NHS
University Hospitals of North Midlands
NHS Trust

Trust Board (Open)

Meeting held on Wednesday 3rd January 2024 at 9.30 am to 12.00 pm
Via MS Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	**2.**	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 6th December 2023	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	**6.**	Chief Executive's Report – December 2023	Information	Mrs T Bullock	Enclosure	
10:15		**HIGH QUALITY**				
10 mins	**7.**	Quality Governance Committee Assurance Report (21-12-23) & Maternity Dashboard	Assurance	Prof A Hassell	Enclosure	1
10 mins	**8.**	Bi-Annual Nurse Staffing Assurance Report	Assurance	Mrs AM Riley	Enclosure	1
10 mins	**9.**	NHS Resolution Maternity Incentive Scheme	Approval	Mrs AM Riley	Enclosure	1
10:45		**RESOURCES**				
5 mins	**10.**	Performance & Finance Committee Assurance Report (19-12-23)	Assurance	Dr L Griffin	Enclosure	5, 7, 8
10:50		**PEOPLE**				
5 mins	**11.**	Transformation & People Committee Assurance Report (20-12-23)	Assurance	Prof G Crowe	Enclosure	2, 3, 4, 6, 9
10:55 – 11:10 COMFORT BREAK						
11:10		**RESPONSIVE**				
40 mins	**12.**	Integrated Performance Report – Month 8	Assurance	Mrs AM Riley Mr S Evans Mrs J Haire Mr M Oldham	Enclosure	1, 2, 3, 5, 8
11:50	**CLOSING MATTERS**					
5 mins	**13.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
	14.	Questions from the Public **Please submit questions in relation to the agenda, by 5.00 pm 1st January to** Nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
11:55	**DATE AND TIME OF NEXT MEETING**					
	15.	**Wednesday 7th February 2024, 9.30 am, Trust Boardroom, Third Floor, Springfield**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 6th December 2023 at 9.30 am to 12.20 pm
Via MS Teams

MINUTES OF MEETING

			Attended	Apologies / Deputy Sent	Apologies

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

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

In Attendance:

Mrs R Ferneyhough	Head of Nursing – County Hospital (item 1)
Mrs N Hassall	Deputy Associate Director of Corporate Governance (minutes)
Mr J James	Patient Leader (item 1)
Mrs S Jamieson	Director of Midwifery (item 10 & 11)
Mrs L Stretton	Patient (item 1)

Members of Staff and Public: 2

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
166/2023	Mrs Stretton referred to her hospital stay at County Hospital. She explained that in December 2022 she had been to her GP previously after noticing blood in her urine, whereby she was initially treated for an infection with precautionary antibiotics as blood tests, an MRI scan and cystoscopy did not reveal anything specific. After a month she felt particularly unwell and after calling a doctor she was sent to County	

	Hospital for further tests. She explained that she had been seen by two doctors and put onto antibiotics with further tests undertaken. She described how frightened and confused she was but added that she was cared for very well. She explained that she was admitted to AMU and given pain relief and as it was her birthday, she was given a birthday cake. Mrs Stretton explained how delirious she was and explained that after a few days she was told she had sepsis. She described how she had enjoyed the food when her appetite had returned and how she was reassured throughout her stay. She added that after discharge she was on antibiotics for over 6 weeks. Ms Bowen thanked Mrs Stretton for sharing her story and the positive points she highlighted. She queried if she would have welcomed being told of her diagnosis earlier and Mrs Stretton explained that because she was confused, she felt being told she had sepsis could have made her more scared. She explained that she was advised that she had a nasty infection and felt she was told at the right time. Dr Griffin welcomed the comments made about the care received at County Hospital, and queried if anything could have been done better. Mrs Stretton explained that the experience was very positive, although there was a lack of fans, and on occasion the toilets were not as clean as they could have been at the weekend, and that she waited 5 hours to be discharged. Mrs Stretton praised the staff and nurse assistants for their respect, kindness, support, concern, care, and compassion. Dr Lewis thanked Mrs Stretton for sharing the positive experience and highlighting the care and appropriate communication as well as recognising the improvements which had been made at County Hospital. **The Trust Board noted the patient story.** Mr James, Mrs Stretton, and Mrs Ferneyhough left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
167/2023	Mr Wakefield welcomed members to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate.	
3.	**Declarations of Interest**	
168/2023	There were no declarations of interest raised.	
4.	**Minutes of the Previous Meeting held 8th November 2023**	
169/2023	The minutes of the meeting held 8th November 2023 were approved as a true and accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
170/2023	There were no outstanding actions.	
6.	**Chief Executive's Report – November 2023**	
171/2023		

	Mrs Bullock highlighted a number of areas from her report and highlighted that the Trust had since received notification of planned Junior Doctor strike action to take place between 20th and 23rd December and the first week of January 2024. Dr Griffin commented on the planning required to mitigate the risks of the junior doctor strikes and the time required to do so. Dr Lewis highlighted that previous planning for strikes had been effective, although discretionary effort from other staff is required and it could not be assumed that this would be available over the Christmas period as a result of planned leave. Mr Wakefield queried how the strike action could impact activity and it was noted that the Trust would prioritise long waiters and cancer patients, but it was inevitable that the Trust would not be able to undertake elective activity as planned. Mr Wakefield referred to the downgrading of maternity units by the Care Quality Commission (CQC) across the country and queried how this triangulated with compliance to CNST standards. Mrs Riley highlighted that maternity teams were held to account on a broad range of metrics which did not always align. She stated that this had been raised with the Chief Midwifery Officer and the amount of work required to manage and report against all requirements. Mrs Jamieson added that this was being reviewed at a national level, for year 6 of CNST. **The Trust Board received and noted the report and approved eREAFs 12840 and 12797.**	
HIGH QUALITY		
7.	**Quality Governance Committee Assurance Report (30-11-23)**	
172/2023	Professor Hassell highlighted the following: • The Committee received an annual resuscitation report which demonstrated continued challenges with staffing and a business case was being prepared. In addition, there was a high level of non-attendance at training, although there had been a positive 10% improvement in training undertaken since the previous year. • The 30 day readmission rate report highlighted that the Trusts rates were higher than benchmark, in part due to the counting of paediatrics who were asked to come back if required. He explained that the Committee had previously received a review into this which highlighted that this was particularly due to the neonatal jaundice pathway, therefore confirmation had been requested that the figures continued to reflect that. In addition, some areas of elective care had higher readmission rates than the benchmark and a further report was to be provided • Medicines optimisation highlighted a continued challenge in respect of the supply chain and responding to these challenges was becoming business as usual • The Trust had improved performance in reporting adverse drug reactions, becoming the highest reporter in the West Midlands. Historically, reporting was generated by doctors, but reports had increased from nurses and other healthcare professionals, including healthcare assistants which was to be applauded Mr Wakefield queried the reference in terms of the CQC Section 29a actions and Mrs Riley stated that a significant programme of work was in place which had resulted in continued improvements but variations in performance. She stated that the Trust had been notified that an inspection would take place before the end of the year to assess compliance with the two notices.	

	The Trust Board received and noted the assurance report.	
8.	**Infection Prevention Board Assurance Framework**	
173/2023	Mrs Riley highlighted that the Trust had rated itself as being partially compliant in 14 / 48 areas and further detail had been considered and discussed at the Quality Governance Committee (QGC). Mrs Bowen referred to blood culture turnaround times and why this was being considered in November. Mrs Riley confirmed that although timeliness of turnaround times was being considered it was not of particular concern. Professor Hassell explained that when considering the detail at QGC, it was recognised that the Trust had set the bar quite high, whereby partial compliance was noted while additional evidence was provided. Professor Hassell referred to the need for assurance to be provided in future reports, in terms of whether the Trust is on track with the trajectory of improvement and Mrs Riley agreed to include this in future updates. **The Trust Board received and noted the update.**	**AMR**
9.	**Care Quality Commission Action Plan Update**	
174/2023	Mrs Riley highlighted a particular area of concern whereby speech and language therapy was being subject to a full service review which was being undertaken by the Chief Allied Health Professional. Mr Wakefield reiterated the need to confirm the trajectory of improvement for the two areas of concern and Professor Hassell added that QGC were not 100% confident that the trajectory for mental health and speech and language would be met. Mrs Riley added that in terms of mental health the Trust was unable to confirm it would achieve 100% every day but noted there had been a sustained improvement. She added that actions for speech and language would be identified after the review had been completed. Mrs Cotton referred to the launch of a self-assessment tool whereby the Trust was taking a more proactive assessment to identify gaps and risks, which would be demonstrated in future reports. She highlighted that the approach would be linked to the risk register and action planning would be undertaken via the action planning module for risk management. **The Trust Board received and noted the update.**	
10.	**Maternity Quality Governance Committee Assurance Report (22-11-23) & Maternity Dashboard**	
175/2023	Professor Hassell highlighted the following from the assurance report: • The re-audit of obstetrician presence at required situations highlighted a small number were identified as suboptimal which were being addressed by training and raising awareness with staff • Some business cases were being prepared to address specific concerns raised at the meeting although the Committee were mindful of the ability to take these forward given the current financial situation	

	• A presentation was provided from the Maternity and Neonatal Voices Partnership which highlighted challenges with representation, and this was to be publicised more widely • Positive assurance was provided on the neonatal nursing workforce and lower attrition rates. In addition, assurance was provided on specialist training • In terms of the Thirlwall inquiry, the Trust was completing the return which would be provided to QGC • A discussion was taking place about the wider implications of the compensatory rest policy Mr Wakefield referred to the issue of the smoking cessation service not being under the host employment of UHNM and queried the issue with this. Professor Hassell highlighted that an effective service was in place by another organisation, although the national requirement suggests this should be hosted by the Trust. Mr Wakefield referred to the recruitment of the neonatal workforce and the change in government policy in international recruits and queried whether the Trust anticipated this would provide a problem for UHNM. Mrs Haire stated that the revised guidance from NHS Employers was being reviewed and that she expected there to be a wider system impact. <u>Maternity Dashboard – October 2023</u> Mrs Jamieson referred to staffing and acuity levels which had improved over the past two years following specific campaigns. She highlighted that vacancies had reduced by 50, from 71 in 2022 to 21 vacancies presently, with the aim of achieving a vacancy rate of between 10 to 12 WTE by the end of the year. Given the national recruitment challenge for midwives this was a significant achievement for UHNM. In terms of training the Trust was on track to achieve the trajectories, and risks were to be reviewed to ensure these reflected the current position in terms of the improvements made in staffing. Dr Griffin referred to the improvements in staffing and queried the operational impact if there were fewer midwives available for a particular shift. Mrs Jamieson explained that staff were redeployed based on acuity in other areas as well as relying on bank midwives. She highlighted that the team used very little agency staff and the daily position was managed via safety huddles. Mrs Riley added that two areas of focus were induction of labour and triage, and sufficient staffing was crucial to those areas. Mr Wakefield referred to the failure rate for induction of labour and triage and queried whether it was expected to be able to meet the targets. Mrs Riley stated that the trajectory was aligned to staffing and ongoing achievement was dependent on staffing. Mrs Jamieson referred to work being undertaken to reduce vacancies and highlighted the progress made with four key actions. Professor Crowe suggested that the additional actions referred to in the discussion would be helpful to be included within the report, in terms of performance against the trajectory. He referred to the minimum data set outlined within the report and suggested including information for all areas, and if there was nothing of note to report this should be included. **The Trust Board received and noted the assurance report and maternity dashboard.**	
11.	**Maternity Serious Incident Report**	

176/2023	Mrs Jamieson highlighted that there had been one Serious Incident reported in quarter 2. 10 incidents remained open and 2 were overdue although this was due to factors not within the Trusts control. In addition, there had been an overall reduction in the number of open and overdue incidents. **The Trust Board received and noted the report.**	
RESOURCES		
12.	**Performance & Finance Committee Assurance Report (28-11-23)**	
177/2023	Dr Griffin highlighted the following: • There continued to be a national and regional focus on the financial position • As the Trust headed into winter, there remained dependency on agency staffing and challenges in managing urgent and elective demand • There had been some improvements in terms of managing patients through the hospital • There continued to be a focus on efficiency and productivity, particularly theatre productivity which was to be considered further • In terms of cost pressures high cost drugs were highlighted and actions continued to seek to scale down dependency on agency staff Professor Maddock referred to the ongoing challenges with endoscopy and queried the plan of action and trajectory for improvement. Dr Griffin highlighted that this had been subject to additional investment to create additional capacity which had been supported by the West Midlands Cancer Alliance and Mr Evans added that the increased capacity would assist in improving the faster diagnostic standard as well as there being a continued focus on improving productivity. Mr Oldham highlighted that the Trust was to meet with the national team to discuss the workforce position and increase in bank and agency. He explained that work had been undertaken to triangulate these areas which demonstrated that the Trust was living within its resources and were not over established. In addition, a review of the movement in workforce from 2019/20 to 2023/24 had highlighted 1200 growth, two thirds of which was due to additional investment which was affordable. There had been a reduction in vacancies primarily within qualified nursing and healthcare, and the increase in bank and agency was driven by the need to cover sickness absence, non-recurrent recovery, and cover for industrial action. It was noted that additional narrative was to be considered by the Transformation and People Committee (TAP). Mr Wakefield suggested that narrative was provided in terms of the change in staffing and the impact of sickness etc to TAP, Performance and Finance (PAF) and the Board. Professor Crowe referred to the workload of the Committee and in particular the positives highlighted which needed to be celebrated such as procurement savings and review of modular build spend. He stated that a lot of the discussion had related to the winter plan and queried if the Committee received assurance on effectiveness of the winter plan. Dr Griffin referred to the way in which he linked with other system performance and finance chairs to consider progress with the winter plan as well as it featuring regularly in PAF discussions. **The Trust Board received and noted the assurance report.**	
PEOPLE		

13.	**Transformation and People Committee Assurance Report (29-11-23)**	
178/2023	Professor Crowe highlighted the following: • Positively, the staff survey had closed with a 45% response rate which was a considerable improvement on last year • The vacancy rate had improved and was better than target • Assurance was provided on post graduate training • In terms of the Guardian of Safe Working, a conversation was held in terms of the number of concerns, although these were able to be dealt with by the guardian rather than being related to safety • The steps taken to address issues in respect of the Workforce Race Equality Standards (WRES) were highlighted, although these had not yet contributed to an improvement • A review of essential to role training continued to be undertaken • An update on the research strategy was provided although the Committee recognised that further action was required to improve the vigour in relation to this area • In terms of culture an appropriate dashboard was required and datasets were being reviewed to ensure these were suitable and reliable • An update was provided on agency staffing and underlying challenges. Mrs Haire highlighted that a review of agency workers was being undertaken and that a paper was to be taken to both PAF and TAP. In addition, the position was being monitored monthly with Divisions. **The Trust Board received and noted the assurance report.**	
14.	**Workforce Race Equality Standards Report**	
179/2023	Mrs Haire highlighted the following: • Areas of focus would be prioritised, where there had been little to no improvement, particularly harassment and bullying and abuse from patients and the likelihood of being shortlisted for promotion / advancement • There had been an improvement in BAME representation, equal opportunities and a reduction in discrimination. • A number of improvement actions continued to be identified, such as the anti-racism campaign. • A new dashboard was being developed, with a focus on civility and respect and behaviours as well as being kind and zero tolerance on racism. • Groups of people with protected characteristics were to be brought together in terms of addressing intersectionality. • Career advancement work continued via CeNREE fellowships Ms Gohil referred to the comparison of performance with peers and suggested that key areas of focus be identified rather than trying to do too many things. Mrs Haire stated that the action plan was being considered by the ethnic diversity network and it had been agreed to focus on a smaller number of high impact actions such as conflict resolution and patient and public communication. She added that the action plan would be reviewed at Transformation and People Committee in January, and that best practice from peers was being considered. Ms Gohil referred to the 11% increase in bullying and harassment from patients and relatives, and queried how the Board could receive assurance of the actions being put in place to address this, due to concerns often being underreported. Dr Lewis stated that the Trust had raised the profile of staff feeling able to report issues	

	of bullying and harassment and accepted that underlying causes needed to be considered. Mr Wakefield queried what had been done to address this area and when the Trust should expect this to decrease. Mrs Haire stated that there was limited data available and often this relied on anecdotal information. Mrs Riley added that in the absence of detail, the context needed to be understood such as the delays patients were facing and that whilst it was not right, staff were often the first person for patients to take out their frustrations. She referred to the need to de-escalate situations as well as the need to further understand the detail from other sources of data. Dr Griffin commented on the percentages provided within the report and suggested that actual numbers be included in future reports. Professor Hassell referred to the need to increase bystander actions i.e. staff witnessing behaviour against another staff member and queried how this could be tackled. Mrs Haire referred to the campaign in respect of microaggressions as well as the focus on being kind and conflict resolution which refer to the role of bystanders. In addition, conversations were being held with medical students by referring to actual stories to help staff understand the wider issues and what can be done. Mr Wakefield referred to the previous actions identified and queried whether TAP had been sighed on whether these had contributed to areas of improvement. Mrs Bullock stated that she did not expect the actions to contribute to a significant change within a year given that the programme was based on long-term changes to culture. Professor Crowe referred to the indicators which were regularly tracked through TAP, in addition to evidencing the actions being taken to enable improvement i.e. microaggressions and the resolution policy. Ms Gohil stated that whilst the changes were related to the culture and that there would be a longer lead in time to establish impact, actions could be focussed on in terms of what could be achieved within a year and these could be subsequently tracked and monitored. **The Trust Board received and noted the report.**	
RESPONSIVE		
15.	**Integrated Performance Report – Month 7**	
180/2023	Mrs Riley highlighted the following in relation to quality and safety performance: • Reporting of incidents had increased although incidents with moderate harm or above continued on a downward trajectory as well as there being a reduction in serious incidents • 1 never event had been reported which was under investigation • There had been no serious incidents related to falls and the impact of implementing diversional therapists in Medicine had been assessed, identifying a 65% reduction in falls and as such this was being considered further • There remained work to be undertaken in respect of c-difficile with additional oversight and assurance in place Mr Wakefield referred to the reference to mechanical thrombolytics and queried if these were serious incidents. Mrs Riley stated that the incidents would be investigated to assess the process followed and any learning would be shared.	

Mr Wakefield referred to timely observations and two wards being less than 50% and Mrs Riley stated that while improvements were being made, this was taking time and ongoing actions had continued with a focus on challenging the frequency of observations.

Mr Evans highlighted the following in terms of operational performance:

- The impact of the surge and winter plan was being considered
- October had forecast a bed deficit which would continue to November and performance in November was expected to reflect that
- The surge plan had identified additional capacity coming online in December and some additional capacity measures were delivering but not as expected
- There continued to be issues with performance and delays in the urgent care pathway
- The tiering system continued, with regular meetings held with NHS England
- There had been improvements in cancer and elective waiting lists but the trajectories had been set to assume no further Industrial Action, therefore it was likely that the Trust would not deliver the planned care improvement trajectories
- Additional schemes were taking place over the holiday period, including focus on discharge processes, increasing availability and discharges

Mr Wakefield referred to bed occupancy being in the upper quartile and the good performance for 12 hour waits and he queried how this contributed to 4 hour performance. Mr Evans stated that whilst the Trust was showing an improvement to peers the size of Royal Stoke skewed many of the indicators. He stated that while there had been improvements in bed occupancy, this was due to protecting beds for elective work and this was not expected to continue. He stated that in terms of 4 hour performance, the Trust had remained in the third quartile but this was challenged in November and December due to the number of patients waiting for admission and being cared for in non-admitted spaces within the Emergency Department.

Mr Wakefield referred to ambulance handover waiting times and queried the current position. Mr Evans stated that the Trust had made good progress with the average time being below the 30 minute target. However, in late October and November, the position had deteriorated and as such the December surge plan was key in creating enough space to improve performance. Mr Evans stated that it was recognised that the delays were considered in terms of the risk to the community and as such discussions were ongoing in terms of identifying shared collective risk assessments, so that these could aid levels of escalation across the system.

Ms Bowen referred to the winter plan and the expectation that November's performance would be worse than plan. She queried whether it was expected that December may see an improvement and Mr Evans stated that the largest proportion of interventions were concentrated to take place in December. However, the rapid reduction in temperature had impacted on admissions and despite additional capacity coming on online the impact of the Industrial Action was expected to worsen the position.

Dr Lewis referred to his role within the system as Accountable Officer for the system Urgent and Emergency Care programme and added that UHNM were fully engaged in system planning for surge/escalation whereby the plan would be agreed via the Urgent and Emergency Care Board which he Chairs.

Mrs Haire highlighted the following in terms of workforce performance:

- Positive position in terms of turnover and vacancies which supported the trajectory for agency reduction

	• Sickness absence was expected to rise over the next few months and the covid and flu vaccination campaigns continued • Continuing to progress with being kind campaigns such as black history month and the sexual safety campaign Ms Bowen referred to staff sickness and queried whether precautions were being taken to avoid an increase in agency during times of increased sickness. Mrs Haire stated that agency controls remained in place and sickness absence was addressed via moving staff to other areas as well as using bank staff. She added that sickness absence did not always flow through to using agency cover. Ms Bowen referred to the possible impact on patient outcomes, safety and wellbeing and whether those factors were taken into consideration when deciding how to fill absences. Mrs Haire confirmed that all factors were taken into account when deciding how to provide cover, as well as recognising the need to balance the risk to financial expenditure. Professor Crowe referred to PDR compliance whereby the data suggested that 1 in 5 staff were not having an appraisal. He queried what actions were being taken to address this performance and Mrs Haire highlighted that the position was discussed with Division on a monthly basis. Mr Oldham highlighted the following in terms of financial performance: • Month 7 ended with a deficit of £7.8 m which was behind plan • The Trust was forecasting a break even position and had secured funding from the centre for the impact of Industrial Action • Further challenges were expected as a result of the junior doctor strike and the ability for individuals to take their leave which could impact on the release of the annual leave accrual as well as potential for income to be lost • There had been some slippage in the capital programme but this was expected to catch up Mr Wakefield queried whether the £9 m which had been received had been included in the year to date position and Mr Oldham confirmed that this had not been included. Mr Wakefield stated that the amount spent on Industrial Action, backfill and escalation beds equated to £9 m and therefore a deficit of £7.8 m put the Trust in a difficult position. Mr Wakefield referred to the capital underspend and queried the impact of this. Mr Oldham stated that the slippage was expected and as such schemes were to be brought forward to ensure the Trust delivered the plan. Mr Oldham referred to the system financial position, and the anticipated £91 m deficit, which took into account the UHNM improvement to achieve a break even position. He stated that the deficit had been impacted by inflation, continuing healthcare costs and high drug costs. **The Trust Board received and noted the report.**	
GOVERNANCE		
16.	**EPRR Annual Assurance Statement**	
181/2023	Dr Lewis highlighted the following: • The criteria had changed and was now much tighter and the Trust had submitted the assessment on time with confirm and challenges held	

	• The Trust had confirmed an assessment of 34% which was non-compliant and noted many other acute providers and systems had struggled to meet the changed standards • There had been a change in substantive leadership of the EPRR team and a plan had been identified to address the immediate concerns Professor Maddock queried the target for the next submission and trajectory of improvement and Dr Lewis stated that the target was to achieve full compliance by August 2024. **The Trust Board received and noted the report.**	
CLOSING MATTERS		
17.	**Review of Meeting Effectiveness and Review of Business Cycle**	
182/2023	Mrs Cotton referred to the areas rated as amber on the business cycle and in particular the Accountability Framework. She highlighted that the document was due to be reviewed every 2 years, although she had undertaken an annual refresh and was to update the IPR metrics and corporate governance structure. Mrs Cotton highlighted that in terms of the well-led self-assessment it had been agreed to commence the process in December, the results of which would be shared with the Board. In addition, discussions had been held regarding commissioning an independent well-led review and a full review was expected to be undertaken in April 2024. Professor Crowe suggested that the actions be tracked through the action log rather than being included within the cycle of business. Mr Oldham agreed to discuss the timetabling of the planning activities once the planning guidance had been received.	
18.	**Questions from the Public**	
183/2023	There were no questions raised by members of the public.	
DATE AND TIME OF NEXT MEETING		
19.	**Wednesday 3rd January 2024, 9.30 am, via MS Teams**	

Trust Board (Open)

Post meeting action log as at **21 December 2023**

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/585	06/12/2023	Infection Prevention Board Assurance Framework	To update future reports to include an assessment as to whether the Trust is on track with the trajectory of improvement	Ann-Marie Riley	06/03/2024		Action not yet due	GB

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

December 2023

Part 1: Contract Awards and Approvals

2.1 Contract Awards and Approvals

Since 14th November to 14th December 2023 1 contract award over £1.5 m was made, as follows:

- **Electronic Patient Records Contract - Contract Extension (e-REAF 12797)** supplied by System C Ltd, for the period 01/01/024 – 30/09/2027 at a total cost of £9,444,727.50, providing cost avoidance savings of £1,183,124.80, approved on 08/12/23

In addition, the following eREAF was approved at the Performance and Finance Committee on 19th December. This requires Trust Board approval due to the value:

Energy, Stapling and Trocars (e-REAF 12877)
Contract Value £9,435,094.20 incl. VAT
Duration 08/01/2024 – 07/01/2027
Supplier Medtronic Ltd, Johnson and Johnson and Applied Medical

The Trust Board is asked to approve the above eREAF.

2.2 Consultant Appointments – December 2023

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Paeds Radiologist	Vacancy	Yes	TBC
Paeds ED Consultant (General Paediatrician)	New	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Consultant Clinical Oncologist - Urology & Colorectal (CRC)	New	04/12/2023
Locum Consultant in Emergency Medicine	Extension	01/12/2023

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

Post Title	Closing date	Note
Locum Oral Maxillofacial Oncology Consultant Surgeon	03/12/2023	No applications

2.3 Internal Medical Management Appointments – December 2023

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Head & Neck Cancer MDT Lead	Vacancy	Yes	01/01/2024

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

Post Title	Reason for advertising	Start Date
Clinical Director - Maternity, Neonates & Gynaecology	Vacancy	12/12/2023
Clinical Director - General Medicine	New	01/12/2023
Clinical Lead for Diabetes & Endocrinology	New	01/12/2023

There were no medical vacancies that closed without applications / candidates during December 2023.

Part 2: Highlight Report

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

National / Regional

2.1 Operational Pressures

On 11 December a joint letter was issued to all Chief Medical and Chief Nursing Officers from NHS England, the Care Quality Commission, the Nursing and Midwifery Council and the General Medical Council. The letter thanked colleagues for all the work done to prepare for winter and recognised the increasing challenges including further industrial action by junior doctors in late December / early January.

It was also recognised that with teams working under pressure, there may be departures from established procedures, and they reminded colleagues that professional codes and principles of practice were there to support judgement and decision making in all circumstances.

The purpose of the letter was to provide assurance to regulated professionals that on the rare occasion that they may be referred to their regulatory body, that the context within which they were working at the time would be taken into consideration. This is an important issue as many staff become concerned about their registered status when under such pressure.

Operational pressures will undoubtedly be further compounded by the Junior Doctor Industrial Action. At the time of writing this report the plans for December were almost complete with cover provided in all areas except ENT (which was still work in progress), which would provide minimum safe staffing levels. However, the fragility of this is recognised in terms of staff absence which is likely to increase due to increasing Covid and Flu and will be more difficult to backfill given the level of annual leave at this time. The plan for January 2024 is still in development.

The Industrial Action has impacted on planned / elective care. During December, at the time of writing it is known that 152 outpatient appointments and 32 In Patient and Diagnostics had to be cancelled. For January 2024 there are 87 outpatients and 12 In Patients and Diagnostics. Numbers will be confirmed during the performance section of the board reporting.

2.2 Ambulance Handovers

On 15 December 2023, ICBs received a letter asking them to co-ordinate a response to NHSE Midlands that provided assurance and a commitment to reduce the number of patients experiencing long waits in ambulances whilst waiting to be transferred into Emergency Departments. The letter referred to the handover of patients to emergency departments from ambulances and the correlation with Category 2 response delays, stressing that a whole system approach to risk across the urgent and emergency care pathway was necessary to ensure the best possible outcomes for our patients.

Guidance has been received in respect of long handover waits and at UHNM we are committed to a zero tolerance approach to very long waiters, with internal and external escalation processes ensuring every effort being made to resolve such delays. The Board are asked to support and recognise that the Executive are prioritising long ambulance waits through the escalation procedures developed. The escalation process was discussed in more detail at the recent Performance and Finance Committee.

2.3 Flexible Working Leadership Development Programme

It was great to receive news on 1 December that we have had a place confirmed on the Flexible Working Leadership Development Programme with NHS England. We know from our Staff Survey last year that we

have more work to do on providing flexible working opportunities for our staff and so this will provide an excellent opportunity to lead in this area, as well as learning from others in best practice models / approaches.

System Focus

2.4 Appointment of Chief Executive at North Staffordshire Combined Healthcare NHS Trust

I was delighted to hear that Dr Buki Adeyemo has been appointed as Chief Executive at our system partner organisation, North Staffordshire Combined Healthcare NHS Trust. I have enjoyed worked closely with Buki, who was Medical Director of the Trust prior to being made interim Chief Executive and very much look forward to continuing to work with her going forward. Many congratulations on behalf of UHNM.

2.5 Integrated Care Partnership Briefing

I have received and shared internally the latest Integrated Care Partnership Briefing which summarises the key discussions at their latest meeting in December 2023. The focus of the discussion was 'Growing Well: Ages 6 – 18 years' where a presentation was shared covering a number of key points including:

- Statistics of those living in relative poverty
- Key themes in outcomes for children and young people across Staffordshire and Stoke-on-Trent
- Disinvestment into family prevention and early help
- Predominant causes of children going into care and associated statistics
- Work underway to look at the family support offer
- Dental and oral health challenges / priorities

The presentation was followed by a 'Deep Dive' discussion where leaders took the opportunity to consider key partnership actions needed to address the challenges.

The full briefing can be accessed here staffsstoke.icb.nhs.uk/your-nhs-integrated-care-board/our-publications/icp-board-papers/icp-briefing-december-23/?layout=default.

Organisational Focus

2.6 National Joint Registry Data Provider Three Tier Award Scheme

It was great to receive notification on 12 December that County Hospital has been awarded a bronze award as a National Joint Registry Quality Data Provider for 2023.

The scheme has been devised to offer hospitals public recognition for achieving excellence in supporting the promotion of patient safety standards through compliance with the National Joint Registry data submission quality audit process.

The award recognises the high standards being reached by our team at County Hospital. Huge thanks and congratulations to all involved.

2.7 CNST Maternity Services

Well done to our maternity services, who are currently the best in the region for compliance against the Saving Babies Lives Care Bundle, which aims to prevent preterm birth and reduce perinatal deaths. I am delighted our maternity services are showing real improvements and this compliance will be essential as

part of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, which has already been achieved at 86%.

I was also really pleased to receive news that we also have the best performance against our national peer group for retention of midwives.

2.8 Organ Donation

It was also lovely to hear that during the last quarter, we facilitated 12 actual solid organ donors from 19 consenting adults, resulting in 24 patients receiving a transplant. Additionally, 30 corneas were received by NHSBT Eye Banks from the Trust. I am proud of the service our specialist nurses and teams provide to patients and their families to help facilitate donors by having sensitive conversations with families and the most difficult of times.

2.9 Health and Safety Executive Inspection – Pathology

It was pleasing to receive formal confirmation from the Health and Safety Executive on 18 December that they are satisfied with the actions we have taken in our Containment Laboratory within Pathology, following an inspection earlier in the year. This means that the file has now been closed from their perspective and we can continue to monitor compliance through our internal governance arrangements.

My thanks go to all the team involved within Pathology as well as Helen Watkiss, Head of Health and Safety for ensuring the safety of our staff in this area of work.

Quality Governance Committee Chair's Highlight Report to Board

21st December 2023

! Matters of Concern of Key Risks to Escalate

For information:

- The patient experience report highlighted that whilst the Trust remained at the national average in respect of the national inpatient survey, there had been a decrease in three questions focused around patient communication and actions had been identified in respect of this. In addition, actions were being taken to address the continued challenges in respect of number of people completing friends and family test surveys.
- There continued to be medical and nurse neonatal workforce challenges whereby a business case was being considered through the double lock process. Work remained ongoing in terms of nursing establishment not being at current BAPM standards, due to the Qualified in Speciality ratio, with the aim of achieving this by December 2024.
- The maternity dashboard for November 2023 highlighted reduced compliance with induction of labours for October and November, and actions had been taken in respect of this, with performance for December expected to achieve 90% against the target of 95%. In addition, the recommended overall ratio for Birthrate Plus was 24.8 births to 1 WTE whereby November's average ratio was 25.1 births to 1 WTE and this was expected to be achieved as recruitment continued. It was highlighted that the latest recruited midwives were supernumerary for all but 3 days of November.
- An increase in C-difficile rates at County Hospital was highlighted with actions being undertaken to use ribotyping and other testing. In addition, whilst there had been an increase in falls at the site, there had not been an increase in associated harm.
- The quality report highlighted that reported incidents had increased, and while there had been a slight reduction in c-difficile and e-coli cases, actions and monitoring remained ongoing until improvement had been sustained.
- An update on reviews of harm suffered by long waiters highlighted challenges to identify retrospective patients due to staffing capacity within the information team and a manual process was to commence in the interim. A question had also been issued to patients as part of long wait patient validation to assess any change in condition, the outputs of which were being utilised to assess clinical priority. The Committee felt that assurance could not be provided in respect of assessing retrospective or prospective levels of harm.
- An update on Quality Safety and Compliance highlighted important gaps in relation to clinical effectiveness provision. The committee does not have assurance that appropriate clinical effectiveness systems are in place, but is aware of steps being taken to mitigate this risk. An update has been requested in 4 months.
- A risk had been identified by the research and innovation team, in respect of the ability to provide direct access to external bodies (e.g. MHRA) to patient notes with an options paper being prepared to address the risk.

Major Actions Commissioned / Work Underway

- To confirm whether divisional boards had considered the patient experience report
- Pilot study being undertaken in respect of tissue donation with the aim of increasing the number of ocular donors nationally
- Statutory phase of the Medical Examiners Service expected to commence in April 2024 with UHNM identified as a pilot site to test the electronic death certificate process. It was agreed that future reports would include an update on progress in moving towards a 7 day service
- To provide 6 monthly neonatal updates to the Maternity and Neonatal Quality Governance Committee
- To provide a further update in respect of clinical effectiveness to the Committee in 4 – 6 months
- To clarify and confirm the governance structure for research and innovation. To avoid duplication between the Quality Governance and Transformation and People Committee.

✓ Positive Assurances to Provide

- The organ and tissue donation bi-annual report highlighted a national reduction in organ donation in part due to lack of potential donors and reduction in consent rates. However, the Trust remained third best with national peers in respect of the number of donations undertaken and was the top donating hospital in the Midlands.
- The medical examiners service update highlighted ongoing work with 41 General Practices. The team were being promoted as a centre of excellence, with other organisations visiting the team to learn from their best practice.
- Neonatal mortality highlighted a sustained decrease in the number of neonatal deaths and good progress had been made against the actions identified in the Local Maternity and Neonatal System (LMNS) Insights Review with the majority of actions complete or 'business as usual'.
- The Trust was expected to report 100% compliance with the 10 CNST safety actions in January 2024 and the improvements in training compliance were also welcomed.
- The Nursing and Midwifery Staffing and Quality report highlighted a positive reduction in vacancies, reduction in turnover and continuing international recruitment. Enhanced support and monitoring was taking place on 9 wards (those with higher levels of hospital acquired patient harm or a bronze CEF) with future updates to be provided to the Committee on the outcome of monitoring.
- The County Hospital update highlighted improvements in undertaking Mental Capacity Act and Deprivation of Liberty audits. In addition, Ward 15 had launched the Johns Hopkins project regarding deconditioning. Timely observations had also increased to 75.8% compared to Trust-wide compliance of 72.3%.
- The research update highlighted that of 10 sponsored studies and 12 monitoring visits, no major concerns had been highlighted.

Decisions Made

- No decisions were required to be made

Comments on the Effectiveness of the Meeting

- Members welcomed the improved quality of the papers provided.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Q2 Patient Experience Report 2023/24	BAF 1	Ext 16	🔴	Assurance	7.	County Report Q2 2023/24	BAF 1	Ext 16	🔴🟢	Assurance
2.	Organ Donation Bi-Annual Report			🟢	Assurance	8.	Quality Performance Report – Month 8 23/24	BAF 1	Ext 16	🔴	Assurance
3.	UHNM Medical Examiner Service Update			🟢	Assurance	9.	Patient Waiting List Backlog	BAF 1 & 5	16 / 20	🔴	Assurance
4.	Neonatal Unit Assurance Update	BAF 1	ID28655 ID29167	🔴🟢	Assurance	10.	Quality Safety and Compliance Overview	BAF 1	ID26887	🔴	Assurance
5.	Maternity Dashboard – November 2023	BAF 1 & 2	ID13420 ID11518 ID13419 ID15993	🔴🟢	Information	11.	Research & Innovation Quality Assurance Update	BAF 9	High 12	🔴🟢	Assurance
6.	Nursing and Midwifery Staffing and Quality Report	BAF 1 & 2	Ext 16	🟢	Assurance	12.	Quality and Safety Oversight Group Highlight Report	BAF 1	Ext 16	-	Assurance

2023 / 24 Attendance Matrix

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

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd Jan 2024
Report Title:	Maternity Dashboard: November 2023	**Agenda Item:**	9.
Author:	Sarah Jamieson - Director of Midwifery & Jill Whitaker – Deputy Director of Midwifery – Workforce & Gynaecology		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

ID	Title	Risk level
13419	Midwifery safe staffing (entered following Birth Rate Plus establishment review 2019)	12
13420	Lack of activity at Freestanding Midwifery Birth Unit (FMBU), County leading to suspension of intrapartum care	15
11518	No current operational Midwifery Continuity of Care team	15
15993	Maternity Assessment Unit Triage	12

Executive Summary

Situation

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

Background

The Maternity incentive scheme - year 5 requires evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board using a minimum data set. The measures within the dataset are included and additional information provided.
Based on the CQC report released 23.6.23, UHNM Maternity is rated “requires improvement”.

Though not part of the maternity support programme, UHNM is part of SMOAG (System Maternity Oversight Assurance Group) which provides additional support and guidance.

Assessment

- Midwifery staffing continues to be a challenge but is improving gradually.
- CNST training target has been achieved.
- Work continues to meet all remaining CNST targets.
- Work continues to improve maternity triage times.

Key Recommendations

The Trust Board is asked to receive this report.

University Hospitals of North Midlands NHS Trust

Maternity Monthly Dashboard

8th December 2023 (November report)

1. Introduction

The Maternity incentivisation scheme - year 5 requires the Trust to:

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

Figure 1: Minimum Data Set

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

Report on:

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

2. Assessment

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

Two incidents were reported as moderate harm in November.

1. Baby dropped on post-natal ward, patient rang the call bell reporting that she found the baby on the floor, dropped from bed. Baby taken to NICU for observation. Root cause analysis underway.
2. Patient injured her own lip through biting due to anxiety, this caused significant trauma.

One serious incident was reported.
Patient attended at term+7 for induction of labour. No fetal heart was heard on admission, the investigation into this incident continues.

2.Training compliance for all maternity staff groups

We are very pleased to confirm that the target for 90% compliance for PROMPT emergency training has been achieved.

Figure 2 - Staff Training Figures Virtual PROMPT Training
(DECEMBER 2022 – NOVEMBER 2023 inclusive (minus November – compliance 100% staff)

	Doctors	Obs consultants	Obs trainees	Anaesthetist	Anaes consultants	Anaes trainees	Midwives/Bank	CSW	TOTAL	Theatre
*Total number staff	65	17	48	49	27	22	306	108	528	7
Staff trained (Inc PROMPT Trainers)	63	16	47	47	26	21	278	100	488	7
*Current compliance	96%	94%	97%	95%	96%	95%	90%	92%	92%	100%

The 90% training target for skills day 3 including Fetal monitoring, saving babies lives and smoking cessation has also been met.

Figure 3 - Staff Training Figures Virtual SKILLS DAY 3
(DECEMBER 2022 – NOVEMBER 2023 inclusive (minus November – compliance 100% staff)

	Doctors	Obs consultants	Obs trainees	Midwives/Bank	TOTAL
*Total number staff	54	16	38	306	360
Staff trained (inc PROMPT Trainers)	52	15	37	276	328
*Current compliance	96%	93%	97%	90%	91%

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

There were no HSIB referrals in November.

4.Service User Voice feedback

Feedback received from women and families supported by the PMA
Individualised care planning/Trauma Informed Care

I just wanted to say a little thank you for all your support when I needed it. You showed me care and gave me much needed reassurance …Thank you so much.

Thank you so much for all the support and care…I never imagined I would be able to have a baby and you made the birth experience truly memorable…we are both so grateful for that.

Dear Jude, I wanted to write to thankyou properly for everything you did for us, both before and during our time in hospital. The c-section was incredible, and I am so grateful to have such wonderful memories of the birth…so much of this is down to you and the time you spent with us beforehand ---we are so grateful! Thanks, and all the best wishes

5.Staff feedback from frontline champions and walkabouts

No walkabout planned for this month.

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

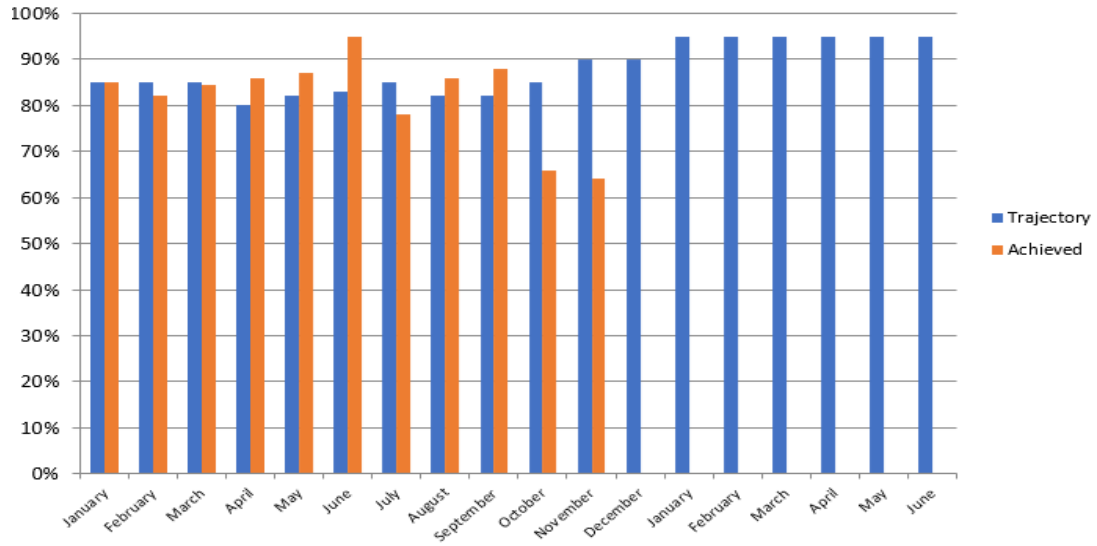
Following a CQC regulatory visit in March 2023, a section 29a safety warning was issued. This was in relation to MAU safety and the Induction of Labour process.

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

6.3 Induction of labour

We continue to monitor the birthing people booked for induction of labour and the percentage that breach current guidance.

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



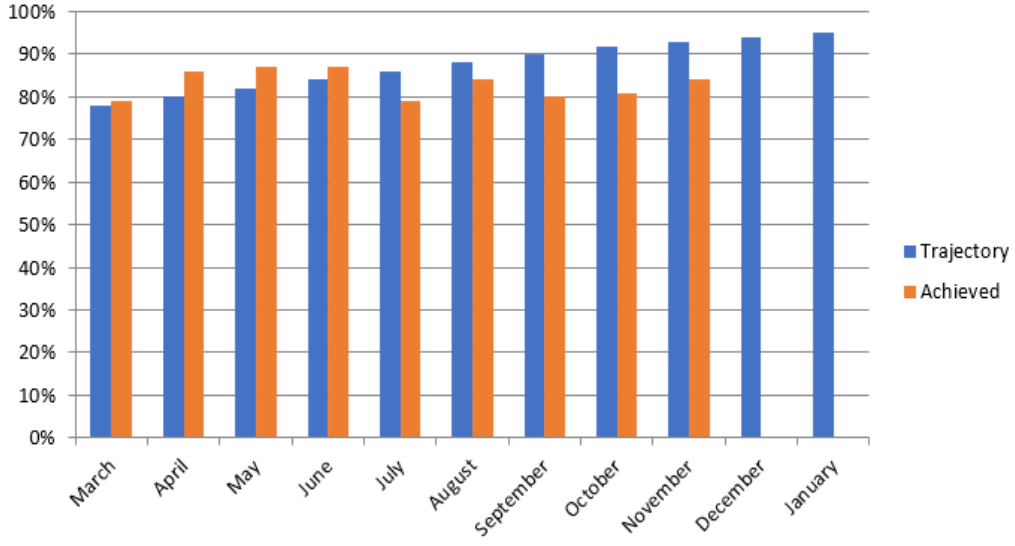
There has been a drop in the percentage of those who achieved their induction of labour in line with guidance in November. review of the data has revealed an increase in the bookings for induction of labour following the change in national and local guidance, this brought the post mature induction date down from term+14 to term+7.

Number of inductions 2023	
June	250
July	269
August	187
September	240
October	280
November	284

6.4 Midwifery triage within 15 minutes

The monitoring of midwifery triage times continues.

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



The process of midwifery triage has been reviewed and the times when the target of 15 minutes was not met has been investigated. We were able to establish that a contributing factor for the breaches were multiple attendees at one time.

An escalation trigger has been introduced for when more than 2 people are waiting to be triaged, this will inform the flow coordinator and a second triage room will be opened.
The audit will continue to assess the success of this escalation trigger.

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

8. Progress in achievement of CNST 10
Figure 6**.**

Perinatal review tool	
Maternity service data set	
Transitional care service	
Clinical workforce	
Midwifery workforce	
Saving babies lives V2.0	
Maternity services partnership	
Training	
Trust Safety Champions	
HSIB	

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

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

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

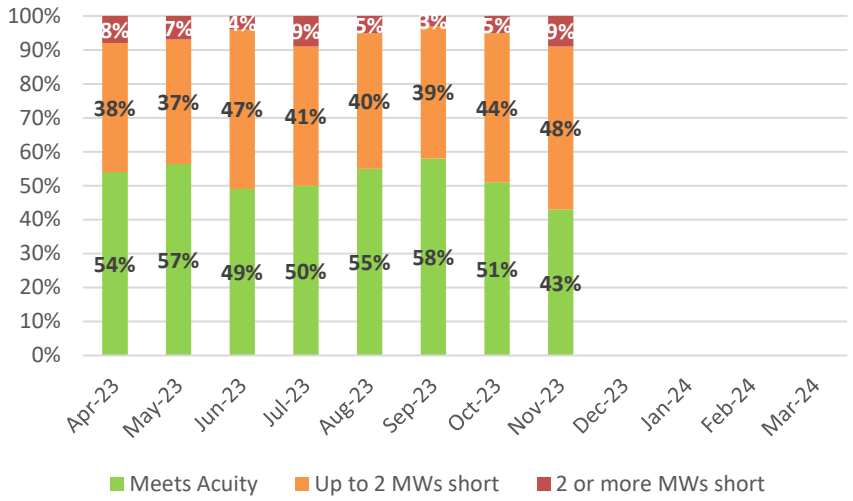
10. Minimum staffing in maternity services

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

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

Budgeted Establishment (clinical) (WTE)	**Actual in post (WTE)**	**Vacancy (WTE & %)**
271.88	**250.35**	**21.53 (7.9%)**

Midwifery staffing acuity



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

12. The midwife to birth ratio

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

13.The percentage of specialist midwives employed

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

Total Clinical WTE	271.88
Non-Clinical	29.91
Clinical, Specialist	301.79

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

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

The Birthrate Plus data for November confirms that all women received one to one care in labour work was rescheduled, and the staff deployed to the delivery suite, members of the management team were pulled to work. The delivery suite coordinator remained supernumerary throughout.

15. Medical staffing

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

16. PMRT, Stillbirths and Neonatal Deaths

4 PMRT meetings were held in November and 100% of these were commenced within 2 months of deaths. There were no emerging themes from the cases reviewed.

There were 4 stillbirths and 2 neonatal deaths.

2 of the stillbirths were un-booked and had not received any antenatal care.
1 of the neonatal deaths was at 23/40 where parents had wished for comfort care only and no resuscitation.

