University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 4th January 2023 at 9.30 am to 12.00 pm
Via MS Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**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 7th December 2022	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
10 mins	**6.**	Chief Executive's Report – December 2022	Information	Mrs T Bullock	Enclosure	
10:05		**HIGH QUALITY**				
10 mins	**7.**	Quality Governance Committee Assurance Report (22-12-22)	Assurance	Prof A Hassell	Enclosure	BAF 1
10 mins	**8.**	CQC Report	Assurance	Mrs AM Riley	Enclosure	
10 mins	**9.**	ED Corridor Risk Assessment	Assurance	Mrs AM Riley	Enclosure	
10 mins	**10.**	NHS Resolution Maternity Incentive Scheme Year 4 Compliance	Approval	Mrs AM Riley	Enclosure	
10:45		**PEOPLE**				
5 mins	**11.**	Transformation and People Committee Assurance Report (21-12-22)	Assurance	Prof G Crowe	Enclosure	BAF 2, 3, 4, 6, 9
10:50		**RESOURCES**				
5 mins	**12.**	Performance & Finance Committee Assurance Report (20-12-22)	Assurance	Dr L Griffin	Enclosure	BAF 5, 7, 8
10:55 – 11:10 COMFORT BREAK						
11:10		**RESPONSIVE**				
40 mins	**13.**	Integrated Performance Report – Month 8	Assurance	Mrs AM Riley Mr P Bytheway Mrs J Haire Mr M Oldham	Enclosure	BAF 1, 2, 3, 5, 8
11:50	**CLOSING MATTERS**					
10 mins	**14.**	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	15.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 3rd January to** Nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:00	**DATE AND TIME OF NEXT MEETING**					
	16.	**Wednesday 8th February 2023, 9.30 am, Trust Boardroom, Third Floor**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 7th December 2022 at 9.30 am to 12.30 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												
Ms S Belfield	SB	Non-Executive Director												
Mrs T Bowen	TBo	Non-Executive Director							Obs.					
Mr P Bytheway	PB	Chief Operating Officer							KT					
Mrs T Bullock	TB	Chief Executive												
Prof G Crowe	GC	Non-Executive Director												
Baroness S Gohir	SG	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Dr M Lewis	ML	Medical Director						GH						
Prof K Maddock	KM	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse	SM				SM							
Mrs R Vaughan	RV	Chief People Officer												

Non-Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Ms H Ashley	HA	Director of Strategy												
Prof A Hassell	AH	Associate Non-Executive Director												
Mrs A Freeman	AF	Director of Digital Transformation												
Mrs L Thomson	LT	Director of Communications												
Mrs C Cotton	CC	Associate Director of Corporate Governance					NH				NH			
Professor S Toor	ST	Associate Non-Executive Director												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI						DR						

In Attendance:

Mrs D Brayford	DB	Quality and Risk Manager (item 11)
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mrs S Jamieson	SJ	Head of Midwifery (item)
Mr J Robinson	RB	Biomedical Scientist (item 1)
Mr C Wallace	CW	Assistant Director – Learning and Education (item 1)

Members of Staff and Public: 6

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Staff Story**	
177/2022	Mrs Vaughan introduced Mr Wallace and Mr Robinson to the Board and explained that Mr Robinson had been invited to discuss his role as a career ambassador. Mr Wallace referred to the career ambassador videos being used to promote some of the 'hidden' roles available at UHNM and the video highlighting Mr Robinsons role was shown to the Board. Mr Robinson stated that he had realised at an early age that he wanted to work in	

	sciences, although when he went to University he was unaware of the roles within Biomedical Science as a lot of people thought that medical knowledge was required. He explained that he hoped the video would help to highlight the roles within the Trust and encourage others to take forward this as a career. Mr Wallace explained that the ambassadors and the videos were being used to promote careers at UHNM to local schools and colleges and he referred to the virtual work experience offer whereby students can explore different roles to identify the areas they enjoyed, which then informed their physical work experience options. Mr Wakefield referred to the misconception of people thinking that they would require medical training to undertake certain roles in the NHS and queried how the Trust could address this. Mr Robinson stated that raising awareness at an early stage was key in addressing the common misconceptions. Professor Maddock queried the breadth of coverage of the careers being focussed on by the ambassadors, and queried the strategy for working with local partners in further and higher education, to enable greater access into local communities when promoting non doctor / non nursing careers. Mr Wallace referred to the strategic partnerships in place, which included working with secondary schools to strengthen the message of the careers on offer as well as the work undertaken with primary schools. He stated that more work was required in terms of working with the ICS to determine the overall strategy for learning and education within Staffordshire and Stoke on Trent. Mr Wallace stated that ambassadors had been identified within a number of 'hotspot' areas initially, such as estates, pharmacy, cardiology as well as considering Allied Health Professionals and healthcare scientists. Dr Griffin welcomed the approach outlined and thanked Mr Robinson for his involvement in highlighting careers within biomedical science. Mr Bytheway agreed with the need to expand on highlighting careers in other areas and also the use of volunteers such as St Johns and NHS cadets. Professor Hassell referred to access to local schools and teachers to increase the ambitions around medicine and nursing as well as the other careers. Mr Wallace agreed and stated that this was being considered by the ICS in terms of a wider engagement strategy with schools. Mr Wakefield thanked Mr Robinson for putting himself forwards as an ambassador and for raising awareness of the roles on offer at UHNM. He also welcomed the focus on T-levels and apprenticeships and wished Mr Wallace well in taking this forward. **The Trust Board noted the story.** Mr Wallace and Mr Robinson left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
178/2022	Mr Wakefield welcomed members to the meeting and confirmed that the meeting was quorate. Mr Wakefield referred to the resignation of Baroness Gohir, given the time she needed to focus on her responsibilities as a peer and stated that she was due to leave at the end of December. He thanked her for her time at the Trust and	

	wished her well for the future. Mr Wakefield referred to the meeting being the last for Mrs Vaughan and he formally thanked her for her time at the Trust and in particular her eight years as Chief People Officer. He referenced her 36 years in the NHS and wished her best on her retirement.	
3.	**Declarations of Interest**	
179/2022	There were no declarations of interest.	
4.	**Minutes of the Previous Meeting held 9th November 2022**	
180/2022	The minutes of the meeting held on 9th November were agreed as a true and accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
181/2022	PTB/546 – It was noted that this was to be discussed at February's Quality Governance Committee (QGC), it was therefore agreed to move the target date accordingly.	
6.	**Chief Executive's Report – November 2022**	
182/2022	Mrs Bullock referred to the national issue in relation to Strep A which is usually very mild. However, nationally there has been an increase in invasive group A Strep (iGAS) infections which can be more serious. So far this season there being 111 cases against 194 for the whole of the previous year. Sadly so far there have been a number of deaths. She stated that no cases of Strep A had been identified in the Trust currently although there had been reported cases of Scarlett Fever in the community. It was noted that a fast pathway had been identified in the Enhanced Primary Care Hub, for parents worried about the symptoms their children had presented with. Mr Wakefield referred to a recent visit to A&E and pressures within the Children's Emergency Department and queried the message being given to parents regarding this. Dr Lewis stated that advice was available on the gov.uk website which stated that parents should trust their own judgement and contact NHS 111 or their GP if they were concerned that children were not feeding normally, were tired/irritable and had a temperature. He added that they were advised to go to the Emergency Department (ED) if their children were having difficulty breathing or if were unable to stay awake. Ms Bowen queried how well the Standard Process for Admissions had bedded in and whether this had been taken on board by clinicians. Dr Lewis explained that since it was agreed in May 2022, this had positively impacted on how patients were being transferred through the hospital, whereby ED would determine the right place for the patient to be looked after, with the aim of quickly moving patients to the right place, with the right staff and equipment. He stated that this had changed clinicians' mindset and going into winter there were further improvements which could be made to embed this more fully. Mr Wakefield thanked the Executive and Charity for the work undertaken to celebrate Christmas throughout the organisation. **The Trust Board received and noted the report and approved the eREAF 9802.**	

7.	**Accountability and Performance Framework**	
183/2022	Mrs Hassall explained that since the approval of the Accountability Framework in August 2020, the document had been refreshed to take into account the continued development of the corporate governance arrangements in addition to the changes to the performance management review process and alignment to Improving Together as well as changes to the divisional leadership structures. She highlighted the following: • A new section regarding Equality, Diversity and Inclusion and associated governance arrangements had been included following the assessment against the RACE Equality Code. • The Divisional Governance Framework had been revised, setting out minimum expectations for Divisions, in particular having a Workforce/Culture group as well as a forum for consideration of Health and Safety matters. This was supported by a revised Divisional Governance Pack, which clarified expectations around annual business cycles, taking into account findings of relevant Internal Audit Reviews and Divisional Board Effectiveness Reviews • Further work was to be undertaken in terms of assessing the effectiveness of Divisional Boards, therefore this was an area of focus for the Corporate Governance team in 2023/24 Mr Wakefield referred to the adherence to the Divisional Governance Framework and queried how assurance would be obtained on their compliance. Mrs Hassall explained that assurance would be provided via Divisional Governance Effectiveness reviews which mirrored the approach used by Internal Audit and these would be undertaken by the Corporate Governance team. Professor Crowe welcomed the work completed and agreed of the need to embed this going forwards. Professor Crowe queried if there were any implications from the ICS on the document and Ms Ashley stated that the accountability agreements for the ICS focussed on accountabilities to the ICB and the document itself was focussed on internal performance and accountability. Mr Wakefield referred to the watch metrics and queried how often these changed. Mrs Bullock referred to the business rules which were utilised and stated that when these were triggered this would inform changes to the driver and watch metrics. She also referred to the annual process of reviewing the strategic objectives and driver metrics via focussed negotiation and added that this was being undertaken presently with Divisions. Dr Griffin referred to the need to dive deeper into areas such as staffing and queried whether there were separate key performance indicators on retention. Mrs Vaughan stated that the metrics focussed on turnover as the main indicator as retention was difficult to capture, although this was supplemented with the stability index which could be reviewed going forwards. **The Trust Board:** • **Approved the revised Accountability and Performance Framework, including the Corporate Governance Structure** • **Noted the programme of corporate support being developed in relation to application of the Divisional Governance Framework**	
8.	**Well-Led Self-Assessment**	
184/2022	Mrs Hassall referred to the requirements of the Well Led Framework whereby the annual self-assessment had been undertaken and considered by the Executive.	

	She highlighted that whilst there had been significant developments in the past year, 7 / 8 key lines of enquiry (KLOE) had remained the same in terms of the assurance rating although the remaining KLOE had improved from 'Partial Assurance' to 'Good', reflecting the work that had been undertaken to develop the overarching Strategic Priorities and enabling strategies. Mrs Hassall referred to the three delayed actions which related to the embedding of the Clinical Effectiveness Group, mobilisation of the Business Intelligence Strategy and development of the Engagement Strategy and in addition to addressing these areas, key areas of focus had been identified for each KLOE. Mr Wakefield referred to the gaps in updates against the actions identified for Section 6 and given this was an area rated as requiring improvement, suggested that this be updated. In addition, it was suggested to include target dates for the actions identified. Mrs Hassall agreed to update the document accordingly and to discuss this further at a future Non-Executive Director meeting. **The Trust Board approved the Well Led Self-Assessment for 2022, including the matters of concern and improvement opportunities identified, with additional narrative to be included as well as target dates.** **The Trust Board noted that a proposal for external assessment against the Well Led Framework during 2023 was to be developed, once the national position between NHS England and the Care Quality Commission (CQC) is clarified.**	**NH/CC**
HIGH QUALITY		
9.	**Quality Governance Committee Assurance Report (01-12-22) & Maternity Quality Governance Committee Assurance Report (23-11-22)**	
185/2022	<u>Quality Governance Committee Assurance Report (01-12-22)</u> Professor Hassell highlighted the following: • Following the introduction of Your Next Patient, associated consequences were being scrutinised and although incidents had been reported none had been identified with patient harm • The national risk regarding the supply chain of medicines was highlighted • 48 Root Cause Analyses were awaited by the ICB for action and review which reflected the current staff pressures • An annual report on resuscitation was provided, which highlighted some gaps in training related to staffing resource, space for training and an increasing need for resuscitation training. It was noted that this was being considered by the Medical Director and Resuscitation Lead • The neonatal action plan identified some slippage in finalising the escalation policy which was expected to be agreed in January and presented to the Committee in March and the Committee paid thanks to the clinical lead on the work undertaken to date • The Committee agreed the approach to determine any harm of long waiters whilst recognising the associated challenges in taking this forward, ensuring the approach taken was proportionate Mr Wakefield referred to the level of resource available which was a common theme in the report and stated that while investment had been made into the workforce, the associated timescales needed to be articulated. Dr Lewis highlighted that in terms of the discussion of harm related to Your Next	

	Patient, there was no evidence to date and this needed to be considered alongside the context of what would have happened if the patients had not been moved from ED i.e. patients waiting on ambulances. In addition, Dr Lewis highlighted that it had been confirmed that the Trust was no longer being advised to take forward an external review associated with paediatric mortality, given the work which had already been undertaken and the remaining ongoing work. <u>Maternity Quality Governance Committee Assurance Report (23-11-22)</u> Professor Hassell highlighted the following: • 33 friends and family test forms had been completed within maternity which was low when compared to the 1600 births therefore various strategies were being considered for increasing completion • There were a continuing high number of midwifery red flags reported which reflected the ongoing staffing challenges although this was expected to improve given the recent investment in midwifery workforce • 96% of women on the delivery suite had moderate or high risk pregnancies which demonstrated the burden facing colleagues in maternity services. Mrs Jamieson explained that 96% had needs over and above normal pregnancy and birth i.e. diabetic, specific pathways requiring additional intervention, extra CTG monitoring etc • Positive assurance was provided by the newly qualified midwife and the Preceptorship approach taken by the Trust • Excellent work had been undertaken in maintaining antenatal and new born screening numbers **The Trust Board received and noted the assurance reports.**	
10.	**Quality Strategy Update**	
186/2022	Mrs Riley referred to the launch of the strategy in June and referred to the improvements being made to the Clinical Excellence Framework (CEF) process as well as the work being undertaken to assess whether harm free care is being delivered across all services. Ms Bowen referred to priority 2 and the digital clinical excellence audits and queried what assurance the audits provided. Mrs Riley explained that a lot of the audits were undertaken by the CEF process and the digital audits aimed at providing monthly data on a broader set of questions. Ms Bowen referred to the Patient Safety Incident Response Framework (PSIRF) and congratulated the work being commenced to develop standards across the system but queried how likely it was that these would be developed. Mrs Riley stated that a response was awaited from the ICB. Mr Wakefield recognised that the strategy remained in the early stages of implementation, and queried to what extent the size of the Improving Together Quality Academy team / lack of resource, would impact on the ability to take forward elements of the strategy. Mrs Riley stated that the trajectory for improvement and pace of the programme was right but further work was required on ensuring teams were using the tools correctly. Mr Wakefield referred to the reference to the increased capacity of virtual wards and queried what the Trust was starting with and what the end point was in terms of how many admissions had been avoided. Mr Bytheway stated that the concept of virtual wards was in place in the system which aimed to save 30 acute beds but	

	while technology and willingness was in place, the staffing was not and this was a risk to the winter plan. Ms Ashley added that the additional information referred to, would be included within the associated business case which would be considered by the Board in due course. **The Trust Board noted the transformational work achieved to date and supported the transformational aspects of the Quality Strategy moving forwards.**	
11.	**Q2 Maternity Serious Incident Report**	
187/2022	Mrs Brayford highlighted that 5 ongoing serious incidents had been completed and were to be presented for approval. Mr Wakefield referred to the chart on ethnicity and queried what this was demonstrating. Mrs Brayford stated that previously, the ethnicity figures did not reflect the population, therefore this had been amended to demonstrate the percentage of mothers involved in serious incidents and their ethnicity, compared to the total number of those booked within that ethnic group. It was agreed to clarify the charts in future reports to explain what was driving the increase and whether local themes reflected national themes. Professor Hassell added that it would be helpful to know the actual total number of deliveries of black Caribbean / white patients so that the validity of the data can be determined. Mr Wakefield referred to time taken to complete investigations and noted that due to staff shortages there had been a delay which was worrying and he queried how this was being addressed. Mrs Brayford stated that as part of the escalation process for staffing shortages some of those midwives completing RCAs were being utilised elsewhere, however, immediate actions were identified and actioned and the families continued to be kept informed of any delays. Mrs Jamieson added that following approval of the business case, midwifery staffing levels would move towards birthrate + and in addition to the previously appointed newly qualified midwives this would have a positive impact in due course. Mrs Brayford added that of those investigations which had been delayed, there had not been a repeat of any similar incidents. **The Trust Board received and noted the report and noted that future reports would include a timeline of the actions completed. In addition, assurance would be provided of how system changes had been successfully embedded in practise.** Mrs Brayford left the meeting.	**DB**
12.	**IPC Board Assurance Framework – November 2022**	
188/2022	Mrs Riley highlighted that the changes which had been made to the self-assessment and highlighted that updates were to be included to address the actions being taken as a result of the gaps had been highlighted. It was noted that the updated document had not been considered by the QGC due to this only being considered by the Committee on a quarterly basis and the document being considered by the Board month. It was agreed to consider this further at QGC. **The Trust Board received and noted the update.**	**AMR**

PEOPLE		
13.	**Transformation and People Committee Assurance Report (30-11-22)**	
189/2022	Professor Crowe highlighted the following: • The focus of the meeting was on the strategic intent of transformation as well as delivering the broader people agenda • A peer review had been undertaken which showed the Trust was utilising similar methods in taking forward the Improving Together approach although there was an opportunity to strengthen some areas of work • Positive assurance was provided by the learning and education team as well as the ongoing work associated with taking forwards the digital strategy Mr Wakefield referred to data security training compliance and queried how this was being focused on. Dr Lewis explained that this was an area of concern and the delivery of training was being explored in order to increase compliance as well as this being an area of focus with divisional colleagues. **The Trust Board received and noted the assurance report.**	
14.	**People Strategy**	
190/2022	Ms Toor joined the meeting. Mrs Vaughan highlighted the following: • The document had been refreshed following the publication of the national people plan and promise and had been produced in conjunction with staff networks and divisional teams • Feedback from the staff survey and feedback from the culture review had been taken into consideration • The strategy had focussed on 4 key domains and incorporated a number of deliverables and associated key performance indicators Mr Wakefield welcomed the ambition highlighted within the document and queried in terms of measuring progress against the 2025 ambition where it would put the Trust in terms of national benchmarking. Mrs Vaughan stated that this was difficult to measure but she hoped to see an improvement in the overall engagement score. Mrs Haire added that a score of 7.7 would take the Trust to the top of the benchmark group which was ambitious and was why the target had been set at 7. Dr Griffin welcomed the aim for the strategy to remain agile and queried how progress would be measured. Mrs Vaughan stated that updates would continue to be provided to the Transformation and People Committee (TAP) in terms of progress against the delivery plan. Mr Wakefield referred to the ambition for year 3 and widening career pathways for disadvantaged groups and queried what this would look like. Mrs Vaughan stated that this would build on work already in place by working with the education sector and undertaking targeted and focused work with those groups. Mr Wakefield queried what the digital passports for doctors identified in year 2 were and Mrs Vaughan stated that this was aimed at improving information sharing between organisations particularly for doctors in training, such as identifying statutory and mandatory training which had been complete and could	

	be transferred. Mr Wakefield summarised that the delivery plan and ongoing monitoring would be undertaken via TAP and he welcomed the reference to the 96 nationalities within the Trust which was positive, as well as welcoming the expansion of the use of volunteers. **The Trust Board approved the People Strategy which was to be communicated widely to stakeholders and would be supported by a "plan on a page" as a summary version.**	
15.	**Workforce Race Equality Standards Report**	
191/2022	Mrs Vaughan highlighted the following: • The annual report assessed the career experience of Black and Minority Ethnic (BAME) colleagues compared to white staff which aimed to enable Trusts to understand areas where they need to improve • Representation had increased year on year and 1 in 5 staff were from a BAME background • Nationally, and locally, BAME staff were less represented at senior levels and sometimes had worse experience in the NHS with more obstacles in progressing their careers • There had been a national worsening of BAME staff feeling harassed and bullied • 5 indicators had improved from the previous year and 4 had deteriorated; the indicators which had worsened related to the experience of BAME colleagues and their belief in equal opportunity for career development • Some suggestions had been provided by TAP on the actions which could be undertaken to reduce the barriers Mr Wakefield referred to chart 6 and the percentage of BAME staff experiencing harassment which had risen significantly above the average and queried if this was this related to the brap findings. Mrs Vaughan stated that a lot of awareness raising had been undertaken in the past year such as promoting speaking up and raising concerns as well as the work to communicate the brap survey results, which would have had an impact. Dr Griffin welcomed the continued promotion of the issues being experienced so that actions could be taken and welcomed the Trust figures for white applicants being 1.25 times more likely to be appointed than BAME which was lower than the national average of 1.61, whilst recognising that this needed to improve further. Professor Hassell referred to the reciprocal mentorship programme and queried if there were any plans to extend this with staff who were not at Board level. Mrs Vaughan stated that this had been extended to Divisional Senior Leaders and agreed that this could be extended further. Professor Crowe referred to the discussion at TAP and the need to break through the glass ceiling of staff not progressing above certain levels as well as continuing to promote the different careers available. Mr Wakefield referred to the priorities and actions identified and queried how progress against these would be measured. Mrs Vaughan stated that this would be measured by staff survey feedback and results. **The Trust Board received and noted the report and the actions identified,**	

	which were intended to close the gaps in career and workplace experience between BAME staff and the overall workforce at UHNM during 2022-23.	
RESOURCES		
16.	**Performance & Finance Committee Assurance Report (29-11-22)**	
192/2022	Dr Griffin highlighted the following: • The Committee continued to balance the discussion between operational and financial performance and noted the continued challenges on urgent care • A focus on discharges and the actions being taken to improve discharges will be considered in December and future meetings will receive updates in relation to theatre utilisation and community diagnostic centres • The Committee received and approved four business cases **The Trust Board received and noted the assurance report.**	
RESPONSIVE		
17.	**Integrated Performance Report – Month 7**	
193/2022	Mrs Riley referred to the ongoing work being undertaken in relation to the number of pressure ulcers being reported and added that one never event had occurred which related to NG tube placement. In addition, the cause of the drop in compliance for written duty of candour was being further explored. Mr Wakefield referred to the Covid numbers and the validity of this given the change in testing. Mrs Riley confirmed that if patients were symptomatic or clinically vulnerable they were tested, and this issue had been raised with the regional team, in terms of determining hospital acquired infections when the patients had not been tested on admission. Professor Maddock queried whether the stop the pressure day had taken place and if so whether this demonstrated particular learning points. Mrs Riley stated that this had been delayed and agreed that any learning needed to be shared throughout the organisation. Professor Maddock welcomed the questions being asked through the new Tendable audit system. Professor Crowe referred to the metrics associated with written duty of candour and Mrs Riley stated that a change in divisional support had caused some difficulty in this metric and this was being explored further in terms of whether the metric should be moved to a driver. Mr Wakefield queried how the induction of newly qualified midwives had gone and Mrs Riley stated that this had gone well but it was still early in their journey. Mr Bytheway referred to urgent care performance and highlighted the following: • An increase in the discharge profile saw a reduction in the total time for ambulance holds as well as a reduction in both 8 hour and 4 hour waits • Additional spaces were being utilised to maintain flow in the ambulatory area • Work was continuing to take place to improve ambulance handover areas and use of Your Next Patient spaces to deal with the number of medical decisions to admit • A task and finish group was in place looking at the complex discharge processes • A reset week had commenced in Medicine looking at long stays Mr Wakefield referred to the winter plan and the assumptions made which had not	

been realised. He queried what else could be done by the system to help the current position and Mr Bytheway referred to the importance of having a plan to demonstrate the direction of travel. He stated that an additional ward had been opened but the opening of the Trent ward had been delayed and although the use of virtual wards was noted the in the plan, this was not yet in place.

Mr Wakefield queried how ambulance wait performance was expected to improve and Mr Bytheway stated that although there had been an initial reduction, the level of risk going into the Christmas and the New Year period needed to be measured; he added that standing down of elective activity to mitigate the risk was therefore likely and this was being discussed regionally. Mrs Bullock stated that UHNM were one of 12 Trusts which met with the national team on a regular basis and as part of that, national data had been provided which demonstrated a significant national deterioration. She added that the 12 Trusts at the start of the national work were responsible for 40% of ambulance delays and this had since reduced to 10%, therefore indicating the pressures with ambulance waits acros the whole NHS.

Mr Bytheway highlighted cancer performance:

- Performance continued to be challenged although recent improvements had started to be made as a result of the work undertaken in the past 3 months to reduce the total patient tracking list (PTL)
- More patients were being treated for cancer and urgent clinical decisions than previously
- The backlog position had previously been 19% of the total PTL which had caused national concern but had reduced to 17% and the regular conversations with the regional team now focussed on coming out of the tier 2

Professor Hassell commented that given the current challenges, the progress being made for cancer was commendable and should be congratulated.

Mr Bytheway stated that it was recognised that further improvements were required for planned care, which included the need to improve upon theatre utilisation. He stated that theatre sickness had improved and more work was being undertaken at County Hospital. The 78 weeks plan was being re-profiled given the Trust was ahead of plan although this may be impacted by the challenges associated with winter.

Mr Bytheway referred to diagnostics performance and stated that the main issue continued to be non-obstetric ultrasound and performance monitoring was underway to track performance given the static position. It was noted that Endoscopy had started to see an improvement in performance and fortnightly meetings continued to be held regarding this.

Mr Wakefield queried whether the Trust was on track to deliver the DM01 standard by the end of March and Mr Bytheway stated that this had been discussed with the regional team who were supportive of the plans in place and the use of outsourcing which was expected to improve the position.

Mrs Vaughan highlighted the following:

- Sickness had increased in October, as expected, largely driven by covid outbreaks but absences had declined through November and covid related absences had reduced to 11% although this remained an area of concern
- Benchmarking information had been presented to TAP and UHNM was identified as an outlier in terms of sickness absence and this was being explored further, although it was recognised that this could in part be due to the use of Empactis

	• PDR performance had slightly improved and a further update was being taken to TAP regarding divisional plans for improvement • The staff survey closed on 25th November and the response rate of 31% was below the average although this excluded paper surveys • In terms of industrial action, the Royal College of Nursing and Unison ballots had closed and UHNM did not meet the threshold, although a number of neighbouring Trusts did and the response to this was being considered by the system Professor Crowe referred to the industrial action prior to Christmas and it was noted that locally this was not expected to cause disruption, albeit strikes were taking place by the West Midlands Ambulance Service. Mr Wakefield referred to vacancy levels and queried the gap and how this linked to use of bank and agency staff. Mrs Vaughan stated that the analytics on the rotas was used to identify the gap and it was noted that a 21% vacancy factor had been built into establishment. Mr Oldham highlighted the following: • A £2.1 m surplus to the end of October was reported which deteriorated in month 7 as a result of the stepping up of winter initiatives although this was in line with the forecast position • The forecast for the year end stood at a £9 m deficit but mitigation was in place to take non-recurrent actions to bring this back to balance • The system position collectively was a break-even for the year whilst accepting the non-recurrent support which would present an underlying challenge • £6 m unvalidated cost improvements had been identified, £4.4 m of which was recurrent against the £13.6 m target. A number of other schemes were being reviewed although a gap was anticipated, therefore this was being considered in terms of how this be offset non-recurrently Professor Crowe queried when the medium term financial plan for Trust and the system was due to be refreshed. Mr Oldham stated that this work was ongoing and further detail following the autumn statement was required before this could progress further, although this guidance was expected before Christmas. Mr Oldham added that capital was behind plan and there had been some slippage on Trent scheme and CT7 although contingency plans were in place. **The Trust Board received and noted the performance report.**	
18.	**UHNM Tier 2 Analysis**	
194/2022	Mr Bytheway referred to the document which had been provided for assurance and had been agreed by Mr Wakefield and Mrs Bullock. He stated that the document had also been considered by the Performance and Finance Committee (PAF) and the plan on a page highlighted the structure in terms of how elective and cancer recovery was being managed. He thanked Mrs Thorpe for undertaking this piece of work. **The Trust Board noted the prior approval of the self-certification which was submitted on 11th November 2022 and confirmed the following:** • **A lead Executive had responsibility for elective and cancer performance and recovery** • **Relevant Committees receive appropriate reports**	

	• **Agreed plan for 78ww and 62 day trajectories** • **Report received on Lower GI, Skin and Prostate pathways** • **Pursuing outpatient transformation** • **Received reports on Super September and Validation** • **Received assurance on clinical prioritisation and reviewed cancer turnaround times** • **Discussed theatre productivity at every Trust Board** • **Reviewed Model Health System theatre productivity** • **Confirmed SRO for theatre productivity** • **Ensured diagnostic utilisation**	
GOVERNANCE		
19.	**Board Development Programme Progress Report**	
195/2022	Mrs Hassall presented the quarterly update of progress made in taking forward the Board Development Programme. She highlighted a number of changes which had been made to the programme which mainly related to changes in timings. It was highlighted that a number of items were to be carried forward onto the 2023/24 programme namely the update on Clinical Research Network/CenREE. Mr Wakefield referred to the annual plan and enabling strategies which were to be considered in March and suggested that an update on the medium term financial plan be considered at that point which was agreed. **The Trust Board noted the updated Board Development Programme and the timing of the remaining sessions and agreed to include an update on the medium term financial plan for March 2023.**	
20.	**Calendar of Business 2023/24**	
196/2022	Mrs Hassall presented the Calendar of Business for 2023/24 which followed similar sequencing of meetings as per 2022/23, although a number of changes had been made to ensure that meetings which the Divisional Triumvirate attend, were held on a Tuesday or Thursday. **The Trust Board approved the Calendar of Business for 2023/24.**	
CLOSING MATTERS		
21.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
197/2022	No further comments were made.	
22.	**Questions from the Public**	
198/2022	No questions were received from the public.	
DATE AND TIME OF NEXT MEETING		
23.	**Wednesday 4th January 2023, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**	

Trust Board (Open)

Post meeting action log as at 22 December 2022

CURRENT PROGRESS RATING		
B	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
GA / GB	On Track	Improvement on trajectory either:
A	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required
R	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/546	08/06/2022	Integrated Performance Report - Month 1	To take an update to a future QGC meeting regarding measuring the impact on patients who had not received appropriate sepsis screening within the Emergency Department	Ann-Marie Riley	02/03/2023		It was noted at December's meeting that this was to be discussed at the QGC meeting in February. Target date moved.	A
PTB/548	08/06/2022	Annual Evaluation of Committee Effectiveness & Rules of Procedure	To provide a summary of changes to the Code of Governance at a future Audit Committee	Claire Rylands	02/02/2023		Action not yet due.	GB
PTB/568	09/11/2022	Patient Story	To provide an update on the areas identified as part of the patient story, to a future Quality Governance Committee (QGC) meeting.	Ann Marie Riley Paul Bytheway Matthew Lewis	02/02/2023		Action not yet due	GB
PTB/569	09/11/2022	CQC Action Plan	To discuss the assurance map with Professor Crowe in order to highlight the work being undertaken to assess the adequacy of assurance.	Claire Cotton	31/01/2023		Action not yet due	GB
PTB/570	09/11/2022	Q2 Board Assurance Framework	To consider the risk and impact associated with the underlying system deficit within BAF 8	Mark Oldham Claire Cotton	08/02/2023		Action not yet due	GB
PTB/571	07/12/2022	Well-Led Self-Assessment	To update the document to include additional narrative for the actions within Section 6, including target dates and to discuss at a future NED meeting.	Claire Cotton Nicola Hassall	31/01/2023		Document updated to include additional narrative for the actions within Section 6. Target dates to be identified and a date to discuss at a future NED meeting to be confirmed.	GA
PTB/572	07/12/2022	Q2 Maternity Serious Incident Report	To expand on the ethnicity chart within the report, to clarify reasons for increases and whether any themes reflected national themes. In addition to identify the associated denominators and the total number of deliveries per ethnic group.	Ann Marie Riley Donna Brayford	08/03/2023		Action not yet due. This has been added to Feb QSOG and MQGC for discussion.	GB
PTB/573	07/12/2022	IPC Board Assurance Framework –November 2022	To consider the frequency of reporting the IPC BAF at QGC / Board going forwards.	Ann Marie Riley	22/12/2022	22/12/2022	Discussed at December's QGC. Suggested to move to quarterly updates to the Trust Board so that QGC could consider the BAF beforehand.	B

NHS University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

December 2022

Part 1: Trust Executive Committee (TEC)

Due to the Christmas period and winter pressures, the Trust Executive Committee did not meet during December 2022. The next meeting is to be held 25th January 2023.

Part 2: Contract Awards and Approvals

2.1 Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 13th November to 14th December, 3 contract awards, which met these criteria, were made, as follows:

- **Outsourcing of Skin Cancer Operative Work to Nuffield Health** supplied by Nuffield Health, for the period 03.12.22 – 31.03.23, at a total cost of £561,225, approved on 14/11/22
- **Insourcing Surgery Services to support the Recovery Elective of Orthopaedic Operating** supplied by 18 Week Support, for the period 03.12.22 – 31.03.23, at a total cost of £600,082, approved on 14/11/22
- **Staff Benefits** supplied by Vivup, for the period 01.12.22 – 30.11.25, at a total cost of £3,000,000, providing savings of £80,000 estimated in salary reduction, approved on 25/10/22

In addition, the following eREAFs were approved at the Performance and Finance Committee on 20th December, and also require Trust Board approval due to the value:

Purchase of Modular Building at Royal Stoke Outpatients (eREAF 10258)

Contract Value	£1,500,000 incl. VAT
Duration	Not applicable
Supplier	Portakabin Ltd

The Trust Board is asked to approve the above eREAFs.

2.2 Consultant Appointments – December 2022

The following provides a summary of medical staff interviews which have taken place during December 2022:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Cardiac Surgeon	Vacancy	Yes	01/01/2023
Locum Consultant, Colorectal & General Surgeon	Vacancy	Yes	TBC
Locum Consultant Neonatologist	Vacancy	Yes	20/03/2023

The following provides a summary of medical staff who have joined the Trust during December 2022:

Post Title	Reason for advertising	Start Date
Locum Consultant in Emergency Medicine	Vacancy	01/12/2022
Consultant Histopathologist	Extension	01/12/2022
Consultant Upper GI Surgeon	Vacancy	01/12/2022
Consultant Thoracic Surgeon	New	01/12/2022
Consultant Thoracic Surgeon	New	01/12/2022
Consultant Stroke Physician	Vacancy	05/12/2022

Post Title	Reason for advertising	Start Date
Consultant Imaging - Breast Radiologist	Vacancy	09/12/2022
Locum Consultant Paediatric Orthopaedic Surgeon	Vacancy	05/12/2022
Locum Consultant Radiologist GI & Uroradiology	Extension	07/12/2022
Consultant Ophthalmologist	Extension	16/12/2022

The following provides a summary of medical vacancies which closed without applications/candidates during December 2022:

Post Title	Reason for advertising	Note
Locum Consultant - Winter Pressures	New	No Applicants
Consultant Microbiologist	Vacancy	No Applicants

2.3 Internal Medical Management Appointments – December 2022

The following provides a summary of Medical Management interviews which have taken place during December 2022:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Foundation Programme Director	Vacancy	Yes	01/01/2023
Surgical Tutor	Vacancy	Yes	TBC
Surgical Tutor	Vacancy	Yes	TBC
Child Health Clinical Lead for PICU	Vacancy	No	N/A

The following provides a summary of Medical Management who have joined the Trust during December 2022:

Post Title	Reason for advertising	Start Date
Joint Local SuppoRTT, LTFT Champion & Doctors Support Lead	New	01/12/2022
Honorary NMCPS Network Medical Director	Vacancy	01/12/2022
Royal College of Radiologists College Tutor	Vacancy	19/12/2022

There were no medical management vacancies that closed without applications / candidates during December 2022.

Part 3: Highlight Report

3.1 Trust Pressures

We have experienced considerable operational pressure throughout December and on Monday 19th December we took the decision to escalate to the highest level of critical incident which allows us to take additional steps to maintain safe services for our patients and help us cope with the additional pressure we were facing and to prepare for the Industrial Action planned by the Ambulance Service on the 21st December. On top of the industrial action we have seen increase in the number of patients with Covid, Seasonal Flu, respiratory infections and Strep A which created difficulties in flow out of ED as a significant number of patients required a side room for isolation purposes and these weren't always available. Also, as a result of the increase in infections, staff sickness has also increased which has further compounded the pressures being faced.

In order to manage demand and ensure patient safety we continued to work with our partners across health and social care to reduce ED attendances and increase discharge from hospital, whilst we continued to improve our internal processes and flow of patients through the hospital. As a result of considerable efforts across the Trust and system, the 24 hours of strike action were managed extremely well despite higher ambulance attendances during that 24 hour period than has been seen for some time.

As a result of the considerable risks during the strike action most senior management, including Executives worked shifts to ensure the most challenged periods were covered, in particular out of hours. The same will happen again for the strike action planned on the 28th December

Unfortunately, the 24 hours prior to the strike were very challenging and disappointingly, except for the period of the strike we remained one of the Trusts who held the most ambulances and for the longest time. Prior to the strike action the ED Clinical Leadership made the very difficult decision to reluctantly recommence corridor care and this has been reluctantly supported by the executive. To enable this, the Chief Nurse, along with ED staff, undertook a thorough risk assessment and the learning from the most difficult periods of corridor care during 2018 were used. This will be discussed in more detail later on the agenda and will be presented through the trusts usual governance processes. We have also discussed this with the CQC and ICB and have invited them to review what we are doing.

3.2 Staffordshire and Stoke-on-Trent Quarterly System Review Meeting

On 8th December, along with system partners, I attended the Quarterly System Review led by our regulators at NHS England. The purpose of the meeting was to review current areas of focus across the system and to discuss progress being made in relation to preventing ill health and reducing inequalities.

There were a number of areas where positive progress was recognised, which included:

- National awards including Combined Healthcare winning NHS Trust of the Year 2022
- Well-developed system partnership as recognised by Amanda Pritchard
- Improvements within Primary Care with regard to face to face appointments
- System leadership in the handling of the Woodhouse closure
- Improvement in the backlog on the lower GI cancer pathway at UHNM

Areas of concern were noted in relation to timely care for patients across the urgent and emergency care pathway (Ambulance Handover delays), Elective Care, Diagnostics Services, challenges within Maternity and End of Life / Palliative care pathways as well as a drive to improve productivity and efficiency. A number of key actions were identified as a result of the discussion into these areas, including:

- Ensuring that data quality improvements are made in order to capture ethnicity data appropriately
- Development of a shared risk management plan for urgent and emergency care along with a summary of changes to be made pre-admission, in hospital and around discharge in order to improve ambulance handovers
- Development of plans to achieve zero patients waiting over 78 weeks by year end and to improve diagnostic performance
- Confirmation of arrangements for escalation of system infection, prevention and control concerns with NHSE
- Further discussion regarding end of life / palliative care
- To identify and adopt learning from other systems in relation to patient experience across the primary care pathway

Finally, workforce and financial challenges were noted although it was acknowledged that there is a system wide approach to managing these risks.

3.3 CQC Inspection Report

We are now in receipt of our final inspection reports from the CQC following their inspection on 4th October 2022; these will follow later in the Board's agenda as we have been working on our response to the actions required.

3.4 JAG Accreditation Awarded

I was delighted to receive a letter to confirm that following submission of an annual review, our Endoscopy Services have demonstrated that they meet best practice quality standards, as required by the Joint

Advisory Group (JAG) on GI Endoscopy and have therefore been awarded accreditation for 5 years (subject to annual review).

The team were congratulated on their hard work during the accreditation process and for such a high standard of achievement. Well done to all involved!

3.5 Focussed Negotiation

As an Executive Team we met with all of our divisional leadership teams during the month to discuss priorities for the forthcoming year. This is part of our Improving Together long term culture transformation journey, giving responsibility and decision making back to staff within their areas. Once these priorities have been finalised, we will be publishing them as part of our annual plan, so that everyone can see how we are working to improve the care we deliver as well as making UHNM a great place to work for everyone.

3.6 Christmas Celebrations

Despite all of the pressures, it has been great to see so many teams getting involved in our Christmas celebrations organised by our UHNM Charity. I have been told that it was extremely difficult to judge our festive competition with more than 40 areas across both hospitals competing. In addition, many of our staff came up with some amazing creations for the bake off competition and it was really heart-warming to see so many of our staff wanting to do something to help the community during this time with donations being made to local food banks and gifts distributed to children and the elderly.

3.7 Partnership Working with the Universities

Along with a number of Executives, consultants and Alison Cooke our Assistant Director of Nursing Research and Academic Development, I met with executives from Staffordshire University. The meeting gave us an opportunity to build on our close working relationship and to discuss our research ambition. We are very research active with them although this is occurs on an informal basis and both organisations have given a commitment to put this on a formal footing as part of developing research and innovation at UHNM.

During the month I have also presented to year 3 medical students at Keele University about the NHS and particularly UHNM; I always enjoy presenting on such sessions and I am delighted to have been given this opportunity.

3.8 Our Partnership Day

Earlier in the month we met with a number of the key organisations from the private and public sector who we work with on a daily basis to provide access to the most up to date estate, technology and equipment to provide the best possible services to our patients. Our Partnership Day was organised by the Estates, Facilities and PFI team and was the first opportunity since pre-Covid to get in one room and discuss the fantastic role our PFI partners play in improving the experience of our patients and to thank them. We also discussed our collective priorities going forward.

3.9 HFMA National Healthcare Finance Awards 2022

The HFMA National Healthcare Finance Awards took place on 8th December, which recognises the work of finance teams and individuals across the UK. The awards cover the fundamental aspects of the finance team role including the production of the accounts, costing, governance, training and development as well as the vital area of innovation.

I am delighted that Staffordshire and Stoke-on-Trent Integrated Care System won ‘Finance Team of the Year Award’ which recognises our creation of a united finance team across the system, characterised by

collective working and demonstrating a clear commitment to supporting system transformation. My congratulations go to all involved in this achievement.

3.10 Supporting Culture and Leadership in our Maternity and Neonatal Services

Following a regional nomination process, our senior perinatal leadership team has been selected to participate in the first wave of the national Perinatal Culture and Leadership Development Programme.

The national funding programme is in direct response to feedback from colleagues in support of nurturing a positive safety culture and supports the response to the Immediate and Essential Actions in the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals. As a Board we are asked to support our teams to attend the programme, to consider the culture within our own service and ensure that our Maternity and Neonatal Board Champion has a strong and positive relationship with the team.

Quality Governance Committee Chair's Highlight Report to Board

22nd December 2022

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• A gap analysis of the Trust's position in relation to local and national clinical effectiveness priorities had been provided to the Clinical Effectiveness Group, which demonstrated a number of areas requiring progression and additional resources which were to be requested. • The End of Life Annual Report highlighted issues in relation to cancellation of meetings, challenges in the identification of patients and quality of ReSPECT forms for which an audit was being undertaken to obtain assurance on this • Conversations were ongoing with Emergency Department staff with regards to utilising corridor care for up to 15 patients, given the risks associated with holding patients on ambulances • The patient experience report included results from the national cancer and national inpatient surveys with a key theme being related to patients not being given enough information in advance. In order to obtain more real time information, in house survey questions had been amended to ask the same questions as those in the inpatient survey • Written duty of candour had been raised with Divisional teams in terms of ensuring that duty of candour letters were issued and documented	• To liaise with the Health Library regarding obtaining a literature search in relation to patient mask wearing • To provide an update to a future Clinical Effectiveness Group of any learning to be taken forward when implementing GIRFT across all specialities following the work undertaken in General Surgery • To consider the actions which could be taken across the system with regards to managing pressure ulcers • Risk assessment to be brought to a future meeting with regards to vacancy challenges and wards which were consistently rated as red in terms of their fill rates • Datix incidents and complaints to be monitored in relation to corridor care • Further update on PSIRF to be provided to the Committee in January • To provide a statistical explanation of how the SHMI is generated at the mortality review group as well as considering with clinical colleagues to determine any areas which needed to be focussed on
✓ Positive Assurances to Provide	**Decisions Made**
• The Medical Examiners Office highlighted that whilst the Trust remains in a non-statutory phase, 27 GP practices were referring community deaths into the Medical Examiner service and this was expected to increase to 104 GP practices • The new approach to managing the Get It Right First Time (GIRFT) portfolio with increased engagement with Divisional Medical Directors was highlighted in addition to the broadening of the portfolio whereby oversight was to be provided to the Clinical Effectiveness Group • The Committee noted the Year 4 Maternity Incentive Scheme submission which confirmed compliance on all 10 safety actions and the submission was to be considered by the Trust Board in January before the deadline • The End of Life Annual Report highlighted a number of updates to key documents and re-introduction of face to face training whereby demand had increased • Nursing and midwifery quality report highlighted the work being undertaken to identify any harm from long waits as well as assessing the quality impact following the introduction of Your Next Patient • An update on CQUIN progress was provided, which highlighted the 5 ICB schemes which were in train and a summary of actions being taken would be provided in future reports	• It was agreed to propose quarterly updates on the Infection Prevention Board Assurance Framework to the Trust Board, which would enable the Committee to scrutinise the document beforehand
Comments on the Effectiveness of the Meeting	
• The chair thanked members for attending despite the current critical incident and members welcomed items being taken as read to enable discussion to focus on key areas	

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Medical Examiner Service Update	-		✓	Assurance	7.	Nursing and Midwifery Staffing and Quality Report: Q2 2022/23 • ED Corridor – Verbal Update	BAF 1/3	16	✓ !	Assurance
2.	GIRFT Summary and Divisional Management Approach	-		✓	Information	8.	Commissioning for Quality and Innovation (CQUIN) Scheme for 2022/23	-		✓	Assurance
3.	Executive Clinical Effectiveness Group Assurance Report (06-12-22)	BAF 1	16	!	Assurance	9.	Q2 Patient Experience Report 2022/23	BAF 1	16	!	Assurance
4.	Infection Prevention Board Assurance Framework	BAF 1	16	-	Assurance	10.	Quality & Safety Report – Month 8 22/23	BAF 1	16	!	Assurance
5.	Maternity Incentive Scheme Year 4	BAF 1	16	✓	Assurance	11.	Quality & Safety Oversight Group Assurance Report (12-12-22)	BAF 1	16	-	Assurance
6.	End of Life Annual Report 2021/22	-		✓ !	Assurance	12.	Quality Impact Assessments	-		-	Assurance

3. 2022 / 23 Attendance Matrix

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

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board	**Date:**	4th January 2023
Report Title:	CQC Report	**Agenda Item:**	8
Author:	Ann Marie Riley, Chief Nurse		
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

BAF1	*Delivering Positive Patient Outcomes*	*16 (Extreme)*

Executive Summary

The CQC inspected the Medical core service and urgent and emergency care service on the 4 October 2022. This was a follow-up focused inspection in response to a warning notice issued in 2021, whereby the Trust was notified that the CQC had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health needs in Medicine at County Hospital required significant improvement.

The Royal Stoke University Hospital (RSUH):
RSUH was inspected only in the areas identified within the warning notice using the CQC focused inspection methodology across the acute medical unit (AMU), Acute Medical Rapid Assessment Unit (AMRAU) and the Acute Short Stay unit. The service was not rated and so the previous rating of requires improvement remains.
We are extremely pleased that the CQC found that the Trust had made improvements in staffing and judged that the warning notice had been met.

The CQC noted 2 areas for improvement for the RSUH site:
SHOULD DO:

- The Trust should ensure that all mental health patients presenting to the emergency department have their mental health risk assessment proforma tool completed and kept with the patient should they be transferred to other departments of the hospitals.
- The Trust should ensure all staff complete relevant training around mental health awareness, including mental capacity and deprivation of liberty safeguards (DoLS).

County Hospital:
County Hospital was inspected only in the areas identified within the warning notice using the CQC focused inspection methodology across the acute medical unit (AMU), and Ward 12. The CQC also visited ED to understand the patient pathway through to the medical wards. The service was rated as follows:

- Safe – rating went down from requires improvement to inadequate
- Effective - rating went down from requires improvement to inadequate
- Responsive – rating remained the same at requires improvement
- Well led - rating remained the same at requires improvement

The overall service rating is inadequate.

The overall County Hospital rating remains the same at requires improvement.

The CQC noted the following areas for improvement for the County Hospital:

MUST DO:

- The trust must ensure that where required, mental capacity assessments and Deprivation of Liberty Safeguards applications are made in line with the trust policy and legal frameworks. (Regulation 11 Need for Consent)
- The trust must ensure that all required assessments including the mental health proforma and within 'seven-day patient risk assessment booklet' are completed as per trust processes. (Regulation 12 Safe Care and Treatment)
- The trust must ensure that where enhanced or therapeutic observations have been identified as necessary within patient care plans, staff are sourced to cover these. (Regulation 18 Staffing)
- The trust must ensure they maintain oversight of performance and risks in relation to the medicine core service when supporting patients with acute mental health needs or cognitive impairment. In particular, the trust must ensure that all risks relating to the care of patients with mental health conditions or symptoms are captured on the risk register for the service and staff follow trust policies and processes. The service must also ensure that learning from serious case reviews, audits and incidents is shared and embedded across the trust. (Regulation 17 Good Governance.)

SHOULD DO:

- The service should ensure that staff stay up-to-date with mandatory and supplementary training around mental health, neuro diversity, cognitive impairment and the Mental Capacity Act.
- The trust should ensure they consistently check and record where a person has a power of attorney for health and welfare on behalf of the patient if that patient lacks capacity to consent for their own care and treatment.
- The trust should ensure that all patients requiring an interpreter are provided with one as soon as is reasonably practical prior to undertaking care and treatment.
- The trust should ensure staff are consistently supported following incidents of violence and/or aggression.
- The trust should consider that they work within the Use of Force Act as appropriate for acute settings.

