Trust Board (Open)

Meeting held on Wednesday 3rd April 2024 at 9.30 am to 12.15 pm
Vis MS Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	**2.**	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 6th March 2024	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	**6.**	Chief Executive's Report –March 2024	Information	Mrs T Bullock	Enclosure	
10:15		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (28-03-24)	Assurance	Prof A Hassell	Enclosure	1
5 mins	**8.**	Maternity Dashboard – February 2024	Assurance	Mrs S Jamieson	Enclosure	1
10:25		**RESOURCES**				
5 mins	**9.**	Performance & Finance Committee Assurance Report (25-03-24)	Assurance	Ms T Bowen	Enclosure	5, 7, 8
10:30		**PEOPLE**				
5 mins	**10.**	Transformation & People Committee Assurance Report (27-03-24)	Assurance	Prof G Crowe	Enclosure	2, 3, 4, 6, 9
15 mins	**11.**	2023 NHS Staff Survey Report	Assurance	Mrs J Haire	Enclosure	2, 3
10 mins	**12.**	Gender Pay Gap Report	Assurance	Mrs J Haire	Enclosure	3
10 mins	**13.**	Leadership Competency Framework	Approval	Mrs J Haire	Enclosure	
11:10 – 11:25 COMFORT BREAK						
11:25		**RESPONSIVE**				
40 mins	**14.**	Integrated Performance Report – Month 11	Assurance	Mrs AM Riley Mrs K Thorpe Mrs J Haire Mr M Oldham	Enclosure	1, 2, 3, 5, 8
12:05	**CLOSING MATTERS**					
10 mins	**15.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
	16.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 1st April to** Jason.dutton@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:15	**DATE AND TIME OF NEXT MEETING**					
	17.	**Wednesday 8th May 2024, 9.30 am, Trust Boardroom, Springfield, Royal Stoke**				

Trust Board (Open)

Meeting held on Wednesday 6th March 2024 at 9.30 am to 12:35 pm
Via MS Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

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

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

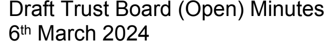
In Attendance:

Mrs N Hassall	Deputy Associate Director of Corporate Governance (minutes)
Mrs S Jamieson	Director of Midwifery (item 7)
Mrs R Pilling	Head of Patient Experience (item 1)
Mrs D Smallwood	Patient Representative (item 1)

Members of Staff and Public: 4

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
031/2024	Mrs Smallwood provided some background to her father-in-law, Fred's life and career before he became ill. She explained that Fred was initially admitted to Royal Stoke with a suspected stroke, before being transferred from AMU to Ward 222. She described the positive care received on the ward and particularly paid thanks to Sam, Advanced Nurse Practitioner and Julie, Ward Clerk for the compassionate care they provided to the 97 year old.	

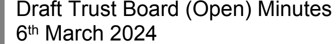
	Mrs Smallwood highlighted that Fred had to have a feeding tube inserted and it soon became apparent that he would not be able to get out of hospital and was put onto an end-of-life care pathway. She highlighted that towards the end of his life he was not stressed or agitated, but he was unfortunately not able to be moved into a hospice, therefore he was moved to a side room and remained in hospital for 2 weeks until he passed away on 11th January 2023. Mr Wakefield thanked Mrs Smallwood for sharing Fred's story and referred to his admission to Ward 222 and queried how the move to another ward went. Mrs Smallwood highlighted that that the move from AMU to Ward 222 went well and this was welcomed by the family due to how busy AMU was. Dr Griffin welcomed Mrs Smallwood's comment in that staff treated him as a person, rather than a patient, and referred to the decision for Fred not to be discharged to a hospice and queried if the risks of transfer were explained and whether that was fair and right. Mrs Smallwood stated that the palliative care team did fully explain the risks, in that he was too poorly to be transferred via an ambulance as there was a possibility of him passing away in the ambulance. Professor Hassell thanked Mrs Smallwood for sharing the story and stated that he was delighted to hear the comments made about the care received. He queried whether the family were happy with how Fred's end of life care was managed and Mrs Smallwood, stated that overall, they were, but after withdrawing care he lived for two weeks which seemed cruel given that he was unable to eat and drink due to not being able to swallow. Ms Bowen referred to the end-of-life care and queried if an explanation was provided and whether the family felt this was comprehensive enough. Mrs Smallwood agreed and stated that this was fully explained. Dr Lewis thanked Mrs Smallwood for the sharing the story and describing the positive care received, which was heartwarming. Mr Wakefield summarised that despite the difficult transition from the Emergency Department / AMU to Ward 222, he thanked Mrs Smallwood for highlighting the care provided by Sam and Julie. He stated that the issue of palliative care needed further consideration in terms of care having been withdrawn although Fred lived for two weeks after that decision. He also welcomed Mrs Smallwood's comments made regarding the support provided to the family by the Veteran's Awareness Team. **The Trust Board noted the patient story.** Mrs Pilling and Mrs Smallwood left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
032/2024	Mr Wakefield welcomed members to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate.	
3.	**Declarations of Interest**	
033/2024	There were no declarations of interest raised.	
4.	**Minutes of the Previous Meeting held 7th February 2024**	



034/2024	The minutes of the meeting held 7th February 2024 were approved as a true and accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
035/2024	There were no further updates made to the action log.	
6.	**Chief Executive's Report – February 2024**	
036/2024	Mrs Bullock highlighted a number of areas from her report. Dr Griffin welcomed the positive maternity survey results and PLACE scores and queried the 'right care, right person' policy and what the scale of challenge was in relation to implementing the policy. Dr Lewis stated that the Trust had initially been informed of the change in July 2023, and further guidance was received in February 2024. He stated that staff had been made aware of the changes before it had commenced and the Trust had not yet seen any significant impact, whilst the policy remained in transition. Ms Bowen referred to the neonatal team and congratulated them for their award at the Paediatric Awards for Training Achievements. She referred to the implementation of home care is best, and Dr Lewis described the aim and the potential benefits of the scheme, which aimed to avoid overusing hospital resources, releasing pressure in the Emergency Department, and providing better quality, tailored care for patients. Mrs Bullock stated that further benefits were expected such as reductions in the number of patients transferred to care / residential homes, fewer frail elderly patients admitted to hospital, and fewer end of life patients dying in hospital, although these aims could be delivered by other initiatives in addition to home care is best. Professor Hassell referred to the works to the cancer centre and the developments undertaken as a result of the donation from the Coates Foundation and he queried if the plans could be shared with members of the Board, and this was agreed. **The Trust Board received and noted the report and approved the e-REAFs 13289, 13326, 13402, 13417 and 13502.**	**LT**
HIGH QUALITY		
7.	**Maternity Quality Governance Committee Assurance Report (21-02-24) & Maternity Dashboard – January 2024**	
037/2024	Maternity Quality Governance Committee Assurance Report (21-02-24) & Professor Hassell highlighted the following from the assurance report: • Safeguarding training for doctors and appraisal compliance remained challenged • A further audit of consultant obstetrician attendance at required situations demonstrated positive findings, although one issue had been identified regarding sepsis which was subject to further review. Secondly, caesarean sections on ladies with a high BMI were being reviewed • The Trust was seeking advice as to what data is available for service users from ethnic minorities • Positively, the Committee noted that Dr Simon Cunningham had been reappointed as Clinical Director for neonates, obstetrics and gynaecology • The Trust was one of the top 5 Trusts who had complied with the saving babies lives care bundle	