All cases will be reviewed using the PMRT tool.

17. Complaints

There were 2 maternity complaints in November.
The first was a lady who had concerns about her birth in July, the second complaint was from a lady who had concerns about care between the postnatal ward and the neonatal intensive care unit.

The theme across both complaints appears to be communication, both cases are currently under review. There is a full and detailed cultural improvement programme in place across maternity services, including all levels of staff, themes of this programme include human factors, behaviours of a cohesive team and kindness.

Summary and discussion

There is a direct link between adequate staffing levels, outcomes, and performance. Following the Birthrate Plus report and recommendations in 2022 the service has increased its midwifery budgeted establishment following a successful business case. Vacancies against Birthrate Plus recommendations in early 2022 were 74.67 WTE. With a consistent and targeted approach to recruitment and retention this vacancy has now decreased to 21.53 WTE. There is a continuing plan to reduce the vacancy rate to around 10 – 12 WTE by late 2023/early 2024. This will of course depend upon successful recruitment.

Minimum safe staffing levels in line with Birthrate Plus will enable adequate midwifery and maternity support worker resources which in turn will enable better flow throughout the unit, facilitating improvements in maternity triage times and induction of labour delays.

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board	**Date:**	3rd January 2024
Report Title:	Nurse Staffing Establishment Review	**Agenda Item:**	8
Author:	Jane Holmes: Deputy Chief Nurse		
Executive Lead:	Ann-Marie Riley: Chief Nurse		

Purpose of Report:

Assurance	✓	**Approval**		**Information**	

Impact on Strategic Objectives (positive or negative):		Positive	Negative
SO1	Provide safe, effective, caring and responsive services	✓	
SO2	Achieve NHS constitutional patient access standards		
SO3	Achieve excellence in employment, education, development and research	✓	
SO4	Lead strategic change within Staffordshire and beyond		
SO5	Ensure efficient use of resources	✓	

Executive Summary:

There is a significant body of national and international evidence highlighting the relationship between registered nurse staffing levels and the resulting impact on care delivery, patient outcomes (including mortality) and patient experience, improved recruitment and retention, and reduction in staff sickness and stress.

Following findings in the Francis Report, the National Quality Board (NQB) set out expectations and a framework within which organisations and staff should make decisions about safe staffing including a review of the nursing and midwifery workforce to be presented to the Trust Board twice per year.

In 2018, NHS Improvement published a document called 'Developing Workforce Safeguards – supporting providers to deliver high quality care through safe and effective staffing' which notes the requirement for organisations to comply with the NQB guidance:

'By implementing this document's recommendations and strong, effective governance, boards can be assured that their workforce decisions will promote patient safety and so comply with the Care Quality Commission's (CQC) fundamental standards, our Use of Resources assessment and the Board's statutory duties'.

This bi-annual report reviews the nursing establishment for adult and paediatric inpatient areas with the exception of midwifery who had an external review utilising nationally recognised Birth-Rate Plus methodology in 2022 and a business case was approved late 2022 in relation to this. From an initial position of circa 70 midwives deficit against Birthrate Plus guidance in 2022, the service has now recruited to all but 18 wte of these posts with the last 9 of these recruits expected to join the Trust before the end of January.

The emergency department and theatres are currently under review will be included in the next update in six months' time.

The establishment review was discussed in detail at both the Executive Team Meeting and Transformation and People Committee (TAP) prior to submission to Trust Board.

Key areas to note:

1. Ward Sister allocation remains at 0.4wte supervisory and 0.6 wte clinical time.

2. The detailed paper to TAP highlighted any area with a nurse to patient ratio of 1:8 during the day as this is the level recognised at which care is likely to be delayed or missed, and harm is likely to occur. Although there is no clear guidance regarding an appropriate nurse: patient ratio for night shifts, the detailed paper highlighted any ward with a ratio of 1:9 or more.

3. The methodology used to conduct the review is in line with national guidance. For additional assurance the Chief Nurse has requested internal audit to assess the establishment review against that guidance.

4. Additional capacity areas remain open and were highlighted in detailed paper to TAP however there are no requests in relation to these areas within this establishment review.

5. Divisional leadership teams will be responsible for producing any business cases relevant to this review, and changes to the e-rostering system will not be made until business cases are approved. The last establishment review did not result in business cases being developed given the number of vacancies, circa 450, at that time. The vacancies have now been reduced to circa 40 and therefore it is expected that Divisions will develop and submit business cases in line with the recommendations noted below. These business cases will then be subject to the usual prioritisation and governance processes.

Summary of Staffing Recommendations:

Staff group	WTE	Cost (including on costs, 21.5% uplift but no enhancements)
Health Care Assistants	**25.7 WTE** of which 8.1wte are for paediatrics	**£894,350**
Registered Nurse Associates	**2.7WTE** for paediatrics	**£112,374**
Registered Nurses	**24.3 WTE** of which 16.2wte are for paediatrics	**£1,276,727**
	Total cost	**£2,283,451**

Key Recommendations:

The Board is asked to:

1. Note the progress made to ensure compliance with national guidance in relation to determining safe nursing and midwifery staffing levels.
2. Note that Divisional leadership teams will be responsible for prioritising requests and developing business cases in line with the recommendations from the establishment review, and that no changes to establishments will be made before a business case is approved.

Nursing, Midwifery and AHP Establishment Review
December 2023

1. Introduction

There is a significant body of evidence to highlight the relationship between registered professional staffing levels and the resulting impact on care delivery, patient outcomes and experience, and staff satisfaction and experience.

In 2013, following findings of the Francis Report (2013) the National Quality Board (NQB) set out 10 expectations and a framework within which organisations and staff should make decisions about safe staffing. From 2016 to 2018 the NQB published updated safe staffing guidance and a set of expectations regarding nursing and midwifery staffing. The guidance emphasises that the NHS provider boards are accountable for ensuring that their organisations have the right skills in place for safe, sustainable and productive staffing. The NQB guidance makes explicit the requirements of NHS providers.

Expectation One Right Staff	Expectation Two Right Skills	Expectation Three Right Place and Time
• Evidence based workforce planning. • Professional judgement. • Compare staffing with peers.	• Mandatory training, development and education. • Working with the multi-disciplinary teams. • Recruitment and retention.	• Productive workforce and eliminating waste. • Efficient deployment and flexibilities. • Efficient employment and minimise agency.

Developing Workforce Safeguards was issued by NHSI in October 2018. This publication supports organisations to use best practice in effective staff deployment and workforce planning utilising evidence based tools and professional judgement to ensure the right staff, with the right skills, are in the right place at the right time. The Trust Board is expected to confirm their staffing governance processes are safe and sustainable through the Trust annual governance statement.

In 2021 the Royal College of Nursing (RCN) published 'Nursing Workforce Standards: supporting a safe and effective nursing workforce' which were designed to support a safe and effective nursing workforce.

There is no single tool that can be used to determine safe staffing levels for ward areas. The guidance recommends consideration and triangulation of a range of metrics including patient activity and acuity, harm incidents and environmental factors alongside professional judgement. This bi-annual report utilised this triangulated approach to review the nursing establishment for adult and paediatric inpatient areas.

Midwifery is not included in this review as they are subject to an external review utilising the nationally recognised Birthrate Plus methodology and a business care was approved late 2022 in response to the recommendations following the last Birthrate Plus review. From an initial position of circa 70 midwives

deficit against Birthrate Plus guidance in 2022, the service has now recruited to all but 18 wte of these posts with the last 9 of these recruits expected to join the Trust before the end of January.

A detailed paper highlighting the methodology and data considered during the establishment review process, which was carried out during September 2023, was presented in full to Executive Team Meeting and to the Transformation and People Committee (TAP) in December 2023.

TAP were assured that the methodology utilised to assess safe nurse staffing was in line with the national standards noted above. As additional assurance, the Chief Nurse has requested that internal audit conduct an assessment of this establishment review to seek independent assurance of the methodology used.

2. Nursing and Midwifery Staffing Review December 2023

The NQB guidance expects a review of the nursing and midwifery workforce to be presented to the Trust Board twice per year. The last staffing review was undertaken in April 2023.

Studies have shown that appropriate nursing and midwifery staffing levels support achievement of clinical and economic improvements in patient care including enhanced patient satisfaction, reduction in medication errors, reduction in incidences of falls, reduction in pressure damage, reduction in healthcare associated infection rates, reduction in mortality, reduction hospital readmission and duration of stay, reduction in patient care costs, and reduction in nurse fatigue and burnout which affects recruitment and retention.

The Royal College of Nursing currently recommend an uplift of 25% (https://www.rcn.org.uk/About-us/Our-Influencing-work/Policy-briefings/pol-003870) to ensure there is adequate uplift to cover absence and reduce reliance on temporary staffing.
UHNM currently supports an uplift of 21.5% for the majority of areas which does not adequately cover the consistent level of absence at UHNM caused by sickness, study leave, other absence or maternity/paternity leave. There are some areas with a higher uplift which reflects additional training time required for those areas.
It is important to note that the rosters across UHNM are set correctly in line with current funded establishment. Any level of absence above that funded within the uplift is mitigated with temporary staffing and/or deployment of staff to ensure areas are staffed as safely as possible.

This paper is not requesting any changes to the level of uplift currently but this may be something to consider in future within the context of reducing reliance on temporary staffing.

3. Approach

The Deputy Chief Nurse led initial discussions with each Divisional Nurse and provided the Harm Review data for the last 6 months and a copy of the previous establishment review for reference. Each Divisional nurse was asked to lead discussions with the ward/dept. leaders in their division to review the data, collate professional judgements and determine the safe staffing levels required within their areas.

The information collected within Divisions included, funded establishment (as agreed by Finance), quality and HR metrics, shift patterns, key performance indicators for staff rostering and a discussion about ward layout and other professional judgement factors that might affect the number of registrants and non-registrants required.

Divisional Nurses each had further meetings with the Deputy Chief Nurse to check and respectfully challenge proposed staffing levels.

Quality metrics for the previous 6 months were also considered, including harm free care metrics, Clinical Excellence Framework (CEF) score, relevant HR data and rostering key performance indicators. Key

performance indicators for rostering were also included. The compliance with recording acuity for the safer care tool was recorded where possible and individual ward compliance was discussed at the review meetings.

All collated data and relevant guidance were triangulated to determine whether the current funded staffing levels were satisfactory, or whether additional staffing was recommended.

4. Review findings and recommendations

Medicine
There are areas of increased acuity which have seen numbers required for 1:1 therapeutic observations for patients increase. The team report having felt the benefit of the previously agreed activity coordinators in their reductions of harm, (in particular falls) within our Frail Elderly patients and in their plight to prevent deconditioning. Since the introduction of these posts, Medicine has seen a 65% falls reduction.

Recommendation for Medicine

Ward area	Staff type	WTE uplift required	Comments
Ward 12	Health Care Assistant	1.4 Band 2	Additional HCA on nights in line with harm data and to align with other wards at County.

Network Service Division
Network Division report an increase in patient acuity and dependency resulting in a request for non-registered workforce. The request aligns to current temporary staffing requests. Additionally there is a recommendation for 8.1 WTE Registered Nurses to bring the nurse to patient ratio in line with National Standards for level 1 care.

Recommendations for Network

Ward area	Staff type	WTE uplift required	Comments
221	Registered Nurse	2.7 WTE	To increase the RN to Patient ratio from 1:9.7 to 1:7.25 at night.
228	Registered Nurse	2.7 WTE	To increase the RN to Patient ratio from 1:10 to 1:7 at night. (Allows 2 RN for Level 1 Beds 1:4 / 4 RN for 28 ward based care 1:7)
127	Registered Nurse	2.7 WTE	To increase the RN to Patient ratio from 1:10 to 1:66 at night. (Allows 2 RN for Level 1 Beds 1:4 / 3 RN for 20 ward based care 1:66)
127	Health Care Assistant	5.4 WTE	To increase HCA to provide a consistent workforce to response to 1:1 care requirement. Data over last 18months to represent this through safer care; temporary workforce requests and professional judgement.
126	Health Care Assistant	5.4 WTE	To increase HCA to provide a consistent workforce to response to 1:1 care requirement. Data over last 18months to represent this through safer care; temporary workforce requests and professional judgement.
225	Health Care Assistant	2.7 WTE	To increase the HCA to patient ratio at night by x1 HCA to support with falls prevention at night.
220	Health Care Assistant	2.7 WTE	To increase the HCA to patient ratio day and night by x1 HCA to support ward acuity and activity. Current ward ratio at night 1:28.

Women's, Childrens & Clinical Support Services
Staffordshire Children's Hospital has identified that the current establishment no longer meets the requirements to address the presenting demand, presentation and acuity of Infants, Children's and Young Adults (ICYP) within the Children's inpatient, outpatient and emergency portals. This was noted in the last establishment review. The review utilised the standards available for Children's Services and also a review of the age range of patients accessing the beds over the last financial year. UHNM are seeing a higher acuity of patient admitted for both medical and surgical admissions and an increasing complexity of children who graduate from the Neonatal Unit services.

The UHNM Urgent and Emergency Care Standards, whilst decompressing the Children's ED from a position of 100+ patients in 24hours to a max of 60-70 patients within 24hours, is having an impact on the Children's Assessment Unit and Surgical admission ward.

Recommendation for Staffordshire Children's Hospital

Ward area	Staff type	WTE uplift required	Comments
CAU	Childrens Registered Nurse Health Care Assistant	5.4 wte 5.4 wte	Profile of ICYP attending over a 24hr period with a resus area. Medication administration at SCH@RSUH is 2 registrants.
Ward 217	Childrens Registered Nurse	10.8 wte	Ward level beds – Standard 1:4 daytime and 1:3 night time based on data relating to <2years and >2 years 364 days utilising the bed base 24/7
217a	Nursing Associate Health Care Assistant	2.7 wte 2.7 wte	

Surgery
Surgery currently has two main concerns, SACU & Theatres. Both of these areas were in the process of undertaking a full staffing review which will be considered in the next establishment review paper.

A summary of the total number of staff recommended and associated costs are detailed below:

Staff group	WTE	Cost (including on costs, 21.5% uplift but no enhancements)
Health Care Assistants	**25.7 WTE** of which 8.1wte are for paediatrics	**£894,350**
Registered Nurse Associates	**2.7WTE** for paediatrics	**£112,374**
Registered Nurses/ Registered Childrens Nurse	**24.3 WTE** of which 16.2wte are for paediatrics	**£1,276,727**
	Total cost	**£2,283,451**

5. Recommendations

The Board is asked to:
1. Note the progress made to ensure compliance with national guidance in relation to determining safe nursing, midwifery and AHP staffing levels
2. Note that Divisional leadership teams will be responsible for prioritising requests and developing business cases in line with the recommendations from the establishment review and that no changes to establishments will be made before a business case is approved.

Executive Summary

Meeting:	Trust Board	**Date:**	3rd January 2024
Report Title:	NHS Resolution Maternity Incentive Scheme Year 5 Compliance	**Agenda Item:**	9
Author:	Donna Brayford, Deputy Director of Midwifery – Governance		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

28655	*Neonatal Junior Doctor Staffing*	*16 (extreme)*

Executive Summary

Situation

UHNM reports compliance with the ten Maternity Safety Actions of the Clinical Negligence Scheme for Trusts (CNST) Maternity Scheme Year 5.

Background

NHS Resolution is operating year five of the CNST Maternity Incentive Scheme to continue to support the delivery of safer maternity care.
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.

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on 1 February 2024 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing the position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Trust Board declaration form must be signed and dated by the Trust's Chief Executive Officer (CEO) to confirm that:
  -The Trust Board are 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 and technical guidance document included in this document.
  -There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB)

investigation reports etc.). All such reports should be brought to the MIS team's attention before 1 February 2024. *(To note - NHS Resolution reviewed the UHNM MIS Year Four submission following the Maternity CQC inspection and confirmed that we met all 10 safety actions - letter to CEO dated 27 November 2023).*

- The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. The Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS resolution.

Assessment

The UHNM submission has been scrutinised by the ICB Maternity team and recommended for sign off for compliance against all 10 elements on Friday 22 December. Therefore UHNM can demonstrate achievement of the ten safety actions (Appendix 1- Board Notification Form).

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.

University Hospitals of North Midlands NHS Trust

NHS Resolution Maternity Incentive Scheme Year 5

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Answer: **Yes**
The following standards are required to be compliant with Safety Action 1:

a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.

UHNM has reported 100% of all eligible perinatal deaths within seven working days and completed the surveillance information where required within one month of the death.

b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.

UHNM has reported 100 % of all parents have had their perspectives of care sought.

c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023.
i) 95% of reviews should be started within two months of the death

UHNM has reported 100% of all reviews have been commenced within 2 months.

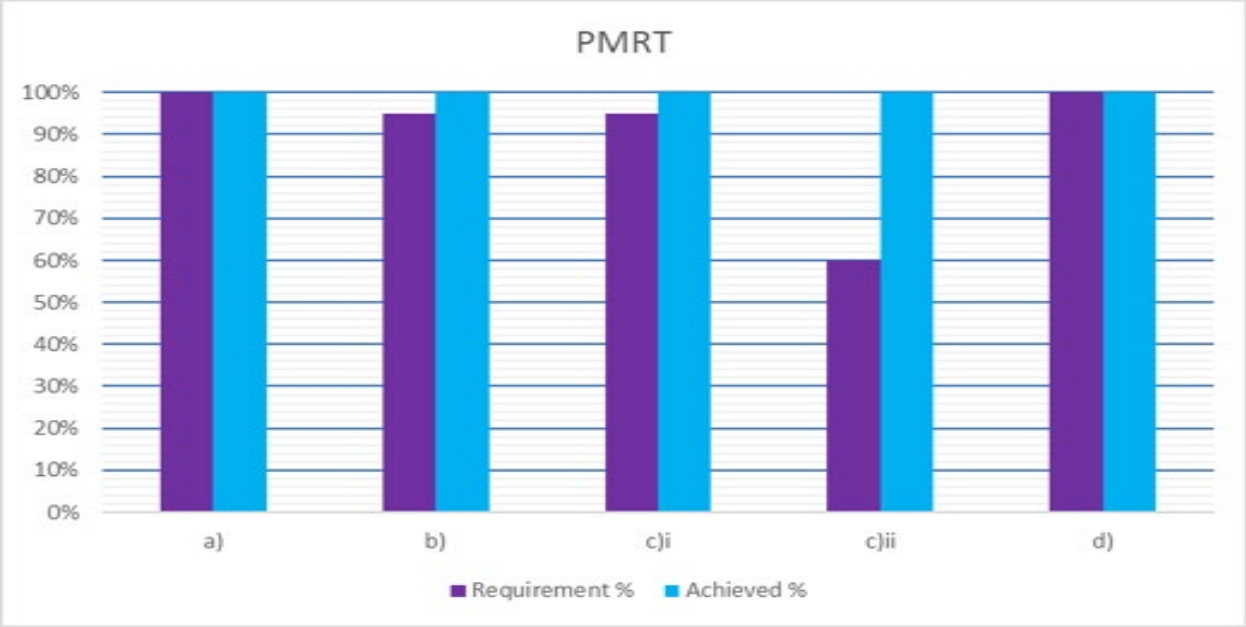
ii) a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.

UHNM has reported 100% of all reviews have been completed to the draft report stage within 4 months and published within 6 months.

d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.

Quarterly reports have been submitted to the Trust Board from MIS tear 3 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports are discussed with the Trust maternity safety and Board level safety Champions.

Table1 – Summary of UHNM Compliance with Safety Action 1



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

Answer: **Yes**
The following standards are required to be compliant with Safety Action 2:

This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.

UHNM are compliant with all 5 elements of Safety Action 2 for the reporting period of July 2023.

1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed 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 2023. Final data for July 2023 will be published during October 2023.

10 out of 11 Clinical Quality Improvement Metrics (CQIMS) have passed the associated data quality criteria.

2. July 2023 data contained 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 2023, UHNM achieved 96.3%. The Trust is therefore compliant.

3. Trust Boards to confirm to NHS Resolution that they have passed 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 2023 for the following metrics:

i) Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and have the CoC pathway indicator completed.

In July 2023, UHNM over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and have the CoC pathway indicator completed.

4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.

UHNM provided an MSDS submission before the provisional processing deadline for July 2023 by the end of August 2023.

5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.

UHNM have 3 people registered to submit MSDS data to SDCS Cloud

Table 2 Copy of MSDS Scorecard for the assessment reporting period of July 2023

Organisation Name: UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST

Reporting Period: July 2023

NHS England

Notes: The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes. If this dashboard is being presented as evidence of your Trust's achievement of criteria within Safety Action 2 of Year 5 of the Maternity Incentive Scheme, please use the information for the assessment month of July 2023 for this purpose.

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	425			Passed
CQIMDQ14	470	510	92.2		Passed
CQIMDQ15	460	460	100.0		Passed
CQIMDQ16	430	460	93.5		Passed
CQIMDQ24	425	430	98.8		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	310	455	68.1	Passed
CQIMDQ08	455	475	95.8	Passed
CQIMDQ09	470	510	92.2	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	470	510	92.2		Passed
CQIMDQ11	10	470	2.1		Passed
CQIMDQ12	10	470	2.1		Passed
CQIMPPH	10	470	26		Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	470	510	92.2		Passed
CQIMDQ22	460	460	100.0		Passed
CQIMDQ23	430	460	93.5		Passed
CQIMPreterm	30	460	61		Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	470	510	92.2		Passed
CQIMDQ15	460	460	100.0		Passed
CQIMDQ16	430	460	93.5		Passed
CQIMDQ18	270	460	58.7		Passed
CQIMDQ20	10	255	3.9		Passed
CQIMTears	10	255	39		Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	470	510	92.2	Passed
CQIMDQ15	460	460	100.0	Passed
CQIMDQ16	430	460	93.5	Passed
CQIMDQ18	270	460	58.7	Passed
CQIMDQ26	460	460	100.0	Passed
CQIMDQ27	590	590	100.0	Passed
CQIMDQ28	255	590	43.2	Passed
CQIMVBAC	5	60	8.3	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	470	510	92.2	Passed
CQIMDQ31	475	475	100.0	Passed
CQIMDQ32	435	475	91.6	Passed
CQIMDQ33	475	475	100.0	Passed
CQIMDQ34	270	475	56.8	Passed
CQIMDQ36	470	470	100.0	Passed
CQIMDQ37	200	470	42.6	Passed
CQIMDQ38	465	475	97.9	Passed
CQIMDQ39	450	470	95.7	Passed
CQIMRobson01	5	50	10.0	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	55	110	50.0	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	70	85	82.4	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	590	510	115.7	Passed
CQIMDQ04	565	590	95.8	Passed
CQIMDQ05	60	565	10.6	Passed
CQIMSmokingBooking	60	565	10.6	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	380	470	80.9	Passed
CQIMSmokingDelivery	30	380	7.9	Passed

2. EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	580	590	98.3	Passed

3. MCoC i

Indicator	Numerator	Denominator	Rate	Result
COC_DQ04	580	595	97.5	Passed

MCoC ii

Indicator	Numerator	Denominator	Rate	Result
COC_DQ05	15	20	75.0	Passed

4. Provisonal Window Submission

Indicator	Result
Provisional Submission	Passed

5. Submission Portal Registration

Indicator	Result
Registered Submitters	Passed

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Answer – **Yes**
The following standards are required to be compliant with Safety Action 3:

a) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

UHNM Transitional Care Policy has been fully implemented – 'Operational Policy Transitional Care Unit' includes:

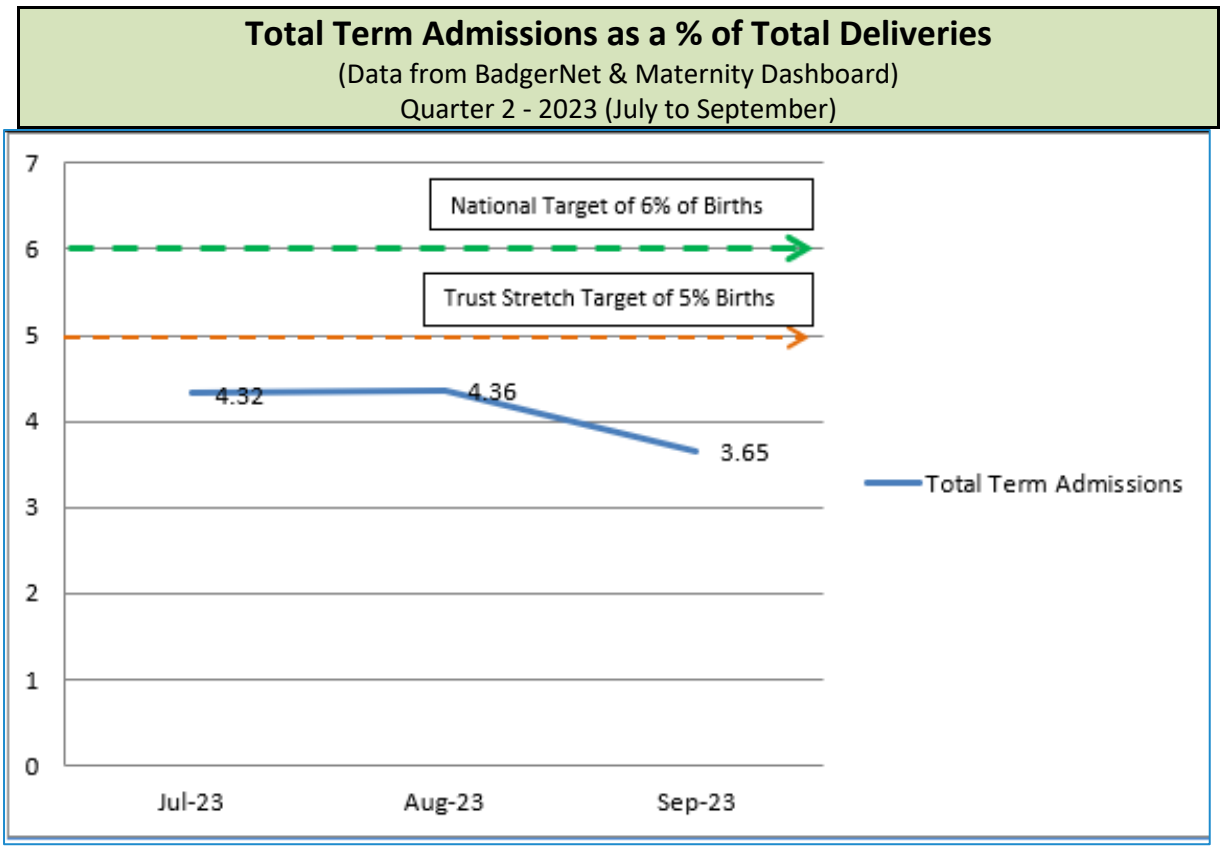
- **evidence of neonatal involvement in care planning**
- **admission criteria that meet at least one element of HRG XA04**
- **staffing model**
- **is signed by maternity and neonatal clinical leads.**

Quarterly audits of compliance within the policy are performed.

b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the

quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.
UHNM perform quarterly audits of admissions to the Neonatal Units equal or greater than 37 weeks. The on-going review of term infant admissions has revealed that rates remain low at UHNM. UHNM minimises separation of mothers and their babies in line with National Guidance.

Table 3 Total Term Admissions to the Neonatal Unit for Q2.



The action plan is shared with the directorate, the Quadrumvirate and Trust Maternity Safety Champions, division, Maternity and Neonatal Quality Oversight Group, Maternity and Neonatal Quality Governance Committee and LMNS.

c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.

UHNM Transitional Care Policy has been fully implemented. Quarterly audits of compliance with the policy are performed.

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

Answer: **Yes**
The following standards are required to be compliant with Safety Action 4:

a) Obstetric medical workforce
1) NHS Trusts/organisations should ensure 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: a. currently work in their unit on the tier 2 or 3 rota or b. 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 c. 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 and action plan to address any lapses.

As per the MIS ask, after February 2023 an audit of 6 months activity has been carried out. During this time, the Obstetrics and Gynaecology department employed 2 out of the 4 short term locums not meeting the required criteria.
A UHNM specific SOP has been produced and shared with the following teams to ensure that moving forward all Obstetrics and Gynaecology short-term locums are complaint with the criteria detailed in the MIS:
• Obstetrics & Gynaecology Management Team
• Obstetrics & Gynaecology Consultant Team
• Medical Staffing
The Obstetrics & Gynaecology department will ensure that moving forward this is audited monthly against compliance.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

As per the MIS ask, after February 2023 an audit of 6 months activity has been carried out. During this time, the Obstetrics and Gynaecology department met the required criterion.
This criterion is directly in line with the Royal College of Obstetricians and Gynaecologists (RCOG) guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland, and Wales (June 2021)

A UHNM specific SOP has been produced and shared with the following teams to ensure that moving forward all Obstetrics and Gynaecology long-term locums are complaint with the criteria detailed in the MIS:
• Obstetrics & Gynaecology Management Team
• Obstetrics & Gynaecology Consultant Team
• Medical Staffing
The Obstetrics & Gynaecology department will ensure that moving forward this is audited on a monthly basis against compliance.

3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

A UHNM specific policy (HR39) Working Time Regulations details the requirement for compensatory rest and provides guidance on implementation.

As per the MIS ask an audit of activity between 30th May and 7th December 2023 has been carried out, to ascertain when we weren't able to implement the compensatory rest guidance. Unfortunately, due to the nature of the current job plans within the directorate, no consultant or SAS doctor within the department has a job plan that is compliant.
UHNM action plan completed.

4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 26 '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 nonattendance.

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 on all occasions. UHNM perform quarterly audits of:
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

Table 3 – Example of data collection of consultant attendance in situations they must attend:

Situation	May 2023	Jun 2023	Jul 23	Aug 23	Sep 23	Oct 23	Trend
Eclampsia	1 / 1	-	-	-	-	1 / 1	→
Maternal Death	-	-	-	-	-	-	N/A
Maternal Collapse (such as massive abruption, septic shock)	-	-	-	-	-	-	N/A
Caesarean section for major placenta praevia or abnormally invasive placenta	2 / 2	-	5 / 5	3 / 4	2 / 2	6 / 6	→
Postpartum haemorrhage of more than 1.5 litres, where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated	4 / 5	10 / 11	7 / 8	3 / 3	2 / 2	6 / 6	→
Return to theatre including laparotomy	-	1 / 1	-	1 / 1	-	1 / 1	→
Uterine rupture	-	1 / 1	-	-	-	-	N/A
When cases cannot be escalated to higher levels of care due to capacity such as second theatre opening or unit closure	-	-	-	-	-	-	N/A
In cases where Red flag sepsis has been identified, initial treatment has been instigated and there has been no clinical improvement after 1 hour or where there is ongoing clinical deterioration and requirement for critical or intensive care within the Lyme building (as opposed to HDU on delivery suite which is used to maintain intensive observations). To be reviewed within an hour of being called.	1 / 6	1 / 3	3 / 3	2 / 4	2 / 3	2 / 2	↑
[In cases of MEOWS ≥6, initial treatment has been instigated and there has been no clinical improvement after 1 hour or where there is ongoing clinical deterioration and requirement for critical or intensive care within the Lyme building (as opposed to HDU on Delivery Suite which is used to maintain intensive observations.) To be reviewed within an hour of being called.	5 / 9	1 / 3	4 / 11	3 / 7	1 / 1	5 / 9	↓
At caesarean section of women who refuse blood products	-	-	-	-	-	0 / 1	→
Premature twins <30/40	-	-	0 / 2	-	4 / 4	-	N/A
Caesarean birth <28/40	2 / 2	-	1 / 3	1 / 1	2 / 2	-	N/A
4th degree perineal tear repair	-	-	-	-	-	-	N/A
Unexpected intrapartum stillbirth	-	-	-	-	-	-	N/A
Caesarean birth for women with a (booking) BMI >50	1 / 1	-	0 / 1	2 / 2	3 / 3	1 / 2	↓
Postnatal re-admission	7 / 10	1 / 2	16 / 16	21 / 23	6 / 12	12 / 14	↑

b) 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. The rota is provided as evidence of UHNM position.

c) Neonatal medical workforce
The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing.

The above requirements were previously met in years 3 & 4. In year 5 of MIS the BAPM standards have changed and therefore the relevant action was the development and submission of a business case to enable the provision of medical staffing in line with BAPM. This business case has been approved by UHNM Trust Board. Therefore, this is compliant with the standard.

d) Neonatal nursing workforce
The neonatal unit meets the BAPM neonatal nursing standards. If the requirements have not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed 27 and include new relevant actions to address deficiencies.

Nursing Staffing:
Table 4 - The current nursing vacancies are as follows:

	Current WTE	Current Gaps WTE
Band 7	5.76	0
Band 6	31.93	6.55
Band 5	44.33	0.52
Band 4	1.78	0
Band 2	14.65	0
Admin	3.0	0.85

UHNM currently reports 46.3% QIS compliance. BAPM requires 80% of the Neonatal Nursing Team to be qualified in Speciality (QIS). This is significantly lower than previous quarter, but it is recognised that this dilution is as a consequence of recent successful recruitment events, and the recruitment of 6.0WTE newly qualified nurses, who do not currently possess the QIS qualification.

The plan to enhance QIS ratio is in place, and as follows: -
- **3.6 WTE nurses are now enrolled on current QIS course**
- **4.92 WTE nurses have been enrolled for January 2024**
- **5.0 WTE nurses will be enrolled for June 2024**

An action plan has been completed and shared with the LMNS and ODN.

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

Answer - **Yes**
The following standards are required to be compliant with Safety Action 4:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

The UHNM Birthrate Plus® assessment was completed in June 2022 and demonstrated the following:
Birthrate Plus® recommendations for UHNM
Based on 25.99% Uplift the workforce requirements are as shown in the table below.

Table 5 - Birthrate Plus recommendations for UHNM

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

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

There was a significant shortfall in the budgeted clinical midwifery establishment, against Birthrate Plus recommendations. The budgeted staffing levels needed to be increased to align to Birthrate Plus. This is the recommendation for delivery of a traditional model of care.

A business case was submitted and approved by Trust Board in 2022 to increase the clinical midwifery establishment in line with Birthrate Plus recommendations. The budgeted establishment has now been increased accordingly.

Table 6 - Current Midwifery staffing status

	Budgeted WTE		Contracted WTE		Difference	
	Clinical	Non-clinical	Clinical	Non-clinical	Clinical	Non-clinical
MIDWIFE BAND 5	27.70	-	27.63	-	-0.07	-
MIDWIFE BAND 6	213.91	2.34	158.13	2.33	-55.78	-0.01
MIDWIFE BAND 7	20.90	23.83	20.50	25.39	-0.40	1.56
MIDWIFE BAND 8A	-	3.00	-	3.00	-	-
MIDWIFE BAND 8B	0.20	1.80	0.20	2.80	-	1.00
TOTAL	262.71	30.97	206.46	33.52	-56.25	2.55

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.

The midwifery coordinator has been supernumerary 100% of the time. This is reported daily via the maternity sitrep.

d) All women in active labour receive one-to-one midwifery care.

All women in active labour have received one to one care. This is reported daily via the maternity sitrep.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.

Maternity services report quarterly to the directorate, division, and executive team

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

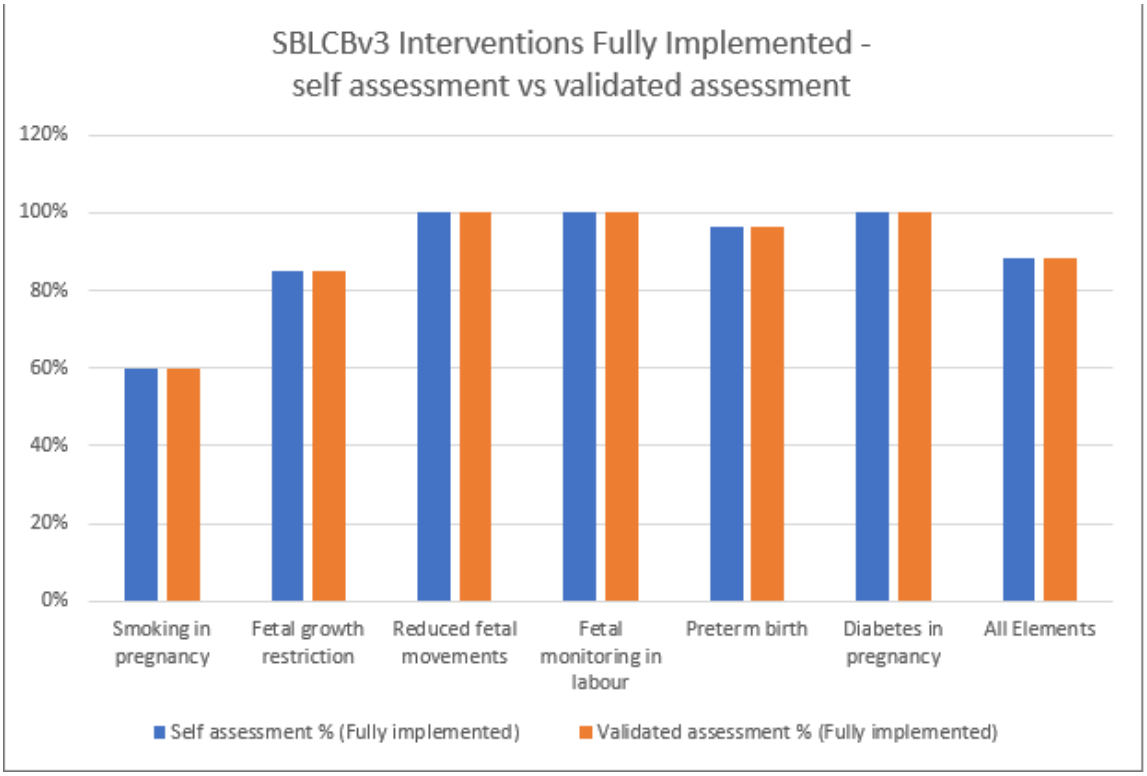
Answer -**Yes**
The following standards are required to be compliant with Safety Action 6:

a) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.

To evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. These percentages will be calculated within the national implementation tool.

Table 7 – UHNM compliance with 6 elements of SBLV2

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	85%	Partially implemented	85%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	96%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	89%	Partially implemented	89%	CNST Met



2) Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust, using the implementation tool and includes the following:

• Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.
• Progress against locally agreed improvement aims.
• Evidence of sustained improvement where high levels of reliability have already been achieved.
• Regular review of local themes and trends about potential harms in each of the six elements.

• Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.

Two quarterly quality improvement discussions have been held between UHNM and the LMNS.

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Answer -**Yes**
The following standards are required to be compliant with Safety Action 7:

Table 8 – Evidence of compliance with safety action 7.

Evidence required	Evidence in place	Evidence to be generated & RAG rating No concerns / At risk / Not in place	Evidence location	Additional Work Required
Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff.	Minutes from MNVP Forum meetings (held bi-monthly)	Ongoing meeting schedule; 28/09/23 | 23/11/23 | 28/03/24	**ICB SharePoint folders - Maternity / MNVP / Meetings_Reports / MNVP Forum Meetings** https://c9online.sharepoint.com/:f:/s/ccg_nurs/Eg8mmC0r7vNIum5UsmhTv3YBgq4GfxHTD_j2pQ-FFkrrpg?e=ZO1Mh6	
	Minutes from LMNS QSOF meetings (held monthly, from Sept 23, MNVP will be reporting every 4 months - Oct 23 & Feb 23)	Ongoing monthly meeting	**ICB SharePoint folders - Maternity / MNVP / Meetings_Reports / QSOF** https://c9online.sharepoint.com/:f:/s/ccg_nurs/Eqezjo2XarpPro71p7TAau4BxR0KPjk5fcZmhNPv3mk9fw?e=7NeOC0	
	Minutes from LMNS Partnership Board meetings (held monthly) - patient stories agenda item	Ongoing monthly meeting	**ICB SharePoint folders - Maternity / MNVP / Meetings_Reports / MTP Board** https://c9online.sharepoint.com/:f:/s/ccg_nurs/EkuAhu4bVc9LrebW_pgb-QYBvK0geID3gWjTyteuBodiDg?e=ifWVVc	
	Quarterly MNVP reports (presented at QSOF meetings)	Ongoing reporting schedule	**ICB SharePoint folders - Maternity / MNVP / Meetings_Reports / QSOF** https://c9online.sharepoint.com/:f:/s/ccg_nurs/Eqezjo2XarpPro71p7TAau4BxR0KPjk5fcZmhNPv3mk9fw?e=7NeOC0	
….with evidence of reviews of themes and subsequent actions monitored by local safety champions.	**UHDB** - monthly meetings with Claire Brackenbury, Senior Midwife and DMNV to discuss and progress the joint action plan, following MNVP feedback, visits, reports etc **UHNM** - monthly meetings with PMA's to discuss and progress the joint action plan, following MNVP feedback, visits, reports etc	→ We do not have any evidence that actions are monitored by local safety champions for either provider	Evidence of You Said, We Did reporting **ICB SharePoint folders - Maternity / MNVP / Feedback_Service user stories / You Said We Did** https://c9online.sharepoint.com/:f:/s/ccg_nurs/EqQgsyj06RFGtxf78C3yXgoBqNzU0uUyGrru2IMqsawQPA?e=sEjMOG	Additional work required; → Closing actions, and generating meaningful You Said, We Did
MNVPs should work in partnership with local specialist voluntary, community, and social enterprise (VCSEs) with lived experience to gather feedback.	The SaSoT MNVP membership includes representatives from Providers, ICB and ICS, as well as; Trusts Patient Engagement Teams Healthwatch Harvey Girls Just Family CIC Action on Postpartum Psychosis East Staffordshire Diabetic support group Maternity and Neonatal Independent Senior Advocate Breastfeeding Network Reed Wellbeing Everyone Health Community/Family Hubs Baby Sensory group Hearts and Minds Partnership FASD training - Elucidate	Ongoing bimonthly MNVP meetings & minutes	Evidence of membership list, although data is subject to GDPR **ICB SharePoint folders - Maternity / MNVP / Meetings_Reports / MNVP Forum Meetings** https://c9online.sharepoint.com/:f:/s/ccg_nurs/Eg8mmC0r7vNIum5UsmhTv3YBgq4GfxHTD_j2pQ-FFkrrpg?e=ZO1Mh6	Additional work planned to enhance and build upon the existing opportunities once the MNVP Chair is in post; → Protected time each month, to visit community settings, to engage face-to-face with service users, to increase the amount of lived experience feedback collected → PSO for MNVP will have time to dedicate to increasing connections with the local VCSEs

Evidence that MNVPs have the infrastructure they need to be successful.	21.09.23 - SaSoT MNVP Chair position was approved by ICB exec, at PPV rate and advert live on TRACS 01.11023	MNVP Chair advert → ICB Executive weekly meeting minutes for approval	→ Evidence of approval, extract from minutes received from Gill Hackett by email on 26.09.23	Working towards MNVP Chair appointment - Agreement for a Chair, agreed by Exec board Finance/budget access still needs to be worked on and process written
MNVP leads, formerly MVP chairs, are appropriately employed or remunerated	21.09.23 - SaSoT MNVP Chair position was approved by ICB exec, at PPV rate. Recruitment will now begin		Evidence of paper submitted to ICB exec meeting on 21st September **ICB SharePoint folders - Maternity / MNVP / MNVP Structure** https://c9online.sharepoint.com/:f:/s/ccg_nurs/EjQdALdSZkJKh3D6Fe1SWMoBWMVrMiZNqbmD07fjjoT-Ng?e=4KJeul Evidence of approval, extract from minutes received from Gill Hackett by email on 26.09.23	Additional work required; → Recruitment journey road map
and receive appropriate training, administrative and IT support.	Current volunteers receive support from the LMNS Project Support Officer for MNVP and the LMNS Project Support Coordinator Admistrative support will be provided by LMNS Project Support Officer for MNVP and the LMNS Project Support Coordinator Recruitment induction package will be provided by LMNS	Additional work required; → Now that the MNVP Chair position has been approved a full induction pack will be finalised by the LMNS Project Support Officer for MNVP Champions	**ICB SharePoint folders - Maternity / MNVP / MNVP Structure** https://c9online.sharepoint.com/:f:/s/ccg_nurs/EjQdALdSZkJKh3D6Fe1SWMoBWMVrMiZNqbmD07fjjoT-Ng?e=4KJeul	Additional work required; → Now that the MNVP Chair position has been approved a full induction pack will be finalised by the LMNS Project Support Officer for MNVP Champions
It is essential that you consider how you will protect people from being retraumatised through giving feedback on their experience. Training for MNVPs to engage with seldom heard or vulnerable communities may be required to ensure unintentional harm is avoided.	Wrote a post on NHS Futures asking what other areas do & if NMV have any resources - 26.09.23 Link with Jude - emailed 12.10.23	Emailed national and regional teams to ask for direction 06.11.23		Awaiting response from region
MNVPs can also work in collaboration with their trust bereavement leads to ensure adequate support is in place for themselves and the families they may engage with. Attendance at the trust training could be beneficial.	Process pending	Emailed national and regional teams to ask for direction 06.11.23		Additional work planned; → 03.11.23 - training session being held for Champions with Sarah & Caroline → Can use me, LMNS, Sarah and Caroline, PMAs for supervision or UHDB Bereavement team if there is a conflict of issue (need to update everyone on this) - emailed Sam Hewitt (QHB Bereavement midwife

The MNVP's work plan.	2023/2024 Work Plan has been written and approved at the MNVP Forum meeting on 3rd August - now waiting for submission to LMNS QSOF in October (August was cancelled and September it was deferred from agenda), then will be presented at the November LMNSPB meeting	No further requirements	Evidence of membership list, although data is subject to GDPR **ICB SharePoint folders - Maternity / MNVP / Meetings_Reports / MNVP Forum Meetings** https://c9online.sharepoint.com/:f:/s/ccg_nurs/Eg8mmC0r7vNIum5UsmhTv3YBgq4GfxHTD_j2pQ-FFkrrpg?e=ZO1Mh6	
Evidence that it is fully funded	Minutes from finance meetings, from October 2023 (held monthly)	No further requirements	**ICB SharePoint folders - Maternity / Finance / 2023-24 / ICB Meetings / ICB Only** https://c9online.sharepoint.com/:f:/s/ccg_nurs/EpUFtVmuxjVKl_XzADmUiaQByU6ftT7YmyILlcLWm1uP0w?e=7W8iso	Funds available, process needs to be written and agreed, and evidence provided from ICB finance
Minutes of the meetings which developed it	Co-production session within the MNVP Forum meeting in March 2023	No further requirements	**ICB SharePoint folders - Maternity / MNVP / Meetings_Reports / MNVP Forum Meetings / 2023 - 2024 / 2023.05.24** https://c9online.sharepoint.com/:b:/s/ccg_nurs/EQeSK916stdPqbIlaQjoNh8BIJTsINZY7lvH78I31vdMWA?e=RSDwd0	
	MNVP Forum meeting in August 2023 where work plan was approved		**ICB SharePoint folders - Maternity / MNVP / Meetings_Reports / MNVP Forum Meetings / 2023 - 2024 / 2023.09.28** https://c9online.sharepoint.com/:b:/s/ccg_nurs/EQ0gpmbkkq9Ah35TeDHdOlMBq_jC_9vQSRgEfldFGZB7JQ?e=xJVGgV	
Minutes of the LMNS Board that ratified it.	Submission planned for November LMNSPB meeting (13.11.23)	LMNSPB meeting minutes once approved		2023/2024 Work Plan has been written and approved at the MNVP Forum meeting on 3rd August - now waiting for submission to LMNS QSOF in October (August was cancelled and September it was deferred from agenda), then will be presented at the November LMNSPB meeting
Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses.	Maternity and Neonatal Champions can claim expenses through the ICB EASY platform. Champions have to send information to set up the account, and then are responsible for adding their expenses on after a visit/event, which then goes to a senior manager at the ICB for sign off		EASY platform managers profile? GDPR?	Additional work planned to enhance and build upon the existing process; → Develop a written process with specific steps, pertinent dates for submission etc, what they can expect from the ICB (timings for reinbursement)
Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families	The Chair position has protected time for engagement with women and families, specific time each month will dedicated to engaging with neonatal and bereaved families		→ Evidence of approval, extract from minutes received from Gill Hackett by email on 26.09.23 → Promotional materials will be displayed and accessible in both neonatal units	Additional work; Development of an ongoing strategy
	UHNM - Currently good relationship with UHNM Neonatal Matron → Visited unit on 16.10.23 to engage with families & collected feedback → 2022 Neonatal 15 steps visit and report → Involvement in 2022 Insight visits with LMNS → Involved in World Prematurity Day celebrations 2023 → Posting on NICU private Facebook Group, promoting MNVP & asking for people to share experiences → Design of infant feeding padlet - codesigned with neonatal staff → Offered involvement in TC reopening workstream → Connected with bereavement midwives, received training and working on a way of connecting with bereaved families		ICB SharePoint folders - Maternity / MNVP / Feedback_Service user stories ** link(s) to be added here **	Additional work planned to develop feedback route to bereaved families in a sensitive and appropriate way, with bereavement midwives - new survey required → Develop a written process with specific steps, pertinent dates for submission etc, what they can expect from the ICB (timings for reinbursement)
	UHDB - Building relationships with QHB Neonatal staff. Bereavement midwife is leaving shortly, & advised to connect with new midwife once in post → Visit planned for Neonatal unit in November → Recent contact from a bereaved mum, who shared feedback for TYT, and hoping to have her join the MNVP volunteer team		**ICB SharePoint folders - Maternity / MNVP / Feedback_Service user stories** ** link(s) to be added here **	Link up with new bereavement midwife, once in post

Engagement needs to be accessible and appropriate, particularly for neonatal and bereaved families.	Currently engagement takes place via the following routes; → Online - social media, emails → Face-to-face - visits to units, and community settings e.g. groups		**ICB SharePoint folders - Maternity / MNVP / Meetings_Reports / QSOF** https://c9online.sharepoint.com/:f:/s/ccg_nurs/Eqezjo2XarpPro71p7TAau4BxR0KPjk5fcZmhNPv3mk9fw?e=7NeOC0	Additional work required; → Regular visits to both units → Link with breavement midwives to develop a suitable pathway for bereaved families to share feedback → Continue to work with MNISA colleague to develop feedback pathways for all families → Ensure literature and information is available in the families language, and translation facilities are available
women from Black, Asian and Minority Ethnic backgrounds	→ The Chair position 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 have been requested at engagement visits from September 2023 → Organised a focus group meeting with system colleagues, to share ideas and advice - Increasing Engagement with Seldom Heard Communities in Staffordshire and Stoke-on-Trent for Maternity & Neonatal Voices Partnership Meeting		**ICB SharePoint folders - Maternity / MNVP / Meetings_Reports / QSOF** https://c9online.sharepoint.com/:f:/s/ccg_nurs/Eqezjo2XarpPro71p7TAau4BxR0KPjk5fcZmhNPv3mk9fw?e=7NeOC0	Additional work required; → Continue to strengthen and use existing contacts and relationships → Build new relationships to increase engagement opportunities with women and families from Black, Asian & Minority backgroups → Continue to work with LMNS and providers to highlight this area → Continue to work with MNISA colleague to develop feedback pathways for all families → Ensure literature and information is available in the families language, and translation facilities are available
and women living in areas with high levels of deprivation,	→ The Chair position has protected time for engagement with women and families, with specific time each month dedicated to reaching seldom heard groups → Recent visit to North Staffordshire Youth Centre, who help to support the community where there are high levels of deprivation. Developing labels to be added to Food Pantry baby items (nappies, wipes, etc) with a QR link to online feedback survey		**ICB SharePoint folders - Maternity / MNVP / Meetings_Reports / QSOF** https://c9online.sharepoint.com/:f:/s/ccg_nurs/Eqezjo2XarpPro71p7TAau4BxR0KPjk5fcZmhNPv3mk9fw?e=7NeOC0	Additional work required; → Continue to strengthen and use existing contacts and relationships → Build new relationships to increase engagement opportunities with women and families from areas of high levels of deprivation → Continue to work with LMNS and providers to highlight this area → Continue to work with MNISA colleague to develop feedback pathways for all families → Ensure literature and information is available in the families language, and translation facilities are available

Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

Answer - **Yes**
The following standards are required to be compliant with Safety Action 8:
1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.
2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.