On 26 October 2022 the Trust was issued with a section 29a warning notice in relation to the findings at County Hospital and is required to make the significant improvements identified by 26 January 2023. A significant programme of work is underway to ensure we are able to demonstrate the required improvements by the deadline given.

The CQC Action Plan is in the process of being updated to reflect the areas for improvement and will be reported via Quality and Safety Oversight Group and Quality Governance Committee.

Key Recommendations

- *To note the CQC inspection report*
- *To note the revised CQC action plan will be reported to Quality and Safety Oversight Group and Quality Governance Committee*

University Hospitals of North Midlands NHS Trust

Royal Stoke University Hospital

Inspection report

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

Date of inspection visit: 4 October 2022
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Royal Stoke University Hospital

Inspected but not rated

We inspected the medicine core service and urgent and emergency care service on the 4 October 2022. This was a follow-up focused inspection in response to a warning notice issued in 2021, whereby we notified the trust that the Care Quality Commission had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health needs medicine at County Hospital required significant improvement.

Medical care (including older people's care)

Inspected but not rated

The inspection took place between 9am and 6pm on Tuesday 4 October 2022 and focused on the care of patients with mental health needs on medical wards, particularly the Acute Medical Unit, Acute Medical Rapid Assessment Unit and Acute Short Stay Unit. We did not cover all key lines of enquiry.

During the inspection we spoke with 26 members of staff, reviewed 15 sets of patient records and 5 medication charts.

We did not rate this service at this inspection. The previous rating of good remains. We found:

- Mental health risk assessments were completed for all patients when admitted to the wards.
- Staff completed and updated risk assessments for each patient and removed or minimised risks when identified.
- Staff on the wards we inspected shared key information to keep patients safe when handing over their care to others.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

However:

- The mental health risk assessment tools were different on each ward leading to inconsistencies in how risks were identified and managed.
- Managers did not always identify training needs or gave staff the time and opportunity to develop their skills and knowledge.

Is the service safe?

Inspected but not rated

Environment and equipment

The maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

The service had suitable facilities to meet the needs of patients' families. The trust approach was to identify and manage patients based on their individual needs. This was detailed in the observations policy and used on the wards we inspected.

Where patients were identified as a risk to themselves or others, the level was determined and appropriate observations were implemented, including 1 to 1 observations. This was described by staff as the main measure they had to help support patients and manage risk while awaiting specialist mental health support. Sometimes staff were required to cohort patients in order for them to be able to undertake the observations. This meant that a number of patients with a requirement for 1 to 1 observations were sometimes placed together in order to require less staff to undertake the observations. They described occasions when patients had acted quickly and staff were unable to prevent attempts to harm. There were ligature cutters available on each ward and staff had been trained how to use them, however incidents relating to patient behaviours were not always reported. The wards were staffed as planned on most days, however the acuity of the ward fluctuated and at times when there were several patients requiring 1 to 1 observations it left a ratio of 1nurse to 8 or 10 patients on some occasions.

Medical care (including older people's care)

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks when identified.

Patients on the Acute Medical Unit, Medical Rapid Assessment Unit and Acute Short Stay were typically transferred from the emergency department (ED), however patients could be admitted directly. When patients presented at ED they were assessed for both physical and mental health and any risks recorded, monitored and mitigated where possible.

There was a formal process in place to enable staff working on medical wards to effectively assess, record and mitigate the risks associated with acute mental health concerns.

Staff completed a mental health risk assessment for each patient on admissionto the ward, and reviewed this regularly.

The trust had created a mental health risk assessment tool which we saw was completed for patients in ED and the document transferred with the patient to the wards. The trust made the decision to have 1 overarching assessment that identified the measures in place across the trust to manage patients who presented at risk of self-harming. The risk assessment was shared with all clinical teams and discussed at the mental health steering group, executive health and safety group quality safety oversight group and through to the quality governance committee and was due for review in December 2022.

We reviewed 15 sets of patient records across three wards: Acute Medical Unit, Medical Rapid Assessment Unit and Acute Short Stay.

We saw completed mental health risk assessments for most patients when admitted to the wards, however, each ward had their own version of a risk assessment tool, which they added to the patient records beside the ED risk assessment. This meant that risks were not easily identified in 1 document and staff did not always know when a patient was a risk to themselves or others. There was not a consistent, trustwide approach.

The Acute Short Stay ward had a 7-day patient risk assessment booklet, which was comprehensive. It included sections such as cognitive impairment, about me, delirium screen, trigger questions, mental health act checklist, safeguarding and checklists for autism, dementia and learning disability care. We reviewed 5 of the booklets and all were completed or commented on to indicate where the assessment was considered but not required. This booklet was used consistently and staff knew where to find the information they required within the booklet.

The Acute Medical Rapid Assessment Unit nursing booklet did not contain any assessment for additional needs but did contain an alcohol screening and referral tool. The ward staff said they referred to the ED risk assessment to check if any risks had been identified.

The Acute Medical Unit nursing assessment document contained a mental health and cognition section in the admission assessment which asked whether the patient had a dementia diagnosis or delirium on admission. It prompted further action if the patient had either of these. It also had a section to complete within the nurse shift assessment for psychological, social, cultural or rehabilitation, however this was not completed in 3 out of the 5 records we reviewed on that ward.

Staff told us that risks identified in ED were not always verbally handed over to the wards, therefore there were some occasions where risks were unknown and therefore not monitored, managed or mitigated. Staff told us of the impact this had on patients and staff by describing incidents that had occurred.

Medical care (including older people's care)

Since our last inspection, the trust had amended their electronic medical records system to include a mental health risk assessment which was to be completed when the patient was reviewed by a member of medical staff. This could not be bypassed, therefore we were assured that an assessment was completed at that stage and all staff had access to this record, however not all staff checked this in the absence of a handover so there was not a shared approach by ED and the wards.

Staff on the wards we inspected shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We saw and staff told us that they provided a detailed handover when patients were transferring from those medical wards to others or discharged into alternative care.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health) and completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. However, the mental health team would only assess a patient if the ward had ruled out any medical cause. On many occasions this meant that patients with suspected mental health needs and challenging behaviours were being cared for by ward staff in the interim while awaiting test results. This presented risks to patients and staff as they did not have the resource or any additional training to adequately meet the needs of those patients in the absence of specialist support.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

When patients transferred to a new team, there were no delays in staff accessing their records. We reviewed patient records which were comprehensive and easily accessed. The service had transferred all medical records to an electronic system, however nursing notes were still in the transition period from paper to electronic. This did not cause delay in accessing records as any staff could access the electronic record and staff could not identify any time that they have not had access to nursing notes in a timely way.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported most incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

The Trust has a policy for critical incident stress management (CISM) support and Royal Stoke University Hospital had access to trained CISM facilitators. However, staff did not always raise concerns, report incidents or near misses in line with trust policy. We were told of several occasions where risks associated with patients with additional or mental health needs had not been handed over from ED and had led to incidents on the wards, however we did not see evidence that these particular incidents were recorded. The trust provided incidents data covering the last three months which did not include the incidents that were described to us by staff during the inspection, however they did include incidents and near misses relating to patients with mental health needs and their behaviours. Staff said that they had come to expect the behaviours that they were regularly subjected to and when they had raised incidents in the past regarding behaviours they had not been taken seriously.

Medical care (including older people's care)

Staff mostly received feedback from investigation of incidents, both internal and external to the service. Lessons learned were fed back to staff through monthly newsletter, Improving Together meetings and handovers.

Managers debriefed and supported staff after most incidents but staff said they did not always receive any feedback following behaviour related incidents nor did they receive any support after the event.

The service acknowledged there has been an issue with the notifications of incidents not being shared with the head of health and safety. This was raised at the mental health steering group and as a result the system had changed so that the matron for mental health and learning disability received all incident reports relating to self-harm directly.

The purpose of the monitoring was to ensure that the measures identified and documented within the risk assessment were effective in managing the risk or whether additional measures were required.

Is the service effective?

Inspected but not rated

Competent staff

The service made sure staff were competent for their roles, however staff told us they needed more training on mental health to make sure they met patients mental health needs.

Staff were not all experienced, qualified or had the right skills and knowledge to meet the needs of some patients with additional or mental health needs. We were told by staff that they did not feel confident or competent to support patients with mental health needs, particularly in the interim when waiting for the mental health team to attend. Some staff told us they had previous experience in mental health or learning disabilities, which was helpful for them, however they were not available for every shift. There was a mental health lead who was dual qualified as a registered general nurse and registered mental health nurse who offered support and advice to staff across the medical wards. Staff said they had increasing numbers of patients with mental health needs and their skills and resources did not provide proportionate support.

Managers did not always identify training needs their staff had or gave them the time and opportunity to develop their skills and knowledge. All staff we spoke with said they would welcome some additional mental health training aside from their mandatory online module, to better equip them to support these patients. They said that the clinical educator was very proactive in advertising any available training and encouraging staff to complete it, however the staff we spoke with had not been made aware of any related to mental health, learning disabilities or dementia.

Leads of the service told us the Psychiatric liaison (MPFT) team had facilitated local training in ED on the County site, providing education on the mental health risk assessment such as how to complete the form and conduct risk assessments. However this was not facilitated at the Royal Stoke site. Additional face to face training sessions had also been facilitated by the matron for mental health and learning disability, delivering mental health training level 1 and a care certificate. This training had been delivered to all newly appointed overseas nurses and nursing assistants, however existing staff said that this was only available for very limited numbers and most were unable to attend.

Medical care (including older people's care)

In June 2022 a mental health conference was organised by the matron for mental health and learning disability. The programme included guest speakers covering specialist topics. The trust provided data showing that 103 delegates attended the session from across the trust.

Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DoLS) training remained through the trust's ELearning platform, however it was planned for monthly face to face sessions to resume in October 2022 across the trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with said they regularly had to make Deprivation of Liberty Safeguard (DoLS) applications for patients, therefore they had good knowledge on how to complete the documentation and knew when this was required. At the time of the inspection there were three patients with restrictions in place, which were appropriate and all documentation was completed and within the patient's records. Once a DoLS was in place, staff followed and reviewed in line with guidance.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The service provided training compliance data which showed that most staff were up to date with their mandatory training, which included a module on mental health and mental capacity legislation. The compliance with mandatory mental health training for the medical division was 84% at the time of the inspection. However, staff said they did not feel this was adequate given the number of patients they cared for on their wards in addition to, the acuity of other patients and would benefit from further face to face training in how to better meet these patients' needs.

There was a registered mental health nurse that they would contact in the first instance if they required advice and they had additional support from the crisis team.

Is the service responsive?

Inspected but not rated

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Medical care (including older people's care)

Staff were keen to make sure patients living with mental health needs, learning disabilities and dementia, received the necessary care to meet all their needs. Staff explained that they were keen to provide the best care for their patients, however at times they said some patients could have received better care if they had more resources and training to support patients with additional needs, to spend more time with them and potentially prevent some of the behaviours that have occurred on the wards.

Is the service well-led?

Inspected but not rated

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

A matron oversaw the provision of mental health and learning disability services within the trust. They were part of a mental health operational group which held regular governance meetings. Relevant aspects from these meetings were escalated to the mental health and learning disability group.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should consider reviewing the mental health training needs of staff so that they are assured they have the skills to meet the needs of patients.
- The trust should ensure that all incidents are consistently reported and investigated, in line with trust policy.

Urgent and emergency services

Inspected but not rated

The Emergency Department (ED) at the Royal Stoke University Hospital is open 24 hours a day, 7 days a week. The trust is a major trauma centre and receives patients by helicopter as well as land ambulance. The helipad where patients were brought in was outside the ambulance entrance. Due to the COVID-19 pandemic and recovery plans from COVID-19, the department had changed the layout. The department now consisted of:

- Six triage cubicles.
- Seven trolley spaces in the ambulance assessment.
- High risk ambulatory with 5 treatment rooms
- Medium risk ambulatory with 4 treatment rooms and 4 trolleys.
- Medium risk majors with 15 cubicles and 1 side room.
- High risk majors with 16 enclosed cubicles and 3 side rooms.
- High risk resus with 8 enclosed cubicles. One bay is set up as a trauma bay and 1 set up for paediatric patients.
- High risk resus with 10 enclosed cubicles. One cubicle was reserved for paediatric patients.
- Children's ED had 1 triage, 1 escalation room, separate waiting rooms (high and medium risk), 4 cubicles, 2 treatment rooms and 3 escalation bays.

During our inspection we had a tour of the new layout of the new children's ED, which is due to open in October 2022.

There is also an urgent care centre located adjacent to the main waiting area. University Hospital of North Midlands NHS Trust ED staff now managed this.

During this inspection, we visited the emergency department only using our focused inspection methodology. We spoke with 12 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We reviewed 8 sets of patient records.

We did not cover all key lines of enquiry just the areas we had identified in the warning notice relating to the emergency department.

We found that the trust had made improvements in staffing and judged that the warning notice had been met. We found the department was working under challenging times when meeting the standards around the 15 minutes from arrival to first assessment. The challenges observed were both around patients who were self-presenting as well as those who were brought in by ambulance. We did not inspect this part of the service during this inspection; however, we did observe the flow of patient arriving to the department. CQC imposed conditions on the trust's registration following an inspection in 2019, because of its performance in assessing patients within 15 minutes of arrival in ED, we are continuing to monitor the trust conditions and conditions remain in place. Our unannounced inspection took place between 9am and 6pm on Tuesday 4 October 2022.

We did not rate this service at this inspection. The previous rating of requires improvement remains. We found:

- The service faced significant challenges on delivering care to meet the needs of local people. People could attend the service when they needed it but faced significant waits for care and treatment.

Urgent and emergency services

- Staff did not always complete the mental health risk assessment proforma tool for each patient arriving to urgent and emergency department with mental health concerns. However, staff were able to identify and seek advice promptly from their mental health colleagues if patients did deteriorate and required mental health support.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty. However, we were not assured medical staff completed all training around capacity and deprivation of liberty safeguards (DoLS).

However:

- The design, maintenance and use of facilities, kept people safe.
- The service had improved around medical staffing requirements following the warning notice which was served in September 2021. The service had plans in place to ensure the department had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available 7 days a week to support timely patient care.

Is the service safe?

Inspected but not rated

We did not rate this service at this time

Environment and equipment

The design, maintenance and use of facilities, kept people safe.

The design of the environment followed national guidance. The department had 1 designated room available for patients attending with significant challenges to their mental health. This room met the specific requirements as advised by the Psychiatric Liaison Accreditation Network (PLAN).

The designated room was placed in a quiet part of the emergency department and close to the Mental Health team. The room had 2 means of exit; doors were fitted with anti-ligature handles and anti-barricade frames allowing for staff to remove the door in the event of an emergency; emergency alarms had been fitted through the room; doors had privacy glass to allow for discrete observations of patients, lighting was adjustable. The furniture such as the chairs and table were heavy and not easy to lift or move.

Assessing and responding to patient risk

Staff did not always complete the mental health risk assessment proforma tool for each patient arriving to urgent and emergency department with mental health concerns. However, staff were able to identify and seek advice promptly from their mental health colleagues if patient did deteriorate and required mental health support.

Urgent and emergency services

Staff shared information to keep patients safe when handing over their care to others. When handing patients over to other departments or wards, staff supported their verbal handover with a written handover document.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff worked closely with the local mental health trust. The department also employed registered mental health nurses (RMNs).

Staff we spoke with told us that pathways for patients with mental ill health had improved since the department employed RMNs, which meant patients were provided with the right support. We reviewed the formal memorandum of understanding in relation to how the services of the urgent and emergency mental health liaison psychiatry service operate in conjunction with the trust. We found the process easy to follow. Liaison psychiatry service are based on site at the Royal Stoke University hospital, the liaison psychiatry service operates 24 hours a day, 7 days a week and operate as per the national standard of 1 hour for urgent and emergency department or 24 hours for Acute Wards.

Patients attending the hospital with physical health and underlying acute mental illness, generally arrived through the emergency department (ED). However, in some cases some patients could be admitted directly to an inpatient ward, which bypassed ED. This did not happen often and followed an agreed process and only when patients were detained under the Mental Health Act at the local mental health hospital. Staff from the mental health hospital attended with the patient and provided all risk assessments, appropriate documentation and necessary care for the patient's mental health needs.

Where patients arrived at ED, it was expected that a mental health risk assessment proforma would be completed in triage for any patient presenting to the department with mental health concerns, such as overdose or self-harm. This proforma was devised specifically to gain a good understanding and assessment of the needs of patients experiencing acute mental health symptoms. Following our previous inspection and enforcement action the proforma had been developed to include a section for ED staff to handover the information to ward staff and for ward-based staff to document that they had understood the handover and the risk assessment.

A trust wide audit was carried out around the completion of the mental health assessment form, which prioritised their 2022/23 clinical audit programme.

The areas highlighted in the audit that needed improvement was:

- Level of risk documented at time of triage to improve.
- Documentation not completed by Doctor and Advance Nurse Practitioners.

The results from the audit covered the below areas:

- Level of risk documented at time of triage (55%)
- Risk matrix documented by doctor / advance nurse practitioner (ANP) (60%)
- Mental capacity assessment tool commenced (27.5%)
- Safeguarding assessments commenced (13%)
- Suicide risk screen commenced (70%)
- Emergency department assessment (doctor / ANP) (77.5%)

- Mental status examination commenced (77.5%)
- Self-discharge form completed for patients leaving the department (3/3)

If a patient was admitted directly to a ward for example following a GP referral, it was expected that the ward staff would complete the mental health proforma.

The guidelines within the assessment tool also aided assessors to consider the risk that the patient may pose to staff members and others. We saw staff in ED were actively completing this tool for those patients who met the criteria. However, during this inspection we reviewed 8 sets of patient records that met the criteria, we found all 8 records were not fully completed.

Shift changes and handovers included all necessary key information to keep patients safe. We attended and observed the department safety huddles meetings, and the discussions held was around current demands within the department and the whole flow of the trust, bed availability and those patients waiting to be discharged. We found the huddles to be robust and well organised.

We found the department was working under challenging times when meeting the standards around the 15 minutes from arrival to first assessment. The challenges observed were both around patients who were self-presenting as well as those who were brought in by ambulance. We did not inspect this part of the service during this inspection; however, we did observe the flow of patient arriving to the department. CQC imposed conditions on the trust's registration following an inspection in 2019, because of its performance in assessing patients within 15 minutes of arrival in ED and submit data to CQC. The trust has been under extreme pressures since 2020 and have continued to submit their conditions data with the CQC.

We reviewed the trust conditions data for September 2022, that showed time to initial assessment for all arrivals within 15 minutes was currently at 67.1%, a drop of 1% when compared to August 2022. The overall performance appeared to show the trust were on an upward trend. The current triage for ambulance arrivals had risen from 70% in August to 72% in September. Triage assessments for walk in patients deteriorated slightly from 66% to 64%.

A new standard operating procedure (SOP) had been implemented jointly with the ambulance trust to keep patients on the ambulances until a trolley was available. Unfortunately, this had been an ongoing system wide issue where there were several ambulances located outside the emergency department waiting to bring patients in throughout the day.

At the start of our inspection on 4 October 2022, there were 8 ambulances waiting to bring patients in. This fluctuated throughout our inspection. Although, staff had received a handover of concerns by the ambulance staff and the patients were under the responsibility of the emergency department, the key performance indicator (KPI) for handover of these patients was recorded from when the patient was finally taken into the department. However, we reviewed the trust latest SOP for management of surges in ambulance arrivals to Royal Stoke University hospital ED. The purpose of the SOP was to ensure a safe and consistent approach in managing ambulance arrivals when there is a necessity to hold patients on the ambulances due to capacity issues in ED. We saw the process around how ambulance crews escalated their patients to staff in ED along with their handover process. All ambulance arrivals were managed through a single entrance of the ambulance arrival doors, ambulance crews supply the receptionist based at ambulance assessment with patients details in order that the patient can correctly be booked on to the system. Ambulance crew provides handover of their patient to the navigator nurse who along with the rapid assessment treatment (RAT) clinician to decide the most appropriate immediate clinical area for each patient. This gave the department an overall oversight of patient waiting to come into the department.

Urgent and emergency services

We saw October 2022 latest data around the ambulance waits outside ED at the Royal Stoke University Hospital, that showed the longest waiting time outside ED was 9 hours and 33 minutes, total of all waits on 27 October 2022 was 196 hours, 70 patients were delayed with an average wait of 2 hours and 48 minutes. Clinical staff communicated closely with the ambulance crews; and doctors from ED were allocated to assess those patients on the back of the ambulance vehicles to ensure patients were being reviewed and risk assessed on a regular basis, those at high risk would be urgently prioritised.

Nurse staffing

The service continued to have challenges around nurse staffing, the service had plans in place to ensure the department had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The manager could adjust staffing levels daily according to the needs of patients.

Managers made sure all bank and agency staff had a full induction and understood the service.

The service did not always have enough nursing and support staff; however, since the 2021 inspection, the department had made significant improvements around nurse recruitment. The department was budgeted for 343.63 whole time equivalent (WTE) nursing and healthcare assistants, an increase from 223.89 WTE in 2021. However, information showed the department currently had 332.85 WTE staff in post, leaving a vacancy rate of around 3%. The trust are actively recruiting for nurses.

The service met the Royal College of Paediatrics and Child Health (RCPCH) standards of ensuring there was always at least 2 registered children's nurses on every shift. Staff told us they tried to ensure there were at least 4 registered children's nurses on each shift. Senior staff told us recruitment was a rolling process which is managed by the education lead. However, during the 2021 inspection, senior staff told us they were hoping to bring this back into the senior nurse's responsibility to review staffing levels and recruitment as well as being able to communicate with the ED team better about staffing going forward, however this had not happened and the education lead still managed staffing.

Medical staffing

The service had plans in place to ensure the department had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix. Managers gave locum staff an induction when present for shifts.

Following the 2021 inspection, we issued a section 29a warning notice to the trust as we found significant improvement was required to medical staffing within the department. We received the trust improvement plans and we were also informed the trust had successfully secured its business case to recruit and increase its medical staffing. We carried out an unannounced focused inspection specifically to the 29a warning notice. We found the trust had made significant improvements and assured the trust had met the requirements.

The department was budgeted for 157.34 whole time equivalent (WTE). However, information showed the department currently had 152.54 WTE staff in post, leaving a vacancy rate of around 3%.

Urgent and emergency services

The trust provided us with a comparative of the changes in budget and vacancy for the ED medical workforce from the previous CQC inspection in August 2021 and October 2022. Which identified that the trust had recruited an additional 31.73 WTE medical staff.

Since the 2021 inspection, the trust had implemented the tiering medical and practitioner staffing in ED based on the Royal College of Emergency Medicine (RCEM) 2015 guidance. The workforce in the RCEM document is divided into 5 tiers. The trust latest tiering work group within the emergency department comprised of:

- 17.27 WTE consultants plus 3 locum consultants and 4 military consultants ranging between 0.6 and 0.9 WTE (24.54 budget)
- 18 Foundation doctors
- 5 Acute Care Common Stem (ACCS) is a three-year core training programme enabling Foundation programme trainees to embark into a career in emergency medicine (EM), anaesthetics, intensive care medicine (ICM) and acute medicine (AM).
- 5 *GP* vocational training scheme (GPVTS)
- 7 Specialty trainee 3 (ST3) is a point at which subspecialty training is commenced and usually attracts a national training number and is equivalent to the previous junior registrar.
- 7 higher specialist trainees (HST 4)
- 1 Paediatric Emergency Medicine (PEM) speciality trainee
- 2 Specialty and Associate Specialist (SAS) doctors. SAS fill NHS service roles which sit outside of the Specialty Training pathway. These roles are non-training 'service' roles where the doctor has at least four years of postgraduate training, at least two of those being in a relevant specialty.
- 20 Certificate of Eligibility of Specialist Registration doctors (CESR). Is a means by which *doctors* who have not completed an approved deanery training programme can be entered on the Specialist Register.
- 3 clinical fellows
- 38 Junior Training Fellows
- 21 Advanced clinical practitioners (ACPs) in post, with an additional 15 recently recruited. ACPs are healthcare professionals, educated to master's level or equivalent, with the skills and knowledge to allow them to expand their scope of practice to better meet the needs of the people they care for.
- Multiple GPs with a speciality interest in Emergency Medicine.

Senior staff told us that 122 staff (and their anticipated new ACPs) were provided with an educational supervisor, with some middle tier doctors providing educational supervisors for junior training fellows on completion of the training the trainer course.

The service always had a consultant on call during evenings and weekends. There was a trauma team leader onsite throughout the evening with an additional consultant on call for telephone advice if required. Although the consultant on call was not required to attend in person, senior staff told us if the department required additional support, they would attend.

Urgent and emergency services

We reviewed the medical staffing rota and found improvements around the skill mix and establishment of shift covering. We saw 449 vacant shifts for September, of which 382 gave a fill rate of 85%, 355 were filled by bank doctors, with 27 filled by agency doctors.

Rota cover overnight according to the RCEM guidance is to have 2 ST4 and above for overnight duties. The trust overnight rota template is based on 3 middle tier doctors, with 2 of which should be ST4 or above and the third an ST3, CESR or clinical fellow. We reviewed overnight rota for August 2022 to October 2022 and identified the number of ST4 or above were on shift overnight, of which were Red, Amber and Green (RAG) rated; Out of 70 shifts, 55 green rated, 5 amber rated and 10 red rated.

Is the service effective?

Inspected but not rated

We did not rate this service at this time.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health.

The service had dedicated support for patients diagnosed with a psychiatric condition or experiencing symptoms of poor mental health based at Royal Stoke and County hospital. Staff could refer to a dementia liaison team to support patients living with dementia. These teams were delivered and managed by the local mental health trust covering the area.

Staff could contact psychiatric support at any time of day or night through the local mental health hospital. Staff told us that the psychiatric liaison team were very responsive to requests for support.

The trust worked with partner agencies to support patients who attended ED frequently. Partner agencies met at a high-volume user meeting which included trust staff, mental health colleagues and staff from the ambulance service. This meeting discussed HVU of the service and investigated cases; where individuals are utilising emergency department of the trust at a higher volume than expected of the Stoke and North Staffordshire population. We saw examples of team working and patients being at the centre of care.

The ED used a standard operating procedure (SOP) process for management of intoxicated patients with mental health needs. The purpose of the SOP was to outline the process for the management of patients that attend ED, who are intoxicated with underlying mental health needs that are suitable for assessments at another service. These patients can self-present, conveyed by ambulance or the police. This SOP supported those patients that did not require to be in ED and should be placed in a more suitable environment for their individual needs.

Urgent and emergency services

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty. However, we were not assured medical staff completed training around capacity and deprivation of liberty safeguards.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us the training they received around mental capacity had enabled them to develop the knowledge and competence to identify when a patient may be lacking capacity and how to assess the patient.

We saw the compliance for all clinical staff within ED around mental capacity and consent training was variable and ranged between 33% and 100%. This meant that the trust did not always meet its target of 85%.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should ensure that all mental health patients presenting to emergency department have their mental health risk assessment proforma tool completed and kept with patient should they be transferred to other departments of the hospitals.
- The trust should ensure all staff complete relevant training around mental health awareness, including mental capacity and deprivation of liberty safeguards (DoLS).

Our inspection team

The team that inspected the service comprised of CQC inspectors, specialist advisors with expertise in urgent and emergency care, medicine care and mental health.

The inspection was overseen by Sarah Dunnett, Head of Hospital Inspection.

University Hospitals of North Midlands NHS Trust

County Hospital

Inspection report

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at County Hospital

Inadequate 

We inspected the medicine core service on the 4 October 2022. This was a follow-up focused inspection in response to a warning notice issued in 2021 whereby we notified the trust that the Care Quality Commission had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health needs medicine at County Hospital required significant improvement.

Medical care (including older people's care)

Inadequate 

We inspected the medicine core service on the 4 October 2022. This was a follow-up focused inspection in response to a warning notice issued in 2021 whereby we notified the trust that the Care Quality Commission had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health needs medicine at County Hospital required significant improvement. At the 2021 inspection we found patients and staff were at risk of serious harm as there were no effective processes in place to assess, record and mitigate risks associated with people with acute mental health needs. A serious incident had occurred at County AMU in February 2021.

We visited the acute medical unit (AMU) and Ward 12 to gather evidence. We also visited ED to understand the patient pathway through to medical wards.

We spoke with 19 staff including site management, matrons, doctors, nurses, healthcare assistants, security staff and support staff. We reviewed 10 patient records and an additional 1 medicine records.

We rated it as inadequate because:

- The service did not have enough staff to care for patients and keep them safe. Not all staff had completed training in relation to mental health. Staff did not consistently assess risks to patients with acute mental health needs, dementia or other cognitive impairment. Lessons were not always learnt following serious case reviews or incidents. We issued a warning notice regarding this to ensure standards were urgently improved.
- Not all staff had access to good information when working with patients with mental health conditions or symptoms. Staff did not assess mental capacity or deprive patients of their liberty in line with the trust policies or legal frameworks. We issued a warning notice regarding this to ensure standards were urgently improved.
- Not all risks relating to mental health were captured on the risk register. Staff did not receive structured support following incidents of violence or aggression. Oversight of some aspects of managing patients with mental health conditions or symptoms was not in place.

However:

- The service had systems in place to mitigate the risks associated with acute mental health concerns.
- Staff worked well together for the benefit of patients. Key services were available seven days a week.
- A governance structure in relation to mental health, learning disabilities, autism and dementia was in place.

Is the service safe?

Inadequate 

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

Mandatory Training

Not all staff were up to date with training around mental health.

Medical care (including older people's care)

Staff had access to training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff undertook training in mental health as part of their mandatory training package. Autism awareness training was offered to staff.

Not all nursing staff were up-to-date with their mandatory training in relation to mental health. Nurses were required to complete mental health training level 1. We saw overall compliance was 84.3%. The acute medical unit (AMU) had the lowest compliance at 69.2%. The highest level of compliance was on Ward 7 which had 100%. Wards 1, 12, 14, and 15, ranged between 89% and 94% compliance against a trust target of 95%.

Compliance for mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards was better on AMU at 97%. Compliance across other wards ranged from 77.2% on Ward 14 and 100% on Ward 12.

Staff undertook conflict resolution training as part of the mandatory training package.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Other training relating to patients with mental health conditions, cognitive impairment, neurological conditions, neuro diversity or learning disabilities was monitored through governance meetings such as the Trust Mental Health and Learning Disability Group. Meeting minutes showed, as of September 2022, 80.6% compliance within the medicine division for ligature knife training. Dementia awareness training was at 95% compliant. Learning disability awareness training was 78.4% compliant. These figures were for compliance within the medicine division within the trust.

Clinical education nurses sent emails and reminders when staff were required to complete training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific to supporting patients who may lack capacity to consent to treatment or care. Compliance for mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards 97% on AMU. Compliance across other wards ranged from 77.2% on Ward 14 to 100% on Ward 12.

We requested Mental Capacity Act and Deprivation of Liberty Safeguards training data for medical staff which showed 3 out of 4 respiratory medical staff had completed this (75%), 10 out of 11 AMU medical staff had completed this (91%), 1 out of a total of 1 elderly care medical staff were complaint (100%) and the one medical staff member for general medicine had not yet completed this (0%).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we asked provided examples of referrals they had made to the local authority following the identification of concerns around the potential abuse of a patient.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we asked, including bank staff, knew how to make a safeguarding referral and where to seek support for this.

Medical care (including older people's care)

Environment and equipment

Ward environments were not designed specifically for patients with mental health conditions or symptoms as this was an acute hospital. However, staff worked within the environment to keep patients safe.

The design of the environment followed some national guidance; however, we acknowledged that an acute setting is not designed for patients with mental health conditions or symptoms. Within the emergency department, we saw a designated room for patients with mental health conditions or symptoms or patients at risk of violence and aggression had two entrances, an alarm and heavy furniture.

The rest of the ward was in line with standard acute hospital wards. This meant lines of sight could be compromised due to corners and cubicles. However, we saw that some patient spaces could be directly observed from the nursing station.

Assessing and responding to patient risk

Staff did not always complete or update risk assessments for each patient. Staff identified and quickly acted upon patients at risk of psychological or behavioural deterioration.

Staff did not always complete risk assessments for each patient on admission or review this regularly, including after any incident. Patients attending the hospital with acute mental illness, whether attending primarily due to their mental health or physical health, generally arrived through the emergency department (ED). However, in particular cases some patients could be admitted directly to an inpatient ward or if attending for a specific clinical test or procedure such as blood tests, could attend the medical receiving unit (MRU) which bypassed ED.

Patients attending the MRU was not a common occurrence and occurred on a structured basis for detained patients at the local mental health hospital. Staff from the mental health hospital attended with the patient and provided all risk assessments and necessary care from a mental health point of view.

Where patients arrived at ED, it was expected that a mental health proforma would be completed in triage if a patient presented with a primary mental health presentation such as intentional self-harm or attempted suicide. Where patients presented with a physical health condition that needed urgent attention, but also had ongoing psychiatric diagnoses or symptoms, triage nurses were expected to complete the mental health proforma. This proforma was separate to the general health triage tools and was devised specifically to gain a good understanding and assessment of the needs of patients experiencing acute mental health symptoms. Following our previous inspection and enforcement action the proforma had been developed to include a section for ED staff to hand over the information to ward staff and for ward-based staff to document that they had understood the handover and the risk assessment.

If a patient was admitted direct to a ward for example following a GP referral, it was expected that the ward staff would complete the mental health proforma.

During our inspection we reviewed 4 sets of records for patients who attended through ED and became inpatients who were eligible to have a mental health proforma initiated in ED. We found 3 out of 4 patients had the mental health proforma initiated. The service audited the completion of these proformas although the audits focused on assessments undertaken in ED rather than the continuation of the form on the wards.

In addition to the mental health proforma, nursing staff opened a ‘seven-day patient risk assessment booklet’ for every inpatient which included a range of risk assessments and screening tools for both physical health such as falls, and mental health, cognitive impairment, safeguarding and neurodiversity.

Medical care (including older people's care)

During our inspection, we checked 7 booklets and found whilst the assessments for physical health were routinely completed, assessments and screening cognitive impairment, safeguarding and neurodiversity were not.

Of the 7 booklets reviewed, 5 out of 7 patients did not have any cognitive screening completed despite some of these patients triggering an automatic screening due to their age. Data from the trust supported this finding. Four out of 6 relevant patients did not have this completed within a ward 'Care Excellence Framework' audit for AMU in February 2022. An action relating to this was set; specifically, 'All patients over 65 years should have a 6 CIT (Six Item Cognitive Impairment Test (6CIT)) assessment undertaken within 72 hours of admission'. For the same audit on ward 12 in December 2021; we saw 3 out of 5 relevant patients checked had received this assessment.

None of the patients had received a safeguarding screening or a neurodiversity screening.

There were also 2 sections for staff to complete for any patients diagnosed with dementia or a learning disability. Whilst there was no evidence that any of the 7 patients had been previously diagnosed with a learning disability, there was evidence that at least 2 patients had a confirmed diagnosis of a form of dementia. Despite this, the dementia checklist tool was not completed. The checklist was designed to prompt staff, upon completion, to make referrals to teams which could offer supportive individualised care.

This meant that staff could not be assured they had a full awareness of patients' risks and needs in relation to these areas. In addition, there were no care plans in place where required. We asked staff why the sections of the form were not completed and were told it was generally handed over to the next shift to complete. However, some patients reviewed had been in the hospital for at least a week at the time of the inspection.

Not all staff knew about and dealt with any specific risk issues. Staff on ward 12 were not aware of the mental health proforma and therefore were not aware one was not in place for a patient who presented at ED with physical health problems but also clear history of and presentation with mental health symptoms as described in general ED paperwork. There was no evidence ward staff had received a handover with regards to the patient's mental health from the emergency department.

If a patient who was not detained under the Mental Health Act or under the Deprivation of Liberty Safeguards wished to self-discharge against medical advice, staff told us they completed a form with them which had a flowchart and checklist to work through to ensure the patient was well informed as to the consequences of this. We did not identify any patient records at the time of our inspection where this had occurred. The service did not specifically audit this paperwork.

The service had 24-hour access to mental health liaison and specialist mental health support. The psychiatric liaison team was available on site from 8am through to 2am each day. Between 2am and 8am, cover was provided by the local mental health trust. However as this was a separate trust, staff at County Hospital could not access the patient notes overnight. No incidents or harm were identified as a result of this.

Staff completed, or arranged, risk assessments for patients thought to be at risk of self-harm or suicide. Three out of 3 records completed by the psychiatric liaison team showed compliance to the National Institute of Health and Care Excellence (NICE) standards of initial assessment within 1 hour and crisis assessment within 4 hours. However, we saw, and staff told us that there could be delays in getting assessments for a patient to be detained under the Mental Health Act.

Medical care (including older people's care)

Staff did not always share key information to keep patients safe when handing over their care to others. Staff handovers to AMU from ED enabled ward staff to understand patients with psychiatric support needs. However, we found on Ward 12, ward staff did not routinely receive handovers regarding psychiatric status from ED. We did not see any evidence of incidents as a direct result of this.

Staffing

The service did not have enough staff to undertake enhanced or therapeutic observations to keep patients safe from avoidable harm. Managers regularly reviewed and adjusted staffing levels and skill mix however this did not always result in increased staffing as needed.

The service did not have enough nursing and support staff to keep patients safe. The service did not have enough staff to adequately support patients who required enhanced supervision to protect themselves or others as related to acute mental illness. We saw evidence during our inspection of instances where one to one supervision was required overnight, but not provided. A patient caused themselves minor harm and compromised dignity. The trust confirmed that staff had not reported this as an incident. The trust did respond to the concerns regarding the monitoring of this patient following the inspection and stated the patient would receive appropriate therapeutic observations.

Data from the trust showed for AMU, from July to September 2022, a total of 26 shifts required one-to-one nursing. Of these shifts, 7 were filled. This equated to 36.8% of shifts where enhanced observations were required being staffed appropriately. Some of these occasions were reported as an incident. However not all were; staff told us they did not incident report all occasions as it was such a frequent occurrence.

In total 332 shifts were identified as requiring additional staffing for one-to-one nursing during this time. Of these, 219 were unable to be staffed which equated to 66% of shifts not having sufficient staff to provide one-to-one nursing as identified within patient care plans.

Where it was identified that patients required additional supervision, managers made effort to request additional staff including bank staff to cover this. However, this was not always possible. Where this was not possible, staff tried to cohort patients who required high levels of supervision in the same bay so that 1 member of staff may monitor the entire bay. Although this provided some oversight of patients, the staff member within the bay would not be able to consistently observe all patients at the same time, for example if they had to see a patient who had their curtains drawn. Staff told us that where possible they did try to mitigate this by asking a colleague to come into the bay to observe the other patients whilst they attended to one individual.

Staff from the psychiatric liaison team also supported with enhanced supervision if they were available. In some cases, where a patient was detained under the Mental Health Act and normally resided at a mental health hospital but was an inpatient at County Hospital for physical interventions, managers could request staff from the psychiatric hospital to attend to support with enhanced supervision. Staff also sought support from relatives to monitor patients when staffing was reduced. We saw evidence of this happening for 2 patients during our inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Shortages in staffing to cover enhanced supervision was escalated to the matron for the relevant area. In addition, the staff rostering system allowed managers to ‘red flag’ shifts as being low on staffing to the extent where full care plans were not able to be carried out. We saw

nurses also recorded within patient records when they had not been able to complete all of their tasks due to short staffing. Managers were aware of the impact of providing enhanced supervision, particularly constant supervision, on staff. Managers told us they tried to rotate staff during their shift to prevent fatigue. However, we saw on some wards staff were expected to fill this role throughout the entirety of their shift except for breaks.

We asked the trust if any incidents have been reported as a result of the lack of staffing for enhanced observations. The trust told us that there had been 3 incidents reported however patient harm had been avoided by using mitigating actions such as cohorting patients and moving patients to a more easily observed area.

The number of nurses and healthcare assistants did not always match the planned numbers.

Overall AMU staffing, from August to September 2022, saw the day shift fill rates for nursing staff ranged from 66.6% to 133.3%. The average fill rate was 94.2%. Nursing staffing at night was better with an average fill rate of 111.8%.

Healthcare assistant staffing for the same dates was an average of 69.8% filled shifts for day shifts and 120.9% filled shifts for night shifts.

The overall fill rate for all shifts for wards 1, 12, 14 and 15 was 90.4%.

The acute medical unit (AMU) had recruited a mental health nurse who was due to start the week after our inspection. This role was to provide additional support to ward staff when working with patients who presented with an acute mental health condition.

The senior clinical education nurse on AMU worked clinically to support staff as required.

Data from the trust showed staffing was impacted by high levels of sickness from August to September 2022 with almost 25% of all sickness being due to respiratory conditions including COVID.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. The service used bank staff to cover vacancies for nurses and healthcare assistants where possible. The use of agency nurses was minimal, however those used worked regularly.

Ward staff told us that, in the main, police stayed with patients detained under section 136 of the Mental Health Act (1983) who had been brought to the ward. Section 136 allows the police to take a person to a ‘place of safety’ if the person is suspected of having a mental disorder, is in a public place, and is identified as requiring immediate care or control. We did not identify any incidents of harm as a result of this and none were recorded in governance meeting minutes.

Records

Staff kept records of patients’ care and treatment. Records were stored securely and easily available to all staff providing care, however did not always contain information needed for staff to manage patients psychological or behavioural needs.

During our inspection we reviewed 10 sets of patient records.

Medical care (including older people's care)

When patients transferred to a new team, there were no delays in staff accessing their records. Staff on the acute medical unit told us the emergency department staff handed over mental health proformas and assessments in a timely way when the patient arrived on the ward. However, on Ward 12 staff were not aware of this form and did not receive a handover in relation to mental health.

As above, we found not all documentation was completed fully by ward staff which meant staff taking over patients' care may not be aware of all risk factors relating to mental health, cognitive impairment, safeguarding and neuro diversity.

When patients detained under the Mental Health Act (1983) were admitted to the acute medical unit as an inpatient, the discharge facilitator reviewed any accompanying paperwork detailing the detention. The discharge facilitator requested any missing paperwork or reviews to ensure patients were not being illegally detained for example if a detention period was due to expire.

Staff could access patients' full medical notes if they needed to review past health information, including mental health related contact with the NHS.

The psychiatric liaison team kept electronic records when they saw a patient. This was on a different system to that used by ward staff as they were employed by the local mental health trust. Ward staff told us they could not access these notes. This was confirmed by the trust who reported that this issue was being discussed to identify if trust staff could access the system used by the mental health trust. After the inspection, the trust told us the psychiatric liaison team did add information to the system used by County Hospital Staff.

When patients were identified as requiring enhanced supervision or observations to protect themselves or others, staff did not complete the required documentation to support this. Within the 'Therapeutic and Engagement Observation (Specialling) of Adult Patients' policy, a template was provided for staff to use for this purpose. This meant that staff were not able to evidence if they had supervised the patient as required in their care plan, for example if a patient needed constant supervision.

Records were stored securely. Paper-based records were kept in lockable storage cabinets on the ward when not in use. We saw the paper-based records on Ward 12 were outside of individual patient rooms however there was a staff member present at all times.

Medicines

Medicines used to manage patient behaviour was in line with national standards.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. During our inspection we reviewed 5 sets of medicine records to review the use of psychiatric medicine. We did not see any evidence of rapid tranquilisation being used, or of patients being over sedated to manage behaviour. Lorazepam was prescribed as required on an individual basis in line with the British National Formulary (BNF) for the management of acute symptoms of conditions such as anxiety.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents however we saw evidence that shared learning was not embedded.

Medical care (including older people's care)

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us, and we saw, they reported incidents relating to patients with cognitive impairment and/or a psychiatric history or presentation. Staff reported incidents when they could not get required staffing to provide enhanced observation for patients who required this. However, this was not consistent; staff told us they did not report every incident where there were not sufficient staff as it was such a frequent occurrence.

Staff reported serious incidents clearly and in line with trust policy. Managers shared learning about incidents with their staff. Data from the trust showed 44 incidents regarding patients with mental health conditions or cognitive impairment over the 12 months preceding the inspection. This information included learning where relevant to prevent incidents recurring.

There was evidence that changes had not been made as a result of feedback. Data from the trust showed an incident had been reviewed under section 42 safeguarding enquiry within the last 12 months. This is where the Local Authority has a duty to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect. This incident had occurred at the Royal Stoke Hospital and related to a patient who was being deprived of their liberty with no capacity assessment or Deprivation of Liberty Safeguards (DOLS) in place. As reported under the 'effective' domain we saw evidence which showed learning had not been shared widely enough to ensure all staff understood their legal requirements under the Mental Capacity Act.

Data from the trust also showed that a Safeguarding Adults Review (SAR), which is a multi-agency review which seeks to determine what relevant agencies and individuals involved could have done differently, that could have prevented serious abuse or neglect or a death from taking place had taken place at the trust within the 12 months prior to the inspection in relation to capacity to consent. As we saw evidence that capacity assessments were not being completed during our inspection at County Hospital, this indicated that again, learning was not sufficiently shared or embedded to ensure a change in poor practice.

Local managers did not formally debrief or support staff after any serious incident. There was no specific process for debriefing or supporting staff following incidents involving violence and/or aggression; despite an increase in violence and aggression toward staff is documented within the May 2022 Trust Mental Health and Learning Disability Group meeting minutes. In the above-mentioned 44 reported incidents, we saw some of these did relate to staff being injured as a result of patient behaviour. Generalised support was available, for example staff could speak to the nurse in charge. Staff could attend Critical Incident Stress Management (CISM) sessions or access third party counselling as part of the trust's well-being provision. Data sent by the trust reported staff from this site had accessed the trust well being support options.

Is the service effective?

Inadequate  

Our rating of effective went down. We rated it as inadequate.

Evidence-based care and treatment

The psychiatric liaison service provided care and treatment based on national guidance and evidence-based practice. However, this was not always monitored at ward level. Staff protected the rights of patients subject to the Mental Health Act 1983.

Medical care (including older people's care)

Staff followed up-to-date policies where available to plan and deliver high quality care according to best practice and national guidance. Staff in the acute medical ward (AMU) had access to 2 folders both containing detailed information about working with patients with a mental health condition or symptoms including trust documentation policies and general information about providing support. Staff also had access to information about the Mental Capacity Act (2005), including how to assess a patient's capacity to consent to care or treatment and information about the Deprivation of Liberty Safeguards (DOLS).

Staff on other medical wards did not have immediate access to printed detailed information, although they could access this information on the trust intranet.

Staff had access to policies on specific patient pathways for example alcohol withdrawal.

We requested the trust policy or standard operating procedure on working with patients who had a lasting power of attorney (LPA). This information was within the trust consent policy and specified 'healthcare practitioners should read the LPA if it is available, in order to understand the extent of the attorney's power'.

Staff mostly protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The hospital completed several audits in relation to mental health across the trust. These included auditing the responsiveness of mental health services, auditing the Mental Health Act policy, auditing the mental health assessment tool in ED, auditing the Mental Health Act, auditing the deprivation of Liberty safeguards and auditing therapeutic observations.

We requested audit data for the completion of mental health assessments on medical wards. However, we did not receive this data; instead we received a full list of audits completed at County Hospital across all areas. We saw an in-depth audit around supporting patients with mental health conditions or symptoms had been completed within ED for June 2022 however audits had not yet been undertaken on the medical ward areas.

At handover, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers on one ward. Staff handovers to AMU from ED enabled ward staff to understand patients with psychiatric support needs. However, we found on Ward 12, ward staff did not routinely receive handovers regarding psychiatric status from ED.

Competent staff

The service mostly made sure staff were competent for their roles in relation to supporting patients with mental health conditions or symptoms or patients with reduced cognitive functioning. Managers held some supervision meetings with staff to provide support and development.

Staff were mostly experienced, qualified and had the right skills and knowledge to meet the needs of patients with mental health conditions or symptoms or patients with additional needs as related to cognitive functioning. A senior clinical education nurse on AMU provided training on the mental health proforma and supporting documentation. Staff were required to sign to say they had received this training. We saw evidence that nurses and healthcare assistants working day shifts in the acute medical ward had undertaken this updated training. Night staff were yet to be trained at the time of the inspection however there were plans for the psychiatric liaison team to deliver this.

Staff on other medical wards were less knowledgeable about the mental health proforma, and support that could be accessed while caring for patients with psychiatric needs. However, data from the trust showed that staff had access to some information for each ward; however, this was not comprehensive on wards other than AMU. Information following incidents was emailed to all staff when learning was available. The mental health policy was also shared with all nursing staff from August 2022.

Some staff told us they would like more training around caring for patients with mental health diagnoses, and the Deprivation of Liberty Safeguards (DOLS).

Three nurses were trained on the acute medical ward (AMU) to restrain patients in line with national guidance as required and the list was maintained. Security staff were also trained to do this. Governance meeting minutes indicated this was being reviewed to be in line with national guidance around the Use of Force Act.

We saw within Trust Mental Health and Learning Disability Group meeting minutes; that the service held patient review panel meetings following cases involving patients with a learning disability, mental health diagnosis or other vulnerability. The purpose of these meetings was to encourage reflective practice and a shared learning. Three reflective practice sessions have been held over the 12 months prior to our inspection.

Managers made sure staff received any specialist training for their role. The discharge facilitators on the acute medical ward (AMU) were knowledgeable about areas relating to patients detained under the Mental Health Act (1983) or who required assessment under the Mental Capacity Act (2005).

Multidisciplinary working

Nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service had a dedicated support for patients diagnosed with a psychiatric condition or experiencing symptoms of poor mental health. A site specific psychiatric liaison team was based at County Hospital from 8am to 2am 7 days a week. Staff could also refer to a dementia liaison team to support patients with a dementia diagnosis. These teams were delivered and managed by the local mental health trust covering the area.

Staff could contact psychiatric support at any time of day or night through the local mental health hospital based close by to County Hospital when the psychiatric liaison team were not available.

Staff told us that the psychiatric liaison team were very responsive to requests for support on the ward.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We saw records of patient referrals to specialist services were maintained; and all medical wards had made referrals, with the majority coming from AMU.

Feedback from staff and patient representatives showed good working relationships between the local mental health trust and County Hospital, particularly where patients were already registered as a patient at the mental health trust.