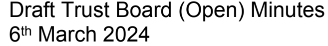
	<u>Maternity Dashboard – January 2024</u> Mr Wakefield referred to the outstanding actions on the Care Quality Commission (CQC) action plan and Mrs Jamieson provided an explanation of the areas of challenge and actions taken. Mr Wakefield requested that an update on these two areas were provided to the next Maternity Quality Governance Committee. Ms Bowen referred to triage within 15 minutes and queried how this compared to last year's performance. Mrs Jamieson stated that MAU triage within 15 minutes had become a driver metric and significant improvements had been made following a deep dive. She stated that whilst the Trust was not achieving its trajectory, she highlighted that there was no national target in place and the high internal target has been identified following the last CQC inspection. Mr Wakefield referred to triage times and when compared to between March and June 2023, most recent performance had not improved, and he queried when it was expected to see an improvement. Mrs Jamieson highlighted that performance for January stood at 88% and whilst this was not at trajectory, this had further improved for February at 92%. She stated that the target was impacted by flow, and optimal flow would not be in place until adequate medical staffing was available and the Department was at full establishment for midwives. She stated that whilst the Trust was close to achieving full establishment for midwives, recruitment to obstetric medical staff was continuing to take place following approval of the business case. Mrs Riley added that the Trust had raised the issue of the triage target with the region due to the disparity of targets, due to there being no national guidance. She stated that this was being considered at a regional/national level in terms of identifying a consistent metric and highlighted that the Trust's target was higher than peers. Mr Wakefield referred to performance in April, May and June which was high 80% and when compared to current performance, this did not seem to correlate. Mrs Riley stated that staffing and activity needed to be considered alongside performance. Professor Hassell stated that an issue previously raised by the CQC was in relation to triage and patients being in direct sight, and he requested an update on this. Mrs Jamieson highlighted that 24/7 cover was now in place and a new reception area had been built so that patients were visible. Mr Wakefield thanked Mrs Jamieson for the improvements made. **The Trust Board received and noted the assurance report and dashboard.** Mrs Jamieson left the meeting.	**AMR/SJ**
8.	**Maternity Serious Incident Report**	
038/2024	Mr Wakefield referred to the recommendation regarding how reporting of maternity serious incidents fit in with the Patient Safety Incident Response Framework (PSIRF) and queried whether this had been clarified. Mrs Riley stated that reporting would follow the same process as for other patient safety incidents. **The Trust Board received and noted the report.**	
9.	**Quality Governance Committee Assurance Report (29-02-24)**	

039/2024	Professor Hassell highlighted the following from the assurance report: • The number of clostridium difficile cases was above the upper limit • A number of areas on the Infection Prevention Board Assurance Framework were noted as having partial assurance, and detail of the actions underway for these areas had been provided separately • Following an increase in Hospital Acquired Thrombosis, a deep dive had been undertaken which highlighted the Trust had followed guidance and patients had been managed accordingly, with no clear theme for the rise. It was noted that the rate had subsequently dropped • An update on measles and the number of confirmed cases and information on staff immunity was to be provided to a future meeting • Further discussions were required following the internal audit findings in relation to the Mental Capacity Act (MCA) Framework Professor Crowe referred to the MCA internal audit and the need to ensure that a robust process was in place for reviews. He welcomed the comment made in respect of holding separate discussions on the audit and the process followed. Mrs Riley highlighted that she was to discuss this with the internal auditors to agree the next steps and she agreed to provide an update to Professor Crowe and Professor Hassell, before providing a summary of actions taken to the Audit Committee. Mr Wakefield referred to the number of c-difficile cases and requested an update on the actions undertaken. Mrs Riley stated that a number of areas had been reviewed, such as individual practice, antibiotic usage and working with antimicrobial stewards. She stated that despite the positive assurance provided, the number of cases had not reduced to an acceptable level although no concerns had been raised by the region in terms of practice, and this continued to be monitored. Ms Bowen referred to the action regarding Your Next Patient (YNP) and Professor Hassell stated that the action referred to receiving clarification of the incidents and whether these were due to the YNP process or flow. **The Trust Board received and noted the assurance report.**	
10.	**Q3 Infection Prevention Board Assurance Framework (IPBAF)**	
040/2024	Mrs Riley highlighted the following: • The IPBAF had been updated and of the 10 criteria, 5 had been assessed as partially compliant. Detail on the actions to be taken for these areas had been provided to the Quality Governance Committee (QGC) and by the time of the next update, it was expected that a number of actions will have been closed • A visit had been undertaken to the laundry plant in relation to criteria 2, and further actions were in place with regards to measles Mr Wakefield referred to the six amber areas for criteria 2 and queried whether Mrs Riley was confident in the ability to address these areas. Mrs Riley stated that she expected four out of the six areas would be compliant by the time of the next report, with plans in place for the remaining areas. **The Trust Board received and noted the report.**	
11.	**Care Quality Commission Action Plan Update**	
041/2024	Mrs Riley highlighted the following:	



	• Main areas of challenge related to Speech and Language Therapy (SLT) and a review of the service and activity had been undertaken, the detail of which was being worked through. It was noted that a staffing deficit was expected to be highlighted, but further detail on the referral process was required to be provided • In terms of the mental health actions, monthly audits were taking place and an update on the actions were being provided to the CQC on a monthly basis. A month-on-month improvement had been identified, but full compliance on the actions would not be provided until the CQC had undertaken a follow up inspection • In terms of the maternity actions, information on the section 29 notice had been provided to the CQC. In addition, representatives from the CQC attend the System Maternity Oversight and Assurance Group (SMOAG) to receive further assurance on the actions taken Mr Wakefield requested clarification of the statement regarding the five actions which were to be reviewed in respect of whether these could be managed via business-as-usual processes. Mrs Riley stated that a number of actions had been identified which were already monitored via business as usual monitoring such as PDR and training compliance, and were therefore monitored via that process as opposed to remaining on the action plan. Ms Bowen referred to use of the mental health tool and queried whether this was under or overachieving. Mrs Riley stated that an improvement was being made and she agreed to formally provide the audit data to the QGC as further assurance. Mrs Cotton highlighted ongoing work in respect of the self-assessment process and the way in which controls and assurances were being identified. She highlighted that where any negative assurance had been noted, actions associated with this would be monitored via the risk management process. Dr Griffin referred to the SLT and queried the actions taken to date. Mrs Riley stated that temporary support had been put in place at County Hospital and the review had included benchmarking against best practice, in order to inform future recommendations. Mr Wakefield queried, should there be a CQC visit tomorrow, whether the Trust would expect a better outcome. Mrs Riley stated that this would depend on what the CQC was to review, but if they were to review the same areas as before, they should recognise the mitigation put in place for maternity and County Hospital. **The Trust Board received and noted the update.**	**AMR**
RESOURCES		
12.	**Performance & Finance Committee Assurance Report (27-02-24)**	
042/2024	Ms Bowen highlighted the following escalations and positive assurances from the report: • The capital programme was behind plan, but it was expected that the programme would be delivered • The financial outlook identified a potential underlying deficit of £47.1 m and discussions were ongoing regarding the Trust's share of the system deficit • Delays to the business case review process were highlighted and the Committee requested strengthening of the process and improved timing of receipt of future case reviews	