UHNM Maternity services have an up-to-date local training plan based on the four key principles as detailed in the 'How to' Guide for the second version of the Core Competency Framework V2 developed by NHS England which has been signed off by the directorate, division, Maternity and Neonatal Quality and Safety Oversight Forum, Maternity and Neonatal Quality Governance Committee and the LMNS.

Table 9 - Maternity Emergencies and multiprofessional training

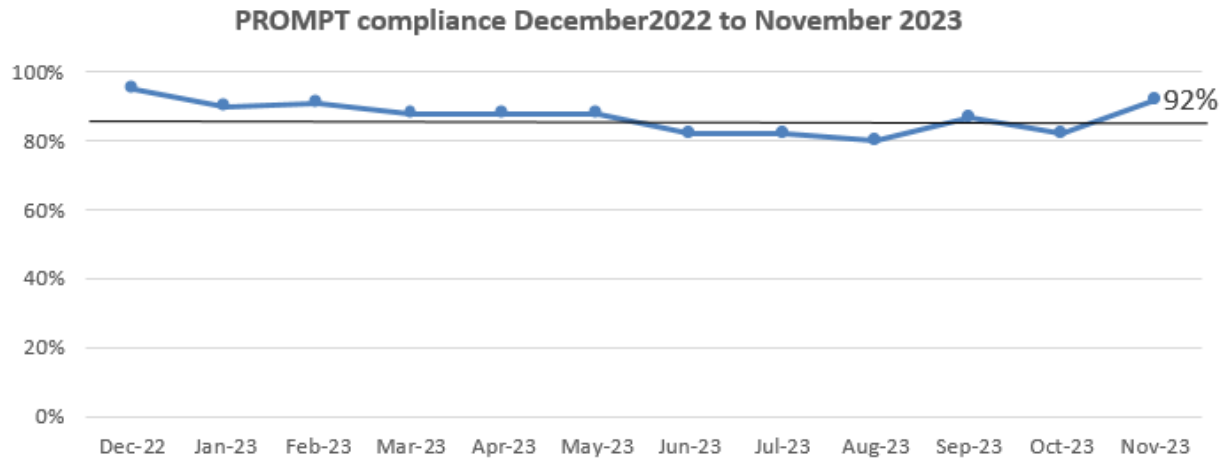


Table 10 - Neonatal Life Support

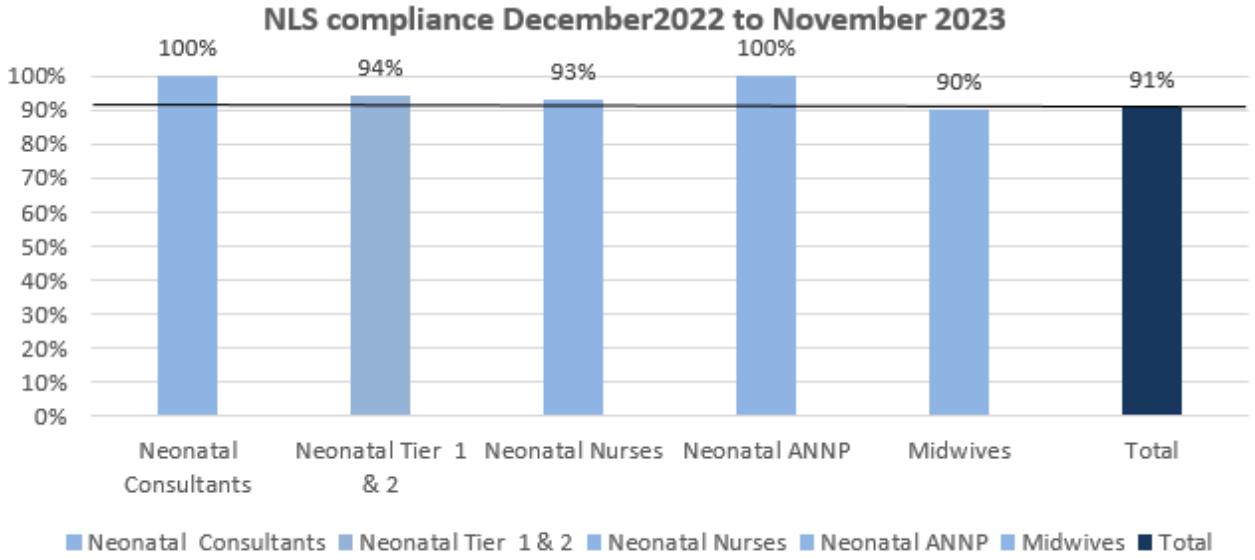
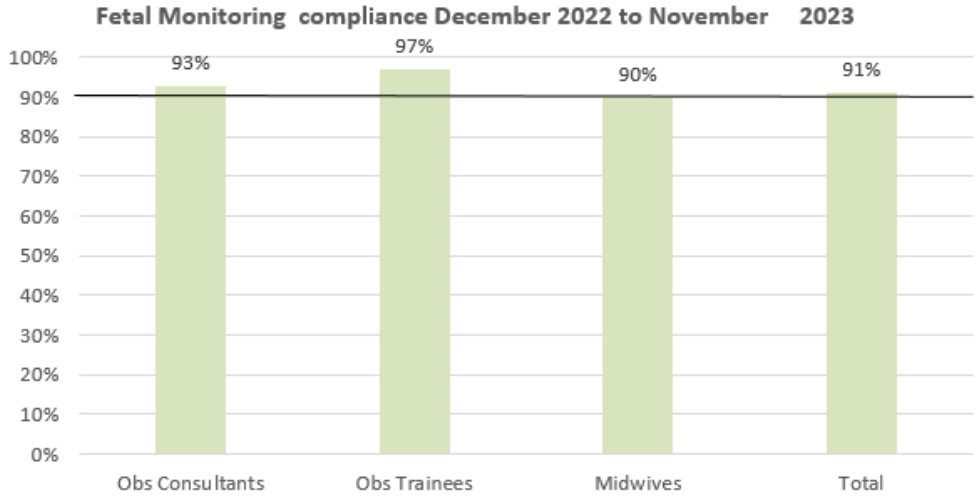


Table 11 - Fetal Monitoring and surveillance (in the antenatal and intrapartum period)



Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Answer -**Yes**
The following standards are required to be compliant with Safety Action 9:

a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.

UHNM has appointed Sunita Toor as the non-executive director Board Safety Champion who is working with the Board safety champion to address any identified quality issues.
A review of maternity and neonatal quality is undertaken by the Trust Board monthly which includes:

- **Number of incidents reported as serious harm**
- **Themes identified and action being taken to address any issues**
- **Service user voice feedback**

- **Staff feedback from frontline champions' engagement sessions**
- **Minimum staffing in maternity services and training compliance**

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 and regional chief midwife via the monthly System Maternity Oversight and Assurance Group (SMOAG) for areas of early action and support for areas of concern.

b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings

The Trust's claims scorecard is reviewed alongside incident and complaints data. These discussions have been held at least twice in the MIS reporting period at a directorate quality meeting.

c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.

Both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated Futures workspace to access the resources available.
A quarterly meeting between the Maternity and Neonatal Board Safety Champions and the QUAD has been implemented. A report of concerns identified, improvement plans, and any support required of the Board is presented quarterly to the directorate, division.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?

Answer -**Yes**
The following standards are required to be compliant with Safety Action 10:

During this reporting period:
UHNM referred 3 cases to the Health Safety Investigation Branch (HSIB).
UHNM was the primary carer in two cases and an external trust was the primary carer in the third case.
The national BadgerNet electronic neonatal records have been crosschecked to identify all babies born at UHNM above 37 weeks' gestation who required therapeutic cooling for the reporting period.
The UHNM quarterly Perinatal Mortality reports (PMRT) and Serious Incident reports have been crosschecked to ensure that all potential HSIB cases have been identified.
100% HSIB referral has been offered to parents when cases met the HSIB reporting criteria.
In all cases referred to HSIB: the parents received a verbal and written duty of candour which contained the information and signposting to the HSIB website.
The UHNM legal team have confirmed that there was no requirement to report any cases to the Early notification scheme for the reporting period.

Maternity incentive scheme - Guidance

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

This document must be used to complete your trust self-certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. **Your trust name will populate each tab. If the trust name box is coloured pink please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.**

The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested.

There are multiple additional tabs within this document:

Tab A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed within each condition of the scheme with each maternity incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The information which has been populated in this tab, will automatically populate onto tab D which is the board declaration form.

Tab B - safety action summary sheet - This will provide you information on your Trust's progress in completing the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet - This sheet will enable your Trust to insert action plan details for any safety actions not achieved.

Tab D - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and 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, commissioners and before submission to NHS Resolution.

Upon completion of the following processes please add an electronic signature into the allocated spaces within this document. Two electronic signatures of the Trust's CEO and AO of the ICS will be required in Tab D as outlined in order to declare compliance stated in the board declaration form with the safety actions and their sub-requirements, one signature to confirm that the declaration form has been submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services and two signatures to declare that there are no external or internal reports covering either 2022/23 financial year or 2023/24 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 1 February 2024.

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

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 here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Submissions for the maternity incentive scheme must be received no later than 12 noon on 1 **February 2024** to nhsr.mis@nhs.net
You are required to submit this document signed and dated. Please do not send evidence to NHS Resolution.

Version Name: MIS_SafetyAction_2024

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?
From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days?	Yes
2	For deaths from 30 May 2023, was MBRRACE-UK surveillance information completed within one calendar month of the death?	Yes
3	For at least 95% of all deaths of babies who died in your Trust from 30 May 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
4	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
5	Were 60% of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death?	Yes
6	Were 60% of the reports published within 6 months of death?	Yes
7	Were PMRT review panel meetings (as detailed in standard C) rescheduled due to the direct impact of industrial action, and did this have an impact on the MIS reporting compliance time scales?	N/A
8	Is there an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period.	N/A
9	If PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many meetings in total were impacted?	N/A
10	PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many cases in total were impacted?	N/A
11	Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
12	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 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 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 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 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
Has the Trust Board confirmed to NHS Resolution that they have passed 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 2023 for the following metrics:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	Yes
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	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 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.		
1	Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Evidence should include: ● Neonatal involvement in care planning ● Admission criteria meets a minimum of at least one element of HRG XA04 ● There is an explicit staffing model ● The policy is signed by maternity/neonatal clinical leads and should have auditable standards. ● The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Yes
2	Are neonatal teams involved in decision making and planning care for all babies in transitional care?	Yes
b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.		
3	Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks?	Yes
4	Is there an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks?	Yes
5	Is there evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan?	Yes
6	Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan?	Yes
c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.		
7	Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occuring?	Yes
8	OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation?	N/A

Safety action No. 4

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

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
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 after February 2023 following an audit of 6 months activity :		
1	a. Locum currently works in their unit on the tier 2 or 3 rota?	No
2	**OR** b. 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 Progression (ARCP)?	Yes
3	**OR** c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	N/A
4	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	Yes
5	**OR** Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings? https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf	Yes
6	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	Yes
7	**OR** Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings? https://www.rcog.org.uk/media/c2jkpjam/rcog-guidance-on-compensatory-rest.pdf	Yes
8	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
9	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 with the above has been shared:		

10	At Trust Board?	Yes
11	With Board level safety champions?	Yes
12	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
13	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)	Yes
	The rota should be used to evidence compliance with ACSA standard 1.7.2.1 (A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. 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)	
c) Neonatal medical workforce		
14	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
15	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	
Was the agreed action plan shared with:		
16	LMNS?	
17	ODN?	
d) Neonatal nursing workforce		
18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	No
19	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
20	LMNS?	Yes
21	ODN?	Yes

Safety action No. 5

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

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated	Yes
2	b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above? Evidence should include: ● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, 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. ● The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified 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 in staffing. ● 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
3	c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. Can you provide 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 status? The Trust can report compliance with this standard if failure to maintain supernumerary status is a one off event, however **the Trust cannot report compliance with this standard if the coordinator is required to provide any 1:1 care for a woman and/or care in established labour during this time.** If the failure to maintain supernumerary status is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in an action plan. This plan must include mitigation/escalation to cover any shortfalls. Please note - Completion of an action plan will not enable the Trust to declare compliance with this standard.	Yes
4	d) Have all women in active labour received one-to-one midwifery care?	Yes
5	If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour?	
6	Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board?	
7	e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period?	Yes

Safety action No. 6

Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?
From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024?	Yes
2	Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool? Confirmation is required from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Progress against locally agreed improvement aims. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.	Yes
3	Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across **all** 6 elements overall?	Yes
4	Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within **each** of the 6 individual elements?	Yes

Safety action No. 7

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

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan?	Yes
2	Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board?	Yes
3	Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions?	Yes
4	Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff?	Yes
5	Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support?	Yes
6	Can you provide the local MNVP's work plan and evidence that it is funded?	Yes
7	Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way?	Yes
8	Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation?	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 1 December 2022 to 1st December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	A local training plan is in place for implementation of Version 2 of the Core Competency Framework	Yes
Can you evidence that the plan has been agreed with:		
2	Quadrumvirate?	Yes
3	Trust Board?	Yes
4	LMNS/ICB?	Yes
5	Has the plan been developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England?	Yes
6	Can you evidence service user involvement in developing training?	Yes
7	Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports?	Yes
8	Can you evidence that you promote learning as a multidisciplinary team?	Yes
9	Can you evidence that you promote shared learning across a Local Maternity and Neonatal System?	Yes
Can you demonstrate the following at the end of 12 consecutive months ending December 2023? 80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period. In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted. If this is the case, please select 'Yes'		
Fetal monitoring and surveillance (in the antenatal and intrapartum period)		
10	90% of obstetric consultants?	Yes
11	90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)?	Yes
12	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) and maternity theatre midwives who also work outside of theatres?	Yes
Maternity emergencies and multiprofessional training		
13	90% of Obstetric consultants?	Yes

14	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota?	Yes
15	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
16	90% of maternity support workers and health care assistants attend the maternity emergency scenarios training?	Yes
17	90% of obstetric anaesthetic consultants?	Yes
18	90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota?	Yes
19	Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care?	Yes
20	Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area **or** does the local training plan (Q1) include a plan to implement attendance at emergency scenarios in a clinical area for 90% of all team members?	Yes
Neonatal basic life support		
21	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
22	90% of neonatal junior doctors (who attend any births)?	Yes
23	90% of neonatal nurses (Band 5 and above who attend any births)?	Yes
24	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
25	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
26	All trusts must have an agreed plan in place, including timescales, for registered RC-trained instructors to deliver the in-house basic neonatal life support annual updates and their local NLS courses by 31st March 2024.	Yes
27	Have you declared compliance for any of Q10-Q25 above with 80-90%?	No
28	If you are declaring compliance for any of Q10-Q25 above with 80-90%, can you confirm that an action plan has been approved by your Trust Board to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period?	N/A

Safety action No. 9

Can you demonstrate that there are robust processes 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	**Required Standard A.** **Evidence that all six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been fully embedded and specifically the following:-**	Yes
2	Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues?	Yes
3	Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents (SIs)? It must include: • number of incidents reported as serious harm • themes identified and action being taken to address any issues • Service user voice feedback • Staff feedback from frontline champions' engagement sessions • Minimum staffing in maternity services and training compliance	Yes
4	Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.	Yes
Required standard B. **Have you submitted evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of:**		
5	The Trust Board?	Yes
6	LMNS/ICS/Local & Regional Learning System meetings?	Yes
7	Do you have evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff?	Yes

8	Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.	Yes
9	**Required standard C.** **Have you submitted evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures?**	Yes
10	Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit?	Yes
11	Have there been a minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024?	Yes
12	Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented?	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Complete 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
2	Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023?	Yes
3	Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2023 until 7 December 2023?	Yes
	For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:	
4	The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme	Yes
5	There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	Yes
	Can you confirm that the Trust Board has:	
6	Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolution?	Yes
7	Sight of evidence that the families have received information on the role of HSIB/MNSI and the EN scheme?	Yes
8	Sight of evidence of compliance with the statutory duty of candour?	Yes

NHS Resolution

Section A : Maternity safety actions - University Hospital of North Midlands NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes

Section B : Action plan details for University Hospital of North Midlands NHS Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

NHS Resolution

Maternity Incentive Scheme - Board declaration form

Trust name	**University Hospital 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 (2023/24) or the previous financial year (2022/23)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.
* If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds 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 the Steering group will escalate 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 Hospital of North Midlands NHS Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
For and on behalf of the board of	University Hospital of North Midlands NHS Trust
Name:	
Position:	
Date:	

Performance and Finance Committee Chair's Highlight Report to Board

19th December 2023

! Matters of Concern of Key Risks to Escalate

For information:

- Month 8 financial performance delivered a deficit of £0.8 m, an adverse variance of £3.2 m, and although the Trust remained on track to deliver a break-even position the continuing risk in relation to the cost of covering Industrial Action was noted
- The challenges in respect of planning for 2024/25 were highlighted, in particular the ability to identify recurrent cost improvements, an update on which was to be provided in January
- Despite deterioration across most urgent care metrics during November the Trust largely remained in the third quartile or better when compared to peers
- Covid and flu cases had increased although these were not having a significant impact on bed closures
- Capital prioritisation for medical devices had identified £4 m investment and next steps were being taken to identify and allocate funding

Major Actions Commissioned / Work Underway

- To obtain benchmarking information in relation to agency spend and reduction in comparison with peers
- Operational plan to be signed off in relation to cover for Industrial Action
- In terms of undertakings, the required improvement plans had been submitted and shared with regional colleagues with initial positive feedback. Going forwards the metrics would be incorporated into existing reporting
- The next steps associated with the waiting list improvement programme were to focus on ensuring fail safes were in place
- Significant guidance in respect of long handover waits had been received and it was agreed that there should be a zero tolerance to these, with every effort being made to reduce long waits. To support this work all Trusts had developed escalation procedures which included internal and external escalation
- To update the financial summary within BC0539 before being presented to the ICB as part of the double lock, to highlight potential losses as well as possible cost savings i.e. agency costs
- Net cost of the pharmacy case to be articulated, taking into account anticipated pharmacy savings and potential benefits for reduced length of stay
- Future reviews into overseas visitor activity to highlight the amount associated with elective activity in addition to benchmarking figures
- To discuss the area of agency expenditure with the Chair of Transformation and People Committee

✓ Positive Assurances to Provide

- An additional £5.9 m capital had been received which had improved the capital position as well as the 2024/25 programme
- The surge and winter plan was delivering as expected although some areas of capacity had not opened as planned
- 78 week waits had continued to reduce and whilst these were not expected to be impacted by the planned Industrial Action, it was expected to impact the 65 week wait position.
- A negative impact on cancer performance was not expected over the holiday period due to protected operating, although there were some risks in respect of patient choice
- An additional £1.5 m of additional funding had been received to support additional capacity
- An update was provided on the ongoing work being undertaken in respect of the independent review into the trusts waiting list. Completed actions were noted and importantly and reassuringly the RTT and Non-RTT validation had concluded which did not identify the anticipated number of unknown long waiters. Thirteen patients had waited over 65 weeks and these had been treated or had plans for treatment.
- The annual audit into the overseas visitors policy compliance highlighted 2 discrepancies following the review of 639 patients which had since been addressed

Decisions Made

- The Committee approved business cases in relation to BC0539 Recurrent Investment in the Medical, Sonographer and robotic assistant workforce for Obstetrics and Gynaecology Services and BC0545 Pharmacy Workforce Resource Requirement to support the current Medicine Division inpatient bed base and activity (option 3), whilst noting these were now required to go through the system double lock process.
- The Committee approved e-REAFs 12882 and 12877
- The Committee noted the escalation from the Executive Infrastructure Group in relation to a wayleave agreement being reached with the National Grid, in relation to a 17 m^2 plot of land at Grindley Hill Court, enabling electrical supply to the new car park

Comments on the Effectiveness of the Meeting

- The focus on considering usual items of business at the beginning of the meeting was welcomed before considering business cases

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance	
1.	Finance Report – Month 8 2023/24	BAF 8	High 12	🔴 🟢	Assurance
2.	Performance Report – Month 8 2023/24 Undertakings Elective and Non-Elective Plans	BAF 5	Ext 20	🔴 🟢	Assurance
3.	Undertakings Elective and Non-Elective Plans	BAF 5	Ext 20	-	Assurance
4.	Waiting List Review Update	BAF 5	Ext 20	🟢	Assurance
5.	BC-0545 Pharmacy Workforce Resource Requirement to Support the Current Medicine Division In-patient Bed Base and Activity	BAF 2	ID23506 ID23569 ID23500 ID29312 ID23569 ID17710	-	Approval
6.	BC-0539 Recurrent Investment in the Medical, Sonographer and Robotic Assistant Workforce for Obstetrics and Gynaecology Services	BAF 2	ID27696 ID15993 ID24272	-	Approval

No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance	
7.	Executive Infrastructure Group Highlight Report	BAF 6, 7, 8	High 12	-	Assurance
8.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	BAF 8	High 12	-	Approval
9.	Overseas Visitor Activity and Income	BAF 8	High 12	-	Assurance
10.	Annual Audit into Overseas Visitors Policy Compliance	BAF 8	High 12	🟢	Assurance
11.	Executive Business Intelligence Group Highlight Report	-	-	-	Assurance
12.					

2023 / 24 Attendance Matrix

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

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

Highlight Report

Transformation and People Committee (20 December 2023) to Trust Board

! Matters of Concern / Key Risks to Escalate

- The Data Security and Protection Toolkit assessment has identified one area of concern whereby 90% staff have undertaken training which is below the 95% target; a campaign is underway to improve compliance.
- A 14-day target of security patching has failed to achieve the standard required although it was noted that work was underway to bring the network internally and segmentation of other devices would be a mitigation in the future
- Some challenges identified in sustaining improving together tools; a number of countermeasures were identified including a new practitioner with key responsibility for sustainability
- There has been an increase in violence and aggression patient related incidents and demand on the security service; an action plan is in place along with locally led initiatives although it was also noted that a lower level of sanctions were being seen – RCA panels are in place to identify learning from incidents
- A letter of contravention has been received following an inspection by the Health and Safety Executive; a response is currently being drafted
- There are 4 areas on the violence and prevention action plan which remain outstanding although work is progressing, these include system working and risk assessment processes
- Based on the due diligence undertaken and contingent workforce levels required, the 3.7% agency target will not be achieved and this will be communicated to NHSE
- Ongoing challenges with Essential to Role training; particularly with Resuscitation although a business case was being progressed

Major Actions Commissioned / Work Underway

- Further development of the Population Health and Wellbeing Strategy, including high level targets, equality, diversity and inclusion, alignment with the ICS/dataset and university teaching.
- Further development of the Transformation Programme Report to bring together the internal and system activities into a coherent programme which supports strategic delivery
- The organisation wide strategy continues to be developed and will be discussed with the Board in January
- A robotics strategy is being developed for the organisation with strong clinical engagement; this includes a distinct workstream around full utilisation of existing capacity
- BAF to be reflective of risks associated with new models of care / strategic solutions which require investment
- An internal audit is underway which is looking at the risks associated with shadow IT systems and this is due to report in January
- Work is underway to address the resource gaps within Data, Security and Protection with posts planned to be in place for the new year
- Digital Strategy Progress Report to include details of whether any of the technological advancements are being taken forward and a 'temperature check' categorisation of projects will be included; consideration will also be given as to how advancements might change the strategy going forward
- The Violence, Reduction and Prevention Standards and being reviewed nationally with a new toolkit and the internal action plan will be refreshed as a result and opportunities to learn from other Trusts through benchmarking will be explored
- The next agency report will include some greater detail in terms of assurance of actions taken to deliver the requirements to achieve the target

✓ Positive Assurances to Provide

- An internal audit review of the Data Security and Protection concluded with substantial assurance
- There are effective working arrangements in place between IM&T and the procurement team which ensure that any systems being sought are reviewed from a data, security and protection perspective
- Significant progress has been made in delivering the Digital Strategy, which was presented in a new style report aligned with the Strategic Priorities
- Improving Together training remains on trajectory
- County Hospital Pharmacy and County Hospital Site Team have been recognised as demonstrating positive behaviours in line with Improving Together
- There has been a reduction in violence and abuse from patients relating to race and there are some very positive departmental led initiatives underway, including within Critical Care and Network Division
- CQC have confirmed the Trust is compliant with the Improvement Notice issued following the IR(ME)R inspection and the HSE have also confirmed that they are satisfied with the action taken in response to their visit to the containment laboratory
- Additional budget awarded in year from NHSE of £1.76m for CPD, workforce development, new roles and apprenticeships
- An effective process has been used in undertaking a nurse staffing establishment review and this will be subject to internal audit (although there was some challenge around the uplift % element and the use of bank / agency which would require a board level discussion)
- Processes have been established in line with NHSE requirements in relation to agency expenditure, and trajectories have been set for divisions

Decisions Made

- There were no items requiring decision

Comments on the Effectiveness of the Meeting

- Very busy agenda with lots of items of business to cover, to reflect on how Population Health can be drawn through other aspects of the agenda

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Population Health and Wellbeing Strategy	BAF 4	Ext 20	-	Approval	9.	Violence Prevention and Reduction Report	BAF 3	High 12	🔴🟢	Assurance
2.	ICS Transformation Update	BAF 4	Ext 20	-	Assurance	10.	Executive Health & Safety Group Highlight Report			🔴🟢	Assurance
3.	Transformation Programme Update			-	Assurance	11.	Learning and Education Annual Report 2022/23			-	Assurance
4.	Executive Strategy & Transformation Group Highlight Report	BAF 4	Ext 20	-	Assurance	12.	Nurse Staffing Establishment Review	BAF 1 & 2	Ext 16	🟢	Assurance
5.	Cyber Security Assurance Report	BAF 6	ID9036 ID28304 ID28595 ID24130	🟢🔴	Assurance	13.	Agency Report – December 2023	BAF 2 / BAF 8	Ext 16	High 12	🔴🟢	Assurance
6.	Supplier Assurance Report	BAF 6	Ext 16	🟢	Assurance	14.	Chief People Officer Report M8 & M9	BAF 2 & 3	Ext 16	High 12	🔴	Assurance
7.	Digital Strategy Progress Report	BAF 6	Ext 16	🟢	Assurance	15.	EWAG Highlight Report	BAF 2/3	Ext 16	High 12	-	Assurance
8.	Improving Together Countermeasure Summary			🔴🟢	Assurance							

2023/2024 Attendance Matrix

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

NO MEETING HELD

Attended | Apologies & Deputy Sent | Apologies

Executive Summary

Meeting:	Trust Board	**Date:**	3rd January 2024
Report Title:	Integrated Performance Report, Month 08 2023/24	**Agenda Item:**	12
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & Safety; Operational Performance: Warren Shaw, Strategic Director of Performance & Information; Matt Hadfield, Associate Director of Performance & Information. Workforce: Jason Ahern, Assistant Director of Workforce Information; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Simon Evans: Chief Operating Officer Jane Haire: Chief People Officer Mark Oldham: Chief Finance Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

High Quality		People		Systems & Partners	
Responsive		Improving & Innovating		Resources	

Risk Register Mapping

Executive Summary

Situation

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

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

Quality & Safety

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

Some of the indicators used in the report have different activity based rates which are those used nationally for

benchmarking i.e. Hospital Associated Thrombosis rate per 10000 admissions or Complaints per 10,000 spells.

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

This latest report includes the newly agreed Assurance Matrix and has also reordered the indicators and dashboard so that indicators are grouped together appropriately.

Assessment

The number of reported patient safety incidents is above the long term mean and has decreased this month although the rate per 1000 bed days has continued to remain relatively stable and is within normal variation limits and above the mean rate. The rate is also above the NRLS mean rate during November. It should be noted that an increase in reported incidents and near misses should be seen as negative but can reflect a positive reporting culture. The breakdown of incidents by harm reflects this and that the increase in reported incidents relate to increases in no harm and near misses.

Moderate harm or above incidents, both raw numbers and rate per 1000 bed days continue downward trend although at time of the report there has been increase in incidents these are under review and the final figure may change.

It is key to note that during November 2023 there has been 1 'Your Next Patient' related incidents reported with moderate harm that was related to a patient requiring mechanical thrombectomy being delayed getting to Interventional Radiology Theatres as there were already patients in the 2 available theatres.

The largest categories for reported PSIs excluding Non-Hospital Acquired Pressure Ulcers are Medication, Patient Flow, Patient Falls, Clinical Assessment and Treatment related incidents. Medication related incidents continue to be the largest category after Tissue Viability in November 2023 but otherwise no significant changes in these categories compared to previous months.

There have been reductions in incidents relating to 'Your Next Patient' with 14 during November (14 in October, 34 during September 2023, 76 in August, 110 in July, 102 in June, 97 in May, 117 in April, 157 in March, 170 in February and 228 in January 2023) for 0.61% (0.57% in October, 1.76% in September, 3.6% in August, 5.1% in July, 4.8% in June and May, 6.21% in April, 7.4% in March, 9.8% in February and 12% in January 2023) of total patient safety incidents. This continues to be significant reduction in the number of reported incidents relating to the YNP processes. During November 2023, only 1 (7%) of these incidents related to Tissue Viability. Previous months were 28.6% in October, 35.3% September, 30.4% August and 28.2% July 2023. This 1 Tissue viability incident was Moisture associated skin damage in Theatres due to longer than anticipated surgery and damage due to repeated inflation of NIBP cuff.

Patient falls rate has continued to show positive trend, not yet statistically significant. During November the overall falls rate was 5.5 and there was also an increase in falls with harm rate of 1.9 during November compared to 1.6 in October 2023.

Medication related incidents have decreased slightly this month but continue to be higher than same period last year as part of the ongoing drive to improve reporting of medication errors/incidents. There has been a slight increase in November (at time of the report) in the percentage of these incidents that have been reported as resulted in moderate harm or above. This profile trend is reflective of the improving and positive reporting culture with increased reporting but level of harm reducing and mirrors the profile for all patient related safety incidents. These incidents will be reviewed at Medicines Optimisation & safety Group to assess the impact on patients and also identify and share learning.

Serious incident numbers and rates, despite an in-month increase continues to show longer term reduction trend which supports the noted reductions in incidents with moderate harm of above and overall patient safety incident reporting. Falls continue to be the main reason for serious incidents being reported during 2023/2024, and in November as well along with 1 diagnostic related and 1 maternity related incident. From December 2023 the Trust will no longer be reporting incidents via the Serious Incident Framework following the introduction of the new national Patient safety Incident Review Framework (PSIRF). The Trust will continue to report, review and respond to all incidents including notification to the ICB but the incidents will not be recorded as 'serious incidents'.

There has been 0 new Never Event reported during November 2023.

Duty of Candour compliance during November has remained constant for verbal notification at 94.4% and decrease in in compliance with the internally set 10-day target with 78%. There were 18 cases recorded as formally triggering duty of candour and 17 of these cases recorded verbal notification being completed with the patients and/or relatives.

14 of the 18 cases have recorded written follow up being provided within the 10-day target but 4 other not complying with the timeframe. It is noted however that all 4 of these cases have subsequently completed the written follow up and the Trust is compliant with the statutory duty of candour regulations.
Continued promotion and support to clinical teams is being provided and the importance of being open and sharing information is shared with teams including a dedicated session on Duty of candour and PSIRF was completed with the Cardiology Directorate during November 2023.

The current position for received patient Safety Alerts shows that there are now zero overdue Patient Safety Alerts. There was 1 new alert received during November 2023 and 1 overdue alert which has been actioned and awaiting final approval and sign during December 2023.

Pressure Ulcer developed under UHNM care have increased however, pressure ulcers with lapses in care have decreases during November 2023 and is below the long-term mean. The decreases in total numbers with lapses in care are related to increases in number of Category 2 pressure ulcers following increases previous months along with increase in DTIs during November. following previous months of reducing DTI numbers. The new PSIRF Tissue Viability toolkit is in use and allows more involvement in clinical areas for developing responses and embedding of learning and sustained improvement.

Friends & Family Test for A&E remains below the 85% target of patients recommending the service. The November figure has continued to decrease below the mean rate but there has been an increase in the raw number of responses received but with increased activity the rate has dipped to 8%. UHNM is 33rd out of 124 Trusts nationally for response rate, which is improvement from previous4ly reported 37th. However, UHNM is 87th for the percentage pf positive results. To promote and increase the response rate the FFT questionnaires are continuing to be handed out to all patients on arrival to ED and the QR codes have been made more visible throughout the department. In addition, a 'You said, we did' board has been put up in the Waiting Area to demonstrate changes to patient/relatives' comments in a bid to further promote and increase the responses received.

Inpatient FFT results remain above the 95% target. The response rate has remained at 21% in November 2023. There were 2341 (2512 in October) responses returned in November 2023 from 68 different inpatient and day case areas across UHNM. UHNM have the 17th highest response rate out of the 154 acute trusts reporting FFT for inpatient areas which is an improvement from previously reported 23rd. There are key improvement initiatives identified previously are continuing and focus on key priorities identified within the FFT returns.

There has been an in-month improvement for Maternity FFT but remains just below the 95% target at 92%. November 2023 saw 85 (97 previously) completed surveys returned and 25 (21 previously) completed from the Birth touchpoint. Compared to the latest national data available (August 2023) out of 113 Trusts, UHNM were 54th for number of responses for antenatal, 39th for number of responses for birth, 63rd for post-natal ward and 38th for post-natal community which shows improvement in all areas. FFT Task & Finish Group for post-natal care established, Maternity services have introduced QR codes in some areas to increase response rates. My Pregnancy Notes, launched in July, provides a direct link to Friends and Family for women to complete and now using the data from the QR codes.

Complaints rate remains below the target/benchmark rate of 35 and within normal variation. Complaints Team are continuing to review the complaints triage process to ensure that it is effective and that the number of PALS escalated to formal complaints does not rise. This is included in the quarterly Patient Experience Reports along with detailed reviews of trends and themes from received complaints.

Mortality indices remain within expected ranges and compare well with our peers and other acute trusts. SHMI is showing significant improvement with 8 consecutive months of reductions. HSMR has also recued for second month in succession.

VTE Risk assessment compliance has dipped during November and is below the 95% target. The new VTE Risk assessment has been introduced across surgical wards.

Hospital Associated Thrombosis rate is noted as above the long term mean in November 2023 with 31 cases and a rate of 1.49 per 10,000 admissions. The use of mechanical thromboprophylaxis for patients attending Theatres is being reviewed following 2 incidents whereby devices were applied despite a contraindication and/or prescription. Refresher training is being provided and early discussions regarding changing the practices of applying intermittent pneumatic compression (IPC) are taking place.

Timely Observations are continuing to improve across the Trust with current performance at 73%. There remains 1 ward with less than 50% of patients having timely observations recorded on VitalPack. As previously noted, Medicine, Surgery and Network Services have all now included Timely Observations as Driver Metrics and focussing as priority to improve compliance. There previously identified and reported data anomalies with the Vitals system including the

impact of system downtime and Wi-Fi connection issues affecting the timely recording of patient observations are being actioned by the Trust's IM&T teams.

C Diff numbers have reduced during November from previous highs and November 2023 is lower than November 2022with 12 cases confirmed. There have been number of key actions taken during the past month including the addition of the CUR-95 score has now been added to the CAP antimicrobial Microguide to support clinicians in treatment decisions.

Sepsis screening and IV Antibiotics continue to be below targets within Royal Stoke Emergency Department. Other emergency portals are achieving these targets. Sepsis Team continue to work with RSUH ED Teams to try and improve compliance and staff are following correct sepsis guidance. Specific targeted actions in ED include having a Deteriorating Patient Reviewer (DPR) in place and managed by Emergency Physician in Charge in ED. There will be a specific clinician assigned and dedicated to log in DPR VOCERA device at the beginning of their shift to review and provide timely assessment, treatment and escalation of patients who triggers for medium to high-risk sepsis.

The audited missed screening cases in Children and Maternity did not result in any harm and related to lack of or incomplete documentation.

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

Operational Performance

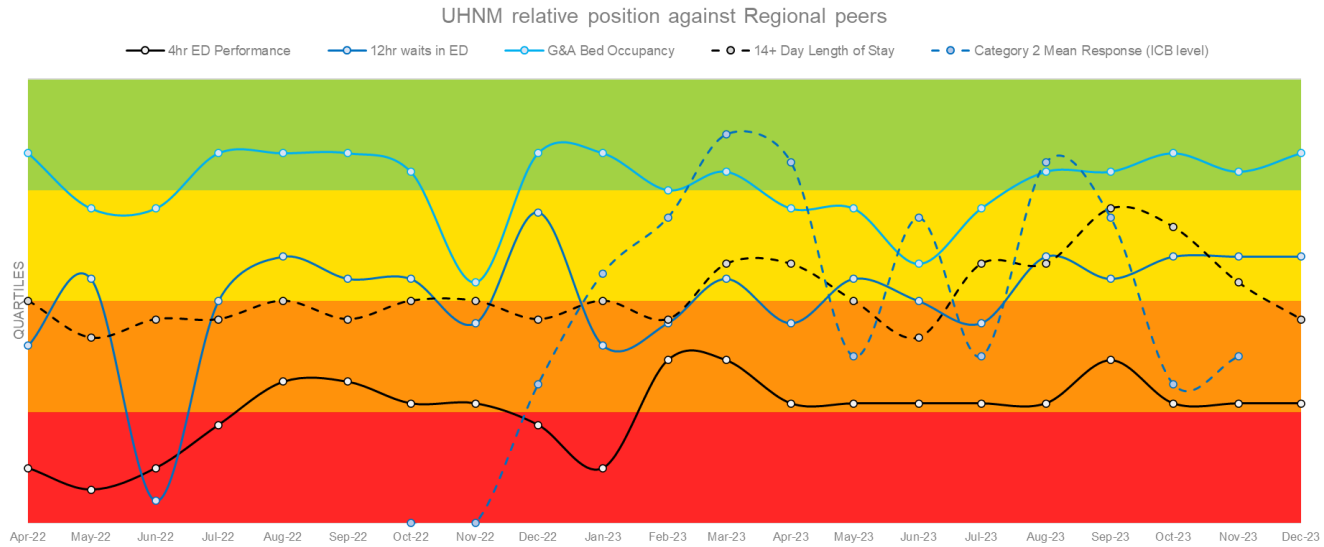
This month's executive summary has been reformatted to summarise key operational challenges into two groups. Urgent and Emergency Care performance (non-elective care) will be described initially and then Planned care, Cancer and Diagnostics services (elective care) will be grouped into a second summary. UHNM has been assessed as NHS Oversight Framework (NOF) Segmentation 3 and as such, a series of 'Exit Criteria' have been agreed which are aimed at making and sustaining the improvements needed across a range of themes / metrics. Two separate improvement plans have been developed to respond to these using this same split between Emergency Care and Planned Care, Cancer and Diagnostics.

Section 1: Urgent and Emergency Care Performance (Non-Elective Care)

How are we doing against our trajectories and expected standards?

Urgent and Emergency Care Indicators across the board have seen deterioration from October to November 2023. Those indicators that are monitored as part of the Tier 2 process (A&E 4 Hour Standard, 12 Hours in Department Standard, and Ambulance Handover) have seen week on week deterioration throughout November.

Despite this deterioration the Trusts relative performance in region has remained the same. 12 hour waits in ED with Category 2 Mean Response times even improving. All indicators remain in 1-3 quartiles indicating that overall performance across the whole region has similarly deteriorated as the impact of winter pressures are felt in acute provider organisations.



What is driving this?

Staffordshire and Stoke-on-Trent Winter planning (Surge Plan) described an approach to winter that increased bed capacity throughout the December-March period. Within this plan there was an identified bed deficit in both October and November that could not be mitigated through opening additional capacity. Although mitigation strategies were developed that identified admission avoidance approaches this has not had the necessary impact to reduce the demand on acute inpatient beds.

Overall bed occupancy at Trust level shows an increase in both October and November, however more significantly the Royal Stoke site specifically has seen a sustained high level of occupancy at times above 92%. This in turn has created sustained bottlenecks felt across the whole emergency pathway and particularly so in both the Emergency Department and in the ability for ambulances to handover patients within the 15 minute window desired.

Schemes to reduce length of stay within the hospital have not offset the natural increase in length of stay effect seen in winter. As increased in infection diseases (Flu, Norovirus, Coronavirus etc.) impact the length of stay they also increase the number of beds that are unavailable in order to protect from nosocomial (patient to patient or staff to patient) transmission. This in turn makes it hard to flow patients through the emergency pathway as periodically beds are closed or restricted.

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

The Trust has now submitted the Non-Elective Improvement plan as part of its response to NOF3 and Undertakings. This plan articulates 4 workstreams described in more detail in the performance report. These workstreams articulate focus of improvement efforts now reduced from the 5 previous workstreams.

Of the 4 workstreams, none are reporting a sustained improvement in their respective parts of the emergency pathway although there are positive developments in the Clinical Decision Unit and Frailty pathway changes. The lack of sustained improvement is likely a symptom of the level of overcapacity across the emergency pathway, and is a result of patients being cared for in non-optimum locations/teams. Examples of this can be seen in data with Emergency Departments caring for patients awaiting inpatient admission, and admission areas caring for patients with long lengths of stay. (Neither of which is optimum or efficient use of their respective expertise.)

In early December 2023, the Stoke and Staffordshire system undertook a deep dive review in to the UEC pathway with the Emergency Care Intensive Support Team (ECIST) and Getting it Right First Team (GiRFT) as a combined review. This team of national experts reviewed all aspects of current performance and improvement plans and fed back a number of areas that would require addressing in order to sustainably improve the emergency pathway and restore performance back to national standards.

These aligned well with the workstreams already in place, however identified a structural deficit in the number of inpatient beds in admissions and frailty services (30-50 deficit) at Royal Stoke hospital. These recommendations will be incorporated into the workstreams update in future reports and a separate inpatient bed right sizing strategy is being developed that will be reviewed by system and board in early 2024.

What can we expect in future reports?

The continuation of the implementation of the surge plan to its next stage in December and January will see an increase in bed capacity across SSOT and within the Trust itself. In addition to this workstreams 1-4 will incorporate recommendations from GiRFT/ECIST teams immediately and will seek to deliver benefits that will further improve emergency pathway metrics in line with trajectories.

December 2024 will therefore likely see improvements across the suite of Emergency Care indicators, however it is likely that with the introduction of additional Industrial Action from the BMA additional measures will need to be taken. Inevitably there will be greater impact on elective care pathways and capacity in order to maintain safety throughout the holiday period.

Section 2: Planned Care, Cancer and Diagnostics (Elective Care)

How are we doing against our trajectories and expected standards?

Diagnostic performance continues to improve both in actual and relative terms compared to other acute hospitals. UHNM remain upper quartile for greatest improvement in this standard.

Patients waiting 78 weeks or more continued to reduce in November following a reducing trajectory that improves

relative performance each month. As a Tier 1 trust NHSE region and national and regional teams have weekly oversight of improvement trajectories. Despite these improvements UHNM remain in the worst quartile for performance. There remains 1 patient waiting over 104 weeks for treatment, however a date is booked and specialist equipment has a delivery date in January 2024.

Cancer treatment backlog numbers have continued to reduce in line with trajectory and latest performance at the close of November have numbers better than trajectory. This performance reflects an improvement in several tumour sites however the most notable and with greatest impact is lower GI (Colorectal) which has seen an improvement to better than trajectory performance. Until backlog reduces to the level set in trajectory overall cancer performance % against the standard will not be the focus of performance reporting.

Cancer diagnostic performance remains a challenge and November performance has not seen the required improvement. Although SPC charts show a sustained improvement, they is not in line with trajectory and further improvement is required to meet national milestones. Endoscopy is the largest single factor contributing to this shortfall.

What is driving this?

Both Diagnostic (6 week standard) and FDS (Cancer Standard) have a heavy reliance on Endoscopy performance. Endoscopy considering current productivity has been shown to be circa £2.5M smaller than it needs to be to meet demand and reduce waiting times. This is through a combination of not having enough staff to complete the required tests but also a lower than required productivity. Productivity levels although not nationally benchmarked are likely to be much lower than in other Trusts as a result of a mixture of lack of digital infrastructure, booking efficiency and therefore higher than expected levels of cancellations.

Patients waiting for 78 weeks or greater have continued to reduce although not the level desired. The largest single component to this waiting list is in Orthopaedics and Spinal services, where the initial waiting list was largest. Much progress has been made in this service with input from the national GiRFT teams, however in the last reporting period two consultant surgeons were unavailable as a result of sickness that unfortunately meant patients could not be operated on with the initially expected window. Without this element issue it is likely that there would have been almost no patients waiting 78 weeks for surgery.

Cancer treatment backlog reduction (62 day) in November and into December were some of the largest volumes of treatment operations recorded this financial year. Increases in capacity supported by West Midlands Cancer Alliance (Lower GI Surgery in particular) have seen a significantly positive impact.

