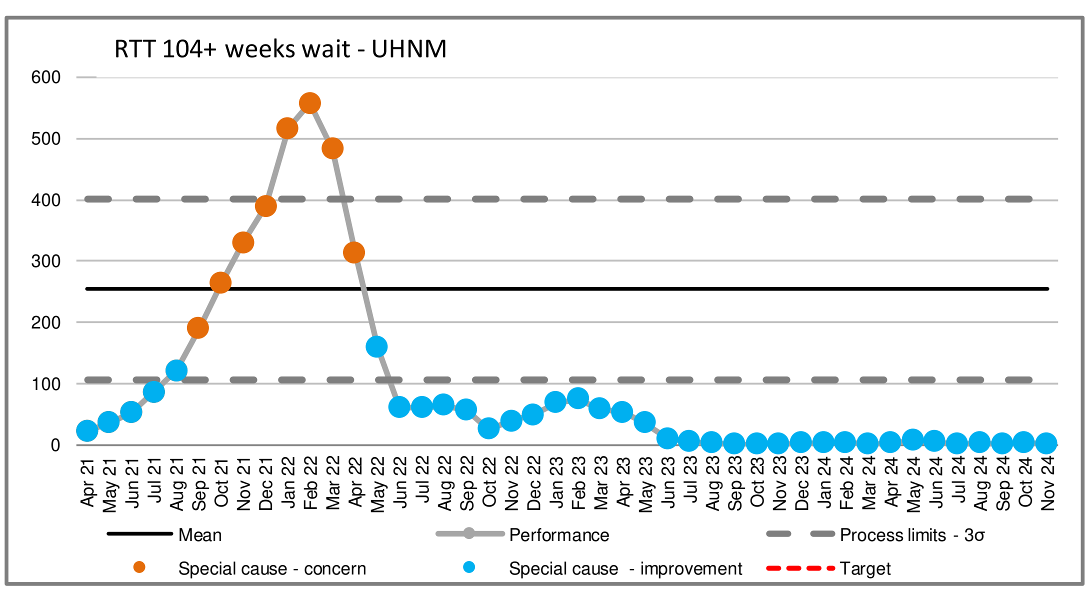
What are we doing about it?

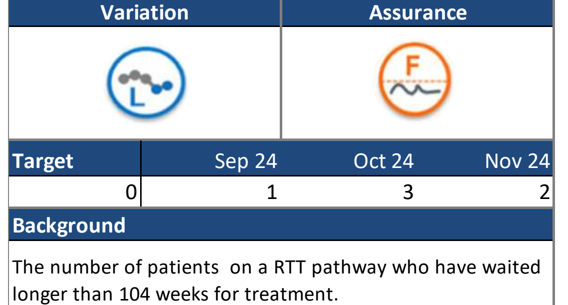
- Actions as per those patients over 65 weeks along with continuing tracking and micromanaging
- of long waiting patients, with regular PTL meetings with each relevant directorate, and support functions.
- From October, validation takes place in month as opposed to month end, providing an opportunity for teams to prevent further 78w + breaches due to data quality issues

Responsive | RTT No. of Patients Waiting Over 104 Weeks

Provide efficient and responsive services

Responsive



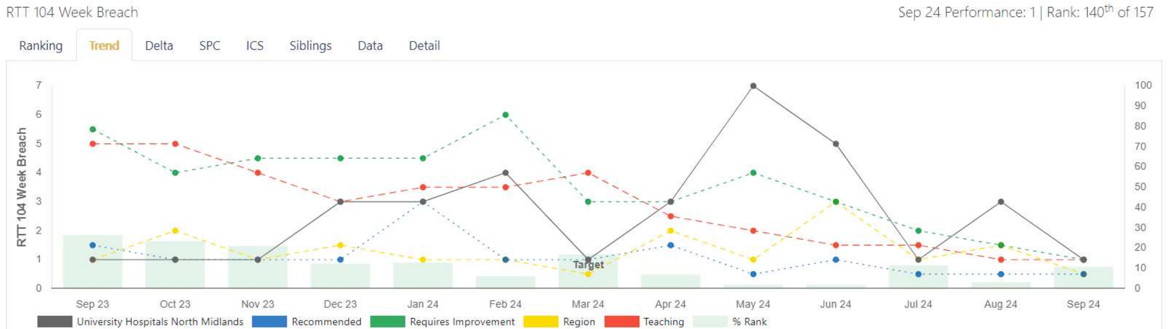


Variation	Assurance
L	F

Target	Sep 24	Oct 24	Nov 24
0	1	3	2

Background

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



What is the data telling us?

- The Trust reported two 104-week breaches for November, an increase of three from September.
- Both patients pathways had inappropriate clock stop or clock start dates applied to their RTT pathway and were identified through validation or patient contact.

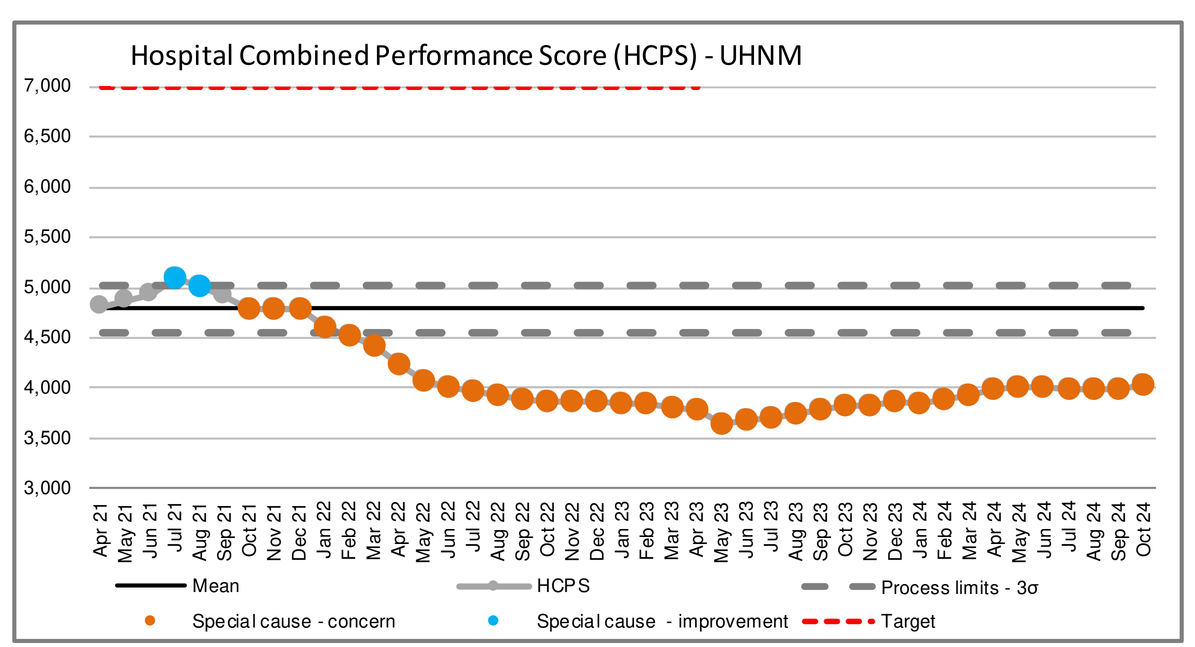
What are we doing about it?

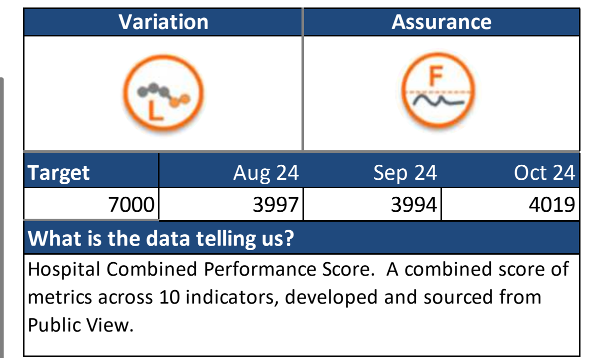
- A whole scale review of validation, RTT training and data quality (DQ) commenced in July. A DQ Task Force has been established and is chaired by the COO. An RTT training plan has been approved at Planned Care Board to ensure all relevant staff are up to date with training by end of December.
- MBI validated 12,000 patient pathways from high risk “fail safe groups” and as a result there is a possibility of “in-month” 104 week breaches. We are working with NHSE in line with NHSE DQ Guidance published in September 2024 to ensure patients that are identified are treated within 4 weeks of that date. We are exploring a wider mass validation exercise to reduce risk to potential patient harm as a result of their pathway not being correct.

Responsive | Treating Patients in a Timely Manner (HCPS)

Provide efficient and responsive services

Responsive





Variation	Assurance

Target	Aug 24	Sep 24	Oct 24
7000	3997	3994	4019

What is the data telling us?

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

What is the data telling us?

The Hospital Combined Performance Score improved marginally in October.

Top concerns and most deteriorated include: 4 hour performance, DTA to Admission > 4 hours and Sickness Absence rate.
Most improved include: Cancer 31 day, Cancer 62 day and RTT performance.

What are we doing about it?

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

People | Overview

Creating a great place to work for everyone

People

Overview from the Chief People Officer

How are we doing against our trajectories and expected standards?

Our most recent *Staff Engagement* score was 6.56 for July 2024, up from 6.42 for April 2024, against a target of 7.2. The Staff Voice Survey is now collected quarterly, meaning the next scoring will not occur until January 2025, following the National Staff Survey's completion. A total of 558 bank staff have signed up for the Wagestream solution, (519 in October 2024) with a further 11 enrolling. There has been a total of 3,633 streams, totalling £554,000 in advances, since Wagestream's launch.

Sickness absence remains above our expected standard of 3.39%. In month we have seen an increase to 5.89%, while the 12-month cumulative rate remains at 5.3% for the seventh consecutive month. The main driver of this continues to be stress and anxiety, followed by Gastrointestinal problems and Cold, Cough, Flu – Influenza as the second and third most common reasons.

Turnover and *vacancy* metrics continue to perform well against our expected standards. The turnover rate in November 2024 remained at 7.4% which remains consistently below our 11% target, for the last 2 Years. Vacancies increased to 8.4% (7.8% in October-24). The main drivers of this were increases across Registered Nursing (+29.23), ST&T (+4.71), Infrastructure (+7.52) and Medical & Dental (+6.69). These increases were counter-balanced by a 132.8 fte uplift in the total budgeted establishment.

Agency costs increased to 2.68%, in November 2024, up from 1.81% in October 2024, which is below the threshold set by NHS England. In real-terms, overall agency usage decreased to 150.76 WTE in November 2024 from 157.97 WTE in October 2024.

What is driving this?

Sickness absence is driven by many factors, including stress and anxiety and seasonal changes such as colds, cough and chest & respiratory problems. Noevmber's sickness absence increases have been influenced by the usual seasonal changes, which is reflected in the higher numbers of Gastrointestinal problems and Cold, Cough, Flu – Influenza problems.

Agency Expenditure is currently below plan but is being driven by the continued need for escalation capacity, additional work related to the elective recovery programme and an increased demand in theatres and endoscopy services. However, the additional scrutiny at executive and divisional level appears to be having the desired affect in reducing overall agency spend, with some agency activity being converted to bank expenditure, as well.

People

Overview from the Chief People Officer

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

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

Sickness absence continues to be monitored at directorate performance reviews. Areas with over 8% or of concern are supported by the People Advisors, focusing on long term sickness cases. Our people are also provided with many online and in-person resources, to improve their personal resiliency when coping with work-related stress. A review of policy compliance of the top 10 cases for short and long term absence is taking place across all divisions.

Agency Expenditure remains subject to continued scrutiny through the Divisional Performance Reviews and the Medical Workforce Assurance Group. There is also regular focus at ICB level on workforce numbers, agency spend and controls. Additional data sources are being provided to allow for more granular discussions.

The system-level controls implemented in our Electronic Rostering solution for all nursing and midwifery rosters continue to serve as the primary layer of control, complemented by the scrutiny provided through Divisional Performance Reviews.

What can we expect in future reports?

We may see a higher sickness absences, as a result of seasonal changes.

There will be further updates regarding the uptake of the Wagestream solution, before a decision is made to implement it for our substantive workforce, as part of our employee benefits package. An options appraisal report is being drafted for the Executive Board's consideration, before any final decision is made, regarding Wagestream's further rollout to the substantive workforce.

Agency spend has fallen below NHS England's 3.2% threshold. We expect agency usage to continue to track close to this threshold, due to on-going elective recovery programme activity, and the continued need for escalation capacity and the additional demand in theatres and endoscopy services. (Note: October's backdated Agenda for Change pay costs decreased last month's agency percentage. This is the main reason for the higher agency costs in November when compared to October)

People

People | Dashboard

Creating a great place to work for everyone

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Employee Engagement	7.2	6.6	6.6		F				
Sickness Absence (In Month)	3.40%	5.71%	5.89%		F				
Vacancy Rate	8.00%	7.82%	8.39%	L	F				
Turnover Rate	11.00%	7.43%	7.42%	L	P				
Appraisal Rate	95.00%	86.03%	85.84%	H	F				
Agency Utilisation	3.20%	1.81%	2.68%	L	?				

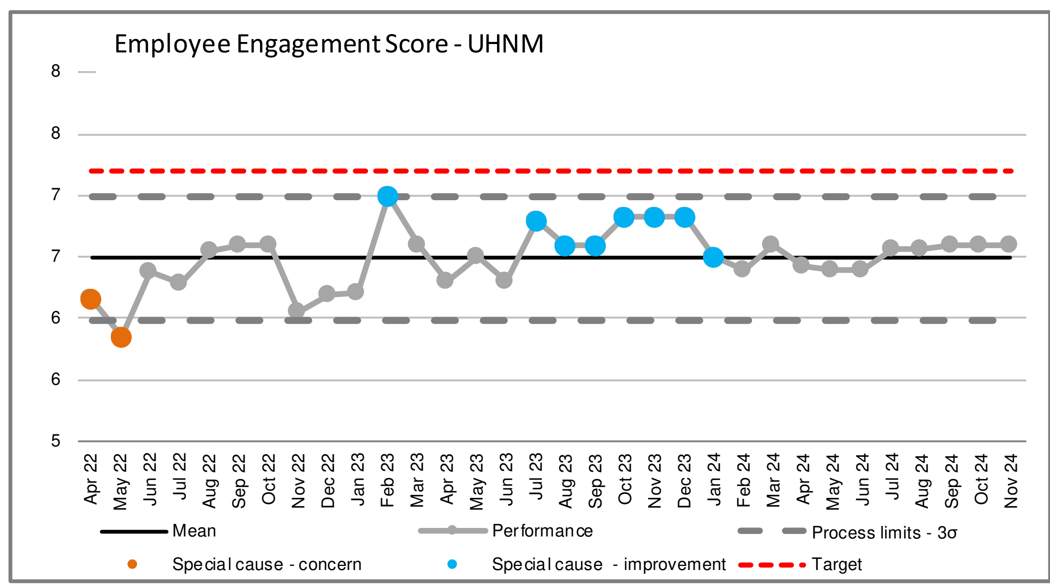
Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 2: Sustainable Workforce	Ext 16	Acceptable	Ext 15	Acceptable			Ext 16	Acceptable

People

People | Employee Engagement

Creating a great place to work for everyone



Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
7.2	6.6	6.6	6.6

Background

What is the data telling us?

Our most recent Staff Engagement score was 6.56, for July 2024, up from 6.42 for April 2024, against a target of 7.2.

The Staff Voice Survey is now collected quarterly, meaning the next scoring period will open from 1st January 2025. (The most recent score will be used in the intervening months.)

The National Staff Survey has now closed, with an overall 45% response rate, which is comparable to the 44.9% response rate we achieved in 2023/24.

What are we doing about it?

The survey has moved to quarterly (with the survey open for 14 days) for FY24/25 to prevent survey fatigue and to allow more time for the divisions to review and respond to feedback 'you said, we will'. The next reportable period is January 2025.

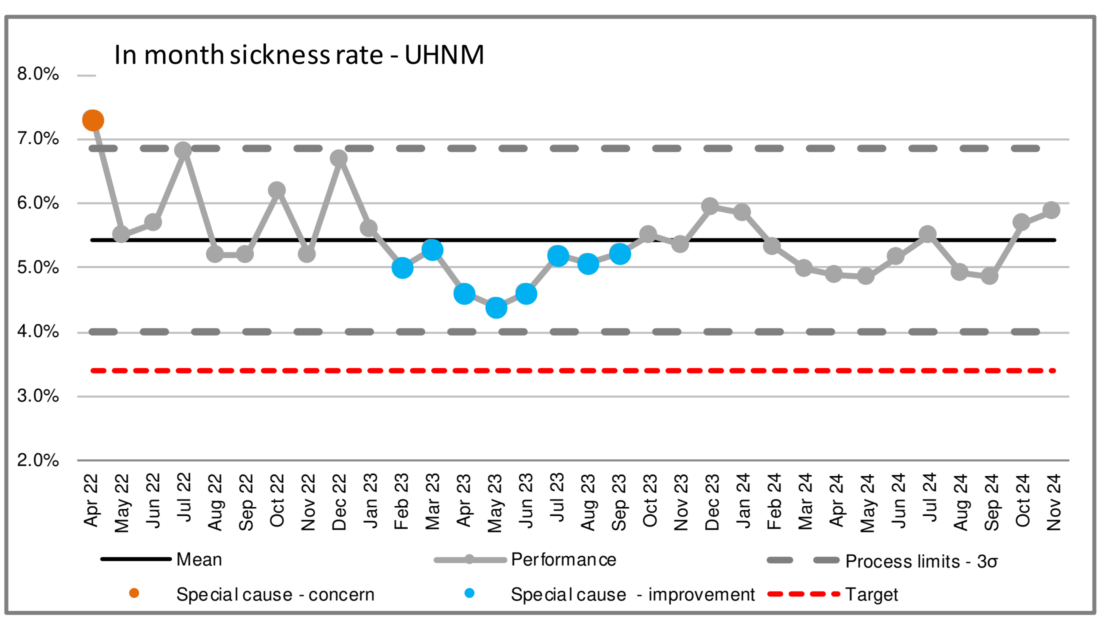
Sustained operational pressures continue to impact on overall employee engagement.

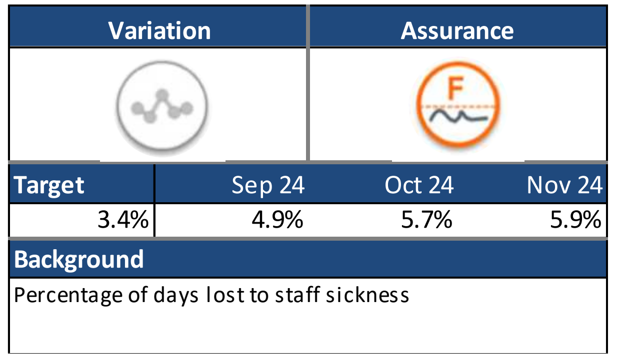
All Divisions are developing staff survey response plans and have a driver metric for staff engagement.

People | Sickness Absence in Month

Creating a great place to work for everyone

People

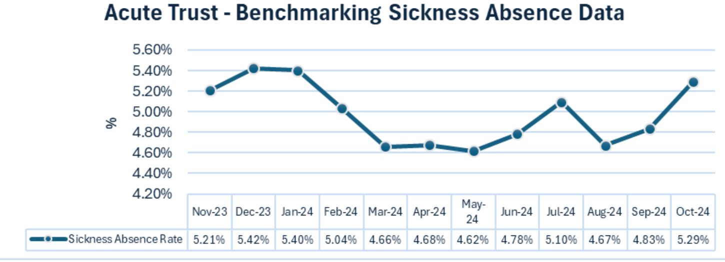




Variation	Assurance		
Target	Sep 24	Oct 24	Nov 24
3.4%	4.9%	5.7%	5.9%

Background
Percentage of days lost to staff sickness

Our sickness absence rates are comparable to other Acute Trust's when examining the available benchmarking data.
(Benchmarking data effective October 2024)



	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Sickness Absence Rate	5.21%	5.42%	5.40%	5.04%	4.66%	4.68%	4.62%	4.78%	5.10%	4.67%	4.83%	5.29%

What is the data telling us?