Staff could refer patients to drug and alcohol services within the community. The trust employed an alcohol liaison nurse however they were based at the Royal Stoke Hospital. Staff could access the alcohol team based at the Royal Stoke; who could update management plans via the electronic patient record. Although not employed in this role, a member of the psychiatric liaison team was a trained alcohol support nurse. Staff told us this member of staff was helpful for additional support with patients withdrawing from alcohol.

Not all medical staff completed mental capacity assessments in a timely way to support patients who may lack capacity to consent to care or treatment. See the 'consent, Mental Capacity Act and Deprivation of Liberty Safeguards' section below for more details.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from mental health services 24 hours a day, 7 days a week. The psychiatric liaison team worked seven days a week from 8amto 2am. Between these hours ward staff could contact the local mental health trust if they required advice or support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not support all patients to make informed decisions about their care and treatment. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not always assess capacity to consent or deprive patients of their liberty within legal frameworks or the trust policy.

Nursing staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS); however, this training was not effectively used in practice. Compliance for mandatory training on the MCA and DOLS was 97% on AMU. Compliance across other wards ranged from 77.2% on Ward 14 and 100% on Ward 12.

We requested MCA and DOLS training data for medical staff which showed 3 out of 4 respiratory medical staff had completed this (75%), 10 out of 11 AMU medical staff had completed this (91%), 1 out of a total of 1 elderly care medical staff were complaint (100%) and the one medical staff member for general medicine had not yet completed this (0%).

We requested data about compliance to consent training modules for both nursing and medical staff across the medicine core service. We received data for medical staff. The data for medical staff showed that 14 out of 17 staff had completed this (82%). Nursing staff completed consent training as part of their MCA and DOLS training referenced above.

Not all staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff did not ensure that legal frameworks were followed as per the MCA. During our inspection staff told us that doctors were responsible for completing mental capacity assessments where it was suspected a patient may not have capacity to consent to care and/or treatment.

We reviewed 3 patient records within which there was evidence to suggest the patient required a mental capacity assessment to confirm if these patients were able to consent to their treatment or not. Within all 3 records, there was no evidence that any capacity assessment had been undertaken as per the MCA. We asked staff about all 3 patients; staff confirmed there had been no capacity assessment recorded.

Following the inspection; the trust told us they had completed capacity assessments for 2 of these patients as we had raised specific concerns. However, we were not assured this would be generalised to other patients who required MCA assessments or that these would be completed in a timely way as per the MCA legal framework.

Staff did not work in line with the trust policy when working with patients who could not consent. We reviewed the trust policy entitled 'Consent to Treatment (incorporating Mental Capacity Act)' which clearly stated that consent should be sought for starting treatment or physical investigation, or providing personal care, for a person. Where it was likely a patient may lack capacity to give consent; the trust mental capacity assessment form and best interest checklist (appendix 5 of the policy) must be completed.

Staff did not implement DOLS in line with approved documentation or legal requirements. Staff did not work in line with the trust policy when depriving patients of their liberty. We saw 2 of 3 patients described above had been deprived of their liberty as defined under the DOLS within the MCA. This included the use of medication to calm 1 patient down, close supervision of both patients and the use of bed rails for both patients. The MCA clearly states that in order to deprive someone of their liberty who may not be able to consent to this, a mental capacity assessment must be undertaken which identifies a lack of capacity to consent at that time; and an application to deprive someone of their liberty must be made to the local authority.

Staff had not made a DOLS application for either patient at the time of our inspection. We acknowledged that an application had been prepared for 1 patient on AMU and was waiting to be sent off as soon as medical staff had completed a mental capacity assessment to confirm the patient did not have capacity to consent. However, by this point that patient had been subject to restrictions for over 48 hours. We asked staff about this patient and were told the reason the patient had not yet received a capacity assessment was because the patient did not speak English. Staff had not sought to arrange an interpreter to undertake a mental capacity assessment, nor any other assessment relating to the patient's health care, since arrival to the hospital. Instead staff relied upon a family member to interpret which was not in line with best practice guidance; and was also outside of the trust policy entitled 'interpreters' which stated 'when gaining formal consent, explaining management plans or delivering bad news that the patient can understand the information given, and request the use of an interpreter if this will improve understanding. In these circumstances the patient's family or friends should not be routinely used'. This meant the patient was not given an opportunity to provide an input into their own healthcare, to consent to any treatment, or to be assessed for a lack of capacity to consent to any care or treatment. Following the inspection, the trust told us they had provided an interpreter, completed a MCA assessment and made a DOLS application in response to us raising our concerns for this patient. However, we were not assured actions were in place at this stage to ensure all patients who required timely interpretation services would receive this; particularly in relation to complying with the MCA.

The second patient, located on Ward 12, also had neither an MCA assessment nor DOLS documented at the time of the inspection. This patient's relatives had lasting power of attorney for health and welfare which meant they could make healthcare related decisions on behalf of the patient if they deemed the patient no longer held the capacity to make their own decisions. However, we saw no evidence within the patient file that staff checked the lasting power of attorney (POA) for health and welfare was in place and were valid at the time of the inspection. We asked the trust for their process on ensuring staff check the legal status of individuals stating they have POA for patients. This was recorded within the trust consent policy.

Discharge facilitators on AMU were aware of the need to confirm any power of attorney for welfare and health before enabling individuals with this power of attorney to make decisions on behalf of a patient who lacked capacity to consent themselves.

Medical care (including older people's care)

Staff had access to information about gaining consent for patients with mental health conditions or symptoms. The trust policy entitled 'Consent to Treatment (incorporating Mental Capacity Act)' provided guidance to staff about working with patients with mental health diagnoses who were or were not detained under the Mental Health Act. The policy also provided guidance for working with patients who were self-harming or who had suicidal ideation or behaviour.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Meeting people's individual needs

The service was not always inclusive and did not always make reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff could not always make sure patients living with mental health problems and/ or dementia, received the necessary care to meet all their needs. See the 'staffing' heading in the 'safe' domain for more details.

When patients were assessed as having a lack of capacity to consent to care or treatment, if the patient had no family, friends or carers to support them in decision-making, Independent Mental Capacity Advocates (IMCAs) should be instructed to represent and support people to make a best interest decision. The trust had access to system based IMCAs; staff had access to information on the trust intranet which told them how to request this service.

Staff accompanied patients who smoked cigarettes outside the hospital building to provide support and supervision. This enabled staff to reduce the risk of distress or conflict that may arise if patients were prevented from smoking.

Staff supported some patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff had access to communication aids to help patients become partners in their care and treatment. Staff had access to communication aids when working with patients who communicated non-verbally.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us they could access appropriate interpretation services such as British Sign Language interpreters if required.

During our inspection we saw 1 instance where staff had not provided an interpreter for a patient, instead relying on the patient's family. General Medical Council (GMC) guidance states that all possible efforts must be made to ensure effective communication with patients. This includes arrangements to meet patients' communication needs in languages other than English. We acknowledged that an interpreter was being booked for the day of our inspection, however by this point the patient had already been on the ward for over 48 hours. As in 'effective', after the inspection the trust told us they had obtained an interpreter in order to undertake a capacity assessment with this patient.

Is the service well-led?

Requires Improvement 

Medical care (including older people's care)

Our rating of well-led stayed the same. We rated it as requires improvement.

Culture

Staff did not always feel supported to care for patients with mental health conditions or symptoms or patients who required enhanced observations. However, staff were focused on the needs of patients receiving care. Staff were able to report incidents involving violence, aggression and short staffing; although did not always do so.

Local managers did not formally support staff after any serious incident. There was no specific process for debriefing or supporting staff following incidents involving violence and/or aggression; despite an increase in violence and aggression toward staff as documented within the May 2022 Trust Mental Health and Learning Disability Group meeting minutes. Generalised support was available, for example staff could speak to the nurse in charge. We saw posters for staff well-being services displayed on the walls.

The service held sporadic patient review panel meetings following cases involving patients with a learning disability, mental health diagnosis or other vulnerability. The purpose of these meetings was to encourage reflective practice and a shared learning. Three reflective practice sessions had been held over the 12 months prior to our inspection.

Staff could attend Critical Incident Stress Management (CISM) sessions or access third party counselling as part of the trust's well-being provision. Data sent by the trust reported staff from this site had accessed the trust well being support options.

Staff told us they worked well as a team and were able to support each other. Staff told us they received support from the psychiatric liaison team and could ask for advice or guidance at any time.

As part of ward 'Care Excellence Framework (CEF) audits on ward 12 in December 2022, and AMU in February 2022, staff identified they felt listened to and supported on the ward; however management had limited capacity to act on concerns and feedback raised.

Staff told us they did not always report incidents when staff numbers were below what was required for a shift as this was a regular occurrence.

Governance

Leaders operated governance processes, throughout the service and with partner organisations in relation to working with patients with mental health conditions or symptoms and patients with a disability relating to cognitive functioning. However, auditing on the ward in relation to mental health was limited and staff did not always follow policies and processes.

A governance structure was in place. A matron oversaw the provision of mental health and learning disability services within the trust. They were part of a mental health operational group which held regular governance meetings. Relevant aspects from these meetings were escalated to the mental health and learning disability group.

We saw meeting minutes from the trust wide mental health and learning disability group, the trust wide learning disabilities and autism working group and the trust wide mental health working group meetings. Meeting minutes demonstrated that information was shared between these groups for fuller oversight. The psychiatric liaison team attended the mental health working group meetings, the child and adolescent mental health services (CAMHS) working group meetings and the overarching mental health and learning disability group.

There was not a medical ward specific audit programme. The trust had a programme of audits in relation to supporting patients with acute mental health needs. These included auditing the responsiveness of mental health services, auditing the mental health policy, auditing the mental health assessment tool in ED, auditing the Mental Health Act, auditing the deprivation of Liberty safeguards and auditing therapeutic observations. However, the majority of these did not extend to medical wards. In particular, we found evidence of staff not following trust policies around therapeutic observations. The lack of auditing meant that there was no recognition, oversight or action plan in relation to this to keep patients safe from harm.

Where audits were undertaken on medical wards; we saw evidence that improvement had not been made. For example, within a ward 'Care Excellence Framework' audit for AMU in February 2022 an action was set; specifically, 'All patients over 65 years should have a 6 CIT (Six Item Cognitive Impairment Test (6CIT)) assessment undertaken within 72 hours of admission'. However, during our inspection, we found no evidence of improvement since this audit indicating the action plan and learning points were not embedded.

The service had access to a psychiatric liaison team which was provided by the local mental health trust and was funded through the local Integrated Care Board (ICB). A draft service level agreement was in place for April 2022 to March 2024. A review date was set for March 2023. This service level agreement set out the expectations of the trust for the psychiatric liaison team provision. This was aligned to current national guidance and the local need of County Hospital. The trust, at the time of inspection, was in discussion with the local mental health trust to design a standard operating procedure to support this service level agreement; and to finalise the service level agreement.

In the acute medical unit, a 'focus of the month' board was used to share updates and information about supporting patients with mental health conditions and symptoms.

Staff had access to a closed social media group the acute medical unit where updates and information was shared. Regular bank and agency staff were included within this group to ensure they were also informed of any necessary information.

When patients were identified as requiring enhanced supervision or observations to protect themselves or others, staff did not complete the required documentation to support this. We saw this was not highlighted within governance meetings nor was this monitored.

Staff told us that matron visibility was not high across all medical wards, although the matron covering AMU did attend this area. Data from the trust told us of staff sickness at this grade; which resulted in temporary matron support being implemented.

Management of risk, issues and performance

Leaders and teams mostly identified and escalated relevant risks and issues and identified actions to reduce their impact. However, some actions were not sufficient to keep patients safe.

The service had a risk register in place which incorporated risks relating to patients with mental health diagnoses or symptoms. We reviewed the risk register for the medicine core service at County Hospital. The risk register was reviewed and updated regularly. We saw that nurse staffing was on the risk register for overall vacancies. We saw a gap in mental health provision had been identified as a risk in October 2021. There were clear actions which had now been completed including the extended psychiatric liaison team working hours which mitigated this risk.

We saw evidence of these positive changes to working with patients presenting with acute mental illness since our last inspection. The psychiatric liaison team had extended their operating hours since our last inspection and from January 2021 were based at the hospital between 8am and 2am.

Previously the psychiatric liaison team did not work with patients unless they were identified as medically fit. This meant often patients with mental health conditions or symptoms would have to wait until they have received physical interventions before receiving a psychiatric assessment. At this inspection we found this had changed. The psychiatric liaison team would see patients as soon as possible which meant risk factors were identified and care plans could be created to keep the patient, other patients and staff safe.

We saw not all risks were captured on the risk register although leaders in this area were aware of concerns. A risk that had been captured was ligature risks with regards to environment, staff knowledge, and staff response in emergency situations was discussed consistently within the mental health and learning disability group. It was clear that an audit had taken place, had been reviewed and resulted in the removal of this item from the risk register across minutes from March 2022 to September 2022.

Risks that were not captured included the lack of supervision for patients who required this as part of their care plan (therapeutic observation). We saw within meeting minutes for March 2022 that therapeutic observation was due to be added to the risk register, however when we reviewed the risk register as part of our post inspection data review, we did not identify this entry. Although staffing was on the risk register, there was no reference to the specific concerns about not always staffing enhanced observations where required. In addition, the use of physical restraint was discussed within governance meetings with regards to inconsistent reporting of this by staff, and not working within current guidance when working with patients with mental health conditions or symptoms. However, this was not registered as a risk.

Where physical restraint was used with patients, staff were expected to submit an incident to the trust incident reporting system. We also saw that some staff were trained in clinical holding rather than restraint which was specific for patients with mental health conditions or symptoms. Clinical holding is generally used for patients requiring physical health interventions and is defined as the proactive holding of part of the body to allow a procedure to be carried out; for example, holding an arm in order to take a blood sample. This was discussed within a mental health working group meeting in September 2022 whereby it was highlighted that due to the large number of patients attending acute hospitals primarily for mental health reasons, national recommendations had been to bring the Use of Force Acts in place in acute settings. We saw within the Mental Health and Learning Disability Group meeting minutes held later in September 2022; the Use of Force Act was introduced to the attendees. The trust's legal team were considering the application of this Act in an acute trust.

Leadership of AMU described local risks as caring for patients with psychiatric care needs. These included staff coverage for enhanced supervision and a potential future risk that when the new mental health nurse had commenced in role, they may not get fully utilised in the way intended due to staff shortages. Another area of potential concern was identified that the local geographical 'place of safety' to place patients detained under a section 136 (Section 136 is part of the Mental Health Act that gives police emergency powers. Police can use these powers if they think a person has a mental disorder, are in a public place and need immediate help. Section 136 says police must think the person needs immediate 'care or control') was within the local mental health hospital. However, if the spaces were already in use police would bring patients to AMU which meant they would then be under the care of AMU ward staff rather than

trained mental health staff. An additional concern was a delay in assessing patients with mental health conditions or symptoms out of hours (between 2am and 8am). The delays presented as other patients in the community were prioritised for assessment. Ward staff felt inpatients within the trust were seen as being in a safer setting by external mental health teams therefore not always prioritised.

During our inspection, staff on AMU demonstrated a good level of knowledge and awareness of working with patients with acute mental illness. They were familiar with the mental health proforma initiated in the emergency department and spoke positively of the psychiatric liaison team. However, staff on Ward 12 did not display the same level of knowledge. Some staff on AMU told us that other medical wards did not have the same level of knowledge and support regarding patients with mental illness as AMU. This indicated that although significant improvements had been made on AMU, within ED and within the psychiatric liaison team, this had not extended to other medical wards. Whilst other medical wards may not see the same number of patients with acute mental illness as AMU, as we saw on inspection, patients experiencing acute mental health symptoms were on these wards and therefore required the same level of intervention and support.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Data from the trust showed the psychiatric liaison team had received feedback demonstrating excellence in practice and excellent communication. This was reflected in what staff told us during the inspection.

Areas for improvement

Action the trust must take to improve:

MUSTS:

- The trust must ensure that where required, mental capacity assessments and Deprivation of Liberty Safeguards applications are made in line with the trust policy and legal frameworks. **(Regulation 11 Need for Consent)**
- The trust must ensure that all required assessments including the mental health proforma and within 'seven-day patient risk assessment booklet' are completed as per trust processes. **(Regulation 12 Safe Care and Treatment)**
- The trust must ensure that where enhanced or therapeutic observations have been identified as necessary within patient care plans, staff are sourced to cover these. **(Regulation 18 Staffing)**
- The trust must ensure they maintain oversight of performance and risks in relation to the medicine core service when supporting patients with acute mental health needs or cognitive impairment. In particular, the trust must ensure that all risks relating to the care of patients with mental health conditions or symptoms are captured on the risk register for the service and staff follow trust policies and processes. The service must also ensure that learning from serious case reviews, audits and incidents is shared and embedded across the trust. **(Regulation 17 Good Governance.)**

Action the trust should take to improve:

SHOULDS:

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Medical care (including older people's care)

- The service should ensure that staff stay up-to-date with mandatory and supplementary training around mental health, neuro diversity, cognitive impairment and the Mental Capacity Act.
- The trust should ensure they consistently check and record where a person has a power of attorney for health and welfare on behalf of the patient if that patient lacks capacity to consent for their own care and treatment.
- The trust should ensure that all patients requiring an interpreter are provided with one as soon as is reasonably practical prior to undertaking care and treatment.
- The trust should ensure staff are consistently supported following incidents of violence and/or aggression.
- The trust should consider that they work within the Use of Force Act as appropriate for acute settings.

Our inspection team

The team that inspected the service comprised of a CQC inspector and specialist advisors with expertise in medicine care and mental health.

The inspection was overseen by Sarah Dunnett, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board	**Date:**	4th January 2023
Report Title:	ED Corridor Risk Assessment	**Agenda Item:**	9
Author:	Ann Marie Riley, Chief Nurse		
Executive Leads:	*Paul Bytheway; Matthew Lewis; Ann Marie Riley*		

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

Risks currently awaiting approval on the risk register

Executive Summary

The situation across the NHS in relation to ambulance holds is causing significant harm for patients in the community who are waiting for an ambulance, with a number of reported poor outcomes for those patients. West Midlands Ambulance Service has a risk score of 25 in relation to this.

At UHNM we are holding more ambulances than we deem acceptable and have taken significant action as an organisation to support the ambulance service to deliver timely care to those in our community.

At the end of October 2022 the Trust implemented an initiative called your next patient (YNP), which allows us to release capacity in our Emergency Department (ED) and assessment portals throughout the day so ambulance crews can be released to respond to 999 calls. This model originated in North Bristol NHS Trust and was been implemented in the 10 Trusts with the most delays of which we are one.
Whilst the YNP initiative supported the organisation to reduce ambulance handover delays, we continued to have an unacceptable level of ambulances being held outside ED for protracted periods of time.

During December, the Emergency Department leadership team proposed that we risk assess the ability to care for patients on the ED corridor (Royal Stoke site). The risk assessment was conducted in partnership with ED colleagues and the ED senior leadership team subsequently developed a standard operating procedure (SOP) to ensure safe management of patients being cared for in the ED corridor. The initiative is now live in practice.

In addition to the Risk Assessment, the risk on the Board Assurance Framework (BAF 5) regarding Responsive Patient Care will be reviewed and updated based on the introduction of corridor care, and Your Next Patient. Accordingly, the risk score for BAF5 will be updated to reflect the associated risks with these initiatives. This will be reported to the Board in February as part of the Quarter 3 update on the BAF.

Key Recommendations

The Board is asked to note the risk assessment and SOP; and related actions to the update of BAF 5

High Quality	Responsive	People	Improving & Innovating	System & Partners	Resources

Risk assessment for a work process or task analysis												
Site: Royal Stoke University Hospital **Division: Medicine** **Ward/ Department: Emergency Department**							**Work activities:** Utilisation of the ED corridor as a cohort area to support timely ambulance handover **Date: November 2022**					
What is the hazard?	**Who is at risk?**	**What are the existing control measures?**	**Severity**	**Likelihood**	**Rating**	**Risk Rating**	**What additional controls are required?**	**Severity**	**Likelihood**	**Rating**	**Risk Rating**
When the Emergency Department (ED) is over capacity and have no capacity in both the Ambulance Assessment area and Majors Cubicles with no immediate ability to create capacity Ineffective flow of emergency care patients, including those members of the public awaiting an emergency response, negatively impacting on safe and timely care delivery. Patients at home awaiting an ambulance response and those held in the back of ambulances are at increased risk of harm.	Patients: due to missed or delayed aspects of care delivery for patients across ED, or ward areas, if not able to secure appropriate staffing levels for the ED corridor an d/or the appropriate equipment is not in place The Trust: due to damage to its reputation, litigation and failure to meet quality related targets.	The Chief Nurse and new Divisional Nurse Director met with the ED leadership team to identify the safest areas to hold patients on the ED corridor and the requisites to go live. A maximum of 15 trolleys can be held in line with the floor plan in Appendix 1 Additional nursing/paramedic staff will be sourced via the Nurse Bank/Agency to support the care of those patients waiting on the ED corridor Cylinder oxygen and portable suction will be identified for use, in case it is required. Portable screens are available to increase privacy and dignity Staff will receive further information about the use of the ED corridor area to improve wider understanding of the need to balance risk across the	4	4	16		The ED corridor area can be enacted 24 hours a day, 7 days a week if appropriately staffed with 1 Registrant/Paramedic per 6 patients All moves to the ED corridor will be co-ordinated by the ED team This SOP distributes risk which essential to ensure that no one group of patients or staff are adversely affected. Where additional staff cannot be sourced ED should escalate concerns to Divisional Leadership Team in hours, SOC/CSM out of hours so an assessment of risk can be undertaken and support can be offered as able During standard working hours individual matrons and above will	4	4	16	

The ED corridor will be utilised alongside the YNP initiative and the ED cohort area in order to optimise patient flow. The specific hazards of this are: The ED corridor area is not designed as a trolley waiting area Holding patients in the ED corridor may pose a greater risk of hospital acquired infection due to limited spacing in between each trolley No substantive nursing/paramedic staff to care for patients in the ED coridor. This could result in an inability to deliver basic care and also reduce patient safety leading to avoidable falls and pressure damage. The highest risk is during the out of hours period due to a reduced number available to staff from individual divisions and the	Staff: due to increased risk of work associated fatigue and stress.	system during periods of extreme pressure. Datix reporting to highlight number of patients affected and any incidents relating to caring for patients on the ED corridor					optimise nursing resources using the safe staffing dashboard. Out of hours this role will need to be completed by the site team in conjunction with the OMOD and Divisional Band 7's. The duration that patients remain in the ED corridor will be monitored by the CSM to enable patients to be moved to the next place of care in the most timely way Monthly walkabout with Deputy Chief Operating Officer, Lead Nurse for Quality & Safety, Lead Nurse – Infection Prevention and Matron for ED in collaboration with Senior Sisters to seek assurance on compliance. Divisional Governance Manager and Lead Nurse – Infection Prevention to monitor any increases in Patient Harm and Nosocomial Infection. To increase Oxygen Safety, Alarmed Oxygen Cylinders will be sourced. Repose overlay trolley mattresses sourced to increase ability for pressure ulcer prevention.				

wider senior team to support. Increased time on a trolley rather than a bed could increase the risk of pressure damage for patients moved onto the ED corridor. Potential poor patient experience for patients nursed in the ED corridor No call bells, piped oxygen or suction increasing the risk of harm. Lack of privacy/dignity for patients Potential harm to the reputation of the Trust due to potential poor patient outcomes, patient experience and/or staff experience Potential increase in complaints from patients or their families Adding to the overall ED capacity has potential to							Walkabout with the ICB Chief Nurse and CQC				

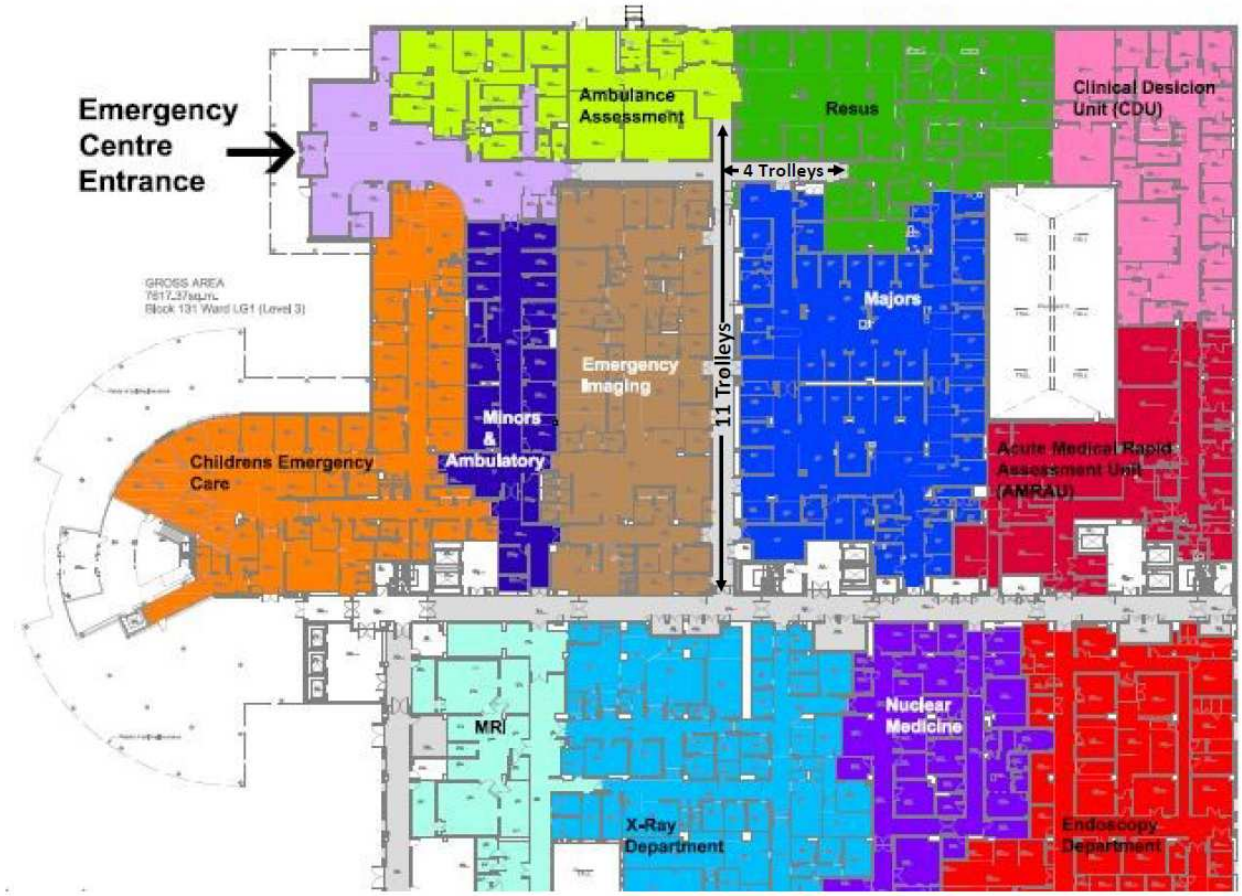
have a detrimental effect upon the well-being of ED staff. Risk of increased regulatory inspection and enforcement notices if assurance regarding safe care delivery cannot be provided.											

Action Plan:

Action Required	Action Agreed / Alternative Action	Person responsible	Target date	Date completed	Manager sign off
Risk assessment to be shared with ED staff, senior sisters, matrons and consultants	Action plan to be emailed out to all senior sisters, matrons and consultants	Matron ED			
Risk assessment to be shared with Chief Nurse, Deputy Chief Nurse, Associate Chief Nurse / Deputy Director (Infection Prevention & Sepsis), Divisional teams and Site team.	Action plan to be been emailed out to Chief Nurse, Deputy Chief Nurse, Associate Chief Nurse / Deputy Director (Infection Prevention & Sepsis), Divisional teams and Site team.	Divisional Nurse Director Medicine			
Risk assessment and SOP to be presented to QSOG and QGC and then shared with NHSEI/ICB and CQC	ICB and CQC made aware of the risk assessment process and SOP being developed	Chief Nurse			
Necessary equipment to be identified and available in readiness to accommodate patients nursed in the corridor					
Staffing requirements to be requested for bank/agency in line with the SOP requirements	Actioned - until end Jan 2023	Chief Nurse			

Assessor *Print*:		Assessor *Sign:*		**Date:**
Manager *Print:*		Manager *Sign:*		**Date:**
Review date:				

Appendix 1 - ED Floor Plan



Standard Operating Procedure (SOP)

Corridor Care Within ED

14th December 2022 Version 2.0

University Hospitals of North Midlands NHS Trust

Introduction

The purpose of this SOP is to define the process of proactive clinical pathway management of patients with RSUH when trust escalation level 4 has not created sufficient capacity to manage acute requirements. This is to ensure timely, safe, and effective care delivery for patients arriving by ambulance, and those members of the public waiting for an emergency response in our community.

This SOP seeks to support distributing risk throughout the Trust and community in order to ensure that no one group of patients or staff are adversely affected.

a) Scope

This SOP links to Trust Escalation Policy, Hospital Full Policy, Outlier Policy, Your Next Patient SOP and ED Corridor Escalation SOP.

This SOP applies to all UHNM staff and relevant Sodexo staff involved in the clinical pathway management of non-elective patients including but not limited to:

- Chief Operating Officer (COO) and Deputy COO
- Clinical Directors and Clinical Leads
- Emergency Physician In Charge (EPIC)
- Ward Managers and Nurse In Charge (NIC)
- Clinical Site Managers (CSM) and the Site Management Team (SMT)
- Divisional Management Teams
- Directorate Management Teams

Escalation/Triggers

The SOP can be enacted at any time or day of the week.
The SOP will be triggered when ED have no capacity in both Ambulance Assessment/Cohort Majors Cubicles and 6 DTA boarders in C Bay and will continue as required to support management of risk throughout the Trust.
The decision to trigger the ECE SOP will be made by the COO, Deputy COO, or their nominated deputies, (Gold On Call for Out Of Hours) in conjunction with the ED Emergency Physician in Charge (EPIC), Nurse-in Charge (NIC), and CSM based on an overall balance of risk.
Once all ED spaces are filled, and WMAS ambulances are waiting to offload, the ECE SOP will be initiated.
YNP SOP will be in operation and patients moved as per that SOP.

Operational Procedure

A total of 15 patients may be managed on the corridor in the ED with the designated Paramedics, booked for this role, to care for them.

Once 15 patients are on the ED corridor, no further patients will be offloaded.

No further increase in patients on the corridor will occur except with the express agreement of the CEO EPIC & NIC. This will trigger an Internal Capacity Incident.

Prior to offloading ambulances within the corridor the EPIC & NIC will ensure all other actions have been confirmed to mitigate risk

ED ACTION

- Ensure all available cubicles in major are used.
- Ensure that a maximum of 6 cubicles in ambulatory are used for DTA patients (mainly from ambulatory patients but also major waiting admission).
- Ensure all patients who are fit to sit have been offloads.

TRUST ACTION

- Ensure all available capacity on wards has been used.
- Ensure all wards are following the process of YNP to create emergency portal capacity.
- Ensure the maximum capacity on speciality wards has been used.
- Ensure all potential outliers have been moved.
- Ensure the trust is working a critical incident level 4.

Staff of Ambulance Corridor

The trust will employ outsourced agency staff (paramedics) to provide the care of patients in the corridor. The maximum staffing levels will be 4 with 1 to 6 patients per paramedic and the Corridor Care Team (CCT) will comprise of 3 paramedics and 1 EMT.

If the CCT is understaffed this impact will immediately reduce the number of patients that can be cared for on the corridor and no further offloads will occur over the staffing ratio. All next discharges from the department will be solely aimed to reduce the corridor patients back to within the CTT capacity or winding down to a close.

Under no circumstances will CCT staffing be provided by the ED nursing workforce.

ED Nurses will support the CCT with treatments that are not covered within the JRCalc to ensure all time critical medications are administered in a timely manner.

Flow of patients

Paramedics will book the patient in at ambulance reception.

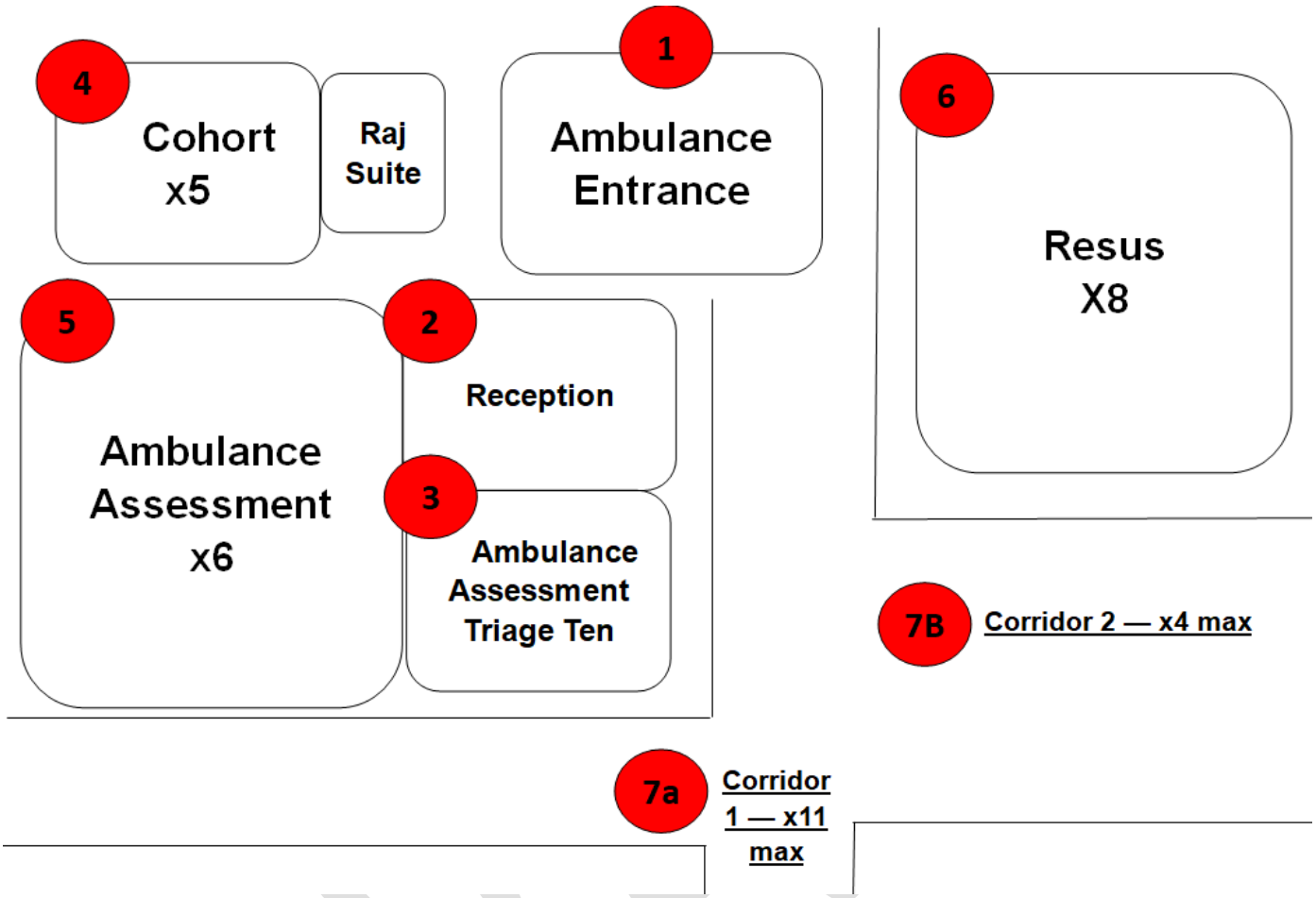
Stretcher patients will be assessed at the ambulance triage station by a B6/7 triage nurse and Tier 4/5 Clinician who will:

- Obtain the appropriate history from the paramedics.
- Undertake appropriate set of triage observations.
- Stream patients to appropriate areas i.e. Ambulatory patients to Ambulatory ED or Unstable patients to ED Resus.

All patients with letters will be redirected back to the ambulance to be driven entrance of the appropriate speciality portal unless requiring immediate resuscitation.

NO PATENT WILL BE ALLOWED TO TRANSFERRED THROUGH THE CORRIDOR OF CARE INTO THE MAIN HOSPITAL IN ANY CIRCUMSTANCES

- All appropriate computer based work (Careflow) will be completed.
- Ambulance crews will be pinned off when directed to area of care.



Area Flow & Functions

1. Ambulances attend by ambulance entrance.
2. Patient booked into Careflow by receptionist.
3. Handover and triage by ambulance triage nurse (Bed 6/7) SDM (Tier 4/5).
4. Appropriate stable patients to be moved to cubicle for RAT. RAT led by tier 3/4 clinician, ACP and Nurse.
   Prep patients.
   Order appropriate investigations – Bloods/Imaging.
5. Stable Patients requiring c? m? ECG/ 02 and Sats ???? ambulance assessment.
6. Resus capped at 5 patients.
   C1 – Only for Trauma.
   C5 – Only for Paeds.
   C8 – For corridor patients' needs.
7. Post RAT assessment patient moved to corridor awaiting capacity.
   May still be awaiting imaging.

7A. Minimum corridor Max 11.
7B. Corridor Max 4.

8. Majors.

Hourly updates on the number of patients on the ED Corridor under the ECE SOP will be provided to the CSM. This will be escalated to Silver on Call and Gold on call at regular meetings and intervals.

Executive Summary

Meeting:	Trust Board	**Date:**	4th January 2023
Report Title:	NHS Resolution Maternity Incentive Scheme Year 4 Compliance	**Agenda Item:**	10
Author:	Donna Brayford, Deputy Director of Midwifery – Governance; Claire Hill, Quality and Risk Manager		
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

Executive Summary

Situation

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

Background

NHS Resolution is operating year four 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.

Assessment

UHNM can demonstrate they have achieved all of the ten safety actions.

Key Recommendations

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. The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution.

NHS Resolution Maternity Incentive Scheme Year 4

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

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

a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from 6th May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.

- **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.**

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6th May 2022 have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.

- **UHNM have started 100% of all PMRT reviews within two months of each death**.

b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6th May 2022 have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

- **UHNM have completed 100% of the PMRT tool to the point that at least a PMRT draft report has been generated by the tool within four months of each death and published the report within six months of each death.**

c) For at least 95% of all deaths of babies who died in your Trust from 6th May 2022, the parents have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.

- **UHNM reports 100% of all parents have been told a review of their baby's death will take place.**

d) 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.

- **The Trust is compliant with all four standards of this safety action.**

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

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

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

1. By 31st October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme.

- **The Trust Maternity Digital Strategy was submitted to the LMNS and signed off 24th October 2022 following sign-off by the Trust.**
  The Trust has dedicated digital leadership (Digital Midwife) who engages with the NHSEI Digital Child Health and Maternity Programme as a member of the National and Regional Digital Maternity Expert Reference Group (DMERG).

2. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022.

- **In July 2022, UHNM achieved 11 out of 11 CQIMS. The Trust is therefore compliant.**

3. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month.

- **In July 2022 UHNM achieved 97.3%. The Trust is therefore compliant.**

4. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month.

- **In July 2022 UHNM achieved 98.5%. The Trust is therefore compliant.**

5. July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2)

- **In July 2022 UHNM achieved 98.5%. The Trust is therefore compliant.**

6. July 2022 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 2022 UHNM achieved 98.5%. The Trust is therefore compliant.**

7. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics:

Midwifery Continuity of carer (MCoC)

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

- **In July 2022 UHNM achieved 97.5%. The Trust is therefore compliant.**

ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.

- **In July 2022 UHNM achieved 100%. The Trust is therefore compliant.**

iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion.

- **In July 2022 UHNM achieved 95.8%. The Trust is therefore compliant.**

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?

The following standards are required to be compliant with Safety Action 3:

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.

b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.

c) A data recording process (electronic and/or paper based) for capturing all term babies transferred to the neonatal unit, regardless of length of stay, is in place.

d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.

e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), Local Maternity and Neonatal System (LMNS) and commissioners, to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.

f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.

An example of the data collected is below:

	Quarter 2 (July, August and September 2022)	Percentage %
Number of live births >37 weeks gestation	1490 ↑ Q1 (1331)	
Number of admissions to Neonatal Unit	68	4.56% ↑ from Q1
Unavoidable admissions	68	4.56% ↑ from Q1
Avoidable admissions	0	0 in Q1 and Q2

g) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.

- **The themes identified by UHNM in the reporting period are decreasing the number of term babies admitted with respiratory issues. To achieve this, we need on-going use of the term assessment care bundle and regular updates for nursing and medical staff, this will be supported by promoting ATAIN E-learning module to trainee induction sessions and assessment in portfolio.**

- **Neonatal hypoglycaemia in babies of a diabetic mother remains static (3 admissions out of 68), therefore education of and awareness (midwives) of early feeds in babies of a diabetic mother is currently included in mandatory face to face training.**

h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level champions, LMNS and ICS quality surveillance meeting.

- **UHNM are compliant with all standards of Safety Action 3.**

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

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

a) Obstetric Medical Workforce
1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service.

- **UHNM Guideline 'Delivery Suite Staffing' is in line with RCOG requirements.**

2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.

- **Compliance of consultant attendance for the clinical situations listed is part of UHNM Audit Programme. UHNM has developed an action plan where it has highlighted non-compliance of consultant attendance.**

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24hours a day and should have clear lines of communication to the supervising 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.

- **UHNM is compliant with this standard.**

c) Neonatal medical workforce

The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

- **UHNM meets the BAPM standard of junior medical staffing.**

d) Neonatal nursing workforce

- **The neonatal unit meets the service specification for neonatal nursing standards. The budgeted establishment is in line with BAPM.**

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 81.95, of which 57.37 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	88.76	80.28	85.27	3.49	-4.99
Total reg nurses	74.12	68.16	78.80	-4.68	-10.64
Total QIS	39.16	33.02	63.70	-24.54	-30.68
Total non-QIS	34.96	35.14	15.09	19.87	20.05
Total non-reg	14.64	12.12	6.47	8.17	5.65
Reg nurses as % nursing staff	83.5%	84.9%	92.4%		
QIS as % reg nurses	52.8%	48.4%	80.8%		

- **UHNM are compliant with all standards of Safety Action 4.**

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

The following standards are required to be compliant with Safety Action 5:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. UHNM completed Birth Rate Plus Assessment in 2022.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. UHNM recently approved to budget midwifery staffing in line with the latest Birth Rate Assessment.

	Birthrate Plus® 2022 Staffing - Baseline staffing requirements based on 25.99% Uplift	2019 Birthrate Plus®	Variance 2019 v 2022	Current budgeted establishment	Variance – current v BR+ 2022
Total Clinical WTE	271.88wte	257.46wte	14.42wte	203.75wte	68.13wte

There was a significant shortfall in the budgeted clinical midwifery establishment, against Birthrate Plus recommendations. The budgeted staffing levels needed to be increased in order to align to Birthrate Plus. This is the recommendation for delivery of a traditional model of care.
(these figures include the Ockenden funding of 3.26 wte clinical and 3.26 wte education/training).

A business case was submitted and approved by Trust Board to increase the clinical midwifery establishment in line with Birthrate Plus recommendations 2022. The budgeted establishment has now been increased accordingly. In Spring 2022 ahead of the Birthrate Plus report, the Board committed to recruit 22 wte midwives, these commenced in post in October 2022, increasing the contracted number by 22 wte midwives.

New Budget 2023

								5.64	24hr day/7d/w						
								1.88	8hr day/7d/w						
								1.34	8hr day/5d/w						
BR+ Staffing recommendations	**Inc 25.99% uplift**	**Proposed clinical budget**								**Non-clinical budget**	**Total proposed budget**				
		B7	B6	B5	B3/4	Total	Check	Midwives per shift	Allowed off per shift (in addition)	B7	B7	B6	B5	B3/4	
Delivery suite	83.57	14.90	55.97	12.70		83.57	-	14.81	3.85	0.60	15.50	55.97	12.70	-	
Triage (MAU)	13.17	0.40	11.77	1.00		13.17	-	2.33	0.61	0.60	1.00	11.77	1.00	-	
Day Assessment Unit (MAU)	5.34		5.34			5.34	-	2.84	0.74		-	5.34	-	-	
MBC	17.79	0.40	15.39	2.00		17.79	-	3.15	0.82	0.60	1.00	15.39	2.00	-	
205	28.96	0.40	23.56	5.00		28.96	-	5.13	1.33	0.60	1.00	23.56	5.00	-	
206	33.92	0.40	28.52	5.00		33.92	-	6.01	1.56	0.60	1.00	28.52	5.00	-	
206 MSW	7.82				12.29	12.29	4.47	2.18	0.57		-	-	-	12.29	
OP Services	8.75		7.75	1.00		8.75	-	6.51	1.69	1.00	1.00	7.75	1.00	-	
Community	62.44	3.00	59.44			62.44	-			2.00	5.00	59.44	-	-	
Community MSW	6.94				14.90	14.90	7.96				-	-	-	14.90	
FMBC (County)	3.17	0.40	1.77	1.00		3.17	-	2.36	0.61	0.60	1.00	1.77	1.00	-	
	271.87	**19.90**	**209.51**	**27.70**	**27.19**					**6.60**	**26.50**	**209.51**	**27.70**	**27.19**	
		19.90	**209.51**	**27.70**	**27.19**						**26.50**	**209.51**	**27.70**	**27.19**	
		-	-	-	-						-	-	-	-	
	Required	**Proposed**	**Check**												
Required Reg'd Midwives	257.11	257.11	-												
Required MSW 90:10 (PN)	27.19	27.19	0.00												
Total	284.30														

The budgeted clinical midwifery establishment has now been increased to reflect Birthrate Plus recommendations for UHNM. This includes the locally calculated uplift of 25.99% in line with Ockenden Immediate and Essential Actions (IEA's) (Ockenden, the Final Report 2022).

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.

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

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period. UHNM submits a quarterly midwifery staffing paper to the directorate and LMNS, and 6 monthly paper to the Board.

- **UHNM are compliant with all standards of Safety Action 5.**

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

The following standards are required to be compliant with Safety Action 6:

1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.

2. Each element of the SBLCBv2 should have been implemented.

3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements.

Evidence of the completed quarterly care bundle surveys are submitted to the Trust Board.

Element 1:

This element requires the following monitoring evidencing an average of 80% compliance over a four-month period:

A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.

- **August to November 2022 showed an average of 84% compliance.**

B. Percentage of women where CO measurement at 36 weeks is recorded.

- **An audit of 60 Consecutive sets of notes showed 84 % compliance where CO measurement at 36 weeks is recorded.**
- **UHNM is compliant with A and B.**

Element 2:

This element requires the following monitoring evidencing at least 80%. An action plan is required if compliance is less than 95%.

A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20-week scan

- **The Trust is compliant with this element. Data showed 100 % compliance for risk assessment at booking.**

Uterine artery Doppler (UaD) can be further used in the second trimester (20-24 weeks alongside the anomaly scan) to further determine the risk of placental dysfunction. UHNM are in the process of having training for UaD.

Element 3:

This element requires the following monitoring evidencing at least 80%.

A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy.

- **The Trust is compliant at 83%.**

B. Percentage of women who attend with Reduced Fetal Movements who have a computerised CTG.

- **The Trust is compliant 100%.**

Element 4:

The Trust board should specifically confirm that within their organisation:

- **90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above.**

- **Compliance with training is 95 % on 29th November 2022.**

Element 5:

An audit was undertaken between July- September 2022 and showed the following compliance.

A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.

- **UHNM Compliance is currently 86 % - accepted standard is greater than 80 %.**

The SBLCBv2 discusses giving antenatal steroids optimally 48hrs before a planned pre-term birth, for example induction for growth restriction, but the above data includes spontaneous onset of labour which is unpredictable.

B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids -

- **UHNM Compliance is at 14 % the percentage of process indicator should be as low as possible. The SBLCBv2 states 'a steroid to birth interval of greater than seven days should be avoided'.**

C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.

- **UHNM Compliance is at 100 % - accepted standard is greater than 80 %.**

D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).

- **UHNM Compliance is at 100%.**

- **UHNM are compliant with all standards of Safety Action 6.**

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?

The following standards are required to be compliant with Safety Action 7:

Evidence should include:

- Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems.

- Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff.

- Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes.

- The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it.

- Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way.

- Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.

- Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP.

The Trust remains fully compliant with this safety action with a well embedded, robust process working in collaborative partnership with the MVP and other key service users.

- **UHNM are compliant with all standards of Safety Action 7.**

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?