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

Endoscopy services have a three part plan for the resolution of demand versus capacity. In November the Trust received confirmation of £1m of additional funding to support additional capacity using support from independent sector insourcing. The Trust is awaiting confirmation of the final gap in funding (to take it to £2.5m) however it is likely this will be available in Q4. Expanding the service in this way will have an impact partially in December but most likely greatest felt in Q4 itself. Alongside this productivity and improvement plans have been developed with an external specialist working with service leadership teams to fully mobilise the digital system now implemented and to improve processes and booking practice. This final element will ensure that the service is sustainable into 2024/25 and that further large additional investments will not be required.

Productivity in elective services, and especially outpatient services are part of the wider planned care improvement plan. Utilising the GiRFT methodologies the Trust will focus on specialties that have particularly long waiting lists and work with the national GiRFT *Further Faster* programme. This clinically developed set of improvement tools has been used in a number of areas nationally and will support the focussed recovery of those specialties with gaps in demand and capacity and that have long waiting lists.

Cancer performance and the protection of capacity for cancer recover will remain a focus during the winter (Surge Plan). It is expected that despite the increased winter pressure and impact from emergency overflow, cancer services will remain protected. This will include the ring fencing of funding for cancer improvement which if mobilised should deliver performance in line with our trajectories.

What can we expect in future reports?

With the recent announcement of Industrial Action by the BMA in December and January it is highly likely that plans and trajectories in both diagnostics and planned care will not be met by March 2024. The full impact of this is still being analysed however the timing of the action is such that it is unlikely any suitable alternatives for the lost capacity

will be available when required.

Cancer services will have the greatest protection of services (including cancer diagnostic services) and recovery trajectories are still expected to be delivered, however it is important to note the increased risk in this area. Ongoing discussions are taking place with regulators on both undertakings and NOF3 exit criteria which now must be considered in relation to the Industrial Action.

Workforce

Key messages

- The 12m Turnover rate in November 2023 decreased fractionally to 8.1% (8.2% in October 2023) which remains below the trust target of 11%.
- M8 vacancies decreased to 8.66% (8.98% in October), influenced by a reduction in Medical & Dental vacancies. Divisions continue to report good progress on their recruitment pipeline to close the gap on vacancies.
- For M8, the in-month sickness rate decreased by 0.16% to 5.36% (5.52% in October 2023). The 12-month cumulative rate remained static at 5.26% (5.26% in October 2023).
- Stress and anxiety continues to be the top reason for sickness in November 2023, which saw an increase of 2.2% in the last month to 26.5% (24.3% in October). Chest & respiratory problems saw an in-month decrease to 9.8% (15.0% in October 2023), and gastrointestinal problems increased from 5th to 3rd most common reason, at 8.9% in November (7% in October 2023), replacing cold, cough & flu.
- Employees may report covid-like symptoms on Empactis, but Managers are then recording this as either chest & respiratory, or cold & flu, on ESR, in the absence of a formal lateral flow test, following the cessation of symptomatic covid testing, since May 2023. The overall number of employees who reported Covid-19 fell, on Empactis, to 202 cases in November 2023 (460 in October 2023). Managers reported 94 covid-related absences on ESR for November 2023, (3 in October 2023).
- November 2023's PDR Rate decreased to 82.0% (82.6% in October 2023). The refreshed PDR paperwork to support colleagues in achieving their potential, is expected to be released in January 2024.
- Statutory and Mandatory training rate on 30th November 2023 increased by 0.3% to 94.2% (93.9% on 31st October 2023). This compliance rate is for the 6 'Core for All' subjects only.
- The Staff Voice trust survey has been paused until January 2024, to prevent survey fatigue, following the NHS National Staff Survey.
- The Being Kind sessions continued in November 2023 with 780 colleagues in attendance. Overall, 9,513 people have attended the training, either in person, virtually, or online, via the ESR virtual training session.
- The raw score data from the NHS National Staff Survey is expected by the end of December, and work will commence on the analysis.

Finance

Key elements of the financial performance year to date are:

- For Month 8 the Trust has delivered a year-to-date deficit of £0.8m against a planned surplus of £2.4m; this adverse variance of £3.2m is primarily driven by underperformance against the Trust's in year CIP target and unfunded additional winter escalation capacity that remained open through the year.
- The Trust has received £9.0m additional funding towards the cost of industrial action and other cost pressures for Month 1 to 7; this additional income has been recognised in the Month 8 position.
- The Trust has incurred £5.0m of costs relating to winter escalation capacity remaining open to Month 7 partially funded by £2.1m of additional funding from the local ICB. Winter and escalation costs from Month 8 are funded as part of the Trust's winter plan.
- To date the Trust has validated £30.2m of CIP savings to Month 8 against a plan of £36.7m. The Trust has recognised £3.4m of CIP due to an assumed reduction in the annual leave provision delivering 50% of the NR ICB stretch CIP target; the balance is expected to be delivered from a further reduction in the provision. Schemes of £48.3m have been identified for delivery in 2023/24. The PMO is currently working with scheme leads to develop robust plan to deliver these savings. The £8.0m divisional schemes remain unidentified.
- The Month 8 actual performance of a £7.0m surplus is in line with the Trust's Month 7 breakeven forecast for the year presented to the Committee in November.
- There has been £36.2m of Capital expenditure which is £6.6m below plan.
- The cash balance at Month 7 is £69.2m which is £6.8m lower than plan.

Key Recommendations

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

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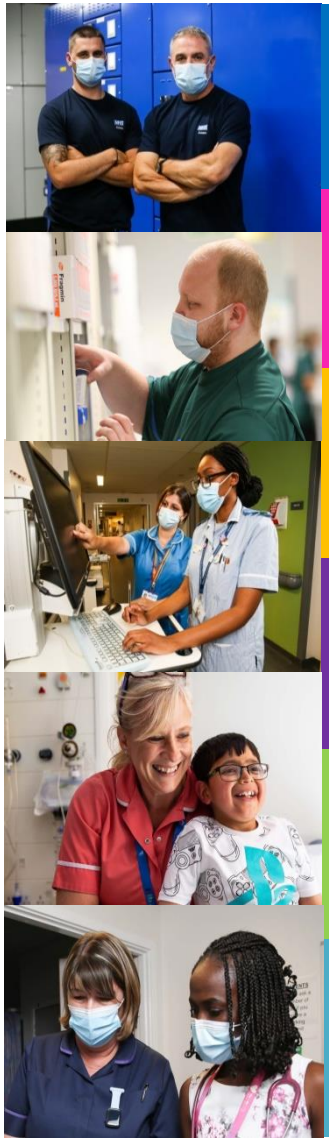

Integrated Performance Report

Month 08 2023/24

Delivering Exceptional Care with Exceptional People

NHS
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Contents

A note on SPC

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

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

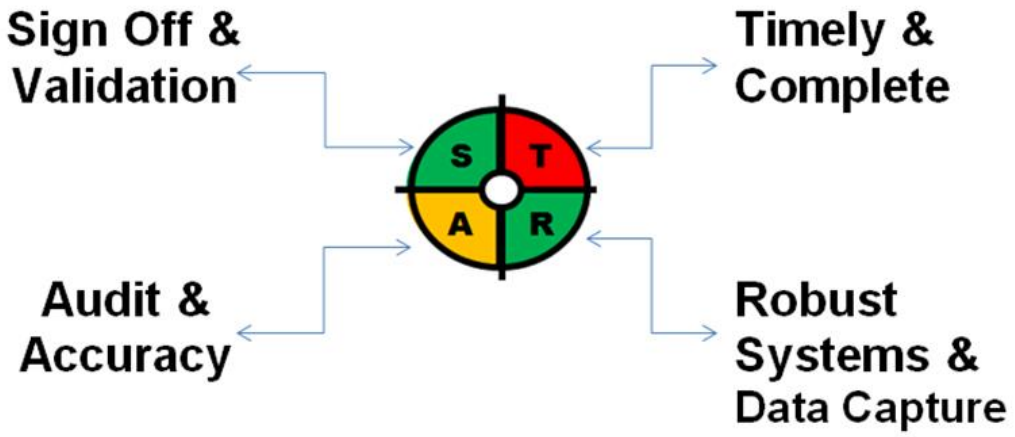
Assurance - how assured of consistently meeting the target can we be?

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

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

A note on Data Quality

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

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

Quality Spotlight Report

University Hospitals of North Midlands NHS Trust

The Trust achieved the following standards in November 2023:

- Falls rate was 5.5 per 1000 bed days for October 2023, 5th consecutive month below benchmark rate, although has increased slightly during November.
- Hospital Associated Thrombosis has continued to remain below the mean rate for the past 7 months and is within normal variation and cases are under review.
- 0 Never Event
- Trust rolling 12-month HSMR continues to be within expected range at 97.91
- Trust rolling 12-month SHMI 98.44 and is Band 2 – as expected. There has been continued improvement in SHMI Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- Inpatient sepsis Screening and Sepsis IVAB within 1 hour achieved 95.1% and 100% respectively and meeting the 90% target rate
- Children's Sepsis Screening compliance achieved the 90% target with 100% during November.
- Children's IVAB within 1 hour achieved 100%
- Maternity IVAB compliance 100% and above the 90% target for audited patients
- Friend & Family (Inpatients) 95.5% and exceeds 95% target.
- The rate of complaints per 10,000 spells is 28.43 and remains below the target of 35 and long term mean rate but within normal variation.

The Trust did not achieve the set standards for:

- Rate of falls reported that have resulted in harm to patients currently at 1.9 per 1000 bed days and continues to be within the control limits and normal variation.
- 94.4% verbal Duty of Candour compliance recorded in Datix.
- 83.3% compliance with Duty of Candour 10 working day letter performance following formal verbal notification and under review for completion and upload of letter on Datix
- Pressure Ulcers per 1000 bed days with lapses in care developed under UHNM care is now 0.74 and above the target rate 0.5.
- There were 31 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 1 overdue Patient Safety Alerts which is awaiting final approval and sign off
- Timely Observations remain below the 90% target but has seen further improvement during October.
- E. Coli Bacteraemia cases above trajectory with 23 in October compared to target of 16.
- C Diff YTD figures above trajectory with 12 against a target of 8.
- Friend & Family (A&E) has declined and remains below 85% target at 60.9%
- Friend & Family (Maternity) 92.0% and below 95% target.
- VTE Risk Assessment completed during admission has dropped below 95% target with 93.8% recorded in November (via Tendable)
- Sepsis Screening compliance in Emergency Portals increased to 78% but remains below the target 90%.
- Emergency Portals Sepsis IVAB improved to 72.2% but remains below the 90% target for audited patients.
- Maternity Sepsis Screening compliance remain below 90% target at 44.4%

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

- Total number and rate of Patient Safety Incidents increased in month.
- Total incidents with moderate harm or above and the rate of these incidents within normal variation levels during November and noted increase in month (incidents are currently under review)
- Medication related incidents rate per 1000 bed days is 6.4 which remains above the target and long term mean rate as is patient related at 5.7. The monthly variation is within the normal expected variation and above the NRLS national rates. The % of medication incidents reported with moderate harm or above has increased for November 2023 but remains under review.
- 11 Serious Incidents reported during with 9 Falls related, 1 Diagnostic related and 1 maternity related incident
- Majority of complaints in November 2023 continue to relate to clinical treatment.

University Hospitals of North Midlands NHS Trust

Quality Performance Report (QPR) | Assurance Grid

Failing

Aiming Here

Strategic Priority Domain Metrics Key

Quality metrics shown in blue text
Responsive metrics shown in pink text
People metrics shown in orange text
Improving & Innovating metrics shown in purple text
System & Partners metrics shown in green text
Resources metrics shown in teal text

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

Variation

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

Worsening

Variance

August 2023	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail
Special Cause - Improvement	All Children's IVAB in 1 hour Inpatient IVAB within 1 hour VTE Risk Assessment	PSI's per 1000 bed days no harm PSI's per 1000 bed days near miss Medication Incidents per 1000 bed days Patient Medication Incidents per 1000 bed days Contracted Adult Inpatient Sepsis Screening Hospital acquired Thrombosis Rate Inpatient Sepsis Screening Approval Lead Time Sickness	Rate of SI's 1000 bed days Rolling 12 month SHMI All Maternity IVAB in 1 hour Timely Observations
Common Cause	Patient Safety Incidents PSI rate per 1000 bed days Rolling 12 month HSMR	PSI's per 100 bed days low harm PSI Moderate Harm and above Falls rate per 1000 bed days Medication incident % moderate harm + Pat Medication incident % moderate harm PU's rate per 1000 bed days Lapses in care PU per 1000 bed days Cat 3 PU with lapses in care Deep Tissue injuries lapses in care Unstageable PU lapses in care Serious Incidents Never Events reported DoC compliance formal verbal & written Friends and Family Maternity Complaints Rate Other Emergency Portal Screening All children sepsis screening Avoidable MRSA Average Usability Patients will receive a variable experience	RS ED IV Abx in 1 hour Other Emergency Portals IV Abx in 1 hour
Special Cause - Concern	Friends and Family INP Contracted Adult Inpatient IVAB in 1 hour	Cat 2 PU with Lapses in care HAI and COHA cases of C Diff toxin HAI E Coli Bacteraemias All ED portals Screening All Emergency Portals IV Abx in 1 hour RS ED Dept Sepsis Screening Childrens Sepsis Screening Net Hours Agency Usage Bank Usage Temporary Staffing	Family and Friends ED All Maternity sepsis screening

Quality Dashboard

NHS
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Metric	Benchmark	Previous	Latest	Variation	Assurance
Patient Safety Incidents	2000	2373	2273		
Patient Safety Incidents per 1000 bed days	50.70	56.93	56.14		
Patient Safety Incidents per 1000 bed days with no harm	34	38.94	36.78		
Patient Safety Incidents per 1000 bed days with low harm	13	15.33	15.64		
Patient Safety Incidents per 1000 bed days reported as Near Miss	2	2.09	2.52		
Patient Safety Incidents with moderate harm +	20	24	45		
Patient Safety Incidents with moderate harm + per 1000 bed days	0.60	0.58	1.11		
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		
Patient Falls per 1000 bed days	5.6	5.3	5.5		
Patient Falls with harm per 1000 bed days	1.5	1.6	1.9		
Medication Incidents per 1000 bed days	6	7.8	6.4		
Medication Incidents % with moderate harm or above	0.50%	0.61%	0.77%		
Patient Medication Incidents per 1000 bed days	6	6.9	5.7		
Patient Medication Incidents % with moderate harm or above	0.50%	0.69%	0.87%		

Metric	Benchmark	Previous	Latest	Variation	Assurance
Serious Incidents reported per month	0	8	11		
Serious Incidents Rate per 1000 bed days	0	0.19	0.27		
Never Events reported per month	0	1	0		
Duty of Candour - Verbal/Formal Notification	100%	94.4%	94.4%		
Duty of Candour - Written	100%	94%	83.3%		
All Pressure ulcers developed under UHNM Care	60	91	97		
All Pressure ulcers developed under UHNM Care per 1000 bed days	1.6	2.18	2.40		
All Pressure ulcers developed under UHNM Care lapses in care	12	34	14		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.82	0.35		
Category 2 Pressure Ulcers with lapses in Care	8	13	4		
Category 3 Pressure Ulcers with lapse in care	4	1	2		
Deep Tissue Injury with lapses in care	0	18	9		
Unstageable Pressure Ulcers with lapses in care	0	2	1		

Quality Dashboard

NHS
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NHS Trust

Metric	Benchmark	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	63.8%	60.9%		
Friends & Family Test - Inpatient	95%	95.5%	96.2%		
Friends & Family Test - Maternity	95%	85%	92.0%		
Written Complaints per 10,000 spells	35	32.96	28.43		
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	98.95	97.91		
Rolling 12 Month SHMI (4 month time lag)	100	99.61	98.44		
VTE Risk Assessment Compliance	95%	95.9%	93.8%		
Hospital Associated Thrombosis Rate per 10,000 Admissions	N/A	1.08	1.19		
Timely Observations	90%	71.0%	73.0%		
Reported C Diff Cases per month	8	11	12		
Avoidable MRSA Bacteraemia Cases per month	0	0	0		
HAI E. Coli Bacteraemia Cases per month	16	23	17		

Metric	Benchmark	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	96.6%	95.1%		
Inpatient IVAB within 1hr (Contracted)	90%	100%	100.0%		
Children Sepsis Screening Compliance (All)	90%	71%	100.0%		
Children IVAB within 1hr (All)	90%	100%	N/A		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	83.0%	78.0%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	71.74%	72.2%		
Maternity Sepsis Screening (All)	90%	70%	44.4%		
Maternity IVAB within 1 hr (All)	90%	100%	100.0%		

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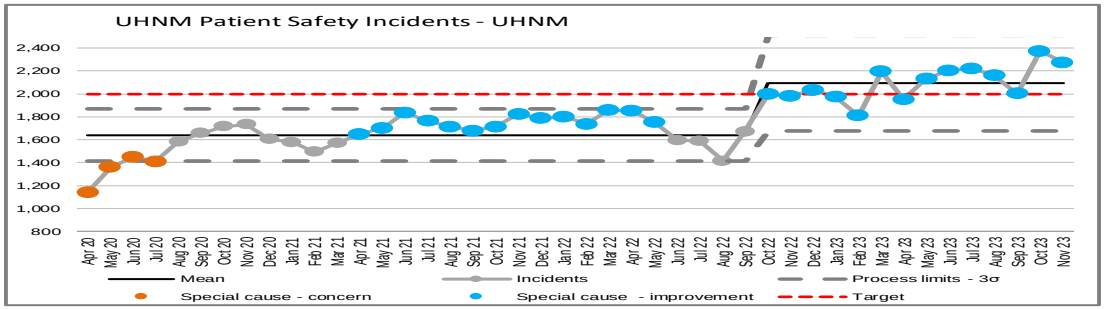
Reported Patient Safety Incidents

NHS
University Hospitals of North Midlands
NHS Trust

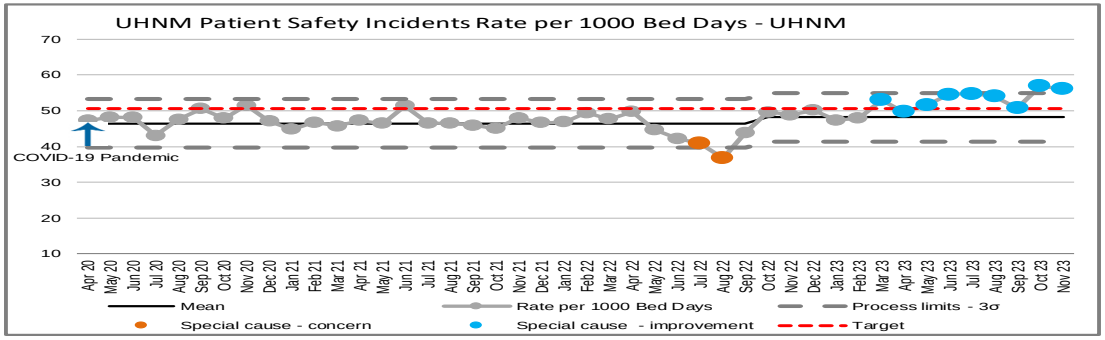


Variation	Assurance
	

Target	Sep 23	Oct 23	Nov 23
2000	2002	2373	2273

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Sep 23	Oct 23	Nov 23
50.70	50.77	56.93	56.14

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The November 2023 total is above the mean total. The rate per 1000 bed days has also increased and is above the NRLS rate.

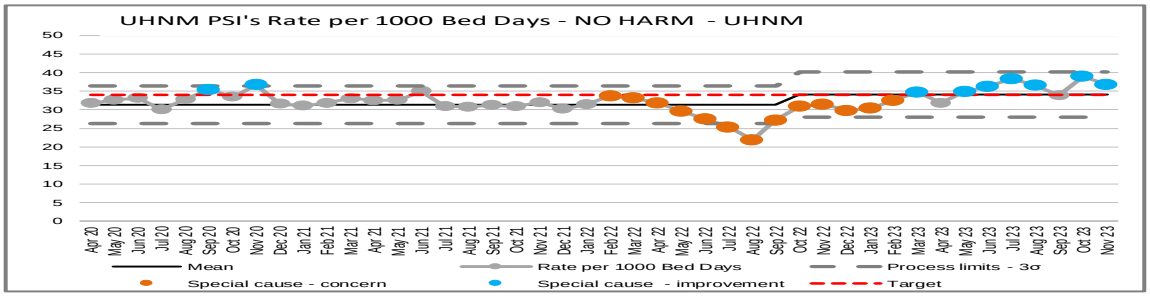
However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers are Medication, Patient Flow, Patient Falls, Clinical Assessment and Treatment related incidents. Medication related incidents continue to be the largest category after Tissue Viability in November 2023.

There have been same number of incidents relating to 'Your Next Patient' with 14 during November (14 during October, 34 during September 2023, 76 in August, 110 in July, 102 in June, 97 in May, 117 in April, 157 in March, 170 in February and 228 in January 2023) which accounts for 0.61% (0.57% in October, 1.76% in September, 3.6% in August, 5.1% in July, 4.8% in June and May, 6.21% in April, 7.4% in March, 9.8% in February and 12% in January 2023) of total patient safety incidents. This is continues to be significant reduction in the number of reported incident relating to the YNP processes. During November 2023, only 1 (7%) of these incident related to Tissue Viability. Previous months were 28.6% in October, 35.3% September, 30.4% August and 28.2% July 2023. This 1 Tissue viability incident was Moisture associated skin damage in Theatres due to longer than anticipated surgery and damage due to repeated inflation of NIBP cuff.

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

NHS University Hospitals of North Midlands NHS Trust

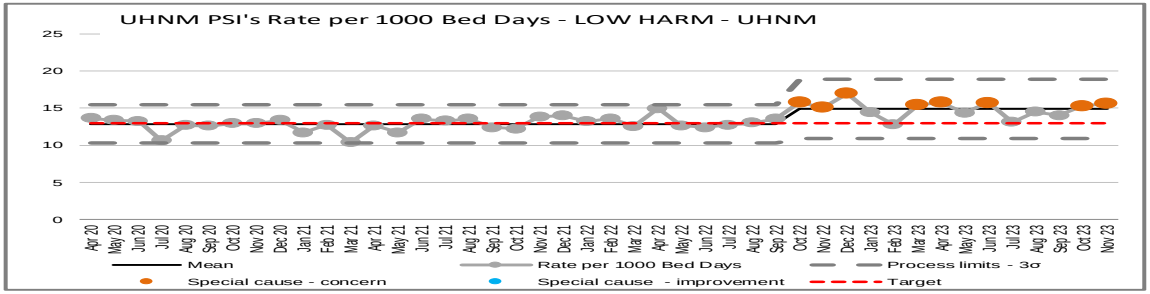


Variation	Assurance
H	?

Target	Sep 23	Oct 23	Nov 23
34	33.90	38.94	36.78

Background

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

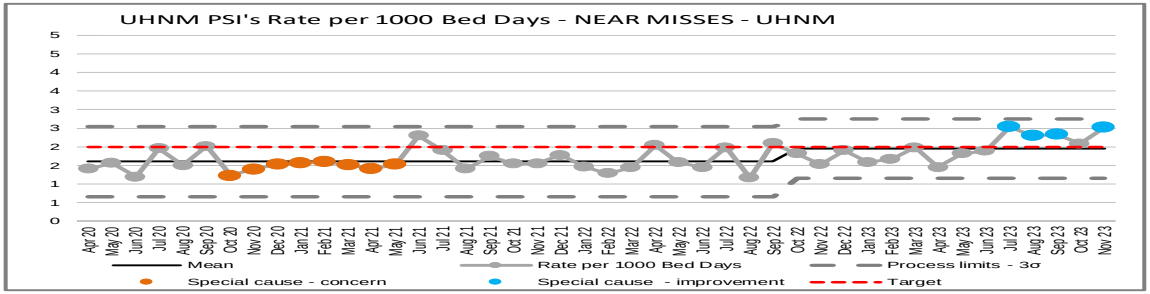


Variation	Assurance
H	?

Target	Sep 23	Oct 23	Nov 23
13	14.02	15.33	15.64

Background

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



Variation	Assurance
H	?

Target	Sep 23	Oct 23	Nov 23
2.0	2.33	2.09	2.52

Background

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

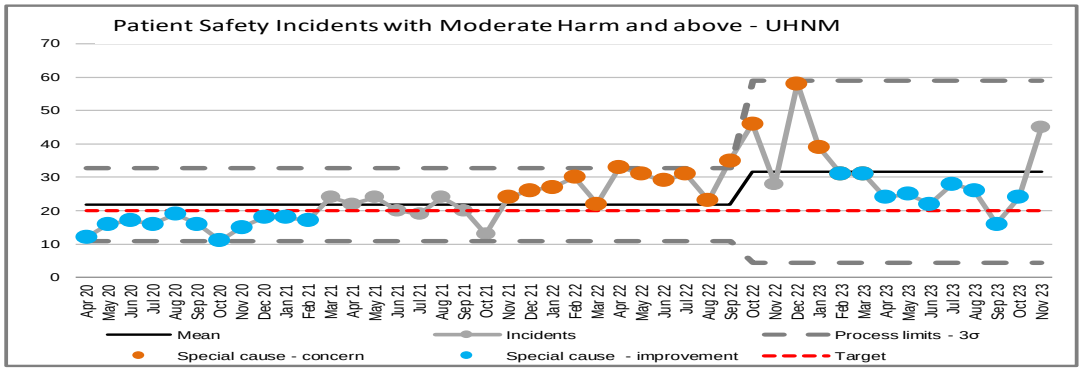
What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm and near misses have seen rates increase in recent months with low harm incidents remaining around the long term mean rate.

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

Reported Patient Safety Incidents with Moderate Harm or above

NHS University Hospitals of North Midlands NHS Trust

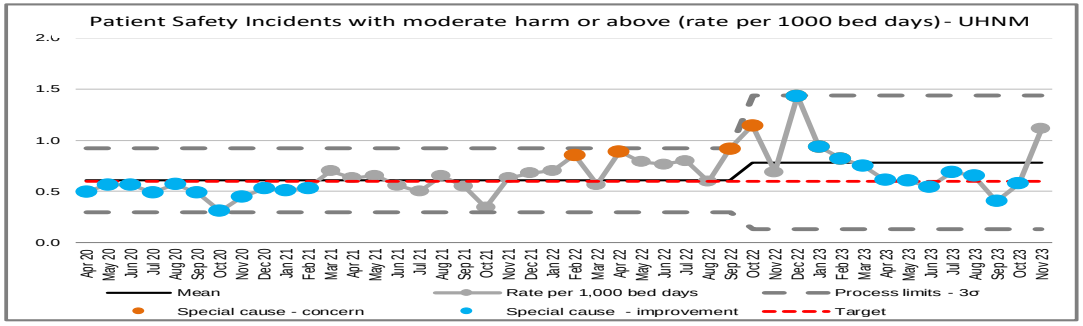


Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
20	16	24	45

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
0.60	0.41	0.58	1.11

What is the data telling us:

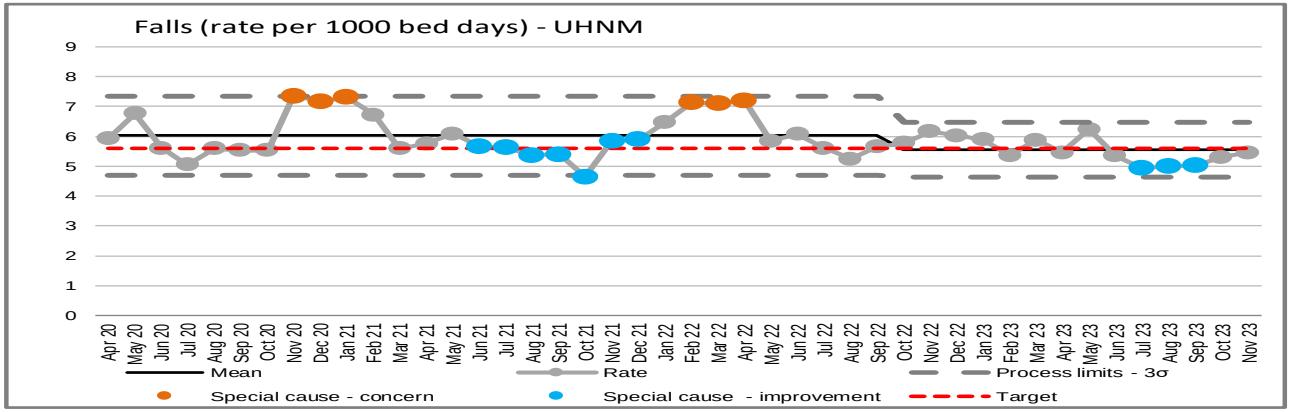
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within control limit but has shown increase total numbers and rate for November 2023 but these remain under review and may alter following completion of the reviews. Prior to November, the last 10 months had seen reducing trend since December 2022 the past 9 months.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with Treatment/Procedure related and Falls, Clinical Assessment and then Medication and Care related incidents.

One of these moderate harm and above incidents were noted as relating to **'Your Next Patient'** and was Treatment related when patient requiring mechanical thrombectomy was delayed as both IR theatres already in full use.

Patient Falls Rate per 1000 bed days

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
5.6	5.0	5.3	5.5

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

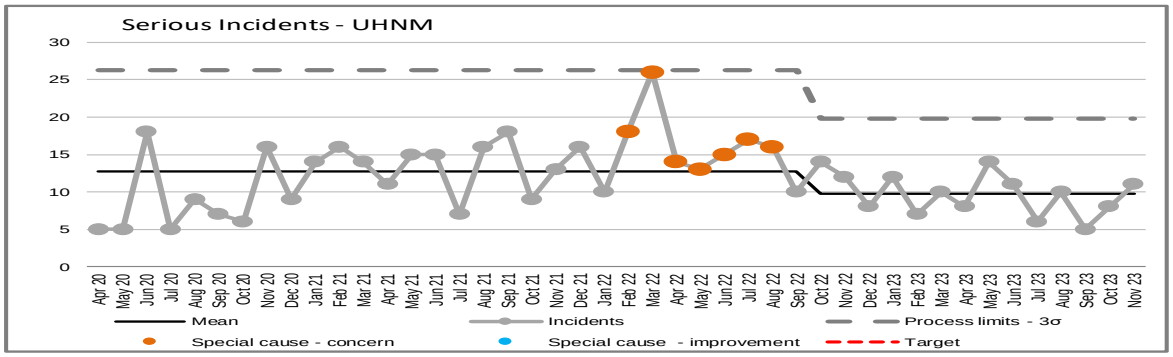
The Trust's rate of reported patient falls per 1000 bed days between July & November 2023 has remained below average but within normal variation

The areas reporting the highest numbers of falls in November 2023 were:-
Royal Stoke ECC – 16 falls, Ward 113 – 13 falls, Royal Stoke AMU – 12 falls, Ward 121 – 9 falls

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

- Audits/spot checks continue to take place.
- 3 Further falls champion days have taken place.
- New N/A induction training has taken place.
- AMU have falls has their improving together driver and the quality and safety team attend these meetings. Although they remain in the Top 5 falling wards falls have reduced.
- ECC continue to be in the Top 5 falling wards however there have been no SI's reported recently. Matron, senior sister and the quality and safety team hold regular meetings to discuss audits and identify where improvements are required and where good practice can be shared.
- AMU, ward 113 and ward 121 have all recently had patients that are multiple fallers and therefore putting falls numbers up.

Serious Incidents per month

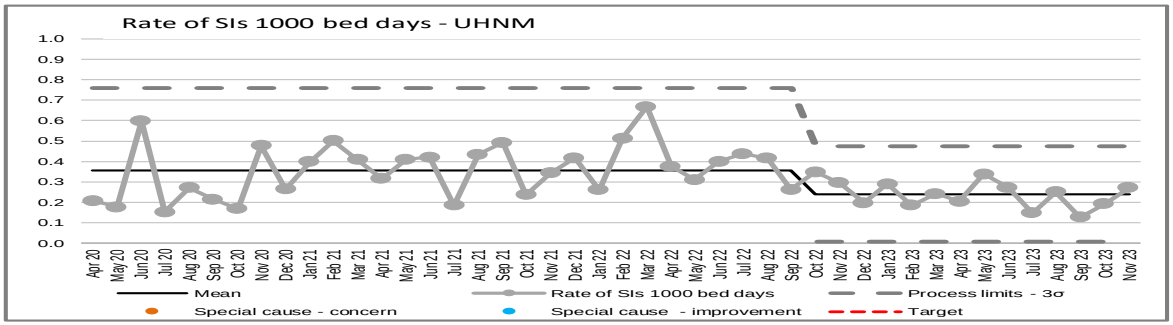


Variation	Assurance

Threshold	Sep 23	Oct 23	Nov 23
0	5	8	11

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
0	0.13	0.19	0.27

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

Monthly variation is within normal limits. Target has been set at 0 for serious incidents but this remains under review to develop trajectory for reducing serious incidents across UHNM. November 2023* saw 11 incidents reported:

- 9 Falls related incidents
- 1 Diagnostic related incidents
- 1 Maternity related

The rate of SIs per 1000 bed days has varied consistently within confidence limits but the past 10 months have shown significant improvement with rate below the previous long term mean of 0.4. The confidence limits have been recalculated from October 2022 to reflect the significant changes. The current rate is 0.27.

**Reported on STEIS as SI in November2023, the date of the incident may not be November 2023.*

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

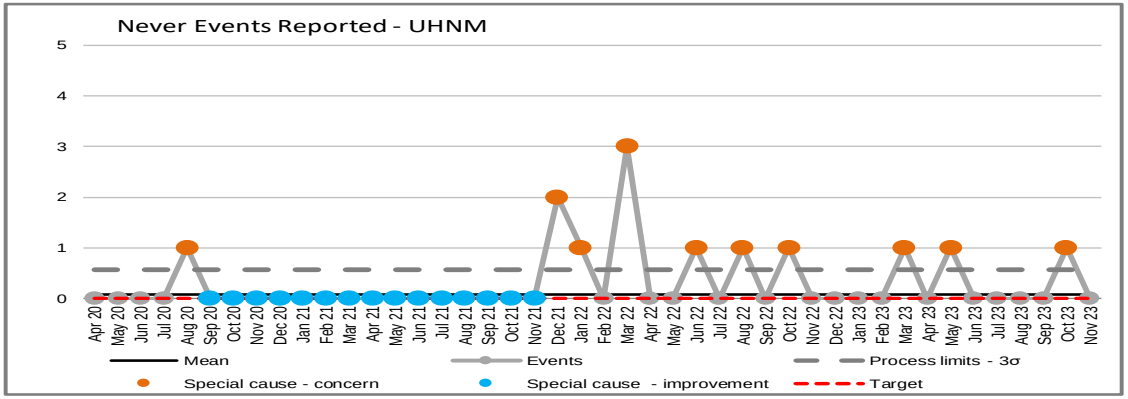
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during November 2023. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

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

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2023/21145		Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant).	13/02/2024	Fetal death

Never Events



Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
0	0	1	0

Background

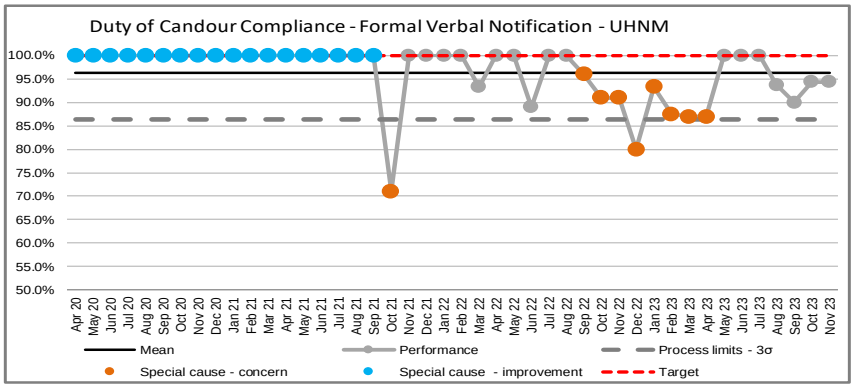
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

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

Log No.	Never Event Category	Description	Target Completion date

Duty of Candour Compliance

NHS
University Hospitals of North Midlands
NHS Trust

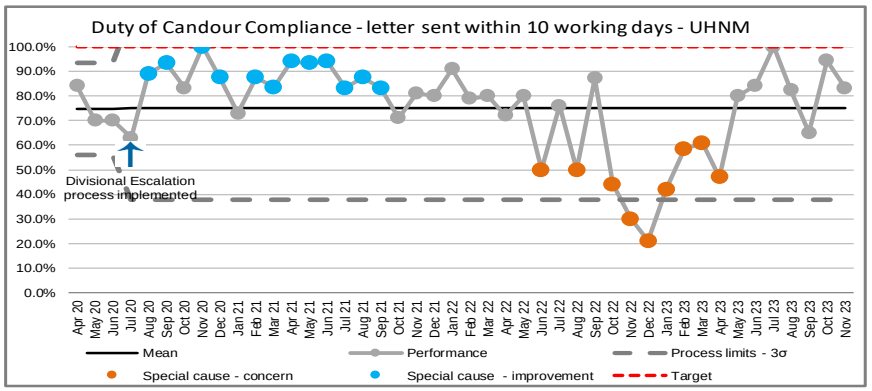


Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
100%	90.0%	94.4%	94.4%

Background

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



Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
100%	65.0%	94.4%	83.3%

Background

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

What is the data telling us:

During November there were 18 incidents reported and identified that have formally triggered the Duty of Candour. 94.4% (17 out of 18) have recorded that the patient/relatives been formally notified of the incident in Datix and within normal variation.

Confirmed Follow up Written Duty of Candour compliance* (i.e. receiving the letter within 10 working days of verbal notification **and recorded in Datix**) during November 2023 is 83.3% as of 8th December 2023 including those letters that are completed within timescale and not yet exceeded the timeframe. 3 cases were outside the 10-day timeframe but completed

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

Actions taken:

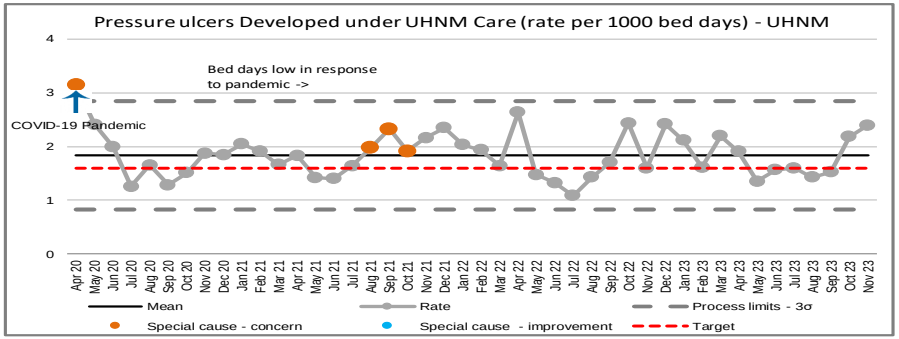
Divisions are continuing to work with and support clinicians and Q&S teams to raise further awareness and education on how and why Duty of Candour is to be completed.

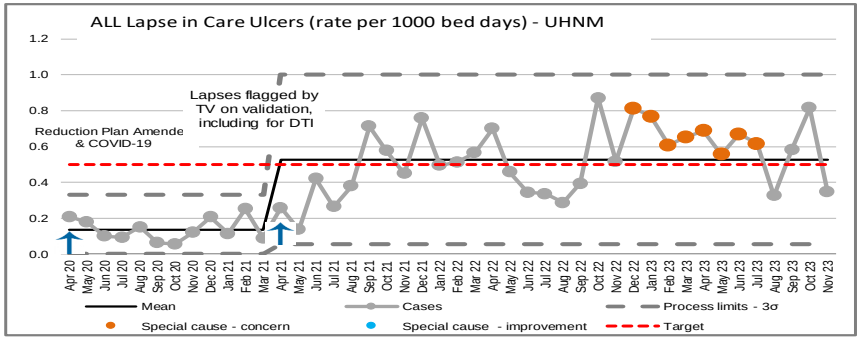
Monitoring of compliance and update with evidence takes place at day 5 and 7 with an escalation process in place which is in the process of being formalised across the Divisions.

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

Pressure Ulcers developed under care of UHNM per 1000 bed days

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
	

Target	Sep 23	Oct 23	Nov 23
1.6	1.52	2.18	2.40

Background

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

Variation	Assurance
	

Target	Sep 23	Oct 23	Nov 23
0.5	0.58	0.82	0.35

Background

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

What the data is telling us

The rate of pressures ulcers reported as developed under UHNM care was within expected limits in November. The rate of cases with lapses in care identified was also within expected range in November.

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

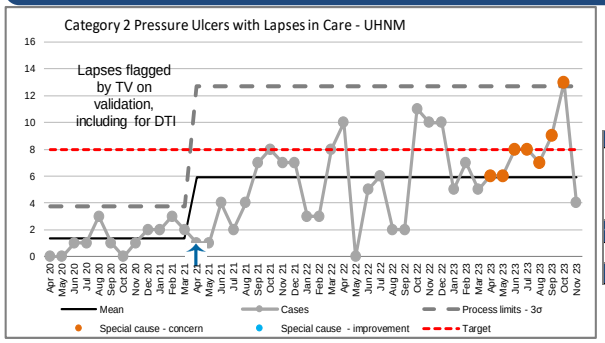
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.

Actions

- Training continues for NA induction, Preceptorship days, overseas nurses, and ED new starters and agency paramedics.
- Education plan for 2024 to be planned which will include pressure prevention, categorization, continence, lower limb, woundcare, and negative pressure.
- ESR approved by Stat & Mand Training group has been approved and underway. The guidelines for categorisation have been released from the NWCS, just awaiting the resources
- A3 for reduction of pressure ulcers for driver lane and scorecard being developed in line with Trust strategy
- Stakeholder group for patient seating have approved patient chair and will now look at recliner chairs and bariatric options
- Mattress audit completed at Royal Stoke, County audit to be completed in the following weeks along with chair audits at both sites.
- Cascade education to be delivered for the implementation of Purpose T in the risk assessment booklet
- Amendments made to the risk assessment booklet to capture patient preference and support improvements in CQIUN audit
- Conference planned for 2024

Pressure Ulcers with lapses in care

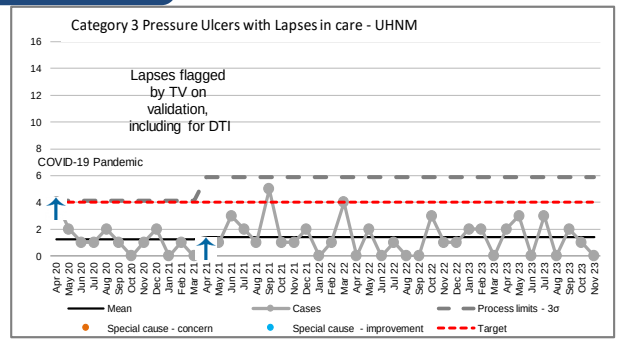
University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Sep 23	Oct 23	Nov 23
	8	9	13	4

Background

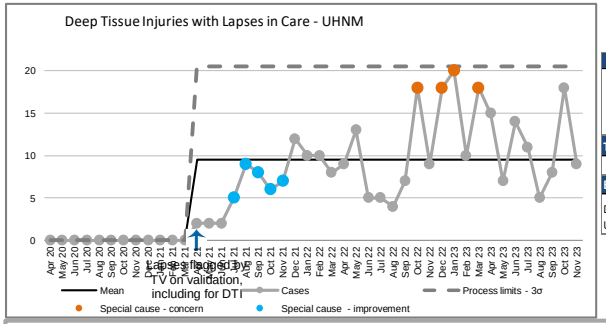


Variation	Assurance
	

Target	Sep 23	Oct 23	Nov 23
4	2	1	0

Background

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

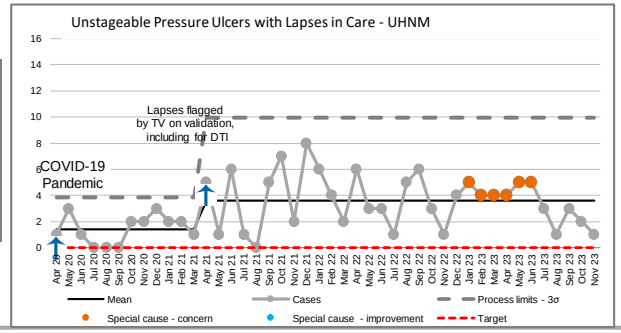


Variation	Assurance
	

Target	Sep 23	Oct 23	Nov 23
0	8	18	9

Background

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



Variation	Assurance
	

Target	Sep 23	Oct 23	Nov 23
0	3	2	1

Background

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

What is the data telling us:

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

Locations with more than 1 lapse in October 2023 were: **ED Stoke (2), AMU Stoke (2), Ward 106-7 (2) , Ward 123 (2)**

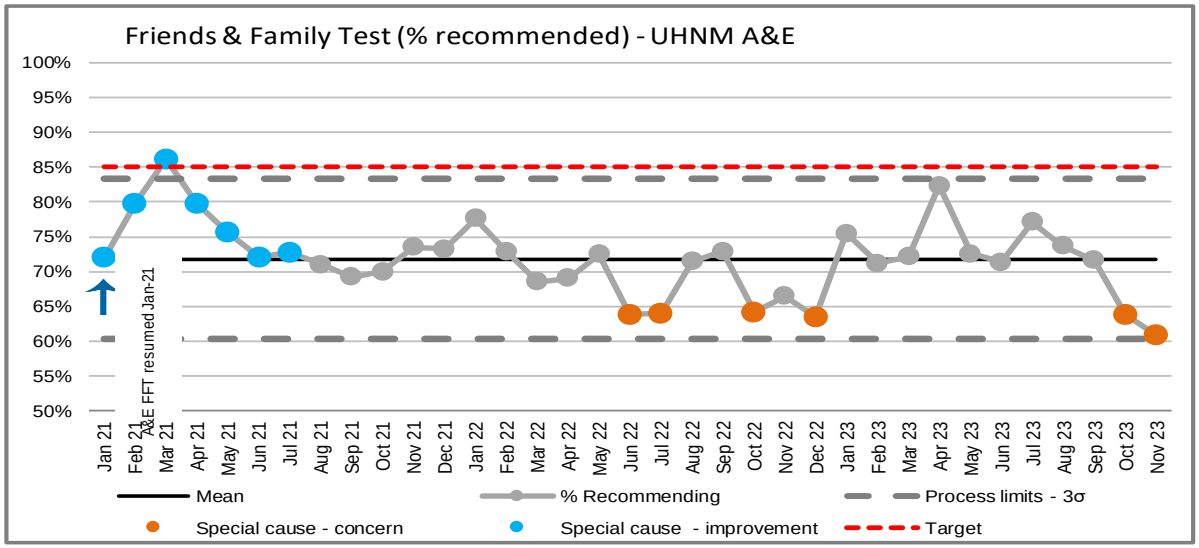
Root Cause(s) of damage - Lapses - Nov 2023	Total
Management of device	6
Management of repositioning	4
Management of heel offloading	4
Management of continence	-

Actions:

- PSIRF toolkit will be sent to wards following reporting HAPU to share learning timely
- Staff attendance for education will be an action when an incident is reported.
- High reporting wards and wards of concern are visited by Quality and Safety using improving together strategies and delivering education. Areas will also be asked to attend an assurance panel so any further support can be offered.
- Visits from Quality and Safety following completion of PSIRF toolkit to gain assurances of learning
- Tendable questions have been updated and support for completion of the audit being given to highlight immediate actions. Audits have been completed by Quality and Safety team at County, next will be the wards in the West building.

Friends & Family Test (FFT) – A&E

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

Target	Sep 23	Oct 23	Nov 23
85%	71.6%	63.8%	60.9%

Background

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

- The overall satisfaction rate for our EDs was significantly below average in October & November 2023.
- The Trust received 1065 responses which is slight increase on the previous month, however the response rate percentage dropped to 8% overall. The Trust's overall satisfaction rate is lower than the national average of 79% (NHS England August) at 61%. UHNM is 33rd out of 123 Trusts for the number of responses in ED (NHS England August 2023), and 87th out of 122 Trusts for the percentage positive results.
- Feedback from patient experience of using 111First and the kiosks continues to be monitored. 23% of respondents in November 2023 reported to have used 111First prior to attending ED, which is an increase on previous months. Key themes from November 2023 are around poor communication, patients feeling abandoned, staff attitude, long waits, pain relief especially related to Royal Stoke.