The rolling 12-month average sickness absence rate increased slightly to 5.32% (5.28% in October 2024) against the target of 3.4%.

The in-month sickness absence increased to 5.89% in November (5.71% in October-24) with Gastrointestinal problems seeing the biggest increase of 1.7%, followed by a 0.4% increase in Anxiety/stress/depression/other psychiatric illness.

In rank order (highest first), the top 3 reasons for absences during November were: (1) Anxiety/stress/depression/other psychiatric illnesses, (2) Gastrointestinal problems and (3) Cold, Cough, Flu - Influenza.

What are we doing about it?

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

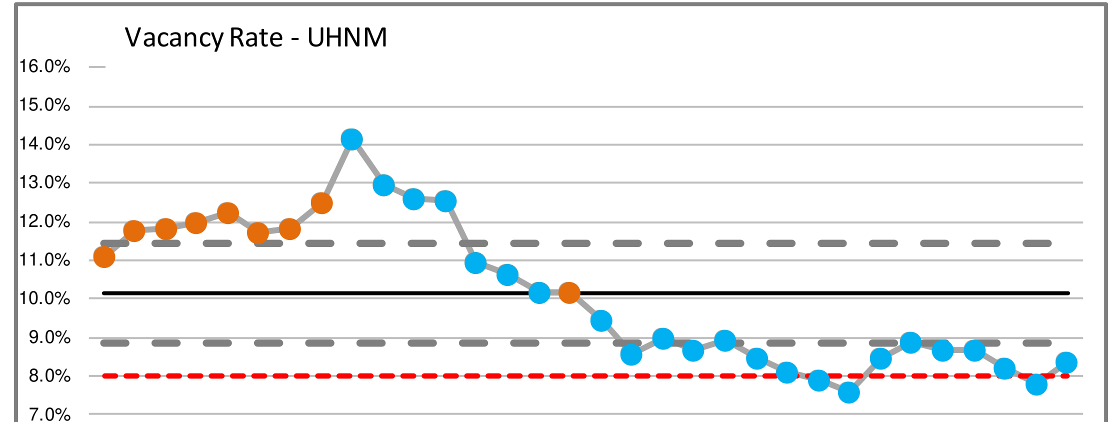
Surgery Division – assessment of hotspot areas for long and short term absences to provide targeted support including re-training.

Network Division - commenced sickness assurance meetings.

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

People | Vacancy Rate

Creating a great place to work for everyone



Variation	Assurance
L	F

Target	Sep 24	Oct 24	Nov 24
8%	8.2%	7.8%	8.4%

Background

Based on Full Establishment (Substantive, Bank & Agency)

Vacancies at 30-11-24	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,781.77	1,591.86	189.91	10.66%	9.03%
Registered Nursing	3826.59	3586.55	240.04	6.27%	5.95%
All other Staff Groups	6985.04	6358.95	626.09	8.96%	8.54%
Total	12,593.40	11,537.37	1,056.03	8.39%	7.82%

What is the data telling us?

The summary of vacancies, by staff groupings, saw a 0.6% increase in the overall vacancy rate. The reasons for this are explained below.

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

Colleagues in post increased in November 2024 by 51.34 fte, across Registered Nursing (+29.23), ST&T (+4.71), Infrastructure (+7.52) and Medical & Dental (+6.69). Budgeted establishment increased by 132.8 fte, which increased the vacancy fte by +81.46 fte overall.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 30/11/24]

What are we doing about it?

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

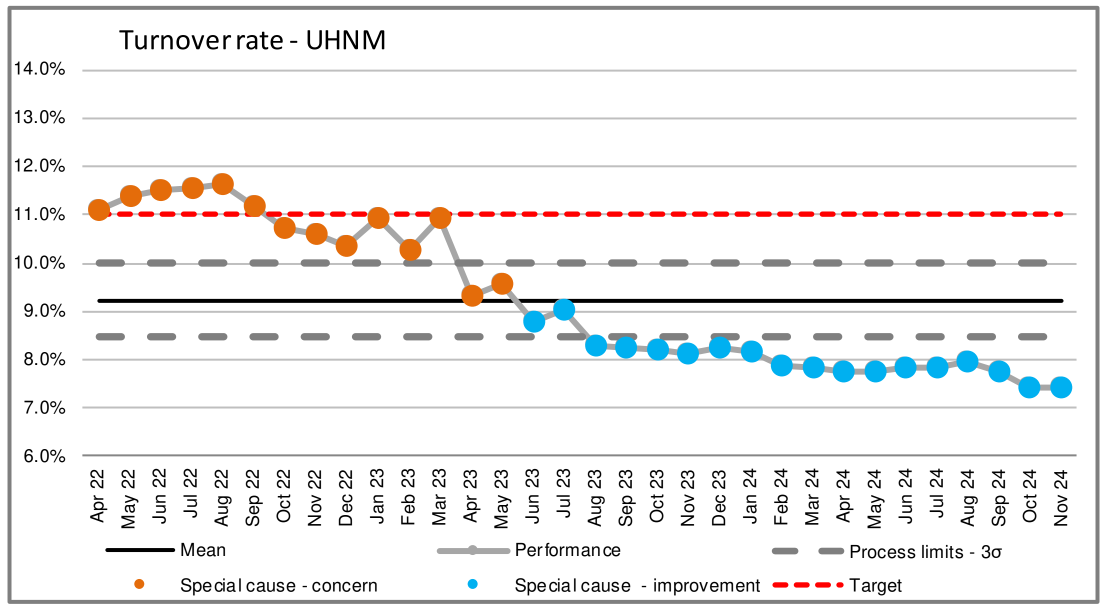
Targeted social media campaigns continue, advertising that our organisation is a great place to work.

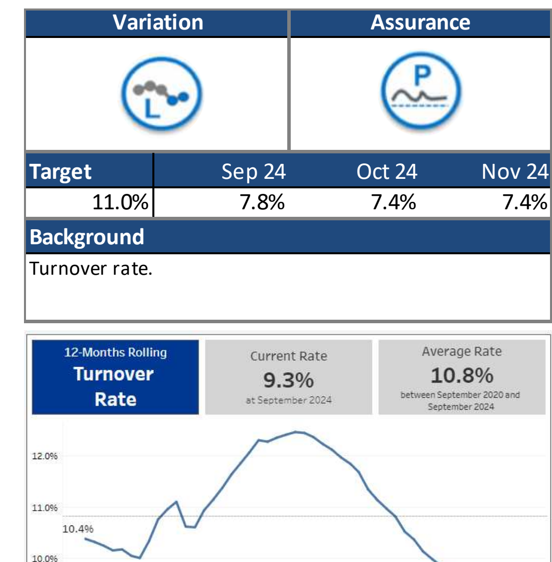
We continue our targeted spotlights on our colleagues, which supplement our recruitment campaigns.

People

People | Turnover Rate

Creating a great place to work for everyone





Target	Sep 24	Oct 24	Nov 24
11.0%	7.8%	7.4%	7.4%

Based on the most recent benchmarking data, comparing ourselves against other Acute Trusts, our overall turnover is much lower.

(Benchmarking data effective September 2024)

What is the data telling us?

The turnover rate in November 2024 remains low, at 7.4% for the second consecutive month, which is consistently below the Trust's 11% target, for the last 2 Years.

Or overall turnover rates are also well below the national averages when compared to other Acute Trusts.

What are we doing about it?

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

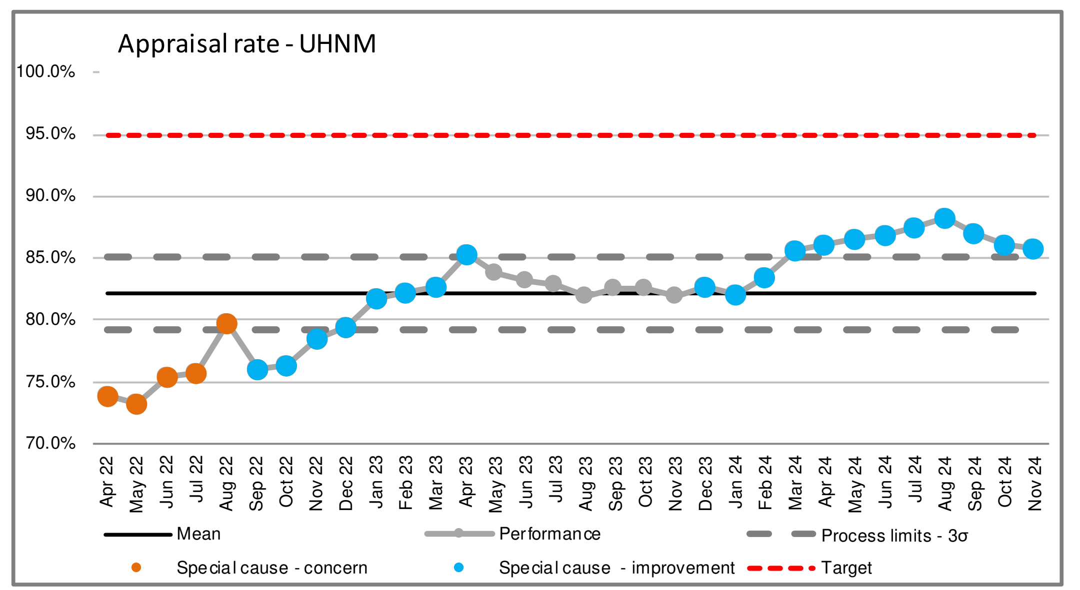
- Medical Staffing finishing school.
- Employment of a People Promise (Retention) Manager who started in a fixed term post.
- Implementation of the Wagestream solution, for bank staff, including our people who work both substantively and on the bank.
- Monthly targeted campaigns aligned to our four People Promise areas of focus (Apr-Nov 2024). For example, People Promise 1 'We are compassionate and inclusive': November & December are Disability History Month.

People | Appraisal Rate

Creating a great place to work for everyone

NHS University Hospitals of North Midlands NHS Trust

People



Variation		Assurance	
Target	Sep 24	Oct 24	Nov 24
95%	87.1%	86.0%	85.8%

Background

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

What is the data telling us?

Performance Development Reviews (PDR's) continue to perform below our 95% target.

November's appraisal rates decreased fractionally by 0.2% to 85.8% (86.0% in October 2024).

The Divisions must continue to monitor and review their PDR performance.

What are we doing about it?

NMCPS - All out of date PDR's are scheduled with line managers.

Network Division – 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.

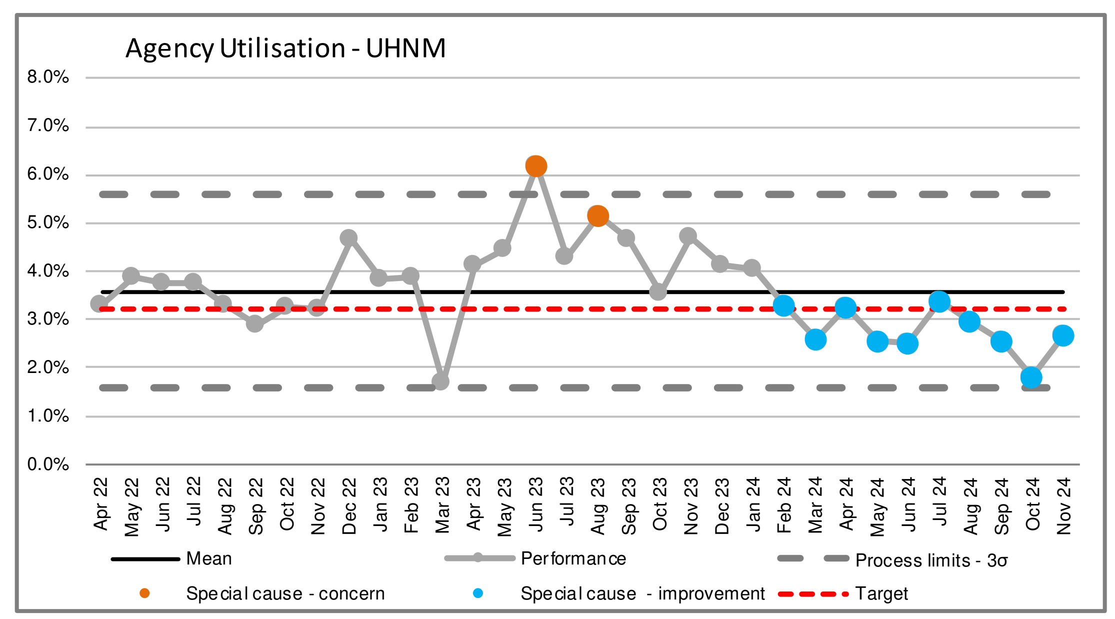
WCCSS – Weekly performance reports and assurance meetings.

People

People | Agency Utilisation

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation		Assurance	
Target	Sep 24	Oct 24	Nov 24
3.2%	2.6%	1.8%	2.7%

Background

Agency cost as a percentage of total pay cost

What is the data telling us?

Agency cost is calculated as a percentage of the total Pay Costs, which increased to 2.68% in November 2024, (1.81% in October 2024), which remains below the threshold set by NHS England. (Note: October's agency percentage was lower because of the Agenda for Change backdated pay rise.)

In real-terms, overall agency usage decreased to 150.76 WTE in November from 157.97 WTE in October 2024, which is -75.54 below plan.

Executive and divisional level scrutiny, in addition to the software level controls would appear to be having the desired effect.

What are we doing about it?

- Agency use is monitored and discussed at monthly divisional meetings. This includes reviewing long-term agency use.
- All current in-sourcing contracts are reviewed monthly, to ensure that they do not breach rules regarding off-framework agency use.
- All off-framework agency arrangements have been reviewed and all off-framework use ceased at the end of July 2024.
- System level controls have been implemented in our Electronic Rostering solution, for all nursing & midwifery rosters, which now require Matron level authorisation prior to being filled by either bank and/or agency. These additional controls are expected to help with controlling the use of bank and agency, through higher levels of scrutiny by the senior clinical nursing teams.

Improving & Innovating | Overview

Excellence in development and research

Overview from the Chief Medical Officer and Chief Nurse

How are we doing against our trajectories and expected standards?

Metric 1: Increasing clinical trial participants:.
Research Participants:
2023/24 Apr-Nov = 1326
2024/25 Apr-Nov = 1545
Positive increase on 23/24, through a month on month sustained increase. NIHR Commercial Research Delivery Centre awarded to UHNM. This £3.2m infrastructure award will see an increase in commercial research from April 2025 onwards.

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

Metric 3: Increasing research active staff: The A3 has shown that we do not know what is meant by 'research active' or how many research active staff we have in UHNM. The data provided indicate what we know only from those staff who have contacted CeNREE or the R&I department for research support or who are current CIs/PIs. This estimated number is probably increasing in part due to newly active staff but also due to gaining awareness of existing research active staff.

What is driving this?

Metric 1 In order to achieve the goal of increasing research participants, it is crucial to maintain a well-balanced portfolio with established recruitment targets. The Research Delivery Network has confirmed that the reputation of Research Active Trusts will be less reliant on recruitment numbers going forward and more focused on maintaining a balanced portfolio of Commercial and Non-Commercial studies

Metric 2: The A3 has shown that we do not collect this data in a systematic way. This number therefore remains unchanged from last month; however, we now have an agreed plan to start collecting this data from January 2025.

Metric 3: The A3 has shown that we do not collect this data in a systematic way; however, we now have an agreed plan to start collecting this data from January 2025. The estimated number has increased from 416 to 430 since the last report.

Improving & Innovating | Overview

Excellence in development and research

Overview from the Chief Medical Officer and Chief Nurse

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

Metric 1: We are actively tracking recruitment progress against targets on a monthly basis during lead practitioner meetings. One of our primary studies, with a significant recruitment target, relies on school participation, and resources have been allocated accordingly. The NIHR Commercial Research Delivery Centre will begin operations in April 2025. Commercial research typically involves greater complexity and fewer recruitment targets. To align with the future strategic direction of the NIHR, participant recruitment will be categorised separately for commercial and non-commercial research

Metric 2: We have two countermeasures in place: 1) we confirmed what type of honorary/joint appointment contract data is considered relevant by stakeholders in the Research and Innovation Strategy Oversight Group (meeting date 18th September 2024) which was agreed by selected members of the Executive Research and Innovation Group on 29th November 2024, and 2) we will conduct a Trust wide census in early 2025, followed by a quarterly census via Divisional Leads.

Metric 3: We have two countermeasures in place: 1) a definition of 'research active' was suggested by stakeholders in the Research and Innovation Strategy Oversight Group (meeting 18th September) which was agreed by selected members of the Executive Research and Innovation Group on 29th November 2024, and 2) we will conduct a Trust wide census in early 2025, followed by a quarterly census via Divisional Leads.

What can we expect in future reports?

Metric 1: We will start evaluating the distribution of targets across the studies being set up, aiming for a proportional allocation of research opportunities for our patients. It will take approximately 12-18 months to see a significant impact on recruitment, during which time we expect our growing reputation to help attract high-recruiting studies.

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

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

Improving & Innovating | Dashboard

Excellence in development and research

Improving & Innovating

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Increase Clinical Trial Participation	208.0	243.0	308.0						
Increase Clinical Academic Posts/Honorary Contracts	-	13.0	13.0						
Increase Research Active Employees	-	416.0	430.0						

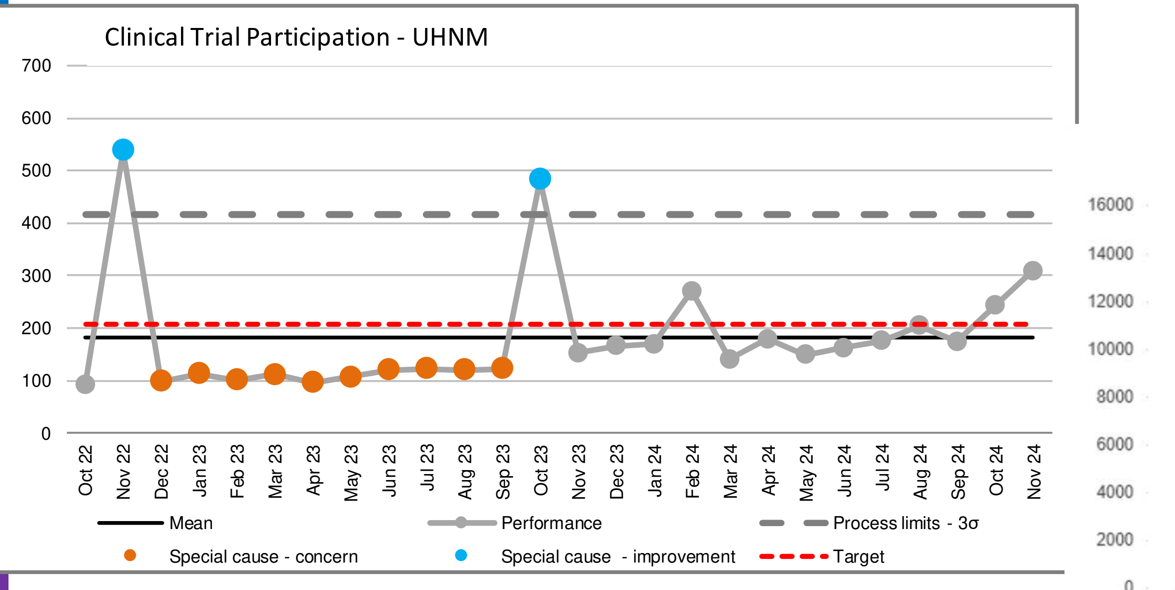
Related Strategy and Board Assurance Framework (BAF)

Quality Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 9: Research Innovation	High 12	Partial	High 12	Partial			High 9	Partial

Improving & Innovating | Clinical Trial Participation

Excellence in development and research

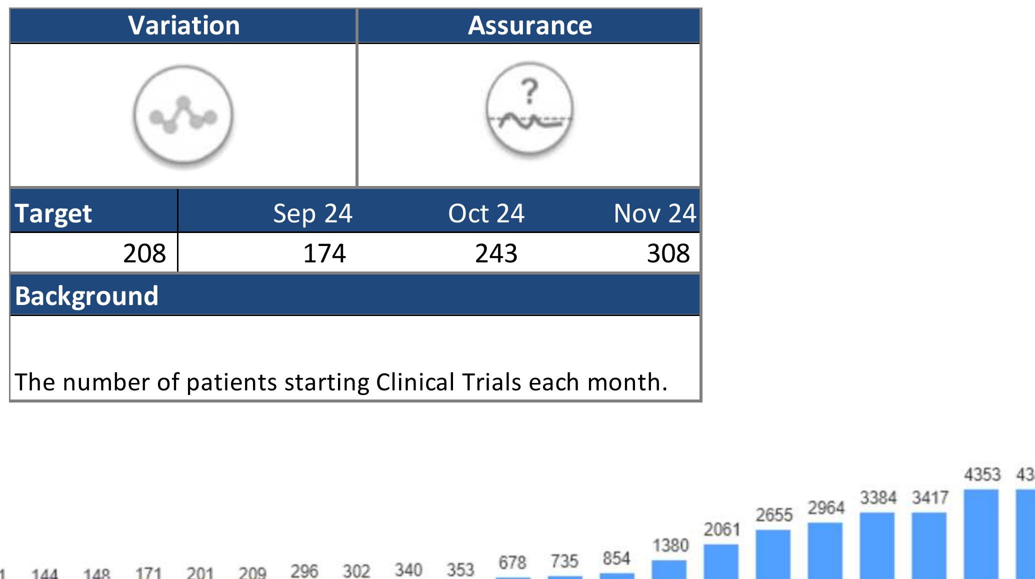


Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
208	174	243	308

Background

The number of patients starting Clinical Trials each month.