	• The Trust had delivered a financial position of £2.1 m deficit which was in line with the projected break-even year end position • Additional capacity was to be sourced for endoscopy • A review of international recruitment of nurses had resulted in a positive reduction of agency staff Dr Griffin echoed the importance of business case reviews and the importance of capturing outcome of cases previously approved. **The Trust Board received and noted the assurance report.**	
PEOPLE		
13.	**Transformation & People Committee Assurance Report (28-02-24)**	
043/2024	Ms Bowen highlighted the following escalations and positive assurances from the report: • Further detail was required in relation to the strategic planning framework • Workforce challenges had been escalated in respect of the research team with mitigating actions being taken • There had been some delays with the Electronic Prescribing programme and the Committee requested further assurance in relation to this • EPR funding for 2025/26 had not yet been identified and a delay in confirmation of this was expected • The Trust had successfully rolled out the Office 365 programme • The Trust's work on sexual safety had been recognised nationally as good practice **The Trust Board received and noted the assurance report.**	
14.	**Q3 Speaking Up Summary**	
044/2024	Mrs Cotton highlighted that Quarter 3 had the highest number of concerns raised which correlated with the work undertaken in respect of Freedom to Speak Up Month. Mr Wakefield referred to increase in Q3 and the Trust's position relative to others on anonymous cases and cases of detriment. Mrs Cotton highlighted that work had been undertaken on focussing on cases of detriment, which had been considered by the Board Seminar. She stated that guidance had been provided on clarifying what was classed as detriment, with a leaflet provided to anyone raising concerns. In addition, further work on the processes surrounding detriment was to be undertaken, although these were discussed with Professor Hassell. Mrs Cotton added that in respect of anonymous cases, work was undertaken to reassure staff that their cases would be handled confidentially. Mr Wakefield queried the link to speaking up with the wider cultural programme and Mrs Cotton confirmed that this formed part of the Trust's People Strategy, enabling staff to have a voice. She stated that the aim was to see less concerns being raised through the service, due to these being handled at a local level. **The Trust Board received and noted the summary.**	
RESPONSIVE		
15.	**Integrated Performance Report – Month 10**	



045/2024	Mrs Riley highlighted the following in relation to quality and safety performance: • Incidents resulting in moderate harm had spiked, marginally in relation to falls and pressure ulcers and these were being investigated • Slow progress was being made in relation to timely observations and each Division had this as a driver metric, with leader standard work in place regarding the process to be followed Mr Evans highlighted the following in relation to urgent and emergency care performance: • Following the increase in ambulances in December the Trust had continued to work with West Midlands Ambulance Service (WMAS) and improvements had been made to ambulance turnarounds, and this remained an area of focus • Performance metrics in January had deteriorated but the Trust remained largely comparable with other Trusts across the region • The Trust had continued to drive improvement in the areas articulated at February's meeting, whilst continuing to deal with Industrial Action and critical incident • There had been a day with zero patients waiting for more than 12 hours in February, and there had been a consistent reduction in the number of people waiting more than 12 hours in the Emergency Department • Discussions continued to be held regarding the 4 hour target and the Trust remained in the upper quartile for most improved performance, both relatively and actual. It was noted that the ability to achieve the 76% target for March would be challenging given present performance ranged between 60% to 70% Professor Maddock referred to ambulance handovers and the improving performance and queried whether this correlated with the reason for the increase in ambulances. Mr Evans stated that as ambulance delays reduced, performance at a local and system level was considered and the actions required. Dr Griffin referred to GP streaming and the increase in the number of patients referred to the model, and queried, given pressures at County Hospital, whether a similar streaming model could be introduced. Mr Evans stated that this had previously been considered and a decision had been made to increase demand at County Hospital whilst there were pressures at Royal Stoke. He stated that it was too early to decide what actions were required at County Hospital, as confirmation of the impact of present interventions was required. Ms Ashley added that this option had been previously explored but funding challenges had been identified. Ms Bowen referred to the alternative forms of care introduced such as acute care at home, call before convoy and requested information on the various alternative pathways and how they worked with each other. Mr Evans suggested exploring this separately with Non-Executive Directors. He stated that acute care at home was being utilised to support patients staying at home and helping patients to go home sooner, whereas call before convey enabled appropriate signposting to take place. Mr Wakefield referred to the 76% target and when considering the total time spent in the Emergency Department, the Trust was 53rd out of 105 units. He queried how it was possible to achieve 76% given the regional and national challenges. Mr Evans stated that the work already undertaken to create portals would help and added that the two metrics were starting to align, although performance depended on the proportion of patients admitted to the Emergency Department. Mr Evans stated that he was encouraged by recent performance and the improvement made which was more than forecast, but there remained risks i.e. further Industrial Action. He agreed to provide further information on conversion rates to the next Performance and Finance Committee (PAF).	**SE**

	Professor Crowe stated that whilst the ambition was to progress to 76% performance, this meant that a quarter of people were not being seen within 4 hours which was not a good outcome and should be noted. He queried the impact on the Trust if it was not to meet the 76% target and Mr Oldham stated that not delivering the target could impact on the Trust's ability to access incentives related to availability of capital, as 50% of the funds related to operational performance. Mr Evans highlighted the following in relation to planned care performance: • There had been a deterioration in 78 week wait performance in January, following previous month on month improvements. The Trust remained committed to delivering a zero position in April 2024, which was considered in the weekly tier 1 sessions • Overall, improvements in planned care performance had been demonstrated, whereby the Trust had moved from 4th worst in the country by 30 places • The Trust awaited formal confirmation of the performance standards for the next financial year • Cancer performance continued to be positive with a reduction of the backlog being the key metric. It was noted that the Trust's ambition was to achieve fair shares allocation • Faster Diagnostic Standard performance continued to be a challenge and the Trust was unlikely to achieve the standard by the end of March although substantial progress had been made • Endoscopy remained the highest area of impact on cancer and planned care performance and despite Industrial Action, capacity had been protected and productivity had continued to deliver improvements. It was noted that continued improvements in capacity was dependent on additional external support Professor Maddock referred to endoscopy and requested clarity of the additional support available. Mr Evans highlighted that the Trust had previously received additional support from the West Midlands Cancer Alliance, non-recurrently, but to deliver the improvements consistently and sustainably, this required recurrent investment. Professor Maddock queried if it was expected that non-recurrent funding would be extended beyond Q1 and Mr Evans confirmed that this would not be available. Mr Wakefield referred to endoscopy and the need to understand the funding restrictions and operational impact at a future PAF. Mrs Bullock stated that many of these were cancer patients and as such would be prioritised although this may cause impacts elsewhere. Ms Bowen queried if the improvement programmes were going to plan, and Mr Evans stated that the programme was going ahead although it was being considered as to whether the programme was ambitious enough. He stated that the level of productivity was being considered as this was behind plan and needed to be addressed. He stated that positive work had been undertaken on Get It Right First Time, but there remained a way to go. Mrs Haire highlighted the following in relation to workforce performance: • Vacancy rates and turnover were consistently delivering below the target • PDR compliance was not progressing as much as expected, and this continued to be managed via performance reviews with a commitment from Divisions on achieving the target. The new PDR paperwork had also been launched • Sickness absence continued to remain static at approximately 5% and this was expected to slightly increase in February	**SE**

	• A recruitment campaign had been undertaken in January with a large-scale social media campaign which had led to an increase in the number of applicants particularly Administrative & Clerical staff • Staff voice response rate was 951 in January which was a little higher than the September position • The National Leadership Competency framework had been received and was being reviewed to determine the actions required Mr Oldham highlighted the following in relation to financial performance: • The Trust had delivered a £2.1 m deficit, which was £2.9 m off plan, although break-even was expected due to the ability to release further annual leave accrual • The Trust had received funding for the costs associated with Industrial Action for December and January • Capital was £4.8 m behind plan and mitigating actions were in place to bring forward items from the 2024/25 programme • The cash position stood at £68.2 m as at the end of month 10 and some additional Public Dividend Capital was to be drawn down, whereby it was expected that the forecast would be in line with plan • 2024/25 system financial position was being considered, as a system deficit of £180 m was anticipated, and the level of cost improvements required in 2024/25 were being considered. A meeting was to take place week commencing 11th March to review the position whilst continuing to wait for the national planning guidance Mr Wakefield referred to the need to demonstrate productivity improvements in light of the Director General of Public Spending and Finance's recent comments. Professor Crowe queried the actions being taken to ensure the Trust's cost improvement trajectory was in a good place, particularly the split between recurrent / non-recurrent savings. Mr Oldham stated that meetings continued to be held on a regular basis with Divisions although this continued to be a challenge. Dr Griffin referred to the need for PAF to focus on productivity and cost improvements, particularly cash releasing cost improvement schemes. **The Trust Board received and noted the assurance report.**	
SYSTEMS AND PARTNERS		
16.	**Health and Wellbeing Strategy**	
046/2024	Ms Ashley highlighted the following: • Key supporting strategy aimed at delivering improvements in the health of the population by working with partners • The framework sought to address health inequalities • There was a need to have a significant impact on priority areas Mr Wakefield stated that he felt the strategy was comprehensive and covered all bases although he was unsure of the timeframe in relation to outcomes. Ms Ashley stated that a supporting delivery plan was to be considered by the Strategy and Transformation Committee. Mr Wakefield referred to Appendix 1 and the indicators listed and suggested that it would be helpful to include a baseline for each measure and the trajectory to 2027. Ms Ashley agreed to highlight examples of where the Trust was able to influence outcomes.	**HA**