Actions :

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

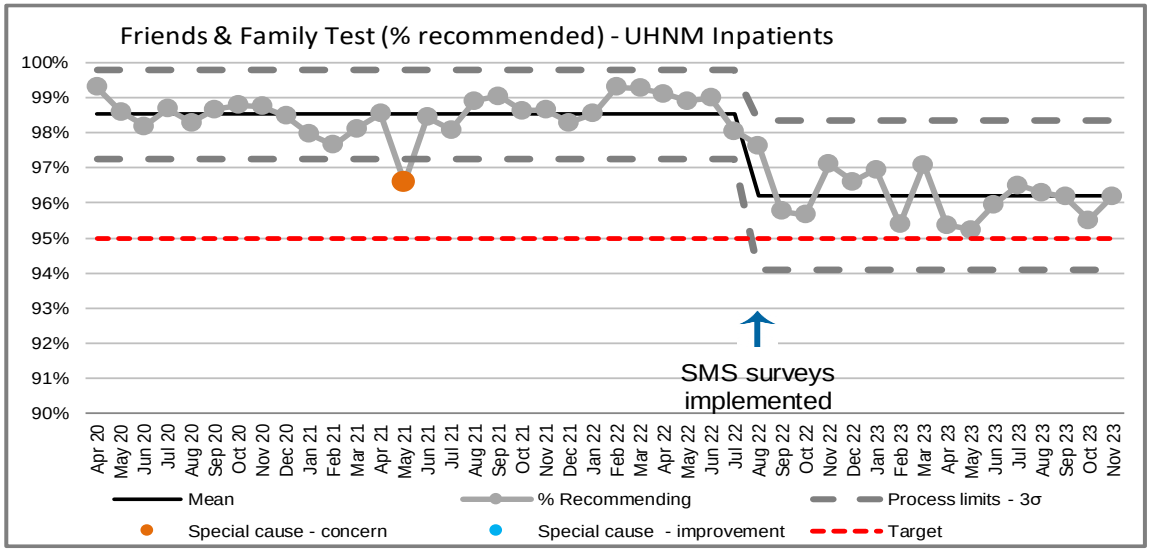
QR code made visible throughout the department.

QR code put onto all future FFTs.

You said we did board in waiting room.

Friends & Family Test (FFT) - Inpatient

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
95%	96.2%	95.5%	96.2%

Background

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

What do the results tell us?

- The monthly satisfaction rate for inpatient areas continue to exceed both the internal target rate of 95% and the national average of 94% (August 2023 NHS England) at 96.2% for November 2023.
- In November 2023 a total of 2341 responses were collected from 68 inpatient and day case areas (11311 discharges) equating to a 21% return rate which is the same as last month and lower than the internal target of 30%. UHNM have the 17th highest response rate for all reporting Trusts in the country (153) NHS England August 2023.

Actions:

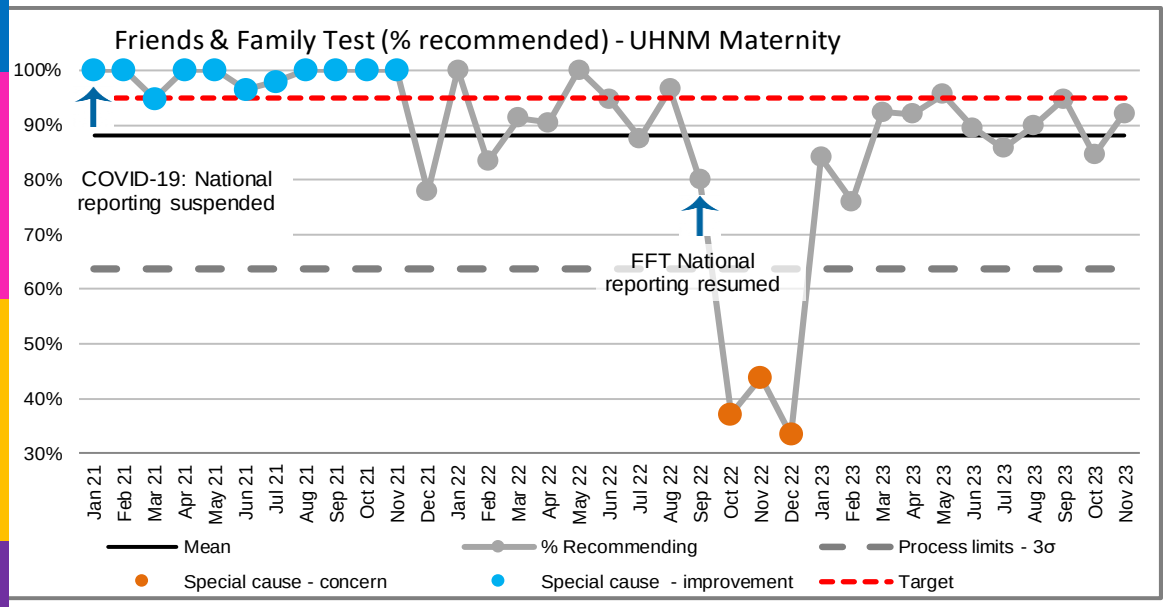
- Support individual areas to ensure they're using the most up to date version of the surveys.
- Continue to focus on Medicine and Surgery to increase response rate.

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

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

Friends & Family Test (FFT) - Maternity

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
95%	94.7%	84.5%	92.0%

Background

FFT Maternity % patients Recommending Service

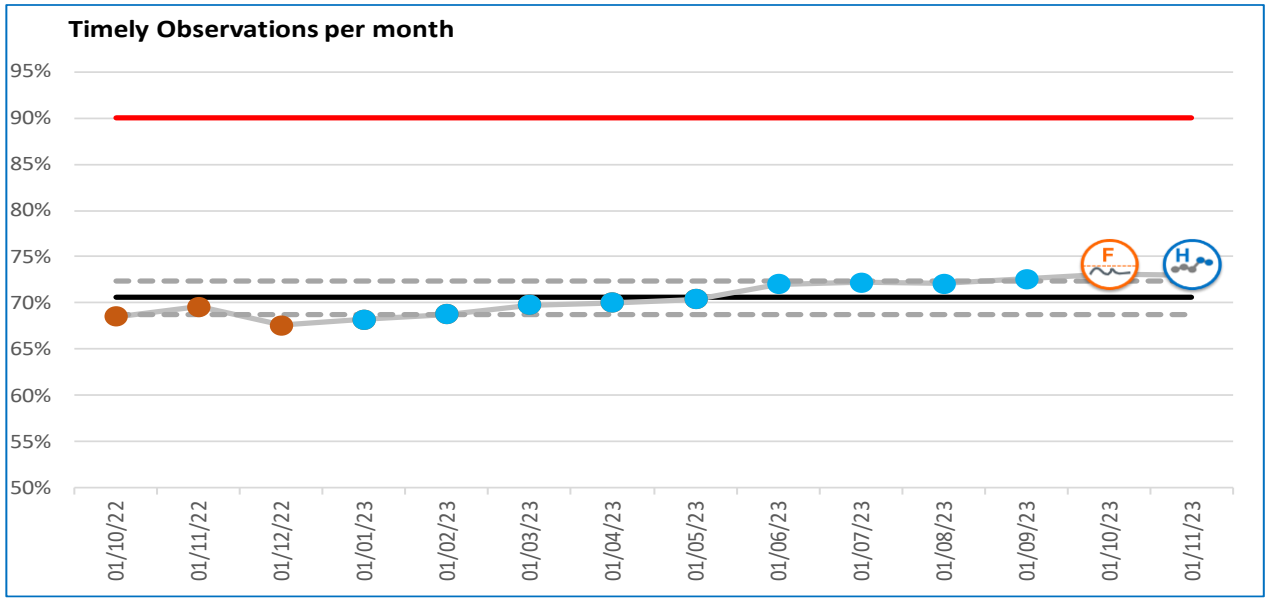
What do these results tell us?

- There were a total of 85 surveys were received in November across all 4 touch-points (ante-natal, birth, post natal ward; post natal community) with 25 of these being collected for the "Birth" touch-point, providing a 5% response rate, equal to last month (based on number of live births) and 100% satisfaction score which is an increase on the previous month's figures.
- The Antenatal touch point scored 83% recommendation and the post-natal ward touch point scored 93% satisfaction rate, both are an increase on the previous month.
- Compared to the latest national data available (August 2023) out of 111 Trusts, UHNM were 54th for number of responses for antenatal, 39th for number of responses for birth, 66th for post-natal ward and 38th for post-natal community which shows decreases in all areas.

Actions:

- Continue to monitor the efficacy of collecting feedback via text message
- Work is on-going with Maternity Voices regarding additional feedback for induction of labour
- Look at incorporating the questions from the National Maternity Survey which requires the most improvement in to the FFT survey.
- Discuss with management team with regards to increasing survey completion for post-natal community.

Timely Observations



What do these results tell us?

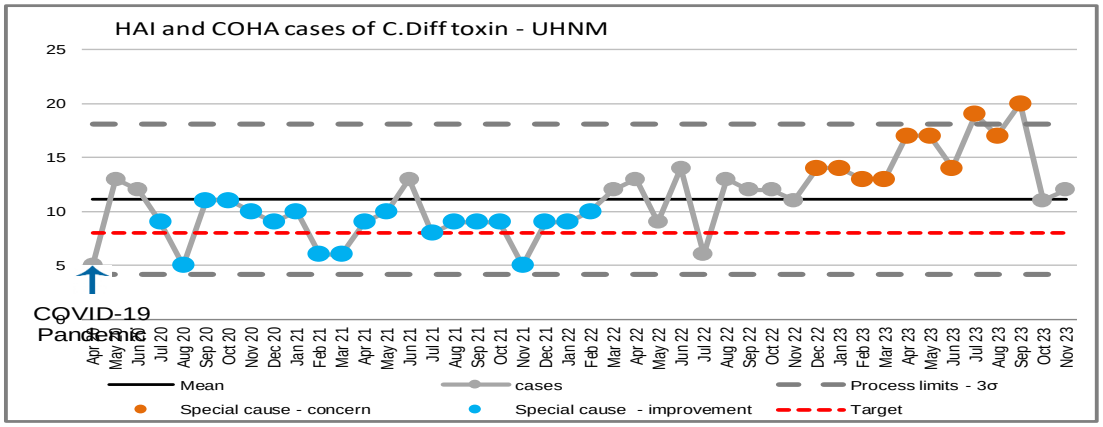
Compliance remains well below the 90% target in November 2023 but has improved a small but significant amount compared to 2022. Compliance for November 2023 was 73.0% (upper control limit is 72.4%)

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.

There was 1 ward / department with Timely Observations recorded at 50% or less during November: Ward 113 (47.5%) – compliance had improved but slipped back in November.

Reported C Diff Cases per month



Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
8	20	11	12

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

Number of C Diff cases are outside SPC limits and normal variation

There have been 12 reported C diff cases in November 2023. 10 HAI and 2 COHA

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

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

There has been two clinical areas with more than one Clostridium *difficile* case within in a 28 day period triggered in October . Where ribotypes are different person to person transmission is unlikely.

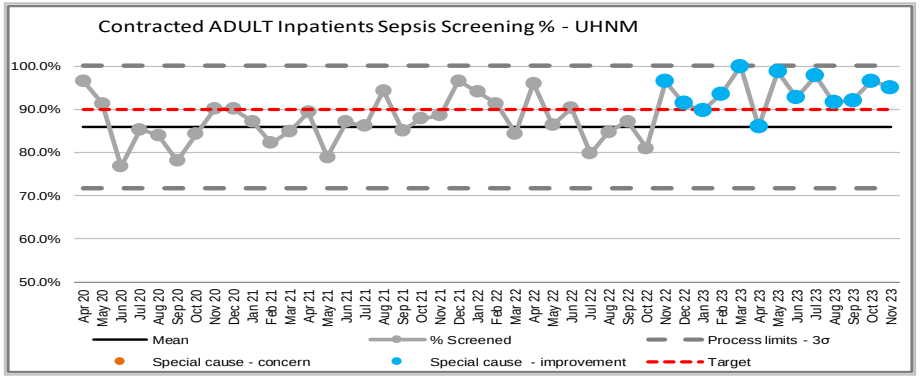
- Ward 228 COHA X 2 - Awaiting ribotypes
- Ward 76B HAI X 2 – Awaiting ribotypes

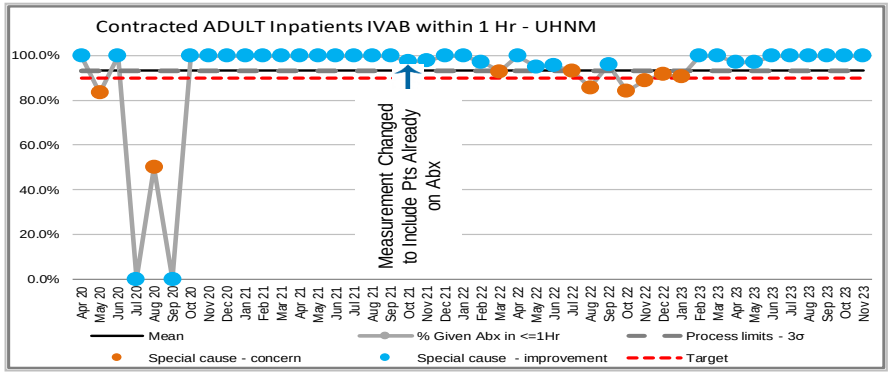
Actions:

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- Recruitment to the C Diff Nurse role has been successful and commenced 20th February 2023. This role is 50% patient reviews/50% staff training
- Task and Finish Group for West Building in place
- CURB -95 score added to CAP antimicrobial Microguide
- Campaign commenced in West Buildings to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- AMU and FEAU also targeted as antibiotics are generally started in the admission portals
- Terminal clean of all wards in West Building completed
- Consultant Microbiologist presented to ED and Elderly Care Doctors on Cdiff and antibiotic guidelines
- Consultant Microbiologist continues rounds on the Elderly care wards in West Building

Sepsis Screening Compliance (Inpatients)

NHS
University Hospitals of North Midlands
NHS Trust





Variation	Assurance
H	?

Target	Sep 23	Oct 23	Nov 23
90%	92.1%	96.6%	95.1%

Background

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

Variation	Assurance
H	P

Target	Sep 23	Oct 23	Nov 23
90%	100.0%	100.0%	100.0%

Background

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

What is the data telling us:

Inpatient areas achieved the screening and the IVAB within 1 hour target for November 2023. There were 102 cases audited with 5 missed screening from different ward areas or divisions. Out of 102 cases audited, 74 cases were identified as red flags sepsis with 45 cases having alternative diagnosis and 29 were already on IVAB treatment.

Actions:

- Sepsis sessions/ kiosks continue to all levels of staff in the clinical areas that required immediate support: on-going
- The Sepsis Team continue to raise awareness the importance of sepsis screening and IVAB compliance by being involved in HCA, students and new nursing staff induction programmes; on-going
- The Sepsis team continue to promote sepsis awareness in both sites

Sepsis Screening Compliance ALL Children

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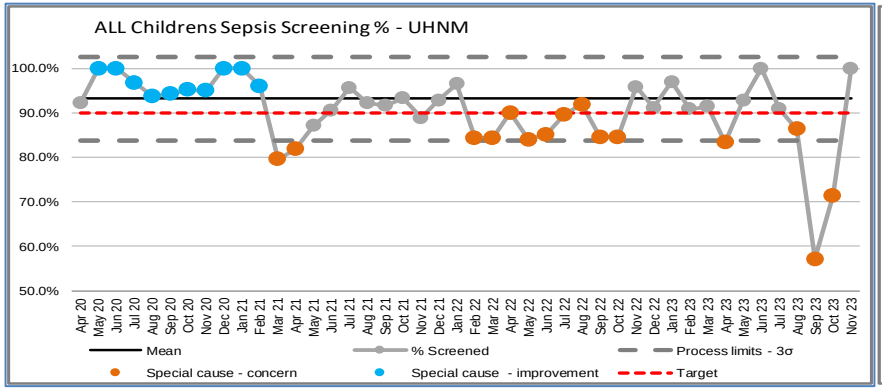

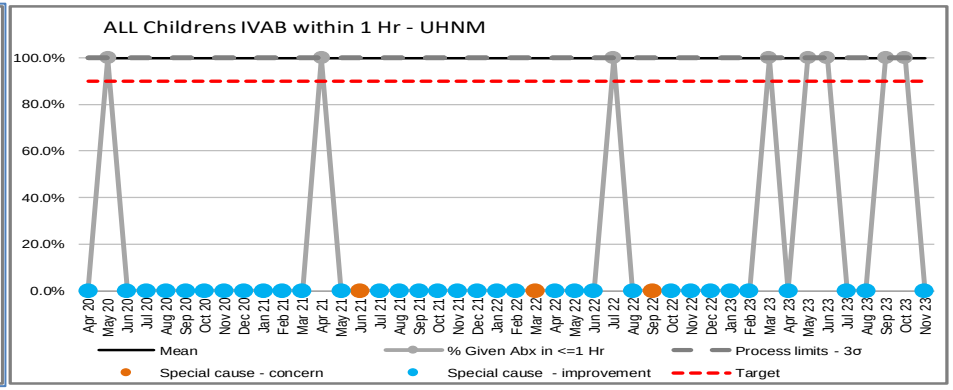

Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
90%	57.1%	71.4%	100.0%

Background

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

Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
90%	100.0%	100.0%	N/A

Background

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

What is the data telling us:

Children's Services target rate of > 90% was achieved for November 2023. We are still seeing a small numbers of children trigger with PEWS > 5 & above in Inpatients areas. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks). There were 13 cases audited for emergency portals and inpatients areas with 0 missed screening. No true red flag sepsis was identified from the randomise audits in inpatients and emergency portals. An excellent improvement.

Actions:

- Children emergency portal sepsis screening and documentation is now available electronically
- The Sepsis Team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective; on-going
- Plan of collaborative work with Children education lead and aiming to deliver Induction training when required: on-going

Sepsis Screening Compliance (Emergency Portals Contract)

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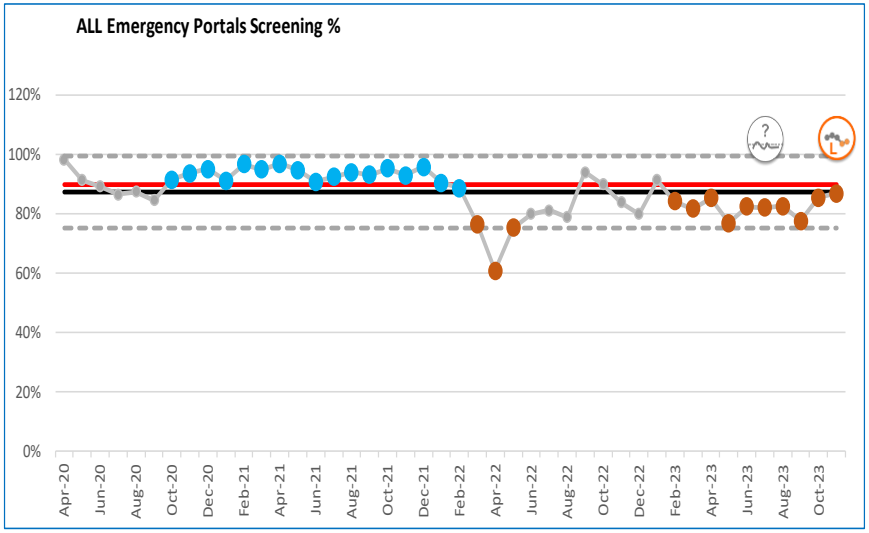

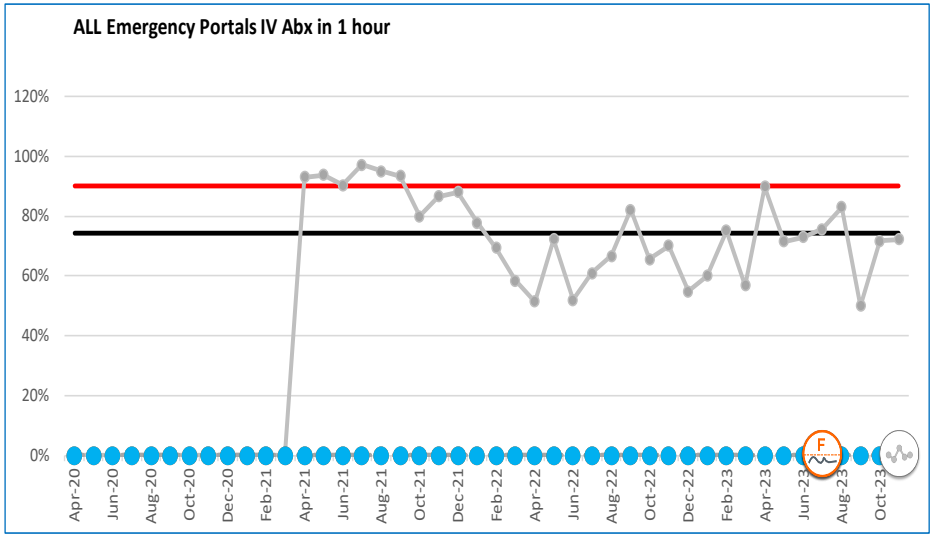

What is the data telling us:

Adult Emergency Portals screening did not meet the target rate for November 2023. There were 80 cases audited with 11 missed screening (patients are escalated but no documentation available in the screening tool) in total from the emergency portals. The performance for IVAB within 1 hour achieved 70.3 %. Out of 80 cases, there were 58 red flags sepsis in which the 14 cases already on IVAB, 37 cases were newly identified sepsis and 21 cases have alternative diagnosis. There were 11 delayed IVAB. Missed screening contributed by A&E at both sites.

Actions:

- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E regularly. Provide sepsis session when staffing and acuity allows.
- Face to face A&E sepsis induction/ training for new nursing staff, nursing assistant and medical staff will continue
- Monitoring impact of long ambulance waits on timely assessment and treatment of sepsis; on-going
- Sepsis Champion Day training is organised for both ED sites: currently re-arranged to early next year due to winter/ capacity pressure
- Deteriorating Patient Reviewer (DPR) Vocera in ED, enable the assigned clinician to review and provide timely assessment, treatment and escalation of patients whose condition meeting the NEWS2 medium to high risk sepsis triggers.
- Working towards implementation of electronic screening

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

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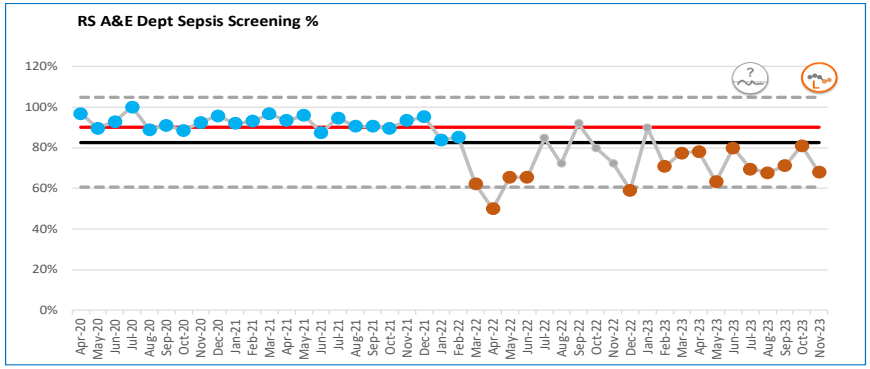

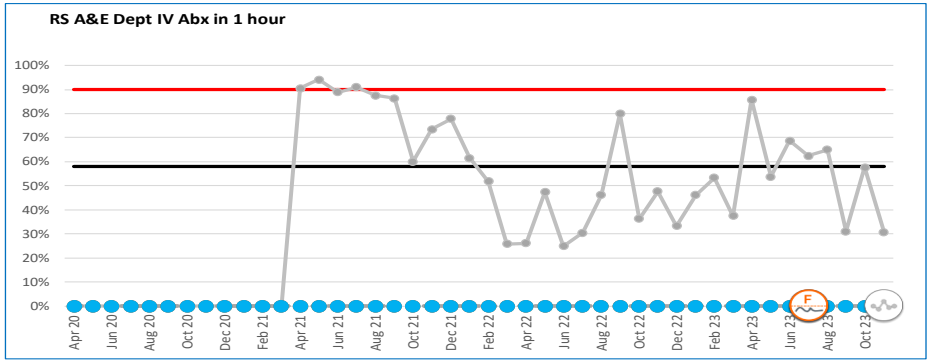

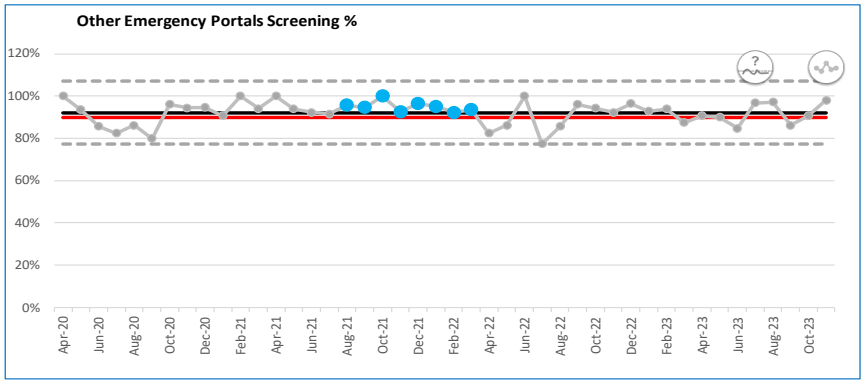

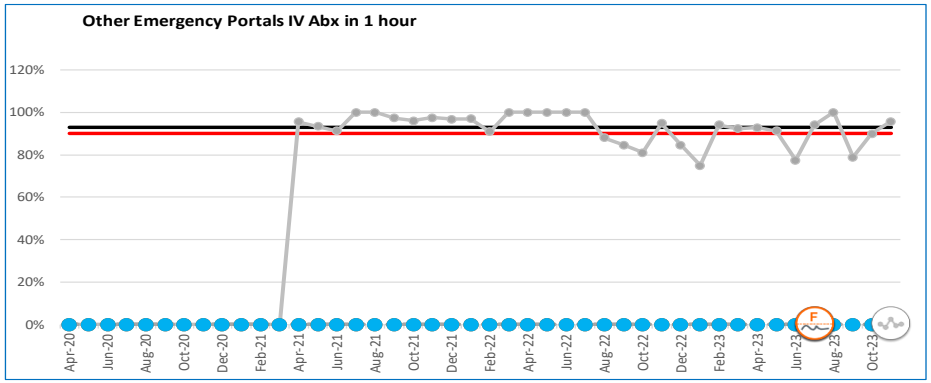

What is the data telling us:

The Emergency Department at RSUH remain below target rate for both screening and IVAB within the 1 hour for November 2023 but other sites achieved both targets.

Actions:

- To provide short sessions in ED staff during the winter months focusing the importance of sepsis screening documentation and urgent escalation for true red flag sepsis triggers
- Deteriorating Patient Reviewer (DPR) is currently in place and managed by Emergency Physician in Charge in ED. There will be a specific clinician assigned and dedicated to log in DPR VOCERA device at the beginning of their shift to review and provide timely assessment, treatment and escalation of patients who triggers for medium to high risk sepsis.

Sepsis Screening Compliance ALL Maternity

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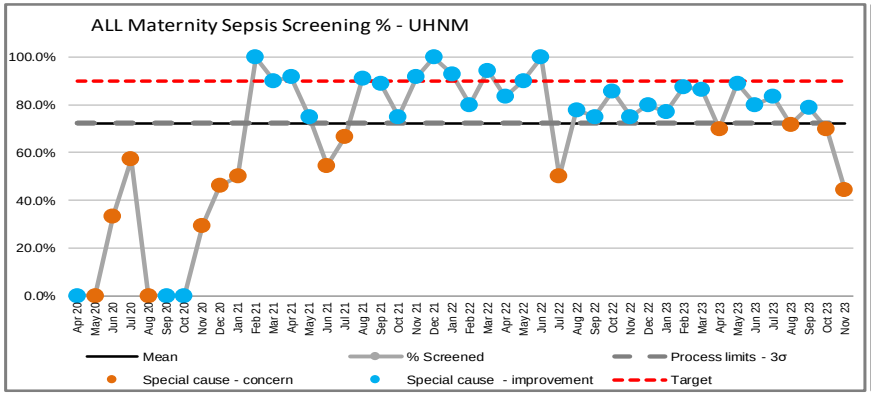

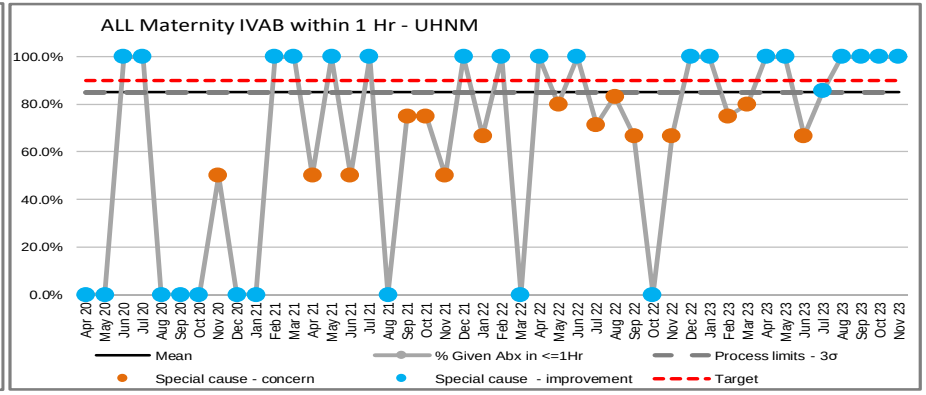

Variation	Assurance
L	F

Target	Sep 23	Oct 23	Nov 23
90%	78.9%	70.0%	44.4%

Background

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

Variation	Assurance
H	F

Target	Sep 23	Oct 23	Nov 23
90%	100%	100%	100%

Background

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

What is the data telling us:

Maternity audits in screening compliance is below target this month for emergency portals. Inpatient areas are also well below target for screening however they achieved 100% for IVAB within 1 hour. This compliance score is based on a very small number (9 cases).

There were 6 cases audited from emergency portal (MAU) and 3 cases from inpatients with total of 5 missed screening (has been escalated but no documentation in the screening tool).

Actions:

- Maternity antibiotic PGD has been drafted and is currently under review by the Pharmacy Team; still awaiting finalisation
- Monthly Maternity sepsis skills drill is now replaced with ad hoc sepsis sessions in each clinical areas; on-going
- 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

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS
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Non-Elective Care

- Context
  - ED Conversion decreased slightly from 32.4% in October to 31.7% in November
  - 12 Hour Trolley Waits deteriorated from 1059 in October to 1175 in November
  - Type 1 A&E Attendances decreased slightly from 14435 in October to 13400 in November

- Driver Metrics
  - Four Hour Performance broadly maintained in November at 64.7% from 65.3% in October
  - 12+ Hours In ED improved to 2019 in November from 2194 in October
  - Ambulance Handovers <60 Minutes again significantly deteriorated to 67.0% in November from 77.0% in October

Diagnostics Summary

- DM01 activity in November remained above 19/20 levels.
- DM01 performance was 78% overall in November, an improvement of 2% from October (76%).
- Endoscopy performance is the main contributor to this performance being below the national target of 99%
- The DM01 position for non obs ultrasound has achieved the trajectory and delivered DM01

Endoscopy:

- Insourced weekend service continues until end Feb 2024 and extending into County site, following external funding from WMCA. This resource is specifically to support reducing cancer wait time
- Routine, urgent, surveillance and planned patients continue to have wait more than their target date. Maximising in week sessions and use of CNS TIs to support these cohorts
- Long term trajectory and resource requirement submitted but funding not currently available to further drive on no-cancer cohorts
- November saw a further reduction in total number of patients waiting above their target date
- Service team continuing to work on demand management strategies and productivity measures to improve utilisation and appropriateness (including clinical audit, admin and clinical validation)
- Improvements in mean referral to test across all priorities
- Sustained improved booking performance for lower cancer PTL patients – now 2-3wks notice (was 3 days)
- Improvement plan ongoing and workstream leads progressing actions

Spotlight Report from Chief Operating Officer

NHS
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Referral to treatment (RTT Planned Care and Elective Recovery

- At the end of November the validated numbers of >104 patients was 1. The current prediction for end of December is 1. This is the same patient who is awaiting a custom made shoulder from Italy.
- The provisional number of 78 week breaches for end of November was 127, an improvement on October (138). This was predicted to be 79 for December, but this will be impacted by further industrial action during December.
- The focus has moved to 65 weeks. There are a number of specialties which are challenged however there are plans being put in place to mitigate these. The un-validated 65 week position for October was 1,189, up from 1,127 in October (validated). This position is likely to improve with validation.
- The overall Referral To Treatment (RTT) Waiting has decreased this month to 80,484 (unvalidated), down from 81,240 in October.
- Day Case activity and Elective Activity have moved from delivering 82% and 82% respectively for October to 89% and 87% for November. The Trust has now launched the national standard 6-4-2 process within theatres with support from the regional theatres team. Day case as a % of all elective work is currently 86.5%.

Cancer

- From October, Cancer Waiting Times standards have been amalgamated in to three simplified metrics; 28 Day Faster Diagnosis set at 75%, 31 Day Decision to Treat to Treatment set at a 96%, and 62 Day Referral to Treatment set at 85%
- Although cancer standards are now combined, UHNM continues to monitor 14 day and subsequent treatment breakdowns as follows:
- Trust overall 14 Day Performance achieved 94% in Oct 23 – un-validated 95% for November. This sustained improvement is as a result of schemes such as the Lower GI Community Referral hub and Community Tele-dermatology pathways being successfully implemented.
- Breast symptomatic 14 Day (where cancer is not suspected) achieved at 90% in Oct and is predicted to achieve the target again in November.
- The combined 62 Day Standard achieved better than predicted in October at 59.3%. The current provisional position for November is 61.2%. This is an un-validated and incomplete position that is expected to change as pathology confirms or excludes cancer for treated patients. Contributing factors include treatment and diagnostic capacity, with robust plans in place to tackle the most challenged specialties (LGI) over the next quarter.
- The combined 31 Day Standard achieved 87.9% in October. It is predicted to land at 83% in November.
- The combined Faster Diagnosis Standard achieved 66% in October. It is also predicted to land at 66% in November.
- The 31 day Subsequent Radiotherapy achieved 95.9% in October and is expected to achieve 88% in November.
- The 31 day Subsequent Surgery achieved 66% in October and is expected to achieve 49% in November.
- The 31 day Subsequent Anti Cancer Drugs achieved 94.7%% in October and is expected to achieve (8% in November.
- The total GP referred suspected cancer PTL sits around 3200 in total currently; a reduction of 400 since last month.
- The number of patients waiting over 62 days on an open pathway as of 03/12/23 was 360 – a reduction of 60 patients since the previous month.
- UHNM continues to receive and see a high volume of GP suspected cancer referrals, more than usual seasonal demand plus the predicted growth, with some weeks exceeding 1000 referrals received.

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Section 1: Non-Elective Care

Headline Metrics

Non-Elective Care – monthly *(context)*

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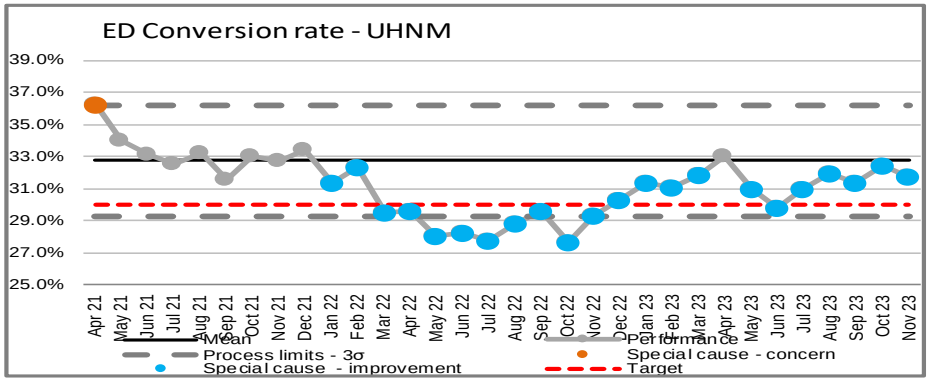
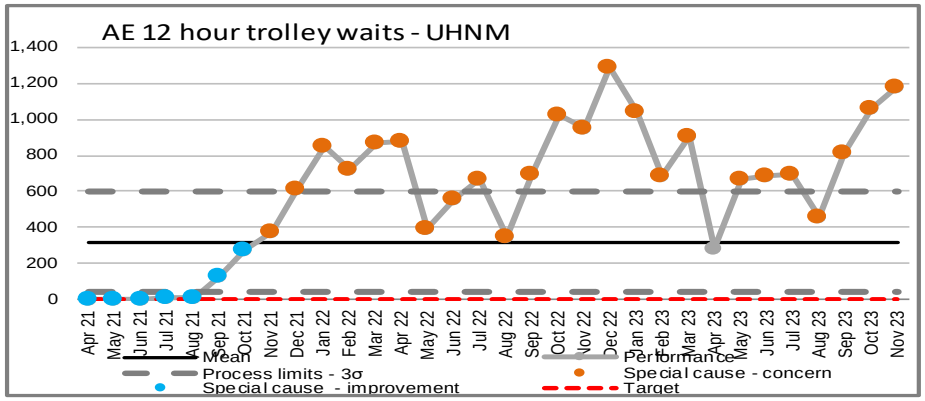


Variation	Assurance
L	?

Target	Sep 23	Oct 23	Nov 23
30%	31.4%	32.4%	31.7%

Background

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

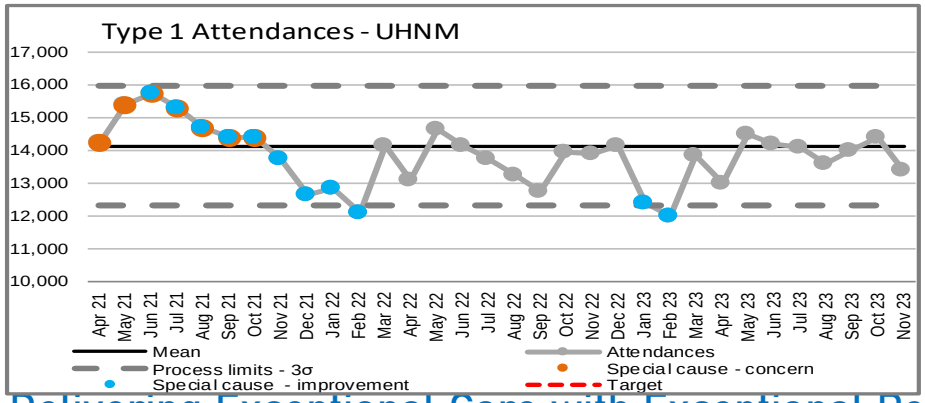


Variation	Assurance
H	F

Target	Sep 23	Oct 23	Nov 23
0	811	1059	1175

Background

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



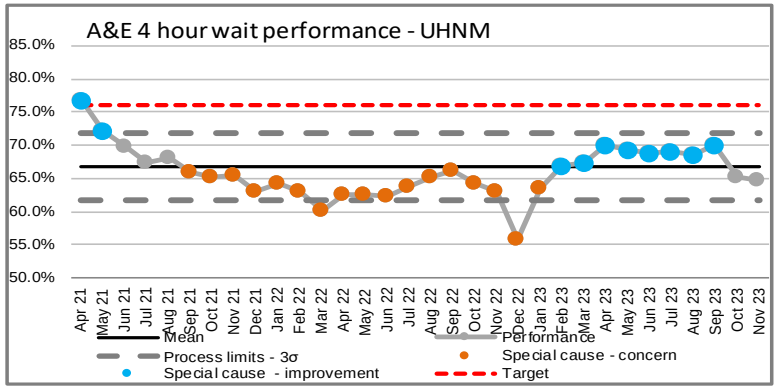
Variation	Assurance

Target	Sep 23	Oct 23	Nov 23
N/A	14005	14435	13400

Background

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

Non-Elective Care – Headline Metrics



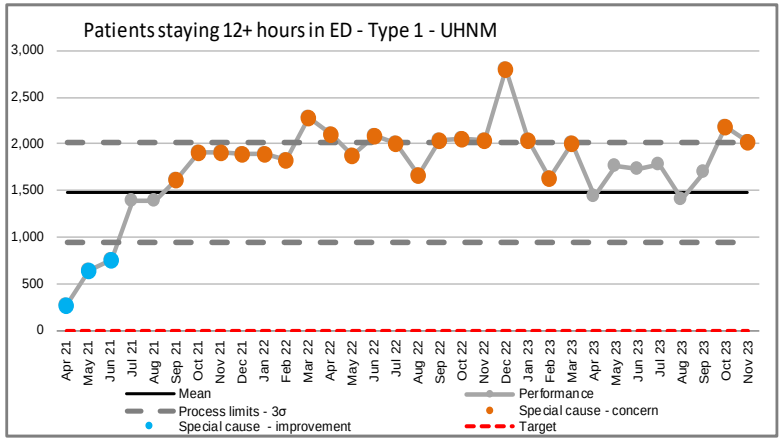
Variation	Assurance
	F

Target	Sep 23	Oct 23	Nov 23
76%	69.9%	65.3%	64.7%

Background

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

4 hour performance remains below the 76% target and has dropped below the two year average for the second month. Performance remains above November 2022 levels.



Variation	Assurance
H	F

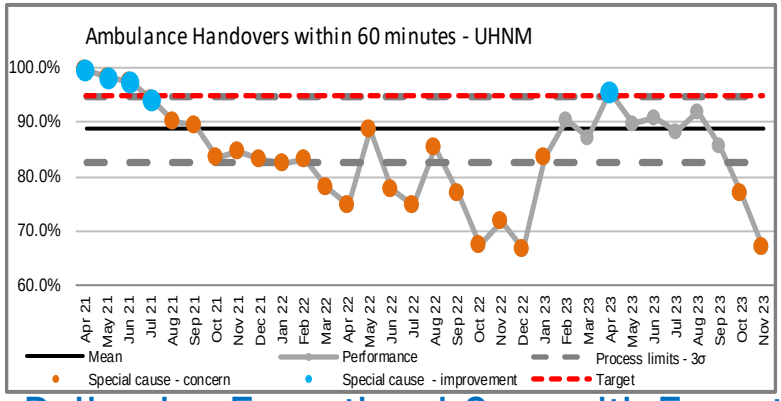
Target	Sep 23	Oct 23	Nov 23
0	1691	2194	2019

Background

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

What is the data telling us?

Patients waiting over 12 hours in reduced in November, but continues to remains above normal variation. Volumes in November were aligned to November 2022.



Variation	Assurance
L	F

Target	Sep 23	Oct 23	Nov 23
95.0%	85.8%	77.0%	67.0%

Background

The percentage of ambulance handovers completed within 60 minutes.

Ambulance handovers within 60 minutes performance dropped considerably in November. These levels are aligned to levels seen during Q3 2022/23.

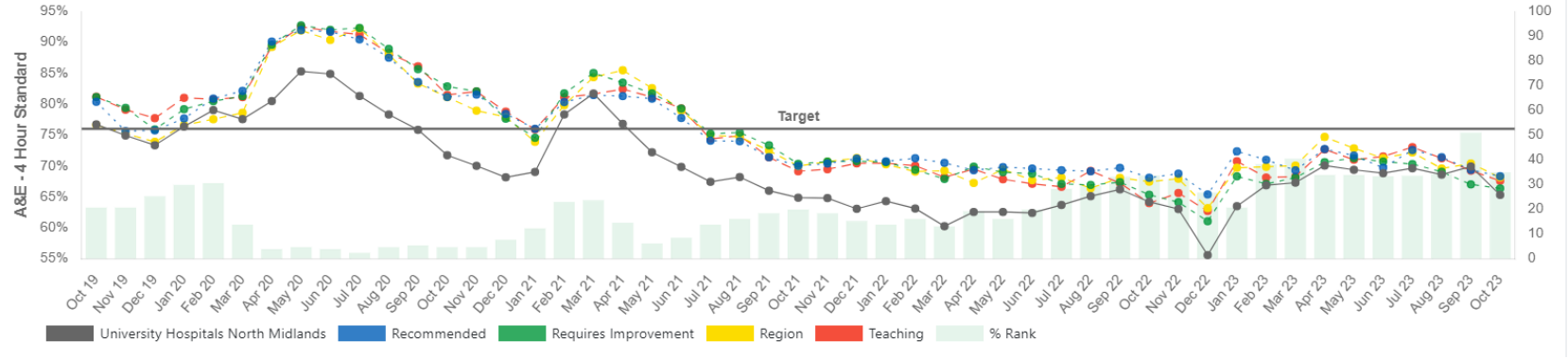
Urgent Care - 4 hour standard

NHS University Hospitals of North Midlands NHS Trust

A&E - 4 Hour Standard

Oct 23 Performance: 65.31% | Rank: 94th of 144

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



- 4 hour performance across all peer groups has been on a declining trend since July 2023.
- UHNM saw a sharp deterioration between September and October than other peer groups.
- UHNM were at the top of quartile 3, however this has deteriorated to the lower half of quartile 3.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Sep 23	1.0%	12.2%	
A&E - 4 Hour Standard	Oct 23	76.00%	65.3%	
A&E - 4 Hour Standard (Type 1)	Oct 23	76.0%	45.9%	
A&E - 4 Hour Standard (Type 2 or 3)	Oct 23	95.0%	97.0%	
A&E - Conversion Rate	Oct 23	25.0%	26.3%	
A&E - DTA to Admission >12 Hours	Oct 23	0.0%	17.3%	
A&E - DTA to Admission >12 Hours#	Oct 23	0.0	1,057.0	
A&E - DTA to Admission >4 Hours	Oct 23	10.00%	32.4%	
A&E - Left Without Being Seen	Sep 23	5.00%	5.2%	
A&E - Reattendance Rate	Sep 23	5.0%	9.1%	
A&E - Time to Initial Assessment	Sep 23	15.0	7.0	
A&E - Time to Treatment	Sep 23	60.0	73.0	
A&E - Total Time in A&E	Sep 23	160.0	169.0	
A&E - Total Time in A&E (Admitted)	Sep 23	180.0	-	
A&E - Total Time in A&E (Non-Admitted)	Sep 23	140.0	147.0	

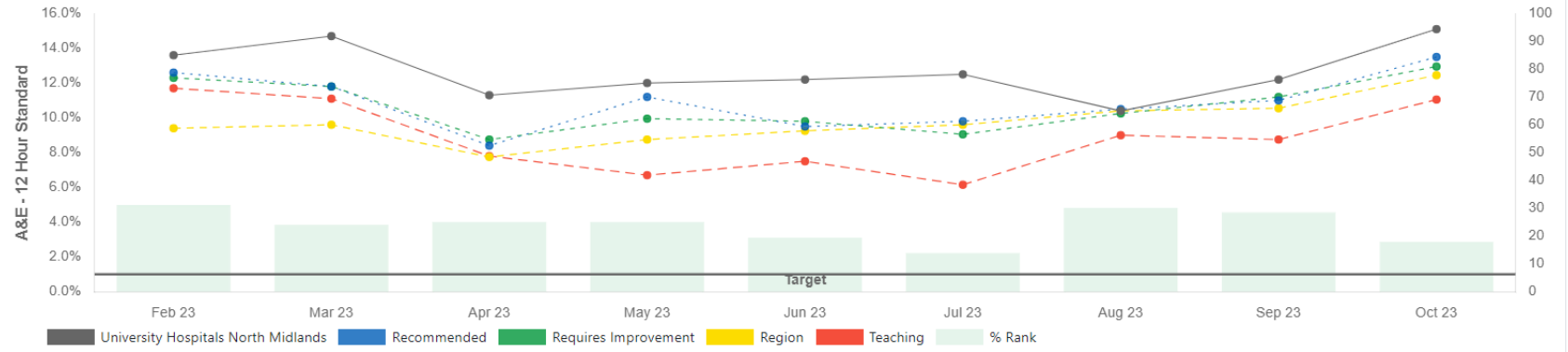
Urgent Care - 12 hour standard

NHS University Hospitals of North Midlands NHS Trust

A&E - 12 Hour Standard

Oct 23 Performance: 15.1% | Rank: 102nd of 124

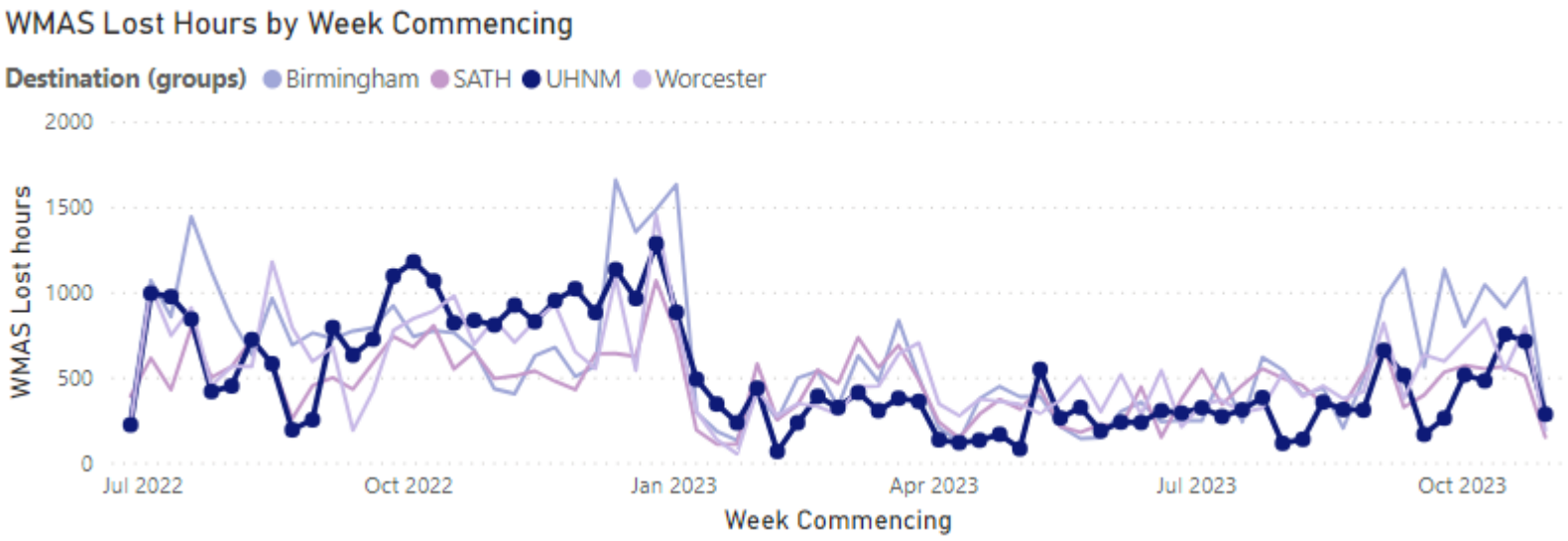
Ranking | Trend | Delta | SPC | ICS | Siblings | Data | Detail



- All peer groups have followed a similar trend since February.
- Although all peers increased in October, UHNM saw a greater increase.
- UHNM have moved to the bottom quartile since the last report where they were in the 3rd quartile.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Oct 23	1.0%	**15.1%**	
A&E - 4 Hour Standard	Oct 23	76.00%	**65.3%**	
A&E - 4 Hour Standard (Type 1)	Oct 23	76.0%	**45.9%**	
A&E - 4 Hour Standard (Type 2 or 3)	Oct 23	95.0%	97.0%	
A&E - Conversion Rate	Oct 23	25.0%	**26.3%**	
A&E - DTA to Admission >12 Hours	Oct 23	0.0%	**17.3%**	
A&E - DTA to Admission >12 Hours#	Oct 23	0.0	**1,057.0**	
A&E - DTA to Admission >4 Hours	Oct 23	10.00%	**32.4%**	
A&E - Left Without Being Seen	Sep 23	5.00%	**5.2%**	
A&E - Reattendance Rate	Sep 23	5.0%	**9.1%**	
A&E - Time to Initial Assessment	Sep 23	15.0	7.0	
A&E - Time to Treatment	Sep 23	60.0	**73.0**	
A&E - Total Time in A&E	Sep 23	160.0	**169.0**	
A&E - Total Time in A&E (Admitted)	Sep 23	180.0	-	
A&E - Total Time in A&E (Non-Admitted)	Sep 23	140.0	**147.0**	

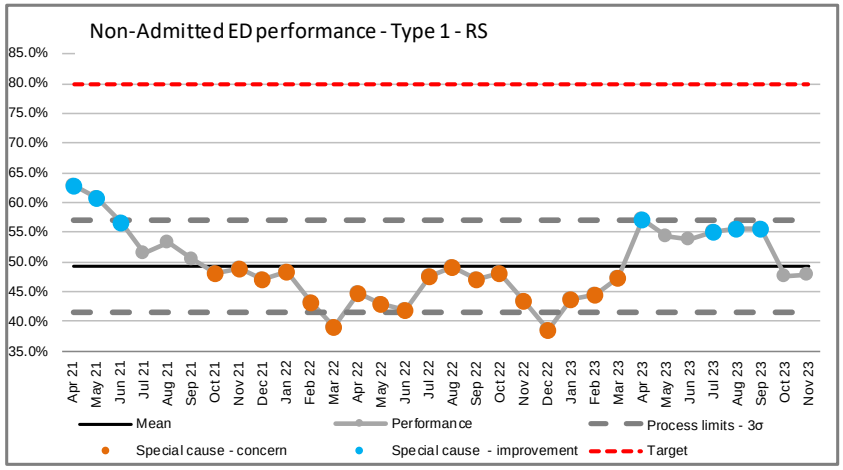
Urgent Care – Ambulance Handover Delays



- WMAS Ambulance handover delays over 60 minutes apportioned to four Trusts.
- During October UHNM have seen a worsening trend, but remains below/within peer trusts.