What is the data telling us?

Running a diverse range of studies provides us with significant benefits. The recruitment spikes reflect our quick-turnaround studies, which are crucial for boosting participant numbers and enhancing our regional reputation.

Additionally, the data highlights our standing within the region in terms of portfolio recruitment.

What are we doing about it?

The directorate are mindful that a balanced portfolio is required, from research participation of questionnaire studies, through to full clinical trial. This portfolio is being developed over time.

We also see our position within the region and are looking at the facilities and resources offered by the top recruiters to inform our investment direction.

Approval for additional recruitment of research nurses and practitioners required clear demonstration on return on investment, due to current financial constraints.

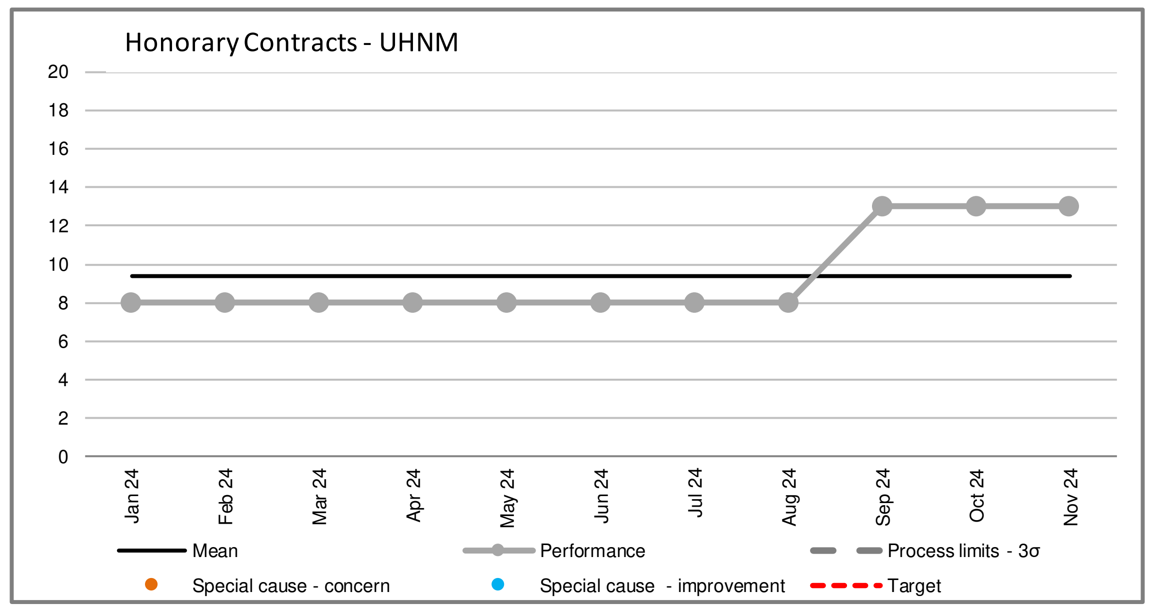
Improving & Innovating

Improving & Innovating | Clinical Academic Posts/Honorary Contracts

Excellence in development and research

University Hospitals of North Midlands NHS Trust

Improving & Innovating



Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
N/A	13	13	13

Background

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

What is the data telling us?

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

What are we doing about it?

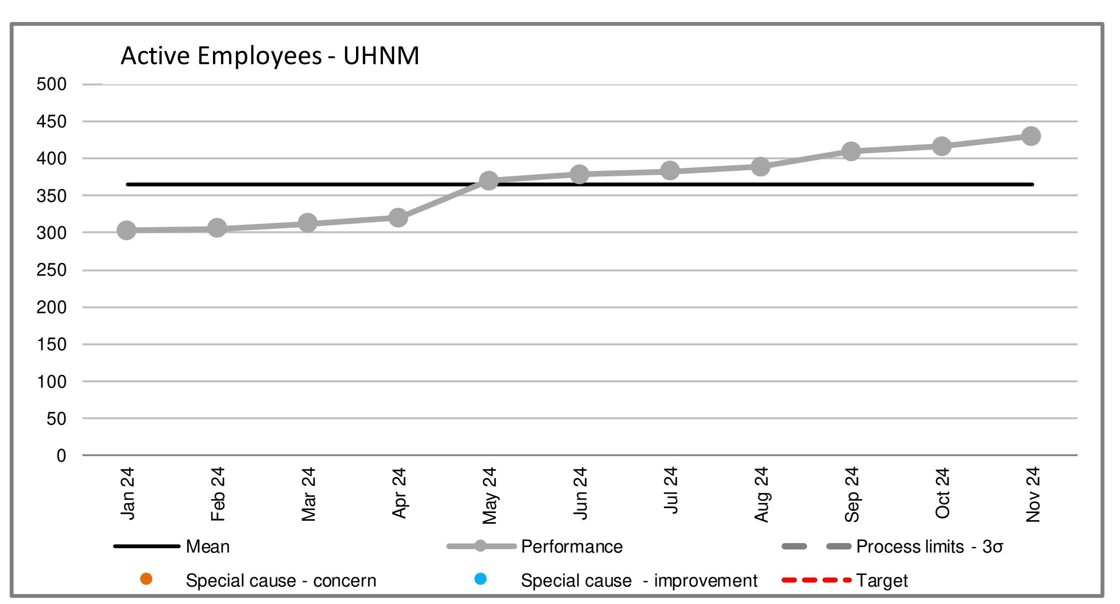
We agreed a suggested definition of type of contract with stakeholders at a meeting on 18th September and this was agreed by selected members of the Executive R&I Group on 29th November 2024.

We will craft a census questionnaire in January 2025 to conduct a Trust wide baseline census, followed by a quarterly census via Divisional leads, to obtain more accurate data. This will indicate where we need to prioritise our negotiations with Higher Education Institutions (HEIs) and other stakeholders.

Improving & Innovating | Research Active Employees

Excellence in development and research

Improving & Innovating



Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
N/A	409	416	430

Background

The number of research active employees in UHNM.

What is the data telling us?

We did not have a confirmed definition of 'research-active' until 29th November 2024, or a process for collecting this data, so this number remains smaller than anticipated.

The data shows us that this number is increasing; however, this claim is made with caution as, while we are finding out about research activity, some may not be new activity.

What are we doing about it?

We agreed a definition with stakeholders on 18th September which gained approval from the Executive R&I Group on 29th November 2024. We will craft a census questionnaire in January 2025 and conduct a Trust wide census to collect accurate data, followed up with quarterly census via Divisional Leads. This will highlight the areas where there is a shortfall in research activity where we can focus our attentions for development and support.

Divisional research lead posts (1 PA) have been agreed and will be open for applications shortly. Expressions of interest are being received, pending appointments in January.

CeNREE are steadily increasing the number of Research Ambassadors across UHNM divisions, clinical areas and professions to signpost staff to research support.

Overview from the Director of Strategy & Transformation

How are we doing against our trajectories and expected standards?

National standards for reporting health inequalities have been introduced for both ICB and Trust levels annual reporting. Trust level reporting is defined as:

- Elective activity vs pre-pandemic levels for under 18s and over 18s (completed with waiting list split by gender, deprivation, ethnicity and age) Proposed Annual Report metric
- Emergency admissions for under 18s (completed as part of ICB assessment) Proposed Annual Report metric

- Number of adult inpatients offered tobacco dependency treatment (Submitted monthly to NHSE – showing increasing referrals as the service is embedded) Proposed IPR metric
- Number of maternity patients offered tobacco dependency treatment (Submitted monthly to NHSE – we are increasing referrals as the service is embedded) Proposed IPR metric
- Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (not yet reported)

It is important to note that the datasets underpinning the full range of metrics is under development nationally.

We have also completed the assessment of our Anchor institution, which has five areas for assessment (employment, procurement, land & buildings, sustainability, partnership & leadership). It shows we are most mature in land & buildings, sustainability and employment. This is a new approach, with targets being agreed. Proposed IPR metric

What is driving this?

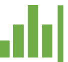
This work is being led by our Population Health and Wellbeing Strategy (approved in 2024). It is informed by the national CORE20PLUS5 framework and the five national priorities to support reductions in health inequality.

Priority 1. restoring NHS services inclusively
Priority 2. mitigating against digital exclusion
Priority 3. ensuring datasets are complete and timely
Priority 4. accelerating preventative programmes
Priority 5. strengthening leadership and accountability.

In addition, the population health and wellbeing strategy (approved in 2024) brings focus to our role as an Anchor Institution, with Strategy Committee approving the use of the Health Foundation developed maturity matrix.

System & Partners | Overview

Working together to improve the health of our population



Overview from the Director of Strategy & Transformation

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

Prevention programme
Focus on integrating inpatient smoking cessation offer with community pathways and increasing the inpatient offer across the trust so it is systematically offered to all current smokers attending as inpatients. Reduction in smoking at time of delivery achieved through maternity smoking cessation offer.
Alcohol Care Team evaluated to understand progress on outcomes and inform business case for expansion to County

Healthcare Inequalities
Development of ICS cancer screening forum by the Trust with representatives from ICS partners
Opportunistic winter vaccination implemented from 1st November with regional grant funding
Transformation of ICS Infant Mortality Steering Group with ICS partners and OHID and increased internal focus with revision of action plan and ICS workshop in January 2025,
Development of access and inequalities research and innovation catalyst group

Anchor Institution
Maturity assessment for programme completed. Initial focus on using data insights on inequalities in staff health and wellbeing with ICS People Function.

What can we expect in future reports?

The next board update proposes to report
- Update on infrastructure developed to enable increased delivery of the Population Health and Wellbeing Strategy
- Update on progress of key prevention priorities- smoking, alcohol, weight management
- Public sector equality duty and links to healthcare inequalities and anchor institution programme

System & Partners

System & Partners | Dashboard

Working together to improve the health of our population

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Alcohol Dependency	-	0.70%	#N/A						
Tobacco Dependency (Inpatients)	-	390.00	335.00						
Tobacco Dependency (Maternity)	-	203.00	194.00						
Anchor Maturity Assessment									

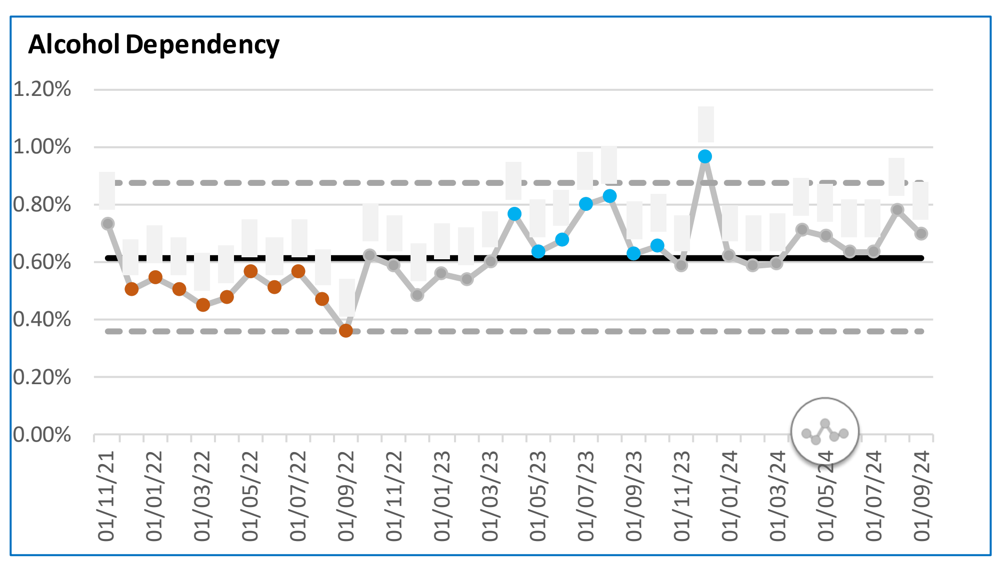
System & Partners

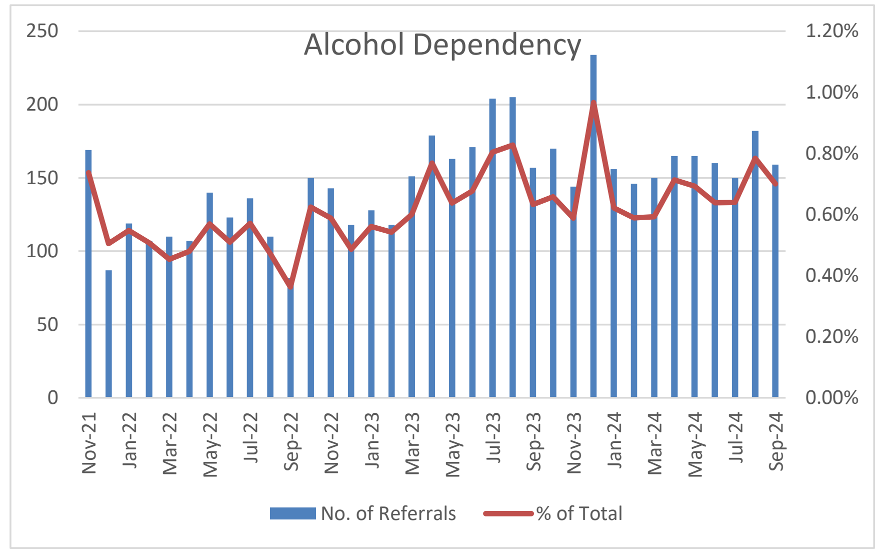
Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 3: Improving the Health of our Population	Ext 15	Partial	Ext 15	Partial				

System & Partners | Alcohol Dependency

Working together to improve the health of our population





What is the data telling us?

Since initiation of the Alcohol Care Team in the Trust, processes to identify and refer patients with alcohol dependency or high risk consumption have improved. 90% of eligible alcohol dependent patients were identified and referred in 2023.

Evaluation of the alcohol care team has identified significant improvements at RSUH through reduced alcohol specific admissions and reduced length of bed stay in the Trust.

This is supporting system efforts to mitigate increasing alcohol harm in the local population as alcohol consumption in high risk consumers of alcohol has increased during and post pandemic.

What are we doing about it?

Evaluation has provided a valuable evidence base of what activity and outcomes the alcohol care team is delivering.

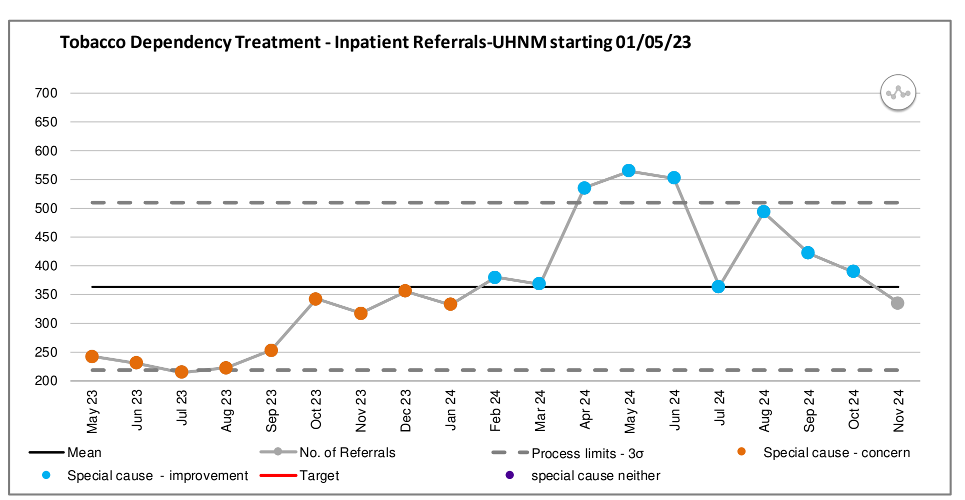
This will be used to inform both service development in the Trust and a Business Case for expansion to County Hospital.

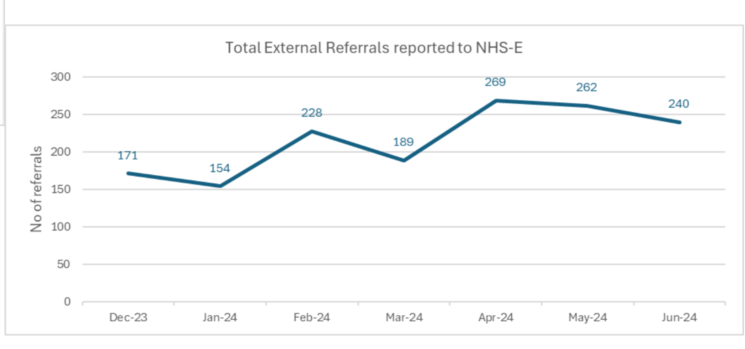
Areas of focus for the service will be expanding capacity in case finding through training to staff groups in key portals alongside expansion to county hospital whilst participating in alcohol pathway review and development.

End stage liver disease steering group established. A database of alcohol related brain damage has also been developed to better understand needs in this group.

System & Partners | Tobacco Dependency Treatment (Inpatients)

Working together to improve the health of our population





What is the data telling us?

Smoking cessation activity in the Trust has increased since the introduction of inpatient and ED smoking cessation offer. There remains improvements to be made in self-reported quit rates to bring the Trust in line with national achievement.

What are we doing about it?

Integrated smoking cessation model has been developed and implemented with community providers to improve transition to community support post discharge. This model is undergoing further development to improve quit rate

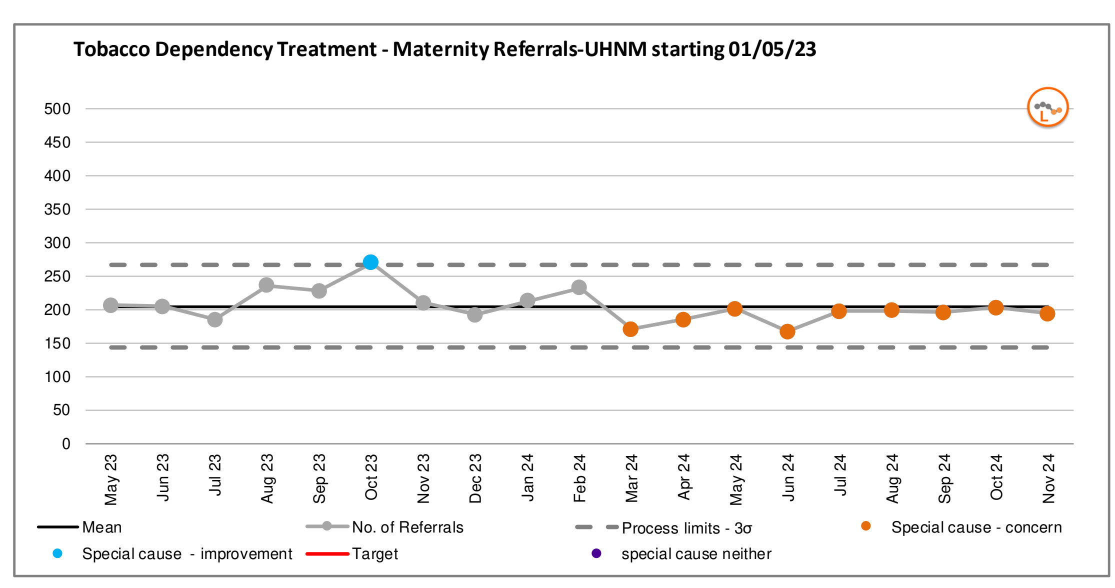
Review of current delivery with A3 used to inform smoking pathway development and improvements in how smoking cessation is offered systematically across Trust settings to patients.