	Ms Bowen welcomed the amount of work undertaken to develop the strategy. She agreed with Mr Wakefield's point of including quantitative targets within the outcomes framework and identifying which metrics the Trust was responsible for or able to influence. Mr Wakefield stated that given the difficulties with investments over the next 3 years, he queried how this could impact on delivery of the strategy and this also needed to be identified, in terms of any areas which were dependent on investment. Dr Griffin referred to the health and wellbeing of the population and stated that reference could be given to the work undertaken by the Charity in supporting this priority i.e. working with local communities on tackling loneliness. Mrs Freeman referred to use of data to support improvements, although the vast majority of information was held in siloed information systems and therefore focussing on consolidating systems would provide a richer picture. **The Trust Board approved the Health and Wellbeing Strategy.**	
GOVERNANCE		
17.	**Revised Performance and Accountability Framework**	
047/2024	Mrs Cotton highlighted the following: • The document had been updated linked to the well-led framework • The document included an updated Corporate Governance Structure and a new finance and operations meeting to be introduced from April. In addition, the Professional Standards Committee would directly report to the People, Culture and Inclusion Committee • Requirements in relation to divisional governance had been strengthened • Proposed metrics for the revised Integrated Performance Report / Committee reports had been identified Mr Wakefield welcomed the comprehensive document and referred to the Corporate Governance Structure. He queried whether the Clinical Effectiveness Group should have more groups reporting into it and Dr Lewis stated that more patient outcome related reports could be considered, but the group remained immature in terms of its effectiveness and required additional back office support and this work remained underway. Ms Bowen referred to the corporate governance structure and Divisional Shadow IT Group. She queried whether it was anticipated that the requirement for this would reduce over time. Mrs Freeman stated that this was possible, depending on whether more systems moved to the control of the Information Management and Technology Team. Ms Bowen referred to the Executive Research and Innovation Group and previous discussions regarding innovation. She queried how frequently the document was to be updated in order to capture changes in year to this area. Mrs Cotton highlighted that whilst the document was reviewed annually, reviews were undertaken periodically to include any changes. She added that changes in relation to innovation were not expected within the next 12 months and Ms Ashley stated that whilst innovation would be an area of focus in 2024/25 and any additional forums were expected to be reflected in the 2025/26 Corporate Governance Structure.	

	Ms Bowen stated that the document included an old reference to the Transformation and People Committee. Professor Crowe welcomed the updated document, particularly greater clarity of divisional governance and the link with Improving Together. He queried how effectiveness of the framework would be measured and given that the Committee Effectiveness reviews had not concluded whether any changes needed to be considered after that point. He suggested that a board development session be held in the future in terms of accountability and how this was being built within the organisation and how it worked in practice. Mrs Cotton stated that the outputs of the Committee Effectiveness reviews would feed into the revised Rules of Procedure. She added that in terms of monitoring, this would be considered by the Independent Well-led Review and the Trust's own self-assessment. In addition, divisional governance was audited by the Internal Auditors. Mrs Riley added that the diagram on page 12 should refer to her operationally managing the Director of Midwifery. Dr Lewis queried whether the divisional outcome metrics should be made more explicit in terms of where these were to be taken and Mrs Cotton agreed to discuss this with Dr Lewis. **The Trust Board approved the performance and accountability framework, subject to the above amendments.**	**CC** **CC**
CLOSING MATTERS		
18.	**Review of Meeting Effectiveness and Review of Business Cycle**	
048/2024	No further comments were made.	
19.	**Questions from the Public**	
049/2024	Mr Syme asked the following questions: <u>Capacity</u> He referred to the Same Day Emergency Care Build at Royal Stoke and queried when it would be opening i.e. fully staffed and fully available to treat patients presenting at Royal Stoke. Mr Evans highlighted that the unit was unlikely to be fully staffed until August 2024. He stated that the service may commence before that time, but in a phased approach. Mr Syme queried if the build would be finished by the end of March and Mrs Whitehead stated that due to some ground condition issues, this had impacted on the timeframe, and it was the aim for the build to be delivered by July 2024. <u>Finance 2024/25</u> Mr Syme referred to the potential underlying deficit of £47.1 m for 2024/2025 and requested clarification of this and what would be the main drivers of the deficit risk.	

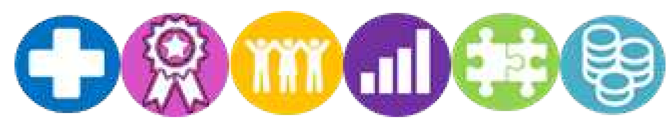
	Mr Oldham stated that £180 m was the in-year position after delivering cost improvements and that the underlying position was worse than that. He added that £91.4 m related to the system deficit, primarily within the ICB which had been driven by assumptions regarding inflation and growth which had not come to fruition. He stated that £47.1 m related to the underlying deficit for UHNM, due to non-recurrent cost improvements and use of balance sheet releases. <u>A&E 4 hour Performance</u> Mr Syme referred to the NHS England directive to NHS Hospital Trusts that they are all to achieve the 76% 4 hour A&E standard in March. He asked the following: (i) What would be financial benefit if UHNM did manage to achieve the 76% A&E standard in March (ii) Whether there were stipulated penalties for non-attainment and if so what would those be for UHNM? Mr Oldham stated that £150 m had been linked to achievement of the performance standard, with capital monies to be added to the 2024/25 programme. He stated that this was to be allocated on two factors; achieving 80% of the 4 hour target during Quarter 4 and completing 90% of ambulance handovers within 30 minutes during Quarters 3 and 4. He stated that the Trust was not expecting to achieve this and the penalty would be not being able to access the funding. Mr Evans stated that a review of criteria may be undertaken. Mr Oldham stated that he was expecting the system to receive £1.4 m as a result of achieving the financial target. (iii) How UHNM could attain this standard without severely curtailing elective work given that nationally, not just locally, the 76% A&E standard hasn't been attained in any month of this year? Mr Evans stated that there had been two months where the Trust had got close to delivering over 70% in the past 12 months, and this was at a time when the Trust had not curtailed electives. He confirmed that any plans would not impact on cancer care and delivery of the target remained a high risk due to the impact of the Easter period.	
DATE AND TIME OF NEXT MEETING		
20.	**Wednesday 3rd April 2024, 9.30 am, via MS Teams**	

Trust Board (Open)