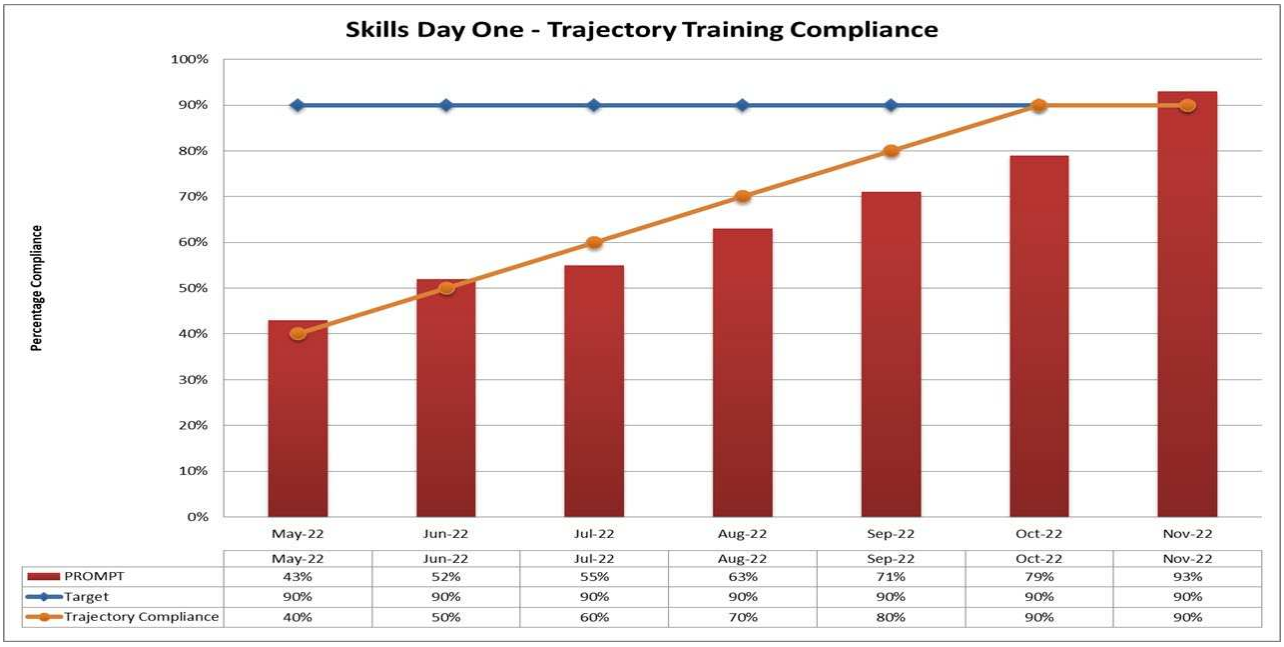
In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

The following standards are required to be compliant with Safety Action 8:

a) 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.

b) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multiprofessional training day, to include maternity emergencies starting from the launch of MIS year four.

- **UHNM Compliance is 93 % at the end of November.**



	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
PROMPT	43%	52%	55%	63%	71%	79%	93%
Target	90%	90%	90%	90%	90%	90%	90%
Trajectory Compliance	40%	50%	60%	70%	80%	90%	90%

	Doctors	Obs consultants	Obs trainees	Anaesthetist	Anaes consultants	Anaes trainees	Midwives/Bank	CSW	TOTAL
*Total number staff minus sick/maternity	50	15	35	46	26	20	275	80	450
Staff trained (inc PROMPT Trainers)	49	15	34	44	26	18	261	73	421
*Current compliance 29/11/22	98%	100%	97%	96%	100%	90%	95%	91%	93%
90% Staff to train to be 100% compliant	45	14	31	42	24	18	249	72	411
Staff outstanding to train (within 90% figures)	0	0	0	0	0	0	0	0	0
				*Figures from trainees confirming completion with signed peer declaration form. **Included in figures are all doctors, anaesthetists and midwives who are prompt trained or have taught on the sessions.					

c) 90% of each relevant maternity unit staff group have received online CTG training and competency assessment, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four.

- **UHNM Compliance is 95 %.**

	Doctors	Obs consultants	Obs trainees	Midwives/Bank	TOTAL
*Total number staff minus sick/maternity	47	14	33	267	314
Staff trained (inc PROMPT Trainers)	46	14	32	253	299
*Current compliance 29/11/22	98%	100%	97%	95%	95%

d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your annual in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four.

- **UHNM Compliance for the Maternity Team is 93 %. UHNM Compliance for the Neonatal Team is 91 %.**

- **UHNM are compliant with all standards of Safety Action 8.**

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?

The following standards are required to be compliant with Safety Action 9:

a) The pathway developed in Year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality surveillance-model.pdf (england.nhs.uk). The revised pathway should formalise how Trust level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.

UHNM has developed a Board approved Maternity and Neonatal Quality Assurance Map.

b) Board level safety champions present a locally agreed dashboard to the Board quarterly including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022.

The Chief Nurse attends Maternity and Neonatal Quality Safety Oversight Group and Maternity and Neonatal Quality Governance Committee, a summary report is presented to the Trust Board.

c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes.

d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP).

Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5 January 2022. UHNM have used findings from the Maternity and Neonatal SIP culture survey to inform the development of their workforce recruitment and retention plan, developed as part of the NHSE/I Direct Support Offer – Workforce – now completed, this programme of work has been commended by NHSE/I.

- **UHNM are compliant with all standards of Safety Action 9.**

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?

The following standards are required to be compliant with Safety Action 10:

A) Reporting of all qualifying cases to HSIB from 1st April 2021 to 5th December 2022.

B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 until 5 December 2022.

C) For qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022 the Trust Board are assured that:

1. the family have received information on the role of HSIB and the EN scheme;
2. 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.

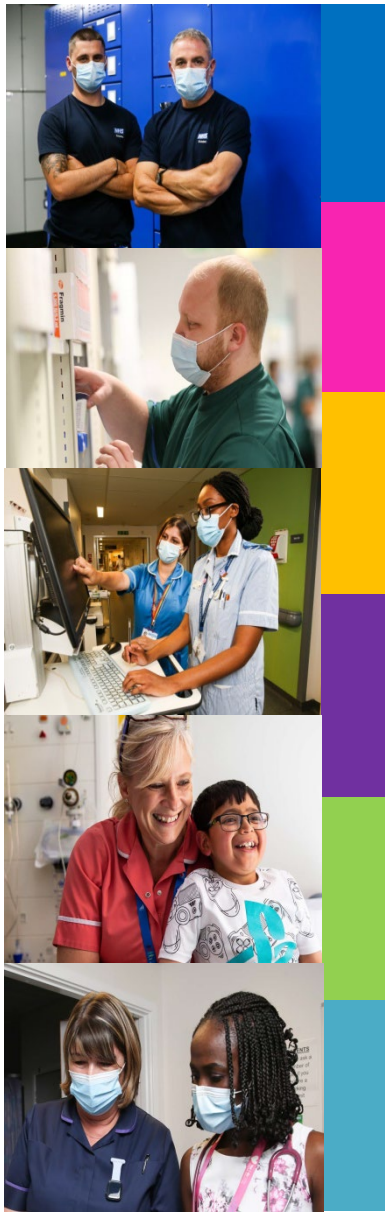
a) 6 Qualifying Cases have been reported to HSIB during the qualifying period.
b) 1 qualifying case reported to EN Scheme.

- **UHNM are compliant with all standards of Safety Action 10.**

NHS
University Hospitals of North Midlands
NHS Trust

NHS Resolution Maternity Incentive Scheme year 4 Compliance

Public Trust Board 4th January 2023



Delivering Exceptional Care with Exceptional People

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

University Hospitals of North Midlands NHS Trust

PMRT Supporting high quality local perinatal reviews

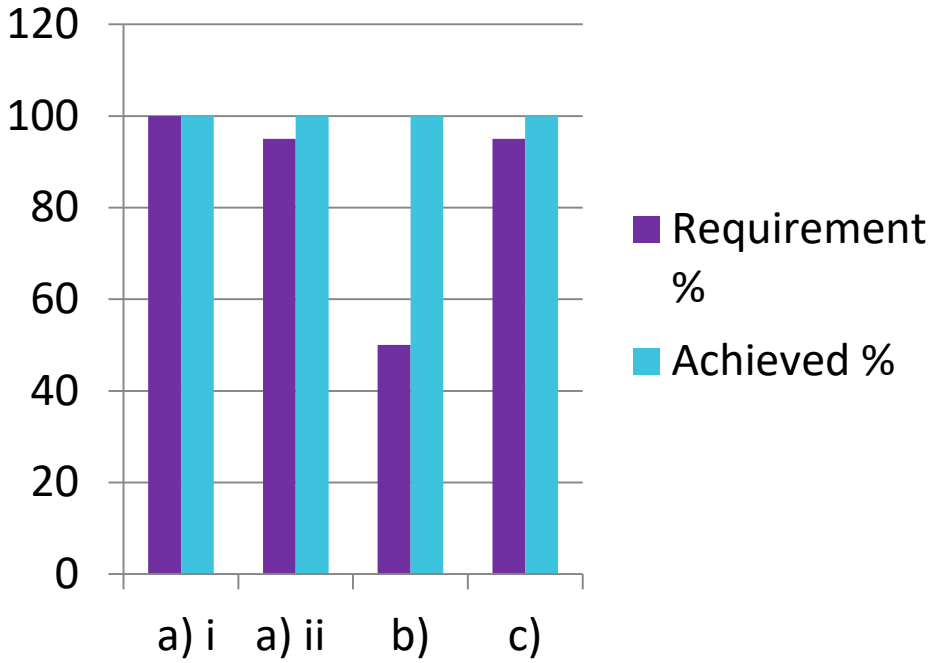
a) i All perinatal deaths eligible to be notified to MBRRACE-UK must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.

a) ii A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, have been started within two months of each death.

b) At least 50% of all deaths of babies (suitable for review using the PMRT) have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

c) For at least 95% of all deaths of babies who died in your Trust from 6th May 2022, the parents have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought.

All of these standards have been externally verified by MBRRACE.



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

University Hospitals of North Midlands NHS Trust

UHNM are compliant in all 7 measures of safety action 2 based on data submitted to the MSDS IN July 2022.

See Table below:

Criteria 1 - **The Trust has dedicated digital leadership (Digital Midwife) who engages with the NHSEI Digital Child Health and Maternity Programme as a member of the National and Regional Digital Maternity Expert Reference Group (DMERG).**

	Criteria_1 By October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme	**Criteria_2** **CQIMs** - Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed for July 2022 data									
Year	Yes/No	CQIMApgar (Yes/No)	CQIMBreastfeeding (Yes/No)	CQIMPPh (Yes/No)	CQIMPreterm (Yes/No)	CQIMRobson01 (Yes/No)	CQIMRobson02 (Yes/No)	CQIMRobson05 (Yes/No)	CQIMSmokingBooking (Yes/No)	CQIMSmokingDelivery (Yes/No)	CQIMTears (Yes/No)	CQIMVBAC (Yes/No)
2022	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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

University Hospitals of North Midlands NHS Trust

Criteria_3 **BMI** - July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month	Criteria_4 **CSF** - July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month	Criteria_5 **PCSP** - July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2)	Criteria_6 **Ethnicity** - July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the reporting 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
Yes / No	Yes / No	Yes/No	Yes/No
Yes	Yes	Yes	Yes

Criteria_7 - Midwifery Continuity of Carer (MCoC) **COC_DQ04** - Over 5% of women who had an antenatal care plan in place for which continuity of carer indicator status was known, by 29 weeks gestation in the month of July 2022 **COC_DQ05** - Over 5% Percentage of women with an antenatal care plan in place and the continuity of carer indicator completed by 29 weeks gestation, who have a named lead midwife and team ID in the month of July 2022 **COC_CareProfLID** - At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion			**Criteria_7** **MCoC (Midwifery Continuity of Carer)** This is the combined results of COC_DQ04, COC_DQ05 and COC_CareProfLID	**Results**
COC_DQ04 Yes/No	COC_DQ05 Yes/No	COC_CareProfLID Yes/No	Yes/No	Achieved Out of 6
Yes	Yes	Yes	Yes	6

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 Admission into Neonatal units Programme?

University Hospitals of North Midlands NHS Trust

- The on-going review of term infant admissions has revealed that rates remain low at UHNM. We are currently 1.44% below the National benchmark of 6% for term admissions into the Neonatal Unit. This identifies that we demonstrate UHNM minimises separation of mothers and their babies in line with National Guidance.

- In Q1 (April, May and June 2022) and Q2 (July, August and September 2022) there have been **no** avoidable admissions to the Neonatal unit. There were 68 unavoidable admissions to the Neonatal unit in Q2.

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

University Hospitals of North Midlands NHS Trust

a) Obstetric Medical Workforce

1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service.

2.Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.

Compliance of consultant attendance for the clinical situations listed is part of UHNM Audit Programme. UHNM has developed an action plan where it has highlighted non-compliance of consultant attendance.

Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24hours a day and should have clear lines of communication to the supervising 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.

UHNM is compliant with this standard.

c) Neonatal medical workforce

The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

UHNM meets the BAPM standard of junior medical staffing.

d) Neonatal nursing workforce

The neonatal unit meets the service specification for neonatal nursing standards. The budgeted establishment is in line with BAPM.

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

University Hospitals of North Midlands NHS Trust

Birthrate Plus UHNM 2022

Midwifery Staffing levels January 22	BR+ (2019)	Budgeted WTE	Contracted WTE	Variance BR+	Variance budgeted/contracted	Variance BR+/contracted
Clinical midwifery staffing	**257.46**	**212.39**	**192.08**	**45.07**	**20.31**	65.38

There was a significant shortfall in the budgeted clinical midwifery establishment, against Birthrate Plus recommendations. The budgeted staffing levels needed to be increased by 45.07 wte in order to align to Birthrate Plus. This is the recommendation for delivery of a traditional model of care. (these figures include the Ockenden funding of 3.26 wte clinical and 3.26 wte education/training).

A business case was submitted and approved by Trust Board to increase the clinical midwifery establishment in line with Birthrate Plus recommendations 2022. The budgeted establishment has now been increased accordingly. In Spring 2022 ahead of the Birthrate Plus report, the Board committed to recruit 22 WTE midwives, these commenced in post in October 2022, increasing the contracted number by 22 WTE midwives.

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

University Hospitals of North Midlands NHS Trust

Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019.
Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.

Element 1

- A. Percentage of women where Carbon Monoxide (CO) compliance is recorded – Data for August to November 2022 showed an average of 84%.
- B. Percentage of women where CO measurement at 36 weeks is recorded – an audit of 60 consecutives sets showed 84% compliance.

Element 2

- A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) at booking data showed 100% compliance.

Element 3

- A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy showed 100% compliance.
- B. Percentage of women who attended with reduced fetal movements who had a computerised CTG showed 100% compliance.

Element 4

- 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. Compliance with training is 95 % on 29th November 2022.

Element 5

- A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids , within seven days of birth data showed 86% compliance

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

University Hospitals of North Midlands NHS Trust

- B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids, compliance is at 14%.

- C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium
  sulphate within 24 hours prior birth data showed 100% compliance.

- D. Percentage of women who give birth in an appropriate care setting for gestation
  (in accordance with local ODN guidance). Data showed 100% compliance.

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?

University Hospitals of North Midlands NHS Trust

Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of implementing Better Births; A resource pack for Local Maternity Systems.

Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff.

Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes.

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?

University Hospitals of North Midlands NHS Trust

Continued

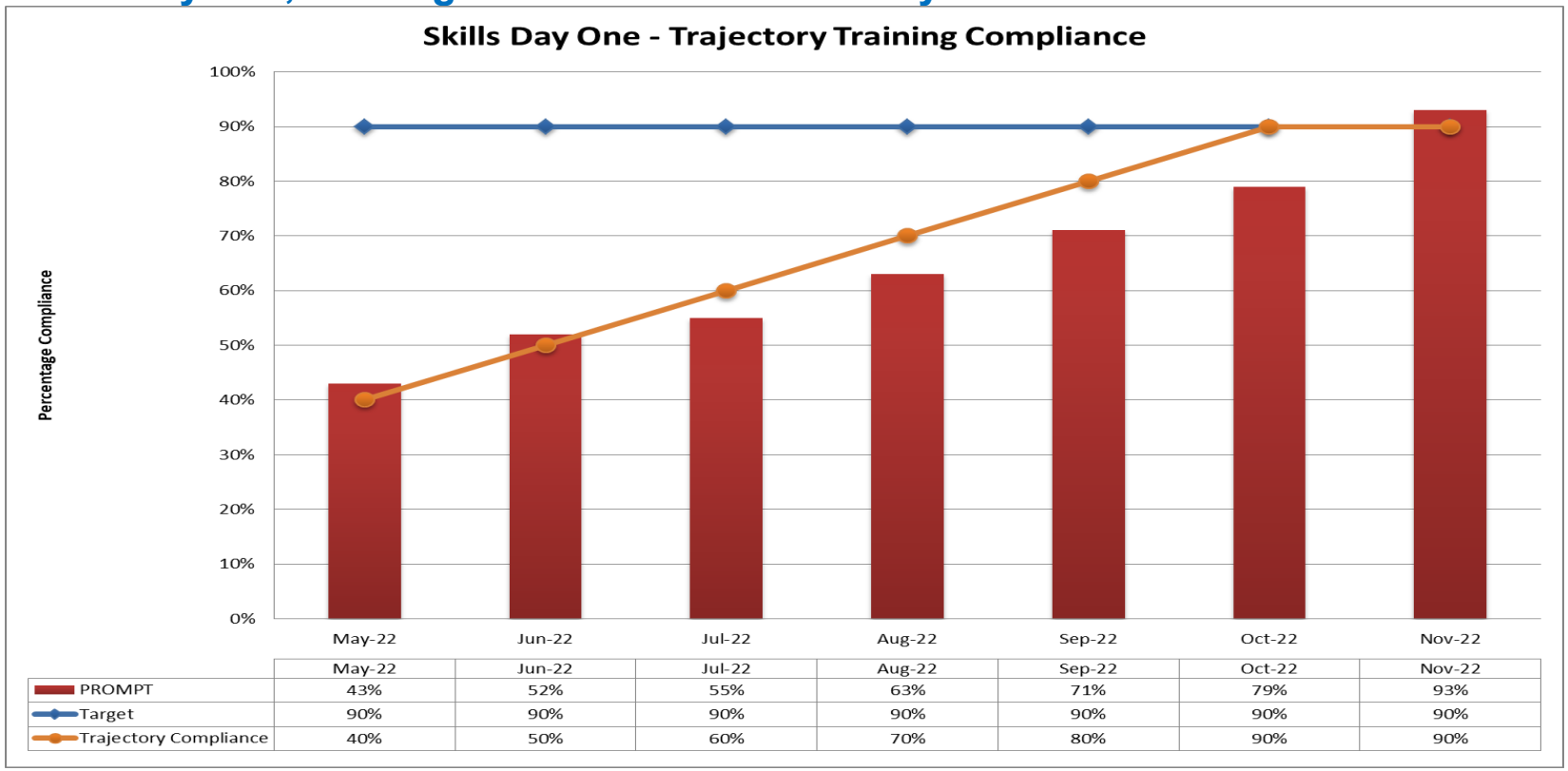
Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality. Action plan completed as part of Equity and Equality strategy.

Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP.

The Trust remains fully compliant with this safety action with a well embedded, robust process working in collaborative partnership with the MVP and other key service users.

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 form the launch of MIS year 4?

University Hospitals of North Midlands NHS Trust



	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
PROMPT	43%	52%	55%	63%	71%	79%	93%
Target	90%	90%	90%	90%	90%	90%	90%
Trajectory Compliance	40%	50%	60%	70%	80%	90%	90%

A local training plan has been implemented to ensure that all six modules of the core competency framework are included in our training programme.

Over 90% of all staff groups have attended a multi professional training day. This has been achieved with a hybrid model of face to face and online training.

Over 90% of all staff groups involved in immediate resuscitation of the newborn have attended neonatal life support training.

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?

a) The pathway developed in Year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality surveillance-model.pdf (england.nhs.uk). The revised pathway should formalise how Trust level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.

UHNM has developed a Board approved Maternity and Neonatal Quality Assurance Map.

b) Board level safety champions present a locally agreed dashboard to the Board quarterly including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022.

The Chief Nurse attends Maternity and Neonatal Quality Safety Oversight Group and Maternity and Neonatal Quality Governance Committee, a summary report is presented to the Trust Board.

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?
Continued

c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes.

d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP).

Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5 January 2022. UHNM have used findings from the Maternity and Neonatal SIP culture survey to inform the development of their workforce recruitment and retention plan, developed as part of the NHSE/I Direct Support Offer – Workforce – now completed, this programme of work has been commended by NHSE/I.

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?

University Hospitals of North Midlands NHS Trust

6 out of 6 cases reported to HSIB.
1 out of 1 case reported to EN scheme.

Transformation and People Committee Chair's Highlight Report to Board

21st December 2022

1. Highlight Report

! Matters of Concern of Key Risks to Escalate

- Staff Wellbeing concerns given significant pressures and the ability to take breaks in line with the Winter Wellbeing Initiatives – this has been discussed with Staff Side partners and a more proactive, visible approach is being taken in addition to Trust communications
- Concern regarding the response to the Staff Survey although the final figures are yet to be issued nationally along with the findings
- General Medical wards are particular hot spots in terms of fill rates and staffing as these are not regarded as being 'desirable' specialties to work within; however ED is also an area that is difficult to staff
- Circa 180 nurse posts are currently vacant and it is extremely challenging, despite recruitment campaigns, to fill those vacancies – a corporate project is planned to look at patient cohorts and to determine whether it is nursing care or another role that can care for those patients, some of this work has already commenced at the County Hospital
- There has been a decrease in uptake to Statutory and Mandatory training and it is envisaged that this will further decline due to current pressures
- Covid related absence is currently at 15% and in addition to this, a large proportion of sickness is due to anxiety, stress and depression
- There has been a considerable increase in activity being seen in the recruitment pipeline which is creating additional pressure in terms of time to hire, further compounded by national issues associated with Visas
- Disappointing uptake from staff to the vaccination programme when compared to the previous year
- Implementation of Health Surveillance continues to be a risk although work is being undertaken to develop a revised matrix and approach to this
- Adoption of Improving Together tools is at around 40% and there is a new vacancy within the team which, whilst training will continue, it may present a risk to the ability to work with and support senior leadership teams and enablement of strategic change

Major Actions Commissioned / Work Underway

- An evaluation of the ENABLE programme has been undertaken and this will be presented to the next Transformation and People Committee; a further evaluation is planned and that will look at effectiveness and embedding of the programme
- The Cultural Heat Map is now well developed; further metrics are to be included within the OD and Culture Report going forward in order to aid better understanding of the position so that the assurance is more data driven aligned with Improving Together
- Consideration is being given as to how progress against the People Strategy will be reported through utilisation of data
- Staff continue to access the Staff Counselling Service and this is regarded as a useful resource; consideration is to be given as to how the benefits and effectiveness of this service can be reported although it was recognised that this might be limited
- As part of the Establishment Review, a plan to address nursing gaps and the strategy to fill those vacancies is to be shared with the Committee
- The Psychological Wellbeing Hub continues to be promoted and discussions are ongoing with system partners to consider what this looks like in the future
- Deep dives have been requested from divisions on agency expenditure and these will be considered at the next Executive Workforce Assurance Group
- A focus on the 'too tired to drive' initiative is currently underway in order to ensure the safety of doctors
- Implementation of actions against the RACE Equality Code is underway
- Work continues to progress on the development of the Health and Wellbeing Strategy previously discussed at Trust Board Seminar
- A suite of online training associated with Improving Together is now available
- An Executive Delivery Group for Improving Together is to be established and a meeting is planned in the first week of January to confirm the Terms of Reference

✓ Positive Assurances to Provide

- Significant progress has been made, in particular with the implementation of the ENABLE programme, Civility and Respect and the development of an e-learning programme for the Be Kind programme which has now been approved as being mandatory
- A dedicated post is being put into place at County to focus specifically on nurse staffing challenges on that site
- There has been a marginal increase on PDRs
- Positive work being undertaken within the Estates, Facilities and PFI Division in terms of recognition of staff, this has been shared with other divisions
- Strengthened governance structures in place within divisions in relation to culture and health and safety and work is being done to deliver the associated frameworks

Decisions Made

- Minutes of the previous meeting approved as an accurate record

Comments on the Effectiveness of the Meeting

- Looking forward, the agenda is looking very busy and some items had been deferred – a meeting is to take place in the New Year to look at the items specifically relating to the People Strategy

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	OD, Culture and Inclusion Update	BAF 2	12	Assurance		6.	Executive Strategy & Transformation Group Assurance Report (14-12-22)	BAF 4		Assurance	
2.	Nursing and Midwifery Staffing and Quality Report	BAF 1/3	16	Assurance		7.	Improving Together Highlight Report	-		Assurance	
3.	Workforce Report – M8 2022/23 • PDRs	BAF 2/3	12 16	Assurance		8.					
4.	Executive Workforce Assurance Group Assurance Report (16-12-22)	BAF 2/3		Assurance		9.					
5.	Executive Health & Safety Group Assurance Report (16-12-22)	BAF 3		Assurance		10.					

3. 2022 / 23 Attendance Matrix

No.	Name	Job Title	A	M	J	J	A	S	O	N	D	J	F	M
1.	Prof G Crowe	Non-Executive Director												
2.	Ms H Ashley	Director of Strategy												
3.	Ms S Toor	Associate Non-Executive Director												
4.	Mrs T Bullock	Chief Executive												
5.	Mr P Bytheway	Chief Operating Officer												
6.	Dr L Griffin	Non-Executive Director												
7.	Mrs S Gohir	Non-Executive Director												
8.	Dr K Maddock	Non-Executive Director												
9.	Mrs AM Riley	Chief Nurse												
10.	Mrs C Cotton	Associate Director of Corporate Governance					NH			NH				
11.	Mrs R Vaughan	Chief People Officer												

Attended | Apologies & Deputy Sent | Apologies

Performance and Finance Committee Chair's Highlight Report to Board

16th & 20th December 2022

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• In terms of business case reviews, 21 were overdue for review and 11 were in the process of approval. The Committee requested that actions be taken with teams to highlight the importance of completing the reviews and clarifying expected timescales • An update was provided in terms of current challenges and pressures which had resulted in the calling of a critical incident which included an increase in trauma demand, ambulance holds and increase in covid and flu cases. The introduction of corridor care and standing down of elective orthopaedics to support trauma demand was highlighted in addition to the continued use of Your Next Patient • It was noted that capital expenditure was £6.3 m behind plan and this was being managed on a day to day basis. Cost Improvement Programme (CIP) savings had been identified of £7.9 m, with a full year impact of £5.3 m, a variance to the recurrent target of £13.6 m. It was highlighted that full CIP plans were not expected to be available before the year end in terms of the savings required to be achieved for 2023/24 • A paper was provided on the financial outlook for 2023/24 which identified significant challenges regarding the non-recurrent savings identified in the Cost Improvement Programme (CIP) and the impact on the underlying position which had been revised to £47.1 m • Following the guidance issued by NHSE the process for making any changes to in-year revenue financial forecasts was highlighted which included the introduction of 'double lock' and 'triple lock' restrictions on expenditure • A presentation was provided on the system bed model which could be used for long, medium and short term planning whereby an excess bed demand was forecast of a worst case scenario of 240 • Ambulance holds had deteriorated to 1000 hours lost in the past week and there had been an increase in the number of discharge to assess patients although it was anticipated to take forward 200 discharges in readiness for the industrial action. Medically optimised for discharge numbers had reduced and Haywood was being utilised to provide additional beds • There had been an increase in the number of 104 week patients in November including some patient cancellations and presently there were 28 patients waiting over 104 weeks in December, and this was being managed via regional calls. The 78 week position continued to reduce, which was below the set trajectory	• 12 month review of covid costs to be undertaken • To confirm the savings associated with eREAF 10171 • To ensure the risk assessment associated with corridor care was discussed at Quality Governance Committee and Trust Board as well as ensuring this was referenced on the Board Assurance Framework • To provide an update on the PwC bed model at a future Board Seminar including the plans and mitigation to address the bed gap
✓ Positive Assurances to Provide	Decisions Made
• The business case review of ED medical workforce highlighted the increase in numbers of doctors available and maintaining the wait to be seen time to 100 minutes despite pressures, although challenges continued to relate to the wait to be seen overnight • Month 8 financial performance demonstrated a £2.7 m surplus against plan and there had been a reduction in the forecast from a £9 m deficit to £7 m deficit although the mitigated position was expected to achieve break even. • There had been a continuing decrease in the patient tracking list for cancer and decreasing backlog position with the 2 week wait and 62 day positions having also improved	• The following business cases were approved: BC-0516 Implementation of NHS 2021 National Healthcare Cleaning Standards, BC-0515 Soft FM Covid Service Increase Cost Pressure Funding Request, BC-0509 Consultant Connect Year 3, Cardiothoracic Theatre Staffing, BC-0512 Midlands Imaging Academy, BC-0510 Public Sector Decarbonisation Scheme, BC-0500 Estates Operations Recruitment and Retention & Structure review • The following eREAFs were approved: 10171 Respiratory Consumables, 10159 Extension of Contract – Insourcing of Neurology Services provided by Elective Services Ltd, 10258 Purchase of Modular Building at Royal Stoke, 10270 Purchase of CTS at County Hospital • The budget setting framework for 2023/24 was approved

Comments on the Effectiveness of the Meeting

- There were no further comments on the effectiveness of the meeting.

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Cardiothoracic Theatre Staffing Business Case	BAF 3	24281 (16)	-	Approval	8.	Financial Outlook 2023/24	BAF 8	9	!	Assurance
2.	BC-0512 Midlands Imaging Academy			-	Approval	9.	Changes to in-year revenue financial forecasts	BAF 8	9	!	Assurance
3.	BC-0510 Public Sector Decarbonisation Scheme	BAF 7	12	-	Approval	10.	PWC System Bed Model	-		✓	Assurance
4.	Business Case Review: BC-0426 ED Medical Workforce	BAF 3	8580 (9) 8442 (20)	✓	Assurance	11.	Performance Report – Month 8 2022/23 • Discharge Processes and Delays • Progress on Ambulance Holds • NHS Oversight Framework 2022-23 Quarter 2 Review Letter	BAF 5	16	! ✓	Assurance
5.	Business Case Review Schedule	-		!	Assurance	12.	Planned Care Improvement Group Highlight Report (15-12-22)	BAF 5	16	-	Information
6.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (PO) Expenditure	-		-	Approval	13.	Non-Elective Improvement Group Highlight Report (6-12-22)	BAF 5	16	-	Information
7.	Finance Report – Month 8 2022/23	BAF 8	9	✓ !	Assurance						

3. 2022 / 23 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	Chair											
3.	Ms H Ashley	Director of Strategy												
4.	Ms T Bowen	Non-Executive Director												
5.	Mrs T Bullock	Chief Executive												
6.	Mr P Bytheway	Chief Operating Officer						KT/OW	KT					
7.	Mr M Oldham	Chief Finance Officer												
8.	Mrs S Preston	Strategic Director of Finance												
9.	Mrs C Cotton	Associate Director of Corporate Governance			NH	NH	NH	NH		NH	NH			
10.	Mr J Tringham	Director of Operational Finance												

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

Executive Summary

Meeting:	Trust Board	**Date:**	04th January 2023
Report Title:	Integrated Performance Report, Month 8 2022/23	**Agenda Item:**	13.
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: Claire Soper, Assistant Director of Human Resources; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse / Paul Bytheway: Chief Operating Officer / Ro Vaughan: 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

Assessment

Quality & Safety

Key messages

The Trust achieved the following standards in November 2022:

- Friend & Family (Inpatients) 97.1% and exceeds 95% target.
- Harm Free achieved 97% against 95% target rate

- 0 Never Event
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.5% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during November 2022.
- Inpatients Sepsis Screening above 90% target rate at 96.5%.
- Children's Sepsis Screening compliance improved to 95.8% and above the 90% target.
- HSMR is significantly lower than benchmark.

The Trust did not achieve the set standards for:
- Friend & Family Test for A&E improved to 66.5% but remains below 85% target.
- Friend & Family (Maternity) improved to 66.7% but remains below 95% target.
- Falls rate was 6.1 per 1000 bed days for November 2022
- There were 21 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 91% verbal Duty of Candour compliance recorded in Datix
- 30% 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
- C Diff YTD figures above trajectory with 11 against a target of 8.
- E. Coli Bacteraemia cases above trajectory with 24 in November compared to target of 16.
- Inpatient Sepsis IVAB within 1 hour achieved improved to 88.9% but remains below 90% target rate
- Sepsis Screening compliance in Emergency Portals reduced to 84% below the target 90%.
- Emergency Portals Sepsis IVAB in 1 hour improved to 68% but remains below the 90% target for audited patients
- Maternity Sepsis Screening compliance decreased to 75% against 90% target
- Maternity IVAB compliance improved to 67% but remains below the 90% target for audited patients

During November 2022, the following quality highlights are to be noted:
- The rate of complaints per 10,000 spells is 20.44 and is below the target of 35 and within normal variation. Majority of complaints in November 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents decreased in month (1864) and the rate per 1000 bed days has also decreased at 45.83
- Total incidents with moderate harm or above and the rate of these incidents are within normal variation levels.
- Rate of falls reported that have resulted in harm to patients currently at 1.3 per 1000 bed days in November 2022. The rate of patient falls with harm continues to be within the control limits and normal variation but is below the mean rate and is statistically significantly below the mean for 7 months indicating improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 5.4 and patient related 4.7 which are higher to previous month and mean rates. The monthly variation is within the normal expected variation and consistent with Trust mean rates.
- Pressure Ulcers per 1000 bed days developed under UHNM care has seen a decrease during November 2022
- Hospital Associated Thrombosis is within normal variation and at mean level.
- Decreased numbers of Definite Hospital Onset / Nosocomial COVID-19 cases reported in November 2022 with 34 in total.
- 2 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 12 Serious Incidents reported during November 2022.
- SHMI has seen increases and under review for diagnosis groups but is within expected range (see funnel plot chart)

Area for improvement is the recording of Duty of Candour completion within Datix. Reporting of compliance with Duty of Candour is confirmed when Datix is updated and copies of the letters uploaded. The compliance with Duty of Candour has been escalated and discussed at QSOG in December 2022 meeting and Divisions are working with clinicians and Q&S teams to raise further awareness and education on how and why Duty of Candour is to be completed. Dedicated sessions are being provided with session in Emergency Medicine on 15th December 2022 scheduled.

Divisions are to provide updates on local actions being undertaken to improve compliance at QSOG and Performance Reviews.

All data used in this report is as recorded on 8th December 2022 and figures may change following further review/investigation/update

Operational Performance

Emergency Care

- November was another challenging month across the Non-Elective Improvement Programme with increasing IP restrictions as winter pressures mount and year high occupancy as a result of significant rising numbers of MFFD patients waiting extended periods of time to leave the care of the Trust. This congestion has resulted in increased delays for specialties to respond to referrals in the Emergency Department (ED), and the availability of SDEC pathways. This in turn resulted in increased time spent in the ED and a lack of improvement in both 1 Hour Ambulance Handover Delays and 12+ Hours In ED.

- In response to this rise in occupancy and departmental congestion, organisation wide focus was applied to the improvement and expediting of Simple & Timely (S&T) discharges, facilitated by the standing down of BAU activities and the mandating of senior operational presence on wards throughout the day. These efforts resulted in the highest discharges for S&T since the summer of 2021 with an accompanying improvement in the percentage of pre-noon discharges. Unfortunately, these improvements were not sufficient to offset the rise in MFFD patients and so performance continued to be impacted.

- The Front Door Reconfiguration timeline has now been confirmed as delayed by approximately one month as a result of supply chain constraints. Possible routes of mitigations have been explored in conjunction with the Chief Operating Officer and Chief Nurse with no acceptable solution identified. This means the last trauch of winter capacity and the final Front Door Reconfiguration moves will now not take place until January 30th. This deficit of expected capacity will need to be addressed and an options appraisal is currently underway for Executive decision in December.

- Your Next Patient (YNP) saw an in month slight dip in performance to approximately 30% of patient moves that were previously occurring in the evening and night, now shifting to the morning and early afternoon, down from a high of 50% in October. Refocusing on YNP as a patient as part of the driving of S&T discharge improvements resulting in a return to previous levels of performance during the later weeks of the month.

Cancer

- Most recent submitted Cancer Waiting Times position is October 22 which was 45.8% for 62 day performance. November is predicted to be 46.4%
- In August the PTL was over 6000 – this has now reduced by 2300 patients to 3706 in total. The PTL has reduced consistently for the past 13 weeks
- The 62 day target is expected to continue an improvement trajectory as additional capacity is put into colorectal by insourcing. Skin have effective recovery plans to reduce their backlog.
- In November the backlog of patients has seen a significant reduction from 1041 at the end of August to 894 at the end of September, 887 at the end of October and now 730 at the end of November.
- The incremental decrease of the Skin and Colorectal backlogs have been modelled up to the end of March 2023 where the new trajectory meets the initial trajectory submitted in 22/23 operational plans. Both specialties have enacted recovery plans and are ahead of the new trajectories to reduce the number of patients waiting beyond 62 days on the pathway.
- Skin have implemented recovery plans which has seen implementation of telederm and builds both triage and excision capacity.
- The 28 Day Faster Diagnosis position is currently 62.6% for November, an increase on the performance from 55.3% in October. This standard will be a focus of an Improving together project covering all pathways.
- Cancer will form a workstream as part of the Planned Care governance structure – this will initially focus on our challenged pathways of Skin and Colorectal, alongside 2WW and FDS more generally.
- The Trust remains in Tier 2 for cancer performance with weekly meetings with the Regional NHSE team.

Planned Care

- Day Case and Elective Activity delivered 96% and 88% respectively for October 22 against the national

ask of 110%/108%.

- Theatre transformation has been added as an additional workstream under Planned Care and begins with a focus on the 6-4-2 booking process with support from the regional theatres team.
- The focus has moved to 78 week waiters with an Annual Plan to reduce them to below 300 patients by March 2023. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge well before March so any treatment can be carried out to meet the 78 week standard. Slide 29 demonstrates we are ahead of trajectory with 726 patients 78+ in November.

RTT

- The overall Referral To Treatment (RTT) Waiting has slightly increased from 77,577 in November from 77,546 in October.
- The number of patients > 52 weeks continues to increase – from 4377 in August, 4,569 in September, 4628 in October and 4979 in November.
- At the end of November the numbers of > 104 weeks was 38. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment.
- The Trust remains in Tier 2 for 104> performance with weekly meetings with the Regional NHSE team.

Diagnostics

- Overall DM01 performance was 62%, a decrease in performance on last months 66%.
- Within DM01, the greatest proportions of > 6 week waits are within Non-obstetric ultrasound and endoscopy. Both ultrasound and endoscopies positions are related to an increase in demand alongside workforce shortfalls
- Full DM01 recovery plan agreed which sees the Trust achieving 6ww by end March 2023 in line with national requirement; this will be monitored through the planned care group.
- Activity across key modalities up against previous month activity. Incentive schemes starting to improve activity (non-obs ultrasound notably)
- The Improving Together A3 Diagnostic paper has been drafted and presented to Planned Care Group. This will focus on both DM01 and wider diagnostic planned patients for recovery.

Workforce

Key messages

- Our two main areas of focus continue to be on addressing staff availability in relation to high absence rates and turnover.
- The 12m Turnover rate in November 2022 reduced to 10.6% and this the 2nd month that this figure has sat below the trust target of 11%. However, the overall vacancy rate has increased to 12.5% meaning recruitment activity remains high as teams work to support additional recruitment business cases and winter plans.
- For November 2022, the in-month sickness rate has decreased by 1% to 5.24% (6.20% in October 2022). The 12-month cumulative rate marginally decreased to 6.24% (6.29% in October 2022).
- Chest and respiratory (which includes Covid) remains top at 26.3%, closely followed by Anxiety and Stress at 22.8%. These top two reasons for sickness absence are replicated across the Divisions.
- Focusing specifically on Covid related absence by 4 December 2022 covid-related absences stood at 71, which was 10.5% of the 674 open absences. This is 5.5% decrease on same time the previous month.
- Internal measures to monitor reduction is agency expenditure continue. Divisional targets for agency ceilings have been calculated.
- The appraisal (PDR) rate has increased marginally to 78.5%. For PDRs, divisions continue to report that due to increasing operational pressures, management time has been reduced and alongside reported high levels of sickness absence and vacancies. Divisions have been asked to review key issues and provide 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.

- We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory
- Training Plan for rollout of civility and respect interventions across UHNM was approved by Execs in November 2022
- A training plan for roll-out of "Being Kind" training across UHNM has been developed and this will include roll-out of an e-learning package (procured from A Kinder Life) which brings together the Resolution policy and Being Kind elements. A paper was presented to Execs in November for the training to be mandated as "core for all", which was approved. This was subsequently approved at the Stat/Mand group on 14th December.
- The National Staff Survey 2022 has now closed, and the latest overall response rate is 31.17% putting the trust under average response rate for an acute setting of 42.75%. The Staff Voice trust survey reopened in November with 118 total submissions providing an overall engagement score of 6.05.
- As part of the monitoring of the reduction to agency spend, divisions were asked to present an update on their action plan to reduce expenditure to EWAG Committee.
- A six-month mandate for industrial action has been received from the CSP, with an indication that action will take place early in the New Year, our EPRR team continue to plan for any action that takes place.

Finance

Key elements of the financial performance year to date are:

- Year to date the Trust has delivered an actual surplus of £2.7m against a planned surplus of £3.8m; this is primarily driven by underperformance against the Trust's in year CIP target.
- The Trust incurred £0.4m of costs relating to COVID-19 in month; with £0.4m of this being chargeable for COVID-19 testing costs. The Trust has overspent by £2.7m against its original in envelope allocation due to the in envelope funding allocation ceasing after Month 2.
- To date the trust has validated £7.9m CIP savings in year; these schemes have a full year impact of £5.3m, which presents a considerable variance to the Trust's recurrent target of £13.6m which was identified as a key risk in the Trust's financial plan submission.
- Capital expenditure in Month 8 is £22.8m which is £6.3m behind the plan of £29.1m. Of the expenditure to date £9.5m is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 8 is £97.8m, which is £24.8m higher than plan. Cash received is above plan due to Capacity and Virtual Ward income received from the ICB.
- The Trust has carried out a forecast for the year based on the actual position at Month 8; this forecast is for a £7.1m deficit before mitigations and has improved by £2m from the forecast at Month 7; the main driver of the improvement is a reduction in the contract gap with Specialised Commissioners.

Key Recommendations

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

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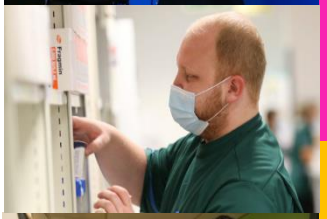


Integrated Performance Report

Month 8 2022/23

Delivering Exceptional Care with Exceptional People

Contents

A note on SPC

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

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

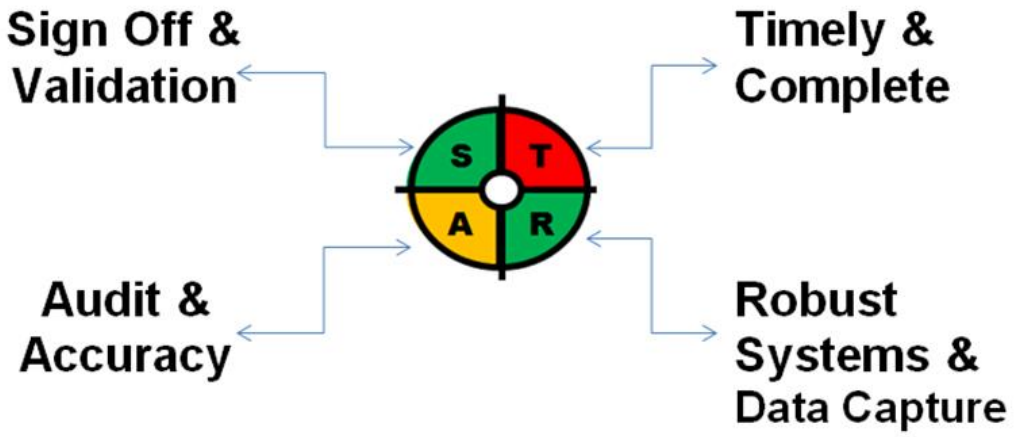
Assurance - how assured of consistently meeting the target can we be?

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

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

A note on Data Quality

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



Explaining each domain

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

RAG rating key

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

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Quality

Caring and Safety

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

Quality Spotlight Report

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The Trust achieved the following standards in November 2022:

- Friend & Family (Inpatients) 97.1% and exceeds 95% target.
- Harm Free achieved 97% against 95% target rate
- 0 Never Event
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.5% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during November 2022.
- Inpatients Sepsis Screening above 90% target rate at 96.5%.
- Children's Sepsis Screening compliance improved to 95.8% and above the 90% target.
- HSMR is significantly lower than benchmark.

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E improved to 66.5% but remains below 85% target.
- Friend & Family (Maternity) improved to 66.7% but remains below 95% target.
- Falls rate was 6.1 per 1000 bed days for November 2022
- There were 21 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 91% verbal Duty of Candour compliance recorded in Datix
- 30% 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
- Timely Observations remain below the 90% target at 67.5% during November 2022 but has seen significant improvement
- C Diff YTD figures above trajectory with 11 against a target of 8.
- E. Coli Bacteraemia cases above trajectory with 24 in November compared to target of 16.
- Inpatient Sepsis IVAB within 1 hour achieved improved to 88.9% but remains below 90% target rate
- Sepsis Screening compliance in Emergency Portals reduced to 84% below the target 90%.
- Emergency Portals Sepsis IVAB in 1 hour improved to 68% but remains below the 90% target for audited patients
- Maternity Sepsis Screening compliance decreased to 75% against 90% target
- Maternity IVAB compliance improved to 67% but remains below the 90% target for audited patients

During November 2022, the following quality highlights are to be noted:

- The rate of complaints per 10,000 spells is 20.44 and is below the target of 35 and within normal variation. Majority of complaints in November 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents decreased in month (1864) and the rate per 1000 bed days has also decreased at 45.83
- Total incidents with moderate harm or above and the rate of these incidents are within normal variation levels.
- Rate of falls reported that have resulted in harm to patients currently at 1.3 per 1000 bed days in November 2022. The rate of patient falls with harm continues to be within the control limits and normal variation but is below the mean rate and is statistically significantly below the mean for 7 months indicating improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 5.4 and patient related 4.7 which are higher to previous month and mean rates. The monthly variation is within the normal expected variation and consistent with Trust mean rates.
- Pressure Ulcers per 1000 bed days developed under UHNM care has seen a decrease during November 2022
- Hospital Associated Thrombosis is within normal variation and at mean level.
- Decreased numbers of Definite Hospital Onset / Nosocomial COVID-19 cases reported in November 2022 with 34 in total.
- 2 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 12 Serious Incidents reported during November 2022.
- SHMI has seen increases and under review for diagnosis groups but is within expected range (see funnel plot chart)

Quality Dashboard

NHS
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NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1971	1864	H	
Patient Safety Incidents per 1000 bed days	50.70	48.90	45.83		?
Patient Safety Incidents per 1000 bed days with no harm	N/A	20.74	25.73	L	
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.47	12.17		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.17	2.17		
Patient Safety Incidents with moderate harm +	N/A	47	33	H	
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	1.17	0.81		
Harm Free Care (New Harms)	95%	95.5%	97.0%		?
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		?
Patient Falls per 1000 bed days	5.6	5.8	6.1		
Patient Falls with harm per 1000 bed days	1.5	1.2	1.3	L	?
Medication Incidents per 1000 bed days	6	5.5	5.4		?
Medication Incidents % with moderate harm or above	0.50%	0.90%	2.75%	H	?
Patient Medication Incidents per 1000 bed days	6	4.7	4.7		F
Patient Medication Incidents % with moderate harm or above	0.50%	1.05%	2.62%	H	?

Metric	Target	Previous	Latest	Variation	Assurance
Serious Incidents reported per month	0	14	12		F
Serious Incidents Rate per 1000 bed days	0	0.35	0.30		F
Never Events reported per month	0	1	0		?
Duty of Candour - Verbal/Formal Notification	100%	91%	91%	L	?
Duty of Candour - Written	100%		30.0%	L	?
All Pressure ulcers developed under UHNM Care	TBC	61	105	H	
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	2.58	1.65		
All Pressure ulcers developed under UHNM Care lapses in care	12	12	17		?
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.3	0.39		?
Category 2 Pressure Ulcers with lapses in Care	8	1	2		?
Category 3 Pressure Ulcers with lapse in care	4	0	0		?
Deep Tissue Injury with lapses in care	0	22	10		
Unstageable Pressure Ulcers with lapses in care	0	5	6		?

Delivering Exceptional Care with Exceptional People

Quality Dashboard

NHS
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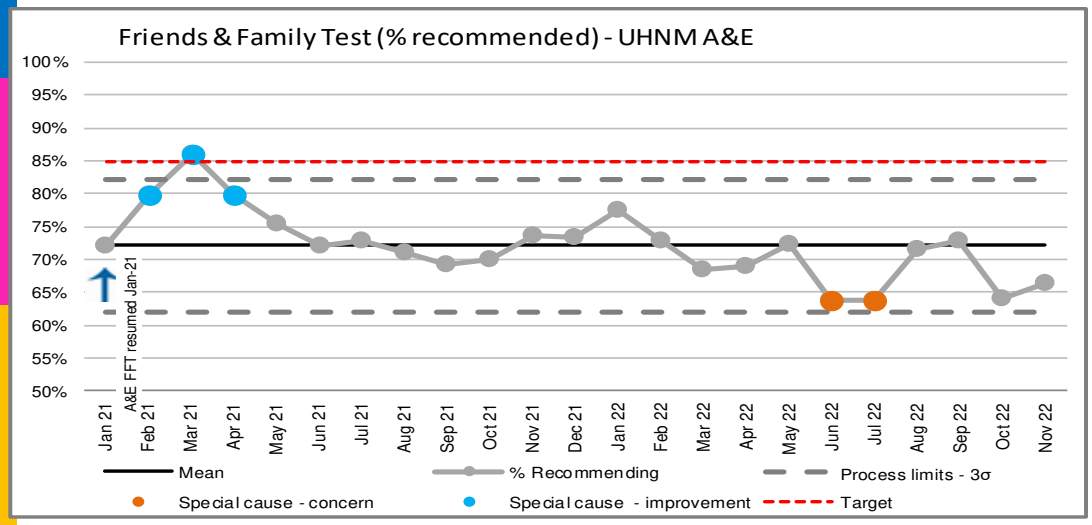
NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	64.1%	66.5%	L	F
Friends & Family Test - Inpatient	95%	95.8%	95.7%	L	P
Friends & Family Test - Maternity	95%	100%	50.0%		
Written Complaints per 10,000 spells	21.11	22.48	13.72		?
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	96.24	94.98		P
Rolling 12 Month SHMI (4 month time lag)	100	107.03	108.20	H	?
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	3	2		
VTE Risk Assessment Compliance	95%	98.6%	99.3%		P
Reported C Diff Cases per month	8	12	11		?
Avoidable MRSA Bacteraemia Cases per month	0	0	0		?
HAI E. Coli Bacteraemia Cases per month	8	15	24	H	?
Nosocomial "Definite" HAI COVID Cases - UHNM	0	34	34		

Metric	Target	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	81.0%	96.5%		?
Inpatient IVAB within 1hr (Contracted)	90%	84%	88.9%	L	P
Children Sepsis Screening Compliance (All)	90%	85%	95.8%		?
Children IVAB within 1hr (All)	90%	N/A	N/A	H	P
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	90%	83.8%		?
Emergency Portals IVAB within 1 hr (Contracted)	90%	66%	68.3%	L	?
Maternity Sepsis Screening (All)	90%	83%	75.0%	H	F
Maternity IVAB within 1 hr (All)	90%	N/A	66.7%	L	F

Delivering Exceptional Care with Exceptional People

Friends & Family Test (FFT) – A&E



Variation	Assurance

Target	Sep 22	Oct 22	Nov 22
85%	72.9%	64.1%	66.5%

Background

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

What do the results tell us?