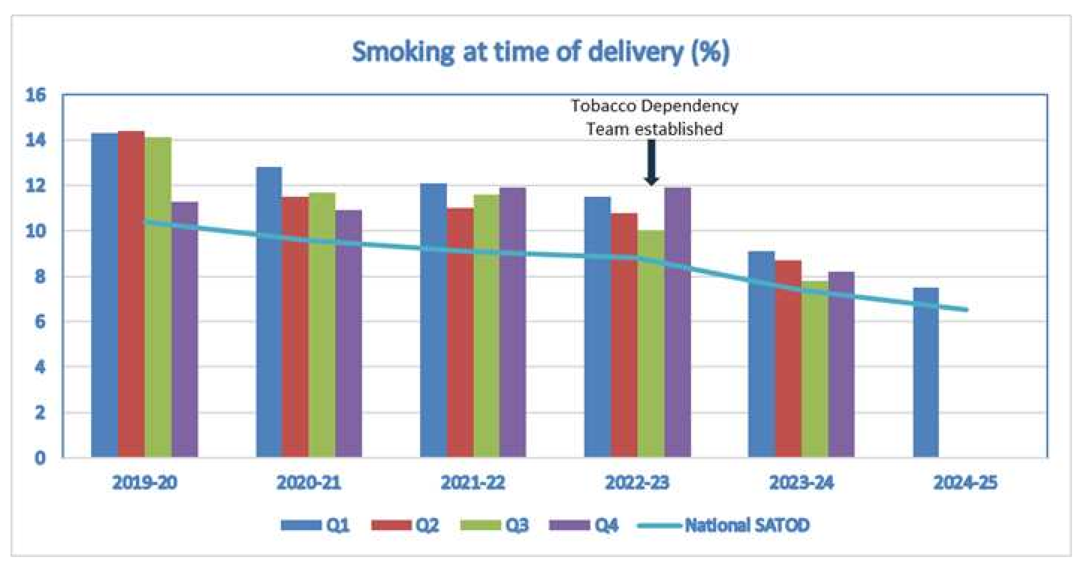
Appraising options and model for developing an outpatient service at the Trust to link in with one of our clinics with a staff service to support staff wanting to quit smoking as well.

Working with Smoking Control Group to develop new policy for the Trust, aiming for smoke free by 2025.

System & Partners | Tobacco Dependency Treatment (Maternity)

Working together to improve the health of our population





What is the data telling us?

Introduction of the maternity smoking cessation offer has achieved an increase in the proportion of pregnant women who have quit smoking at time of delivery.

This has been a significant success but there remains work to be done to further reduce and eliminate smoking during pregnancy.

What are we doing about it?

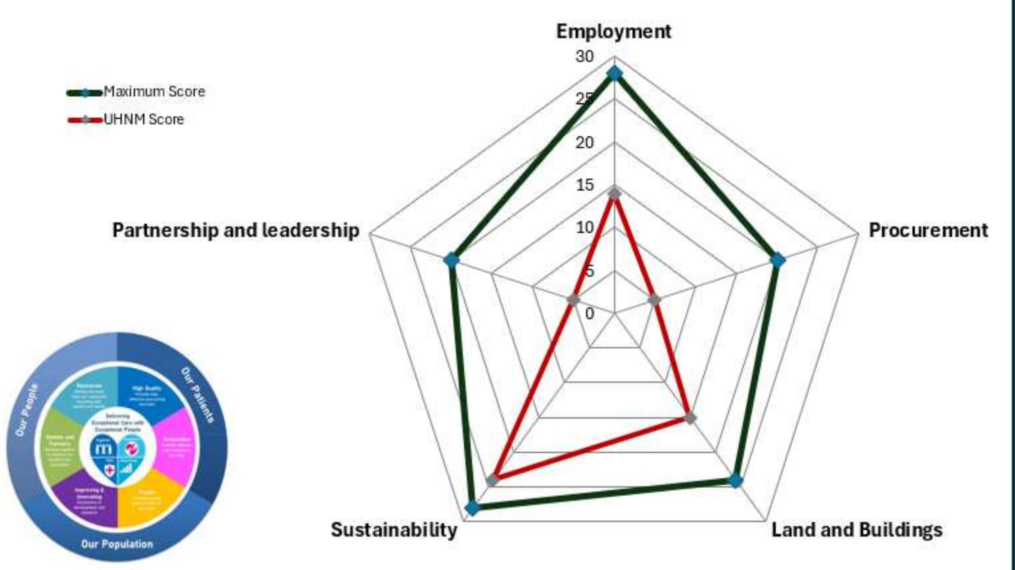
Ongoing delivery of the Trust maternity smoking cessation model, building on existing achievement.

LMNS has submitted an expression of interest for the national maternity incentive scheme to support this evidence based approach to enabling expectant mothers to quit.

System & Partners | Anchor Maturity Assessment

Working together to improve the health of our population

NHS
University Hospitals of North Midlands
NHS Trust



Our maturity score: 63
Maximum score: 120

Key areas for focus
1. Employment
2. Partnership and Leadership

What is the data telling us?

Whilst the anchor institution programme is new to the Trust, there are existing initiatives which support delivery, particularly on sustainability, employment and how we use Trust assets.

There is limited work in place with system partners at this point as there is no system approach to the NHS as an anchor organisation locally.

Procuring for social value is also supported by the Trust but there are further actions the Trust can take to mature the anchor institution approach.

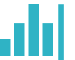
There are internal initiatives supporting the Trust as a good employer locally and offer pathways to employment. There is an opportunity to improve how these are targeted to local communities and priority population groups to reduce local inequalities as well as understand what impact these initiatives are having.

What are we doing about it?

This is a new programme of work for the Trust and the maturity assessment will inform priorities and the delivery plan.

Promoting existing sustainability initiatives and exploring opportunities to work with system partners on the warmer homes/beat the cold programme with the Keep Warm Keep Well intervention, NHS netzero agenda and ICS climate adaptation plan.

With unemployment and workplace health significant public health issues locally we are undertaking analysis to understand inequalities in the workforce. Findings will be presented to ICS Staff Health and Wellbeing project to take forward as an ICS partnership project.



Overview from the Chief Operating Officer and Chief Information Officer

How are we doing against our trajectories and expected standards?

Non – elective
Non-elective activity continues at high levels although slightly below plan. This continues the general growth over the last 12 months. Plans for this year incorporate a rebase position incorporating growth in the use of Clinical Decision Unit and a continued review is in place.. These were patients who otherwise would wait for excessive periods of time in ED. A review has been undertaken collaboratively with UHNM and the ICB to assess whether an increase in 'walk-ins' can be demonstrated. This undertaking has established that 'walk-ins have more than doubled since April and a subtle connection aligned to the GP Collective action can be seen. Higher than planned and a higher-than-expected respiratory infection presentation the Emergency Departments has impacted on both performance and flow.
The HRD Tool was launched at Royals Stoke on 2nd December and will feature in onward reporting.

Elective
November activity
Day case 101.4%
Elective 84.4%
First OP Proc 97%
First Outpatient 97.9%
Follow up 97.3%

Freedom of information (FOI) requests are not being completed against the nationally mandated standard although there has been a slight increase in performance. The new FOI system is expected to improve compliance against the standards from February as the system is due to go-live in January. Subject Access Requests response times have remained at 96%.

What is driving this?

Non – elective
Although demand management schemes were in place over winter and past the Easter period this has not necessarily seen a reduction in admissions, however a formal analytical review is complete and is now demonstrated through our internal Winter Plan and supported by the submitted System Surge Plan.
An important note on admissions is the use of the Clinical Decisions Unit which was, for a period, closed. This resulted in several patients waiting in ED for 24hours+ receiving treatment in an inappropriate environment. Those patients are now accessing the CDU and that will have contributed to the increased admissions shown from October 2023. AMRAU continues to impact positively as does the Frailty service at County Hospital with notable positive impact.

Elective
Although overall inpatient and daycase activity reduced in November compared with October, performance remains ahead of plan.
Additional theatres and outpatient capacity delivered through ERF bids for 52week trajectories delivery via combinations of Insourcing support and ECH.
Theatre list allocation is delivering a reduction in fallow sessions.

The manual management of Freedom and Information Requests continues to make it a challenge to monitor the high volume of complex requests, this will improve when the new FOI management system is implemented in by the end of January.

Resources | Overview

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

Overview from the Chief Operating Officer and Chief Information Officer

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

Non – elective
The System Demand Management Collaborative is tasked with identifying schemes to reduce demand. This programme commenced in April and is likely was have its greatest impact from October 2024 and onward but sadly, this has not yet bore the results anticipated. This will feature more prominently once a full review of the October and November has been completed.
The Trust, System Partners and the ICB have reviewed all services, schemes and initiatives that will influence this and preparing for our winter planning and resilience and external and internal additional funding has been agreed and plans are being mobilised.

A hot debrief of the Critical incident declared on 26th November is in train and a UHNM 'cold debrief is planned to take place on 17th December 2024.

Elective
There are now monthly executive led FAP meetings with all divisions to review their activity outputs. This sits alongside Outpatient and Theatre improvement workstreams to support improvements in utilisation. The County strategic programme also is looking at the utilisation and development of work across County theatres and its STS facilities. Additional activity has been agreed through ERF bids to achieve 65w with bids to support 52w.

A new information management system will help manage the workflow and approvals for both FOI and SARs; this is due to be implemented by the end of January.

What can we expect in future reports?

Non – elective
Impact and outputs will be made available regarding the schemes funded to reduced non-elective admissions. This assessment, alongside a challenge and confirm exercise. Will feed into both our weekly Winter Planning and weekly System Winter Surge meeting.
The newly agreed improvement and recovery trajectories set against the 4hr standard and Cat2 mean will be featured more prominently but work is still ongoing in respect of this.
With the commencement of the 45minutes ambulance handover process on 11th November, additional compliance data and performance monitoring will be included in this report. This will be presented as an addition SPC chart and will include information drill down from the ICB.

Elective
Agreement of 52w ERF bids has led to an increase in activity from November onwards
There is a risk that the gap between plan and actual will grow over Q3/4 due to the delay in approval of the County Surgical Hub business case. Divisions are currently undertaking a gap analysis to identify potential risk and additional further mitigations to close the gap.

Improvement in the FOI performance is expected from February onwards.

Resources | Overview

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

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Daycase / Elective Activity	7,900	11,535	10,609						
Non-Elective Activity	variable	9,342	8,661						
Outpatients' 1st	27,430	32,960	29,515						
Outpatients' Follow Up	41,048	49,848	44,484						
Freedom of Information Performance	90.0%	62.0%	64.0%						
Subject Access Request Performance	100.0%	96.0%	96.0%						
Data Security Breaches	0.0	0.0	0.0						

Related Strategy and Board Assurance Framework (BAF)

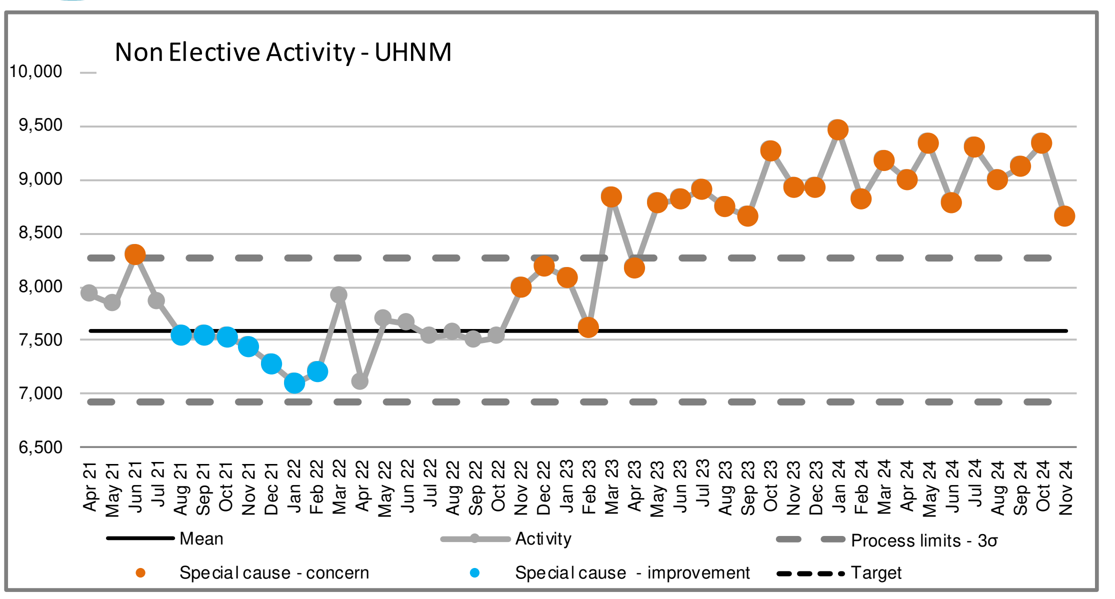
Digital Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 8: Financial Sustainability	Ext 16	Partial	Ext 16	Partial			Low 3	Partial
BAF 5: Digital Transformation	High 12	Partial	Ext 16	Partial			High 9	Acceptable

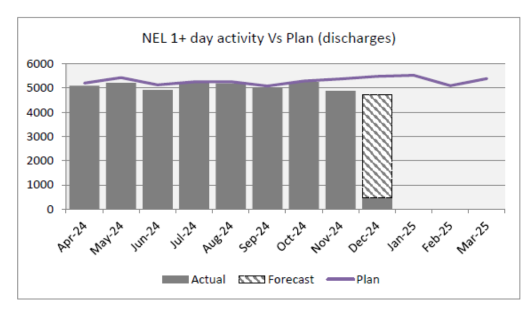
Resources | Non elective Activity

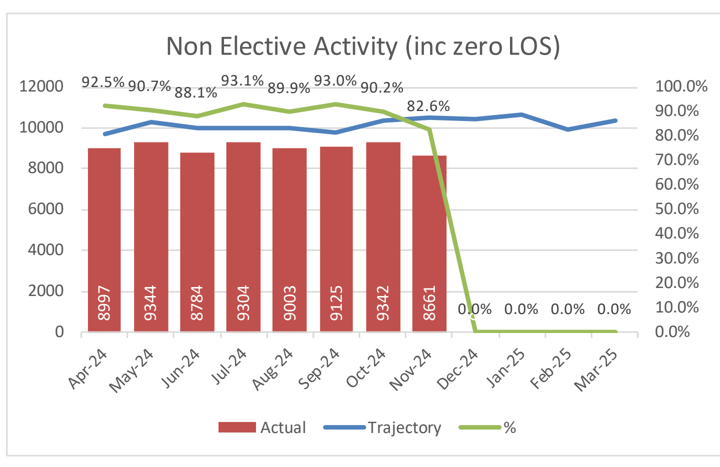
Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust



Variation		Assurance	
Target	Sep 24	Oct 24	Nov 24
variable	9,125	9,342	8,661
Background			
Non elective discharges following an inpatients spell at the Trust each month (includes zero LOS).			





What is the data telling us?

In November we experienced a slightly lower demand in respect of our non-elective activity. October saw a reduced NEL+1 day length of stay and a NEL zero-day length of stay.

Activity verse plan for NEL 0, Year To Date – the plan was 38,570 patients but actual was 31,725 which equates to 82.3% plan verses actual. Medicine saw the largest decrease actual verse plan by 27.5%, Surgery experienced 11% reduction in Actual verse plan, whilst both Network and WCCS saw increases in actual verses plan – 11.8% and 5.5%, respectively.

NEL+1 activity verse plan, Year To Date – the plan was 42,077 verses actual outturn was 40,784, which equates to 96.9% plan verses actual. Medicine saw the largest decrease actual verses plan by 8% but all other divisions experienced an increase. Surgery 2.4%, WCCS 4.7% and Networks 0.6%.

The total expected discharges were 10,483 verses and actual of 8,661. Representing 681 fewer discharges in November verse October and 1,822 fewer discharges than expected.

What the data does not tell us is any variation in average length of stay by pathway and the expected daily discharges by pathway. Nor does it describe the increase in Covid or other infectious diseases. Paediatric RSV impacted on length of stay and Covid experienced a higher-than-expected impact on admissions. This continues to be formally reviewed at System and Trust level.

What are we doing about it?

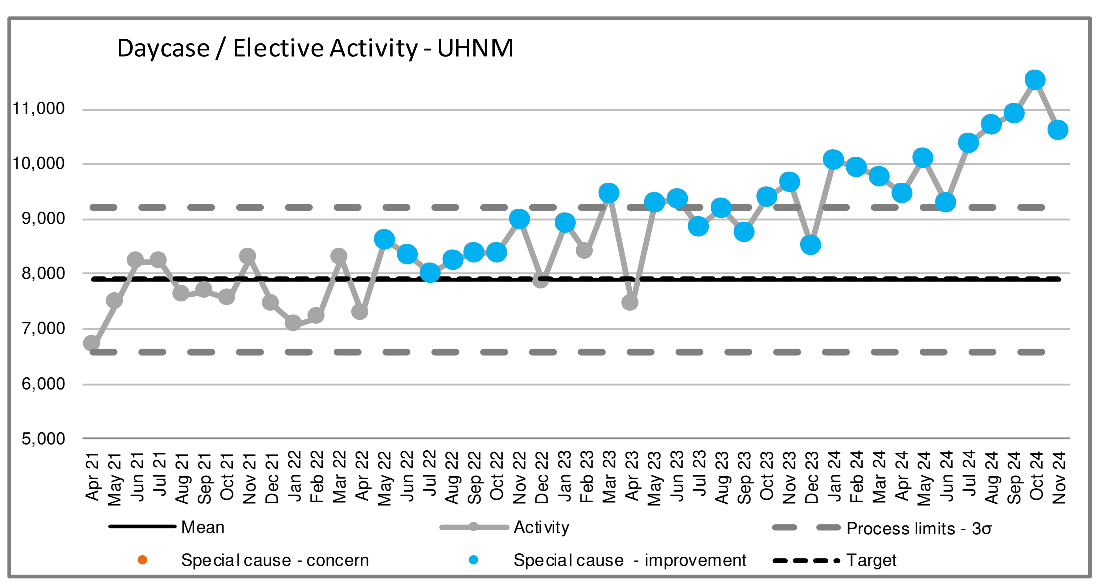
The attends and admission profile is not directly within UHNM control; however, we continue to focus on and further develop alternative pathways to admission avoid.

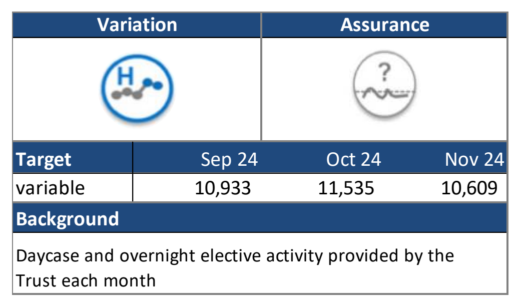
Renewed focus through Acute Care at Home (ACaH), has positively impacted on the utilisation of 'virtual ward' capacity. 2 in reach practitioners are in post to support a 'pull' model. This is now becoming 'Business As Usual' (BAU).