Post meeting action log as at 27 March 2024

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/586	03/01/2024	Integrated Performance Report – Month 8	To provide an update on admission avoidance schemes at a future Performance and Finance Committee.	Simon Evans	~~27/02/2024~~ 26/03/2024		**Update to be provided.**	A
PTB/588	07/02/2024	Integrated Performance Report - Month 9	To provide an update to all board members on the revised NHS England guidance on what should be reported on in terms of ethnicity.	Helen Ashley	03/04/2024	27/03/2024	Information circulated to Board Members.	B
PTB/590	06/03/2024	Chief Executive's Report – February 2024	To share the plans for the Cancer Centre, as a result of the Coates Foundation donation, with members of the Board.	Lisa Thomson	08/05/2024		Action not yet due.	GA
PTB/591	06/03/2024	Maternity Dashboard - January 2024	To provide an update on the outstanding CQC actions to a future Maternity Quality Governance Committee.	Ann-Marie Riley	22/05/2024		Action not yet due.	GA
PTB/592	06/03/2024	Care Quality Commission Action Plan Update	To provide further assurance to the Quality Governance Committee in respect of the audit data into use of the mental health tool.	Ann-Marie Riley	02/05/2024		Action not yet due.	GA
PTB/593	06/03/2024	Integrated Performance Report - Month 10	To provide an update on endoscopy funding and operational impact at a future Performance and Finance Committee	Simon Evans	30/04/2024		Action not yet due.	GA
PTB/594	06/03/2024	Health and Wellbeing Strategy	To provide a supporting delivery plan to a future Strategy and Transformation Committee, in addition to including quantitative targets, both baseline and trajectories, within Appendix 1,	Helen Ashley	01/05/2024		Action not yet due.	GA
PTB/595	06/03/2024	Revised Performance and Accountability Framework	To make the suggested amendments to the document.	Claire Cotton	03/04/2024	07/03/2024	Complete. Amendments made and final version circulated.	B



Chief Executive's Report to the Trust Board

March 2024

Part 1: Contract Awards and Approvals

2.1 Contract Awards and Approvals

Since 14th February to 14th March 2024, 5 contract awards over £1.5 m was made, as follows:

- **Supply Chain Coordination Limited (SCCL) - Trust wide Annual Expenditure - Amendment for outstanding 23/24 invoices (e-REAF 13502)** supplied by Supply Chain Coordination Limited, for the period 01.04.23 - 31.03.24 at a total cost of £8,000,000.00, approved on 07/03/2024
- **Holistic Cancer Centre - Final design and construction works (e-REAF 13417)** supplied by IHP Vinci Construction Ltd, capital bid, at a total cost of £3,059,570.51, approved on 07/03/2024
- **Breast Care Unit (e-REAF 13402)** supplied by IHP Vinci Construction Ltd, for the period 01.04.24 - 31.03.25 at a total cost of £1,511,967.14, approved on 07/03/2024
- **Services of Junior Doctors via Health Education England Contract with St Helens & Knowsley Hospitals (e-REAF 13326)** supplied by St Helens & Knowsley Hospitals Teaching NHS Trust, for the period 01.04.24 - 31.03.25 at a total cost of £3,480,000.00, approved on 07/03/2024
- **Cytotoxic Dose Banded - Chemo, Immunotherapy and Monoclonal Medicines (e-REAF 13289)** supplied by Baxter, Qualasept Bath ASU, Sciensus Pharma, Quantum Pharmacutica, for the period 01.07.24 – 30.06.25 at a total cost of £14,000,000.00, approved on 07/03/2024

In addition, the following eREAFs were approved at the Performance and Finance Committee on 25th March. These require Trust Board approval due to the value:

Off-Site Storage for Health Records (e-REAF 13299)

Contract Value	£2,383,440.00 incl. VAT
Duration	01.04.24 – 31.03.29
Supplier	Iron Mountain UK Ltd

Day-Case Unit at County Hospital (e-REAF 13737)

Contract Value	£5,097,335.40 incl. VAT
Duration	(Capital Bid 6742)
Supplier	IHP Vinci Construction Ltd

The Trust Board is asked to approve the above eREAFs.

2.2 Consultant Appointments – March 2024

The following provides a summary of medical staff interviews which have taken place during March 2024:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Consultant Cardiothoracic Anaesthetist	Vacancy	Yes	TBC
Consultant Hepatologist	Vacancy	Yes	TBC
Consultant Anaesthetist special interest in Vascular & Pre-assessment	Vacancy	TBC	TBC
Locum Consultant Cardiothoracic Anaesthetist	Vacancy	Yes	TBC

The following provides a summary of medical staff who have taken up positions in the Trust during March 2024:

Post Title	Reason for advertising	Start Date
Locum Consultant Neonatologist	Extension	20/03/2024
Locum Consultant Gastroenterologist	Vacancy	14/03/2024

The following table provides a summary of medical staff vacancies which closed without applications / candidates during March 2024:

Post Title	Closing Date	Notes
Locum Oral & Max	12/03/2024	No Applications
Locum Respiratory Consultant	17/03/2024	No Applications

2.3 Internal Medical Management Appointments – March 2024

The following provides a summary of medical management interviews which have taken place during March 2024:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Lead - Dermatology	Vacancy	Yes	TBC
Clinical Lead - Orthodontics	Vacancy	Yes	TBC
Clinical Lead - Ophthalmology	Vacancy	Yes	TBC
Clinical Lead - ENT	Vacancy	Yes	TBC
Clinical Lead - Restorative Dentistry	Vacancy	Yes	TBC

No medical management have taken up positions in the Trust during March 2024.

The following table provides a summary of medical management vacancies which closed without applications / candidates during March 2024:

Post Title	Closing Date	Notes
Clinical Lead - Respiratory Medicine	17/03/2024	No Applications
Clinical Director for Specialised Medicine	19/03/2024	No Applications

Part 2: Highlight Report

High Quality Responsive People Improving & Innovating System & Partners Resources

National / Regional

1.1 CQC Inspection – Emergency Department

On Thursday 14th March, the Care Quality Commission (CQC) made an unannounced visit to our Emergency Department (ED) as part of their new winter assurance programme. We were the first in the region to have this new type of inspection and whilst this was not a rated inspection visit, it is important for our regulators to see the efforts we are making to keep our patients safe. We received some initial feedback, with the inspection team reporting that despite it being a very busy day, it was a positive visit. They thanked all those in ED for making the inspectors feel welcome and said staff spoke about enjoying working in the department, they felt able to raise concerns if needed and were supported by leaders. They said the department had a positive culture.

During the day long visit, inspectors reviewed the use of the corridor in relation to numbers of patients and the criteria for patients with risk of falls or dementia. They also queried diverting ambulances to County Hospital and the process used, which the team were able to explain in full.

I have expressed my thanks to all involved in the visit and for taking the time to speak to the inspection team. An official report is to follow and that will be shared once available.

1.2 NHS England Midlands Region Chief Nurse Visit

On Friday 15th March, Professor Nina Morgan, Chief Nurse at NHS England Midlands Region visited Royal Stoke to see our maternity unit and talk to colleagues about the service improvements we have been making.

Professor Morgan spoke highly about the midwifery team she met, commenting on their positivity and the work they were doing to deliver outstanding services.

Again, the formal feedback will be shared with the Board when it is available although I was very pleased to receive the verbal feedback provided. I know this positive recognition will be a well-deserved boost for the staff within the maternity unit who have worked so hard on a range of improvement initiatives for our patients.

System / Regional Focus

1.3 Laboratory Information Management System (LIMS)

Within the month our Laboratory Information Management System (LIMS) saw a very successful major change over to a new IT system. The hard work done by the North Midlands and Cheshire Pathology Service (NMCPS) teams really paid off in making this a smooth transition, despite the programme encountering many challenges along the way. My thanks go to all involved in the effort and planning which made the change such a success.

1.4 Midlands Imaging Training Academy

It was great to hear news that the Midlands Imaging Training Academy (MITA) has been shortlisted as a finalist in three separate categories at the 2024 Health Services Journal (HSJ) Digital Awards, recognising digital projects transforming care delivery, enhancing efficiency and improving patient outcomes. The categories are:

- Digital Team of the Year
- Digital Innovator of the Year
- Enhancing Workforce Engagement, Productivity and Wellbeing through Digital

Following a thorough judging process, ahead of the official awards ceremony to be held on 6 June 2024, it was recognised that the Academy stands out as a real 'success story' worthy of a prized place on the panel's shortlist. I wish them all the very best.