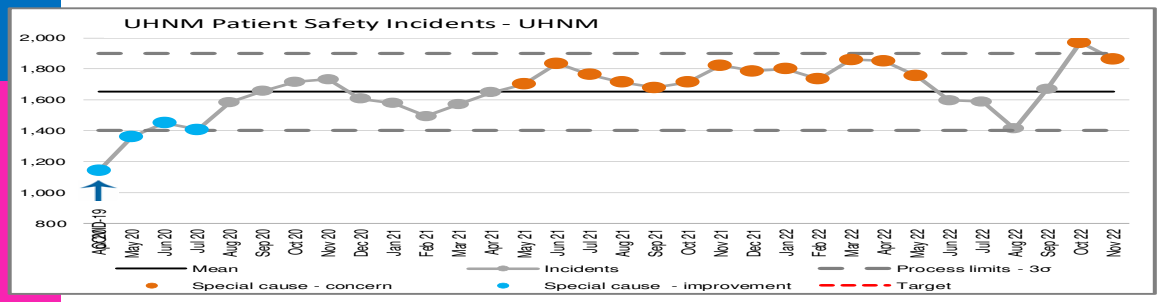
- The satisfaction rate for ED remains below our internal target at 64.1% for October 2022, and is a decrease of previous months. The Trust received 1056 responses which is a slight decrease on the previous month with a 11% response rate for both sites. The Trust's overall satisfaction rate is only significantly lower than the national average of 76% (Sept 22 NHS England).
- Feedback from patient experience of using 111First and the kiosks is being monitored. 27% of respondents in November 22 used 111First prior to attending ED, which remains static. Satisfaction score of patients using 111First was 58% for November 22 which is a decrease on the previous month and is lower than the overall satisfaction rate for ED attendees.

Actions :

- Themes from patient feedback remain the same and are around wait times, staff attitude and access to pain relief.
- Volunteer in ED supporting with refreshment rounds is also going hand out paper copies of the survey.
- Patient Experience team have now met with the ED team to reinstate their Patient Experience Group meetings
- New posters have been designed to encourage more feedback around the use of the 111 Kiosks in ED.

Reported Patient Safety Incidents

University Hospitals of North Midlands NHS Trust

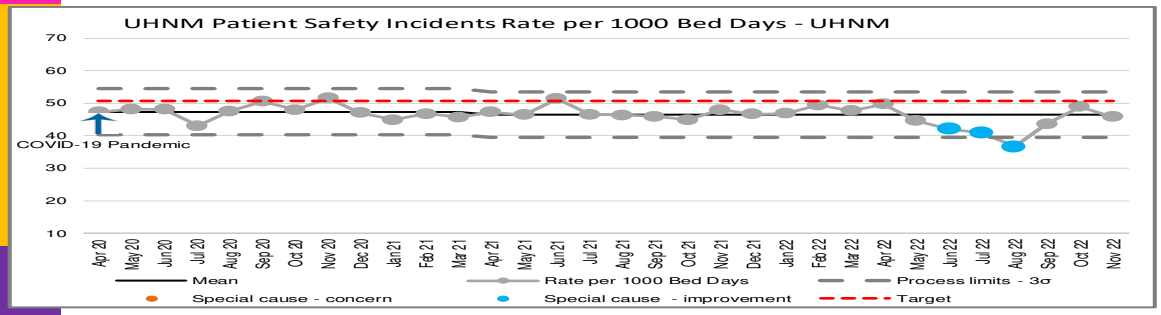


Variation	Assurance
H	

Target	Sep 22	Oct 22	Nov 22
N/A	1669	1971	1864

Background

Total Reported patient safety incidents



Variation	Assurance
	?

NRLS Mean	Sep 22	Oct 22	Nov 22
50.70	43.61	48.90	45.83

What is the data telling us:

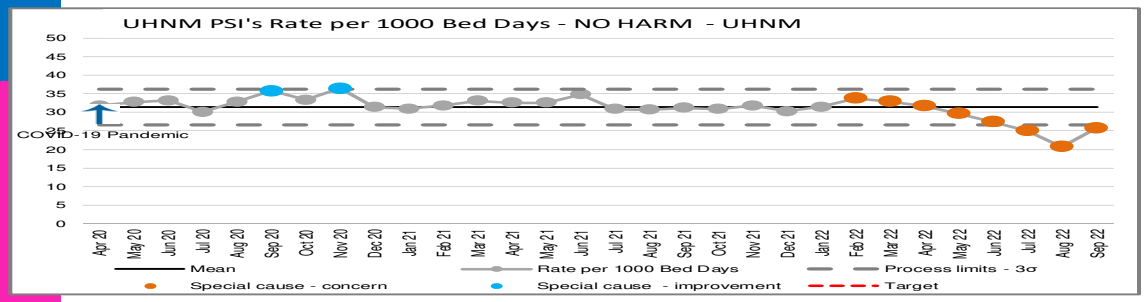
The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The November 2022 total is above the mean total since COVID-19 started. However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers are Patient Falls, Medication, Patient Flow and Clinical Assessment related incidents. There has been no significant changes in these categories compared to previous months.

The rate of reported PSIs per 1000 bed days has decreased in November but remains similar to the long term mean rate.

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

NHS University Hospitals of North Midlands NHS Trust

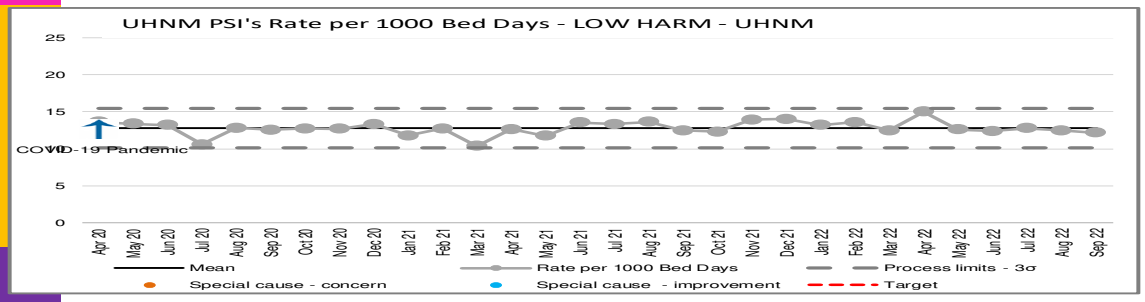


Variation	Assurance

Target	Jul 22	Aug 22	Sep 22
N/A	25.08	20.74	25.73

Background

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

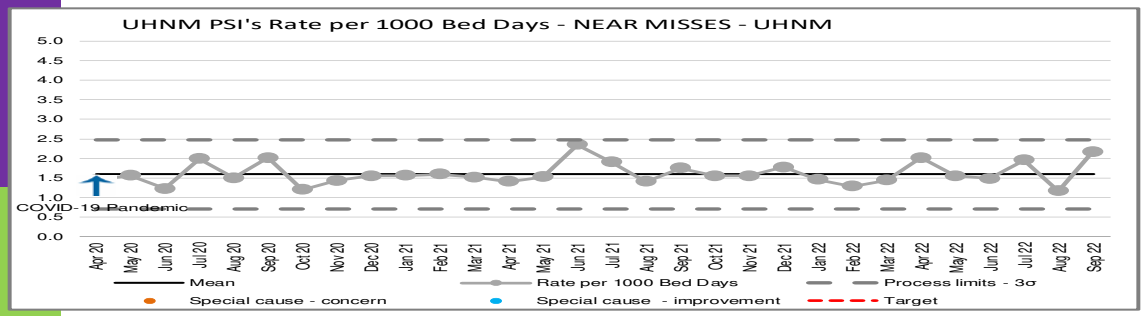


Variation	Assurance

Target	Jul 22	Aug 22	Sep 22
N/A	12.80	12.47	12.17

Background

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



Variation	Assurance

Target	Jul 22	Aug 22	Sep 22
N/A	1.96	1.17	2.17

Background

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

What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with low harm or near misses are showing consistent trends and within normal variation. The no harm incidents have seen reductions in last 6 months but have increased during the last 3 months. These are no clear reasons for change in no harm except for increase in rate of near misses.

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

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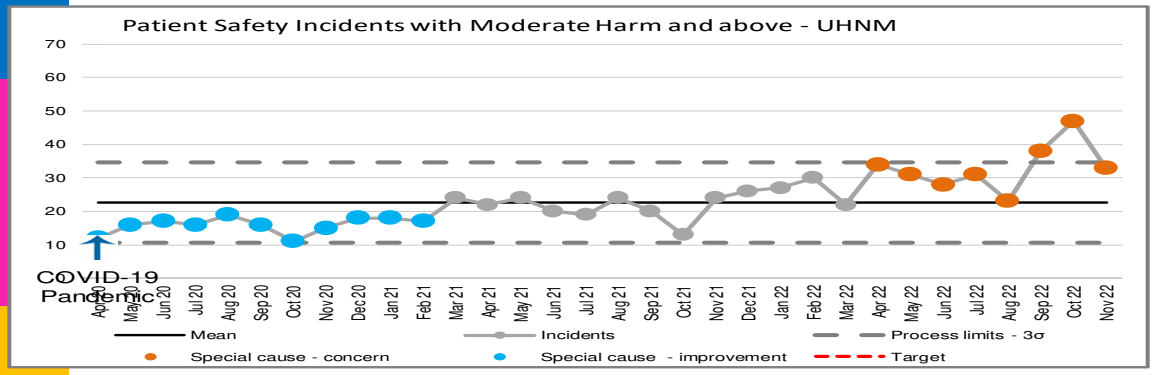
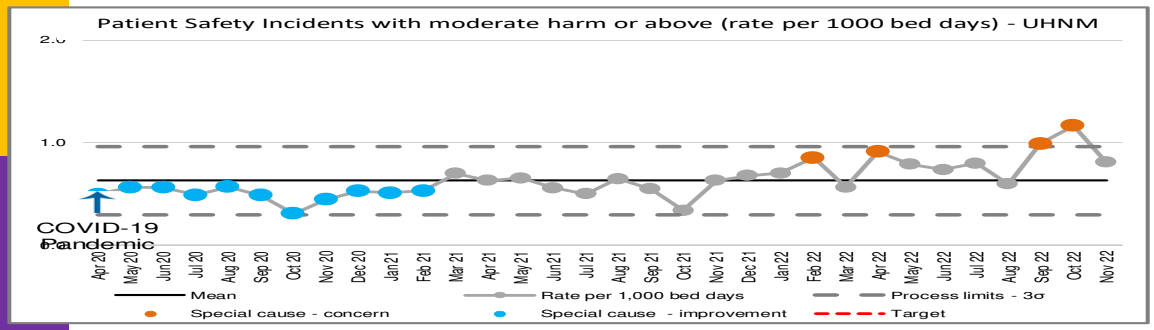


Variation	Assurance
H	

Target	Sep 22	Oct 22	Nov 22
N/A	38	47	33

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Sep 22	Oct 22	Nov 22
N/A	0.99	1.17	0.81

What is the data telling us:

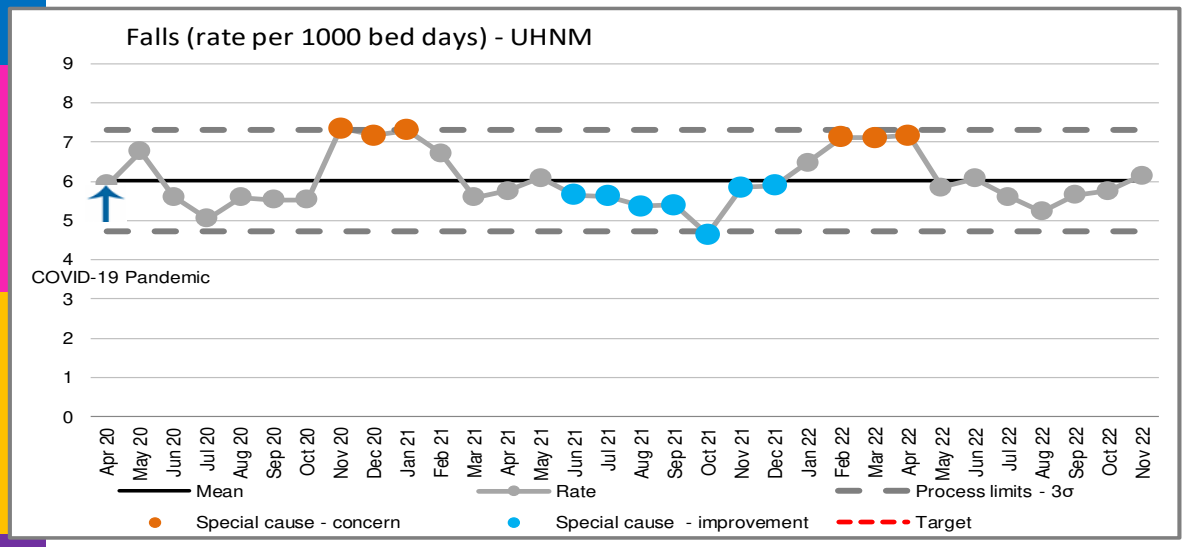
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is above the upper process control limit. The previous 5 months were around the mean rate hence the higher variation indicator. The monthly total may be amended following investigation of the incidents and level of harm reviewed and confirmed. October 2022 total decreased from reported 50 to 47 following data refresh for November reporting. November 2022 total is lower than October with 33 and is within normal variation limits

The reason for the increased totals are linked to patient related falls and also Pressure Ulcer related incidents.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 6 Falls, 6 Clinical Assessment, Treatment/procedure, 5 Pressure Ulcer (hospital acquired), 4 Patient Flow, 4 Medication

Patient Falls Rate per 1000 bed days

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance

Target	Sep 22	Oct 22	Nov 22
N/A	5.6	5.8	6.1

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

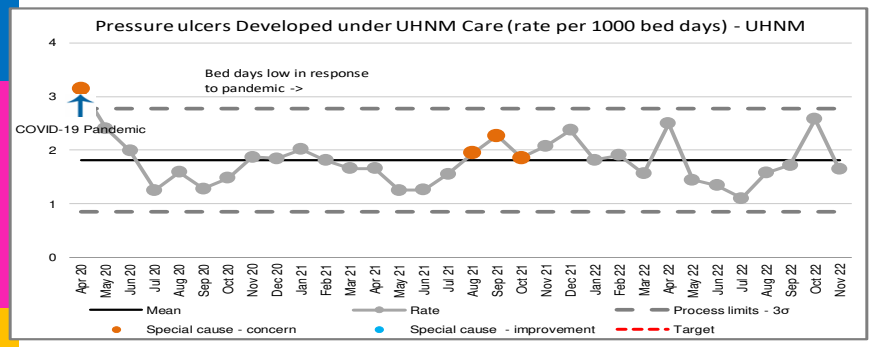
The Trust's rate of reported patient falls per 1000 bed days was within the normal range in November.

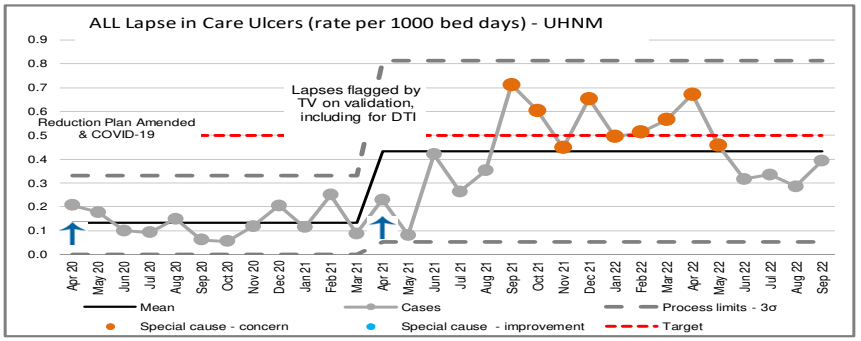
Recent actions taken to reduce impact and risk of patient related falls include:

- Audits continue to take place on the TOP 5 reporting areas and those areas where SI's occur.
- A new falls champion day and new nursing assistant training has taken place.
- Ward 220 falls have increased however they have a patient that has fallen several times. When visiting the ward it was observed that all documentation and interventions were in place.
- Feedback has been provided to wards 14 and 15 where improvement can be made to support the prevention of falls.
- Due to Datix's submitted detailing that patients have fallen due to patients using the bed tables has mobility frames, the wards have been informed that they should consider purchasing a few bed tables with lockable wheels for these patients.

Pressure Ulcers developed under care of UHNM per 1000 bed days

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Sep 22	Oct 22	Nov 22
N/A	1.72	2.58	1.65

Background

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

Variation	Assurance

Target	Jul 22	Aug 22	Sep 22
0.5	0.33	0.29	0.39

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 and the rate of ulcers with lapses in care remain within expected limits for November. Acuity for ward areas is taken into account in line with lapses in care.

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

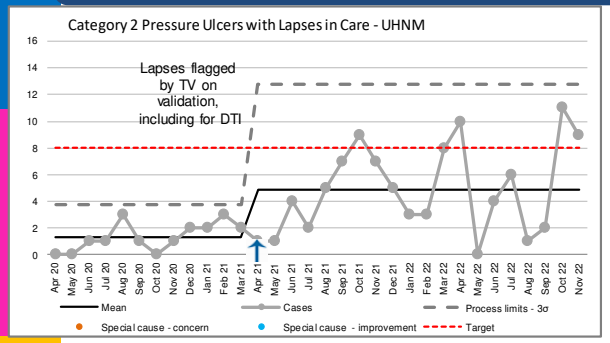
Pressure Ulcer prevention is an annual objective and a key driver metric as part of the Trust's Improving Together programme.

Actions

- Support mornings were provided to all high reporting wards for STP day by TV team and Sister for Q&S
- Training continues for PUP champions, nursing assistants and on ED statutory and mandatory training days and bespoke on request.
- Categorisation training dates have now been confirmed into next year. Training has now been provided to registered nurses and nursing assistants through nurse bank.
- ESR training request made for prevention, awaiting confirmation
- Training video has been made for care of catheters after an increase in urethral damage, along with the catheter life chart being updated and plans to re-launch
- Tendable has now been launched at County, ED and AMU, pressure ulcer prevention questions have been included.

Pressure Ulcers with lapses in care

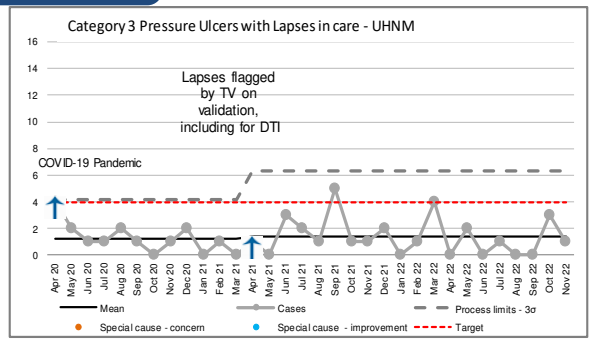
University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Sep 22	Oct 22	Nov 22
8	2	11	9

Background

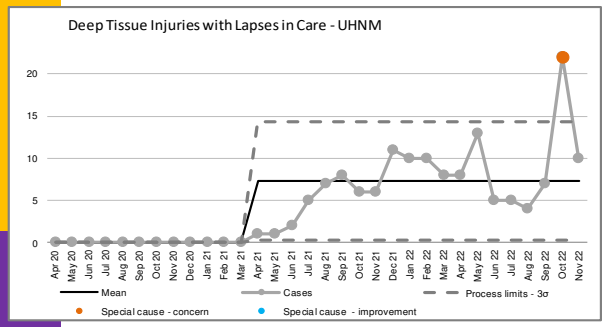


Variation	Assurance
	

Target	Sep 22	Oct 22	Nov 22
4	0	3	1

Background

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

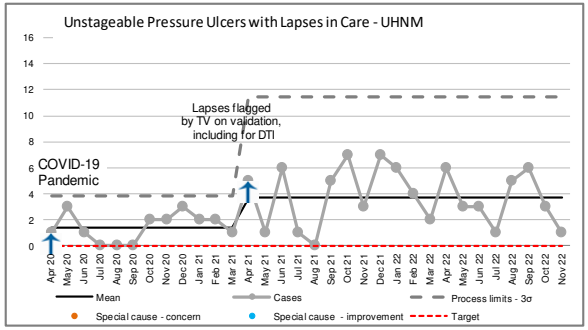


Variation	Assurance
	

Target	Sep 22	Oct 22	Nov 22
N/A	7	22	10

Background

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



Variation	Assurance
	

Target	Sep 22	Oct 22	Nov 22
0	6	3	1

Background

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

What is the data telling us:

The number of pressure ulcers reported as developing under UHNM care with identified lapses in care is showing only normal variation in each of the categories for November. As shown in the table below, the most common lapses identified were management of repositioning.

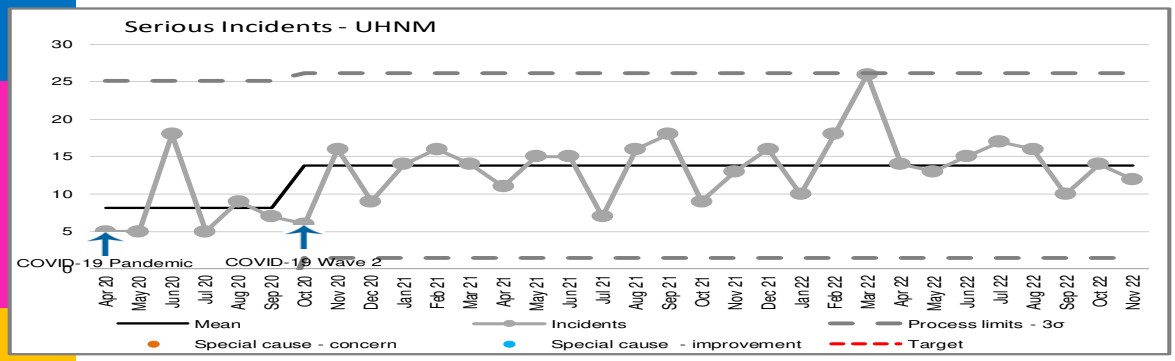
Root Cause(s) of damage - Lapses - Nov 2022	Total
Management of heel offloading	14
Management of repositioning	9
Management of device	1

Locations with more than 1 lapse in November 2022 were:
AMU (Stoke) (6) , Ward 14 (2)
In addition 2 urethral splits with lapses were identified in November 2022 on AMU (Stoke).

Actions:

- Working with Supplies and procurement to ensure AMU have adequate stock of utility pads for heel offloading
- AMU audit of documentation fed back to ward manager and AP mattresses supplied
- Plans are now in place for the continuation of RCA panels as pressures continue.
- High reporting wards will be sent notification, with audits and action plans to be implemented to support improvement
- Wards are invited to RCA panels to focus on improvements and learning, to focus on the lapse identified. Support is being offered to wards along with assurance visits following panels. Wards are being asked for feedback on the RCA process for adjustments and/or improvements to be made
- Pressure Ulcer Prevention (PUP) Champions training dates have commenced, along with other training from the TV team

Serious Incidents per month

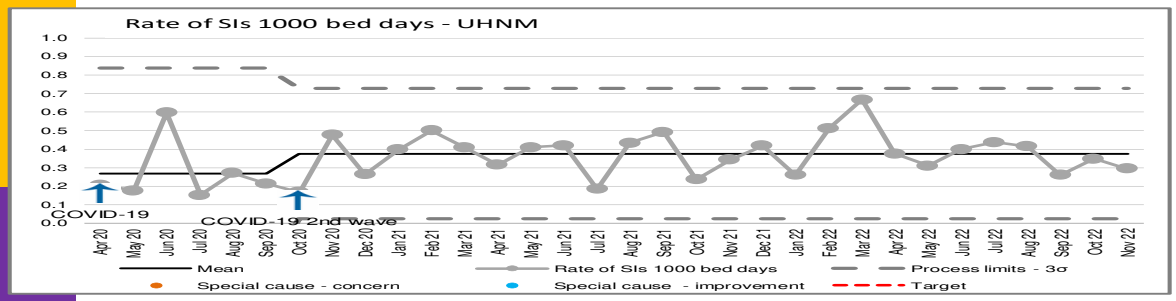


Variation	Assurance
	F

Threshold	Sep 22	Oct 22	Nov 22
0	10	14	12

Background

The number of reported Serious Incidents per month



Variation	Assurance
	F

Target	Sep 22	Oct 22	Nov 22
0	0.26	0.35	0.30

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 2022* saw 12 incidents reported:

9 Falls related incidents

2 Diagnostic related

1 Maternity/Obstetric incident (mother only)

The rate of SIs per 1000 bed days has varied consistently within confidence limits indicating normal variation and there has not been any significant trends. The current rate of SIs per 1000 bed days for November 2022 is 0.30 and is lower than the long term mean of 0.4 since COVID-19 started in December 2020.

**Reported on STEIS as SI in November 2022, the date of the incident may not be November 2022.*

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

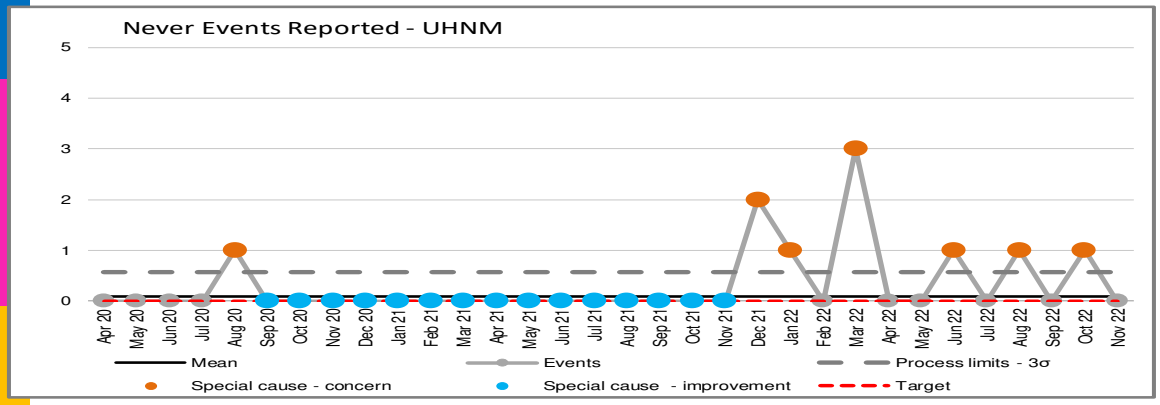
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during November 2022. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary 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 2022

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2022/24978	Mixed – White Asian	Maternity/Obstetric incident (mother)	01/02/2023	Maternal Death at 34 weeks and 3 days gestation (Reported as SI and referring to HSIB) Arrived in a collapsed state to ED from home, husband had driven the mother to the hospital, at home mother had reported back pain, vomited, and then collapsed On arrival, CPR initiated immediately efficiently by the ED team. Obstetric Medical team bleeped to perform peri-mortem c/s, performed by Registrar 2. On-call Consultant Obstetrician attended Baby born in poor condition, no heart rate, not breathing. Baby remains on the Neonatal Unit, but is very unwell.

Never Events



Variation	Assurance

Target	Sep 22	Oct 22	Nov 22
0	0	1	0

Background

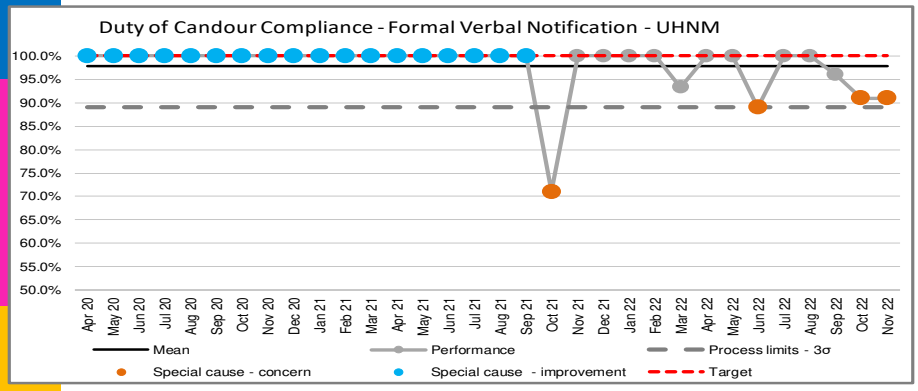
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

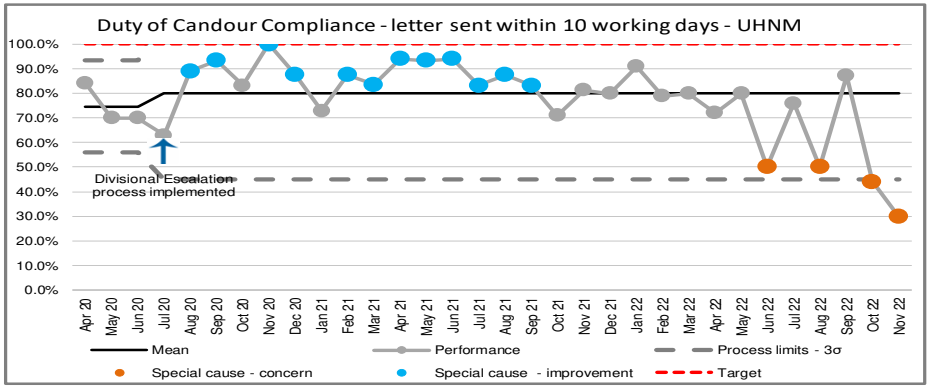
There has been 0 reported Never Event in November 2022. The target is to have 0 Never Events.

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

Duty of Candour Compliance

University Hospitals of North Midlands NHS Trust





Variation	Assurance
	

Target	Sep 22	Oct 22	Nov 22
100%	96.0%	91.0%	91.0%

Background

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

Variation	Assurance
	

Target	Sep 22	Oct 22	Nov 22
100%	87.3%	44.0%	30.0%

Background

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

What is the data telling us:

During November there were 22 incidents reported and identified that have formally triggered the Duty of Candour. 91% have recorded that the patient/relatives been formally notified of the incident in Datix.

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 2022 is 30% as 8th December 2022 including those letters that are still within timescale. Outstanding letters / information uploaded to Datix has been escalated with individual wards/departments and via Directorate/Divisional structures.

Actions taken:

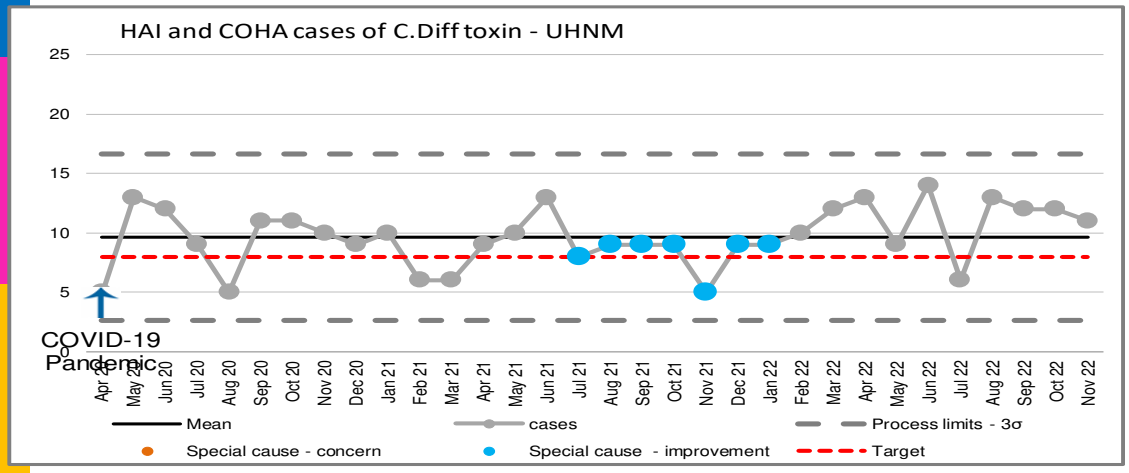
The compliance with Duty of Candour has been escalated and discussed at QSOG in December 2022 meeting and Divisions are working with clinicians and Q&S teams to raise further awareness and education on how and why Duty of Candour is to be completed. Dedicated sessions are being provided with session in Emergency Medicine on 15th December 2022 scheduled.

Escalations on outstanding letters are provided to relevant directorates and divisions via the Divisional Quality & Safety Managers and these are provided once identified and Duty of Candour required and where there has been no response prior to the deadline date.

Compliance is included in Divisional reports for discussion and action.

Reported C Diff Cases per month

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Sep 22	Oct 22	Nov 22
8	12	12	11

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

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

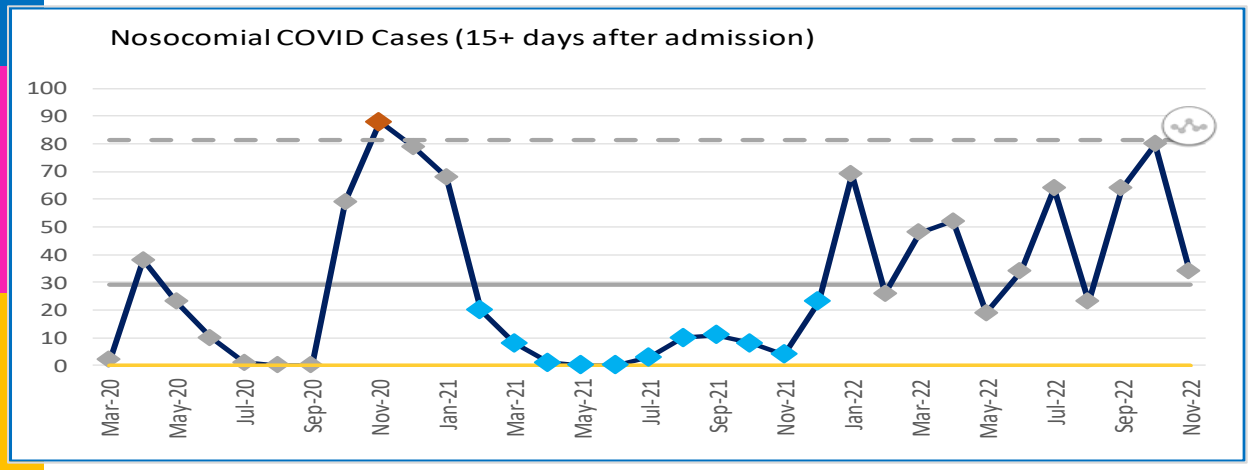
There have been 11 reported C diff cases in November with 8 being Hospital Associated Infection (HAI) cases and 3 COHA cases.

HAI: cases that are detected in the hospital three or more days after admission (day 1 is the day of admission)
COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
There has been one clinical area that has had more than one Clostridium *difficile* case in a 28 day period. Ribotyping results have been reported however in one of the specimens CDiff was not grown by the testing centre so it is not possible to determine whether patient to patient transmission has occurred.

Actions:

- Continue surveillance for HAI C diff with continued immediate implementation of control measures to prevent transmission
- In all cases control measures are instigated immediately
- Each in-patient is reviewed by the C *difficile* nurse and forms part of a multi-disciplinary review
- Routine ribotyping of samples continues

HAI Nosocomial COVID Cases per Month



What do these results tell us?

- Decrease in cases throughout November 2022 with 34 definite Healthcare Acquired COVID -19 cases.
- Monthly total is within normal variation and similar to long term mean
- Follows national profile for increasing cases within the community during November 2022
- COVID screening guidance changed 14/09/2022. Patients only swabbed on admission if being admitted to high risk area, immunocompromised or symptomatic for COVID. Otherwise patients are now not routinely screened.

Actions :

- UHNM COVID screening changed in line with National guidance 14th September.
- No routine asymptomatic admission screening for COVID
- Screening for symptomatic, admission to high risk areas and immunocompromised patients
- In addition close patient contacts of a COVID case are also screened and patients who develop symptoms during their hospital stay
- COVID 19 themes report provided to IPCC
- UHNM Guidance on Testing and re-testing for COVID 19 plus step down of suspected/positive cases
- Isolate suspected patients on identification of symptoms
- Process for patients identified as a contact with positive patients
- Process in place for outbreak management and reporting

NHS
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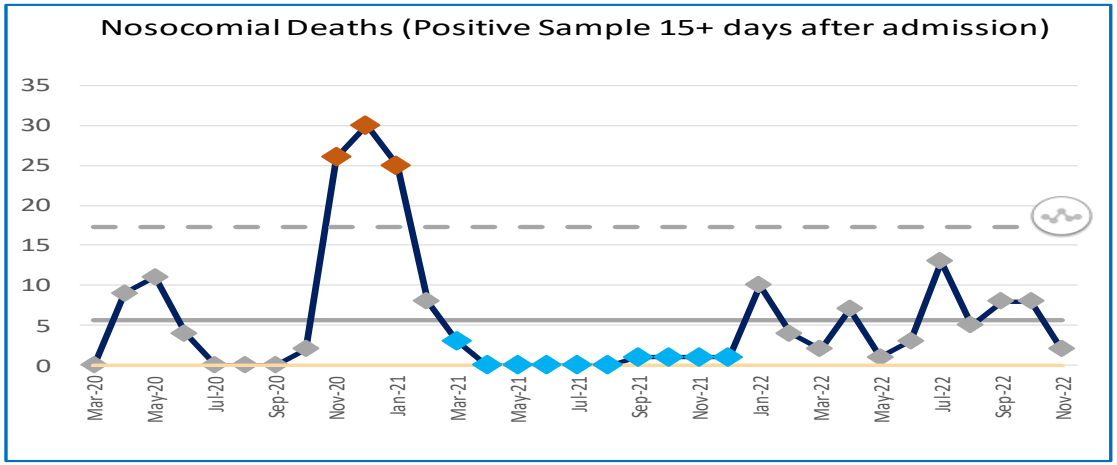
NHS Trust

	UHNM		
	Total Admissions	COVID cases	
		Prob	Def
Nov 20	14956	109	88
Dec 20	14701	107	79
Jan 21	14255	128	68
Feb 21	14101	31	20
Mar 21	17105	12	8
Apr 21	16554	3	1
May-21	17273	0	0
Jun-21	18527	0	0
Jul-21	18168	4	3
Aug-21	17160	14	10
Sep-21	17327	11	10
Oct-21	17055	8	8
Nov-21	17700	4	4
Dec-21	16688	13	23
Jan-22	16109	67	69
Feb-22	16278	39	26
Mar-22	18518	71	48
Apr-22	16538	72	52
May-22	18484	14	19
Jun-22	18380	34	34
Jul-22	17983	45	64
Aug-22	18247	16	24
Sep-22	18279	58	64
Oct-22	18374	81	80
Nov-22		29	34

Nosocomial COVID-19 Deaths per month (with 1st positive result 15 days or more after admission)

University Hospitals of North Midlands NHS Trust



What do these results tell us?

Increase in monthly total but within normal variation limits

The criteria for the Definite Hospital acquired/Nosocomial COVID-19 is that the patient had **first positive** COVID-19 swab result 15 days or more following admission to UHNM.

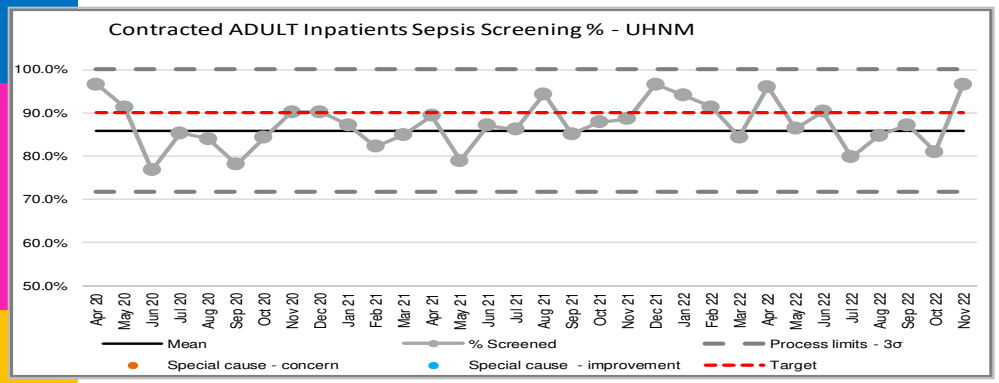
- 2 recorded definite hospital onset COVID-19 deaths in November 2022
- Total 183 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since 1st March 2020 up to 30th November 2022
- 47 Definite Hospital acquired COVID-19 deaths during 2022/23 YTD
- The mean number of deaths per month since March 2020 is 6.

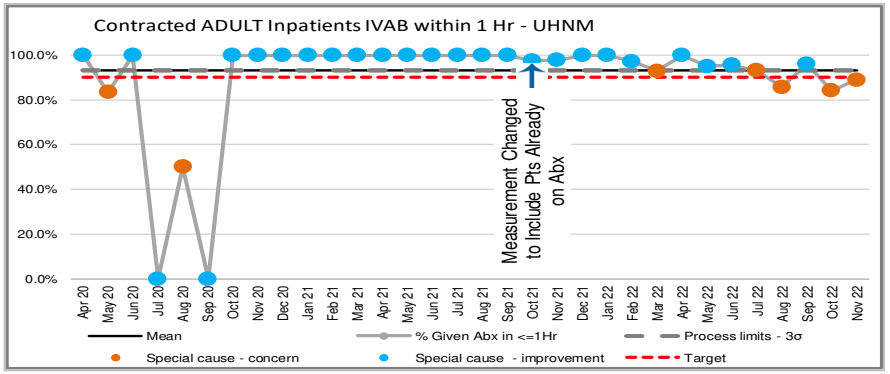
Actions :

Nosocomial COVID-19 deaths are continuing to be reviewed via the COVID Nosocomial Review Panel and updated report is due to be presented to Mortality Review Group identifying the outcome of the case reviews assessing the aspects of COVID-19 management of the patients in November 2022.

Sepsis Screening Compliance (Inpatients Contract)

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
	

Target	Sep 22	Oct 22	Nov 22
90%	87.2%	81.0%	96.5%

Background

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

Variation	Assurance
	

Target	Sep 22	Oct 22	Nov 22
90%	96.0%	84.2%	88.9%

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:

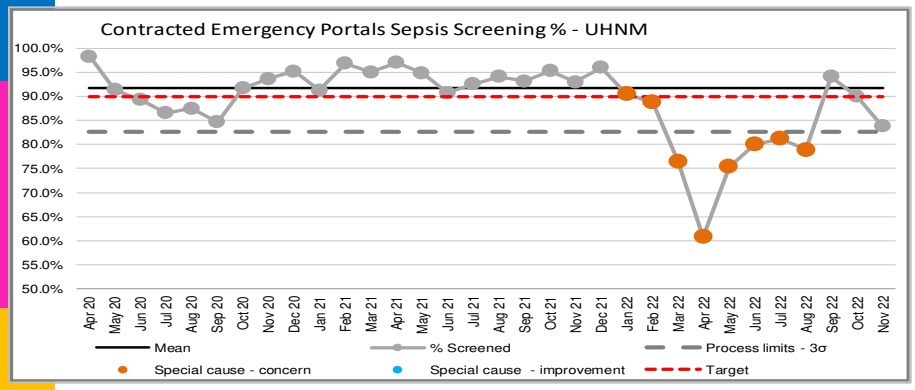
Inpatient areas achieve both the screening & IVAB within 1 hour target in November 2022. There were 114 cases audited with 4 missed screening from different ward areas. Out of 114 cases audited, 64 cases were identified as red flags sepsis with 39 cases have alternative diagnosis and 25 cases were true red flags. Out of 25 true red flags cases, 23 were already on IVAB treatment, 1 delayed treatment in which given above two hours.

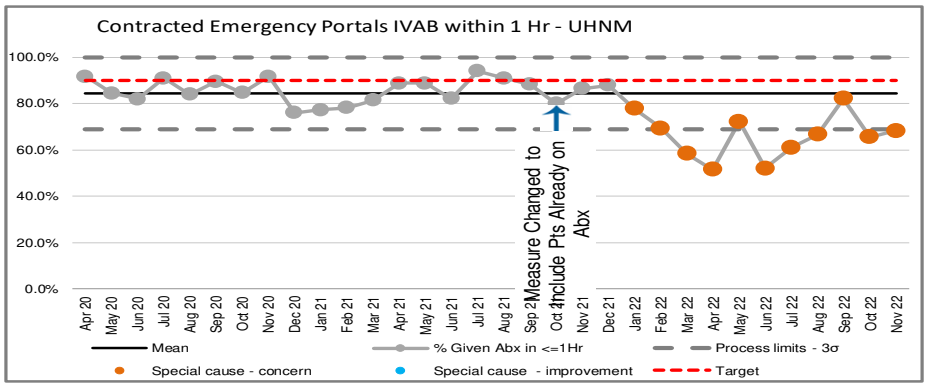
Actions:

- The Sepsis team have continued to focus on providing ward based sepsis drop in session/kiosks on targeted clinical areas and division: on-going
- The Sepsis team regularly identify areas of poor compliance and prioritise those areas for more focused sepsis re-enforcement: on-going
- The Sepsis team continued to work closely with the VitalPac team in order to address issues in timely manner: on-going
- Continued focus and support provided to all divisions to maintain and sustain compliance: on-going
- The Sepsis Team continue to raise awareness of importance of sepsis screening by being involved in HCA, students and new nursing staff induction programmes
- The Sepsis team will continue to promote sepsis awareness in both sites and will prioritise areas to visit with the clinical lead consultant

Sepsis Screening Compliance (Emergency Portals Contract)

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Sep 22	Oct 22	Nov 22
90%	94%	90%	84%

Background

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

Variation	Assurance

Target	Sep 22	Oct 22	Nov 22
90%	82%	66%	68%

Background

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

What is the data telling us:

Adult Emergency Portals screening has not met the target for November 2022. There were 68 cases audited with 11 missed screening in total from 7 of the emergency portals.

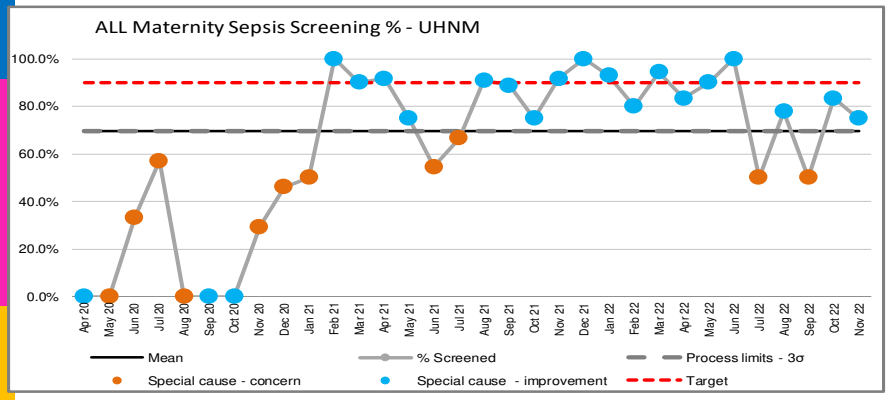
The performance for IVAB within 1hr below target rate in October 2022 is at 68.3%. Out of 68 cases, there were 54 red flags sepsis in which the 14 cases already on IVAB, 40 cases were newly identified sepsis and 14 cases have alternative diagnosis. There were 12 delayed IVAB with 5 cases delayed within 2 hours and 7 cases above 2 hours. Delayed IVAB within 1 hour is mainly contributed by both ED Royal Stoke and County.

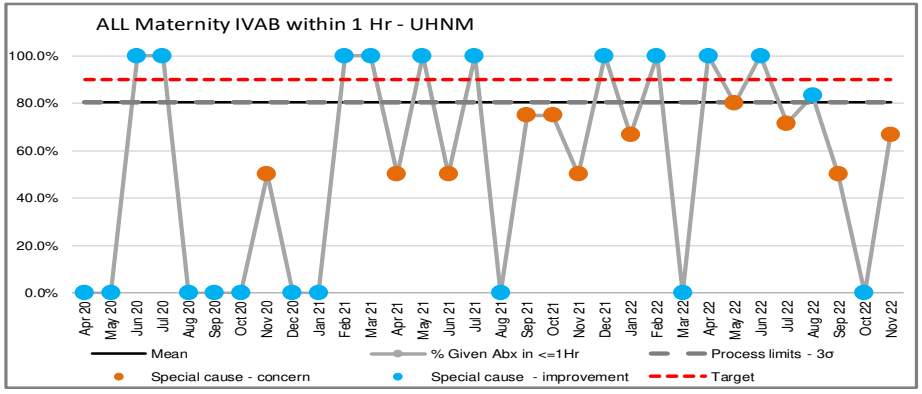
Actions:

- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E regularly. Provide sepsis session when staffing and acuity allows: on-going
- The Sepsis team is working collaboratively with the A&E Quality nurses, sepsis champions, senior team and A&E sepsis clinical lead to provide support with late IVAB incidents and missed screens. Issue with holding ambulances remain a challenge.
- Face to face A&E sepsis induction for new nursing staff, nursing assistant and medical staff will recommence once capacity pressure/flow improve in the department
- Regular meeting with A&E senior team reinstated to review current robust actions in place

Sepsis Screening Compliance ALL Maternity

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
H	F

Target	Sep 22	Oct 22	Nov 22
90%	50.0%	83.3%	75.0%

Background

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

Variation	Assurance
L	F

Target	Sep 22	Oct 22	Nov 22
90%	50%	N/A	67%

Background

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

What is the data telling us:

Maternity audits in screening compliance is below the target at 75% and IVAB within 1 hour is reported at 67% during November 2022 randomise audits .