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

Resources | Daycase/Elective Activity

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

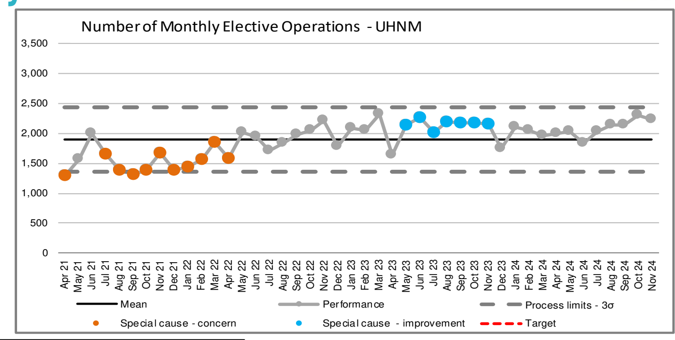


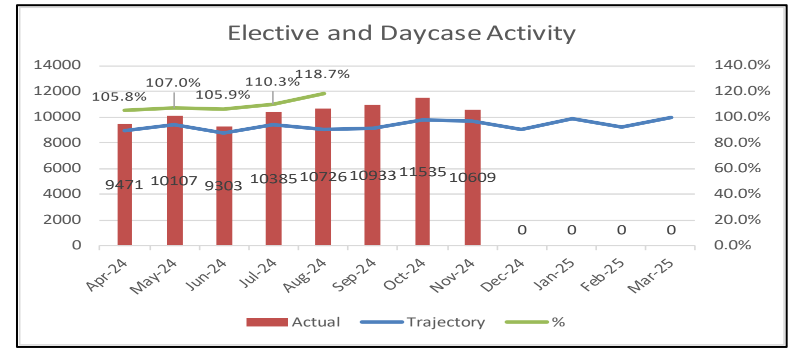


Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
variable	10,933	11,535	10,609

Background
Daycase and overnight elective activity provided by the Trust each month





What is the data telling us?

There has been a special cause improvement since April 22 across day case and elective activity. This fell in November to 10,609 from a high in October of 11,491. Data above relates to Trust wide Daycase & Elective activity.

Theatres:
After a drop in October Capped utilisation for theatres, viewed through MH data, has recovered to 78.3%. this in Quartile 2 as a provider against national median of 79.6%. RSUH reported 78% and County Elective Hub reported 79.3%.

Number of cases across theatres as a subset reduced slightly by 89 to 2224 in Nov 24.

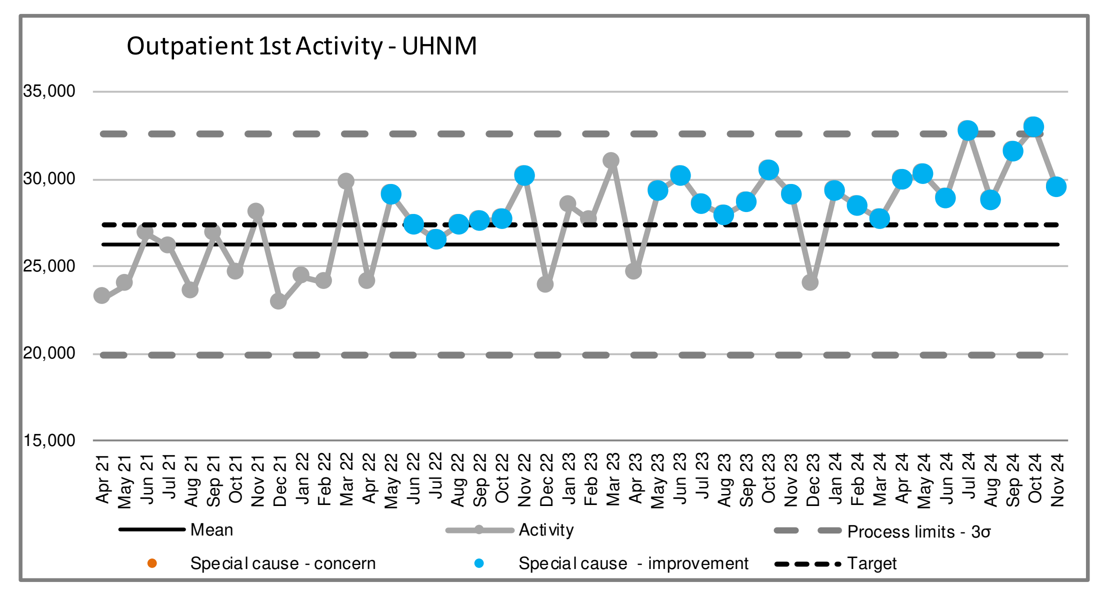
Cancelled operations on the day reduced to 7.2% (176) with most notable reduction at County down to 3.79% (24)

What are we doing about it?

- Theatres across both sites are accommodating and hosting increasing amount of additional activity, much of which is ERF funded for 52week trajectories delivered via combinations of Insourcing support and ECH.
- MH benchmark data continues to show upward trend, alignment of internal utilisation measures to MH methodology now possible following BlueSpier upgrade. Date to be confirmed. .
- Standby Pt pathway progress continues, >7pts in October & 5pts in November
- County Elective Hub Timetable confirmed, theatre staff recruitment progressing although some risk with band 5 staff with >10wte still required
- List allocation process working well 3 or 4 lists re-allocated per week which otherwise may have remained fallow.
- Perioperative Medicine Pathway Transformation – key stakeholders attended regional workshop, several leads identified and being pursued to aid the transformation. Digital screening questionnaire now live and in pilot phase with general surgery.
- Comms & Engagement strategy for next steps under development.

Resources | Outpatient First Appt

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

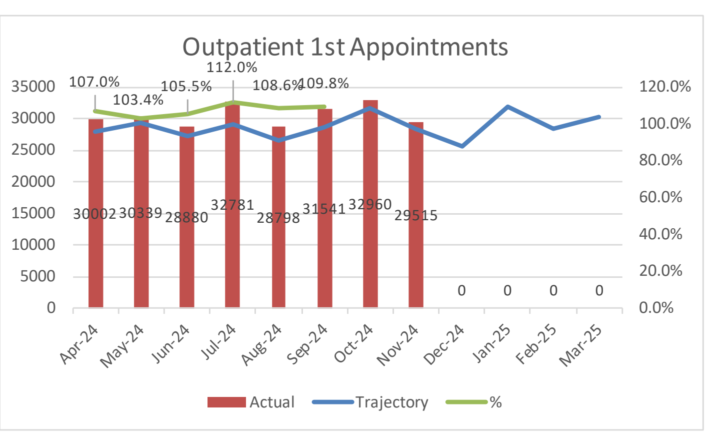


Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
variable	31,541	32,960	29,515

Background

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



What is the data telling us?

Activity saw a sustained increase vs 3 year mean from May 2023 with all points (apart from Dec 2023) above mean, therefore mean needs recalculating from April 2023 onwards.

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

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

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

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

What are we doing about it?

Advice & Guidance (A&G) Effective engagement with A&G prior to referral to ensure patients are effectively optimised prior to referrals

Missed Appointments: 2 Way Messaging; IM&T & supplier technical testing for implementation. Final testing underway, go live December.
Health Inequalities Audits – dashboard developed, aligning with wider health inequalities approach, closely linking with public health consultant

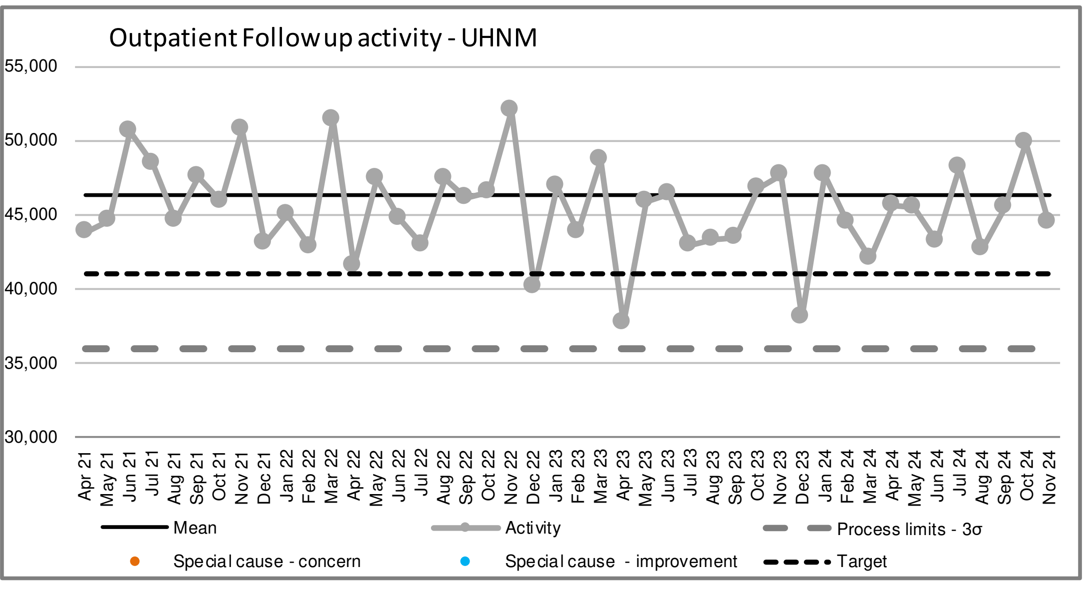
Results Waiting List review: Targeted validation by Divisions for overdue patients starting with the longest overdue. Reporting reviewed, first draft incorporated in regular weekly view, further development required.

Outcomes process review: Scoping approach; targeting those outstanding from previous months initially, outliers in limited number of medical specialties. Still challenges in clearing backlog, reviewing approach. Clinic outcome training actions being identified, form being re-reviewed, including capturing of OP Procedures.

Resources | Outpatient Follow Up Appts

University Hospitals of North Midlands NHS Trust

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

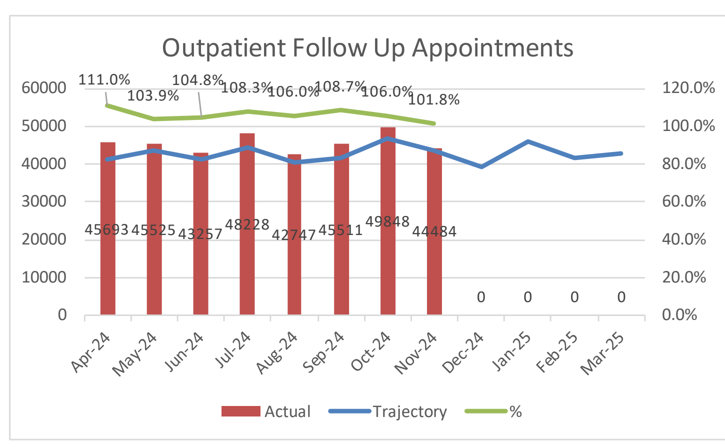


Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
variable	45,511	49,848	44,484

Background

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



What is the data telling us?

No significant change at this level; however from Jan to Nov 8 points of 11 below mean.

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

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

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

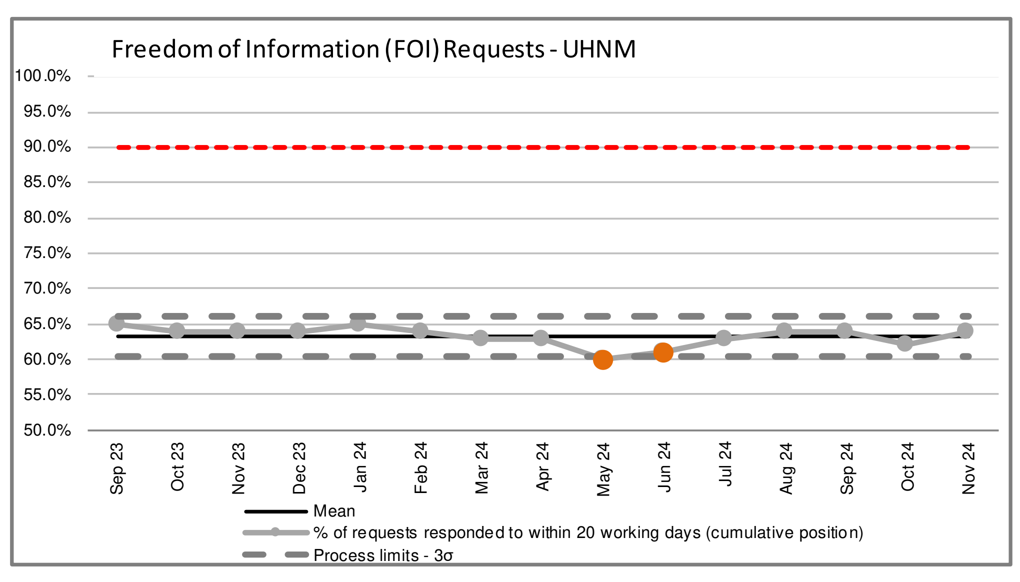
Any capacity released should therefore be used for additional new patients, or to address the long waits / backlog.

What are we doing about it?

Patient initiated Follow Ups (PIFU): Currently 10 specialties live with additional specialties being scoped.
UHNM volunteered to support PIFU Discovery Wayfinder Programme led by NHSE re PIFU & NHS App, awaiting confirmation from NHSE.

Resources | Freedom of Information Performance

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



Variation	Assurance

Target	Sep 24	Oct 24	Nov 24
90%	64%	62%	64%

Background

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

What is the data telling us?

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

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

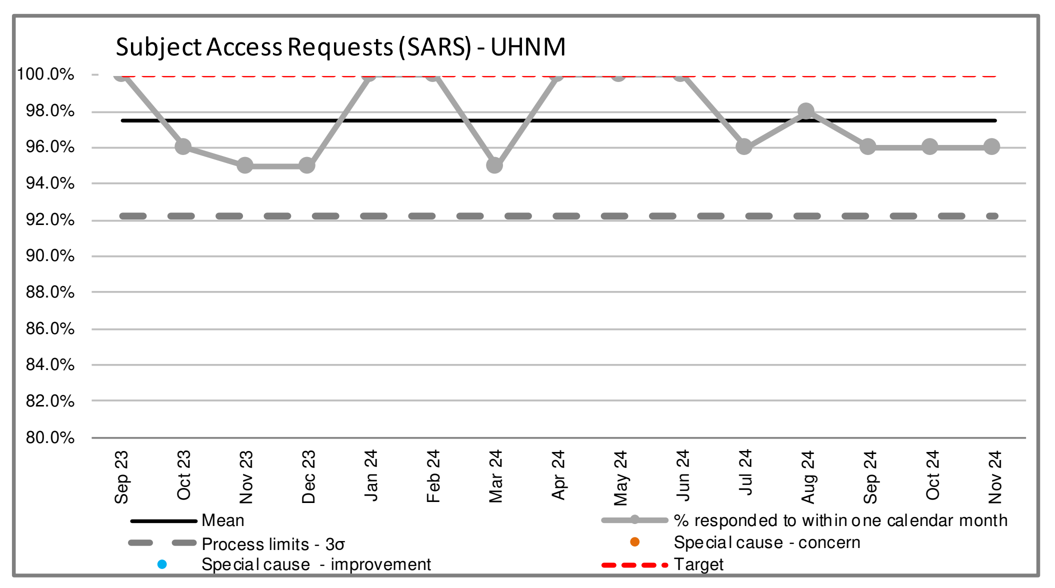
The data shows a slight increase in performance this month

What are we doing about it?

- A digital system has been procured following consultation with key stakeholders.
- The disclosure log work stream is complete which will make the disclosure log more intuitive for the requestor
- The system is currently undergoing final testing:
    - New templates have been loaded and working as expected,
    - Training sessions have been undertaken,
    - Accounts have been created for users,
    - Access controls established and users have confirmed they can access the system.
- Final steps are underway to make the portal and disclosure log live. The Infrastructure Team are supporting with the creation of a dedicated url.

Resources | Subject Access Request Performance

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



Variation		Assurance	
Target	Sep 24	Oct 24	Nov 24
100.0%	96.0%	96.0%	96.0%

Background

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

What is the data telling us?

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

The response times have remained steady at 96%, due to annual leave and sickness absence.

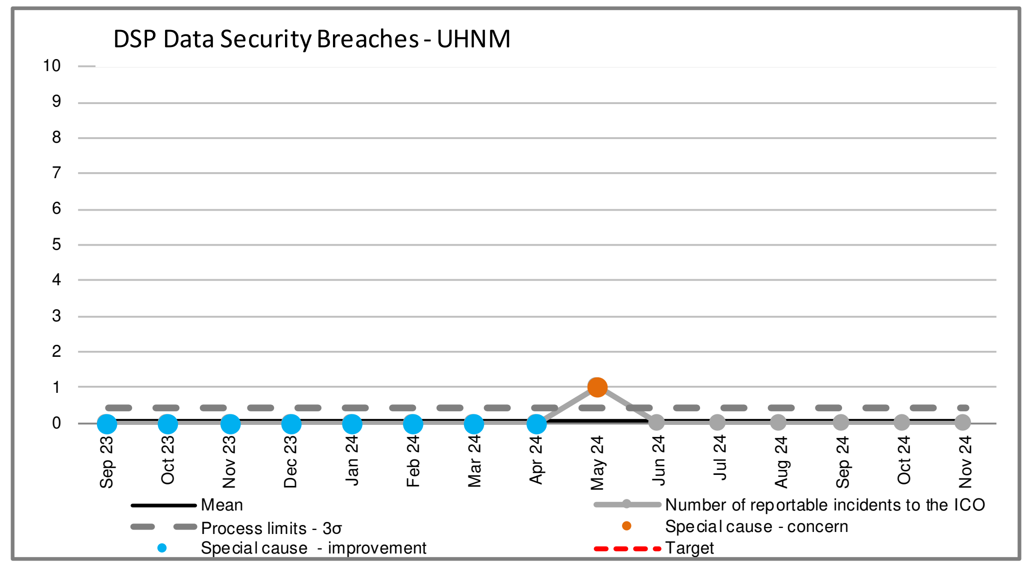
What are we doing about it?

The Data, Security & Protection team are implementing a digital system for Freedom of Information Requests. This will also support the management of SARs. The People Directorate have agreed to move to the digital solution. This will facilitate a review of practice across DSP/Health Records and People Directorate in the management of SARs with the aim of standardising practice across the Trust. A project plan is being developed (as per the detail outlined on the FOI slide). The SAR module will be rolled out once the FOI module has been embedded across the Trust.

Monitoring of performance continues and additional support has been provided for the Ministries Team.

Resources | Data Security Breaches

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



Variation		Assurance	
Target	Sep 24	Oct 24	Nov 24
0	0	0	0

Background

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

What is the data telling us?

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

No serious breaches have been reported this month.

What are we doing about it?

A governance and assurance programme is in place to support staff in understanding Data, Security & Protection (DSP) and hence minimise a data security breach:

- Policies and Standard Operating Procedures are reviewed in line with latest/best practice.
- Statutory and Mandatory training is undertaken on a yearly basis
- DSP manual in place to support staff in their day-to-day duties.
- Training awareness survey to identify staffs understanding of DSP.
- Dedicated training material, for example Information Asset Owners, responsible for the management of digital systems.
- A meeting has taken place with the ICO to discuss the incident reported in May. Discussions are ongoing with the ICO.

Resources | Digital Project Delivery Lifecycle

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

	Progress Status						
Project Priority	**COMPLETE**	**IN PROGRESS**	**MOVED TO BAU**	**NOT STARTED**	**ON HOLD**	**MOVED TO 25_26**	**Grand Total**
Essential	4	11	1	2	1		**19**
Essential – Proof of Concept (PoC)			1	1		2	**4**
Mandated	2	18	2	14	7	4	**47**
Other - High Priority		5		7	1	2	**15**
Other - Medium Priority		6		3	1	3	**13**
Other - Low Priority	1	2	1	1		10	**15**
Parked						1	**1**
PoC						1	**1**
TBC							
Grand Total	**7**	**42**	**5**	**28**	**10**	**23**	**115**

Variation		Assurance	
Target	Sept 24	Oct 24	Nov 24
N/A	104	104	80

Background

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

What is the data telling us?