1.5 Working with our Partners

As part of the Integrated Care System, we work closely with all our NHS and local authority partners and so were pleased to welcome our colleagues from North Staffordshire Combined Healthcare NHS Trust for another joint executive meeting. Whilst it is a mental health trust, we do share a number of challenges and we took the opportunity to address some of the issues we face collectively and share where we are in relation to planning for the next year. These types of meetings are also great for building relationships where we need to work together for the benefit of our local population.

Organisational Focus

1.6 Celebrating our Staff

Recognising the amazing work of our people is very important and it has been great to see the featured stories on our 600 healthcare scientists as well as those involved in the Clinical Nurse Specialist Day. It is fantastic to see so many of our people joining in and celebrating their profession and the key role they play in delivering exceptional care.

I was also pleased to hear that two of our consultants have been made Professors by Keele University; Dr Mark Lambie consultant in Renal Medicine and Nephrology and Ms Pensee Wu, Honorary Consultant Obstetrician and Subspecialist in Maternal Fetal Medicine. This is great news for Pensee and Mark, the units they work in and for us at UHNM. These awards aligns with our strategic priority to be a leading centre in research and innovation and my congratulations go to Mark and Pensee.

We also held a celebration day at County Hospital, where staff took time to reflect and enjoy the amazing journey and successes achieved by everyone working at the hospital. It was a pleasure to be part of the celebrations and my thanks go to those involved in making it such a success.

At the HSJ Partnership Awards on 21st March, we were awarded first prize 'gold' for the partnership with Becton Dickenson and NHS Supply Chain in the 'value-based procurement pilot to improve clinical practice and patient experience' category. Another great example of how we are living our values and working together to deliver our strategic priorities.

1.7 Nursing & Midwifery Excellence in the Midlands

I was really pleased to receive news that we have been selected as an exemplar organisation for Nursing & Midwifery Excellence and our Chief Nurse has been invited to participate in an interview to showcase UHNM in published case studies.

The case studies will cover our accreditation arrangements, meaningful recognition, quality improvement, distributed leadership and research along with some of the positive impacts we have seen as a result.

It is great to see this sort of recognition and is very much welcome and deserved.

1.8 Supporting Staff during Ramadan

During the month we saw the start of Ramadan and we have shared some very helpful information from the NHS Muslim Network to our staff, line managers and senior leaders which not only explains Ramadan but also provides guidance on how to support colleagues who are fasting at this time.

Also, on the 21st March Jane, Lisa and I along with a number of staff from the People Directorate and Organisational Development, were privileged to participate in Iftar after fasting for the day. This was a hugely successful event organised by our staff and saw over 50 of our colleagues who celebrate Ramadan take part. Based on this there is huge appetite for doing something even more spectacular next year.

We recognise that this is an incredibly important time for our Muslim colleagues and wish them health and happiness during Ramadan Mubarek.

Highlight Report

Quality Governance Committee 28th March 2024 to Trust Board

Matters of Concern / Key Risks to Escalate

For information:

- Results from the 2023 national maternity survey highlighted similar scores as per the 2022 survey, and patient choice was a particular area of challenge, although this was hoped to improve following the reintroduction of the home birth service, and the 2024 survey about to commence
- Eight adult inpatient wards had been identified as requiring additional monitoring or support, 6 of which had been awarded a bronze Care Excellence Framework (CEF) award; the way in which the process was being strengthened was highlighted, which included a patient representative at support meetings
- Two maternity incidents were reported in February, although neither met the threshold for a Patient Safety Incident Investigation (PSII), in addition to three cases having been referred to Healthcare Safety Investigation Branch (HSIB). Further actions were also being taken to address compliance in relation to level 4 safeguarding training
- An update in relation to a national issue was provided, regarding the Very High Risk Screening Programme, whereby 47 women had been identified and asked to make an appointment for urgent screening, which were to take place by June 2024.
- One never event had been reported in February and a deep dive was to be provided to QSOG in relation to lessons learnt given the previous never events in relation to wrong site surgery
- A Preventing Future Deaths report identified issues with the subsequent action taken by General Practitioners following receipt of outpatient letters and this was being discussed with system partners.

Major Actions Commissioned / Work Underway

- Complaints response time targets were to be reviewed as part of reviewing the complaints policy
- To consider the way in which the Patient Experience team could improve their confidence in obtaining ethnicity data in relation to complaints
- Ongoing work was being undertaken in respect of tackling e-coli and clostridium difficile cases across the Trust, given the number of cases having been confirmed
- Work was being undertaken to further understand how the Trust could improve interactions and engagement with pregnant women in ethnic minorities / areas of deprivation
- An update in relation to the actions being taken to improve friends and family results was to be undertaken and provided to QSOG
- To provide an update in relation to 7 day services and the way in which future audits would be undertaken, to the Committee in June

Positive Assurances to Provide

- An update on the cardiothoracic surgical review highlighted that good progress had been made in completing the action plan; with 6 actions outstanding, all of which were ongoing and subject to a business case, although this was being phased and alternative options were being considered. It was agreed that due to the assurance provided, that the remaining actions could be covered via business as usual reporting
- Four patient safety partners had been recruited and allocated a harm, a new end of life volunteers programme had been launched and no complaints cases had been upheld by the Parliamentary and Health Service Ombudsman (PHSO) in over 12 months. Friends and family feedback remained stable at a response rate of 21% and whilst this was below the Trust target, it was the fourth highest response rate when compared to peers
- The quality report for County Hospital highlighted that the number of falls remained static and Hospital Associated Thrombosis rates had stabilised. A recent County Away Day had been held whereby 100 members of staff had been in attendance
- A summary of the MBRRACE-UK Annual Report of the Confidential Enquiry into Maternal Deaths and Morbidity was provided, and it was highlighted that the majority of key recommendations had been implemented by the Trust, although work was required in respect of pre-pregnancy counselling, and this was subject to an ICB led steering group
- Recruitment of midwifery staff had continued to improve in line with trajectory, in addition the Committee welcomed the improvement in induction of labour and triage time figures. The Committee also welcomed the positive feedback provided by Professor Nina Morgan, after her recent visit to the Trust
- An update on 7 day services was provided which highlighted that the Trust was fully compliant with three of the four key standards (2, 5, 6), and partially compliant with the remaining key standard (8) as a formal audit in relation to this standard had not been undertaken since 2019
- Following an audit of outpatient letters, the proportion of letters sent to patients (cc GP) rose from 31% in 2022 to 84% in 2023.

Decisions Made

- It was agreed to monitor the progress in relation to screening the 47 patients identified by the Very High Risk Screening Programme, via the Quality and Safety Oversight Group (QSOG), with any issues to be escalated to the Committee as required

Comments on the Effectiveness of the Meeting

- The Committee welcomed the papers presented to the Committee and areas of discussion

Summary Agenda

No.	Agenda Item	BAF Mapping: BAF No.	BAF Mapping: Risk	BAF Mapping: Assurance	Purpose	No.	Agenda Item	BAF Mapping: BAF No.	BAF Mapping: Risk	BAF Mapping: Assurance	Purpose
1.	Patient Experience Report Q3 23/24	BAF 1	High 12		Assurance	6.	Cardiothoracic Surgery Review Update	BAF 1	ID17967 ID24253		Assurance
2.	Head of Nursing County - Report Q3	BAF 1	High 12		Assurance	7.	Breast Imaging Response to NHSE Very High Risk (VHR) Screening Programme Issue – Executive Briefing	BAF 1	ID31553		Assurance
3.	Nursing and Quality Report: Quarter 3 2023/2024	BAF 1 BAF 2	High 12 Ext 16		Assurance	11.	Quality Performance Report – Month 11 23/24	BAF 1	High 12		Assurance
4.	Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019 - 21	BAF 1	High 12		Assurance	12.	7 Day Services Update	BAF 1	High 12		Assurance
5.	Maternity Dashboard: February 2024	BAF 1	ID15993		Assurance	13.	Quality & Safety Oversight Group Highlight Report	BAF 1	High 12		Assurance