This compliance score is based on a very small number, however a regular spot checks audit is being conducted monthly.

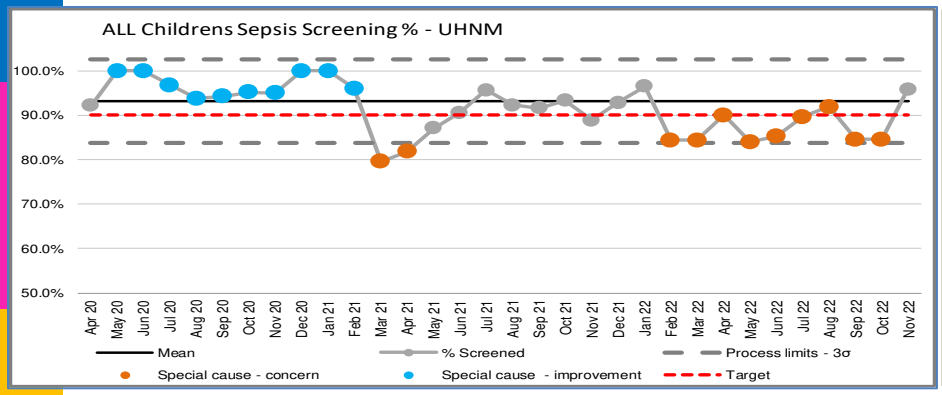
There were only a total of 8 cases audited from emergency portal (MAU) and inpatients with 2 missed screening. There were 3 red flag identified from the randomise audits, 1 is already on IVAB treatment, 2 cases were newly identified sepsis with 1 only case delayed IVAB within 2 hours.

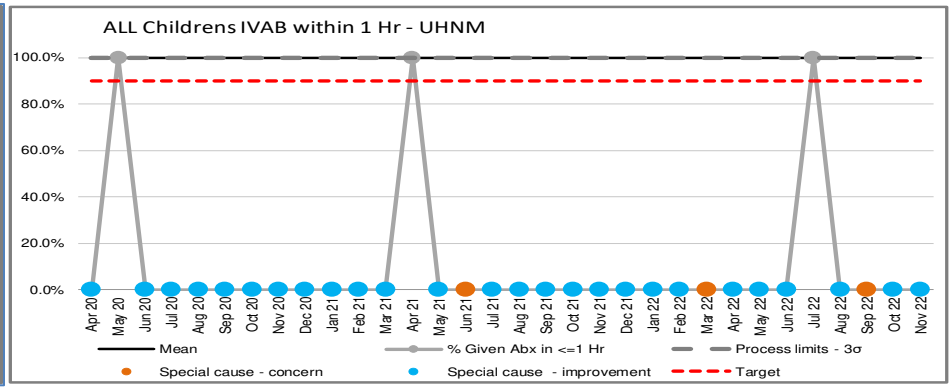
Actions:

- Maternity have already developed and awaiting finalisation of their antibiotic PGD: on-going
- Maternity educator is supporting the sepsis team by conducting independent / in-depth sepsis audits in the whole Maternity department , staff who had missed the screening documentation will be given constructive feedback and offered support/ training: on-going
- Future plan for Maternity 5 hour sepsis CPD champion training remain in the pipeline however, has been temporarily put on-hold due to current operational pressures: on-going
- Plan of delivering sepsis awareness in each clinical areas in September-October with the support of the clinical educator

Sepsis Screening Compliance ALL Children

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Sep 22	Oct 22	Nov 22
90%	84.6%	84.6%	95.8%

Background

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

Variation	Assurance

Target	Sep 22	Oct 22	Nov 22
90%	0.0%	N/A	N/A

Background

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

What is the data telling us:

Children's Services show normal variation but higher than target of 90%. Still seen small numbers of children trigger with PEWS > 5 & above in Inpatients areas. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks).
There were 24 cases audited for emergency portals and inpatients with 1 missed screening. No red flag identified from the randomise audits. None was identified trigger with PEWS 5> in Inpatients areas during audits.

Actions:

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

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Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

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Emergency Care

- Focus continued in November with respect to the Non-Elective Improvement Plan and the three core elements to support the Ambulance Handover Improvement Plan. Your Next Patient (YNP) continues in operation with twice weekly Executive chaired review meetings. The data shows that this initiative is supporting a reduction in the tail of the longer ambulance handover delays over eight and six hours, despite an increase in those over one hour. The Frailty Decision Unit continues in operation and is staffed to allow the maximum of 8 patients to be turned around by an integrated MDT at the front door, work is now underway to remove the area from the 4 hour "clock" in line with a CDU type model but for Frail patients, further assurance required from ICB around the active timely pull from the unit to Community beds/packages of care. On-going agreement for any patients hitting 36 hours in the department to be moved into the medical bed base enacted. The ED Reconfiguration (Workstream 1) is nearing completion with residual works required all planned in and awaiting equipment to be delivered to see the full impact of the layout changes.

- November attendances remained static from the previous month but with this , performance against some KPI's declined further which can be attributed to poor egress from ED due to increasing Flu presentations, increased MFFD numbers in the bed base and increasing staff sickness.

    - Four Hour performance marginally reduced to 63% for November.
    - 12 hour trolley waits in the department did however decrease slightly to 990 from 1100
    - WTBS in the ED increased from 101 to 120 minutes, ambulatory space was impacted by high numbers of DTA's in the dept
    - Ambulance handovers remain a challenge with those over 60 minutes declining from 1419 to 1298 but still an outlier as a Trust

Cancer

- Trust overall 2WW Performance predicted to land at 91% in November – increasing from 78% in October, as a result of schemes such as the Lower GI Community Referral hub and Community Teledermatology pathways being successfully implemented. Breast symptomatic (where cancer is not suspected) is expected to 93% achieve in November.
- The 62 Day Standard is predicted to land at 45% in November. 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 capacity, with robust plans in place to tackle the most challenged specialties (Skin & LGI) over the next quarter.
- The 31 Day Standard is predicted to land at 87% for November and the 31 day Subsequent Anti Cancer Drugs standard is expected to achieve 97% in November.
- The 28 Day Faster Diagnosis Standard is predicted to land at around 60% in October. Breast Screening is predicted to achieve the FDS in October. The November position is incomplete and is currently being collected.
- Suspected Breast Cancer, Skin and Lower GI are now booking 2WW referrals within 7 days, for first appointments – an improvement since last month.
- The backlog has reduced since last month and total PTLs in Skin and LGI has significantly reduced.
- In August the PTL was over 6000 – this has now **reduced by around 2300** patients to 3706 in total for WE 04.12.22.

Spotlight Report from Chief Operating Officer

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Planned Care

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

- Day Case activity and Elective Activity have both shown a increase from 78% and 80% in Sept to **96% and 88%** respectively in November. This is still some way from the national ask of 110%/108%. This is against a backdrop of increase cancelations. There is a real focus on the reintroduction of 6-4-2 with support from the regional theatres team.
- The focus has moved to 78 week waiters with an Annual Plan to reduce them to below 300 patients by March 2023. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge well before March so any treatment can be carried out to meet the 78 week standard.

RTT

- The overall Referral To Treatment (RTT) Waiting has slightly increased from 77,546 in October to 77,577 in November.
- The number of patients > 52 weeks continues to increase – from 4377 in August, 4,569 in September, 4628 in October and 4979 in November.
- At the end of November the numbers of >104 patients was 38. An increase of 15 from the end of October (albeit different patients). The Trust has continued to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment.

Diagnostics Summary

- During November the Diagnostic activity was consistently over 100% when compared with 19/20 BAU
- DM01 performance was 62% overall, with key areas of underperformance in non-obstetric ultrasound and Endoscopy

Histology position :

- Urgent - 95% reported at Day 17, 80% of cases reported by Day 12
- Accelerated - 95% reported at Day 36, 80% of cases reported at Day 27
- Routine - 95% reported at Day 49, 80% reported at Day 39

Radiology reporting backlog:

- High risk relating to 'routine / non cancer reporting' due to reporting capacity and delays in diagnosis RISK register no 25512 score 16

Endoscopy:

- Improvement plan being developed

Improving Together A3 presented at Planned Care group

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Section 1: Urgent Care

Headline Metrics

Urgent Care – monthly *(context)*

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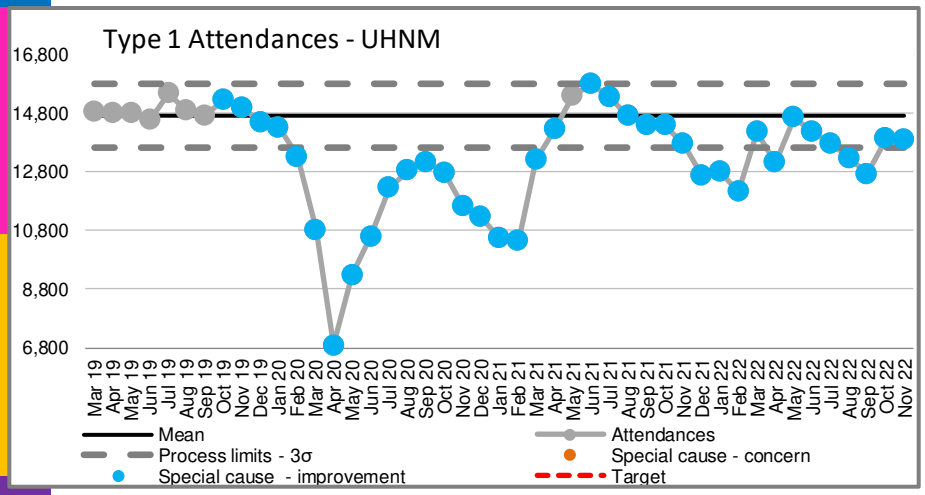

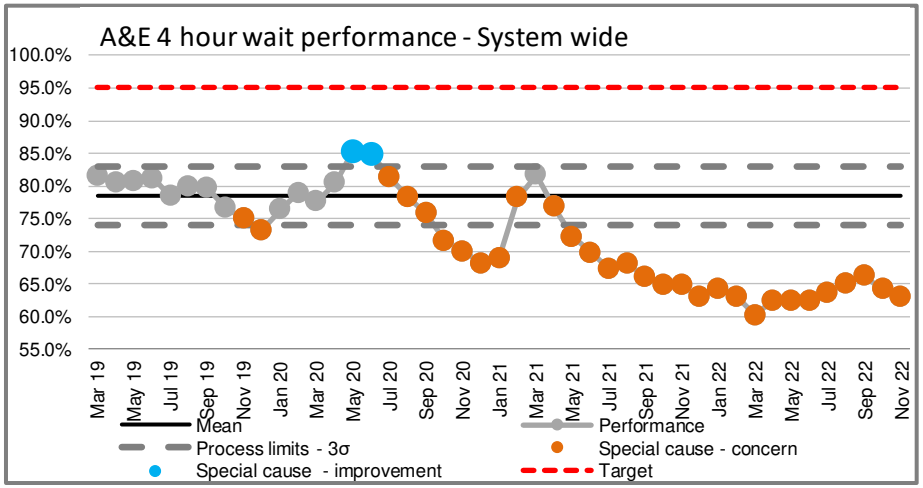

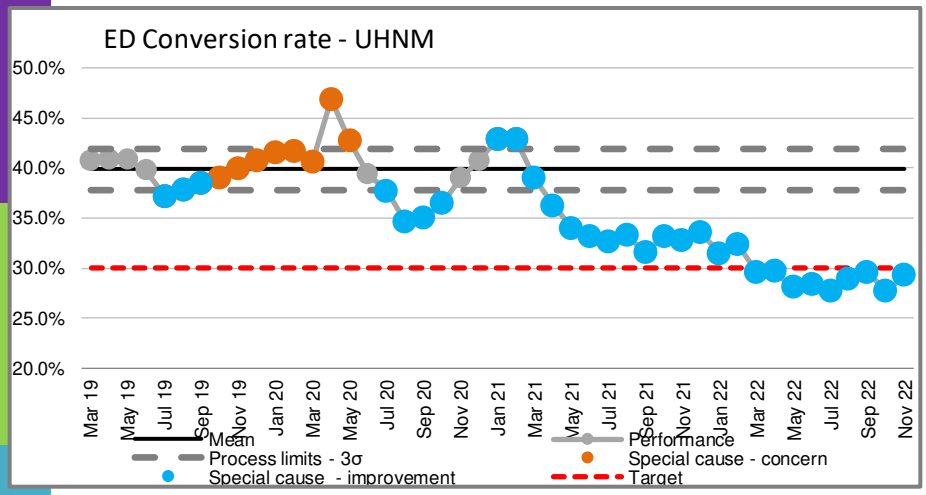

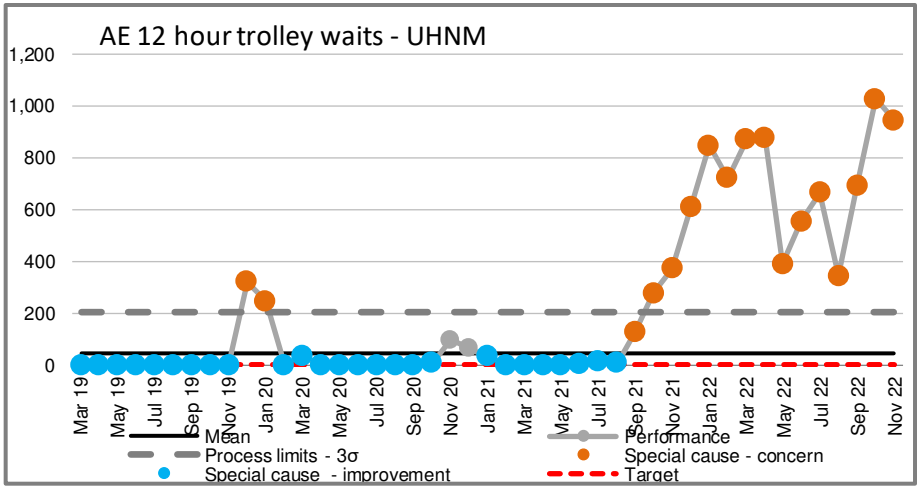

Delivering Exceptional Care with Exceptional People

WTBS & 12 Hour in department

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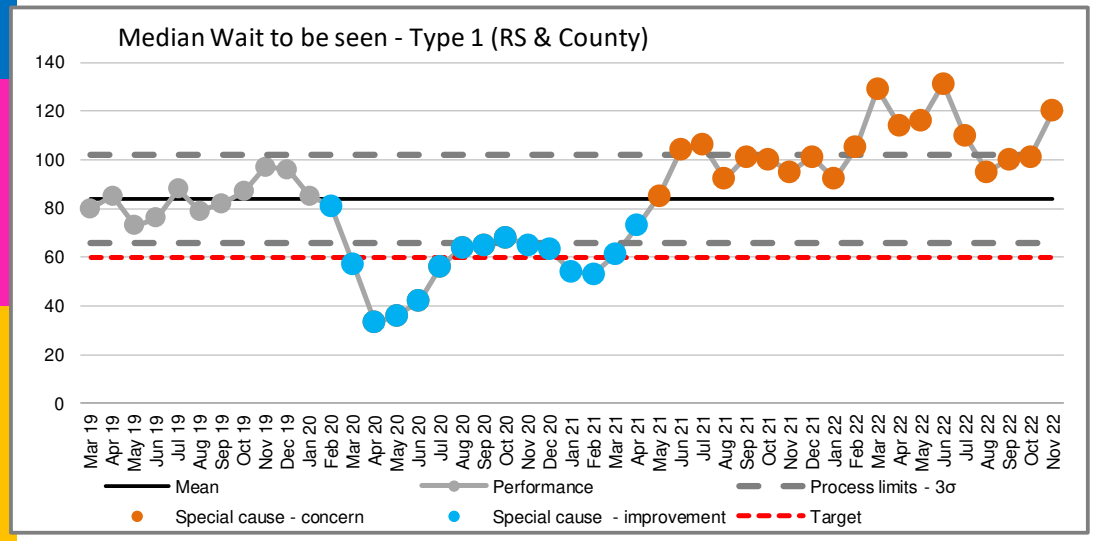


Variation	Assurance
H	F

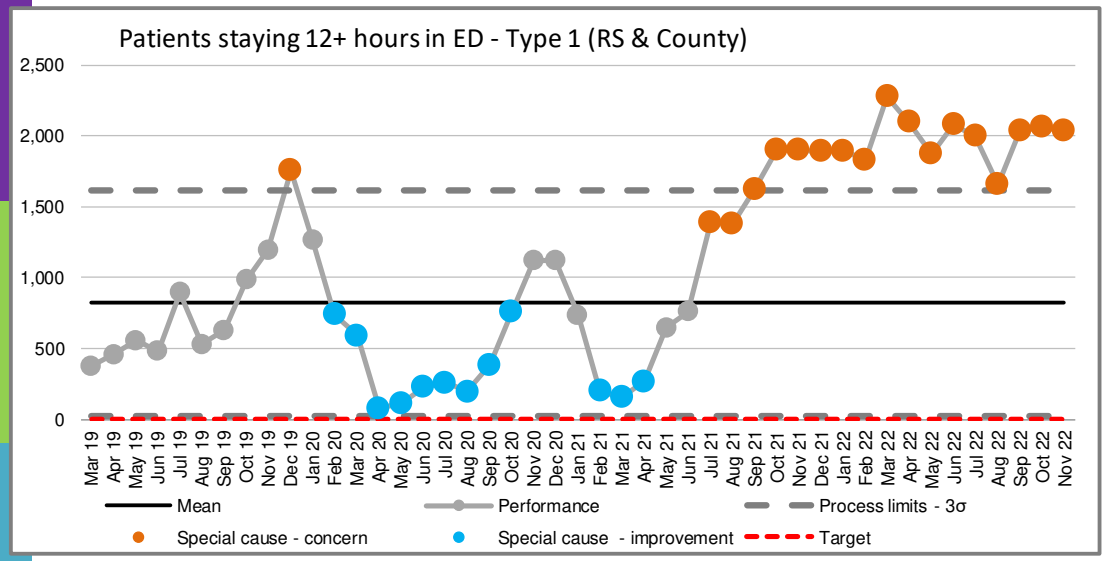
Target	Sep 22	Oct 22	Nov 22
60	100	101	120

Background

The average (median) time in minutes for a patient to be first seen

What is the data telling us?

Median wait to be seen remains above the pre pandemic average with November seeing a peak following the previous three months being consistent.



Variation	Assurance
H	F

Target	Sep 22	Oct 22	Nov 22
0	2035	2062	2038

Background

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

What is the data telling us?

The number of patients waiting over 12 hours has increased significantly over the last 12 months. With 13 points sitting above the upper control limit

Delivering Exceptional Care with Exceptional People

Urgent Care – Time to Treatment

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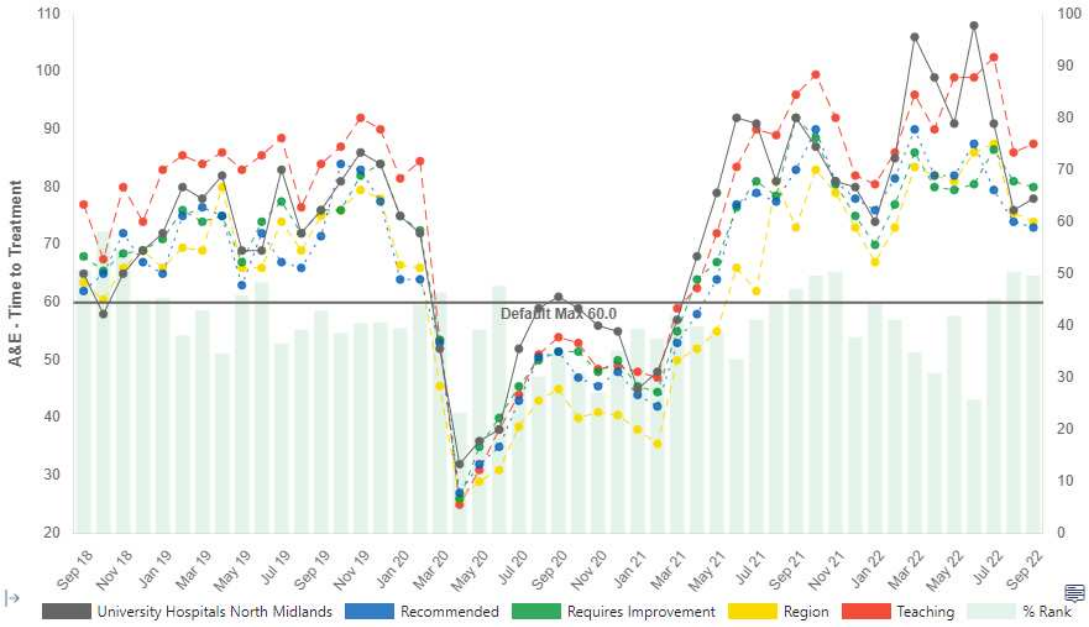
Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Oct 22	95.00%	64.2%	L	35
A&E - 4 Hour Standard (Type 1)	Oct 22	95.0%	44.7%	L	17
A&E - 4 Hour Standard (Type 2...	Oct 22	95.0%	96.0%	L	33
A&E - Conversion Rate	Oct 22	25.0%	22.4%	L	27
A&E - DTA to Admission >12 H...	Oct 22	0.0%	20.4%	H	27
A&E - DTA to Admission >12 H...	Oct 22	0.0	1,028.0	H	5
A&E - DTA to Admission >4 Ho...	Oct 22	10.00%	37.5%	H	58
A&E - Left Without Being Seen	Sep 22	5.00%	0.0%	C	100
A&E - Reattendance Rate	Sep 22	5.0%	10.2%	C	8
A&E - Time to Initial Assessment	Sep 22	15.0	9.0	C	57
A&E - Time to Treatment	Sep 22	60.0	78.0	H	50
A&E - Total Time in A&E	Sep 22	160.0	179.0	H	63
A&E - Total Time in A&E (Admi...	Sep 22	180.0	413.0	C	52
A&E - Total Time in A&E (Non-...	Sep 22	140.0	158.0	C	65

A&E - Time to Treatment | Ranking | Trend | Delta | SPC | Commentary



- Time to treatment pre pandemic was in line with peers
- In recent months UHNM have seen a decrease.

Urgent Care – DTA waits over 12 hours

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Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Oct 22	95.00%	64.2%	L	35
A&E - 4 Hour Standard (Type 1)	Oct 22	95.0%	44.7%	L	17
A&E - 4 Hour Standard (Type 2...	Oct 22	95.0%	96.0%	L	33
A&E - Conversion Rate	Oct 22	25.0%	22.4%	L	27
A&E - DTA to Admission >12 H...	Oct 22	0.0%	20.4%	H	27
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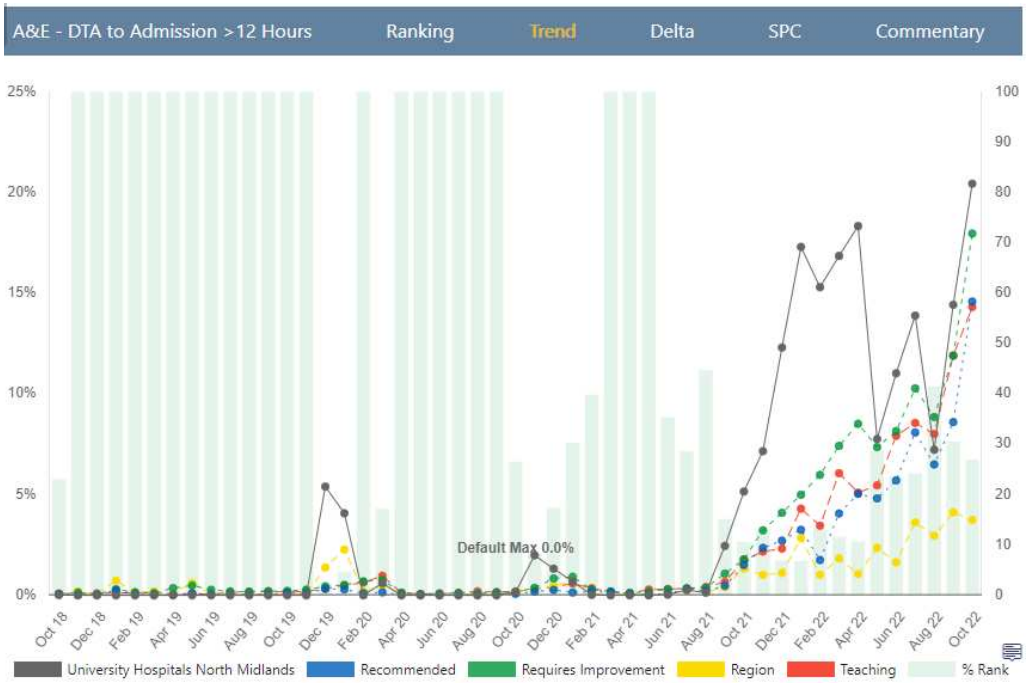
A&E - Total Time in A&E (Admi...	Sep 22	180.0	413.0	C	52
A&E - Total Time in A&E (Non-...	Sep 22	140.0	158.0	C	65



- The percentage of patients waiting over 12 hours from the point of DTA has been much higher than peers since September 21. Following an improvement during August, volumes have been higher than peers since then.

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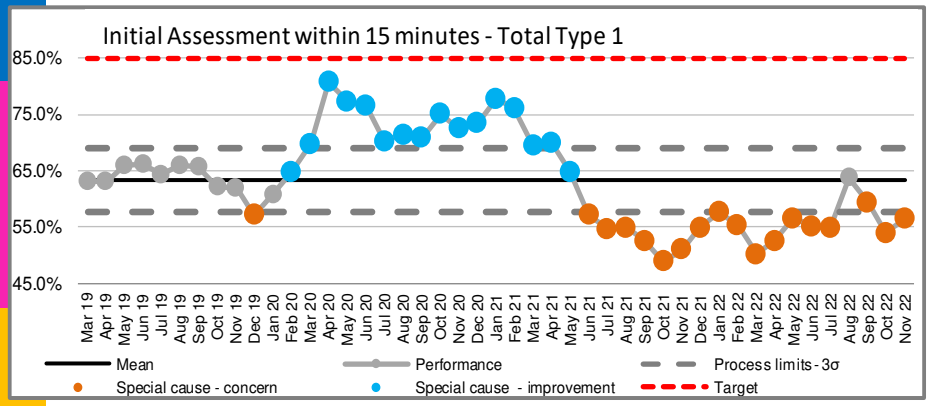
Section 1: Urgent Care

Workstream 1; Acute Front Door

Time To Triage, Ambulance Handover, & Non admitted average time

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

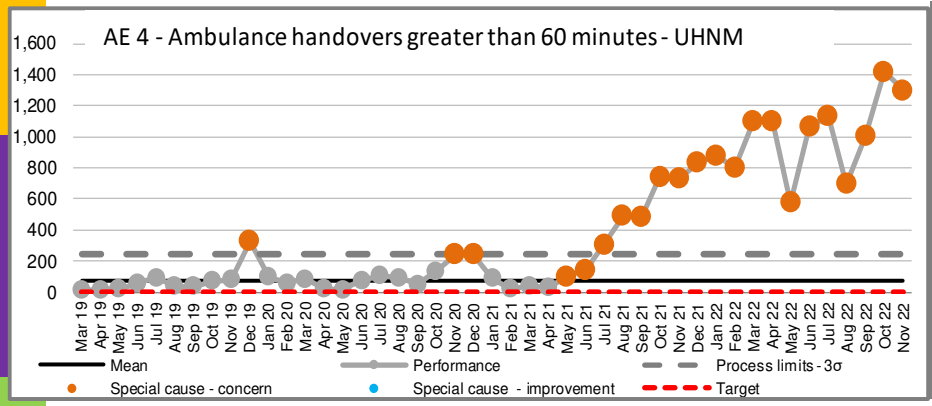
Target	Sep 22	Oct 22	Nov 22
85%	59.4%	54.0%	56.4%

Background

The Percentage of patients attending Type 1 A&E, triaged within 15 minutes of arrival

What is the Data telling us?

Performance remains below the 1920 lower control limit at 56%. This is back at the level seen at the beginning of last summer.



Variation	Assurance
H	?

Target	Sep 22	Oct 22	Nov 22
0	1002	1419	1298

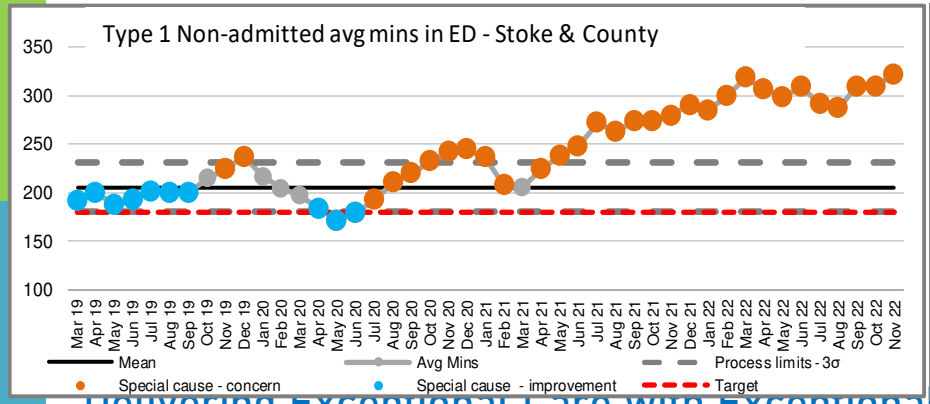
Background

The number of ambulance handovers greater than 60 mins

What is the Data telling us?

Handover delays over 1 hour have risen dramatically over the last 17 months with these data points sitting outside of the upper control limits of 201920.

Last month saw a slight reduction compared to October's peak.



Variation	Assurance
H	?

Target	Sep 22	Oct 22	Nov 22
180	309	309	322

Background

The mean time spent in A&E department for patients not admitted to an inpatient bed

What is the Data telling us?

Mean time in department has been increasing since March 2021. The last four months have seen an increasing trend, with November reaching the highest levels ever seen.

Time To Triage, Ambulance Handover, & Treatment

University Hospitals of North Midlands NHS Trust

Summary

- Despite increased occupancy the time to initial assessment improved slightly to 56.4% from the previous month of 54.0% and continues the trend of incremental overall improvement since October 2021.
- Ambulance handovers remain a challenge with 60 minute delay instances slightly reducing to 1298 in November from 1419 in October. Following the embedding and development of YNP the long tail of waits continues to decrease despite ambulance attends remaining static.
- The average time in department for non-admitted patients rose slightly from 309 in October to 322 minutes in November. This will have been affected by the higher number of DTA patients following the highest occupancy recorded for a number of years.
- EhPC performance continues to support the improvement of wider KPI by consistently achieving 100% daily performance against the Four Hour standard with a daily average of 64 patients up from 54 in the previous month.

Actions

- Following the intensive implementations of Your Next Patient and the ED Reconfiguration Project, Workstream 1 has resumed BAU work focussing on Triage, Ambulance Handovers, Workforce, EhPC, and Ambulatory/Minors Performance.
- Negotiations are underway with Vocare to relocate the GPOOH service alongside EhPC from the CDC building commencing January 2023. This will include an extension of the GPOOH service to ensure greater overlap and evening coverage, increasing deflection of primary care attendances to UHNM and removing an average of 20 additional patients every evening.

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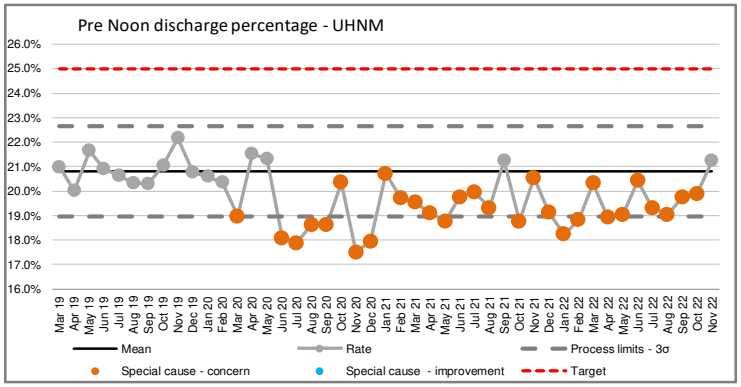
Section 1: Urgent Care

Workstream 2; Acute Patient Flow

Pre-Noon, Simple & Timely, & Occupancy

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

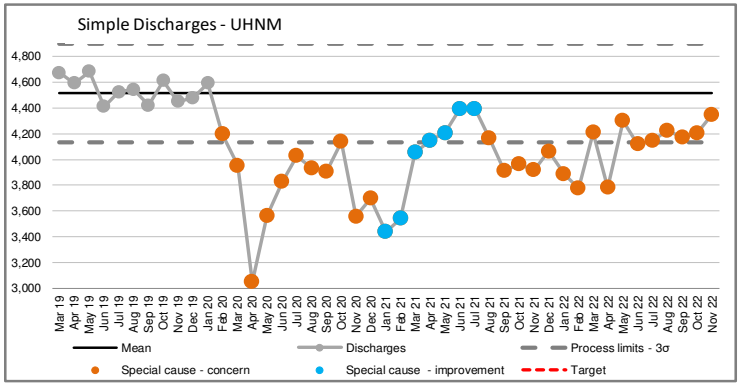
Target	Sep 22	Oct 22	Nov 22
25%	19.7%	19.9%	21.2%

Background

The percentage of discharges complete before 12 noon.

What is the data telling us?

Pre noon discharges have been below the 1920 mean for the last 13 months however November performance exceeded mean levels.



Variation	Assurance
L	

Target	Sep 22	Oct 22	Nov 22
N/A	4171	4203	4349

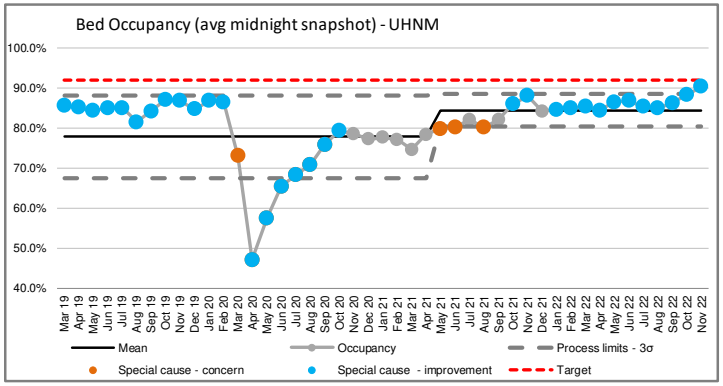
Background

Patients discharged without complex needs

What is the data telling us?

Simple & timely discharges are below pre pandemic levels.

For the last 5 months have been fairly consistent marginally within the lower control limit. November saw an improvement to prior months, reaching 4349.



Variation	Assurance
H	F

Target	Sep 22	Oct 22	Nov 22
92%	86.2%	88.3%	90.3%

Background

The percentage of general and acute beds occupied overnight at UHNM

What is the data telling us?

COVID had a significant impact on bed occupancy. Occupancy levels are now exceeding 19/20 rates.

Pre-Noon, Simple & Timely, & Occupancy

University Hospitals of North Midlands NHS Trust

Summary

- Pre-noon discharges rose above baseline for the first time in over a year this month to 21.2% up from 19.9% in October. This is largely a consequence of an extraordinary focus on S&T discharges and ICS agreement to accept 5 Complex Golden Patients every morning at the Haywood Hospital.
- The number of Simple & Timely (S&T) discharges improved again from 4226 in October to 4349 in November.
- Despite increased numbers of S&T discharges the overall occupancy rose in November to the highest percentage seen in recent years (90.3% from 88.3% in October). This is as a direct result of increased numbers of MFFD patients in UHNM with numbers reaching in excess of 190+ patients across both sites. This culminated with the declaration of a Level 2 Critical Incident in early December.

Actions

- Renewed focus has been placed on the YNP process in October following a dip from the high of 50% of patients moves brought significantly forward to around 30%. This has evidenced that further embedding is required to ensure sustained performance.
- In order to support the Divisional Step Change Projects the Performance & Informatics Team have undertaken work to determine how many discharges are required each day in order to meet incoming demand across both the S&T and Complex pathways for RSUH and County Hospital. These numbers total 550 discharges per week and will support the management of performance down to ward level. This work will now be replicated for the other Divisions.
- The Non-Elective Improvement Group is to be stood down in January in response to operational pressures and to allow time to complete the alignment to Improving Together methodology.

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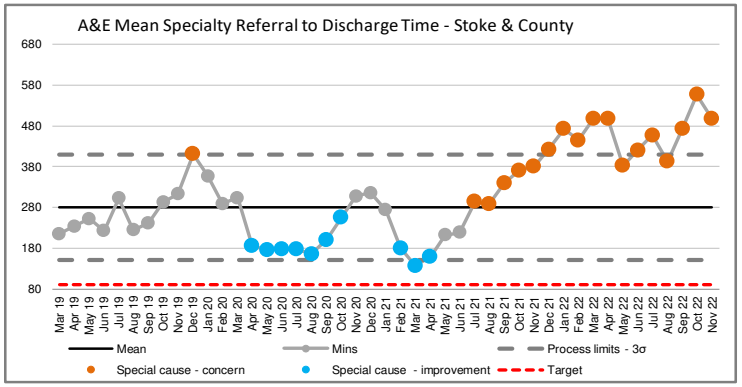
Section 1: Urgent Care

Workstream 3; Delivering UEC Standards

CRPT+1, SDEC Utilisation, & Mean Time In ED

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Sep 22	Oct 22	Nov 22
90	473	557	497

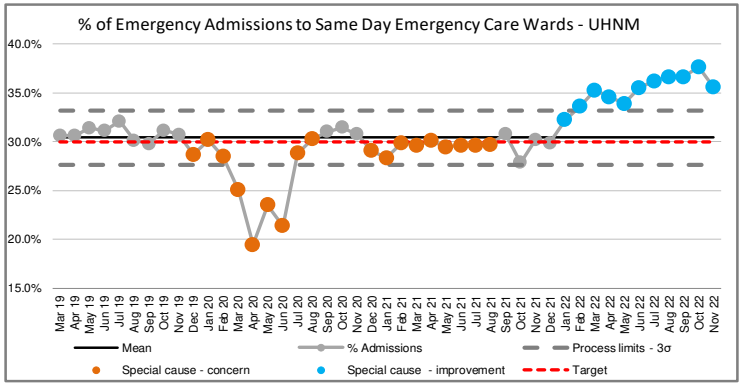
Background

The average time from the ED referral to a specialty to discharge from the ED

What is the data telling us?

The average time from referral to discharge has increased since March 2021.

Following October's peak, November's average time has reduced.



Variation	Assurance
H	?

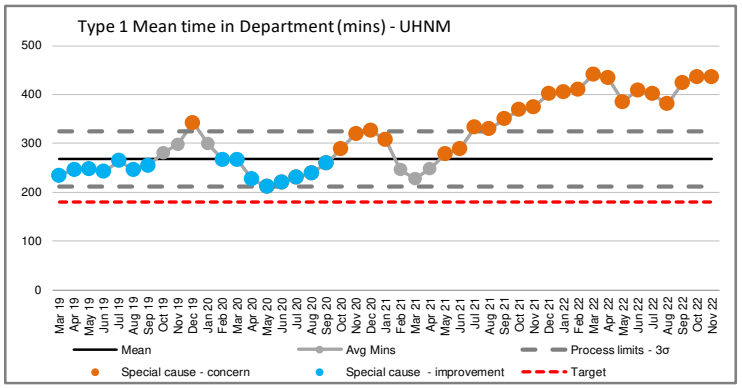
Target	Sep 22	Oct 22	Nov 22
30%	36.6%	37.6%	35.5%

Background

% of emergency admissions that are admitted to the Trust's SDEC wards, and discharged within 24 hours

What is the data telling us?

The Trust has been consistently above the upper control limits for the last 10 months, with November performance dropping slightly to 35.5%



Variation	Assurance
H	F

Target	Sep 22	Oct 22	Nov 22
180	424	437	436

Background

The mean time (in minutes) spent in the A&E department

What is the data telling us?

Total time in department has been increasing since March 2021 with the last 15 data points sitting above the control limits.

CRTP+1, SDEC Utilisation, & Mean Time In ED

NHS
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Summary

- The average time from specialty referral to discharge reduced in November to 497 from 557 in October. This has been driven by direct escalation to Divisional Medical Directors in the event of non-compliance.
- SDEC utilisation remains static now at around 36% following a trend of steady improvement from October 2021.
- The mean time in the ED for all patients decreased slightly from 437 to 430. Given non-admitted performance has remained static month on month this deterioration can be seen to be driven by increasing numbers of MFFD patients, admitted pathways, and subsequent departmental congestion.

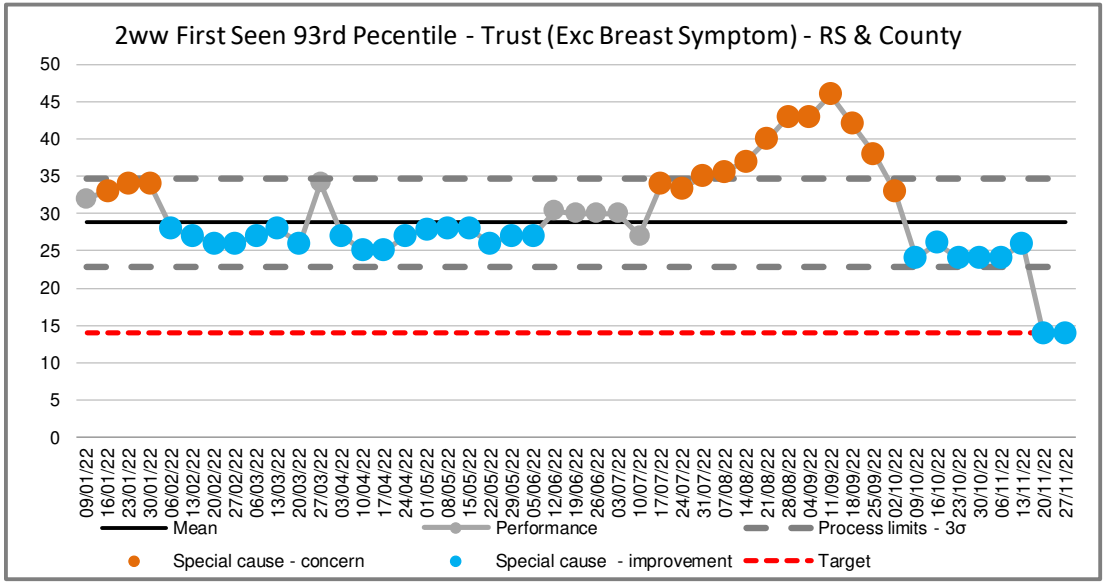
Actions

- Continued intensive education with and engagement with the senior ED Consultant body in order to ensure the portal push model of patients and timely escalations as necessary.
- Further work is underway with NHS 111 around deflection opportunities within the streaming and redirection tool to compliment recent improvements in internal navigation with a focus on specific clinical pathways (for example low acuity palpitations).
- Following confirmation that Workstream 3 would formally take over all Portal improvement work as part of the wider Non-Elective Improvement Programme an A3 will now be produced in order to identify the improvement necessary to deliver a 24/7 push model of Portals which are able to accept and appropriately turnaround or admit patients regardless of capacity.

Section 2: ELECTIVE CARE

Cancer – Headline metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

Target	13/11/2022	20/11/2022	27/11/2022
14	26	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 November had a 14 day clock stop within day 25 of the pathway.
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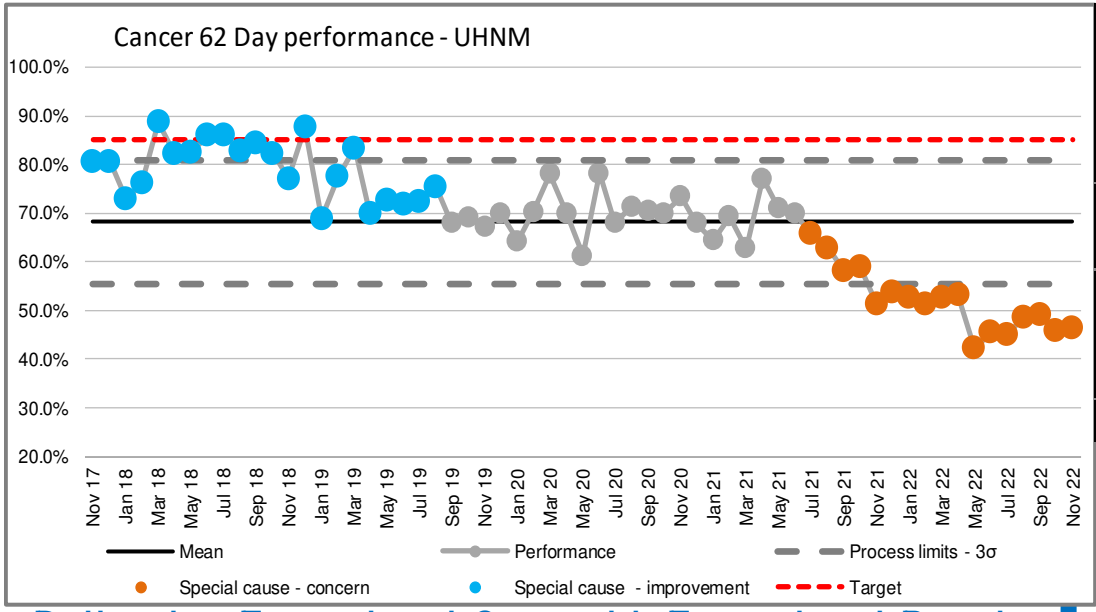


Variation	Assurance
L	F

Target	Sep 22	Oct 22	Nov 22
85%	49.1%	45.8%	46.4%

Background

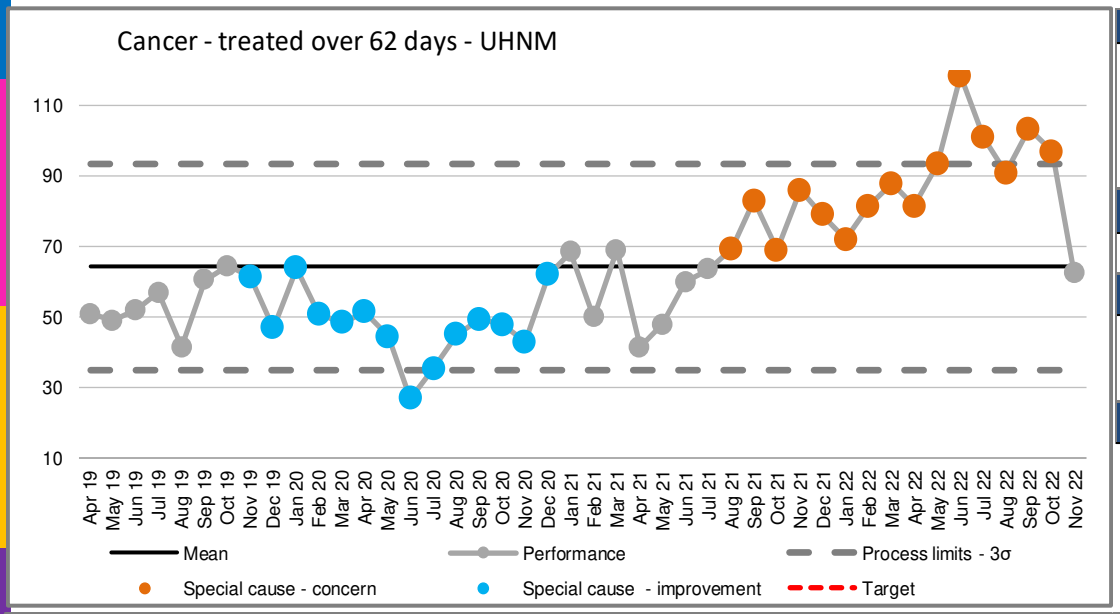
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

Performance significantly challenged and below standard for the past 12 months with a steep decline in May and predicted at for 46% for November – position still to be validated

Cancer - Headline metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance

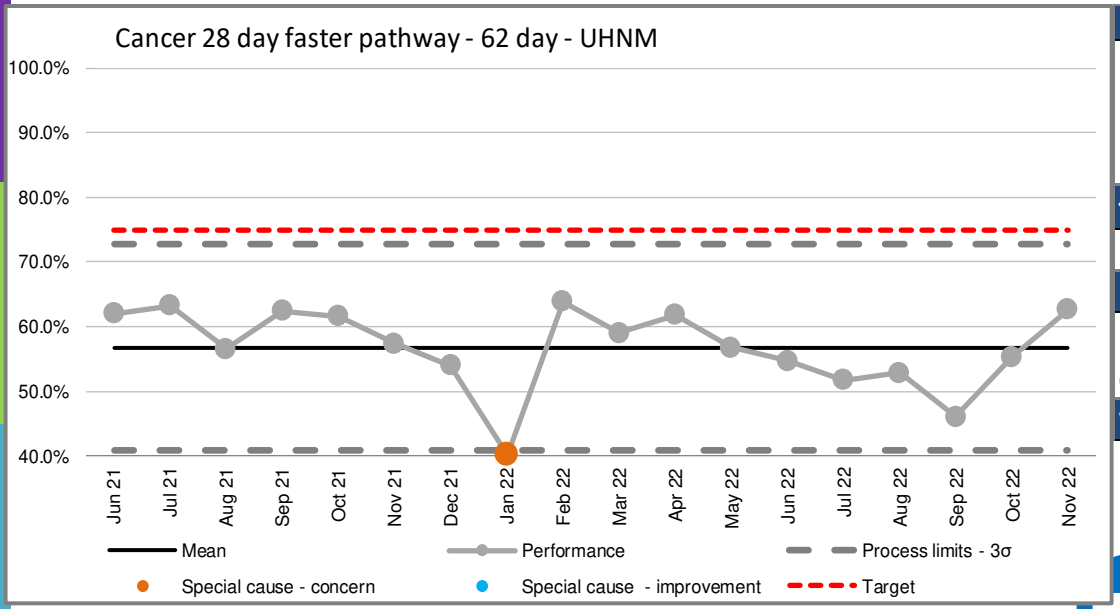
Target	Sep 22	Oct 22	Nov 22
N/A	103.5	97.0	62.5

Background

The number of patients treated over 62 days

What is the data telling us?