There are currently 42 IM&T projects that are in progress (a decrease of 2 from last month). 7 projects have been completed during November 2024. 38 projects have either not started or are currently on hold (a decrease of 22 from last month) as a number of projects have now been moved to start next financial year (see table above). As noted in the last report, there continues to be a large volume of IM&T projects slated for delivery during 2024_25 however there has been an overall decrease due to the rescheduling to 2025_26, project consolidation or projects no longer required.

What are we doing about it?

To ensure that projects are prioritised correctly, IM&T will periodically undertake a review of priorities utilising a defined scoring mechanism based on criteria such as alignment to national/local strategy, benefits and risk reduction. IM&T have also introduced a new project request process and will also be developing a new Project Management tool to provide a centralised view and oversight of IM&T projects in addition to associated standardised project management processes. We will continue to review projects that have not started with a view to transfer some of these to the 2025_26 IM&T project pipeline as required.

Resources | Financial Summary

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

This report presents the financial performance of the Trust for November 2024 (Month 8).

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

- For Month 8 the Trust has delivered a year-to-date deficit of £15.3m against a planned deficit of £1.6m; this adverse variance of £13.7m is primarily driven by an underperformance against the Trust's in year CIP and overspends within Purchase of Healthcare relating to diagnostics.
- There is a difference between the budget profile of the Trust's financial plan and the final plan submitted to NHSE; the Trust will continue to monitor performance against its financial plan and inform the committee of the position reported externally. It should be noted that this issue only effects the budget profile not the actual position and is neutral across the year.
- The Trust has a CIP target of £56.6m in 2024/25. The Trust has validated £25.8m of CIP savings to Month 8 against a plan of £35.5m. Of the £25.8m saving delivered, £20.8m are non-recurrent.
- The full year forecast at Month 8 indicates that the most likely position remains a £23.1m deficit; this includes the expected impact of a series of agreed actions across the system which are incorporated into a draft system wide recovery plan.
- There has been £41.7m of Capital expenditure to Month 8. This is £5.9m below planned expenditure to Month 8.
- The cash balance at Month 8 is £74.5m which is £5.5m higher than plan mainly due to the profile of cash payments from the ICB; the forecast for the year is for a reduction of £20m due to non-cash elements, a requirement of £7.7m of Trust cash to be used for the 2024/25 capital programme and the payment in 2024/25 of capital payables at 31 March 2024.

Resources | Income and Expenditure

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

The Trust has delivered a £15.3m deficit at Month 8 which is a £13.7m adverse variance from the planned deficit of £1.6m. The table below summarises the I&E position at Month 8.

Income & Expenditure Summary Month 08 2024/25	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,119.6	92.6	92.3	(0.3)	745.3	749.4	4.1
Other Operating Income	94.9	9.5	9.2	(0.4)	63.9	64.2	0.4
Total Income	1,214.5	102.2	101.5	(0.7)	809.2	813.7	4.5
Pay Expenditure	(740.0)	(62.9)	(59.9)	3.0	(490.4)	(489.3)	1.0
Non Pay Expenditure	(441.2)	(36.2)	(42.0)	(5.8)	(298.3)	(318.1)	(19.7)
Total Operational Costs	(1,181.3)	(99.0)	(101.9)	(2.9)	(788.7)	(807.4)	(18.7)
EBITDA	33.2	3.1	(0.4)	(3.6)	20.5	6.3	(14.2)
Interest Receivable	4.0	0.3	0.5	0.2	2.7	4.4	1.7
PDC	(2.0)	(0.2)	(0.3)	(0.1)	(1.3)	(2.4)	(1.1)
Finance Cost	(35.2)	(2.9)	(2.9)	(0.0)	(23.5)	(23.5)	(0.1)
Other Gains or Losses	0.0	0.0	(0.0)	(0.0)	0.0	0.0	0.0
Surplus / (Deficit)	0.0	0.4	(3.2)	(3.5)	(1.6)	(15.3)	(13.7)
Plan phasing adjustment	0.0	(0.7)	0.0	0.7	3.2	0.0	(3.2)
Surplus / (Deficit) reported to NHSE	0.0	(0.4)	(3.2)	(2.8)	1.6	(15.3)	(16.9)

Key issues to note within the Month 8 position include the following.

The year-to-date adverse variance of £16.9m is mainly driven by an under achievement against CIP targets of £9.7m and overspends in the purchase of healthcare from other bodies (mainly relating to external reporting in Radiology and Pathology) of £4.0m. Income is over recovered by £4.5m mainly due to additional excluded drugs and devices income; this is offset by non-pay overspends. The Month 8 position includes an additional £1.1m of income to cover the costs of industrial action earlier in the year.

Resources | CIP

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

The Trust has a £56.6m CIP target for 2024/25. To Month 8, the Trust is reporting £25.8m savings in year, of which £20.8m relates to non-recurrent schemes. The in-month under-delivery of £2.9m is driven by the under-achievement of recurrent CIP delivery in the clinical divisions below the planned level and the additional £10.2m Cip to achieve breakeven which is phased in from Month 7.

The table below summarises the Month 8 position:

CIP Savings Month 8 2024/25	Annual Target	In Month			Year to Date		
		Budget	Actual	Variance	Budget	Actual	Varia
Divisional position							
Medicine & Urgent care	3.9	0.3	0.1	(0.3)	2.6	0.4	(2.1
Surgery, Theatres & Critical Care	3.6	0.3	0.1	(0.2)	2.4	0.4	(2.0
Network services	2.8	0.2	0.2	(0.0)	1.8	0.5	(1.3
Womens, Childrens & Clinical Support Services	2.6	0.2	0.1	(0.1)	1.8	0.6	(1.2
Central functions	1.6	0.1	0.1	(0.1)	1.0	0.4	(0.6
Estates, Facilities & PFI	1.0	0.1	0.1	(0.0)	0.7	0.8	0.1
North Midlands & Cheshire Pathology Services	1.2	0.1	0.1	(0.0)	0.8	0.6	(0.2
Divisional CIP	16.6	1.4	0.6	(0.8)	11.1	3.8	(7.3
Pay Underspend	6.0	0.5	0.5	-	4.0	4.0	-
Bank interest	2.0	0.2	0.4	0.2	1.3	3.0	1.7
Energy savings	3.2	0.3	0.3	(0.0)	2.1	2.1	(0.0
Investment slippage	5.0	0.1	0.1	(0.0)	4.5	4.5	(0.0
Other non recurrent	7.3	0.6	-	(0.6)	4.8	4.1	(0.7
Additional CIP to 4% of cost base	6.3	0.5	0.5	-	4.2	4.2	-
Additional CIP to achieve breakeven	10.2	1.7	-	(1.7)	3.4	-	(3.4
Recovery action - non recurrent mitigation							
Recovery actions - balance sheet							
Recovery actions - discretionary expenditure							
Recovery action - pay controls							
Total CIP	56.6	5.3	2.4	(2.9)	35.5	25.8	(9.7

The table below summarises the recurrent and non-recurrent CIP delivery.

2024/25 CIP target	Annual Target	In Month			Year to Date		
		Budget	Actual	Variance	Budget	Actual	Variance
Recurrent	24.9	2.5	0.8	(1.7)	14.9	4.9	(9.0)
Non Recurrent	31.7	2.8	1.6	(1.3)	20.6	20.8	(0.7)
Total CIP target	56.6	5.3	2.4	(2.9)	35.5	25.8	(9.7)

Resources | Capital

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

UHNM Capital Plan	2024/25 Plan £000	2024/25 Forecast £000	YTD Plan M8 £000	YTD Actual M8 £000	Variance M8 £000
Capital funding					
PFI & Loan Commitments	31.5	32.1	18.9	18.9	-
Base STP allocation	22.1	22.1	14.8	14.8	-
ICB fair share reduction	(0.5)	(0.5)	(0.3)	(0.3)	-
ICB brokerage	(3.1)	(3.1)	(2.0)	(2.0)	-
ICB IFRS16 CDC lease funding	5.0	5.0	-	-	-
ICB IFRS16 incremental increase allocation	4.4	4.4	3.0	3.0	-
Public Dividend Capital funding	40.9	41.8	14.7	14.7	-
Donated, granted other capital funding	7.0	6.7	3.3	3.3	-
Internal funding source (including capital receipts)	1.8	0.8	-	-	-
Total Capital funding	109.2	109.4	52.4	52.4	-
Capital expenditure					
PFI & Loan Commitments	(31.5)	(32.1)	(18.9)	(18.9)	-
Investment items (ICB allocation)					
PFI enabling costs	(0.2)	(0.2)	(0.2)	(0.1)	0.0
Network & Comms BC525	(1.3)	(1.3)	(1.3)	(1.2)	0.1
IM&T computer hardware refresh programme	(5.2)	(2.3)	-	-	-
LED lighting BC546	(0.2)	(0.2)	-	-	-
Pharmacy Robot BC487 -	(0.0)	(0.0)	-	-	-
Investment funding	(0.5)	(0.6)	(0.3)	(0.3)	-
Central Contingency & risk	(0.3)	(0.3)	-	-	-
Project Star - car park completion/RI remedial work	(0.7)	(0.7)	(0.2)	(0.4)	(0.2)
Emergency Department (restatement costs)	(0.2)	(0.2)	(0.2)	(0.1)	0.1
Air heat boiler replacement Trust Contribution	(0.8)	(0.8)	-	-	-
EPMA (Electronic Prescribing) BC	(0.4)	(0.5)	(0.3)	(0.3)	(0.1)
Patient Portal roll out costs (BC 462)	(0.1)	(0.1)	(0.1)	(0.0)	0.1
ED ambulance off - enabling ward moves	(0.3)	(0.1)	(0.1)	(0.1)	-
Endoscopy works 7th room - PDC ICB allocation	(0.4)	(0.0)	-	-	-
County theatre holding bay	(0.3)	(0.3)	(0.1)	(0.0)	0.0
Omnicell Cabinet for AMU	(0.3)	-	-	-	-
Car park barriers BC550	(0.8)	(0.8)	-	-	-
Electronic Patients records BC/specification	(0.1)	-	-	(0.0)	(0.0)
Approved minor investments CIG SON	(0.2)	(0.5)	-	-	-
Purchase of County Medical Records building	-	(1.3)	-	-	-
Spinal Navigation BC	-	(0.8)	-	-	-
Omnicell Cabinet replacement ED	-	(0.2)	-	-	-
County CTS2 Equipment	-	(0.4)	-	-	-
County mammography equipment (brought fwd)	-	(0.7)	-	-	-
Medical devices additional allocation	-	(3.5)	(0.7)	(0.7)	-
I-portal server replacement	-	(0.6)	(0.2)	(0.2)	-
Funding to be (allocated)/shortfall	(2.5)	(0.1)	-	-	-
Total Pre committed Investment items	(14.6)	(16.4)	(3.4)	(3.4)	(0.0)
IMT Sub Group Funding	(3.5)	(1.9)	(0.9)	(0.7)	0.2
IM&T lap top replacement top-slice	1.3	-	-	-	-
Medical Devices Sub Group Total Funding	(3.6)	(3.6)	(1.5)	(1.5)	-
Medical Devices Sub Group brought forward	-	(1.0)	-	-	
Estates Sub Group Total Funding	(4.3)	(4.3)	(1.8)	(2.0)	(0.2)
Health & Safety compliance	(0.2)	(0.2)	-	(0.0)	(0.0)
Net zero carbon (sustainability) initiatives	(0.1)	(0.1)	-	-	-
Total Sub Groups	(10.3)	(11.1)	(4.2)	(4.2)	(0.0)
Lease liability re-measurement	(0.4)	0.2	0.1	0.1	-
IFRS16 - lap top extension	(0.1)	(0.5)	(0.5)	(0.5)	-
IFRS16 CDC building lease	(5.0)	(4.1)	-	-	-
IFRS16 - cancer digital pathology	-	(0.6)	-	-	-
IFRS16 - hardware refresh	-	(3.0)	(2.0)	-	2.0
IFRS16 - pathology extension	-	(0.3)	(0.3)	(0.3)	-
IFRS16 - Bentilee health centre	-	(0.6)	-	-	-
IFRS16 new lease/lease extension	(0.5)	(0.7)	(0.4)	(0.4)	-
IFRS16 efficiency requirement	0.9	-	-	-	-
Total IFRS16 leases	(5.1)	(9.5)	(3.0)	(1.0)	2.0
Total Internal Capital Expenditure programme	(61.5)	(69.2)	(29.5)	(27.6)	2.0
Additional CRL / Externally Funded PDC					
CDC phase 2 endoscopy - 24/25 PDC	(6.2)	(6.6)	-	(0.0)	(0.0)
CDC phase 2 endoscopy - 24/25 IM&T	(0.5)	(0.5)	-	-	-
CDC phase 1 estates enabling - 24/25	(14.5)	(6.8)	(3.2)	(1.7)	1.5
ICB brokerage allocated to CDC slippage	3.1	-	-	-	-
TIF 2 PDC (Breast care unit)	(7.5)	(4.5)	(2.5)	(1.2)	1.3
TIF 2 PDC (Day Case Unit) -	(8.7)	(8.1)	(5.1)	(4.8)	0.2
PDC - UEC modular build (AMRA) 23/24 PDC	(2.9)	(2.9)	(2.9)	(2.5)	0.4
Digital - EPR 2023/24 PDC	(2.1)	(1.9)	(1.1)	(0.6)	0.4
Digital - EPR 2024/25 PDC	(1.4)	(1.4)	-	-	-
Pathology cancer reporting PDC	-	(0.4)	-	-	-
Mobile breast screening PDC	-	(0.4)	-	-	-
Air heat boiler replacement PSDS Grant BC 510	(2.5)	(2.5)	(0.2)	(0.2)	-
Equipment - endoscopy CDEL	(1.0)	(1.0)	-	-	-
Charitable funded expenditure	(3.5)	(3.1)	(3.1)	(3.1)	-
Total Additional CRL / PDC Funded expenditure	(47.8)	(40.2)	(18.1)	(14.2)	3.9
Total Capital Expenditure	(109.2)	(109.4)	(47.6)	(41.7)	5.9
Planned under/(over) spend	(0.0)	0.0	4.8	10.7	5.9

The 2024/25 forecast included in the table above includes the additional mitigations below to ensure that all capital funding is utilised by the year end.

•reduction of internal funding by £1.4m through accounting for VAT refunds on completed schemes.
•approval at CIG of capital funding for the Spinal Navigation business case, County CTS2 equipment and ED Omnicell cabinet replacement.
•allocation of a further £3.5m of funding to the medical devices sub-group to replace high risk medical equipment that is beyond its useful life.
•allocation of £0.6m in relation to support of improvements to i-portal; and
•£0.7m brought forward replacement of mammography equipment which will be situated in the new County Breast Unit.

The capital forecast to Trust Board included risks with regard to the theatre equipment required for the Elective Hub (including Day Case ward) which has yet to be approved by the clinical teams and costed by the procurement team. This equipment has planned expenditure of £1.25m and progress against the sign off of this is being chased by the Elective Hub Programme Manager. There is a risk of £0.1m relating to the IM&T expenditure around the CDC due to uncertainty over access to the site.

The above risks mitigating actions have been reported to EIG in November. The on-going monitoring of all schemes and allocation of the contingency balance will be discussed monthly at CIG.

There are a number of risks associated with the funding of the 2025/26 and future years capital programme including.
•outstanding confirmation that the Trust will receive £15m of PDC funding for the CDC in 2025/26, which, without this funding, may need to be funded through the ICB system capital allocation. This rephasing was agreed prior to 2024/25 with PDC funding in 24/25 being reduced by £15m to £18m. Expenditure of £22.3m for the CDC scheme is forecast in 2025/26 (including the £15m PDC funding to be confirmed and £7.3m brokerage mentioned above)
•the land sale for the former RI/COPD needs to be completed in 2025/26 to ensure capital financing is available to fund expenditure on the County Breast Unit and the CDC
•the ICB capital funding allocation for future years is not yet known, including IFRS16 funding.
•confirmation has not been received that the Trust will be repaid the £3.057m of ICB system capital that it brokered to MPFT and NSCHT in 2024/25 to fund expenditure on the RAAC and Mental Health dormitory schemes.

Overall, there is a risk that all capital expenditure planned for 2025/26 cannot be funded.

At Month 8 capital funding is in line with plan, and capital expenditure is £5.9m lower than plan. Of the £41.7m expenditure, £18.9m relates to pre-committed items for the repayment of PFI and IFRS16 lease liabilities and PFI lifecycle expenditure. Overall Investment items and capital sub-groups expenditure is in line with plan.

The IFRS16 IM&T hardware refresh scheme is £2m behind plan however the Business Case has now been fully approved, and the equipment will begin to be available for the Trust to use in the coming months.

The PDC schemes for CDC and the County Breast Unit are currently underspent by £1.5m and £1.3m respectively and this reflects the expected slippage at the year end as detailed above. The slippage on the UEC modular build reflects an underspend on the scheme. This underspend and a VAT refund are being reinvested into the restoration of car parking which was included within the original business case, and this work will be completed by the year-end.

The slippage on the 2023/24 PDC funded EPR scheme of £0.4m is due to a slight delay in the delivery of equipment, and expenditure will be in line with plan by the year end.

The planned underspend of £4.8m at Month 8 relates to the timing difference between the capital funding provided by depreciation, and planned expenditure. The depreciation charge is generally phased equally over the course of the financial year however capital expenditure is phased largely in the second half of the financial year.

Resources | Balance Sheet

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

Balance sheet as at Month 8	31/03/2024	30/11/2024			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	686.3	693.9	690.3	(3.6)	Note 1
Right of Use Assets	18.1	18.5	16.3	(2.2)	Note 2
Intangible Assets	16.3	13.0	13.1	0.1	
Trade and other Receivables	1.1	1.1	1.1	0.0	
Total Non Current Assets	721.7	726.5	720.8	(5.7)	
Inventories	17.7	17.7	18.9	1.2	Note 3
Trade and other Receivables	44.4	44.4	67.7	23.3	Note 4
Cash and Cash Equivalents	82.0	69.0	74.5	5.5	Note 5
Total Current Assets	144.1	131.1	161.2	30.1	
Trade and other payables	(125.6)	(111.6)	(154.7)	(43.0)	Note 6
Borrowings	(25.7)	(25.7)	(25.9)	(0.2)	
Provisions	(5.7)	(5.7)	(5.5)	0.2	
Total Current Liabilities	(156.9)	(143.0)	(186.0)	(43.1)	
Borrowings	(477.1)	(477.8)	(475.9)	1.8	Note 2
Provisions	(2.3)	(2.3)	(2.2)	0.1	
Total Non Current Liabilities	(479.4)	(480.1)	(478.2)	1.9	
Total Assets Employed	229.5	234.6	217.8	(16.8)	
Financed By:				-	
Public Dividend Capital	693.9	693.9	693.9	-	
Retained Earnings	(669.1)	(664.0)	(680.8)	(16.8)	Note 7
Revaluation Reserve	204.7	204.7	204.7	-	
Total Taxpayers Equity	229.5	234.6	217.8	(16.8)	

Note 7. Retained earnings are showing a £16.8m variance from plan which reflects the month 8 financial performance deficit of £15.3m and adjustments relating to.

- donated income and donated depreciation £2.1m.
- adjust PFI revenue costs to a UK GAAP basis £1.5m.

Variances to the plan at Month 8 are explained below:

Note 1. Property, plant and equipment is £3.6m lower than plan at Month 8. This is mainly due to slippage on the capital programme in relation to PDC funded schemes for the CDC, County Breast Care Unit and Frontline Digital (EPR) schemes. The capital section of the report details the expected year end position and mitigating actions in relation to the CDC and County Breast Unit schemes.

Note 2. Right of use assets are £2.2m behind plan and borrowings are £1.8m below plan. This is mainly due to the IM&T hardware refresh lease starting later than planned. The Business Case has now been approved and the assets and liability will be shown once assets are available for use to the Trust.