Attendance Matrix

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Prof A Hassell	AH	Associate Non-Executive Director (Chair)												
Mrs C Cotton	CC	Director of Governance			NH	NH		NH		NH	NH	NH	NH	NH
Mr S Evans	SE	Chief Operating Officer	PB											
Ms A Gohil	AG	Non-Executive Director												
Mrs J Haire	JH	Chief People Officer				KMy								
Dr M Lewis	ML	Medical Director				ZD		AM						
Prof K Maddock	KM	Non-Executive Director												
Mr J Maxwell	JM	Head of Quality, Safety & Compliance												
Mrs A Riley	AR	Chief Nurse	JHo			JHo	JHo		FH					
Prof S Toor	ST	Non-Executive Director												

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3 April 2024
Report Title:	Maternity Dashboard: February 2024	**Agenda Item:**	8
Author:	Sarah Jamieson - Director of Midwifery & Jill Whitaker – Deputy Director of Midwifery – Workforce & Gynaecology		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

ID	Title	Risk level
13419	Midwifery safe staffing (entered following Birth Rate Plus establishment review 2019)	9
13420	Lack of activity at Freestanding Midwifery Birth Unit (FMBU), County leading to suspension of intrapartum care	6
11518	No current operational Midwifery Continuity of Care team	6
15993	Maternity Assessment Unit Triage	12

Executive Summary

Situation

The Maternity Dashboard report provides an overview of the Maternity performance for February 2024.

Background

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

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

Assessment

- Midwifery staffing continues to be a challenge but is improving gradually.
- CNST targets have now been achieved.
- Work continues to improve maternity triage times.
- Work continues to reduce the induction of labour breaches.

Key Recommendations

The Trust Board is asked to receive this report.

Maternity Monthly Dashboard

7th February 2024 (February report)

1. Introduction

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

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

Figure 1: Minimum Data Set

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

Report on:

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

2. Assessment

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

In February 2 incidents were reported via the PSIRF incident response.

- Term baby delivered by failed forceps - cat 1 LSCS, admitted to the NNU and developed seizures on day 2.
- Drug error in theatre.

2.Training compliance for all maternity staff groups.

We are very pleased to confirm that the target for 90% compliance for PROMPT emergency training has been achieved and this data has been submitted as evidence of achieving this element on CNST safety action 8.
December figures indicate a slight fluctuation in the percentage, this is as people become out of date within the rolling year.
All training is now prebooked by the ward managers.

Figure 2 - Staff Training Figures Virtual PROMPT Training.

Training has continued through February.

Compliance has remained good for doctors including and anaesthetists, midwife and support worker compliance has dropped slightly but this will improve over the coming months.

(MARCH 2023 – FEBRUARY 2024

	Doctors	Obs consultants	Obs trainees	Anaesthetist	Anaes consultants	Anaes trainees	Midwives/Bank	CSW	TOTAL THEATRE NOT INC	Theatre	HDU NURSES
*Total number staff	64	17	47	58	27	31	335	106	563	7	4
Staff trained (inc PROMPT Trainers)	60	14	46	53	26	27	286	94	493	5	0
*Current compliance	93%	82%	97%	91%	96%%	87%	85%	88%	87%	71%	

The HDU nurses are new in post and training has been booked.

<u>Figure 2.3 Staff Training Figures FETAL WELLBEING Training.</u>

March 2023-february 2024 inclusive

	Doctors	Obs consultants	Obs trainees	Midwives/Bank	TOTAL
*Total number staff	54	16	38	335	389
Staff trained (inc PROMPT Trainers)	48	15	33	300	348
*Current compliance	88%	93%	86%	89%	89%

Training has continued and maintained as a priority through February.

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

There were 3 HSIB referrals in February.

- The tragic case of the maternal death was referred to HSIB, the baby was cooled and so, was also referred.
- 1 tentative case of suspected HIE was referred, however, this case has not yet been accepted by HSIB

4.Service User Voice feedback.

On 2nd January I was booked in for a planned section, however though unfortunately it was cancelled at 16.30pm. However though, my daughter was born later that evening. I want to say a massive thankyou to midwife Lauren who carried out my observations and placed me on the monitor to check baby's movements and heart rate. Lauren was so friendly and ensured I had my self-examined before going home. Thanks to her; I didn't go home or otherwise I would of given birth at home due to being 4cm dilated when the midwife Gemma checked me later on in the shift. Gemma's enthusiasm and she was so lovely that she had me laughing when I was so nervous for an emergency section. She was so reassuring and I couldn't of asked for better care. Even when I was worried about my little girl after giving birth, she carried out observations on her and reassured me once again. She even looked after my husband and ensured my dressing was dealt with quickly. Thankyou from the bottom of my heart Gemma.

5.Staff feedback from frontline champions and walkabouts.

There were no walkabouts in February.

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

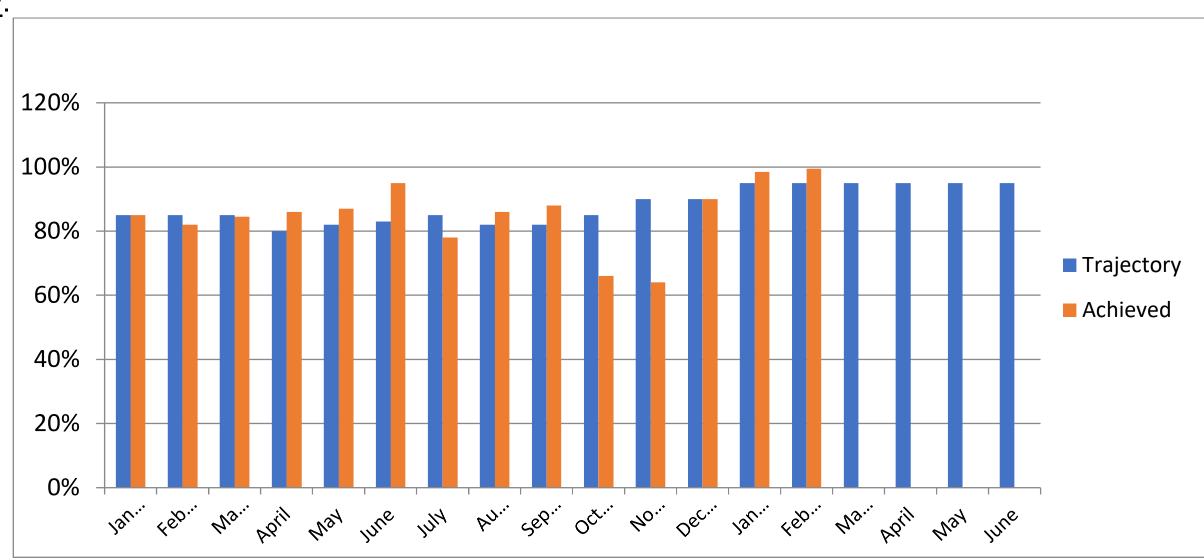
Following a CQC regulatory visit in March 2023, a section 29a safety warning was issued. This was in relation to MAU safety and the Induction of Labour process.