Data source: WMAS 09/11/23

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



Variation	Assurance
	F

Target	Sep 23	Oct 23	Nov 23
80%	55.7%	47.6%	47.9%

Summary

Four Hour Non-Admitted (NAD) performance was 47.9% in November against a trajectory of 80%. While this has undoubtedly been impacted by operational pressures, it is significantly below expected performance and that of our peers. The weekly Four-Hour Recovery Cell meetings continue now chaired by the Chief Operating Officer in order to ensure robust oversight and scrutiny.

Actions

1) Following a below expected impact of the Ambulatory CDU opening on 14-Nov a review of practice and inclusion criteria is now to be undertaken to identify how to increase referrals into this area to ensure optimised utilisation

2) Implementation of a 24/7 Progress Chaser in Ambulatory has again faced delays as a result of long-term sickness and recruitment challenges. Posts have once again been recruited with full night coverage schedule to commence 18-Dec.

3) Productivity actions have been implemented by the CD which includes a two-hour hour see, treat, and discharge window for ambulatory patients. This is to be supported by the upcoming Capacity, Demand, & Productivity Dashboard currently in its final phases of testing and scheduled to go live 02-Jan.

4) SiFT and EhPC virtual training for the middle grade medical tier is being developed during December which aims to increase the EhPC referrals and diversion to other portals early in the patient journey

5) Expansion of the EhPC operating model is due to go live on 09-Jan which will lead the greater utilisation as a result of a single streaming model across the entire service.

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

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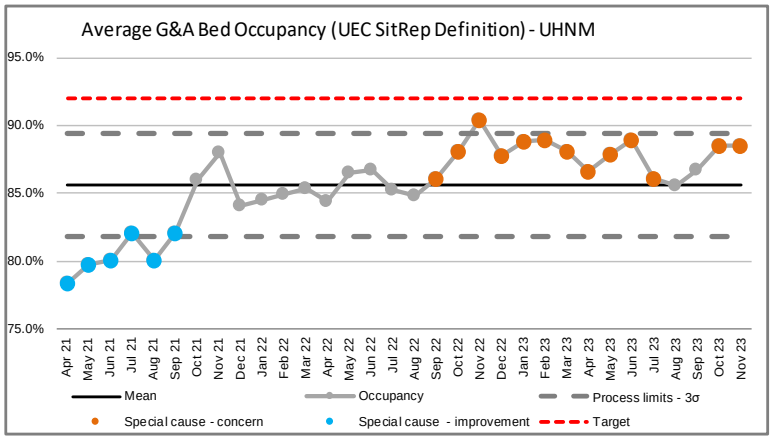
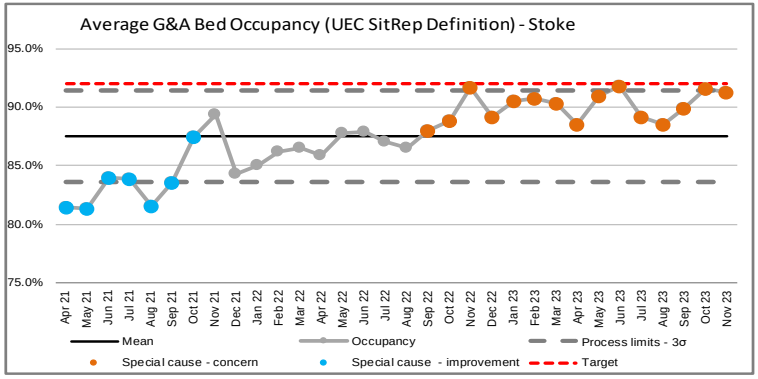


Variation	Assurance
H	P

Target	Sep 23	Oct 23	Nov 23
92%	86.8%	88.5%	88.5%



Summary

UHNM G&A Bed Occupancy achieved again 88.5% for November. This is slightly worse than the submitted Annual Operational Plan trajectory of 91.63% and continues to place UHNM well above median regionally supported by County Hospital and Paediatric occupancy.

This slightly worse than expected position is aligned to extremely challenged November which saw Critical Incident level pressures, particularly towards the end of the month. While this was described in the SSOT System Winter Surge Plan, delays in a number of community schemes created extreme risk throughout the system.

It should be noted that it is expected that in January there will be an improvement in occupancy as the final delayed community winter escalation capacity comes online.

Actions

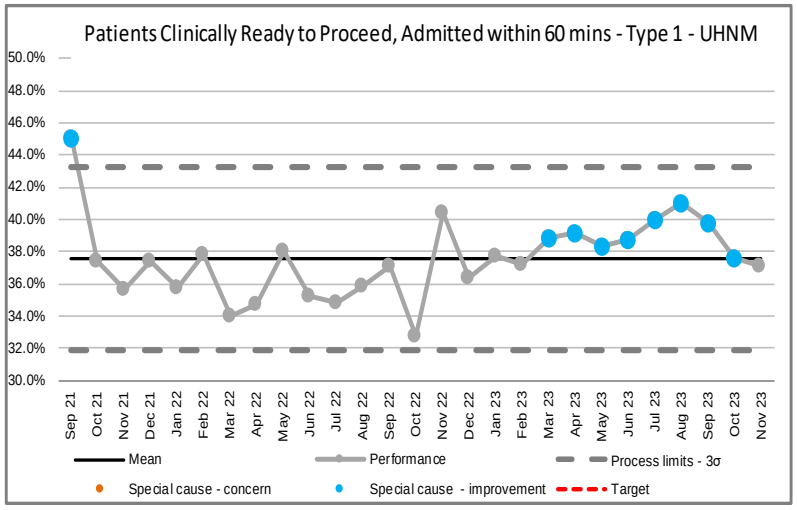
1) Continue OPAT development as per the agreed project plan targeting an acute bed equivalent increase of five per month until March. Estates provision has been provisionally agreed in October with Space Utilisation Group ratification expected 14-Dec in order to ensure appropriate clinical space for the service to operate under current circumstances and room for future growth

2) Complete the NELIP Refresh which has been delayed as a result of Trust wide pressures and Critical Incident declarations. This refresh will build on the existing Workstream 2 and ultimately target LOS and early discharges.

3) It has been announced that two years of non-recurrent funding is available to support Trust Bed Management. Options are currently under discussion in light of recent digital investment scrutiny.

Workstream 3; Acute Portals & Navigation
CRTP+1

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
	

Target	Sep 23	Oct 23	Nov 23
90%	39.8%	37.6%	37.2%

Summary

CRTP+1 performance was 37.2% in and remains one of the areas requiring the most significant improvement across the NEL Improvement Plan. This performance improvement remains challenging with high occupancy in the deep bed base, driven in part by a high frailty conversion rate of 57.8% well above GIRFT benchmarking target of 39%. These factors then have contributed to an AMU LOS now at its highest for this financial year of 39.5 hours. However, these impacts will have been mitigated by a continued strong SDEC utilisation performance at RSUH of 41.1% compared with the national target performance of 30%.

Actions

1) The Frailty TOC remains ongoing following the positive initial outcomes previously shared including a 133% increase in TOC referrals (which were previously delayed), a 157% increase in discharges, and a fivefold increase in reinstatements. Given these results plans are now been scoped to extend and further develop this TOC the maximise opportunities including the potential recruitment of an AHP Frailty Consultant to lead further work.

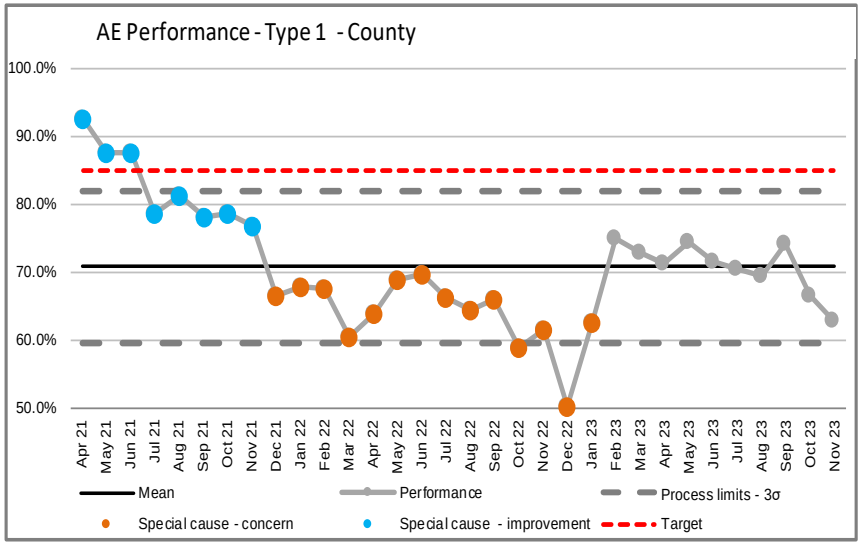
2) The recent GIRFT and ECIST visit highlighted a significant deficit in required acute medical capacity, specifically AMU beds, nursing ratios, and medical workforce to process expected demand. Options are now being considered for how this might be addressed, although it is expected that this will not be a short term solution.

3) The development of standard process for management and completion of discharge summaries and TTO on AMU is underway which is scheduled to be completed by 08-Dec and will support a consistent approach to the movement of patients off AMU.

4) Implementation of standard work with robust monitoring within ED to ensure all appropriate COVID19 patients are identified and swabbed prior to moving to AMU, this is due to be completed by 01-Dec and will aim to minimise highlighted preventable delays in patients moving after an already extended amount of time to the acute portal.

Workstream 4; County Hospital UEC
County Hospital Four Hour Performance

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
	

Target	Sep 23	Oct 23	Nov 23
85%	74.1%	66.5%	62.8%

Actions

1) Review of AMU specific actions continues and is led by new the Clinical Champion in response to a lack of sustained improvements.

2) LOS reviews continue for long stay patients as part of wider LOS improvement standard work focussing on EDD, frailty scoring, and criteria to reside.

3) Exploration on the surge in attendances that affect triage is being undertaken with the aim to run a Test of Change of a more responsive workforce model with a view to build in further resilience.

4) Process confirmation underway to determine further efficiencies that can be gained through Standard Work in the Ambulatory Areas in order to decongest the department in times of high activity and improve Four Hour Performance with quick wins.

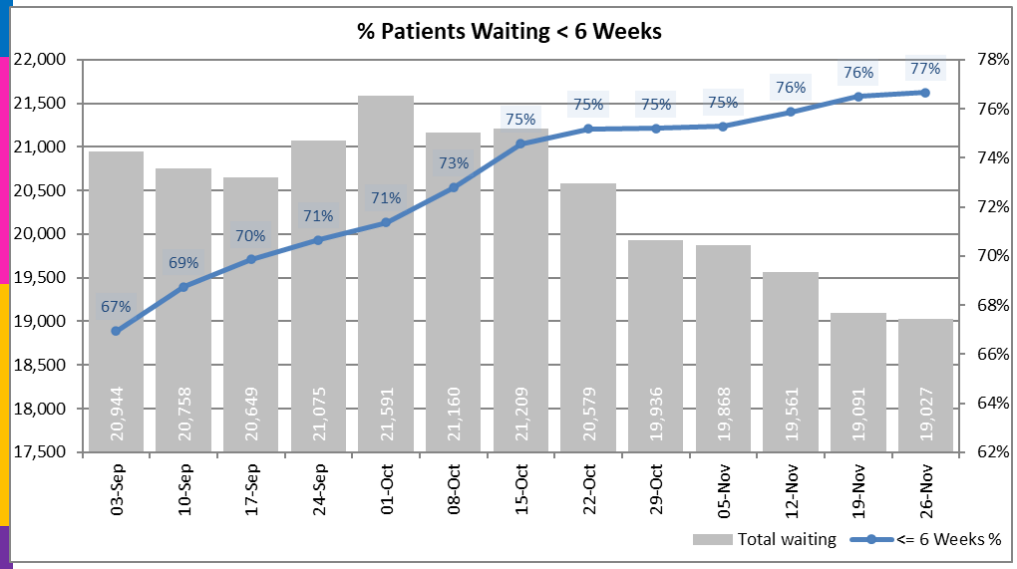
Summary

The Four-Hour Standard for County Hospital in November performed at 62.8% against a trajectory of 80%. While triage time is currently performing at a mean time of 33.4 minutes, below the national target of fifteen minutes, it is worth noting that this is a maintenance of significantly improved performance over the last six months and heading into a challenged winter.

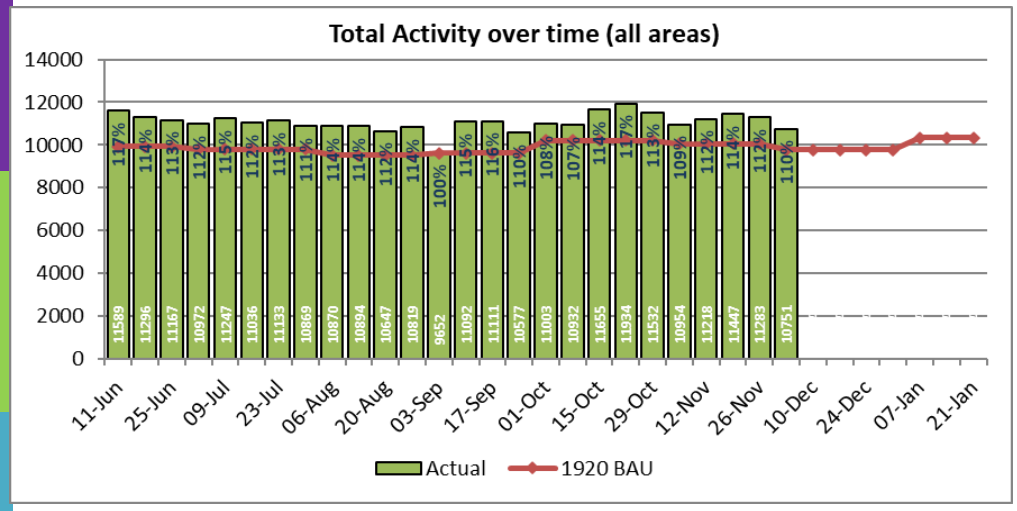
Section 2: ELECTIVE CARE

Planned Care - *Diagnostics*

NHS University Hospitals of North Midlands NHS Trust



Test	<=6	6-9	10-12	13+ Wks	Total	% <6Wks
Magnetic Resonance Imaging	3,091	67	1	1	3,160	98.0%
Computed Tomography	3,490	53	1	7	3,551	98.8%
Non-obstetric Ultrasound	4,014	51	8	0	4,073	98.0%
DEXA Scan	0	0	0	0	0	
Cardiology - Echocardiography	1,321	624	50	47	2,042	64.3%
Cardiology - Electrophysiology	0	0	0	0	0	
Colonoscopy	588	223	125	1,108	2,044	29.3%
Flexible sigmoidoscopy	324	142	74	835	1,375	23.7%
Cystoscopy	180	19	7	49	255	68.7%
Gastroscopy	462	189	128	327	1,106	40.9%
Neurophysiology	406	77	0	0	483	94.7%
Respiratory physiology	341	51	42	24	458	72.3%
Urodynamics	0	0	0	0	0	
Total	**14,217**	**1,496**	**436**	**2,398**	**18,547**	**77%**



Pathology:

The following represents performance as at November 2023;

- **Urgent** (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day 16 (Previously Day 15), with 80% of cases reported by Day 10

- **Accelerated (include all Cancer Resections):** 95% reported at Day 28 (Previously Day 27), with 80% of cases reported by Day 17 (Previously Day 17)
- **Routine (all Specimens not in above categories):** 95% Day reported at Day 28 (Day 27), with 80% of cases reported by Day 16 (Previously Day 18)

7 day reporting turnaround time (TAT) for Urgent cases: 60.5% against the Royal College of Pathologists' target of 80% within 7 days (61.9% previously)

Delivering Exceptional Care with Exceptional People

Planned care - *Diagnostics*

NHS University Hospitals of North Midlands NHS Trust

Diagnostics Summary

- DM01 activity in November remained above 19/20 levels.
- DM01 performance was 78% overall in November, an improvement of 2% from October (76%). Endoscopy performance is the main contributor to this performance being below the national target of 99%
- In pathology 7 day reporting turnaround time (TAT) for Urgent cases is at 60.5% against the Royal College of Pathologists' target of 80% within 7 days (61.9% previously)
- The DM01 position for non obs ultrasound has achieved the trajectory and delivered DM01

Endoscopy remains the highest impact on diagnostic pathways. The specialty has now been taken into internal special measures with a turnaround lead being allocated and a number of actions in place:

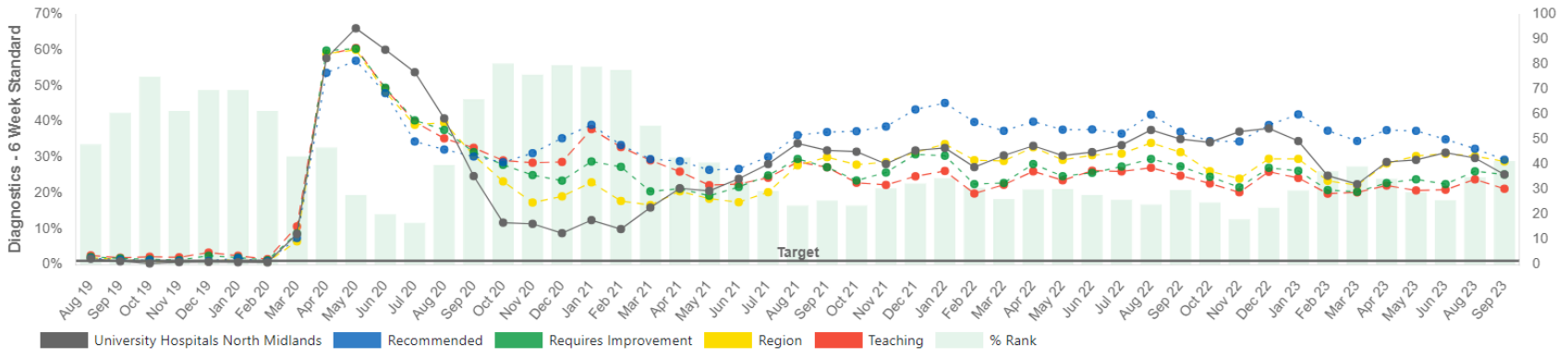
- Insourced weekend service continues until end Feb 2024 and extending into County site, following external funding from WMCA. This resource is specifically to support reducing cancer wait time
- Routine, urgent, surveillance and planned patients continue to have wait more than their target date. Maximising in week sessions and use of CNS TIs to support these cohorts
- Long term trajectory and resource requirement submitted but funding not currently available to further drive on no-cancer cohorts
- November saw a further reduction in total number of patients waiting above their target date
- Service team continuing to work on demand management strategies and productivity measures to improve utilisation and appropriateness (including clinical audit, admin and clinical validation)
- Improvements in mean referral to test across all priorities
- Sustained improved booking performance for lower cancer PTL patients – now 2-3wks notice (was 3 days)
- Improvement plan ongoing and workstream leads progressing actions

Diagnostics

Diagnostics - 6 Week Standard

Sep 23 Performance: 25.16% | Rank: 92nd of 156

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

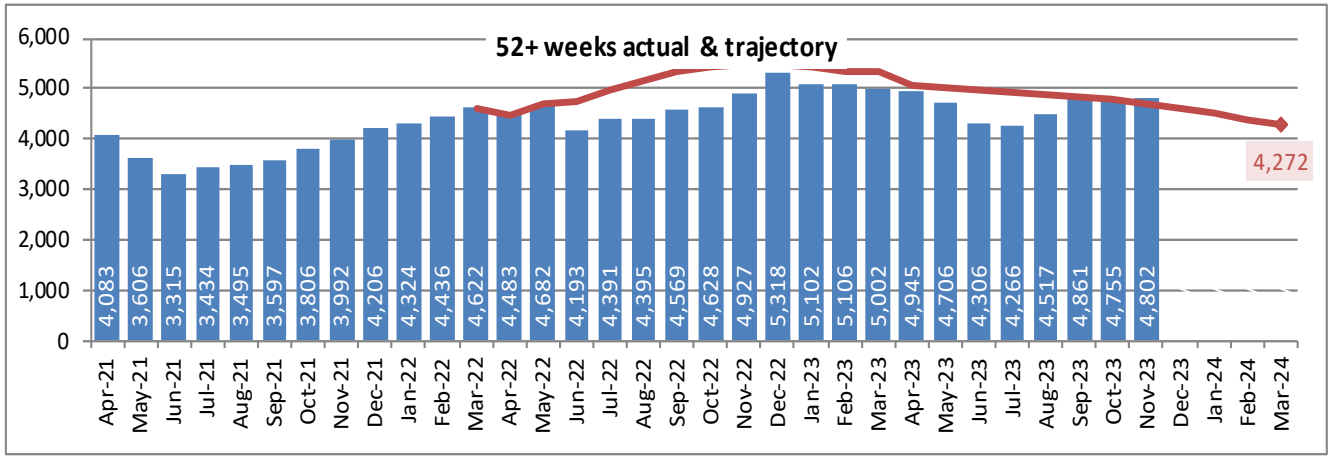


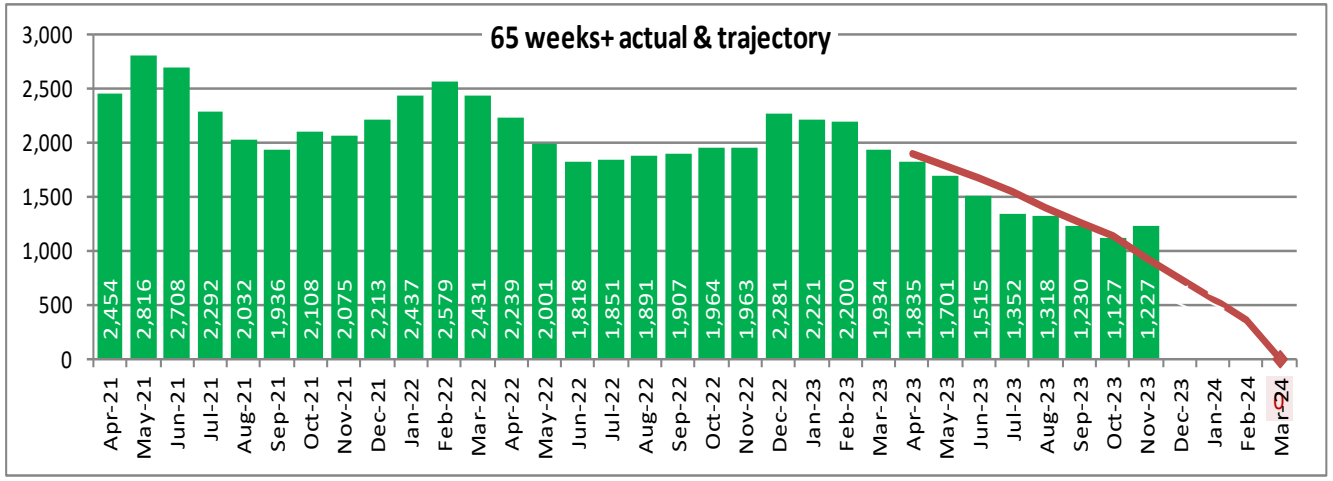
Key Performance Indicator	Period	Target		SPC
Audiology	Sep 23	1.00%	7.7%	
Colonoscopy	Sep 23	1.00%	64.5%	
Computed Tomography	Sep 23	1.00%	1.5%	
Cystoscopy	Sep 23	1.00%	4.6%	
DM01 Waiting <13 Weeks	Sep 23	100.00%	90.0%	
Diagnostics - 6 Week Standard	Sep 23	1.00%	25.2%	
Diagnostics - 6 Week Standard Reversed	Sep 23	99.00%	74.8%	
Echocardiography	Sep 23	1.00%	50.1%	
Electrophysiology	Sep 23	1.00%	100%	
Flexi Sigmoidoscopy	Sep 23	1.00%	72.6%	
Gastroscopy	Sep 23	1.00%	68.4%	
Magnetic Resonance Imaging	Sep 23	1.00%	2.6%	
Neurophysiology	Sep 23	1.00%	0.0%	
Non-obstetric Ultrasound	Sep 23	1.00%	14.8%	
Sleep Studies	Sep 23	1.00%	14.3%	
Urodynamics	Sep 23	1.00%	-	

- All peer groups are performing at a similar level, with UHNM in the middle of all groups.
- All groups including UHNM remain significantly above the 1% national target.
- Endoscopy and Echo modalities are seeing the biggest deterioration.
- UHNM remain in the 3rd Quartile.

Planned Care – *RTT*

NHS
University Hospitals of North Midlands
NHS Trust

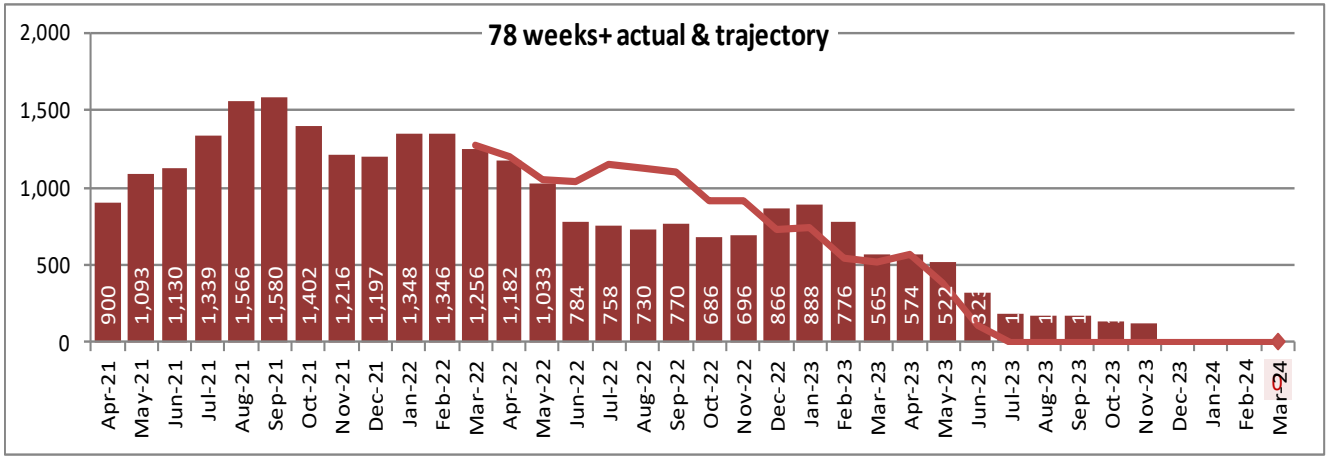




Patients waiting 52+ weeks increased further in November and exceeded the trajectory for the second month.

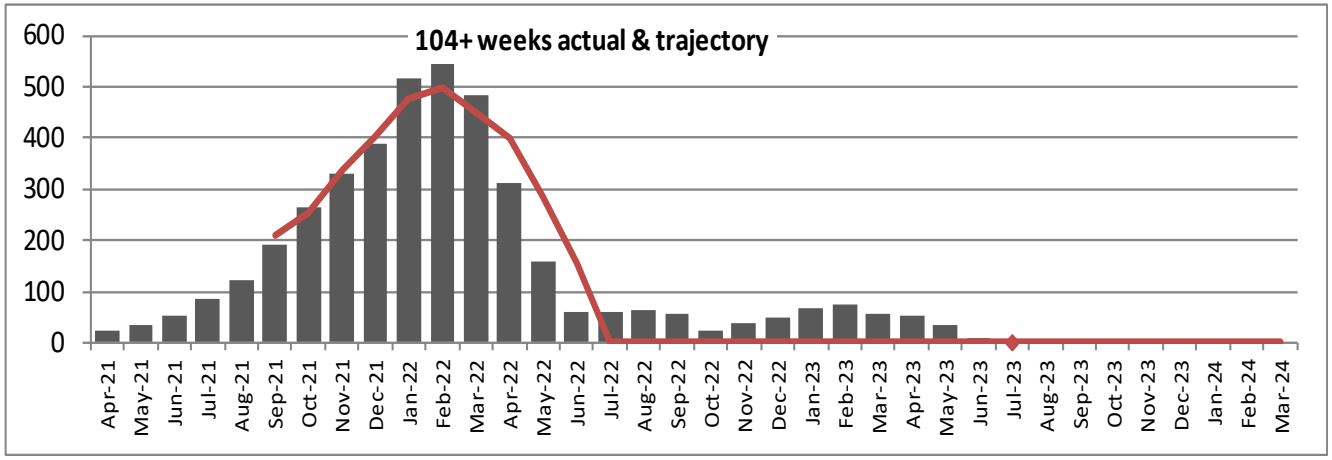
65+ week waiters increased in November following a reduction each month since February 2023. November exceeded trajectory for the first time.

Planned Care – *RTT Long Waiters*



The number of patients waiting over 78 weeks reduced by 12 in November, at 128.

November data is unvalidated.



There is one patient who has been waiting 104+ weeks in November.

Planned care - *RTT*

NHS University Hospitals of North Midlands NHS Trust

Summary

- 52+ week patients decreased during November to 4,802 (unvalidated).
- 78+ patients have been gradually reducing, but had reached a plateau in July at 186, this reduced to 177 for August, 170 for September, 138 in October and the unvalidated number for November was 127.
- The trust did not achieve the national ask of eliminating 78 weeks waits by end of March 2023. Plans are in place to minimise the number of breaches, so that only patients who choose not to be treated before end of March or who have a highly complex case are still waiting at 78+ weeks. Trajectories have been shifting due to industrial action.
- The overall Referral To Treatment (RTT) Waiting list now sits 80,484 end of November (unvalidated).
- The focus continues on 78w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 65 week+ patients with the introduction of a weekly elective management oversight group.
- At the end of November the number of > 104 weeks was 1.
- The IS have taken over 700 patients from Orthopaedics & Spinal (out of over 1000 considered), with a further 120 patients being worked through to contact & transfer.

RTT

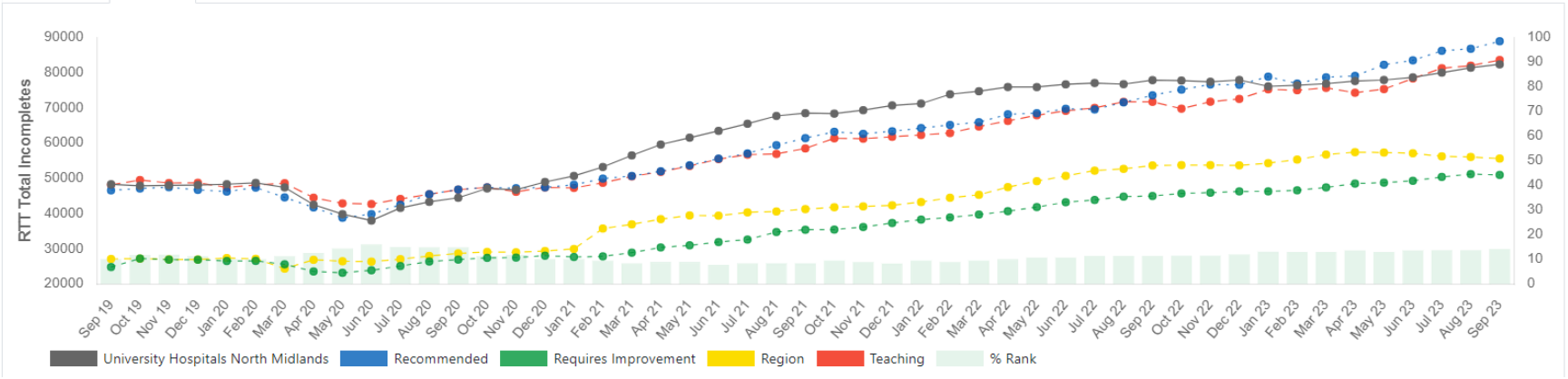
- Validation has increased slightly with some additional resource in the short term. The team are currently looking at validation capacity to provide an accurate picture of the resource required in the medium term to reduce the list, this includes electronic solutions.
- RTT Performance sits at 51.4% , an improvement on 50.4% in October.
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.
- The Trust is currently at 94% of all pathways over 52 weeks having been validated within the last 12 weeks. This is an improvement on last month's 85.2%
- The next national ask was to have all patients waiting longer than 12 weeks validated by 28th April 2023. The number currently not validated in the last 12 weeks is currently 39,865 down from 40,775 in October.
- 31,068 eligible patients waiting 12+ weeks were sent a validation form in October 2023, with 1,532 patients confirming they no longer wish to continue their pathway. 2,990 patients said their condition had changed since their referral. These are being worked through by the clinical divisions.
- Trust wide revamp of validation & training underway, the IST are supporting the Trust with events in September – December to train all admin staff working with RTT.
- NHSE's RTT training lead to deliver lecture style training and engagement sessions with specialty groups to enhance shared knowledge and address issues where national rules are not always followed. Sessions commenced September 18th.
- RTT Training now available on 'Articulate' eLearning software.
- RTT Training Strategy to be refreshed and re-launched starting in January 2024.
- Active reporting focus on ensuring the right patients (urgent and longest waiters) are the patients booked into all available capacity so that the limited resource available continues to be used for the right patients by clinical need. This is being scrutinised through a divisional weekly meeting with COO/Deputy
- Patient by patient monitoring by each specialty and by the corporate team on the patients at risk of the breaching 104 and 78 weeks by end of month, and month following.
- Key enablers to the continued focus on long waiting patients are ring fencing of beds for Orthopaedics at RSUH, modular theatre at County and improvement in theatre utilisation and booking.
- Increased focus on non-admitted patients and increasing outpatient & diagnostic capacity, improving utilisation and business processes to move patients to a decision to admit.
- Roll-out of Palantir's Foundry platform underway, validation of NON-RTT outpatient referrals commenced 21st November.
- External validation support sought from MBI, commenced 4th October

RTT

RTT Total Incompletes

Sep 23 Performance: 82,329 | Rank: 147th of 171

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



- UHNM saw relatively stable volumes from 2022 to June 2023, whilst other peers continued to see an upward trend.
- Since June, UHNM have seen a steeper increase.
- UHNM remain in the bottom quartile.

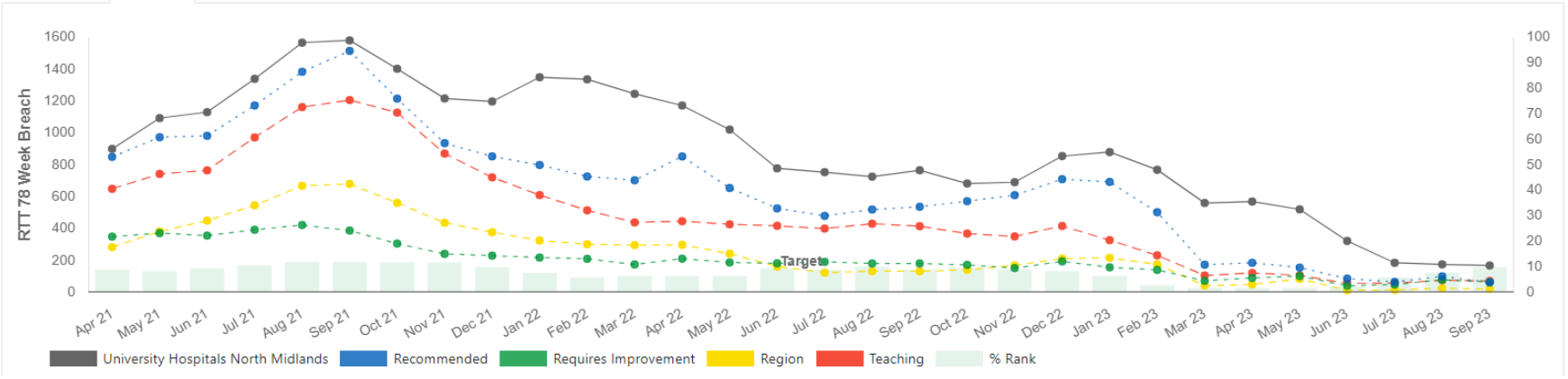
	Key Performance Indicator	Period	Target		SPC
950	RTT 104 Week Breach	Sep 23	0	1	
56	RTT 52 Week Breach	Sep 23	0	4,850	
1202	RTT 65 Week Breach	Sep 23	-	1,226	
949	RTT 78 Week Breach	Sep 23	0	169	
142	RTT 95th Percentile Admitted Waiting Time	Sep 23	18.0	75.1	
144	RTT 95th Percentile Non-Admitted Waiting Time	Sep 23	18.0	58.1	
135	RTT Admitted Treatment Within 18 Weeks	Sep 23	90.0%	55.6%	
141	RTT Average (Median) Admitted Waiting Time	Sep 23	9.0	13.9	
143	RTT Average (Median) Non-Admitted Waiting Time	Sep 23	5.0	8.9	
55	RTT Average Wait for Incomplete	Sep 23	7.00	17.6	
133	RTT Incomplete 92nd Percentile	Sep 23	-	49.1	
134	RTT Incomplete Pathways With a DTA	Sep 23	25.0%	15.1%	
136	RTT Non-Admitted Treatment Within 18 Weeks	Sep 23	95.0%	68.2%	
138	RTT Total Clock Starts	Sep 23	-	15,740	
137	RTT Total Clock Stops	Sep 23	-	14,274	
132	RTT Total Incompletes	Sep 23	-	82,329	

RTT

RTT 78 Week Breach

Sep 23 Performance: 169 | Rank: 154th of 171

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



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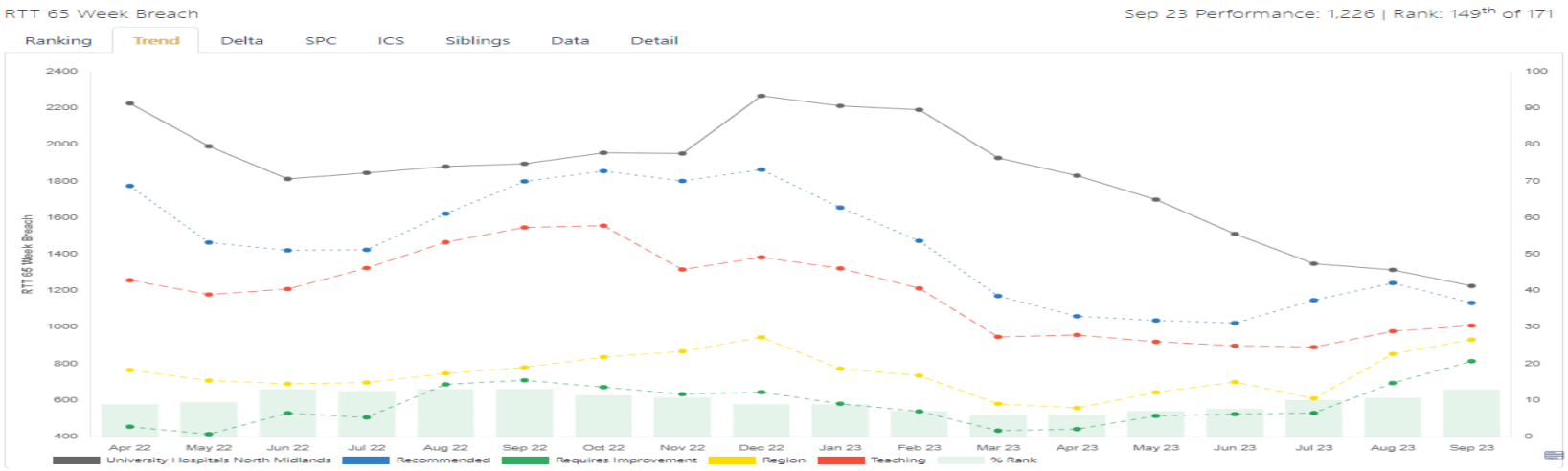
- After seeing a considerably drop in the volume of patients waiting 78+ weeks during 2023, volumes in July and August have plateaued and remain above all peers.
- UHNM remain in the bottom quartile.

Delivering Exceptional Care with Exceptional People

RTT



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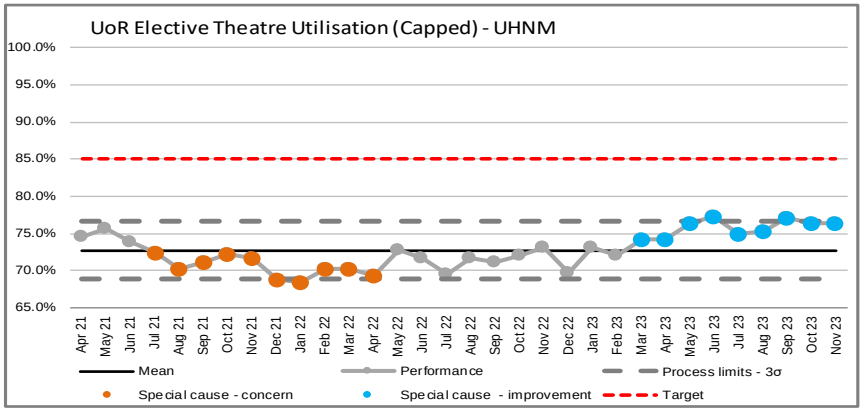
RTT Total Incompletes	Sep 23	-	82,329	

- Most peer groups have seen an upward trend over the last 3 months, however UHNM have continued to see a reduction.
- UHNM volumes still remain above all peer groups, but are now much closer to peers.
- UHNM remain in the bottom quartile.

Planned Care – *Theatres*

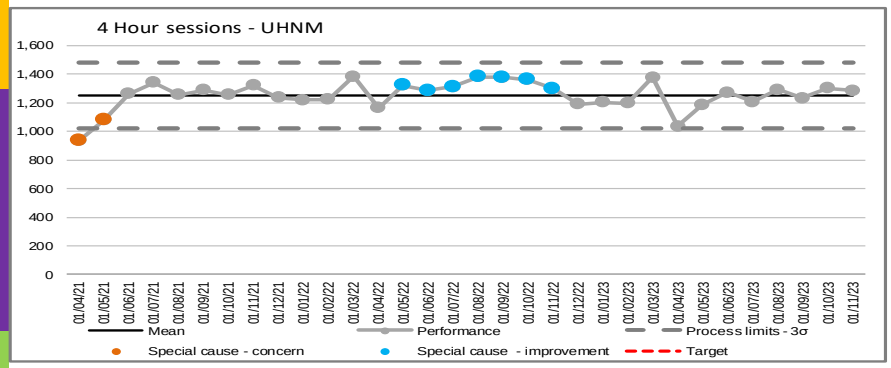


Variation	Assurance
H	F

Target	Sep 23	Oct 23	Nov 23
85%	77.1%	76.3%	76.4%

Background

The percentage of theatre time used (capped).

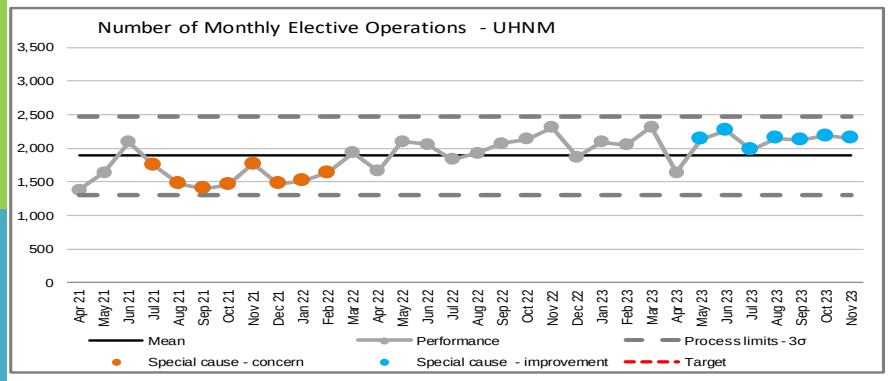


Variation	Assurance

Target	01/09/23	01/10/23	01/11/23
N/A	1233	1302	1285

Background

The number of 4 hour sessions during the month.