Note 3. Inventories are £1.2m higher than the year-end value. The main area of movement is an increase of £1.2m in the level of pharmacy stock compared to 31 March 2024. This is due to preparations for the Christmas & New Year period to ensure stock availability, particularly due to current supply problems and supplier and wholesaler Christmas shutdowns. Note 4.Trade and other receivables are £23.3m higher than plan. This is mainly due to NHS accrued income which is higher than plan at £28.5m. NHS accrued income includes accruals with Staffordshire and Stoke ICB of £13m relating to additional ERF, mobile endoscopy, SDEC funding and additional convergence included within efficiency. Accrued income of £8.8m with NHS England includes £4.1m relating to drugs costs and £4.4m variable growth funding.

Prepayments of £12.5m are higher than expected, the prepayments mainly relate to managed service contracts and annual licences which are paid for the 12-month period.

Note 5. At Month 8 our cash balance was £74.5m, which is £5.5m higher than the plan of £69m. Cash received is £42.2m higher than plan overall, of which £31.1m relates to the Staffordshire and Stoke ICB block mandate. At Month 8 cash has been received of £5.5m relating to change in the reporting requirement for PFI in 2024/25, and £14.2m in relation to funding for the Agenda for Change pay award.

The Trust received £14m of cash in Month 7 relating to Education Contract Training Income which covers the period October 2024 to January 2025, the cumulative plan of £24.2m is up to December 2024.

Payments are £36.8m ahead of plan at Month 8 of which £23.8m relates to payroll in relation to the Agenda for Change, consultants and junior doctors pay awards. In Month 9 the deductions for tax, NI and pension contributions for consultants and junior doctors will be paid over.

Note 6. Trade and other payables are £43m higher than plan. This is mainly due to deferred income of £52.6m at Month 8 being significantly higher than plan. Of this balance £29.5m relates to Staffordshire and Stoke ICB due to the upfront payments of ERF funding (£7.1m), 2024/25 block contract (£6.3m), CDC (£2.3m), efficiency of RRL (£3.5m), and West Midlands Cancer Alliance funding (£1.5m). Deferred income includes the deferral of £6.2 cash received in Month 7 for the Education Contract Training as detailed in the cash section of this report.

Trade and other payables are also higher than plan at Month 8 due to additional payroll deductions relating to the consultants and junior doctor pay award arrears. This includes tax, NI (employees and employers) and pension (employees and employers) contributions which will be paid over in Month 9.

Resources | Forecast revenue outturn

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

The Trust's forecast, updated to reflect the actual run rate for Month 8, is for a £23.1m deficit; this includes the impact of additional actions that have been agreed by Chairs and CEOs. The table below provides the profile of the £23.1m deficit over the remainder of the year.

2024/25 I&E forecast surplus/(deficit) £m	YTD Mn 5	Mn 6	Mn 7	Mn 8	Mn 9	Mn 10	Mn 11	Mn 12	Total
Base forecast	(9.4)	(2.6)	(2.9)	(3.0)	(3.1)	(4.2)	(3.5)	(3.5)	(32.2)
Divisional CIP schemes above base forecast			0.5	0.5	0.5	0.5	0.5	0.5	3.0
Divisional risk bias		0.3	0.3	0.3	0.3	0.3	0.3	0.3	2.1
Non recurrent mitigations								5.0	5.0
I&E forecast surplus/(deficit)	(9.4)	(2.3)	(2.1)	(2.2)	(2.3)	(3.4)	(2.7)	2.3	(22.1)
Band 2 to 3 mitigation								(15.0)	(15.0)
System recovery plan									
Band 2 to 3 mitigation								7.0	7.0
Additional balance sheet flexibility						1.2	1.2	1.2	3.6
Further CIP/Mitigation discretionary expenditure				0.1	0.1	0.1	0.1	0.1	0.7
Further CIP/Mitigation pay controls				0.3	0.3	0.3	0.3	0.3	1.4
Additional Education funding for junior medical staff		0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4
Industrial action funding					0.9				0.9
In month I&E forecast surplus/(deficit)	(9.4)	(2.3)	(2.1)	(1.7)	(0.9)	(1.7)	(1.1)	(4.0)	(23.1)
Cummulative I&E forecast surplus/(deficit)	(9.4)	(11.6)	(13.7)	(15.4)	(16.3)	(18.0)	(19.1)	(23.1)	

The Month 8 actual year to date deficit of £15.3m is a £0.1m better than the forecast profile of £15.4m deficit although £0.9m of this is due to the Trust receiving Industrial action income earlier than forecast; once adjusted for this the Trust is £0.8m behind the forecast.

As reported at Month 8 there has been a favourable impact on the forecast due to a non-recurrent benefit relating to the Pay Award. However, this has been offset by continued pressures within non-pay as emergency demand increases and additional mitigations not having the expected impact at Month 8.

The Trust is still forecasting to deliver a £23.1m deficit for the year although this does not reflect the impact of any additional mitigations identified through the I&I process.

Resources | Conclusion

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

The Trust has delivered a year-to-date deficit of £15.3m against a planned deficit of £1.6m; this adverse variance of £13.7m is primarily driven by underperformance against the Trust's in year CIP and the purchase of Healthcare from external bodies.

A series of actions incorporated into a system recovery plan result in a forecast deficit for the year of £23.1m (including the impact of the Band 2-3 rebanding). The system and Trust are being supported by a recovery director and an I&I team with the impact of any additional actions identified improving the financial position for the year. It is likely that this impact will be non-recurrent nature, and the Trust therefore needs to focus on identifying and delivering recurrent savings to ensure that the underlying financial position does not worsen.

Highlight Report

Quality Governance Committee | 28th November 2024

Matters of Concern / Key Risks to Escalate

For information:

- **Partial assurance** was provided in relation to **medicines optimisation and safety**, which highlighted the actions taken to mitigate the risk following Lloyds Pharmacy serving notice on outpatient dispensing and this had since successfully novated to Rowlands Pharmacy
- The **Medicines and Healthcare Products Regulatory Agency** (MHRA) had inspected the Trust in June 2024, with no critical deviations identified. The action plan to address the 7 deviations had been accepted by the MHRA and good progress had been made in implemented the identified actions
- Following the failure of **aseptic isolators**, the contingency plans worked as planned and it was noted that this was due to air filters having been damaged which had been highlighted as a common fault. Actions taken including looking at the storage of the filters and other manufacturers
- It was noted that whilst the **discharge medicines service CQUIN** had continued with mainly improved performance, the end of external funding in March 2025 could result in lack of dedicated resource, a decrease in referrals and negative impact on future CQUIN compliance

Major Actions Commissioned / Work Underway

- Ongoing recruitment being undertaken within **Neonatal Intensive Care** to appoint a Consultant, Specialty Doctor and Senior Clinical Fellow
- Two outstanding **serious incidents** were awaiting closure from the Integrated Care Board (ICB) and these had been escalated and were expected to be closed within quarter 3
- A paper had been considered by the Executive Team in respect of an **automated dispensing system** which was to go out to market
- In terms of **controlled drugs compliance**, a paper had been considered by the Quality and Safety Oversight Group (QSOG), with Divisions being asked to assess compliance and identify any associated risks. It was agreed to provide any further escalations in respect of this to the Committee via future QSOG highlight reports
- Further guidance was awaited in relation to **Liberty Protection Safeguards**

Positive Assurances to Provide

- The update from the **Neonatal Intensive Care Unit** provided **Acceptable Assurance**, highlighting a stable mortality rate compared to 2023, despite an increase in preterm admissions. In addition, Perinatal Mortality Review Tool (PMRT) compliance stood at 100% and all actions had been completed for the culture action plan. The Committee welcomed the unit being nominated as Best Training Unit in the West Midlands Paediatric Awards for Training Achievement (PAFTAs)
- **Acceptable Assurance** was provided in relation to the **Maternity and Neonatal Patient Safety and Incident Response Plan** (PSIRF) report, whereby 2 Patient Safety Incident Investigations (PSII) were reported during Quarter 2 and all actions following review had been implemented within 6 months of the incident
- **Significant Assurance** was provided for the **PMRT** report which reported 100% compliance with CNST Safety Action 1
- The Committee queried why the Trust was reporting a higher number of adverse incidents via the **Yellow Card System** and it was noted that this was positive, where the Trust had moved from one of the lowest reporters to sustaining the highest reporting in relation to adverse drug reaction reporting. It was noted that this did not correlate to medication errors
- **Acceptable Assurance** was provided in relation to the **Care Quality Commission (CQC) Action Plan** and an update for six specific actions was provided in terms of obtaining further assurance prior to closing down the actions or moving these to business as usual. It was noted that within the maternity action plan, ongoing work was being undertaken in relation to safeguarding training, and it was expected for this area to be compliant by the end of the year
- The **Legal Services Annual Litigation and Inquest Report** provided **Acceptable Assurance** but highlighted particular challenges in obtaining assurance from key specialties in learning from claims. It was noted that a covid group action claim had been received, and a potential group claim was expected in relation to Aspergillus in addition to claims expected for audiology. As a result of inquests, there had been 4 neglect conclusions and 4 prevention of future deaths reports throughout the year.

Decisions Made

- It was agreed that no further detailed reports were required to be provided to the Committee, in relation to **Neonatal Intensive Care Unit**, given the improvements made

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Members commented that the key papers had been considered adequately	• It was agreed that the internal audit recommendations in relation to the CQC Action Plan

Summary Agenda

No.		Agenda Item	BAF Mapping			Purpose	No.		Agenda Item	BAF Mapping			Purpose
			BAF No.	Risk	Assurance					BAF No.	Risk	Assurance	
1.	➕	Assurance of the safety of the Neonatal Intensive Care Unit – Overview and Action Plan Update	1	High 12	Acceptable	Assurance	8.	➕	Legal Services Annual Litigation & Inquest Report			Acceptable	Assurance
2.	➕	Maternity and Neonatal PSIRF Investigation Report: Q2 2024/25	1	High 12	Acceptable	Assurance	9.	➕	Maternity Quality & Safety Oversight Group Assurance Report	1	High 12	Not applicable	Assurance
3.	➕	Perinatal Mortality Report Tool Q2 2024/25	1	High 12	Significant	Assurance	10.	➕	Executive Quality & Safety Oversight Group Highlight Report	1	High 12	Not applicable	Assurance
4.	➕	Medicines Optimisation and Safety Quarter 1 & 2 Report	1	High 12	Partial	Assurance	11.	➕	Quality Performance Report - Month 7 24/25	1	High 12		Information
5.	➕	Care Quality Commission Action Plan Update	1	High 12	Acceptable	Assurance							

Attendance Matrix

Members:		M	J	J	A	S	O	N	D	J	F	M
Andrew Hassell	Associate Non-Executive Director (Chair)											
Claire Cotton	Director of Governance	NH	NH	NH			NH	NH				
Matthew Lewis	Chief Medical Officer		AM									
Katie Maddock	Non-Executive Director											
Jamie Maxwell	Head of Quality, Safety & Compliance											
Wendy Nicholson	Associate Non-Executive Director											
Ann-Marie Riley	Chief Nurse											
Sunita Toor	Non-Executive Director											

Highlight Report

Quality Governance Committee | 20th December 2024

Matters of Concern / Key Risks to Escalate

For information:

- Specific concerns in relation to mortality and Ambulance to Hospital Professional Standards of Care Gap Analysis were highlighted from the **Quality and Safety Oversight Group** report which required further consideration
- The **Quality Performance** report highlighted a deterioration in Venous Thrombosis Embolism (VTE) compliance with EPMA being the solution to this in terms of reporting
- **Maternity dashboard** demonstrated that assessment and induction of labour were above trajectory and work was continuing in improving Sepsis Screening compliance and booking women by 9 weeks and 6 days
- There remained a number of wards with 'Bronze' outcomes within the **Care Excellence Framework** and support was being provided to ensure continuous improvement, education and audit; this amounted to 7 adult areas identified during Quarter 2
- Compliance for **Resuscitation training** had remained static at 68%; due to capacity, DNA rates and appropriateness for e-learning versus face to face
- **Patient Experience** report identified an increased number of complaints
- **Looked after children annual report** highlighted an increase in numbers, with unaccompanied asylum-seeking children leading to delays in the timeliness of Initial Health Assessment appointments, with only 14% meeting the deadline in 2023/24. Work had since been undertaken to increase capacity in this area.

Major Actions Commissioned / Work Underway

- Further information in relation to **Clinical Effectiveness** to be added to the Integrated Performance Report
- Better understanding of **mixed sex accommodation / single sex breaches** to be provided to the Committee
- **Audiology** continued to work on the necessary requirements in order to attain accreditation status; this was alongside a business case being developed to improve the estate
- A retrospective 5 year look back exercise was being led by the ICB following a snapshot review of the **Audiological Brainstem Response testing**
- A digital 'dials of the day' dashboard was under development to provide real time **patient harm data** correlated with staffing / workforce metrics
- Work to be undertaken on the **Resuscitation** report to ensure it is aimed at providing assurance to the Committee
- A revised **complaints** policy with triage timeframes and an enhanced escalation process has been produced to improve response timescales

Positive Assurances to Provide

- The **Care Quality Commission** (CQC) had increased its rating of County Hospital to 'Good'
- The **maternity dashboard** highlighted that all women received one to one care in labour during October 2024, 100% compliance was achieved for the Perinatal Mortality Review Tool (PMRT) and supernumerary status was maintained for the delivery suite co-ordinator
- Unannounced 'mock CQC' inspections were being undertaken, led by ICB colleagues and patients, to test the robustness of the **Care Excellence Framework** (CEF) process
- Funding has been identified following a successful business case to increase **resuscitation** training infrastructure which will increase training places available
- A new role is being appointed to support the **Patient and Public Involvement** agenda
- The **Looked After Children** Annual Report highlighted the ongoing training for junior doctors and resident doctors to assist in completing Initial Health Assessments and additional training was being provided to complete Adult Health reports to assist with the demand for foster parents. There were no overdue Initial Health Assessments at the point of reporting, as a result of the work undertaken.

Decisions Made

- No items requiring decision

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Attendance was impacted by the Critical Incident and the quoracy of the meeting • Some papers were not as up to date as the verbal assurance provided and further support was to be given around effective report writing	• To ensure that the People, Culture and Inclusion Committee have oversight of specific issues within midwifery associated with international nurses and patient safety • It was noted that an Allied Health Professional Report had been considered by the People, Culture and Inclusion Committee and it was proposed to log this as a cross-committee item for future reference

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Executive Quality & Safety Oversight Group Highlight Report	1	High 12	Not Applicable	Assurance	5.	Care Excellence Framework (CEF) Summary Q2	1	High 12	Partial	Assurance
2.	Quality Performance Report – Month 8 24/25	1	High 12	Partial	Assurance	6.	Resuscitation Annual Report	1	ID34423 ID26815	Partial	Assurance
3.	Maternity Dashboard	1	High 12	Acceptable	Assurance	7.	Q2 Patient Experience Report 24/25	1	High 12	Partial	Assurance
4.	Audiology Position Statement Update	1	ID31429 ID31347	Acceptable	Assurance	8.	Looked After Children Annual Report	1	ID26554	Partial	Assurance

Attendance Matrix

Members:		M	J	J	A	S	O	N	D	J	F	M
Andrew Hassell	Associate Non-Executive Director (Chair)											
Claire Cotton	Director of Governance	NH	NH	NH			NH	NH				
Matthew Lewis	Chief Medical Officer		AM									
Katie Maddock	Non-Executive Director											
Jamie Maxwell	Head of Quality, Safety & Compliance											
Wendy Nicholson	Associate Non-Executive Director											
Ann-Marie Riley	Chief Nurse								JH			
Sunita Toor	Non-Executive Director											

Highlight Report

Performance and Finance Committee | 18th December 2024

Matters of Concern / Key Risks to Escalate

For information:

- The **Operational Performance** report provided an update on Urgent and Emergency Care (UEC), whereby performance had deteriorated. Data on ambulance handovers within 45 minutes had been included and it was highlighted that additional medical, operations and nursing leadership had been put in place within the Emergency Department to help provide rapid improvement support and consistent application of the actions required. The Committee queried how implementation of these actions would be monitored, and this was described to the Committee. The Committee agreed with the **partial assurance** rating, but recognised that further assurance was required to be provided in terms of the impact of ongoing actions
- A deep dive into the November **critical incident** had been undertaken which highlighted that bed occupancy two days prior to the critical incident was, at Royal Stoke, higher than the expected worst day in January and at County Hospital, higher than the expected worst day in January, due to flu, covid and Respiratory Syncytial Verus (RSV) cases, which was unusual for the time of year.
- The **finance** report for month 8 demonstrated a £15.3 m deficit, against a planned deficit of £1.6 m, and the year end forecast continued to be expected as £23.1 m. £25.8 m of Cost Improvement (CIP) savings had been validated to date against a plan of £35.5 m although £20.8 m of this was non-recurrent. Capital expenditure was £41.7 m, £5.9 m below plan and the Trust Board had already received an update on the revised capital programme. The Committee agreed with the **partial assurance** rating.
- The **CIP** update provided **partial assurance** and highlighted that the resources allocated to manage the CIP programme by the Project Management Team had been diverted to assist with the I&I schemes, alongside the Transformation Team. In addition the need for system wide transformation, in particular pathway changes, was highlighted as being crucial in ensuring sustainable cost savings.
- An update in relation to the progress made in completing **business case reviews** was provided and the Committee welcomed the additional information and clarity provided, although **partial assurance** was provided based on divisional performance and the number of outstanding reviews yet to be received, noting that dates for receipt had been identified

Major Actions Commissioned / Work Underway

- National UEC Recovery Team assisting and providing support to the Trust in providing an external view of **UEC pressures** to identify any suggestions for improvement
- It was agreed to confirm the actual performance of **call before convey**
- An update was provided on the completion of **external validation** of activity although this continued to be undertaken by UHNM. It was acknowledged that further work was required to ensure business as usual processes met the required standards, which required further resource, with robotic processes to be utilised where possible to undertake largescale validation. It was agreed to provide updates in relation to this would be incorporated into the existing Operational Performance Report
- Phase 1 of the **Investigation and Intervention** (I&I) regime had concluded, with five workstreams identified, and work was ongoing to enhance controls, optimise resource utilisation and drive productivity. It was agreed to continue to provide regular updates on the progress being made and the impact the actions were having on current year performance

Positive Assurances to Provide

- In terms of **elective performance**, the Committee noted the Trust was on trajectory for cancer performance, there had also been an improving trend for diagnostics in addition to reducing the number of long wait patients
- An update on **productivity** was provided which highlighted progress and the activities undertaken with the six workstreams being taken forward. Further assurance was requested in terms of assessing the impact of the schemes with further data required. The Committee agreed with the **acceptable assurance** rating
- The Committee noted the **significant assurance** provided by the **Project STAR** update and progress made to maximise capital receipts in line with the 2025/26 capital plan
- **Acceptable assurance** was agreed in terms of the programme status of the **Community Diagnostic Centre** and the increase in deferral of income from £2.4 m to £2.9 m for the due to the delay in go live was noted

Decisions Made

- The Committee approved **Business Case BC 0583 – recurrent investment in the Endoscopy Service** which would be taken to the Trust Board for approval given the positive contribution
- The Committee approved **e-REAFs** Extension of the NMCPS Pathology Managed Service contract (e-REAF 14965), Mammography Equipment at County Hospital (e-REAF 15317), Hardware Refresh Plan 24/25 Direct Capital Purchase (e-REAF 15301), Hardware Refresh 3 Year Lease Plan (e-REAF 15300), Curve & Kick Navigation Systems (e-REAF 15364) and Recharge costs for the Occupational Health Services contract
- The Committee approved the recommendation to declare the Royal Infirmary and Central Outpatients Department land as **surplus land for sale**
- The Committee approved the purchase of the **County Medical Records Building**

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Members welcomed the discussion held	• No items identified.