Demonstrates total volume of patients who have been treated beyond day 62 is a cause for concern and has been rising over the past 12 months, although there is significant improvements demonstrated in August and further in October.



Variation	Assurance
	F

Target	Sep 22	Oct 22	Nov 22
75%	46.0%	55.3%	62.6%

Background

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

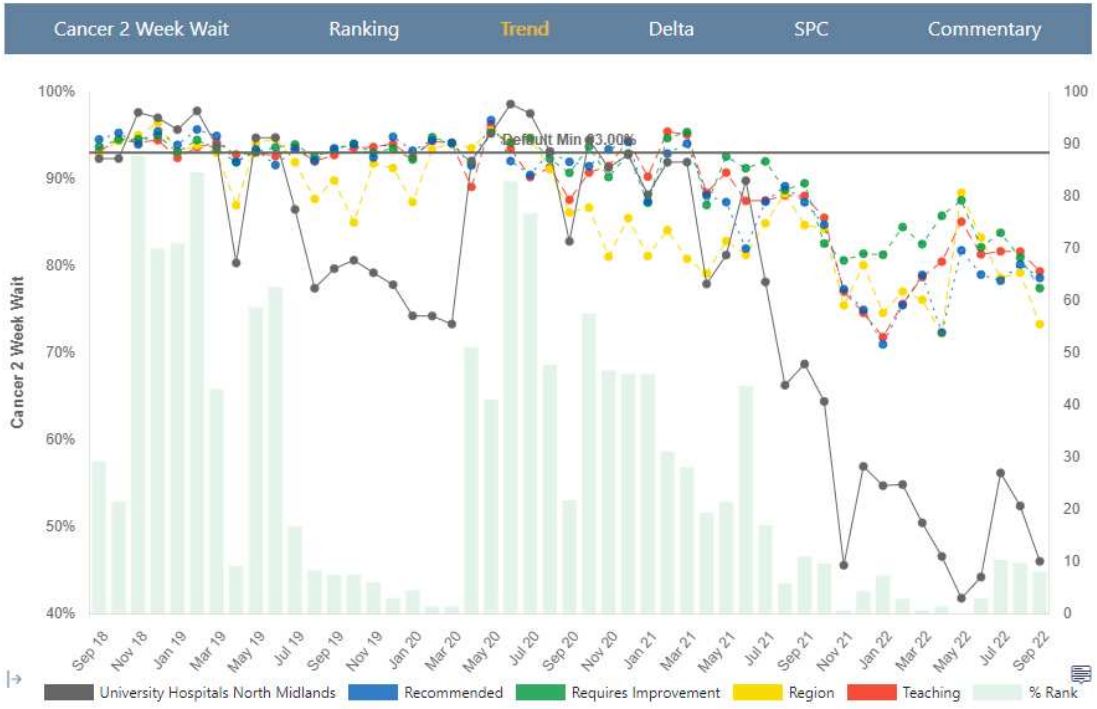
What is the data telling us?

The FDS performance remains stable with pockets of good practice. E.g. Breast, Lung and Upper GI all achieve the standard. October position is yet to be finalise d and is predicted to land around 55%

Cancer – benchmarked

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Cancer 2 Week Wait	Sep 22	93.00%	46.1%	L	8
Cancer 2 Week Wait Breast Sym...	Sep 22	93.0%	96.7%	C	87
Cancer 31 Day First Treatment	Sep 22	96.00%	84.7%	L	15
Cancer 31 Day Subsequent Trea...	Sep 22	96.0%	87.0%	L	23
Cancer 62 Day All Sources	Sep 22	85.00%	59.2%	L	26
Cancer 62 Day Consultant Upgr...	Sep 22	85.0%	77.8%	L	54
Cancer 62 Day Screening	Sep 22	90.0%	61.5%	L	33
Cancer Sub Treat Drugs	Sep 22	96.0%	97.7%	C	22
Cancer Sub Treat Radiotherapy	Sep 22	96.0%	93.0%	C	47



- UHNM have seen 14 day performance deteriorate at a greater scale than it's peers since July 2021.
- August and September 2022 saw a slight dip after a much improved position in July. UHNM are still in the lowest quartile but have seen it's rank improve from worst to 10.

Cancer - Benchmarked

NHS
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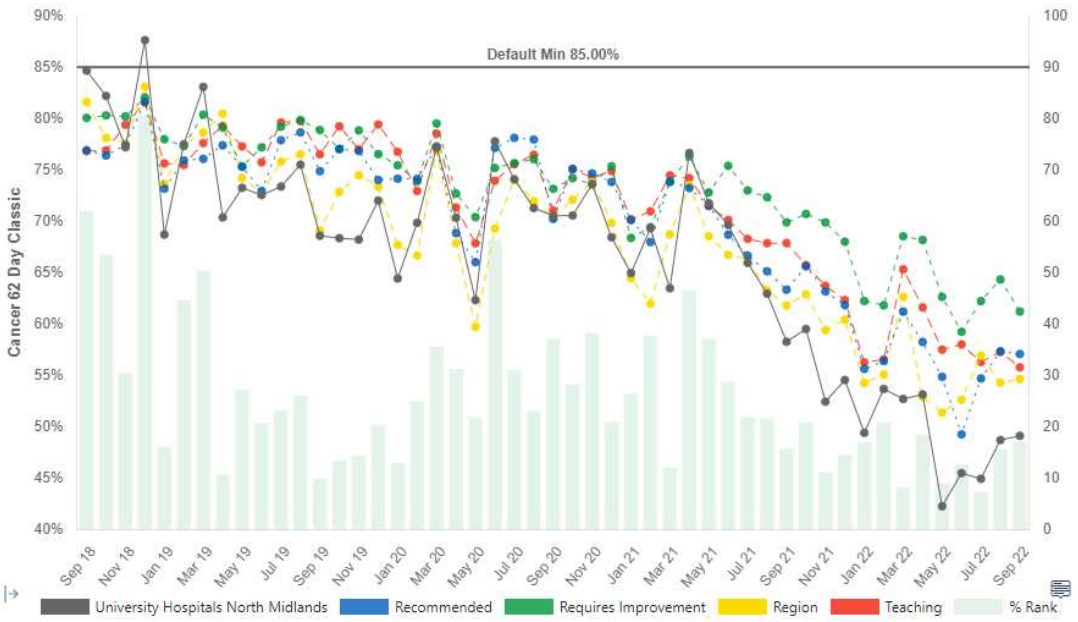
Key Performance Indicator

Key Performance Indicator	Period	Target	SPC	
Breast Cancer	Sep 22	85.00%	71.4%	43
Cancer 62 Day Classic	Sep 22	85.00%	49.1%	17
Lower Gastrointestinal Cancer	Sep 22	85.00%	13.8%	12
Lung Cancer	Sep 22	85.00%	22.2%	15
Other Cancer	Sep 22	85.00%	33.0%	11
Skin Cancer	Sep 22	85.00%	61.9%	14
Urological Cancer	Sep 22	85.00%	64.1%	65

Cancer 62 Day Classic | Ranking | Trend | Delta | SPC | Commentary



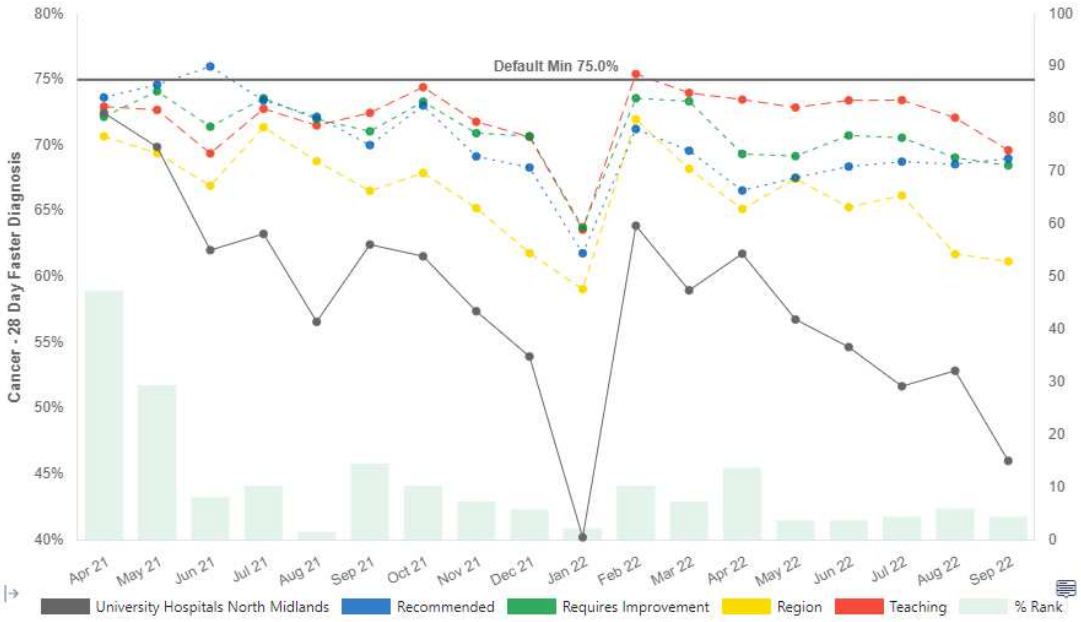
- Deterioration has been seen across all peer groups over the last 12 months with UHNM seeing this more dramatically from August 2021
- Improvements have been made since May 22, however UHNM remain in the lowest quartile for the 62 day performance.

Cancer

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Cancer - 28 Day Faster Diagnosis	Sep 22	75.0%	46.0%	L	4
FDS Acute Leukaemia	Sep 22	75.0%	0.0%	C	25
FDS Brain Tumours	Sep 22	75.0%	-	C	-
FDS Breast Cancer	Sep 22	75.0%	89.8%	C	41
FDS Breast Symptoms	Sep 22	75.0%	100%	C	100
FDS Children's Cancer	Sep 22	75.0%	38.9%	L	5
FDS Gynaecological Cancer	Sep 22	75.0%	60.1%	L	48
FDS Haematological Malignanci...	Sep 22	75.0%	27.8%	C	22
FDS Head & Neck Cancer	Sep 22	75.0%	54.2%	C	11
FDS Lower Gastrointestinal Can...	Sep 22	75.0%	7.0%	L	0
FDS Lung Cancer	Sep 22	75.0%	75.0%	C	53
FDS Missing or Invalid	Sep 22	75.0%	-	C	-
FDS Other Cancer	Sep 22	75.0%	-	C	-
FDS Sarcoma	Sep 22	75.0%	-	C	-
FDS Skin Cancer	Sep 22	75.0%	37.4%	L	11
FDS Testicular Cancer	Sep 22	75.0%	84.2%	C	51
FDS Upper Gastrointestinal Can...	Sep 22	75.0%	84.8%	H	90
FDS Urological Malignancies	Sep 22	75.0%	41.4%	C	20

Cancer - 28 Day Faster Diagnosis | Ranking | Trend | Delta | SPC | Commentary



- The 28 Day Faster Diagnosis position for all peers has seen a drop since earlier this year.
- UHNM affected more than peers and remains in the lowest quartile nationally

Cancer Trajectories

NHS University Hospitals of North Midlands NHS Trust

Provider Level					April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	E.B.32	Count	The number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site specific symptoms	462	440	420	400	380	360	340	320	300	280	250	191
				UHNM snap-shot PTL position	579	632	639	815	1041	894	887	730				

National planning guidance 22/ 23 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. The PTL Backlog trajectory for UHNM is set out above; the actuals shown above are a snap shot in time of the PTL position. This is for the week ending last full week of the month per PAF report.

For the month of November 2022, the backlog position was 730 - this includes patients with a decision to treat and a future treatment date scheduled. The majority of the backlog is attributable to Skin and Colorectal. High proportion of patients waiting over 62 days in both tumour sites have future scheduled treatment dates.

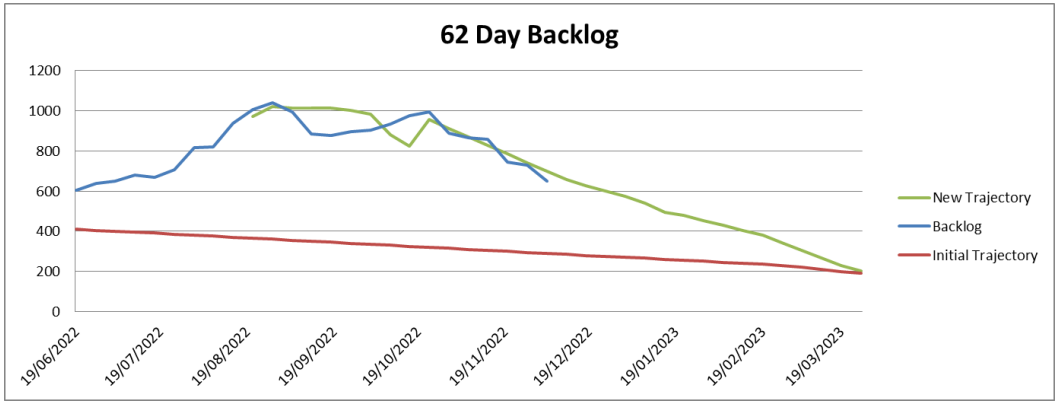
There are multiple contributing factors include delays to pathology reports, urology robotic surgery capacity, complex pathways, increasing element of patient choice and outstanding clinical reviews.

All Divisions are focusing on the backlog and discharge patients where appropriate. Pathway plans are detailed overleaf – there is a concentration on the first appointments and diagnostics and treatments including Surgical and Oncology. All diagnostic modalities have submitted plans for a reduction in waiting times which includes additional staffing, insourcing and outsourcing and building additional capacity through CDC's.
Intensive exec level support is being provided to Skin and Colorectal pathways, which are the main drivers for the backlog position.

Cancer

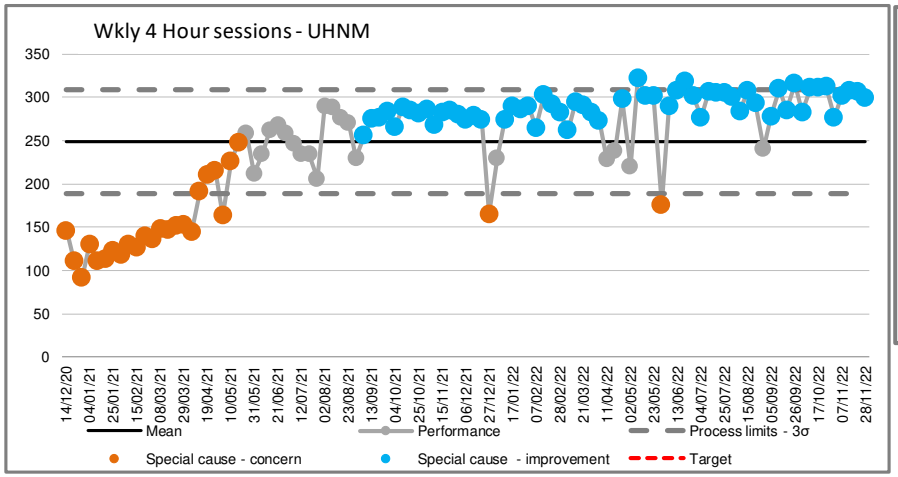
Actions

- The backlog has reduced – UHNM provide assurance to the regional NHSEI team, with detailed plans, on a weekly basis.



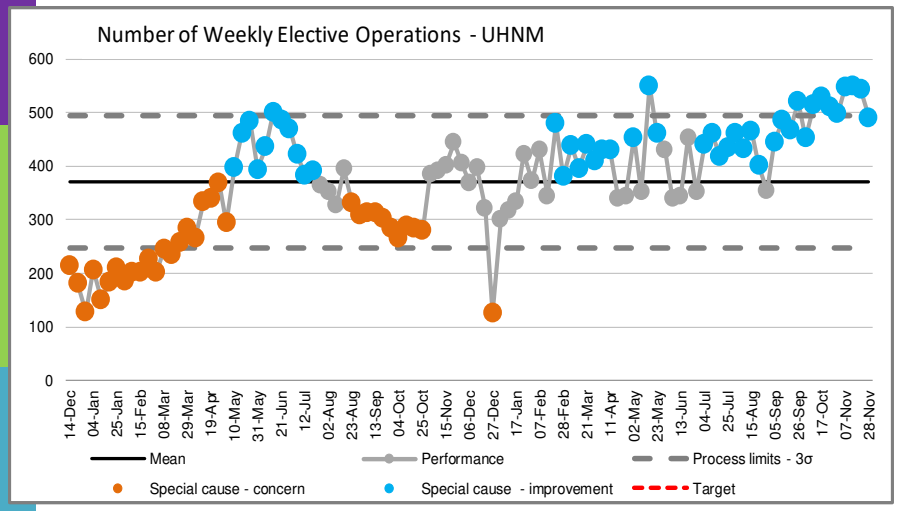
- The incremental decrease of the Skin and Colorectal backlogs have been modelled up to 05/02/23, where the new trajectory meets the initial trajectory submitted in 22/23 operational plans. Both specialties have enacted recovery plans and reducing the number of patients waiting beyond 62 days on the pathway.
- Breast continue to achieve the 14 day standard and have reduced the overall PTL.
- Over the past 4 weeks the block backlog in Pathology has reduced, supporting overall PTL recovery.
- UHNM is still recording a high number of first treatments, demonstrating increased activity which supports PTL reduction.
- The overall PTL has reduced for and is down to levels seen 6 months ago. In August the PTL was over 6000 – this has now reduced by around 2300 patients to 3706 **in total**. This is a reduction of 704 since last PAF report.
- Improvements have mainly been in the overall Skin PTL – which was at 2259 in Aug and has **reduced by 1262 patients to 997** currently.
- Recovery schemes continue to be successful – with the LGI hub optimising referrals, and the community Teldermatology service contributing to a huge reduction in wait times for patients on a skin cancer pathway.
- The day by which 93% of patient receive a 2WW 14 day Clock Stop on the LGI pathway has reduced by over 45 days since September – to a current position of within 6 days.
- The day by which 93% of patient receive a 2WW 14 day Clock Stop has **reduced by over 50 days** to a current position of within 9 days.
- **Next steps for LGI:** to implement guidance received in Tier 1 &2 letters to systems – advising that FIT negative patients (some exclusions apply) should not be referred on a 2WW pathway. Post FIT referral hub implementation - clinical pathway has been suggested, but needs to be agreed and implemented with priority.
- As the backlog is cleared there has been a dip in FDS performance in September = 46% however this is expected to improve in October which is predicted to land at around 60% .

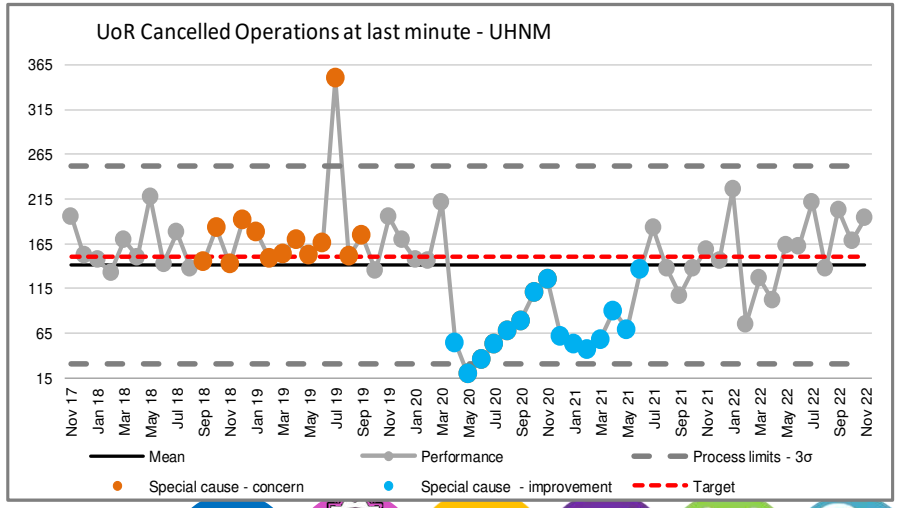
Planned care – *Inpatient Activity*



The number of weekly elective operations have been on an upward trajectory over the last 12 months. This coincides with the increases in the number of weekly 4 hour sessions which is now remaining constant.

The number of patients cancelled on the day continues to fluctuate and is seeing an increasing trend.





Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

Elective inpatients Summary

- Day Case and Elective Activity delivered 96% and 88% respectively for November 22 against the national ask of 110%/108%.
- There is a real focus on 104w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 78week+ patients.
- At the end of November the numbers of > 104 weeks was 38. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity.
- Insourcing arrangements at weekends continue and have been bolstered to provide more weekend capacity in T&O this started in Feb.
- Nuffield have agreed to take all T&O patients at risk of breaching 78 weeks by end of March who are clinically suitable
- County and Royal Stoke Theatres have re-implemented a "6-5-4" weekly operational meeting to ensure a higher proportion of available lists are fully used and to move capacity to the specialties most needing it. This also tracks and ensures bookings so that patients and staff are given more notice so cancellations and non-attendances can be driven down

Actions

- External validation support completed end of October, with final report expected by mid November detailing themes and issues. 3 validators have been approved and are out for advert.
- Trust wide revamp of validation & training underway, focusing on tracking long waiters, exposing and addressing bottlenecks in pathways. Phase 1 to deep dive training needs analysis complete. Phase 2 underway – RTT Bitesize training now available to divisions., focused on key areas requiring improvement.
- 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
- Patient by patient monitoring by each specialty and by the corporate team on the small number of patients at risk of the breaching 104 weeks by end of month, combined with forecasting for December and onwards
- Long wait focus moved to patients due to breach 104 weeks in Q4, with plans to eliminate 78 weeks by end of March 2023. Key enablers are ring fencing of beds for Orthopaedics as RSUH, modular theatre at County and improvement in theatre utilisation and booking.
- Increased focus on non-admitted patients and increasing outpatient & diagnostic capacity, improving utilisation and business processes to move patients to a decision to admit.
- Roll-out of Palantir's Foundry platform underway, with working group to be up and running by mid Jan.

Planned care – *RTT Trajectories*

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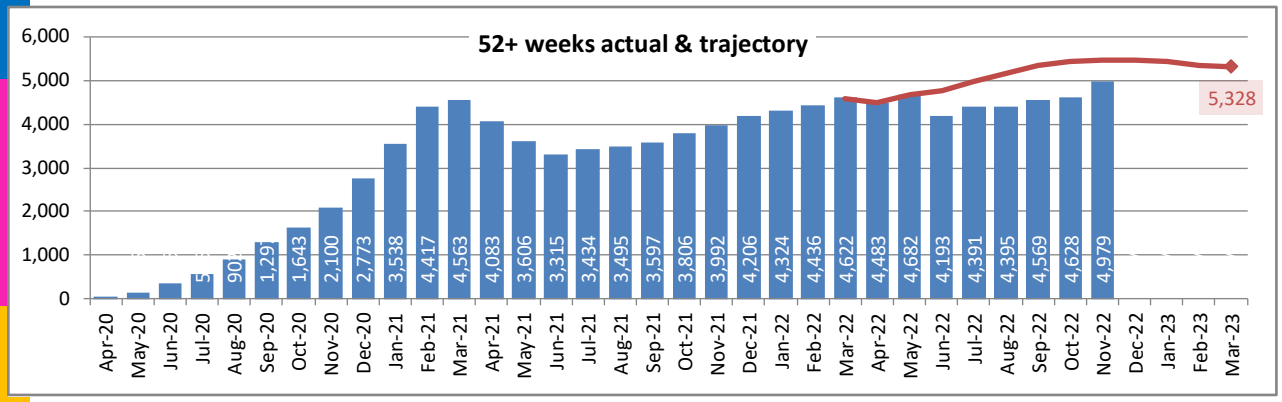
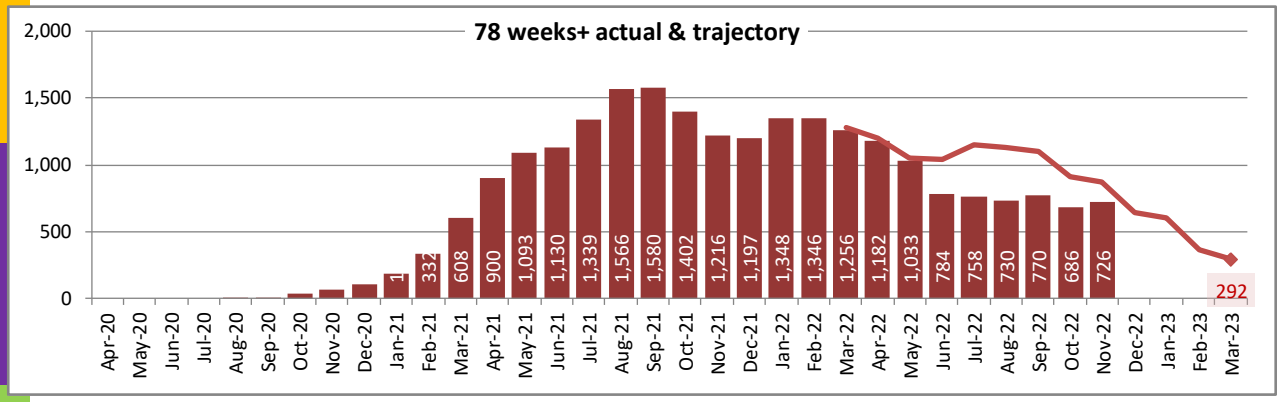
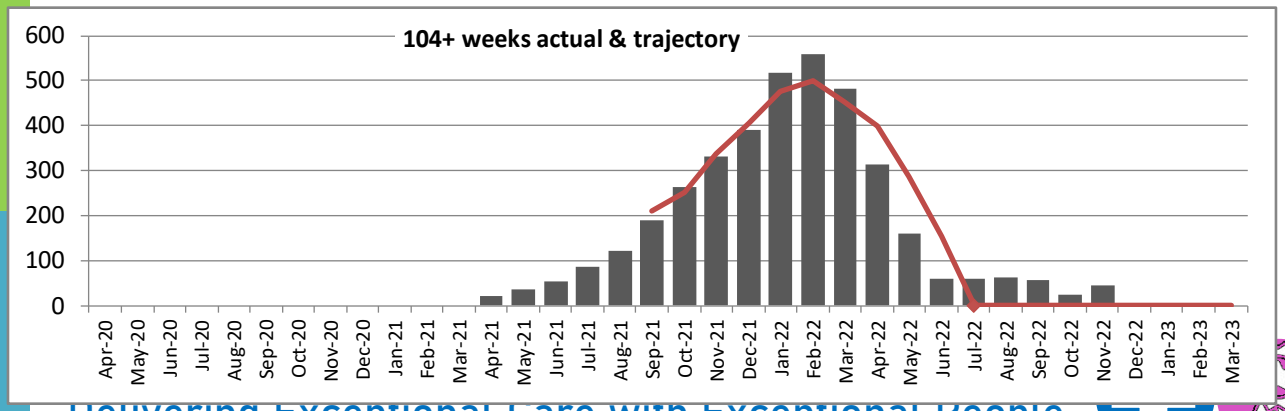


52 Week Waits have been gradually growing since June 21.



78 Week Waits have been reducing for the last 9 months, currently ahead of trajectory.



104 Week Waits have been continually decreasing since early March. Number now at 45. This is made up of patient choice, patients presenting unwell or complex pathways.

RTT - Benchmarked

University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
RTT 104 Week Breach	Sep 22	0	56	C	6
RTT 52 Week Breach	Sep 22	0	4,552	H	13
RTT 78 Week Breach	Sep 22	0	766	L	9
RTT 95th Percentile Admitted W...	Sep 22	18.0	82.7	H	10
RTT 95th Percentile Non-Admitt...	Sep 22	18.0	52.2	H	27
RTT Admitted Treatment Within...	Sep 22	90.0%	54.4%	L	34
RTT Average (Median) Admitte...	Sep 22	9.0	15.2	H	35
RTT Average (Median) Non-Ad...	Sep 22	5.0	8.8	H	51
RTT Average Wait for Incomplete	Sep 22	7.00	16.2	H	16
RTT Incomplete 92nd Percentile	Sep 22	-	47.5	H	23
RTT Incomplete Pathways With ...	Sep 22	25.0%	14.9%	H	44
RTT Non-Admitted Treatment ...	Sep 22	95.0%	72.3%	L	54
RTT Total Clock Starts	Sep 22	-	14,637	L	81
RTT Total Clock Stops	Sep 22	-	12,402	C	82
RTT Total Incompletes	Sep 22	-	77,843	H	11

- 78 Week waits are seeing a slight increase in the last month across all peers groups except “Recommended”.
- UHNM are following this same trend where volumes have increased slightly in September.
- UHNM remain in the lowest quartile

Planned care

NHS
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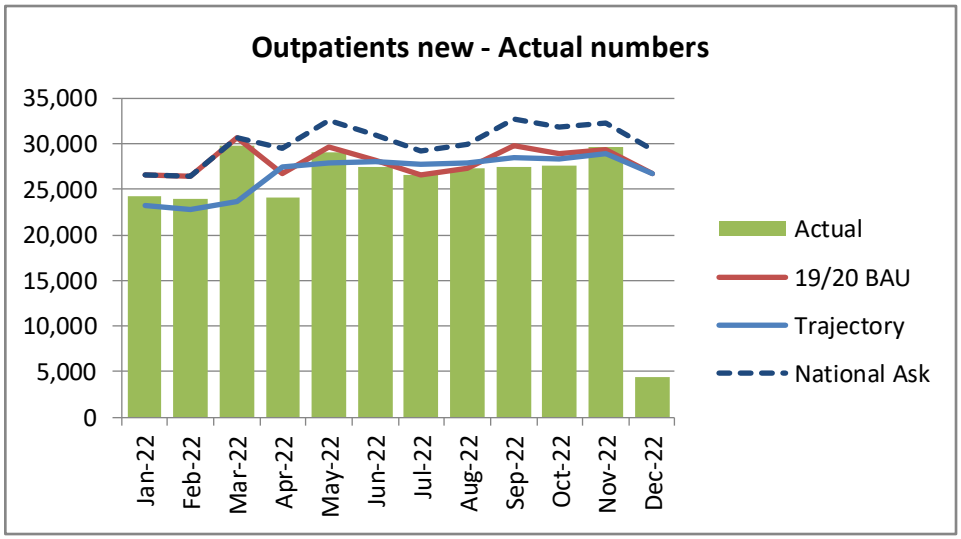
Summary

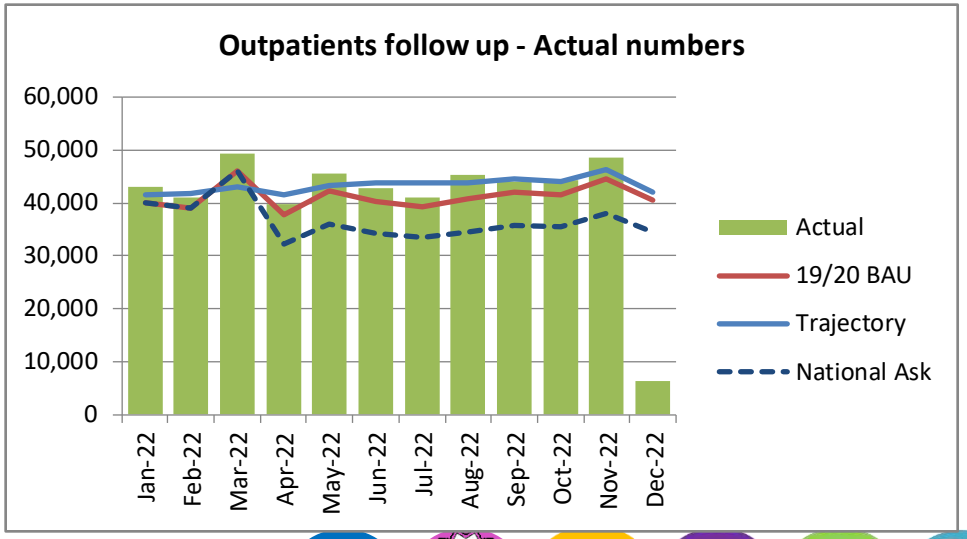
- 52+ week patients increased in November to 4,947
- 78+ patients have been gradually reducing, but has reached a plateau in November at 725 – trust is still on trajectory to eliminate 78 weeks waits by end of March 2023, with several key enablers and risks around staffing issues, covid waves and winter pressures.
- Positive 104+ week position at month end with only those complex patients where this is not possible or if patients have chosen to wait now waiting to be treated.
- The overall Referral To Treatment (RTT) Waiting list has started to show signs of stabilisation. April was 76,023, May 75,858, June 75,538 , July 77,242 and August 76,838, September 77,985, October 77,546, November 77,577. However, this is likely to increase again over winter.

RTT

- Validation has increased with extra resource. This will provide an accurate picture of the resource required in the medium term to reduce the list.
- At the end of November the numbers of > 104 weeks was 38 - a increase from 24 in October. All patients in this cohort are either there due to patient choice, or complexity of pathway. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance has plateaued at 53.7%. (53.6% October)
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

Planned care – *Outpatient activity & RTT*





Planned care – *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Actions

- OP Cell Programme Structure & TOR updated for 22/23 to reflect Elective Recovery Planning Guidance.
- **Work stream 1 Outpatient Service Delivery & Performance**
  - Partial Booking Rollout, Netcall Rollout, CAF Issues Action Plan, and OP Clinic Process vs. Maturity model. Review Date training with DQ Alert circulated & Quick Reference Guides. Wider training links to DQ group. Utilisation focus; bookings, DNAs & cancellations, OP Cell Dashboard revised with utilisation at Trust / Division / Specialty / session code level; Divisional Targets to be set in December with improvement trajectory
- **Work stream 2 Outpatient Transformation**
  - **OP GIRFT:** issued November, aimed at clinicians & operational teams with clinical webinars. Common Themes & Specialty-Specific Guidance for 12 specialties including waiting list validation, specialist advice/triage and specific pathway guidance including remote consultations & PIFU. UHNM detailed template devised for gap analysis, collating current position vs specialty areas of focus. Midlands acknowledgement return due Dec 14th.
  - **Enhanced Advice & Guidance** ICS Referral Optimisation Steering Group set up (now termed Demand Management Steering Group), A3 drafted to define the programme of work (will include Colorectal/Gastro system wide working group). Following a review of the A&G data requirements the system submission has been amended to include additional RAS data for a T&O service at MPFT. This has impacted the ICS utilisation significantly showing a performance in September of 30% vs 16% target. NHSEI challenging latest data submission, December meeting requested. Further data validation continues for post referral advice @ UHNM, whilst focus for providers expected to shift to pre-referral advice & diverted requests.
  - **PIFU**; divisional % PIFU Targets and trajectory to meet 5% in March 2023. PIFU Divisional Challenge with COO July 11th. Ahead of plan on rollout volume, PIFU captured for >25 specialties (Nov 4.4% vs 3.0% plan). Benchmarking vs national median Oct 2022- UHNM: 19th out of 143 providers (4.3% vs 1.6%). Scoping Robotic Process Automation with UHNM BI for PIFU Discharge letters, identifying pilot specialties. Exploring post-proc PIFU opportunities with T&O to support pathway work. Alternatives for estimating waiting list / appt benefits are being modelled. Clarifying reporting methods/requirements for new CDS April 2023 onwards. Identifying additional PIFU pathway opportunities from OP GIRFT guidance
  - **Virtual Care >25%;** SUS submission 'fix' implemented from Nov 2021 (with BI); longer term, alignment of clinic booking and media type outcomes. NHS Remote Monitoring Toolkit issued early December, baseline assessment response due 19th December.
  - **Patient Portal**; support provided to identify potential OP benefits; PKB config working groups - reps invited to OP Cell for updates / discussion. Director of Digital Transformation attended OP Cell in October to share Digital Vision.
  - **SMS via Netcall to Waiting List**. From successful trial in derm & plastics to backlog pts, Partial Booking module purchased for similar approach with other specialties. Used to contact New Waiting List pts (>38wks) during Super September. 44% response rate, with 3% of those receiving an SMS (51 from 1684) no longer require an appointment. Rolling out vs plan for follow ups in top 14 backlog specs from Nov to Feb. Gastro & Urology completed (3000pts, 38-40% response rate, 3.5%-5% of those contacted no longer require appt). Next specialty going live Gynaecology.
  - **Virtual Clinic reviews** enabled 432 clock stops from 1693 pathways validated. NHSE identified UHNM as a potential national case study for this approach during feedback at regional network.

Risks

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

Diagnostic Activity

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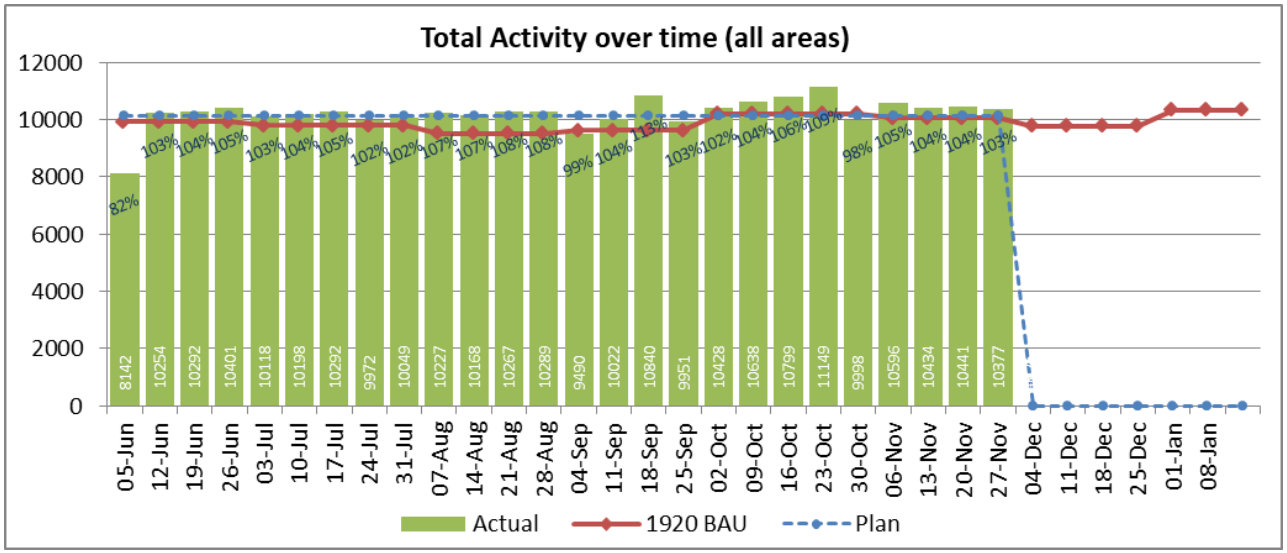
		Unvalidated Data											
		Sep-22				Oct-22				Nov-22			
Area	DM01 Test	Total WL	6+	%	Activity	Total WL	6+	%	Activity	Total WL	6+	%	Activity
Imaging	Magnetic Resonance Imaging	4,832	694	85.6%	3,564	4,634	774	83.3%	3,666	4,722	1,052	77.7%	3,726
	Computed Tomography	3,292	1	100.0%	8,200	4,141	12	99.7%	8,292	3,731	26	99.3%	8,641
	Non-obstetric ultrasound	11,446	6,562	42.7%	5,451	11,224	6,171	45.0%	5,343	10,841	6,205	42.8%	5,325
	Barium Enema												
	DEXA Scan												
Physiological Measurement	Audiology - Audiology Assessments	253	6	97.6%	324	283	1	99.6%	285	306	42	86.3%	328
	Cardiology - echocardiography	2,358	654	72.3%	1,242	2,283	651	71.5%	1,330	2,410	766	68.2%	1,336
	Cardiology - electrophysiology	0	0		2	0	0		3	0	0		3
	Neurophysiology - peripheral neurophys	343	0	100.0%	212	307	0	100.0%	267	311	0	100.0%	272
	Respiratory physiology - sleep studies	718	180	74.9%	242	556	124	77.7%	293	473	113	76.1%	324
	Urodynamics - pressures & flows	0	0		1	0	0		0	0	0		
Endoscopy	Colonoscopy	850	342	59.8%	328	933	417	55.3%	364	1,004	586	41.6%	170
	Flexi sigmoidoscopy	522	177	66.1%	71	553	236	57.3%	88	643	358	44.3%	35
	Cystoscopy	142	12	91.5%	214	135	6	95.6%	226	222	96	56.8%	221
	Gastroscopy	778	313	59.8%	689	810	429	47.0%	727	910	532	41.5%	343
	Totals	25,534	8,941	65%	20,540	25,859	8,821	66%	20,884	25,573	9,776	62%	20,724



Diagnostics - benchmarked

NHS
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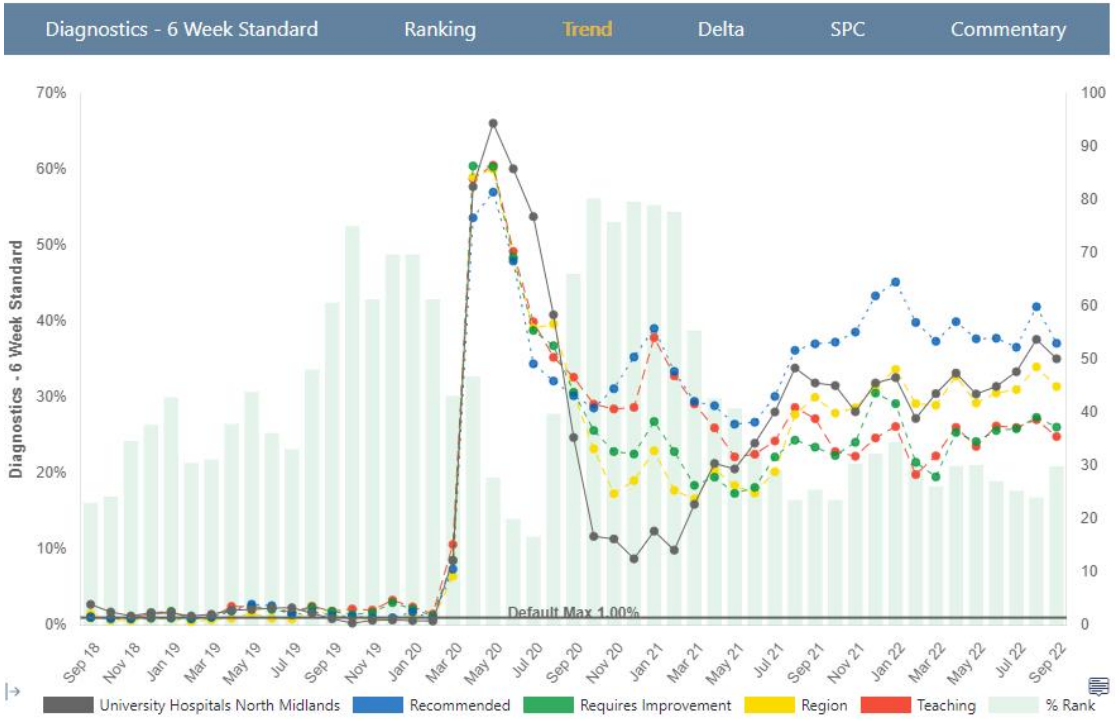
NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Audiology	Sep 22	1.00%	2.4%	L	71
Colonoscopy	Sep 22	1.00%	40.2%	H	34
Computed Tomography	Sep 22	1.00%	0.0%	L	85
Cystoscopy	Sep 22	1.00%	8.5%	L	73
DM01 Waiting <13 Weeks	Sep 22	100.00%	89.2%	L	38
Diagnostics - 6 Week Standard	Sep 22	1.00%	35.1%	H	30
Diagnostics - 6 Week Standard ...	Sep 22	99.00%	64.9%	L	30
Echocardiography	Sep 22	1.00%	27.7%	H	54
Electrophysiology	Sep 22	1.00%	-	C	-
Flexi Sigmoidoscopy	Sep 22	1.00%	33.9%	H	36
Gastroscopy	Sep 22	1.00%	40.3%	H	28
Magnetic Resonance Imaging	Sep 22	1.00%	14.4%	H	41
Neurophysiology	Sep 22	1.00%	0.0%	L	100
Non-obstetric Ultrasound	Sep 22	1.00%	57.4%	H	3
Sleep Studies	Sep 22	1.00%	25.1%	C	45
Urodynamics	Sep 22	1.00%	-	C	-



- Performance at UHNM is better than "Recommended" peers and inline with region
- UHNM have seen a similar trend to it's peer groups however the initial deterioration seen March to June 2021 was more severe causing the national rank to reduce.

Planned care - *Diagnostics*

NHS University Hospitals of North Midlands NHS Trust

Diagnostics Summary

- During November the Diagnostic activity was consistently over 100% when compared with 19/20 BAU
- DM01 performance was 62% overall, with key areas of underperformance in non-obstetric ultrasound and Endoscopy

Histology position :

- Urgent - 95% reported at Day 17, 80% of cases reported by Day 12
- Accelerated - 95% reported at Day 36, 80% of cases reported at Day 27
- Routine - 95% reported at Day 49, 80% reported at Day 39

Actions

Top 6 contributors for DM01 performance have developed recovery plans, and have been requested to refresh these plans in line with National timescales for recovery (March 23). To be monitored once complete by Planned Care Group.

DM01 performance 62%: 9,776 patients waiting 6 weeks +

Top Contributors – in order of highest breach %

1.	Gastroscopy (41.5%)	532 breaches of 910 patients
2.	Colonoscopy (41.6%)	586 breaches of 1004 patients
3.	Non-Obstetric Ultrasound (42.8%)	6205 breaches of 10841 patients (total waiting list size reduced for third month)
4.	Flexi Sigmoidoscopy (44.3%)	358 breaches of 643 patients
5.	Cystoscopy (56.8%)	96 breaches of 222 patients
6.	Echocardiography (68.2%)	766 breaches of 2,410 patients

- **Radiology reporting backlogs;** Outsourcing maximised, full reporting capacity and demand completed. Business case progressing through Trust executive approval process, 6 radiologists applications ready to interview, TI's for cancer backlog agreed.
- High risk relating to 'routine / non cancer reporting' due to reporting capacity and delays in diagnosis (RISK register no 25512)
- Current no of radiology reports in the backlog is: c16,000
- Risk re Imaging reports for 2 week wait internal TAT failure Risk Register no – 23410 score 12
- Risk re GI Imaging reports Risk Register no 23647 - score 12
- **Non – obs Ultrasound capacity for routine patients** New outsourced provider procured & reflected in boost in activity. Trajectory to meet DM01 by March '23
- **Endoscopy;** Fluctuating cancer referral demand against lack of scopist availability. Full recovery plan requested

Inpatient and Outpatient Decile & Ethnicity

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

Inpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	10.42%	9.04%	8.88%	7.34%	7.64%	11.79%	12.57%	10.31%	14.06%	7.50%	0.46%
Weeks Waited- 78-104	14.79%	13.20%	9.57%	8.33%	6.91%	9.48%	10.45%	8.24%	12.58%	4.87%	1.59%
Weeks Waited- 52-77	13.12%	12.10%	10.18%	8.57%	6.93%	11.45%	10.83%	9.25%	11.54%	5.14%	0.87%
Weeks Waited- Under 52	13.65%	11.59%	10.17%	9.08%	7.34%	10.36%	10.86%	8.85%	11.44%	5.44%	1.22%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.21%	9.91%	8.97%	8.67%	7.79%	11.14%	11.66%	10.30%	13.05%	6.40%	0.90%
Weeks Waited- 78-104	13.15%	10.43%	10.17%	9.41%	7.82%	10.45%	10.31%	9.61%	11.80%	5.93%	0.93%
Weeks Waited- 52-77	13.34%	11.08%	9.72%	9.20%	7.50%	10.88%	10.42%	8.65%	11.63%	6.45%	1.11%
Weeks Waited- Under 52	13.50%	11.47%	10.09%	8.95%	7.53%	10.59%	10.54%	8.99%	11.23%	5.96%	1.16%

Inpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.24%	0.38%	0.08%	0.30%	0.35%	0.62%	0.05%	0.05%	0.19%	0.38%	0.46%	0.24%	0.05%	0.03%	93.31%	0.38%	0.70%	1.89%	0.30%
Weeks Waited- 78-104	0.27%	0.71%	0.09%	0.53%	0.18%	1.51%	#N/A	0.27%	#N/A	0.09%	1.06%	0.09%	#N/A	0.09%	90.26%	0.18%	1.59%	1.42%	1.68%
Weeks Waited- 52-77	0.19%	0.46%	0.15%	0.65%	0.46%	1.02%	0.15%	0.15%	0.19%	0.62%	1.52%	0.12%	0.15%	0.09%	87.87%	0.25%	2.26%	1.70%	#N/A
Weeks Waited- Under 52	0.42%	0.65%	0.22%	0.62%	0.64%	1.21%	0.10%	0.19%	0.14%	0.49%	1.56%	0.26%	0.14%	0.20%	84.45%	0.27%	2.91%	2.60%	2.92%

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	0.25%	0.43%	0.21%	0.49%	0.42%	0.77%	0.12%	0.22%	0.10%	0.52%	1.21%	0.18%	0.14%	0.12%	88.36%	0.32%	2.73%	2.10%	1.32%
Weeks Waited- 78-104	0.31%	0.60%	0.12%	0.73%	0.51%	1.16%	0.05%	0.23%	0.08%	0.39%	1.79%	0.35%	0.22%	0.15%	86.58%	0.29%	2.33%	2.19%	1.93%
Weeks Waited- 52-77	0.38%	0.62%	0.18%	0.61%	0.55%	1.11%	0.17%	0.13%	0.18%	0.60%	1.72%	0.31%	0.11%	0.22%	85.23%	0.26%	2.85%	2.38%	2.39%
Weeks Waited- Under 52	0.45%	0.66%	0.20%	0.63%	0.58%	1.24%	0.14%	0.17%	0.15%	0.58%	1.80%	0.33%	0.17%	0.24%	82.83%	0.29%	3.26%	2.82%	#N/A

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APPENDIX 1

Operational Performance

Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	Percentage of Ambulance Handovers within 15 minutes	0%	48.61%			
	Ambulance handovers greater than 60 minutes	0	1298	H	?	
	Time to Initial Assessment - percentage within 15 minutes	85%	56.40%	L	F	
	Average (mean) time in Department - non-admitted patients	180	322	H	?	
	Average (mean) time in Department - admitted patients	180	436	H	F	
	Clinically Ready to Proceed	90	497	H	F	
	12 Hour Trolley Waits	0	947	H	?	
	Patients spending more than 12 hours in A&E	0	2038	H	F	
	Median Wait to be seen - Type 1	60	120	H	F	
	Bed Occupancy	92%	90.34%			
Cancer Care	Cancer 28 day faster pathway	75%	62.60%		F	
	Cancer 62 GP ref	85%	46.35%	L	F	
	Cancer 62 day Screening	90%	71.43%	L	?	
	31 day First Treatment	96%	88.35%	L	?	
	2WW First Seen (exc Breast Symptom)	93%	91.45%		?	