Variation	Assurance
H	

Target	01/09/23	01/10/23	01/11/23
N/A	2125	2184	2152

Background

The total number of elective operations during the month.

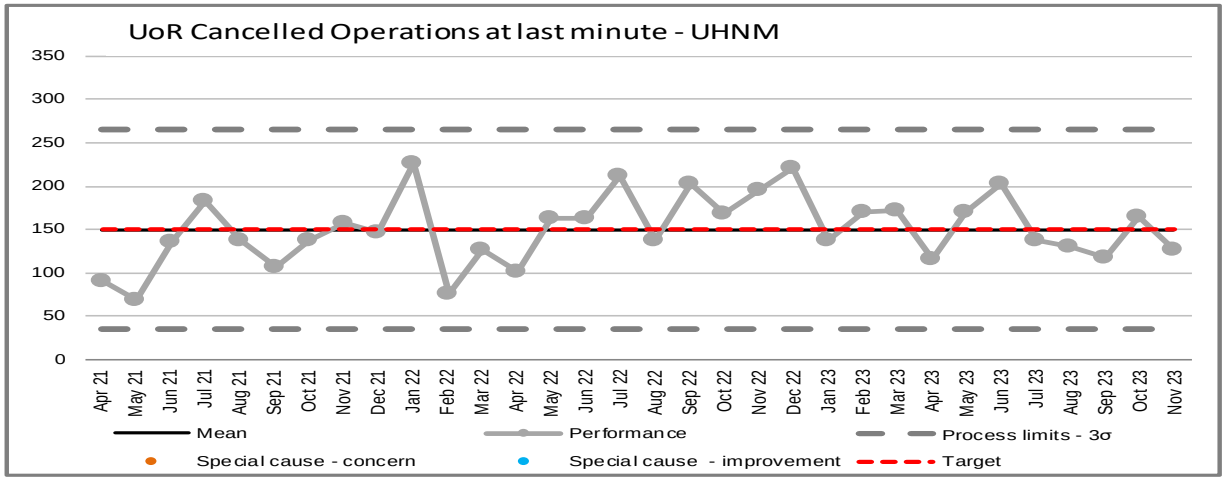
Capped Utilisation performance remained unchanged in November and remains within normal variation.

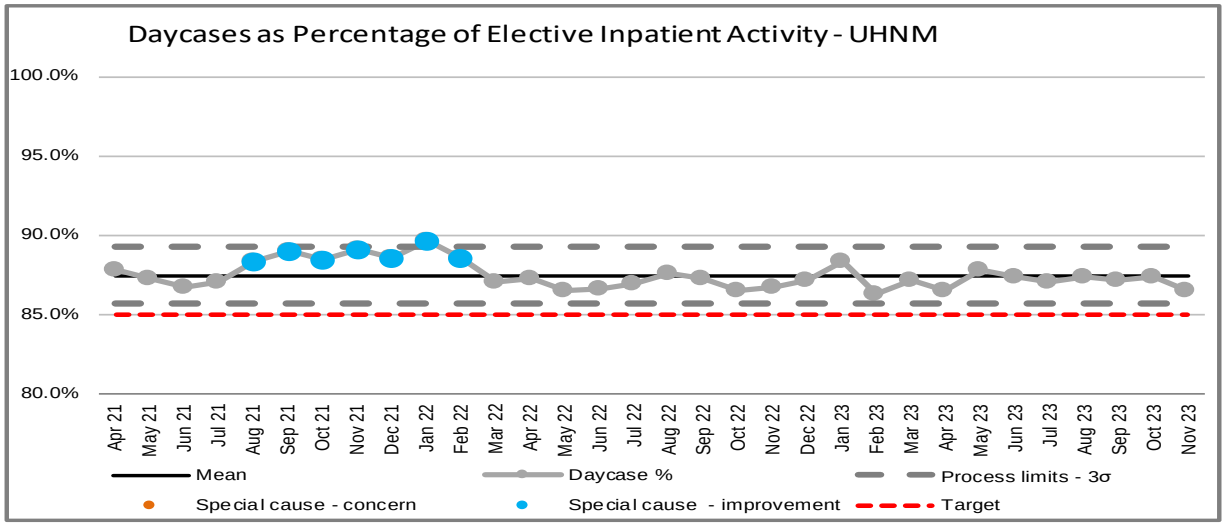
The number of 4 hour sessions saw a slight dip and remains above the 2 year average.

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

Delivering Exceptional Care with Exceptional People

Planned Care – *Theatres*





November saw a reduction in the number of cancelled operations and is much lower than November 2022.

The proportion of Daycase activity has dipped slightly in November, but continues to remain above the 85% target, *(total Trust split).*

Planned Care - *Theatres*

University Hospitals of North Midlands NHS Trust

Elective inpatients Summary

- Capped utilisation remains stable and above mean at 76.38% & Case numbers remain above the annual mean at 2152 for the month.
- Cancelled operations 9.1% which is improvement on October but remains as concern as higher than target – drivers include bed capacity and diagnostic delays leading to late scheduling and incomplete patient optimisation / delayed Pre-Assessment.
- Benchmarking to MHS demonstrated improved performance for caped utilisation. Work on-going to reconcile internal reported performance and MHS data – inclusion of 3rd site (County Hub) data set appears to have skewed reporting

Actions

- PACU patient flow escalation process launched
- 3rd Supportive Performance week focusing on Data Quality & PACU delays / Surgical Flow – Outcomes in final draft incorporating NHSE observations of Ward
- List Lockdown being re-inforced
- APOM regional Familiarisation meeting attended
- Session allocation meetings reviewed by NHSE support, observations feedback and suggestions for change being adopted
- Standby Patients process being trialled for Urology and specialised surgery with view to roll out to all appropriate areas
- Theatre Performance oversight to be increased to inform wider strategy – Meeting ToR re-drafted.

Theatres - Benchmarked

University Hospitals of North Midlands NHS Trust

University Hospitals of North Midlands NHS Trust

Include independent provider data? Chart View Table View

Select level: Provider

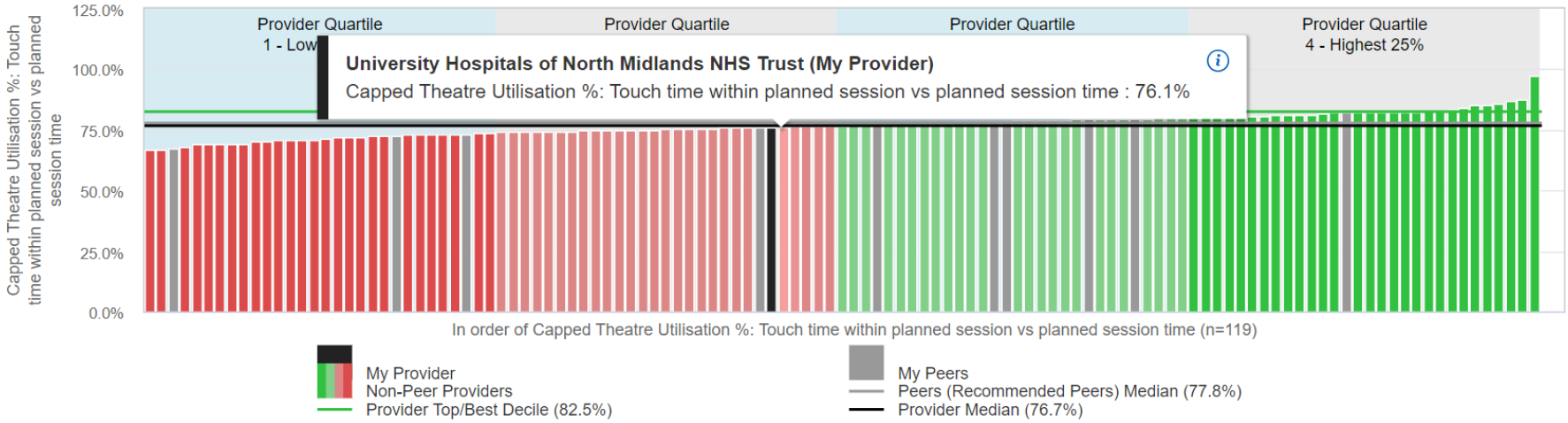
Select scope: National

Highlight system providers

Select chart type: Variation Chart

Capped Theatre Utilisation %: Touch time within planned session vs planned session time, National Distribution

Download



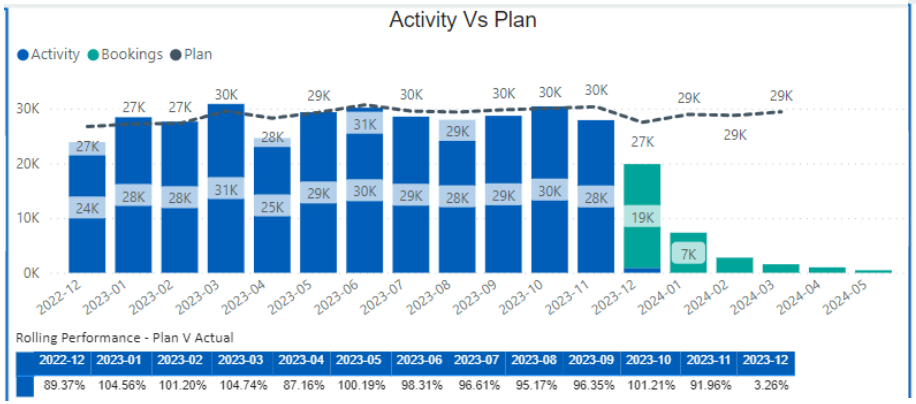
- UHNM have improved since last month from 70% to 76% and have moved from the bottom quartile to the third quartile.

Source data: Model Hospital 05/10/23

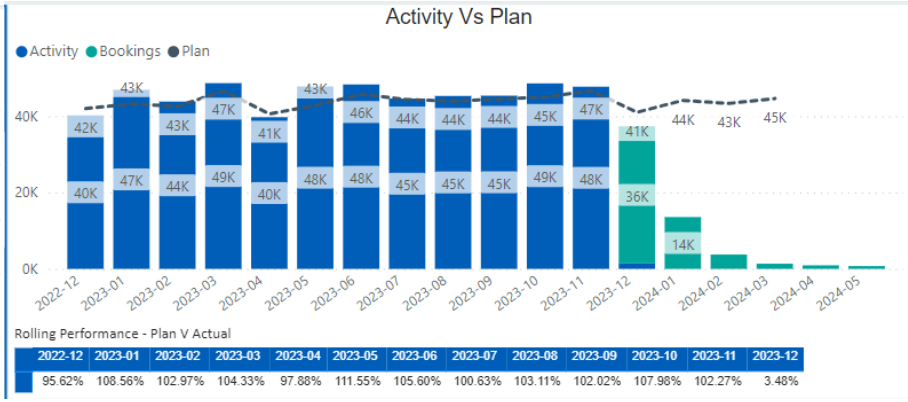
Planned Care – *Outpatients*

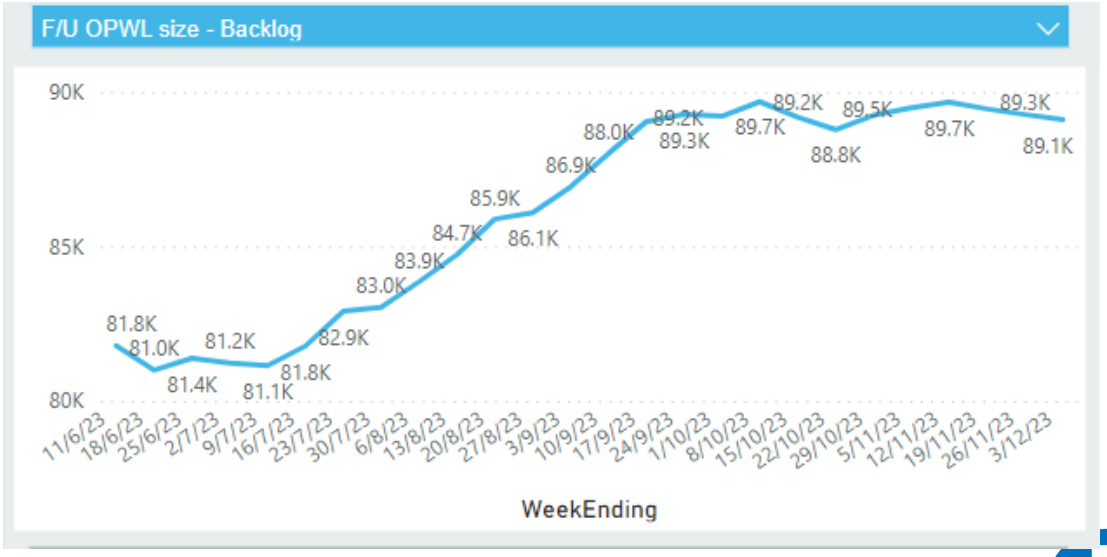
University Hospitals of North Midlands NHS Trust

New Outpatient Performance to Plan



Follow Up Outpatient Performance to Plan





New Outpatient activity performance was 92% of plan in November and 96% YTD. Outpatient Follow Up performance was 102% in November with YTD at 104%.

The Follow Up Backlog waiting list has reduced marginally through November.

Planned care – *Outpatients*

NHS
University Hospitals of North Midlands
NHS Trust

Actions

- **OP Cell Programme Structure** - revised and reframed to focus on reducing follow ups without a procedure by 25%, reflecting the latest Elective Recovery Guidance ambition. Meetings with NHSE have confirmed main elements covered. OP Cell following A3 format, monitoring identified countermeasures. Key actions from Elective Care Review are incorporated, updates for these are reported to the Elective Steering group.

  Risks: - Business plans signed off include increase in follow ups, in part to clear follow up backlog
  - Clinically Led challenge required to facilitate clinical conversations and encourage engagement
  - Lack of pace on schemes linked to System Partners, previously escalated at Planned Care Improvement Board
  - PKB functionality to support waiting list validation & 2way SMS: timeline risk, (revisiting 2 way SMS targeting DNAs)
  - Impact of further Industrial Action (IA) on cancelled OP sessions / attendances, impact on improvement work
  - CIP impact on admin vacancies process – admin resource remains critical for transformation & sustained performance

- **Referral Management / Variation**

  Advice & Guidance - Advice & refer 'triage by default': plan to present data on how to progress back to System Group. Also reviewing usage variation Trust-wide / by GPs

- **Activity Management / Variation**

  PIFU – Position Nov 2023: 5.2% Benchmarking vs national median October – UHNM: 28th of 142 providers (4.9% vs 3.0%).

  'PIFU by Default' initiative – with NHSE support; clinical workshop held November 7th with Medical Director & Clinical Leads, incl reducing F Ups context. Well attended, with positive discussions – comms updated & shared. Next step: specific clinical discussion with 4 initial priority specialties (linking with NHSE clinical support & GIRFT Further Faster), chasing dates for meetings. NHSE template to feed back on progress to date, for return end of December.

  Outcomes – Tail broadly cleared, continuing progress on backlog (cohorts not high risk). Following iportal directive, new reporting views shared to target improvement actions more effectively (for example unoutcomed where iportal outcome captured). Over 45% of outcomes initially recorded on iportal**. RPA OP Outcomes** - Scoping specialty pilot with UHNM BI, agreement in principle for pilot in a specialty using available robot capacity.

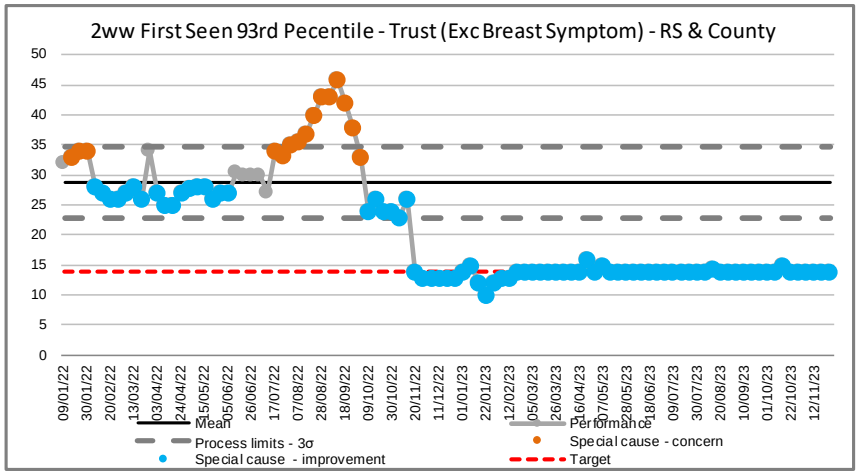
  OP Productivity; Utilisation – Position Nov 2023: Clinic Utilisation: 89.5% vs 90.0% (plan); Booking rate: 96.5% (vs 96.3%) DNA rate: 7.2% (vs 6.5%) bookings on track, detailed review of bookings by TFC to understand under-utilised slots; DNAs, overbooking to compensate, revisiting 2 way messaging to target DNAs

- **Key Enablers**

  GIRFT Further, Faster – key programme, UHNM a cohort 2 Trust. Handbooks shared; monitoring onboarding (11/17) & follow on meetings with clinical & mgt specialty teams. Many actions for outpatient themes as included previously in OP GIRFT Guidance. Specialty Checklists to be completed with clinicians.

  PIFU RPA – Discharge Letters (at Review Date),with UHNM BI, controlled go-live pilot in Urology, rolling out vs plan for other specialties by Feb/March 2024.

Cancer – Headline metrics



Variation	Assurance
	

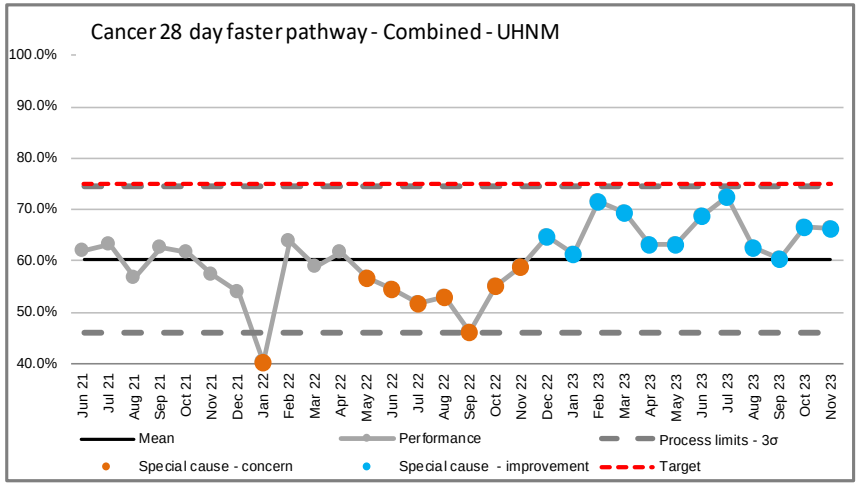
Target	12/11/2023	19/11/2023	26/11/2023
14	14	14	14

Background

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

What is the data telling us?

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



Variation	Assurance
	

Target	Sep 23	Oct 23	Nov 23
75%	60.3%	66.6%	66.3%

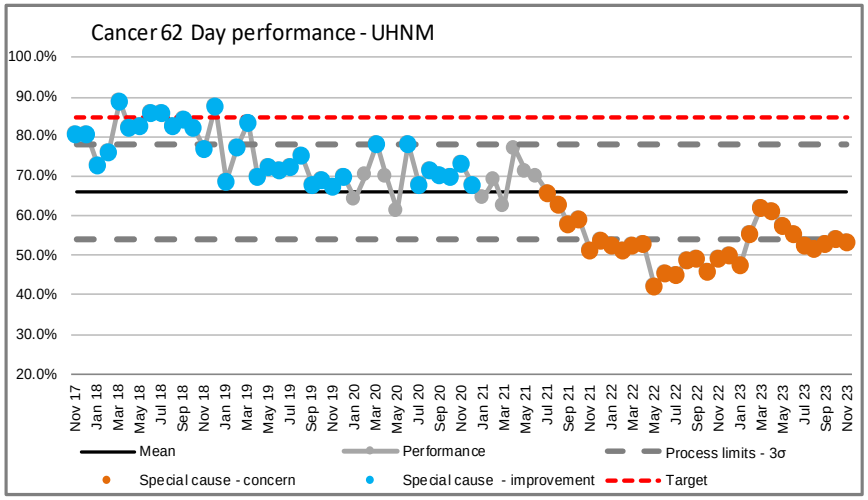
Background

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

What is the data telling us?

The FDS performance remains stable with pockets of good practice. E.g. Breast, Lung and Upper GI all achieve the standard . The October position landed at 66% - November is currently incomplete.

Cancer – Headline metrics



Variation	Assurance
L	F

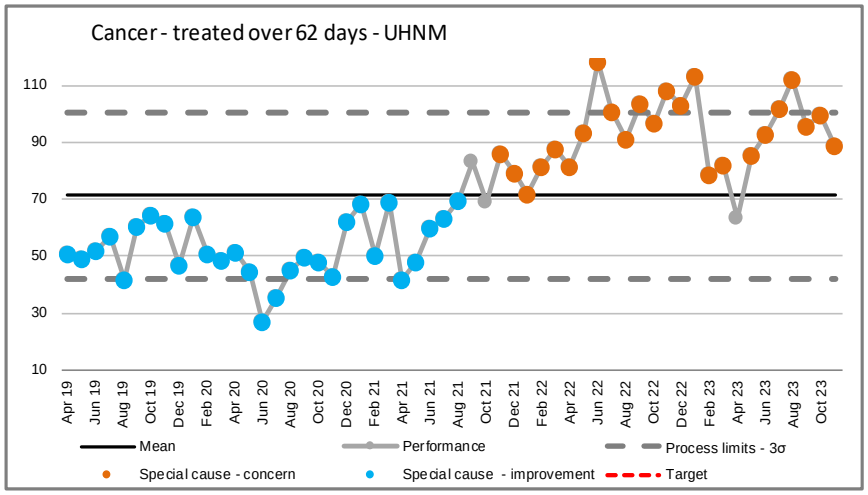
Target	Sep 23	Oct 23	Nov 23
85%	53.2%	54.3%	53.5%

Background

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

What is the data telling us?

Performance significantly challenged and below standard for the past 2 years. Performance very similar for Aug, Sept and Oct 23. The November 23 position is still being validated.



Variation	Assurance
H	

Target	Sep 23	Oct 23	Nov 23
N/A	96.0	100.0	89.0

Background

The number of patients treated over 62 days

What is the data telling us?

Demonstrates total volume of GP referred patients who have been treated beyond day 62 is a cause for concern and has been rising over the past 2 years. However a reduction demonstrated in Sept & Oct23.

Cancer Actions

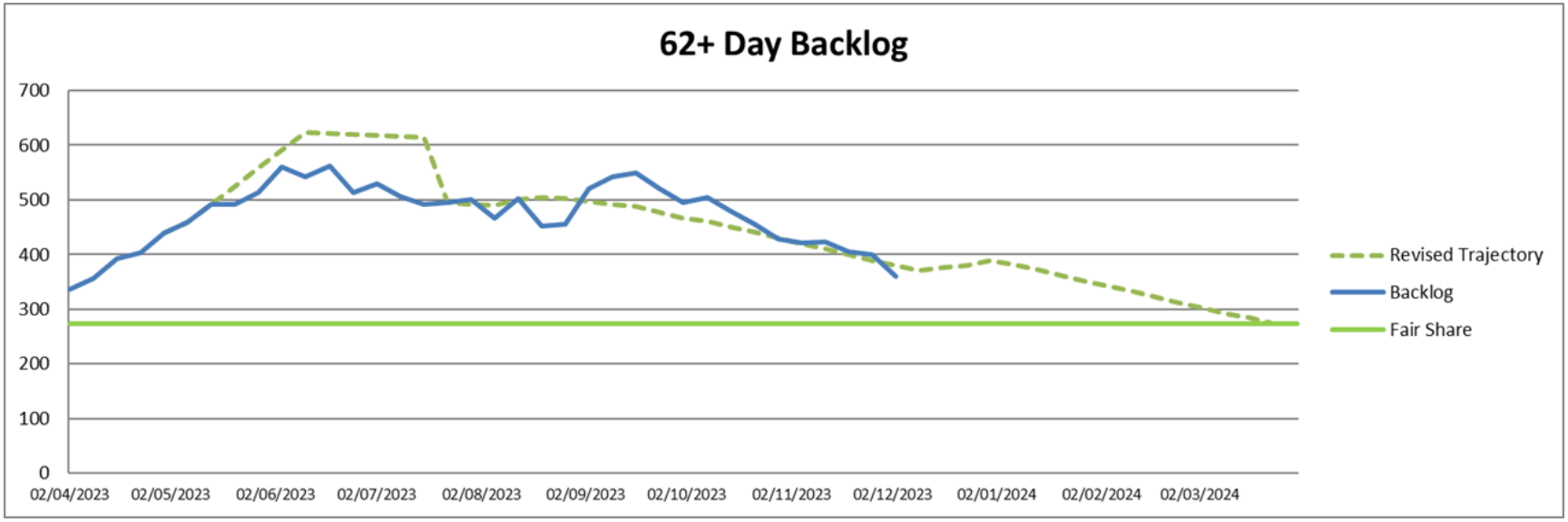
NHS University Hospitals of North Midlands NHS Trust

- The Faster Diagnosis Standard has improved over the past few months for most challenged tumour sites Urol, LGI and Skin.
- The 62 day backlog has consistently reduced for the past 8 weeks with Colorectal and Skin ahead of trajectory.
- The ICB is supporting with increased UROL referrals by reviewing the work of Choice & Referral Centre to explore expansion of referral optimisation hub to include all suspected cancer referrals. This is expected to improve FDS performance due to improved quality of referrals. Timescales for the completed review TBC.
- The UROL Expert Advisory Group of the west midlands is focusing on targeted case finding in primary care and the ICB have agreed to support with managing improved quality of referrals.
- NHSE National Cancer team deepdive at UHNM provided feedback on a well structured governance process for managing PTLs. The team reported good data analytics available to guide discussions and escalations relating to cancer patients and their priority across the trust.
- Cancer navigators have been implemented across the trust to be the first point of contact for patients on a cancer pathway and streamline the referral to treatment timelines.
- Pathologists are prioritising reporting into Urgent and Accelerated streams, particularly for high volume pathways such as Skin and Colorectal.
- Granular analysis of BPTP milestones achievement has been completed by cancer services to inform targeted pathway improvement efforts. The analysis breaks down turn around times on each element of the pathway i.e. from test request, to test performed, to test reported. This shows 'hot spots' of the pathway will support PRM conversations and additional capacity business cases / bids.
- Support has been enlisted from the National Cancer Team (NHSE) to support a deep dive in to Colorectal and skin specific pathways, due 18/10, with the aim of spotting any further improvement opportunities.
- Across relevant pathways, front end referral triage has been implemented, with 7 day KPIs met for most patients.
- For increased Radiology reporting capacity to support cancer pathways, TIs are being offered, in addition recruitment is underway for an additional fellow, plus a review of outstanding reports and allocation / escalation is continuous.
- There are a growing number of patients waiting for surgical treatment on the Urology pathway. Surgical capacity for RALPs at SaTH is being utilised. Further to this, mutual aid and internal theatres solutions such as reallocation, are being explored.
- The Elective Oversight framework supports theatre allocation with exec scrutiny on pressured pathways.
- There is an expected bottleneck in demand for colorectal surgical procedures, as the endoscopy booking backlog is cleared. To tackle this, additional activity plans have been submitted to meet the increasing pace in Endoscopy. E.g Surgical TIs / weekend lists to run the remainder of the year.
- FDS improvement plan, with support from commissioners, focusing on improved direct access to pre-requisite tests for GPs and referral optimisation is being worked through. There is the opportunity to expend the LGI referral hub to include all cancer referrals, requiring local ICB agreement.
- WMCA funding has been requested to support all of the above recovery initiatives with a focus on most pressured areas; Endoscopy, Radiology, Colorectal, Skin and Urology. Bids have been approved for all of the above and spending plans are being enacted.
- Analysis on patients who are FIT negative but sent for Colonoscopy has been completed. Around 25% of referrals received on the lower GI 2WW pathway are FIT negative however are within the exclusion criteria agreed with commissioners (IDA, Rectal Bleeding), demonstrating appropriate use of the pathway and endoscopy capacity.

Cancer Trajectories

University Hospitals of North Midlands NHS Trust

- National planning guidance 23/ 24 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. This was based on a fair share total allocated to Trusts, shown in green on the graph below. An internal PTL Backlog trajectory for UHNM is shown by the green dotted line below, which was revised and modelled to bring us back in line with the fair share target by March 24, taking into account the unpredicted workforce challenges in Endoscopy.
- The actual total of patients waiting over 62 days on a 2WW pathway are shown in blue below, and are a snap shot in time of the PTL position. This is for the week ending 03.12.23.
- UHNM provide assurance to the regional NHSEI team, with detailed plans on a weekly basis. Tiered Progress to date:
    - The 62 day backlog has reduced to a current position of 360.
    - The number of days waited for 1st OPA (93rd Percentile) has reduced to within target of 14 days.
    - The total PTL has reduced to a current position of around 3200.
    - The number of patients waiting over 104+ has halved to a current position of 104.
    - The Faster Diagnosis Standard was submitted at a final October 23 position of 66%.

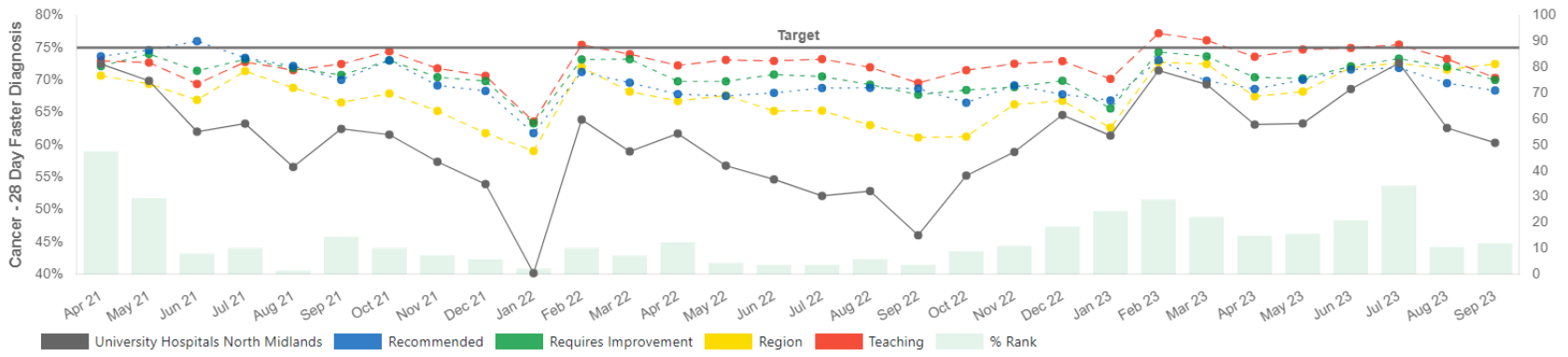


Cancer

Cancer - 28 Day Faster Diagnosis

Sep 23 Performance: 60.3% | Rank: 118th of 134

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



Key Performance Indicator	Period	Target		SPC
Cancer - 28 Day Faster Diagnosis	Sep 23	75.0%	60.3%	
FDS Acute Leukaemia	Sep 23	75.0%	-	
FDS Brain Tumours	Sep 23	75.0%	50.0%	
FDS Breast Cancer	Sep 23	75.0%	88.7%	
FDS Breast Symptoms	Sep 23	75.0%	91.8%	
FDS Children's Cancer	Sep 23	75.0%	84.6%	
FDS Gynaecological Cancer	Sep 23	75.0%	48.6%	
FDS Haematological Malignancies	Sep 23	75.0%	33.3%	
FDS Head & Neck Cancer	Sep 23	75.0%	66.0%	
FDS Lower Gastrointestinal Cancer	Sep 23	75.0%	18.8%	
FDS Lung Cancer	Sep 23	75.0%	77.3%	
FDS Missing or Invalid	Sep 23	75.0%	-	
FDS Other Cancer	Sep 23	75.0%	-	
FDS Sarcoma	Sep 23	75.0%	28.6%	
FDS Skin Cancer	Sep 23	75.0%	72.7%	
FDS Testicular Cancer	Sep 23	75.0%	80.0%	
FDS Upper Gastrointestinal Cancer	Sep 23	75.0%	84.2%	
FDS Urological Malignancies	Sep 23	75.0%	44.1%	

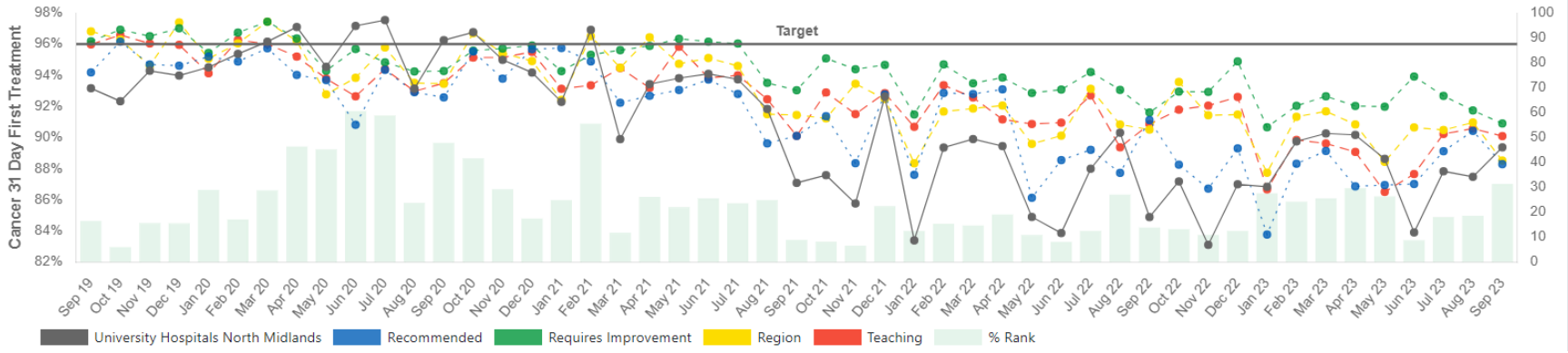
- The 28 Day Faster Diagnosis position for UHNM continues to be below all peer groups.
- All peer groups have seen a deterioration over the last three months. For UHNM this deterioration is more significant.
- Lower GI and Sarcoma have deteriorated the most since July.
- UHNM remain in the bottom quartile.
- Some areas consistently achieve the standard, such as Breast and Upper GI.

Cancer

Cancer 31 Day First Treatment

Sep 23 Performance: 89.36% | Rank: 93rd of 135

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



- Since June 2023, UHNM performance has seen an improving trend, whilst not all peer groups are seeing this same improvement.
- In September, UHNM are now mid point between peers.
- UHNM have moved from the bottom quartile to the 3rd quartile.

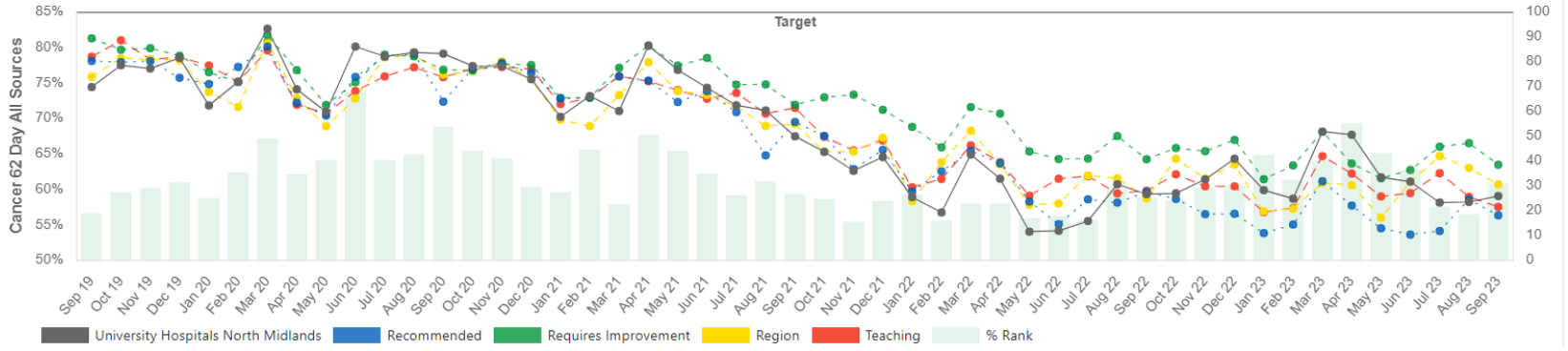
	Key Performance Indicator	Period	Target		SPC
45	Cancer 2 Week Wait	Sep 23	93.00%	95.7%	
99	Cancer 2 Week Wait Breast Symptomatic	Sep 23	93.0%	93.8%	
46	Cancer 31 Day First Treatment	Sep 23	96.00%	**89.4%**	
120	Cancer 31 Day Subsequent Treatment	Sep 23	96.0%	**82.9%**	
51	Cancer 62 Day All Sources	Aug 23	85.00%	**58.2%**	
100	Cancer 62 Day Consultant Upgrade	Aug 23	85.0%	**71.2%**	
35	Cancer 62 Day Screening	Sep 23	90.0%	**44.4%**	
118	Cancer Sub Treat Drugs	Sep 23	96.0%	**92.9%**	
119	Cancer Sub Treat Radiotherapy	Sep 23	96.0%	97.0%	

Cancer

Cancer 62 Day All Sources

Aug 23 Performance: 58.20% | Rank: 111th of 136

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



- All peer groups are currently performing at similar levels.
- Whilst peer groups have seen a downward trend since July, UHNM have seen an improving trend.
- UHNM are in the 3rd quartile.

	Key Performance Indicator	Period	Target		SPC
45	Cancer 2 Week Wait	Sep 23	93.00%	95.7%	
99	Cancer 2 Week Wait Breast Symptomatic	Sep 23	93.0%	93.8%	
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119	Cancer Sub Treat Radiotherapy	Sep 23	96.0%	97.0%	

Inpatient and Outpatient Decile & Ethnicity

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

Inpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.10%	9.97%	9.04%	7.62%	7.70%	11.26%	12.11%	10.52%	13.29%	6.82%	0.58%
Weeks Waited- 78-104	12.77%	11.18%	9.83%	10.34%	7.48%	11.09%	9.16%	10.17%	10.84%	5.97%	1.18%
Weeks Waited- 52-77	14.16%	11.51%	10.51%	9.96%	8.17%	10.51%	9.17%	9.06%	10.44%	5.31%	1.21%
Weeks Waited- Under 52	13.66%	11.09%	10.39%	9.12%	7.46%	10.97%	10.67%	8.64%	11.10%	5.45%	1.44%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	10.60%	9.67%	8.91%	9.06%	7.88%	11.39%	11.39%	10.17%	13.33%	6.32%	1.26%
Weeks Waited- 78-104	11.42%	10.34%	10.13%	8.75%	7.27%	10.29%	11.39%	9.97%	12.49%	6.54%	1.39%
Weeks Waited- 52-77	12.83%	11.10%	9.91%	8.98%	7.98%	10.83%	10.19%	9.34%	11.48%	6.08%	1.29%
Weeks Waited- Under 52	13.32%	11.39%	10.13%	8.87%	7.47%	10.51%	10.54%	9.08%	11.24%	5.96%	1.48%

Inpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White British	White Irish	Not Specified	Not Stated	Unknown	
Weeks Waited- >104	0.14%	0.47%	0.08%	0.41%	0.36%	0.63%	0.03%	0.11%	0.25%	0.38%	0.49%	0.16%	0.03%	92.99%	0.36%	1.04%	1.78%	0.30%	
Weeks Waited- 78-104	0.17%	0.50%	0.25%	0.84%	0.42%	1.09%	0.08%	0.08%	0.17%	0.59%	0.76%	0.17%		90.00%	0.34%	1.85%	1.18%	1.09%	
Weeks Waited- 52-77	0.48%	0.83%	0.34%	0.90%	0.65%	1.48%	0.10%	0.17%	0.07%	0.52%	1.69%	0.34%	0.07%	85.53%	0.55%	2.27%	1.65%		
Weeks Waited- Under 52	0.47%	0.69%	0.27%	0.72%	0.56%	1.56%	0.15%	0.18%	0.13%	0.56%	1.53%	0.32%	0.19%	83.95%	0.32%	2.60%	2.31%	3.23%	

Outpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.26%	0.39%	0.24%	0.45%	0.55%	0.84%	0.11%	0.11%	0.10%	0.55%	1.50%	0.26%	0.12%	0.21%	88.48%	0.36%	2.32%	1.91%	1.24%
Weeks Waited- 78-104	0.51%	0.55%	0.20%	0.67%	0.68%	1.27%	0.11%	0.13%	0.16%	0.62%	1.39%	0.27%	0.16%	0.17%	85.87%	0.36%	2.72%	2.05%	2.09%
Weeks Waited- 52-77	0.38%	0.72%	0.19%	0.61%	0.60%	0.99%	0.21%	0.16%	0.17%	0.62%	1.57%	0.37%	0.13%	0.21%	83.36%	0.26%	3.04%	2.66%	3.74%
Weeks Waited- Under 52	0.59%	0.72%	0.23%	0.66%	0.59%	1.33%	0.16%	0.17%	0.15%	0.66%	1.84%	0.33%	0.18%	0.24%	82.52%	0.30%	3.19%	2.54%	

APPENDIX 1

Operational Performance

Constitutional standards

NHS University Hospitals of North Midlands NHS Trust

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	Percentage of Ambulance Handovers within 15 minutes	0%	22.35%	L		
	Ambulance handovers greater than 60 minutes	1	1	L	F	
	Time to Initial Assessment - percentage within 15 minutes	85%	57.28%		F	
	Average (mean) time in Department - non-admitted patients	180	292		F	
	Average (mean) time in Department - admitted patients	180	441	H	F	
	Clinically Ready to Proceed	90	606	H	F	
	12 Hour Trolley Waits	0	1175	H	F	
	Patients spending more than 12 hours in A&E	0	2019	H	F	
	Median Wait to be seen - Type 1	60	108		F	
	Bed Occupancy	92%	88.52%			
Cancer Care	Cancer 28 day faster pathway	75%	66.27%	H	F	
	Cancer 31 Day Combined	96%	85.02%	L	F	
	Cancer 62 Day Combined	85%	62.28%	L	F	
	2WW First Seen (exc Breast Symptom)	93%	96.06%	H	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.4%	L	?	
	Cancelled Ops	150	126		?	
	Theatre Utilisation	85%	81.3%			
Inpatient / Discharge	Same Day Emergency Care	30%	38%	H	?	
	Super Stranded	183	177	L	?	
	MFFD	100	99	L	?	
	Discharges before Midday	25%	20.4%		F	
	Emergency Readmission rate	8%	13.4%		F	
Elective waits	RTT incomplete performance	92%	50.95%	L	F	
	RTT 52+ week waits	0	4802	H	F	
	Diagnostics	99%	77.84%	H	F	

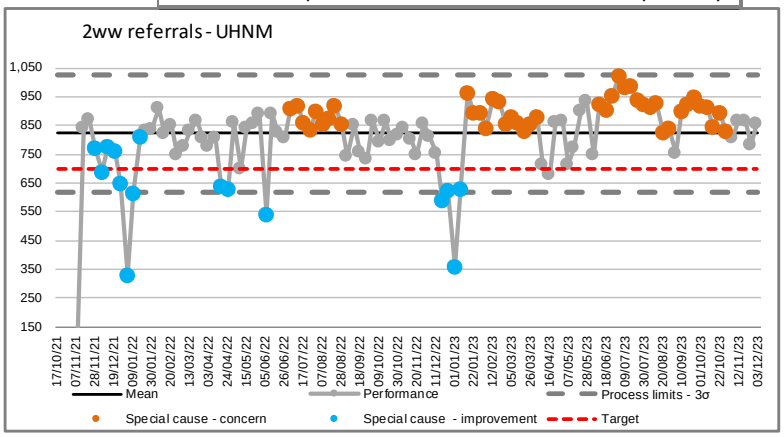
Delivering Exceptional Care with Exceptional People

Cancer – 62 Day

Target	Sep 23	Oct 23	Dec 23
700	868	784	857

Background

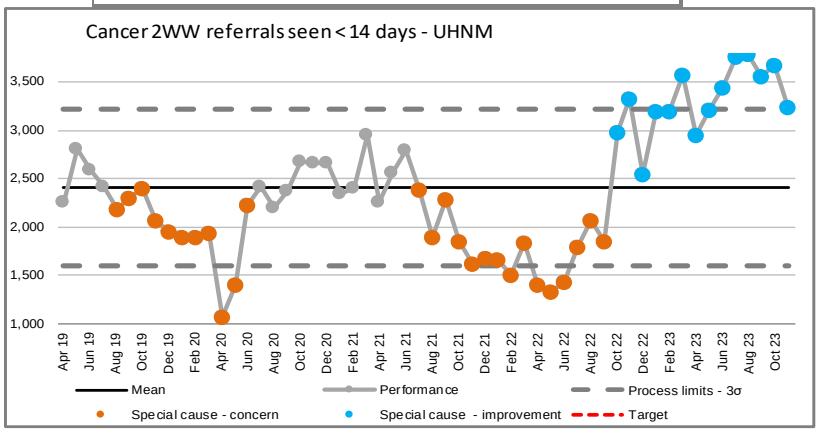
The number of patients referred on a cancer 2ww pathway.



Target	Sep 23	Oct 23	Nov 23
N/A	3556.0	3675.0	3246.0

Background

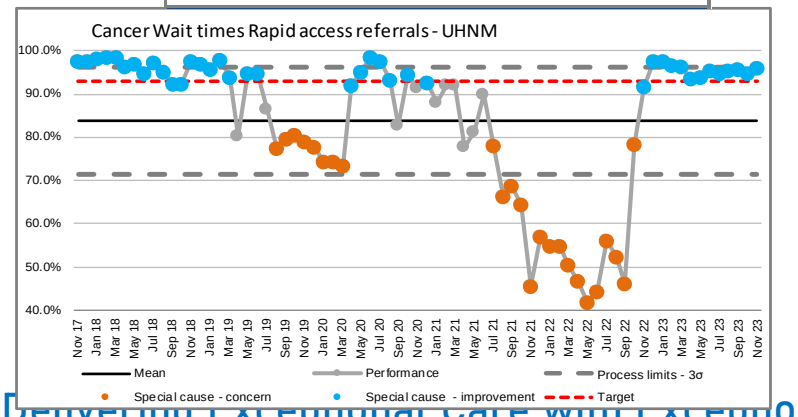
The percentage of patients waiting over 18 weeks for treatment since their referral.