Summary Agenda

No.	Agenda Item	BAF Mapping: BAF No.	BAF Mapping: Risk	BAF Mapping: Assurance	Purpose
1.	Performance Report – Month 8 2024/25	4	Ext 15	Partial	Assurance
2.	MBI Validation of Data Quality Failsafes	4	Ext 15	Not applicable	Information
3.	Productivity Update	4 / 7, 8	Ext 15 / Ext 16	Acceptable	Assurance
4.	Finance Report – Month 8 2024/25	7, 8	Ext 16	Partial	Assurance
5.	Investigation and Intervention (I&I) Support	7, 8	Ext 16	Not applicable	Information
6.	Cost Improvement Programme (CIP) Report	7	Ext 16	Partial	Assurance
7.	BC-0583-Recurrent Investment in the Endoscopy Service	4	ID15697 ID20739 ID23842 ID15788 ID29645	Not applicable	Approval

No.	Agenda Item	BAF Mapping: BAF No.	BAF Mapping: Risk	BAF Mapping: Assurance	Purpose
8.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-		Not applicable	Approval
9.	Business Case Review Update – December 2024	-		Partial	Assurance
10.	Community Diagnostic Centre (CDC) Business Case Update – Review of Revenue Position	6	High 12	Acceptable	Assurance
11.	Project STAR – Planning, Marketing, Valuation and Land Disposal	6	High 12	Significant	Approval
12.	BC-0587 Purchase of County Medical Records Building	6	High 12	Not applicable	Approval
13.	Medium Term Plan	8	Ext 16	Not applicable	Information

Attendance Matrix

No.	Name	Job Title	A	M	J	J	A	S	O	N	D	J	F	M
1.	Prof G Crowe	Non-Executive Director (Chair)												
2.	Mrs L Bainbridge	Non-Executive Director												
3.	Ms T Bowen	Non-Executive Director												
4.	Dr L Griffin	Non-Executive Director	Chair	Chair										
5.	Ms A Gohil	Non-Executive Director												
6.	Mrs M Monckton	Non-Executive Director												
7.	Mrs A Rodwell	Non-Executive Director												
8.	Ms H Ashley	Director of Strategy												
9.	Dr S Constable	Chief Executive	TB	TB										
10.	Mrs C Cotton	Director of Governance	NH		NH	NH		NH	NH		NH			
11.	Mrs K Thorpe	Acting Chief Operating Officer	SE	SE	SE	SE	SE		MH					
12.	Mr M Oldham	Chief Finance Officer												
13.	Mrs S Preston	Strategic Director of Finance												
14.	Mr J Tringham	Director of Operational Finance												

Attended | Apologies & Deputy Sent | Apologies

Since 14th October to 14th November 2024, 2 contract awards over £1.5 m were made, as follows:

- **Reporting of the Targeted Lung Health Check,** supplied by Heart and Lung Health, for the period 01.04.25 – 31.03.28, at a total cost of £3,078,300.00, providing savings of £41044.00, approved on 7th November 2024
- **Arthroscopy & Sports Medicine,** supplied by Arthrex Ltd, for the period 01.10.24 – 30.09.28, at a total cost of £1,829,866.61, providing savings of £92,522.31, approved on 7th November 2024

Highlight Report

People, Culture & Inclusion Committee | 18th December

Matters of Concern / Key Risks to Escalate

- **Chief Allied Health Professional (AHP) Workforce** report identified that further investment in infrastructure to support the workforce was required alongside further detail on demand and capacity.
- **Freedom to Speak Up** report highlighted some emerging themes in relation to handing concerns and race / racial stereotyping. A number of actions had been supported by the Executive Team although particular concern was expressed around needing to 'shift the dial'.
- Sickness absence, appraisals, training, apprenticeship uptake, Bands 2 – 3, UKVI changes and resource within the People Directorate were highlighted as key risks through the **Chief People Officer** report. A particular risk within the employee relations team was noted.

Major Actions Commissioned / Work Underway

- Further work was being undertaken in relation to **job planning and productivity** although this is a longer-term piece of work which will be oversee via the Executive Management Team meeting in the first instance.
- A workforce development programme has identified funding to address the **AHP** infrastructure risk.
- Next **AHP** report to concentrate on role / pathway development and redesign as well as emerging areas of risk.
- Work is underway to redesign our leadership development programme so that it responds to concerns raised and is more skills based; this will form part of the broader **People Plan** which is currently under review.
- Work is underway to better understand the risk associated with some of the **workforce metrics**, particularly in relation to essential to role training
- Further work required around implementation of the **digital health and safety management system** and proactive auditing is required to increase the level of assurance although good progress was recognised.
- Past 6 months had been an extremely busy period for the **Violence, Prevention and Reduction** agenda, predominantly resulting from the period of Civil unrest and discussion at the Trust Board around action needed.
- National standards for **Violence, Aggression and Reduction** have been published and work is now underway to ensure assessment and compliance.
- **Gender Pay Gap** will be updated following the Staff Survey and will be presented to the Committee.

Positive Assurances to Provide

- Positive progress has been made in relation to **job planning** with colleagues having been asked to present this work nationally.
- Benefits have been seen through convening **AHP's** through dedicated corporate leadership and the development of a strategy.
- The first network of **Freedom to Speak Up (FTSU) Champions** was established during Speaking Up Month and investment into the services has been made which will see the recruitment of a deputy and admin support; the Committee were clear that the resource was necessary and should remain under review as to whether it remained sufficient.
- Quarters 1 and 2 saw the highest number of **FTSU** reports and this is attributed to the ongoing success of promotional campaigns and awareness raising.
- 45% response rate for the **Staff Survey** and good progress being seen across all four of the People Strategy domains
- Additional resource into the **Health and Safety team** has been confirmed, as well as a digital management system which will support compliance with Health & Safety Executive (HSE) expectations
- Some real positive work undertaken by the **Critical Care Team**, using improvement methodology, to reduce violence against staff within their clinical setting.
- **2024 Gender Pay Gap** shows continued improvement in the metrics with a 1.2% reduction in the median pay gap and a 1.3% reduction in the mean pay gap.

Decisions Made

No items requiring decision.

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Freedom to Speak report very well delivered and should be commended, important to continue to provide a psychologically safe environment for raising concerns and a session on the Self Reflection tool is being planned • Good open discussion and a shaping of the direction • February meeting to focus on strategy development	• Quality Governance Committee around the risk associated with compliance with essential to role training and the need to triangulate safety / training data

Summary Agenda

No.	Agenda Item	BAF No.	Risk	Assurance	Purpose
1.	Chief AHP Workforce Report	2	Ext 15	Partial	Assurance
2.	Freedom to Speak Up Bi-Annual Report Q1 / Q2	2	33184	Partial	Assurance
3.	Chief People Officer Report	2	Ext 15	Acceptable	Assurance
4.	Health and Safety Report, Q2 2024/25		ID18673 ID22876	Partial	Assurance
5.	Violence Prevention & Reduction 6 Month Report April – September 2024	6	High 12	Significant	Assurance
6.	Gender Pay Gap Report	2	Ext 15	Partial	Assurance
7.	Executive Workforce Assurance Group Highlight Reports (17-10-24 & 12-12-24)	2	Ext 15	Not Applicable	Assurance

2024/25 Attendance Matrix

No.	Name	Job Title	M	J	S	N	D	M
1.	Prof G Crowe	Non-Executive Director (Chair)						
2.	Mrs C Cotton	Director of Governance						
3.	Ms A Gohil	Non-Executive Director						
4.	Mrs J Haire	Chief People Officer						
5.	Ms W Nicholson	Associate Non-Executive Director						
6.	Prof K Maddock	Non-Executive Director						
7.	Mrs A Riley	Chief Nurse						
8.	Mrs L Thomson	Director of Communications			JD	JD	JD	
9.	Prof S Toor	Non-Executive Director						

Attended | Apologies & Deputy Sent | Apologies

Speaking Up

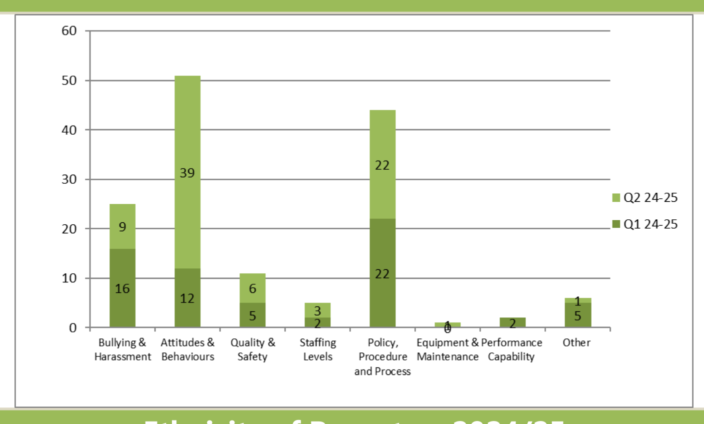
Board Brief – Quarter 1 and 2, 2024/25

1. Headlines

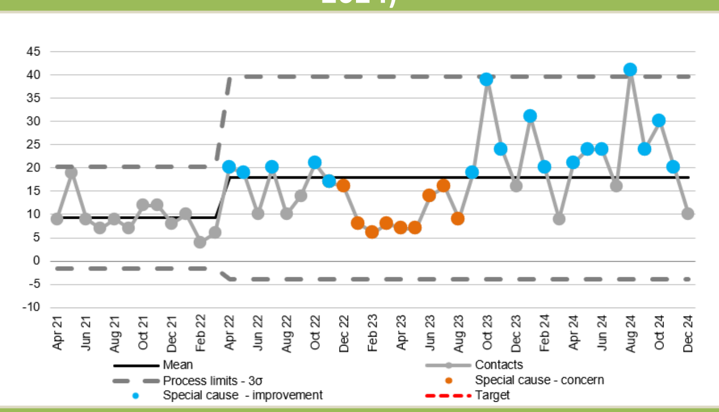
- **149 concerns** raised through the Freedom to Speak Up (FTSU) Guardian's Office during Quarter 1 and Quarter 2 2024/25
- **'Attidudes and Behaviours'** has continued to be our highest theme with 51 concerns (34%) in the reporting period. **'Policies and Procedures'** accounted for 45 (30%) concerns
- Highest reporting staff group was registered Nurses/Midwives (60 concerns, 40%)
- Highest areas for the reporting period included Theatres, Gastoenterology, Trauma and Orthopaedics and Finance

2. Summary of Concerns Raised During the Quarter

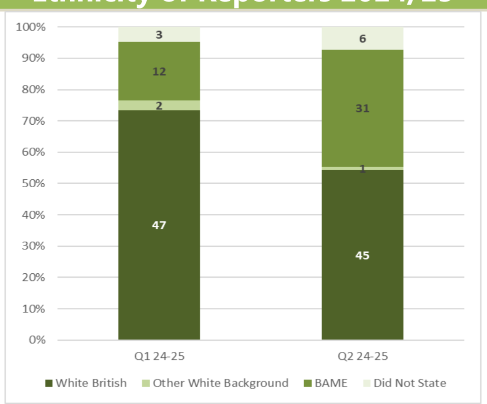
Types of Concerns Raised 2024/25



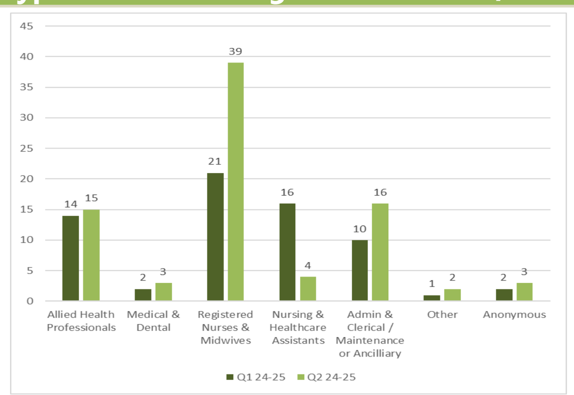
SPC – Concerns Raised (April 2021 to December 2024)



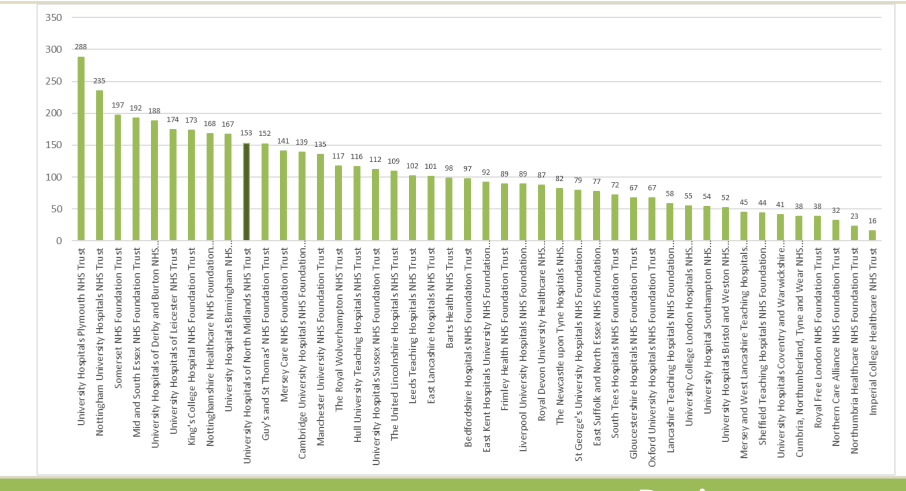
Ethnicity of Reporters 2024/25



Type of Staff Raising Concerns 2024/2025

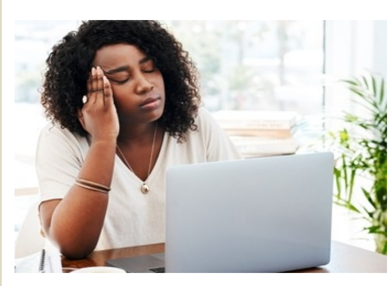


National Benchmarking – Quarter 1 and Quarter 2 2024/25



- UHNM ranked 20 / 212 NHS Trusts, for **total number of concerns raised during Quarters 1 and 2**, with above average total number of concerns (153 concerns)
- When compared with all NHS or Foundation Trusts (who submitted data) with 10,000 or more staff, UHNM ranked 10 / 44 for the **total number of concerns raised**

Detriment



- During the reporting period, of the 149 cases reported, 10 individuals reported detriment as a result of raising their concern
- This is a increase in both actual cases and percentage (7% from 3%). It is difficult to determine if this increase is a genuine increase in staff suffering a detriment as a direct result of raising a concern or if this is a perception of the individual reporters
- On occasions reporters have difficulty differentiating between a general feeling that they are being detrimentally treated and suffering detrimental treatment as a direct and sole result of raising a concern.

3. Key Developments During the Quarter

Local Developments

	Additional resource into the service. Business case approved allowing recruitment to a full time Deputy FTSU Guardian post, and part time admin support.		Continue to improve and adapt data recording and triangulation methods.
	Launch of initial network of FTSU Champions to signpost and provide support to staff in clinical areas		FTSU Guardian presented on UHNM's 2023 Speaking Up Month achievements at the NGO's Lunch and Learn Webinar.
	Responding and reacting to Lord Darzi's report into the NHS in England and the introduction of Martha's Rule into the NHS.		Launch of the UHNM FTSU Managers Guide. Providing information and guidance on how to handle FTSU concerns for managers

4. Priorities for the Next Quarter

No.		Strategic Priorities	Action
	1.		Appoint to Deputy Freedom to Speak Up Guardian and Admin support roles
	2.		Implement induction of successful candidates into the team and embed systems of working
	3.		Work alongside Space Utilisation team to establish office space and meeting room for FTSU service delivery.
	4.		Produce action plan to address themes developing around Speaking Up Culture within the organisation
	5.		Continue work to review and enhance The Speaking Up Policy (G26) in order to improve our processes and give reporters confidence in those processes.
	6.		Further expansion and development of our FTSU Champions network

5. Key Conclusions

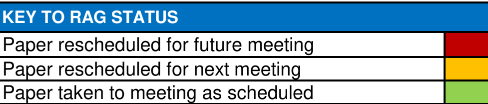
Attitudes and behaviours remain one of the highest categories of concern. Together with Bullying and Harassment they continue to account for over 50% of all concerns raised Our Cultural Improvement Programme and Be Kind agenda are designed to tackle attitudes and behaviours of staff and the issues contained within this report will be used to influence and inform further improvement activities.

Concerns remain at an unprecedentedly high level, with concerns raised in Q2 higher than in any previous reporting quarter. This indicates the continued success of the measures implemented by the Guardian.

The number of detriment cases continues to fluctuate and this reflects its subjective nature. This highlights the continued need for the guardian to discuss the difference between a general feeling of detrimental treament, and a belief that detriment has been suffered as a direct result of having raised concerns.

Trust Board

2024/25 BUSINESS CYCLE



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

Title of Paper	Executive Lead	Apr 3	May 8	Jun 5	Jul 10	Aug 7	Sep 4	Oct 9	Nov 6	Jan 8	Mar 12	Notes
HIGH QUALITY												
Chief Executives Report	Chief Executive											
Patient / Staff Story	Chief Nurse		Staff			Staff			Staff	Pt	Staff	
Quality Governance Committee Assurance Report	Director of Governance			NA								
Quality Strategy Update	Chief Nurse / Medical Director											
Care Quality Commission Action Plan	Chief Nurse											
Bi Annual Nurse Staffing Assurance Report	Chief Nurse											
Quality Account	Chief Nurse											
NHS Resolution Maternity Incentive Scheme	Chief Nurse											
Maternity Serious Incident Report	Chief Nurse											
Winter Plan	Chief Operating Officer											
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI											
Infection Prevention Board Assurance Framework	Chief Nurse											Update for February moved to March
RESPONSIVE												
Integrated Performance Report	Various											
Clinical Strategy Update	Director of Strategy											Deferred from May due to purdah and General Election period. November update to be considered at Trust Board Time Out
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer											
PEOPLE												
Transformation and People Committee Assurance Report	Director of Governance			PCI	PCI	S&T	N/A	PCI	S&T	PCI		
People Strategy Update												
Gender Pay Gap Report	Chief People Officer											
Revalidation	Medical Director											
Workforce Disability Equality Report	Chief People Officer											
Workforce Race Equality Standards Report	Chief People Officer											
Staff Survey Report	Chief People Officer											
Raising Concerns Report	Director of Governance											Report provided to EWAG and to be considered by the Board once it has been received at PCI Committee
Bi-Annual Establishment Review (Other Professions)	Chief People Officer											
IMPROVING AND INNOVATING												
Research Strategy Update	Medical Director / Chief Nurse / Director of Strategy											Interim update to be provided at Trust Board Time Out in November, as revised version not expecting to be ready until end of March / April 2025.
SYSTEM AND PARTNERS												
System Working Update	Chief Executive / Director of Strategy											
Population Health and Wellbeing Strategy	Director of Strategy											
RESOURCES												
Performance and Finance Committee Assurance Report	Director of Governance			N/A			N/A					
Estates Strategy Update	Director of Estates, Facilities & PFI											Exec decision to defer the strategy to November's Trust Board Time Out, to be presented with other enabling strategies
Digital Strategy Update	Chief Digital Information Officer											
Going Concern	Chief Finance Officer											
Annual Plan	Director of Strategy											
Board Approval of Financial Plan	Chief Finance Officer											
Final Plan Sign Off - Narrative/Workforce/Activity/Finance	Chief Finance Officer											
Activity and Narrative Plans	Director of Strategy											

Title of Paper	Executive Lead	Apr 3	May 8	Jun 5	Jul 10	Aug 7	Sep 4	Oct 9	Nov 6	Jan 8	Mar 12	Notes
Capital Programme 2022/23	Chief Finance Officer											
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												
Fit and Proper Persons Annual Assurance Report	Director of Governance											
Audit Committee Assurance Report	Director of Governance											
Trust Strategy	Director of Strategy											TBC
Board Assurance Framework	Director of Governance											
Annual Evaluation of the Board and its Committees	Director of Governance											
Annual Review of the Rules of Procedure	Director of Governance											
Board Development Programme	Director of Governance											Update for February moved to March
Calendar of Business	Director of Governance											
Well-Led Self Assessment	Director of Governance											Considered at July's Trust Board Seminar
Risk Management Policy	Director of Governance											Next due for review February 2027
Complaints Policy	Chief Nurse											