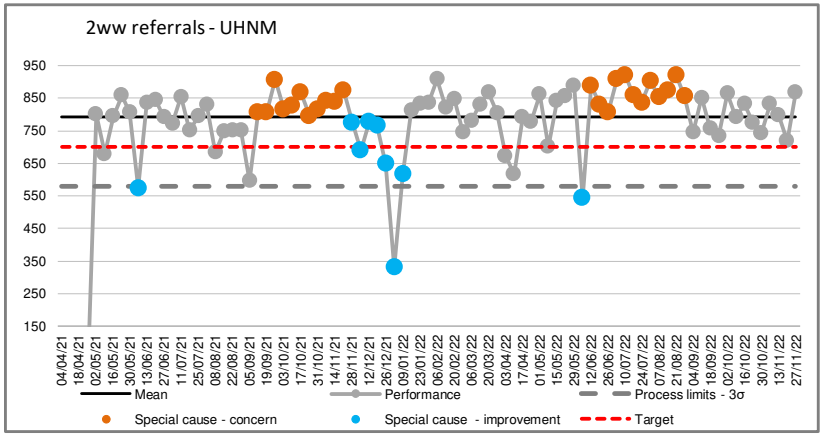
	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%		?	
	Cancelled Ops	150	194		?	
	Theatre Utilisation	85%	79.4%			
Inpatient / Discharge	Same Day Emergency Care	30%	36%	H	?	
	Super Stranded	183	223	H	?	
	MFFD	100	128	L	F	
	Discharges before Midday	25%	21.2%		F	
	Emergency Readmission rate	8%	9.7%	L	F	
Elective waits	RTT incomplete performance	92%	53.70%	L	F	
	RTT 52+ week waits	0	4979	H	F	
	Diagnostics	99%	61.76%	L	F	

Cancer – 62 Day

Target	Sep 22	Oct 22	Nov 22
700	798	718	869

Background

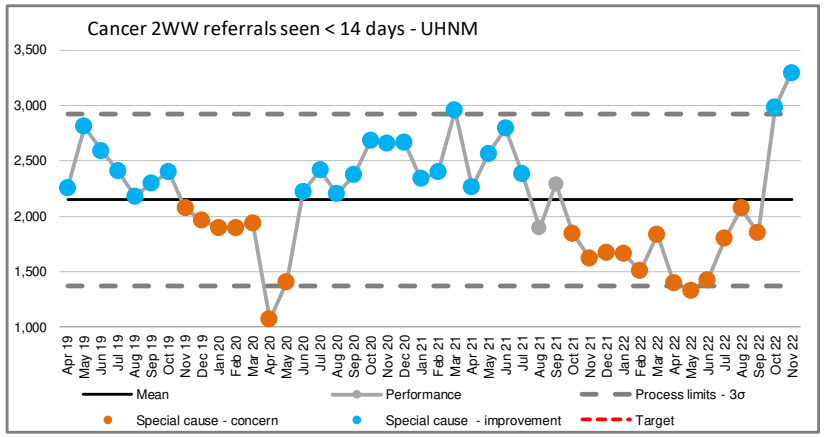
The number of patients referred on a cancer 2ww pathway.



Target	Sep 22	Oct 22	Nov 22
N/A	1847.0	2984.0	3295.0

Background

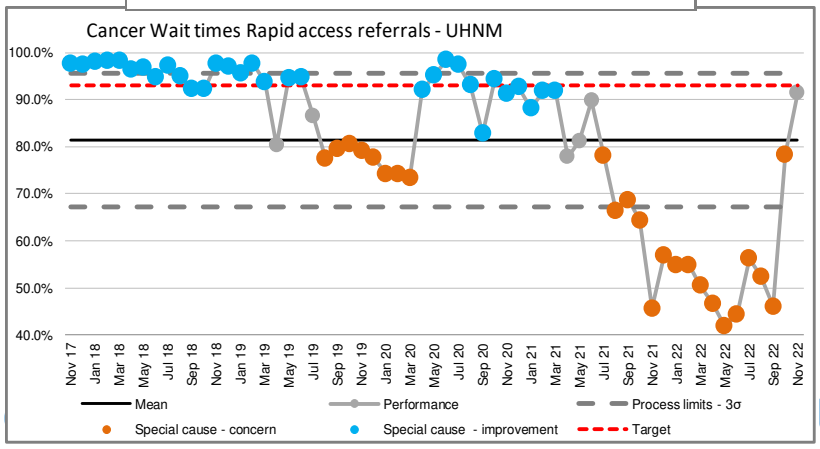
The percentage of patients waiting over 18 weeks for treatment since their referral.



Target	Sep 22	Oct 22	Nov 22
93%	46.1%	78.4%	91.5%

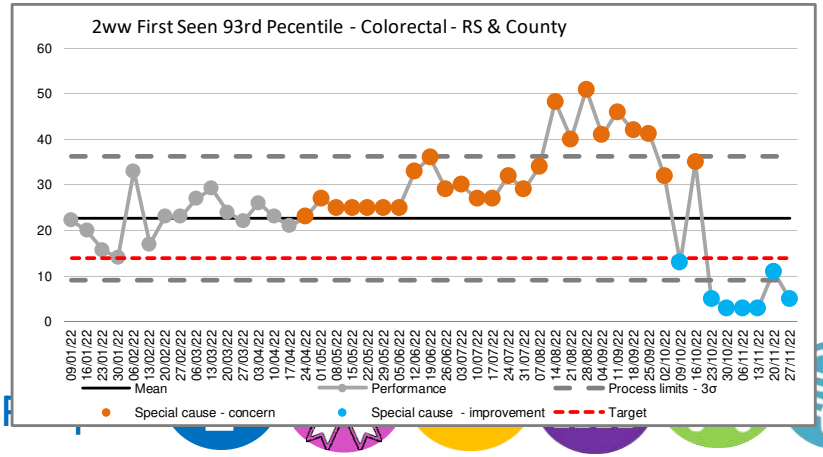
Background

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

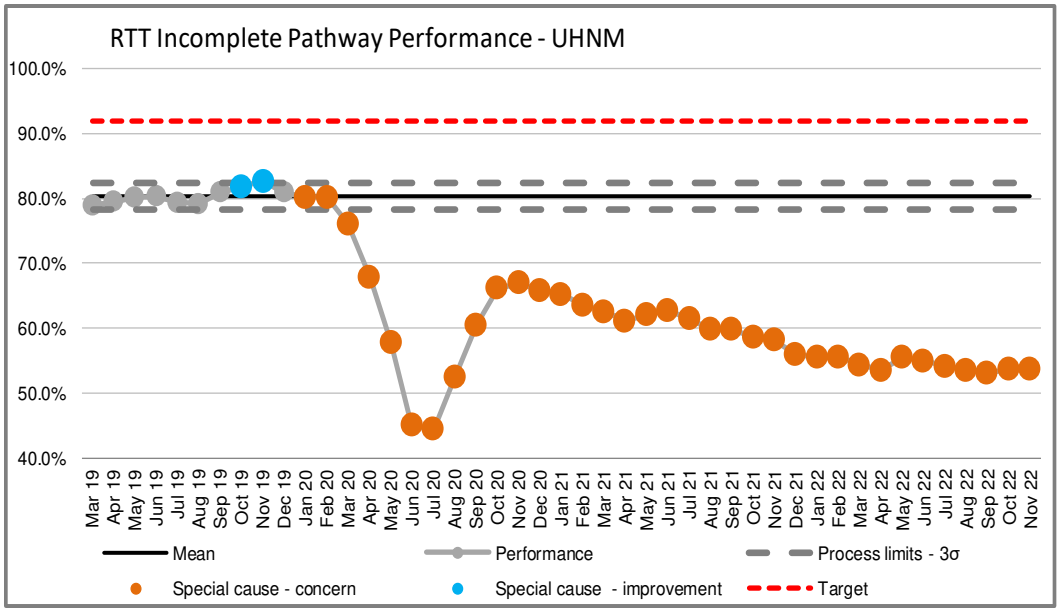


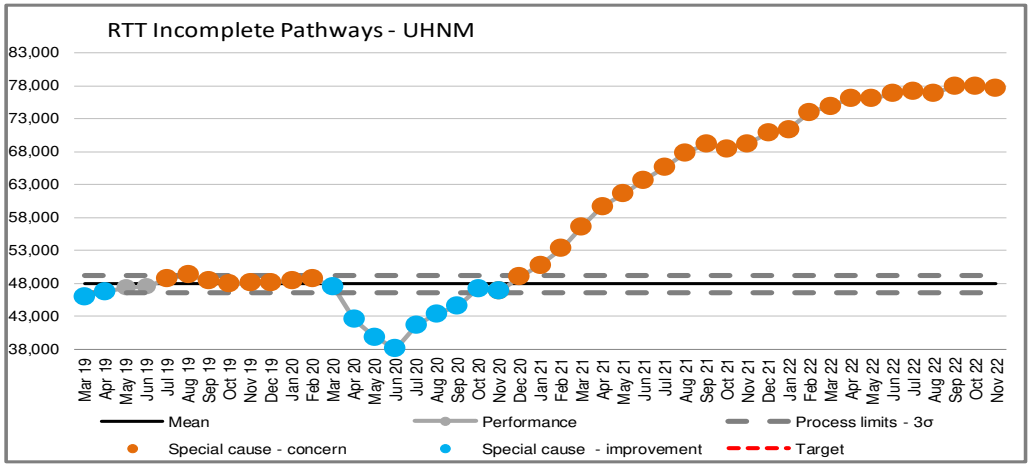
Variation	Assurance

Target	Nov 22	Nov 22	Nov 22
14	3	11	5



Referral To Treatment





Variation	Assurance
	

Target	Sep 22	Oct 22	Nov 22
92%	53.1%	53.6%	53.7%

Background

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

What is the data telling us?

Steady decline in performance since the pandemic began.

Diagnostic Standards

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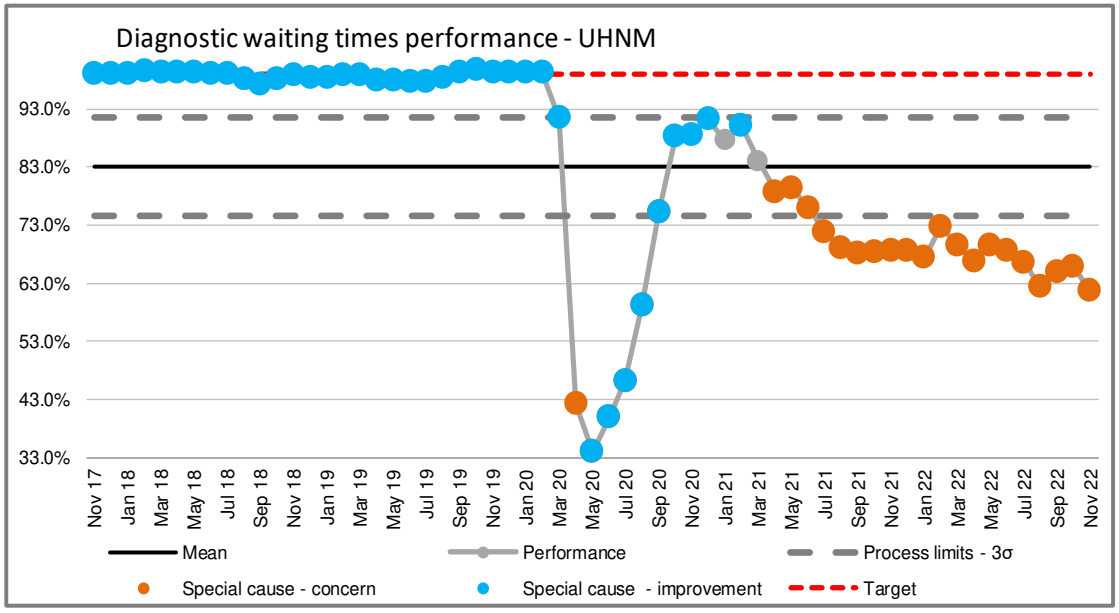


Variation	Assurance
L	F

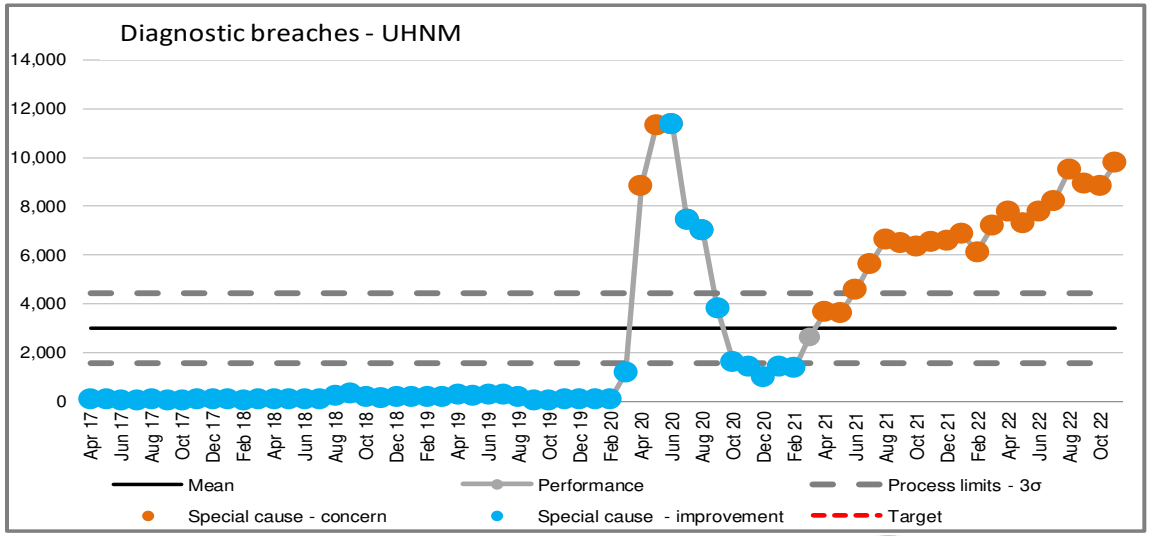
Target	Sep 22	Oct 22	Nov 22
99%	65.0%	65.9%	61.8%

Background

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

What is the data telling us?

The diagnostic performance has shown normal variation up until March 2020. Special cause variation occurred from March (COVID-19). Recovery has been evident until the second wave of the pandemic



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

University Hospitals of North Midlands NHS Trust

Key messages

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

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

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

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

- Training Plan for rollout of civility and respect interventions across UHNM was approved by Execs in November 2022
- A training plan for roll-out of "Being Kind" training across UHNM has been developed and this will include roll-out of an e-learning package (procured from A Kinder Life) which brings together the Resolution policy and Being Kind elements. A paper was presented to Execs in November for the training to be mandated as "core for all", which was approved. This was subsequently approved at the Stat/Mand group on 14th December.

Chest and respiratory (which includes Covid) remains top at 26.3%, closely followed by Anxiety and Stress at 22.8%. These top two reasons for sickness absence are replicated across the Divisions. Focusing specifically on Covid related absence by 4 December 2022 covid-related absences stood at 71, which was 10.5% of the 674 open absences. This is 5.5% decrease on same time the previous month.

The National Staff Survey 2022 has now closed, and the latest overall response rate is 31.17% putting the trust under average response rate for an acute setting of 42.75%. The Staff Voice trust survey reopened in November with 118 total submissions providing an overall engagement score of 6.05.

For PDRs, divisions continue to report that due to increasing operational pressures, management time has been reduced and alongside reported high levels of sickness absence and vacancies. 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.

As part of the monitoring of the reduction to agency spend, divisions were asked to present an update on their action plan to reduce expenditure to EWAG Committee.

A six-month mandate for industrial action has been received from the CSP, with an indication that action will take place early in the New Year, our EPRR team continue to plan for any action that takes place.

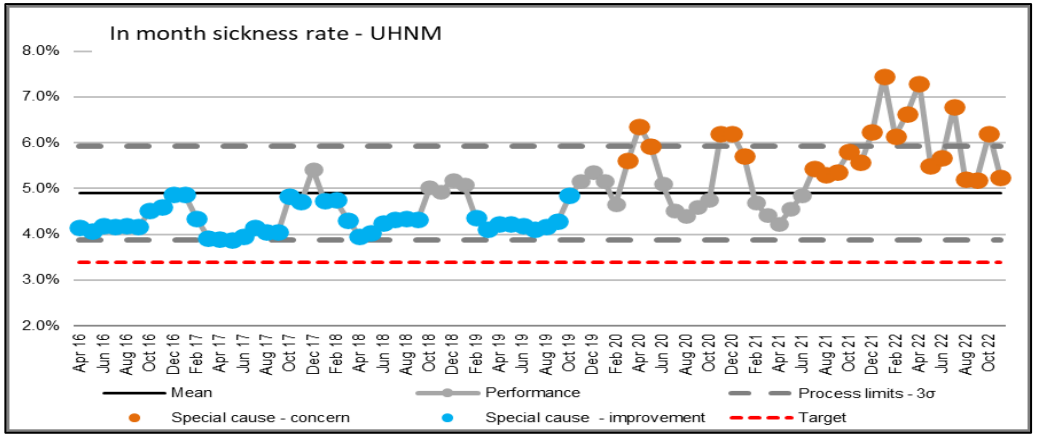
Workforce Dashboard

University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.24%		
Staff Turnover	11%	10.61%		
Statutory and Mandatory Training rate	95%	92.77%		
Appraisal rate	95%	78.54%		
Agency Cost	N/A	3.20%		

Sickness Absence

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Sep 22	Oct 22	Nov 22
3.4%	5.2%	6.2%	5.2%

Background

Percentage of days lost to staff sickness

What is the data telling us?

Sickness rate is consistently above the target of 3.4%.

Summary

(12m cumulative Absence FTE %)

Org L2	Divisional Trajectory - March 2023	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Trajectory
205 Central Functions	3.39%	3.80%	3.83%	3.89%	4.13%	4.13%	4.11%	4.19%	4.21%	4.20%	3.74%	3.71%	↓
205 Women's, Children's & Clinical Support Services	5.25%	5.20%	5.29%	5.53%	5.88%	5.94%	5.97%	6.03%	6.07%	6.25%	6.35%	6.29%	↓
205 Estates, Facilities and PFI Division	5.25%	5.13%	5.26%	5.56%	5.81%	5.75%	5.76%	5.85%	5.98%	6.04%	6.20%	6.22%	↑
205 Medicine and Urgent Care	5.25%	6.01%	6.14%	6.33%	6.56%	6.64%	6.67%	6.76%	6.82%	6.85%	6.94%	6.86%	↓
205 Division of Network Services	5.25%	4.64%	4.78%	4.96%	5.32%	5.47%	5.69%	5.89%	5.81%	5.78%	5.73%	5.75%	↑
205 Division of Surgery, Theatres and Critical Care	4.50%	6.46%	6.57%	6.75%	7.02%	7.18%	7.30%	7.45%	7.39%	7.31%	7.30%	7.20%	↓
205 North Midlands & Cheshire Pathology Service (NMCPS)	5.25%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	5.57%	5.61%	↑

For M8, the in-month sickness rate has decreased by 1% to 5.24% (6.20% in October 2022).

Chest and respiratory (which includes Covid) remains top at 26.3%, closely followed by Anxiety and Stress at 22.8%. The 12 month cumulative rate marginally decreased to 6.24% (6.29% in October 2022).

Divisional trajectories for achieving a reduction in Sickness Absence can be seen in the table above. Many of the Divisions have seen a decrease in sickness against the previous month.

By 4 December 2022 covid-related absences stood at 71, which was 10.5% of the 674 open absences. This is 5.5% decrease on same time the previous month.

Actions

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

For the Medicine division a sickness assurance meeting is planned with the new Heads of Nursing and new People Advisor. Sickness absence continues to be monitored at monthly directorate performance reviews.

Surgery Division continue to implement a cycle of improvements.

Network Division have commenced sickness assurance meetings.

Women's Children's and Clinical Division have had successful Empactis training sessions delivered within Pharmacy and certain areas of MNG. Updated sickness surgeries have been implemented across all areas with higher levels of attendance. However, there are a High number of staff on sickness Stage 2.

NMCPS will be undertaking a deep dive into the short term absence increase with the help of their People Advisor.

Appraisal (PDR)

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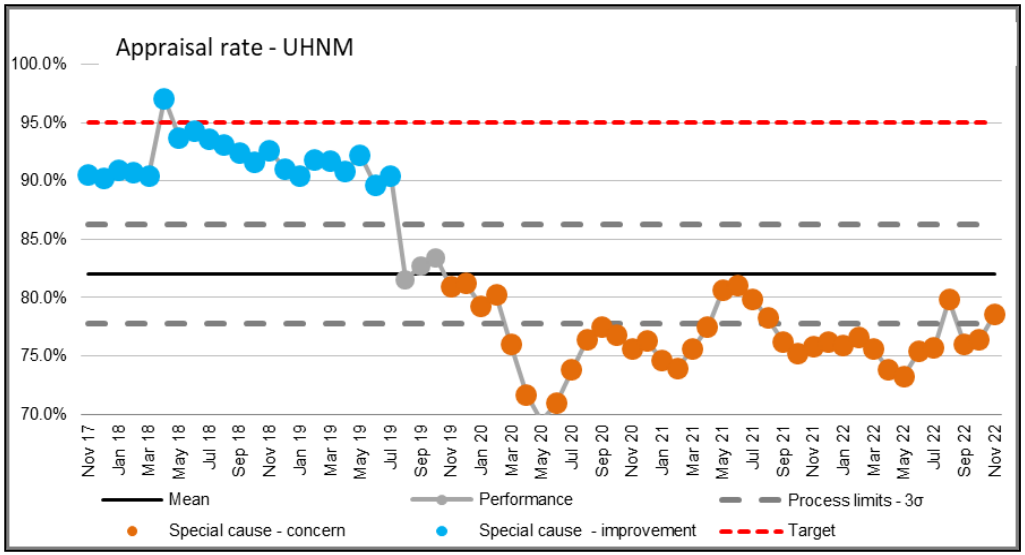
NHS Trust



Variation	Assurance
	

Target	Sep 22	Oct 22	Nov 22
95.0%	76.0%	76.4%	78.5%

Background

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

What is the data telling us?

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

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

Summary

At 30 November 2022, the PDR Rate increased marginally to 78.5% (76.4% at 31 October 2022).

Although this is an increase there has been a continued negative position towards the overall target and divisions have been asked to review key issues and actions to work towards meeting target. Indicative trajectories have been provided.

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 also making the process enhance employee experience.

Actions

The focus on ensuring completion of PDRs is continuing with:

Medicine Division are focusing on low compliance areas. Working with ward and unit managed to enable staff overdue to receive a PDR.

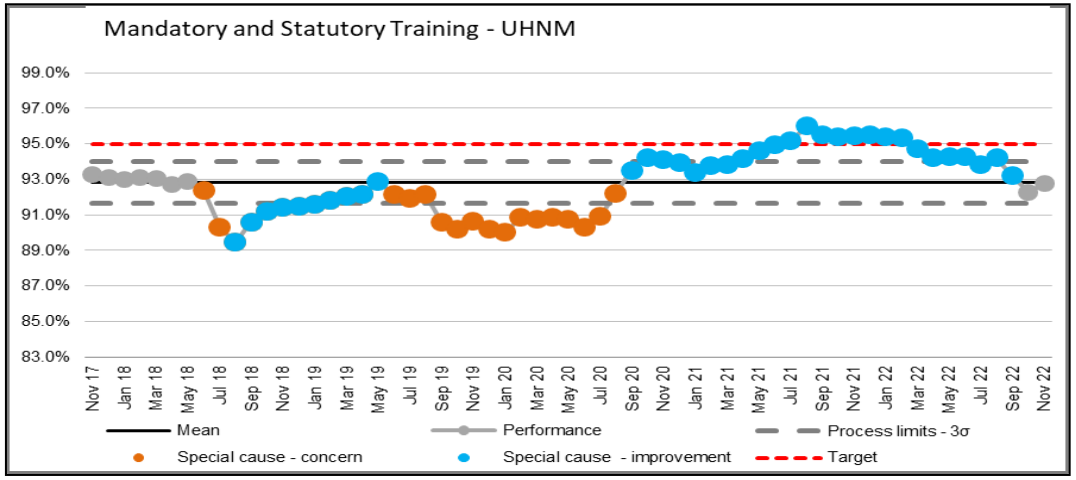
Surgery Division are undertaking a management time required project and also reviewing the number of PDRs per reviewer.

In Network Division a dedicated weekly PDR compliance hotspot and assurance meeting is being held.

Women's Children's and Clinical Division are having Staff engagement plans being brought to DWAG to be reviewed. All Divisions are arranging for proxy access to be setup as a support mechanism for uploading completed PDRs on ESR.

Statutory and Mandatory Training

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Sep 22	Oct 22	Nov 22
95.0%	93.2%	92.3%	92.8%

Background

Training compliance

What is the data telling us?

At 92.3%, the Statutory and Mandatory Training rate is just below the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate at 30 November 22 was 92.8% (92.3 % at 31 October 22). This compliance rate is for the 6 'Core for All' subjects only

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10666	10666	9880	92.63%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10666	10666	9904	92.86%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10666	10666	9960	93.38%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10666	10666	9899	92.81%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10666	10666	9936	93.16%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10666	10666	9780	91.69%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10666	10666	9272	86.93%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10666	10666	9319	87.37%

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.

Workforce Turnover

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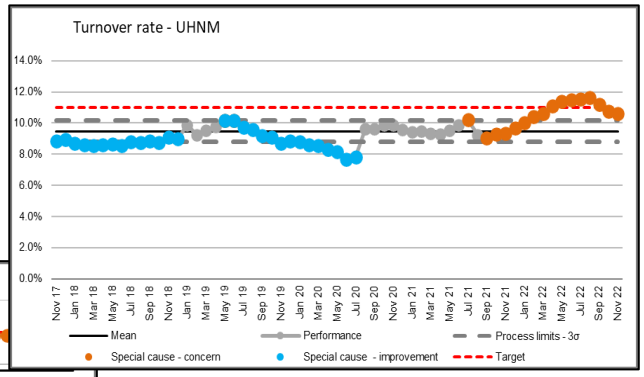
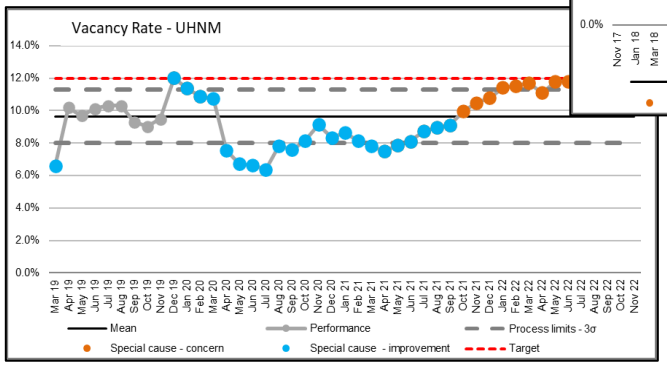
The SPC chart shows the rolling 12m cumulative turnover rate.





Variation	Assurance
H	P

Target	Sep 22	Oct 22	Nov 22
11.0%	11.2%	10.8%	10.6%

Background

Turnover rate

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

What is the data telling us?

The turnover rate for November 2022 has continued to decreased and remains below the trust target of 11%.

Vacancy rate has increased from 11.8 last month to 12.5%

Summary

The 12m Turnover rate in November 2022 reduced to 10.6% and this the 2nd month that this figure has sat below the trust target of 11%.

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

Vacancies at 30-11-22	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,532.44	1,320.68	211.76	13.82%	12.92%
Registered Nursing	3,523.02	2,975.76	547.26	15.53%	14.86%
All other Staff Groups	6,634.57	5,931.22	703.35	10.60%	9.96%
Total	11,690.03	10,227.66	1,462.37	12.51%	11.82%

The November 2022 figure of 12.51% highlights an increase in the overall vacancy rate over the previous month. Although staff in post increased in November 2022 by 96.90 FTE, budgeted establishment also increased by 200.82 FTE, which increased the vacancy fte by 103.92 FTE overall [*Note: the Staff in Post FTE is a snapshot at a point in time, so may not be the final figure for 30/11/22]

Actions

Divisional targets for agency ceilings have been set out and put forward. Divisional progress reports were presented at the December Executive Workforce Assurance Group.

Business case is currently going through approval for medical ad recruitment resource to meet the demands of recruitment activity.

Recruitment event on 9 December 2022 to capture redundant employees following local organisation going into Administration.

Discussions underway with ICS People Function on reservists to support winter escalation.

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS
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NHS Trust

Key elements of the financial performance year to date are:

- Year to date the Trust has delivered an actual surplus of £2.7m against a planned surplus of £3.8m; this is primarily driven by underperformance against the Trust's in year CIP target.
- The Trust incurred £0.4m of costs relating to COVID-19 in month; with £0.4m of this being chargeable for COVID-19 testing costs. The Trust has overspent by £2.7m against its original in envelope allocation due to the in envelope funding allocation ceasing after Month 2.
- To date the trust has validated £7.9m CIP savings in year; these schemes have a full year impact of £5.3m, which presents a considerable variance to the Trust's recurrent target of £13.6m which was identified as a key risk in the Trust's financial plan submission.
- Capital expenditure in Month 8 is £22.8m which is £6.3m behind the plan of £29.1m. Of the expenditure to date £9.5m is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 8 is £97.8m, which is £24.8m higher than plan. Cash received is above plan due to Capacity and Virtual Ward income received from the ICB.
- The Trust has carried out a forecast for the year based on the actual position at Month 8; this forecast is for a £7.1m deficit before mitigations and has improved by £2m from the forecast at Month 7; the main driver of the improvement is a reduction in the contract gap with Specialised Commissioners.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	80.1		
	Expenditure - Pay	variable	49.6		
	Expenditure - Non Pay	variable	30.4		
Activity	Daycase/Elective Activity	variable	8,348		
	Non Elective Activity	variable	9,680		
	Outpatients 1st	variable	26,655		
	Outpatients Follow Up	variable	41,830		

Income & Expenditure

NHS
University Hospitals of North Midlands
NHS Trust

Income & Expenditure Summary Month 08 2022/23	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	915.0	77.4	78.6	1.2	607.8	609.3	1.5
Other Operating Income	86.4	7.2	6.9	(0.3)	57.6	59.8	2.2
Total Income	1,001.4	84.6	85.5	0.9	665.4	669.1	3.7
Pay Expenditure	(607.1)	(51.1)	(49.9)	1.1	(398.5)	(387.4)	11.2
Non Pay Expenditure	(334.0)	(29.0)	(30.0)	(1.0)	(222.8)	(239.9)	(17.1)
Total Operational Costs	(941.1)	(80.1)	(79.9)	0.1	(621.3)	(627.2)	(5.9)
EBITDA	60.3	4.5	5.5	1.0	44.1	41.9	(2.2)
Depreciation & Amortisation	(33.6)	(2.8)	(3.0)	(0.2)	(22.4)	(22.5)	(0.2)
Interest Receivable	0.3	0.0	0.2	0.2	0.2	0.8	0.7
PDC	(8.9)	(0.7)	(0.7)	(0.0)	(6.0)	(6.0)	(0.0)
Finance Cost	(18.1)	(1.5)	(1.4)	0.1	(12.1)	(11.9)	0.1
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Surplus / (Deficit)	0.0	(0.5)	0.6	1.1	3.8	2.4	(1.4)
DHSC PPE adjustment	0.0	0.0	0.0	0.0	0.0	0.3	0.3
Total	0.0	(0.5)	0.6	1.1	3.8	2.7	(1.1)

The main variances for the year to date are:

- Income from patient activities is £1.5m above plan due to additional income in respect of pass through devices and drugs for which corresponding additional costs have been noted with non-pay.
- Other operating income has over performed year to date and this is primarily driven by additional educational and training income and additional income from the North Midlands and Cheshire Pathology Alliance. Car parking and research income continue to under delivery against plan.
- Pay is underspent year to date by £11.2m which is significantly impacted by the £3.1m release of the premium element of the annual leave accrual in Month 3. The remaining variance is driven by underspends across registered nursing and NHS Infrastructure. Within the year to date budget is £2.5m non-recurrent CIP of which the nursing and NHS Infrastructure elements have delivered.
- Non-pay is overspent year to date by £17.1m. Non-delivery of recurrent CIP continues to impact the position by £5.2m, there remains a cost pressure due to the lack of COVID-19 in envelope funding past Month 3 and both drugs and devices to continue to spend above plan (for which we have noted additional income above).

Capital Spend

NHS University Hospitals of North Midlands NHS Trust

Capital Expenditure as at Month 8 2022/23 £m	2022/23 Forecast Revised/ plan M08	In Month			Year to Date		
	Actual	Plan	Actual	Variance	Plan	Actual	Variance
PFI lease liability repayment	(10.5)	(0.9)	(0.9)	-	(7.0)	(7.0)	-
Repayment of IFRS16 leases	(3.7)	(0.3)	(0.3)	-	(2.5)	(2.5)	-
Pre-committed items	(14.3)	(1.2)	(1.2)	-	(9.5)	(9.5)	-
PFI lifecycle and equipment replacement (MES/PAC	(3.5)	(0.2)	(0.2)	(0.0)	(2.0)	(1.4)	0.6
PFI enabling cost	(0.2)	-	-	-	-	(0.0)	(0.0)
PFI related costs	(3.7)	(0.2)	(0.2)	(0.0)	(2.0)	(1.4)	0.6
Wave 4b Funding - Lower Trent Wards	(5.1)	(1.0)	(1.0)	0.0	(3.7)	(3.3)	0.4
Project STAR multi-storey car park	(6.8)	(0.6)	(0.6)	0.0	(1.7)	(1.7)	0.0
TIF 2 PDC (CTS Phase 1)	(4.6)	(0.6)	(0.5)	0.0	(0.7)	(0.6)	0.1
TIF 2 PDC (Day case unit)	(0.4)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
TIF 2 PDC (Women's Hospital)	(0.3)	-	-	-	-	-	-
TIF 2 PDC (CTS Phase 2)	-	-	-	-	-	-	-
Emergency Department (restatement costs)	-	-	-	-	-	-	-
Home reporting breast care - PDC	(0.2)	-	(0.1)	(0.1)	(0.1)	(0.1)	0.0
MRI acceleration upgrades	(0.2)	-	-	-	-	-	-
Endoscopy equipment and works - PDC ICB allocatic	(0.7)	-	-	-	-	-	-
CT9 enabling and equipment - PDC	(1.2)	-	-	-	-	-	-
Frontline digitalisation equipment - PDC	(0.5)	-	-	-	-	-	-
EPR Business Case development - PDC	(0.7)	-	-	-	-	-	-
Schemes funded by PDC and Trust funding	(20.7)	(2.2)	(2.3)	(0.0)	(6.3)	(5.8)	0.5
LIMS (Laboratory Information Management System	(0.5)	(0.0)	(0.1)	(0.0)	(0.3)	(0.2)	0.0
EPMA (Electronic Prescribing)	(0.6)	(0.0)	(0.1)	(0.0)	(0.3)	(0.3)	0.0
CT7 enabling works (BC 415)	(1.1)	-	(0.1)	(0.1)	(1.1)	(0.2)	0.9
Patient Portal roll out costs (BC 462)	(0.5)	(0.2)	(0.0)	0.1	(0.2)	(0.0)	0.2
Pharmacy Dispensary	(0.3)	-	-	-	(0.3)	(0.3)	-
Anaesthetic medical records (Nasstar) (BC 444)	(0.2)	(0.1)	(0.0)	0.1	(0.1)	(0.0)	0.1
Home reporting implementation costs (BC 453)	(0.1)	-	(0.0)	(0.0)	(0.1)	(0.1)	0.0
Market testing refresh - CRIS/PACS/MRI	-	-	-	-	-	-	-
New Scanner CT 8	(1.4)	-	-	-	-	-	-
ED ambulance offload - enabling ward moves	(0.7)	-	-	-	(0.4)	(0.4)	(0.0)
Schemes with costs in more than 1 financial year	(5.4)	(0.3)	(0.3)	0.1	(2.8)	(1.6)	1.2
2022/23 schemes	(14.7)	(0.6)	(0.9)	(0.3)	(5.9)	(4.1)	1.8
IFRS 16 New Vehicles lease	(0.1)	-	-	-	-	-	-
IFRS 16 County Theatres TIF1 (IFRS16)	(2.1)	(2.1)	-	2.1	(2.1)	-	2.1
IFRS16 lease additions (incremental impact of IFRS1	(0.7)	-	-	-	-	-	-
Lease liability re-measurement	(0.1)	-	-	-	(0.1)	-	0.1
IFRS16 funded schemes	(3.0)	(2.1)	-	2.1	(2.2)	-	2.2
Donated/Charitable funds expenditure	(4.6)	(0.1)	(0.1)	-	(0.4)	(0.4)	-
Charity funded expenditure	(4.6)	(0.1)	(0.1)	-	(0.4)	(0.4)	-
Overall capital expenditure	(66.4)	(6.8)	(4.9)	1.9	(29.1)	(22.8)	6.3

Key variances at Month 8 are:

- PFI lifecycle and equipment replacement is £0.6m behind plan at month 8 due to no refreshes of MES or PACS equipment having taken place in the year to date. The element of the PFI unitary payment relating to this is accounted for as a pre-payment therefore this does not represent a slippage in the capital programme in respect of capital financing, however additions of £0.6m to the PPE balance in respect of this replacement were expected at Month 8.
- The Lower Trent ward scheme is £0.4m behind plan at Month 8 due to contractor delays and the opening of the new ward is expected to slip by four weeks in to January 2023. As part of the Winter Plan ward 80/81 will be retained in the West Building and additional equipment required for the new Trent ward has been included in the capital plan.
- The enabling works for CT7 are behind plan at Month 8 and the completion of the scheme and installation of the equipment has slipped to January 2023 due to delays relating to lender approval, which has now been received.
- The County Theatres TIF1 (IFRS16) scheme is £2.1m behind plan due to delays in the process and enabling for the modular theatre. The modular building and lease are expected to be in place and recognised in February 2023.

Balance sheet

Balance sheet as at Month 8	31/03/2022	30/11/2022			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	576.4	577.1	569.1	(7.9)	Note 1
Right of Use Assets	-	17.6	17.1	(0.4)	
Intangible Assets	20.7	17.3	17.1	(0.3)	
Trade and other Receivables	1.4	1.4	1.4	0.0	
Total Non Current Assets	598.6	613.4	604.7	(8.7)	
Inventories	16.3	16.3	16.8	0.6	
Trade and other Receivables	41.6	39.8	40.3	0.5	
Cash and Cash Equivalents	87.6	73.0	97.8	24.8	Note 2
Total Current Assets	145.5	129.0	154.9	25.9	
Trade and other payables	(116.6)	(106.0)	(122.8)	(16.9)	Note 3
Borrowings	(10.7)	(13.5)	(13.5)	0.0	
Provisions	(2.5)	(2.5)	(3.2)	(0.7)	Note 4
Total Current Liabilities	(129.8)	(122.0)	(139.6)	(17.6)	
Borrowings	(257.8)	(259.5)	(260.1)	(0.6)	
Provisions	(3.9)	(3.9)	(3.8)	0.1	
Total Non Current Liabilities	(261.6)	(263.4)	(263.8)	(0.4)	
Total Assets Employed	352.6	357.1	356.3	(0.8)	
Financed By:				-	
Public Dividend Capital	648.2	648.2	648.2	-	
Retained Earnings	(437.0)	(432.5)	(433.3)	(0.8)	Note 5
Revaluation Reserve	141.4	141.4	141.4	-	
Total Taxpayers Equity	352.6	357.1	356.3	(0.8)	

Note 1. This variance reflects slippage of £6.3m in capital expenditure in the revised year to date capital plan. The remaining variance is due to the timing of PFI equipment replacement as part of the managed equipment scheme which is funded through the PFI unitary payment in 2021/22.

Note 2. Cash received in the year to date is £20.2m higher than plan mainly due to cash received from Health Education England relating to Q3 training income and full year funding relating to Nursing CPD and staff placements. The plan assumed this cash would be received in Month 9. Cash received from ICBs is £5.6m ahead of plan in the year to date and reflects funding received relating to capacity and virtual wards from local commissioners in prior months. Payments are £4.6m lower than plan.

Note 3. Deferred income is higher than plan partly as a result of £4m cash received from Staffordshire and Stoke on Trent ICB for a number of schemes. The deferred income balance also includes significant balances relating to Health Education England training (£8.4m); digital pathology (£2.2m); and high cost devices (£4.3m). General payables are higher than plan in the year to date which reflects the revenue position and capital creditors of £7.5m which includes accruals on significant schemes including the car park and Lower Trent ward scheme. There remains a residual impact of the unavailability of efinancials during August however this impact has reduced in Month 8.

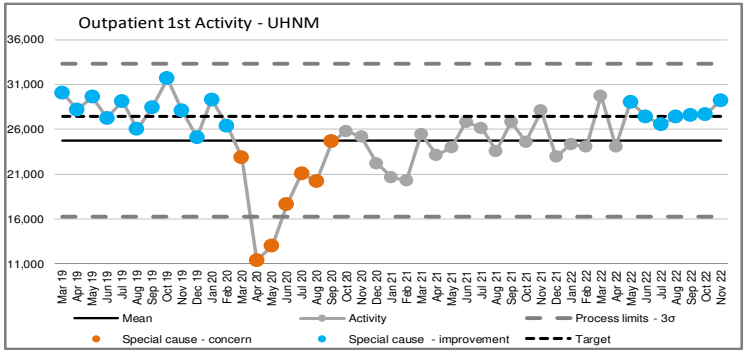
Note 4. Provisions are £0.7m higher than plan due to unforeseen new provisions arising in 2022/23. A case has arisen which relates to a staffing issue and which has a total potential cost to the Trust of £0.2m. A £0.6m provision is also required for a potential fine from the Care Quality Commission (CQC) relating to an on-going investigation.

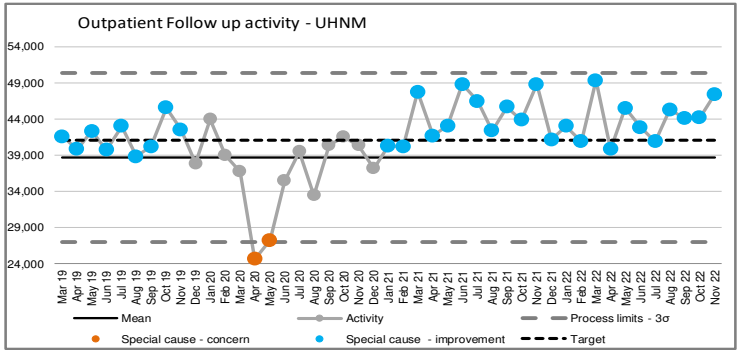
Note 5. This variance reflects the surplus/deficit position as would be reported in the Statement of Comprehensive Income within the Trust's annual accounts. Financial performance shows a variance of £1.1m from plan. This excludes the impact of donated income, depreciation and DHSC consumables which show a variance of £0.3m to plan at Month 8.

Activity

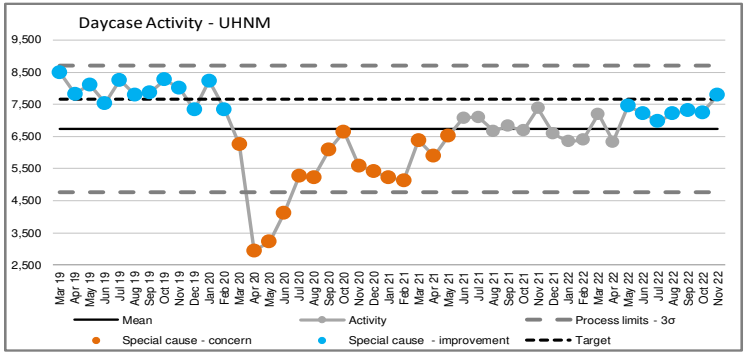
NHS
University Hospitals of North Midlands
NHS Trust

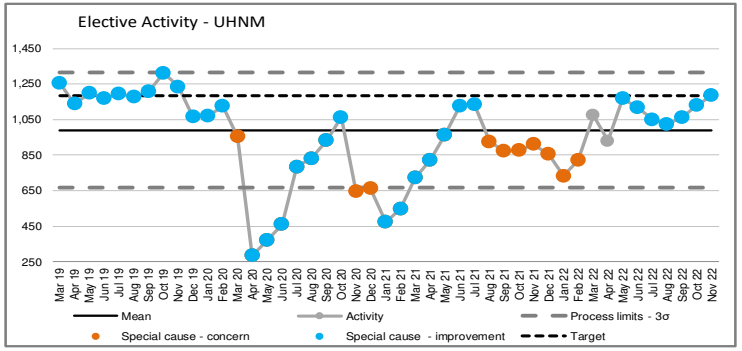
Planned care Outpatient



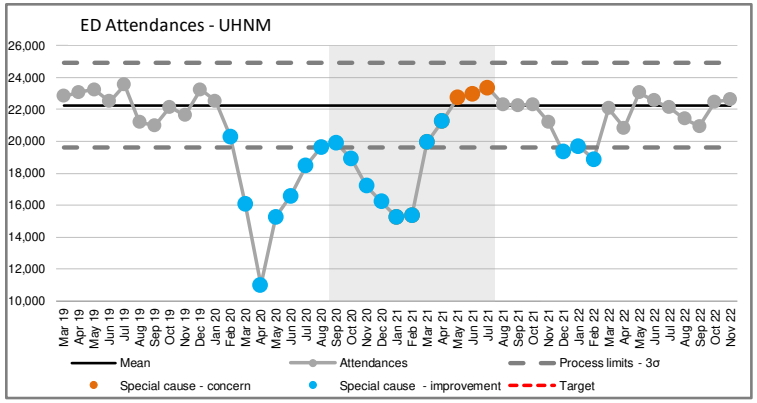


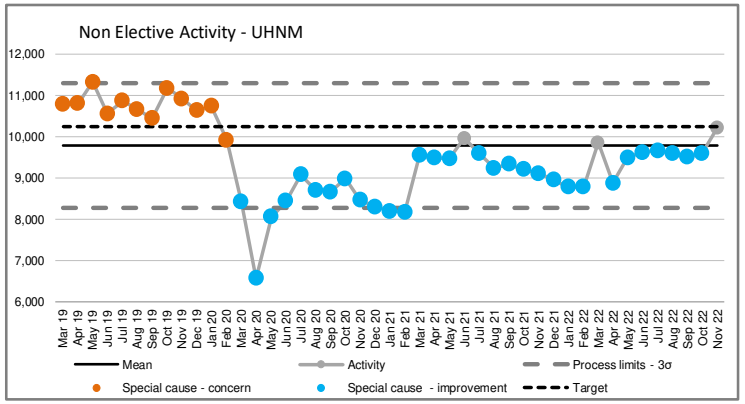
Planned care Inpatient





Urgent Care





Delivering Exceptional Care with Exceptional People

Trust Board

2022/23 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
		6	4	8	6	3	7	5	9	7	11	8	8	
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse					Staff		Staff		Staff				
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Quality Strategy Update	Chief Nurse													
Clinical Strategy	Director of Strategy													To be provided to TAP before being brought to Board
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse						→							
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													
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													TBC
Infection Prevention Board Assurance Framework	Chief Nurse													
RESPONSIVE														
Integrated Performance Report	Various	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
PEOPLE														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Chief People Officer													
People Strategy Update	Chief People Officer													
Revalidation	Medical Director													
Workforce Disability Equality Report	Chief People Officer													
Workforce Race Equality Standards Report	Chief People Officer													
Staff Survey Report	Chief People Officer													
Raising Concerns Report	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
IMPROVING AND INNOVATING														
Research Strategy	Medical Director				→									Taken to TAP in April. Final version to be presented to Board in September (due to annual leave during August)
SYSTEM AND PARTNERS														
System Working Update	Chief Executive / Director of Strategy													
RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy		N/A											
Digital Strategy Update	Director of Digital Transformation													
Going Concern	Chief Finance Officer													Taken to Audit Committee
Estates Strategy Update	Director of Estates, Facilities & PFI													Date to be confirmed
Annual Plan	Director of Strategy													
Board Approval of Financial Plan	Chief Finance Officer													

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		6	4	8	6	3	7	5	9	7	11	8	8	
Activity and Narrative Plans	Director of Strategy													Guidance not received as at Dec 22
Final Plan Sign Off - Narrative/Workforce/Activity/Finance														
Capital Programme 2022/23	Chief Finance Officer													Taken to PAF
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
Accountability Framework	Associate Director of Corporate Governance													
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													Deferred from Nov. due to number of items on the agenda