Target	Sep 23	Oct 23	Nov 23
93%	95.7%	95.0%	96.1%

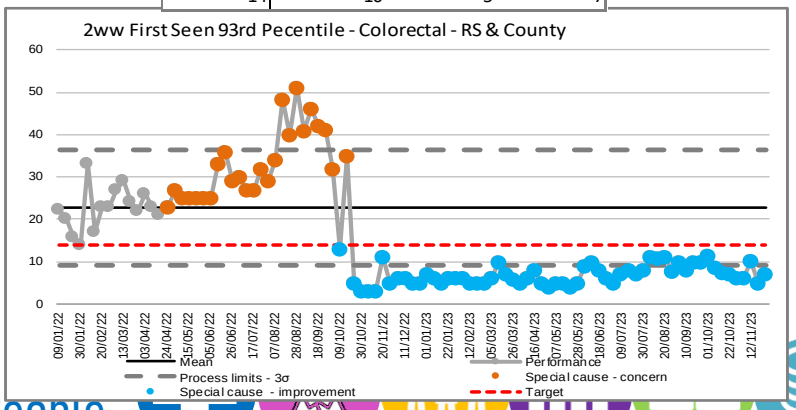
Background

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

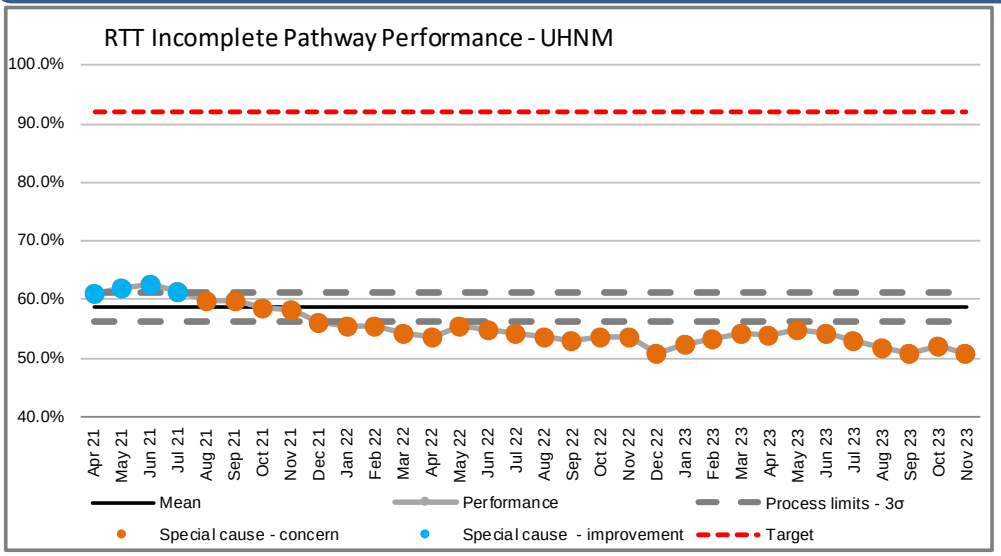


Variation	Assurance
L	?

Target	Nov 23	Nov 23	Nov 23
14	10	5	7



Referral To Treatment



Variation	Assurance
L	F

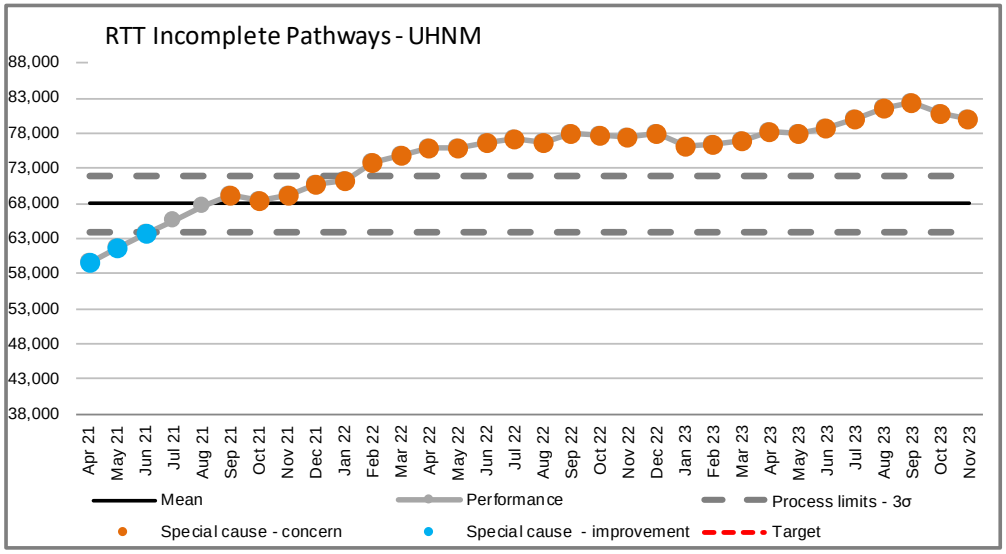
Target	Sep 23	Oct 23	Nov 23
92%	50.7%	52.0%	51.0%

Background

The percentage of patients waiting less than 18 weeks for treatment.

What is the data telling us?

RTT performance dipped in November and has seen a deteriorating trend since May 23.



Variation	Assurance
H	

Target	Sep 23	Oct 23	Nov 23
N/A	82469	80768	80107

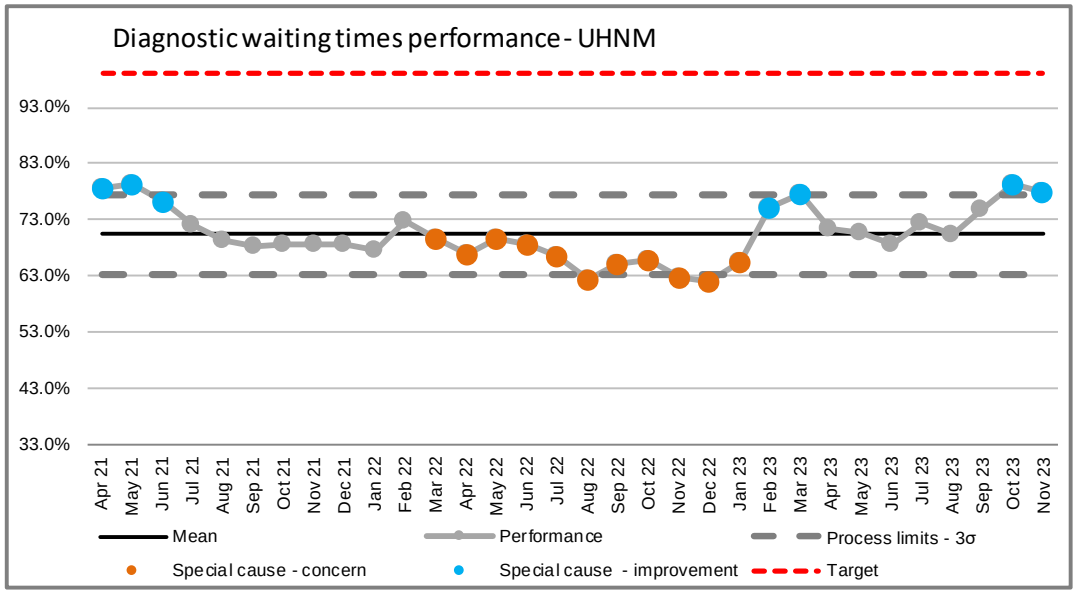
Background

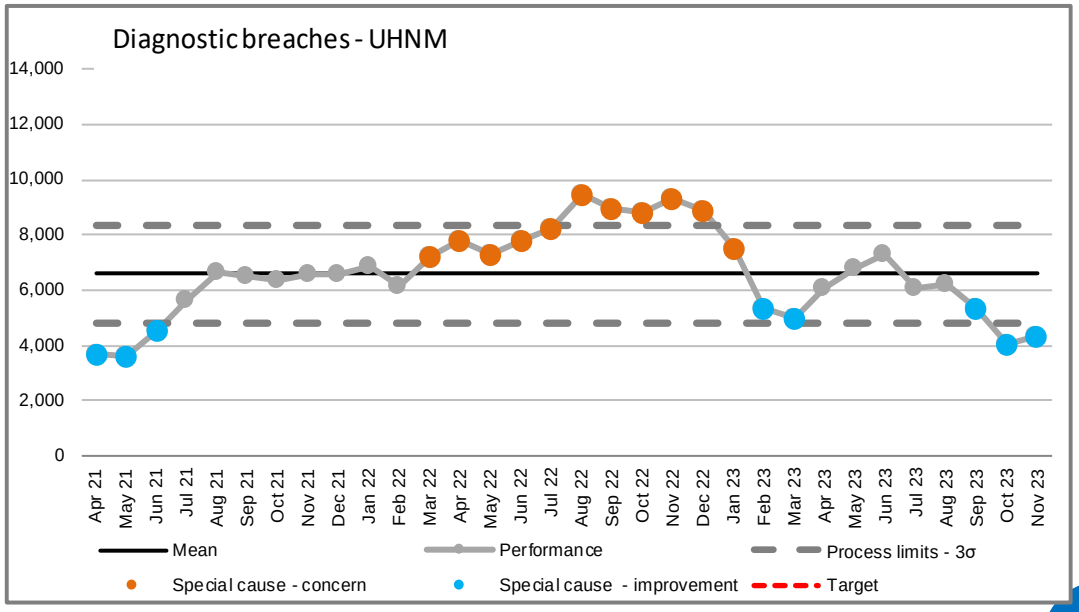
The number of patients waiting over 18 weeks for treatment since their referral.

What is the data telling us?

Following an increasing trend during 2023, November saw a reduction for the first time.

Diagnostic Standards





Variation	Assurance
H	F

Target	Sep 23	Oct 23	Nov 23
99%	74.9%	79.4%	77.8%

Background

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

What is the data telling us?

Waiting time performance saw a slight dip in November compared to October.

Following a decreasing trend since May 2023, November saw a marginal increase.

Workforce

University Hospitals of North Midlands NHS Trust

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

Delivering Exceptional Care with Exceptional People

Workforce Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key messages

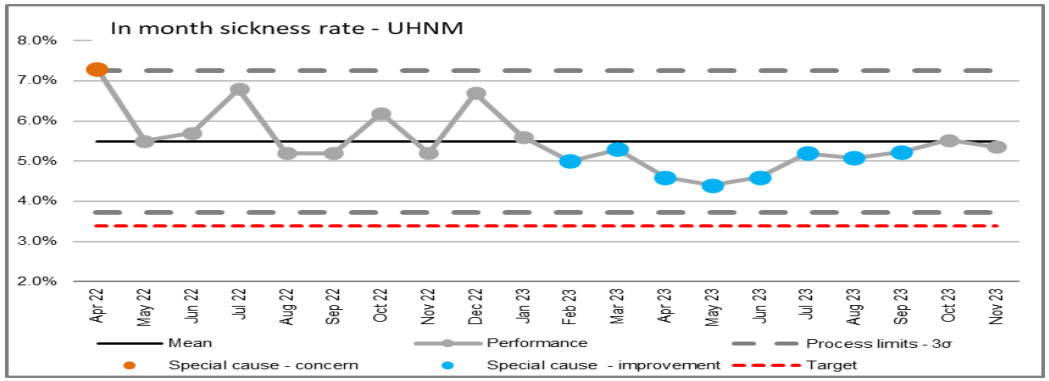
- The 12m Turnover rate in November 2023 decreased fractionally to 8.1% (8.2% in October 2023) which remains below the trust target of 11%.
- M8 vacancies decreased to 8.66% (8.98% in October), influenced by a reduction in Medical & Dental vacancies. Divisions continue to report good progress on their recruitment pipeline to close the gap on vacancies.
- For M8, the in-month sickness rate decreased by 0.16% to 5.36% (5.52% in October 2023). The 12-month cumulative rate remained static at 5.26% (5.26% in October 2023).
- Stress and anxiety continues to be the top reason for sickness in November 2023, which saw an increase of 2.2% in the last month to 26.5% (24.3% in October). Chest & respiratory problems saw an in-month decrease to 9.8% (15.0% in October 2023), and gastrointestinal problems increased from 5th to 3rd most common reason, at 8.9% in November (7% in October 2023), replacing cold, cough & flu.
- Employees may report covid-like symptoms on Empactis, but Managers are then recording this as either chest & respiratory, or cold & flu, on ESR, in the absence of a formal lateral flow test, following the cessation of symptomatic covid testing, since May 2023. The overall number of employees who reported Covid-19 fell, on Empactis, to 202 cases in November 2023 (460 in October 2023). Managers reported 94 covid-related absences on ESR for November 2023, (3 in October 2023).
- November 2023's PDR Rate decreased to 82.0% (82.6% in October 2023). The refreshed PDR paperwork to support colleagues in achieving their potential, is expected to be released in January 2024.
- Statutory and Mandatory training rate on 30th November 2023 increased by 0.3% to 94.2% (93.9% on 31st October 2023). This compliance rate is for the 6 'Core for All' subjects only.
- The Staff Voice trust survey has been paused until January 2024, to prevent survey fatigue, following the NHS National Staff Survey.
- The Being Kind sessions continued in November 2023 with 780 colleagues in attendance. Overall, 9,513 people have attended the training, either in person, virtually, or online, via the ESR virtual training session.
- The raw score data from the NHS National Staff Survey is expected by the end of December, and work will commence on the analysis.

Workforce Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.36%		F
Staff Turnover	11%	8.13%	L	?
Statutory and Mandatory Training rate	95%	94.24%		F
Appraisal rate	95%	81.98%	H	F
Agency Cost	N/A	4.71%		P

Sickness Absence



University Hospitals of North Midlands NHS Trust

Variation	Assurance
	F

Target	Sep 23	Oct 23	Nov 23
3.4%	5.2%	5.5%	5.4%

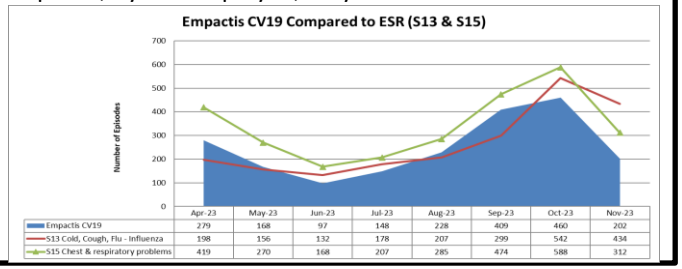
Background

Percentage of days lost to staff sickness

Summary

Org L2	Divisional Trajectory - March 2024	2022 / 12	2023 / 01	2023 / 02	2023 / 03	2023 / 04	2023 / 05	2023 / 06	2023 / 07	2023 / 08	2023 / 09	2023 / 10	2023 / 11	Trajectory
205 Central Functions	3.39%	4.87%	4.01%	4.03%	3.61%	2.80%	2.37%	2.81%	3.54%	3.46%	3.44%	3.81%	3.80%	↓
205 Division of Network Services	5.25%	6.56%	4.99%	4.51%	4.64%	3.90%	3.76%	3.97%	4.35%	4.81%	4.54%	5.36%	5.17%	↓
205 Division of Surgery, Theatres and Critical Care	5.25%	7.38%	6.37%	5.93%	6.48%	5.47%	4.90%	5.24%	6.62%	6.15%	6.12%	6.13%	6.09%	↓
205 Estates, Facilities and PFI Division	5.25%	7.55%	5.98%	5.65%	6.30%	6.00%	5.32%	5.09%	4.69%	5.11%	4.87%	6.11%	5.19%	↓
205 Medicine and Urgent Care	5.25%	7.28%	5.72%	5.05%	5.25%	5.10%	4.88%	4.78%	5.67%	5.35%	6.12%	6.22%	5.70%	↓
205 North Midlands & Cheshire Pathology Service (NMCPS)	4.50%	6.35%	5.60%	5.49%	5.61%	4.71%	4.68%	5.38%	4.71%	4.37%	4.82%	5.64%	5.02%	↓
205 Women's, Children's & Clinical Support Services	5.25%	6.65%	6.00%	5.00%	5.11%	4.63%	4.62%	5.09%	5.08%	5.01%	4.90%	4.90%	5.15%	↑

- For M8, the in-month sickness rate decreased by 0.16% to 5.36% (5.52% in October 2023).
- The 12-month cumulative rate was static at 5.26%.
- Stress and Anxiety continues to be the top reason for sickness in November but saw an increase of 2.2% in the last month to 26.5% (24.3% in October). Cold, Cough & Flu dropped from 3rd to 5th most common reason, in October, which correlates with the decrease in reported Covid-19 cases.
- Covid 19 cases reported on Empactis, by the employee, may be recorded as either chest & respiratory, or cold and flu, on ESR, by the manager, in the absence of a formal lateral flow.
- Both ESR reasons have seen a marked decrease, consistent with Empactis.



Sickness rate is consistently above the target of 3.4%.

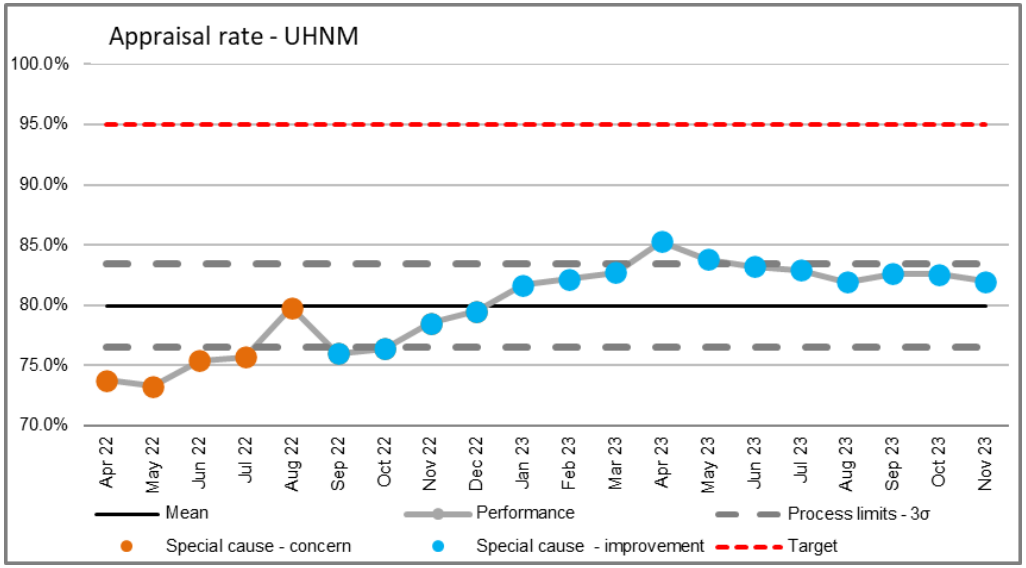
Actions

- For areas of high sickness daily monitoring of absences continues
- **Medicine Division** - sickness absence continues to be monitored at directorate performance reviews. Areas with over 8% or of concern are supported by the People Advisor focusing on long term sickness cases
- **Surgery Division** – assessment of hotspot areas for long and short term absences to provide targeted support including re-training
- **Network Division** - commenced sickness assurance meetings.
- **Women's Children's and Clinical Division** - Deep dives into hot spot/high absence areas to target interventions as well as continuing absence surgeries.

Delivering Exceptional Care with Exceptional People

Appraisal/Performance Development Review (PDR)

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Sep 23	Oct 23	Nov 23
95%	82.6%	82.6%	82.0%

Background

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

The appraisal rate is consistently below the target of 95%. More recently the rate shows special cause variation. There has been a drop below the lower control limit since August 2019.

Summary

- On 30th November 2023, the PDR Rate decreased to 82.0%, compared to 82.6% for October 2023.
- This figure remains below the overall target and divisions have been asked to review key issues and actions to work towards meeting target.
- The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance and making the process enhance employee experience.

Actions

The focus on ensuring completion of PDRs is continuing with:

NMCPS - All out of date PDR's to be scheduled with line managers, and ESR hierarchy changes and training gaps to be identified.

Network Division - Hold a dedicated weekly PDR compliance hotspot and assurance meetings

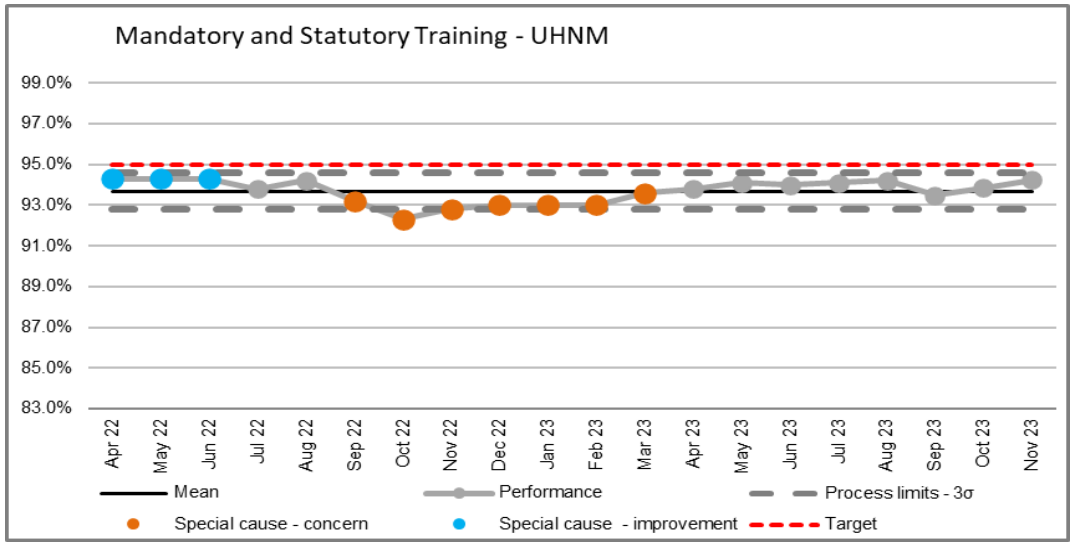
Surgery Division – Monthly compliance report, with a focus on hotspots

Medicine Division – Weekly updates reports on compliance. With focused assistance on those areas with the lowest compliance.

Delivering Exceptional Care with Exceptional People

Statutory and Mandatory Training

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Sep 23	Oct 23	Nov 23
95%	93.5%	93.9%	94.2%

Background

Training compliance.

At 93.5%, the Statutory and Mandatory Training rate remains just below the Trust target for the core training modules

Summary

Statutory and Mandatory training rate on 30th November 2023 increased by 0.3% to 94.2% (93.9% on 31st October 2023). This compliance rate is for the 6 'Core for All' subjects only.

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|LOCAL|Security Awareness - 3 Years|	11554	11554	10860	93.99%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years	11554	11554	10922	94.53%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	11554	11554	10857	93.97%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Y	11554	11554	10916	94.48%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	11554	11554	10982	95.05%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Y	11554	11554	10797	93.45%

Compliance rates for the Annual competence requirements were as follows:

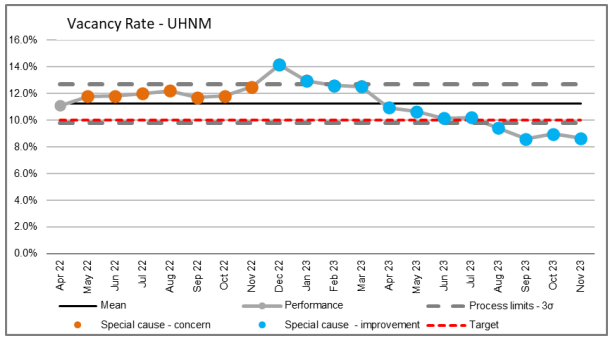
Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	11554	11554	8794	76.11%
NHS|CSTF|Information Governance and Data Security - 1	11554	11554	10456	90.50%

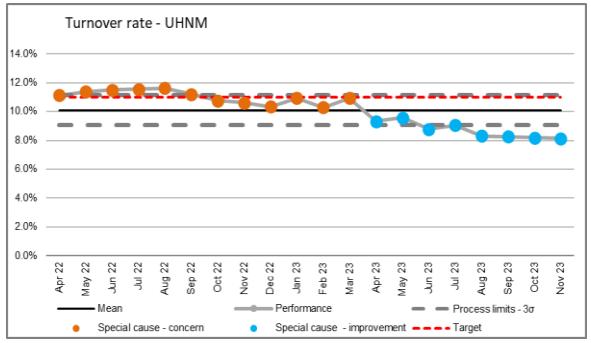
Actions

- We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.
- Compliance is monitored and raised via the Divisional performance review process.
- The Being Kind sessions continued in September with 1,805 colleagues in attendance. Overall, 8,091 people have attended the training, either in person, virtually, or online, via the ESR virtual training session.

Workforce Vacancies and Turnover

University Hospitals of North Midlands NHS Trust





Variation	Assurance
	

Target	Sep 23	Oct 23	Nov 23
11.0%	8.3%	8.2%	8.1%

Background

Turnover rate

What is the data telling us?

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

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

Vacancy rate when measured against total establishment decreased to 8.66% from 8.98% last month.

Vacancy rate when measured against substantive budgets only, decreased to 1.25% from 1.92% last month, resulting from low turnover and recruitment into substantive vacancies.

Summary

- The 12m Turnover rate in November 2023 decreased fractionally to 8.1% (8.2% in October 2023) which remains below the trust target of 11%.
- The summary of vacancies by staff groupings highlights a 0.32% decrease in the vacancy rate over the previous month.
- M8 vacancies decreased to 8.66% (8.98% in October). Colleagues in post increased in November 2023 by 70.91 fte, budgeted establishment increased by 35.27 fte, which decreased the vacancy fte by 35.64 FTE overall [*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 30/11/23]

Vacancies at 30-11-23	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,652.40	1,421.78	230.62	13.96%	15.43%
Registered Nursing	3679.18	3294.75	384.43	10.45%	10.27%
All other Staff Groups	6664.75	6241.13	423.62	6.36%	6.65%
Total	11,996.33	10,957.66	1,038.67	8.66%	8.98%

Actions

- Significant amount of recruitment events targeting specific roles across multiple divisions.
- Continued targeted social media campaign. Recruitment are actively updating LinkedIn pages and have created a new UHNM recruitment Facebook group.
- Targeted spotlight on UHNM colleagues continue and supplement the recruitment campaigns

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key elements of the financial performance year to date are:

- For Month 8 the Trust has delivered a year-to-date deficit of £0.8m against a planned surplus of £2.4m; this adverse variance of £3.2m is primarily driven by underperformance against the Trust's in year CIP target and unfunded additional winter escalation capacity that remained open through the year.
- The Trust has received £9.0m additional funding towards the cost of industrial action and other cost pressures for Month 1 to 7; this additional income has been recognised in the Month 8 position.
- The Trust has incurred £5.0m of costs relating to winter escalation capacity remaining open to Month 7 partially funded by £2.1m of additional funding from the local ICB. Winter and escalation costs from Month 8 are funded as part of the Trust's winter plan.
- To date the Trust has validated £30.2m of CIP savings to Month 8 against a plan of £36.7m. The Trust has recognised £3.4m of CIP due to an assumed reduction in the annual leave provision delivering 50% of the NR ICB stretch CIP target; the balance is expected to be delivered from a further reduction in the provision. Schemes of £48.3m have been identified for delivery in 2023/24. The PMO is currently working with scheme leads to develop robust plan to deliver these savings. The £8.0m divisional schemes remain unidentified.
- The Month 8 actual performance of a £7.0m surplus is in line with the Trust's Month 7 breakeven forecast for the year presented to the Committee in November.
- There has been £36.2m of Capital expenditure which is £6.6m below plan.
- The cash balance at Month 7 is £69.2m which is £6.8m lower than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	100.8		
	Expenditure - Pay	variable	55.5		
	Expenditure - Non Pay	variable	36.4		
Activity	Daycase/Elective Activity	variable	9,658		
	Non Elective Activity	variable	10,952		
	Outpatients 1st	variable	27,892		
	Outpatients Follow Up	variable	45,624		

Income & Expenditure

Income & Expenditure Summary Month 08 2023/24	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,013.2	93.3	93.6	0.3	676.9	677.7	0.7
Other Operating Income	87.8	7.7	7.2	(0.5)	58.9	59.1	0.1
Total Income	1,100.9	101.0	100.8	(0.2)	735.9	736.7	0.8
Pay Expenditure	(672.2)	(60.5)	(55.5)	5.0	(445.5)	(437.9)	7.7
Non Pay Expenditure	(402.4)	(39.0)	(36.4)	2.6	(270.4)	(284.1)	(13.7)
Total Operational Costs	(1,074.6)	(99.5)	(91.9)	7.6	(715.9)	(722.0)	(6.0)
EBITDA	26.3	1.5	8.9	7.4	19.9	14.7	(5.2)
Interest Receivable	2.9	0.2	0.5	0.3	1.9	3.9	2.0
PDC	(10.3)	(0.9)	(0.9)	0.0	(6.8)	(6.8)	0.0
Finance Cost	(19.0)	(1.6)	(1.6)	0.0	(12.6)	(12.6)	0.0
Other Gains or Losses	0.0	0.0	(0.0)	(0.0)	0.0	0.0	0.0
Total	0.0	(0.7)	7.0	7.7	2.4	(0.8)	(3.2)

The overspend at of £3.2m at Month 8 is mainly driven by.

- an under delivery of CIP by £6.5m. The main CIP schemes behind plan at Month 8 are the ICB non-recurrent stretch of £3.4m and the divisional target of £8.0m.
- additional capacity costs of £5.0m have been incurred to Month 7; additional funding of £2.1m has been agreed with the Staffordshire and Stoke on Trent ICB and this has been reflected in the Month 7 position. Additional winter and escalation costs from Month 8 are funded as part of the Trust winter plan.
- The additional £9m funding received to cover the costs of Industrial Action and other pressures has been allocated to cover the additional pay costs incurred due to industrial action of £4.1m with the remaining £4.9m allocated against non-pay pressures.

Capital Spend

NHS
University Hospitals of North Midlands
NHS Trust

UHNM Capital Plan	2023/24 Plan/forecast £000	Movement £000	2023/24 Revised Plan/forecast £000	YTD Plan M08 £000	YTD Actual M08 £000	Variance M08 £000
Capital funding						
PFI & Loan Commitments	19.6	-	19.6	12.5	12.5	-
Base STP allocation	22.1	-	22.1	14.8	14.8	-
Share of ICB 2022/23 surplus re-distribution	0.7	5.9	6.6	4.4	4.4	-
Public Dividend Capital funding	19.3	8.2	27.4	-	-	-
Donated, granted other capital funding	5.0	1.0	6.0	1.6	1.6	-
Internal funding source (including capital receipts)	2.7	(1.4)	1.3	-	-	-
Total Capital funding	69.5	13.7	83.1	33.3	33.3	-
Capital expenditure						
PFI & Loan Commitments	(19.6)	-	(19.6)	(12.5)	(12.5)	-
Pre-committed investment items (ICB allocation)						
PFI enabling costs	(0.2)	-	(0.2)	-	-	-
Project Star	(20.7)	-	(20.7)	(15.9)	(14.3)	1.6
Emergency Department (restatement costs)	(0.2)	-	(0.2)	(0.1)	(0.1)	(0.0)
Air heat boiler replacement Trust Contribution	(0.7)	-	(0.7)	-	-	-
Wave 4b Funding - Lower Trent Wards	(0.2)	0.2	-	-	-	-
EPMA (Electronic Prescribing) BC	(0.7)	-	(0.7)	(0.4)	(0.3)	0.1
Pathology LIMS BC (Trust funded)	(0.6)	0.6	-	-	-	-
Pathology MSC Siemens refresh	(0.1)	-	(0.1)	-	-	-
Patient Portal roll out costs (BC 462)	(0.4)	0.1	(0.3)	(0.2)	(0.1)	0.2
Bi plane enabling (BC 425)	(0.2)	-	(0.2)	(0.2)	-	0.2
CT8 enabling works	(0.6)	-	(0.6)	(0.6)	(0.6)	-
Network and Communications (BC 510)	(1.2)	-	(1.2)	-	-	-
Pharmacy Robot BC487 - equipment	(0.5)	0.5	-	-	-	-
Pharmacy Robot BC487 - enabling and other	(0.8)	0.8	(0.0)	(0.0)	(0.0)	-
Electronic Patients records BC/specification	(0.8)	0.1	(0.7)	(0.4)	(0.0)	0.4
ED ambulance drop-off - enabling ward moves	(0.7)	-	(0.7)	(0.7)	(0.2)	0.5
Endoscopy works - 22/23 PDC ICB allocation	(0.4)	-	(0.4)	(0.1)	(0.0)	0.1
Remaining 2022/23 commitments	(0.3)	0.0	(0.3)	(0.2)	(0.2)	0.1
County CTS equipment (TIF) remaining equipment	(0.2)	-	(0.2)	(0.2)	(0.1)	0.0
County Modular remaining equipment	(0.1)	-	(0.1)	(0.1)	(0.1)	(0.0)
Investment funding - minor cases	(0.4)	(0.1)	(0.5)	(0.1)	(0.1)	(0.0)
Central Contingency & risk	-	(0.5)	(0.5)	-	-	-
Total Pre committed Investment items	(30.0)	1.8	(28.2)	(19.2)	(16.1)	3.0
IMT Sub Group Total Funding	(2.3)	-	(2.3)	(1.7)	(0.5)	1.2
Medical Devices Sub Group Total Funding	(2.4)	-	(2.4)	(1.9)	(1.1)	0.8
Estates Sub Group Total Funding	(3.6)	-	(3.6)	(1.1)	(1.1)	0.1
Sub-group brought forward from 2024/25	-	(1.5)	(1.5)	-	-	-
Health & Safety compliance	(0.2)	-	(0.2)	(0.1)	(0.1)	(0.0)
Net zero carbon initiatives	(0.1)	-	(0.1)	(0.0)	-	0.0
Central funding beds, mattresses, hoists	(0.1)	-	(0.1)	(0.1)	(0.0)	0.0
Total Sub Groups	(8.7)	(1.5)	(10.2)	(4.9)	(2.8)	2.1
New IFRS16 leases (previously classified as operating leases and charged to revenue)						
Lease liability re-measurement	(0.2)	(0.1)	(0.4)	(0.4)	(0.4)	-
IFRS 16 leases	(0.9)	(1.5)	(2.4)	(0.3)	(0.3)	-
Community Diagnostic Centre lease	-	-	-	-	-	-
IFRS16 funding offset	1.1	1.6	2.7	0.6	0.6	-
Total Internal Capital Expenditure programme	(58.2)	0.3	(58.0)	(36.6)	(31.4)	5.2
Additional CRL / Externally Funded PDC						
Wave 4b Funding - Lower Trent Wards	(1.6)	0.3	(1.3)	(0.1)	(0.1)	0.0
TIF 2 PDC CTS phase 1 - enabling slippage	(0.4)	-	(0.4)	(0.4)	(0.4)	(0.0)
TIF 2 PDC (Day Case Unit)	(2.7)	1.2	(1.5)	(0.3)	(0.3)	0.0
TIF 2 PDC (Women's Hospital)	(1.2)	0.6	(0.7)	(0.1)	(0.1)	(0.0)
PDC - additional General & Acute beds	(13.4)	2.0	(11.4)	(3.0)	(1.5)	1.5
PDC - Community diagnostic centre phase 1	-	(1.1)	(1.1)	(0.3)	(0.3)	-
PDC - Pathology LIMS	-	(1.3)	(1.3)	(0.4)	(0.5)	(0.2)
PDC - Frontline digitalisation EPR	-	(1.5)	(1.5)	-	-	-
Required NHSE plan re-phasing adjustment	7.2	(7.2)	-	-	-	-
Equipment - endoscopy CDEL (transfer from NCA)	-	(1.0)	(1.0)	-	-	-
Air heat boiler replacement PSDS Grant BC 510	(2.9)	-	(2.9)	(0.3)	(0.3)	-
Charitable funded expenditure	(2.1)	-	(2.1)	(1.3)	(1.3)	-
Total Additional CRL / PDC Funded expenditure	(17.1)	(8.1)	(25.2)	(6.2)	(4.8)	1.4
Total Capital Expenditure	(75.3)	(7.8)	(83.1)	(42.8)	(36.2)	6.6
Planned under/(over) spend	(5.9)	5.9	(0.0)			

At Month 8 capital expenditure was £36.2m against a revised plan of £42.8m, an underspend of £6.6m. Of the £31.5m expenditure, £12.5m is related to pre-committed items for the repayment of PFI and IFRS16 lease liabilities and PFI lifecycle expenditure.

The main reasons for the underspend of £6.6m relate to the following schemes:

- Project Star is £1.6m behind plan based on costs from the latest statement of works, which showed an underspend in Month 8. A review of the forecast for the remainder of the financial year has been undertaken and the year end forecast remains unchanged.
- Electronic Patient Records business case is £0.4m behind plan due to contractual delays with the scheme and 2 months of the expenditure will slip in to 2024/25; and
- ED ambulance drop-off - enabling ward moves is £0.5m behind plan due to delays in finalising costs and the scope of work within the available funding.

The IM&T sub-group is showing an underspend of £1.2m at Month 8, which is mainly due to delays in the radiation oncology equipment scheme (£0.75m) forecast with expenditure now expected in Month 9.

The Medical Devices sub-group is showing an underspend of £0.8m at month 8 mainly due to the phasing of the roll-out of the monitor fleet replacement that is expected to take place in Month 9.

The PDC funded scheme for general and acute beds is £1.5m behind plan at Month 8 and reflects the latest certified value of expenditure, the current underspend has been rephased over the remaining months of the financial year.

The overall forecast for the 2023/24 capital plan is that capital funding and expenditure will be in line with plan at the year-end.

Balance sheet

Balance sheet as at Month 8	31/03/2023	30/11/2023			
	Actual £m	Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment *	627.6	641.6	634.4	(7.2)	Note 1
Right of Use Assets	18.8	16.4	16.7	0.3	
Intangible Assets	18.4	15.0	14.5	(0.4)	
Trade and other Receivables	1.4	1.4	1.4	0.0	
Total Non Current Assets	666.1	674.3	667.0	(7.3)	
Inventories	16.8	16.8	18.3	1.5	Note 2
Trade and other Receivables **	57.9	42.7	50.5	7.8	Note 3
Cash and Cash Equivalents **	84.0	76.0	69.2	(6.8)	Note 4
Total Current Assets	158.7	135.5	138.0	2.5	
Trade and other payables **	(134.0)	(123.7)	(124.2)	(0.5)	
Borrowings	(14.0)	(14.0)	(13.7)	0.3	
Provisions	(5.6)	(5.6)	(5.6)	0.0	
Total Current Liabilities	(153.5)	(143.3)	(143.4)	(0.1)	
Borrowings	(256.8)	(248.1)	(248.3)	(0.2)	
Provisions	(2.7)	(2.7)	(2.6)	0.1	
Total Non Current Liabilities	(259.5)	(250.7)	(250.8)	(0.1)	
Total Assets Employed	411.7	415.8	410.8	(5.0)	
Financed By:				-	
Public Dividend Capital	665.0	665.0	665.0	-	
Retained Earnings *	(427.5)	(423.4)	(428.1)	(4.7)	Note 5
Revaluation Reserve *	174.2	174.2	173.9	(0.3)	
Total Taxpayers Equity	411.7	415.8	410.8	(5.0)	

The cash position reflects the revenue deficit reported in previous months and this will be mitigated when the £9m cash is received from the ICB to cover additional expenditure incurred by the Trust as a result of industrial action and other cost pressures.

Note 5. Retained earnings are showing a £4.7m variance from plan which reflects the revenue variance from plan of £3.1m at Month 8. The remaining variance is due to lower than planned capital donated income (relating to donated capital expenditure) and higher than planned donated depreciation.

Variances to the plan at Month 8 are explained below:

Note 1. Property, plant and equipment is £7.2m lower than plan and reflects the slippage in the capital programme at Month 8. The main variances relate to lower than planned expenditure on a number of projects including the multi-storey car park, the PDC funded general and acute beds scheme, and lower than forecast spend by capital sub-groups. Expenditure is expected to be in line with plan at the year-end.

Note 2. The inventory balance has increased by £1.5m in comparison to the balance at 31 March 2023. The main areas showing an increase are pharmacy £0.8m, TAVI's £0.2m, and pacemakers £0.1m. These balances are being increased in readiness for the Christmas and New Year period to ensure appropriate inventory levels are maintained.

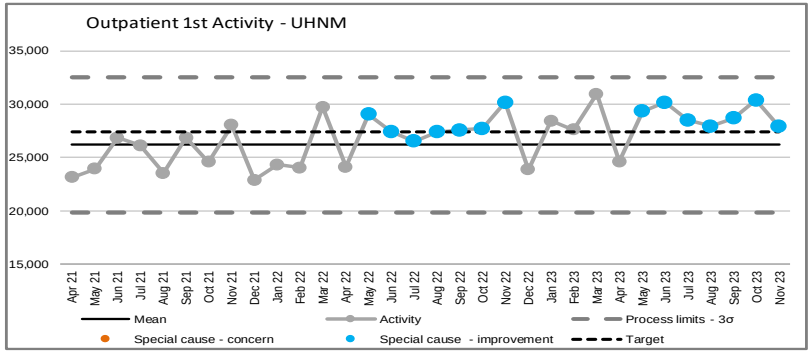
Note 3. This increase is mainly due to a new accrual of £9m relating to funding expected from the ICB to cover additional expenditure incurred by the Trust as a result of industrial action.

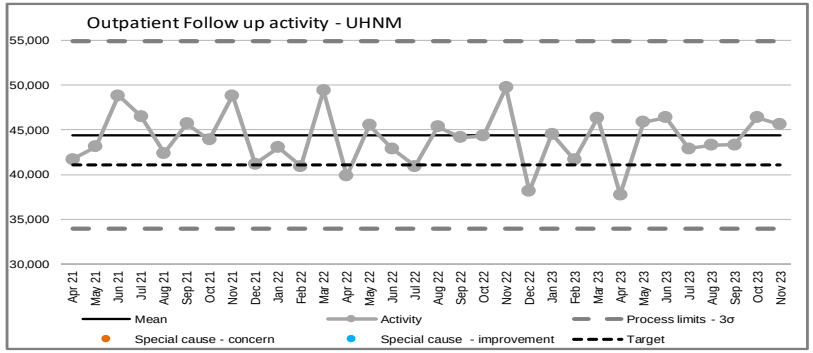
Note 4. At Month 8 the cash balance was £69.2m, which is £6.8m lower than the revised plan of £76m. Cash received is £5.8m higher than plan overall mainly due to other income and VAT reimbursements which are £2.9m and £1.8m ahead of plan respectively. Payments are £12.7m ahead of plan at Month 8. General payments and payroll related payments are £10m and £0.8m ahead of plan respectively. The general payments in-month position reflects the payment of high value invoices relating to NHS Supply Chain, pharmacy and managed service contracts.

Activity

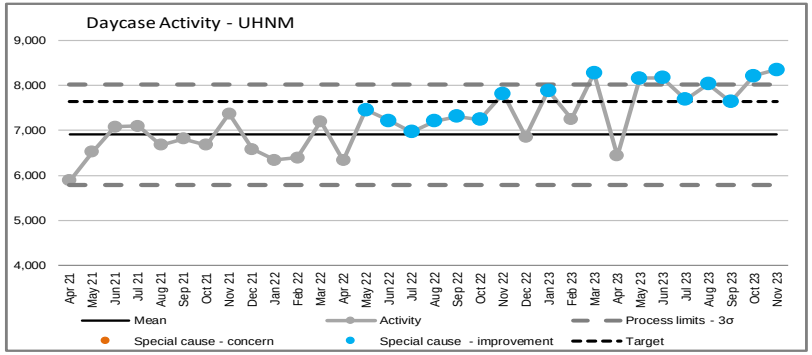
NHS
University Hospitals of North Midlands
NHS Trust

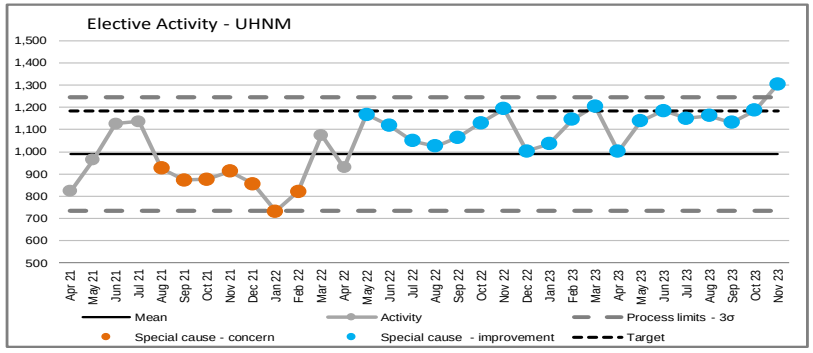
Planned care Outpatient



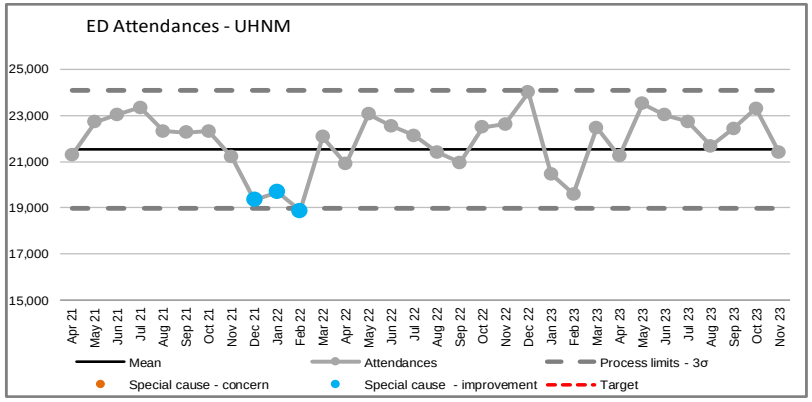


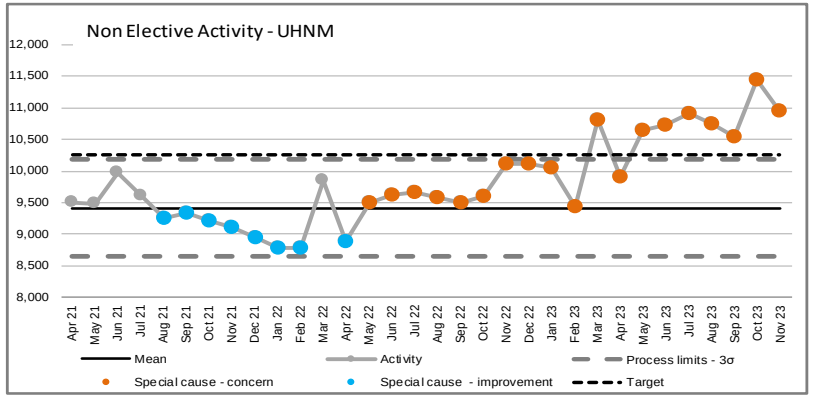
Planned care Inpatient





Urgent Care





Delivering Exceptional Care with Exceptional People

Trust Board

2023/24 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		5	3	7	5	2	6	4	8	6	3	7	6	
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse		Staff		Staff				Staff			Staff		
Quality Governance Committee Assurance Report	Director of Governance													
Quality Strategy Update	Chief Nurse													To be considered at the Trust Board Time Out - November 2023
Clinical Strategy	Director of Strategy													To be considered at the Trust Board Time Out - November 2023
Care Quality Commission Action Plan	Chief Nurse													Deferred to December pending further consideration by the Executive & Committees
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													To be considered in January after discussion at TAP in December
Quality Account	Chief Nurse													
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													
Infection Prevention Board Assurance Framework	Chief Nurse	Q3		Q4		Q1				Q2			Q2	
RESPONSIVE														
Integrated Performance Report	Various	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													Deferred to December due to ongoing discussions
PEOPLE														
Transformation and People Committee Assurance Report	Director of Governance													
Gender Pay Gap Report	Chief People Officer													
People Strategy Update	Chief People Officer													To be considered at the Trust Board Time Out - November 2023
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					Q4 & Q1			Q2			Q3		
IMPROVING AND INNOVATING														
Research Strategy	Medical Director													To be considered at the Trust Board Time Out - November 2023
SYSTEM AND PARTNERS														
System Working Update	Chief Executive / Director of Strategy													
RESOURCES														
Performance and Finance Committee Assurance Report	Director of Governance													

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		5	3	7	5	2	6	4	8	6	3	7	6	
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above	Director of Strategy	N/A	N/A			N/A			N/A		N/A			
Digital Strategy Update	Chief Digital Information Officer													
Going Concern	Chief Finance Officer													
Estates Strategy Update	Director of Estates, Facilities & PFI													To be considered at the Trust Board Time Out - November 2023
Annual Plan	Director of Strategy													
Board Approval of Financial Plan	Chief Finance Officer													Approved at PAF April 2023
Final Plan Sign Off - Narrative/Workforce/Activity/Finance	Chief Finance Officer													Approved at PAF April 2023
Activity and Narrative Plans	Director of Strategy													Approved at PAF April 2023
Capital Programme 2022/23	Chief Finance Officer													Approved at PAF April 2023
Standing Financial Instructions	Chief Finance Officer													Next due for review February 2026
Scheme of Reservation and Delegation of Powers	Chief Finance Officer													Next due for review February 2026
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Director of Governance													
Audit Committee Assurance Report	Director of Governance													
Board Assurance Framework	Director of Governance		Q4			Q1			Q2			Q3		
Accountability Framework	Director of Governance													Not due for formal review until Q3 2024/2025. Interim refresh taking place January 2023
Annual Evaluation of the Board and its Committees	Director of Governance													Board review considered at Trust Board Seminar in July
Annual Review of the Rules of Procedure	Director of Governance													
G6 Self-Certification	Chief Executive													
FT4 Self-Certification	Chief Executive													
Board Development Programme	Director of Governance													
Well-Led Self Assessment	Director of Governance													Timing TBC - proposal being considered November 2023
Risk Management Policy	Director of Governance													
Complaints Policy	Chief Nurse													Next due for review June 2024