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

6.3 Induction of labour.

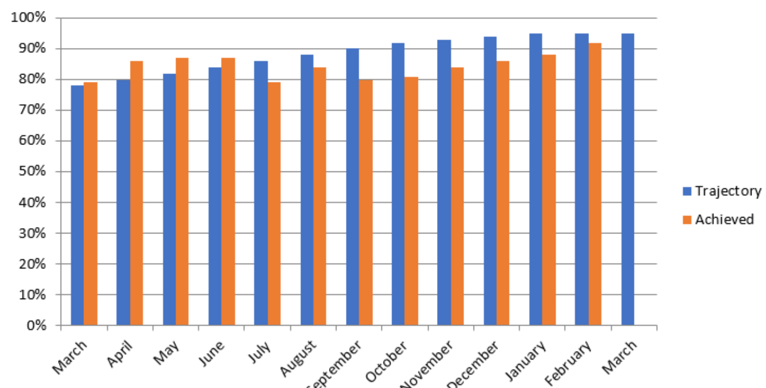
We continue to monitor the birthing people booked for induction of labour and the percentage that breach current guidance. There has been a steady improvement in the percentage of people commencing induction of labour in line with guidance and in February it was above the trajectory.

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



6.4 Midwifery triage within 15 minutes.
The monitoring of midwifery triage times continues. The steady improvement continues in the percentage of people triaged within 15 minutes.

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



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

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

Perinatal review tool	
Maternity service data set	
Transitional care service	

Clinical workforce	
Midwifery workforce	
Saving babies lives V2.0	
Maternity services partnership	
Training	
Trust Safety Champions	
HSIB	

All elements of CNST10 have been achieved and agreed by the ICB and Trust Board.

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

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

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

10. Minimum staffing in maternity services.

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

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

The current midwifery vacancy is 19.17 WTE (7.07%)

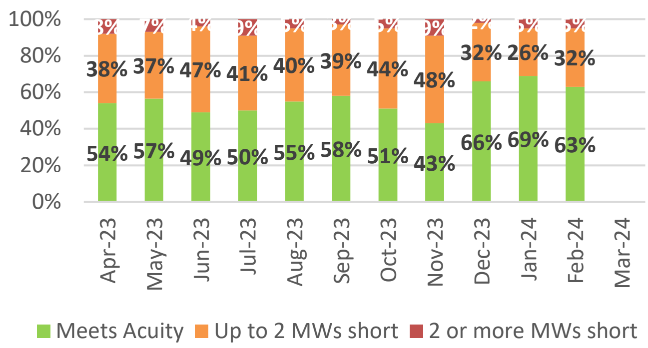
We now have seven international recruits in the unit, 1 is now working independently as a band 5, 4 have passed their OSCE's and are working in a supervised capacity, 2 are booked to take their OSCE's in April. We are also supporting an internationally educated midwife, who was working as a health care assistant in another area of the organisation, to undertake her OSCE. This will further reduce the vacancy by 7 WTE midwives.

Midwifery recruitment trajectory.

Current vacancy	19.17WTE
International recruits who will gain professional UK registration	5 WTE
Recently recruited band 6 midwives	2.4 WTE
Projected vacancy once all in position (May 2024)	11.77WTE

Midwifery staffing acuity.

The chart below shows acuity on the delivery suite.



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

12. The midwife to birth ratio.

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

13.The percentage of specialist midwives employed.

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

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

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

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

The Birthrate Plus data for February confirms that all women received one to one care in labour.
The delivery suite coordinator remained supernumerary at all times.

15. Medical staffing.

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

16. PMRT, Stillbirths and Neonatal Deaths.

In February 10 PMRT were completed. 7 of the reports have been published and graded, all of which were graded A +/or B.

Case 1	B+B (joint with Leighton)
Case 2	B+A
Case 3	B+B
Case 4	B (postnatal care as unbooked and delivered at home)
Case 5	B+B

Case 6 twin 1	B+B
Case 7 twin 2	B+B+A

Categories used to grade the different aspects of care for each death.
A. No issues with care identified.
B. Care issues that would have made no difference to the outcome.
C. Care issues which may have made a difference to the outcome.
D. Care issues which were likely to have made a difference to the outcome.

In February 1 baby was transferred to Alderhey with a congenital abnormality and sadly died.
3 babies died of extreme prematurity, 2 intra uterine deaths occurred, 1 at 26+4 weeks of pregnancy and 1 at 27+1 weeks.

All cases will be reviewed using the PMRT tool.

17. Complaints.
2 complaints regarding maternity services were received in February.
1 in relation to bereavement care and 1 in relation to care on the MAU and ANC, these are being reviewed.

18. Sepsis management.

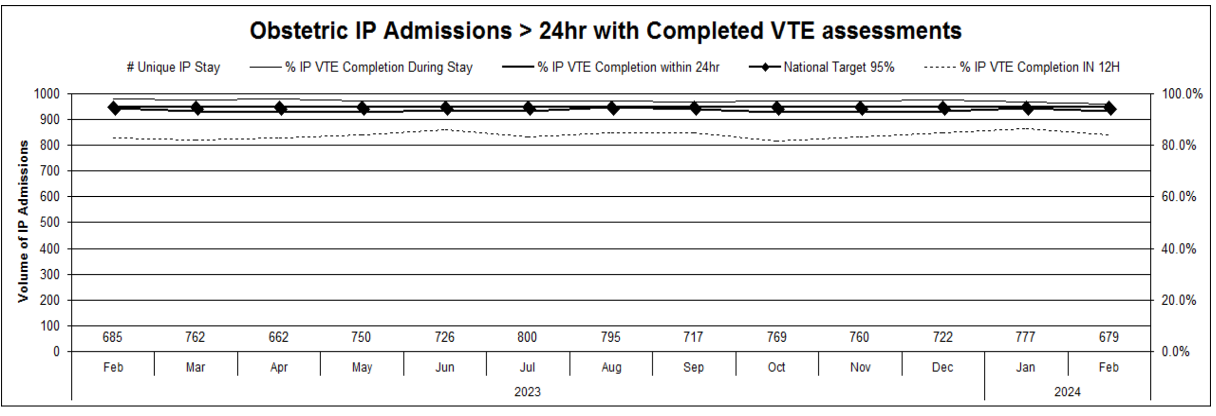
Month	February 2024		
Dept	**Pt Count**	**Screened Count**	**Screened %**
206	5	4	80%
Delivery Suite	3	1	33%
MAU	12	9	75%

The data for sepsis management is based on 5 cases pulled each month.
To look more closely at reasons for reduced compliance a working party has been established. The aim is to have sepsis champions on each area who will be part od the review process for each case. This will lead to shared learning and improvement.

19. Venous Thrombosis Embolism (VTE) management

Thrombosis and thromboembolism were the leading cause of maternal death in 2020-22 (MBRRACE- Jan 24)

VTE assessment is assessed within 12 hours of admission.



Data retrieved from the Badgernet electronic records system shows that the target of VTE assessments within 24 hours is being achieved, however, our aim is to complete the assessment within 12 hours of admission.
The data shows that delivery suite is consistently achieving over 98% in assessment,
MAU are consistently between 60 and 70%, however, the apparent non-compliance is because MAU is an outpatient facility and VTE assessment is only completed on admission to hospital.

Summary and discussion

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

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

Highlight Report

Performance and Finance Committee 25th March 2024 to Trust Board

Matters of Concern / Key Risks to Escalate

For information:

- The colorectal pathway redesign business case review highlighted ongoing challenges in respect of endoscopy, although it was noted that a corporate endoscopy improvement plan was in place. It was agreed to provide revised timescales for the remainder of KPIs which had not yet delivered, alongside the endoscopy business case and plan
- In terms of the 2024/25 financial outlook, discussions remained ongoing in respect of the size of the deficit and the mitigating actions required such pay and non-pay controls
- In terms of the 76% end of March forecast for urgent and emergency care, the Trust was not expected to achieve this, and this presently stood at 69.7%. However, the Trust had regularly discussed the ambition of achieving 70% or above, with regional colleagues, as it was accepted that this would be a significant improvement from previous months. It was highlighted that during February, increased capacity and the resulting critical incident, as well as Industrial Action had impacted on performance
- In terms of planned care, there remained 3 patients waiting over 104 weeks
- The risk in relation to the funding associated with the Community Diagnostic Centre was highlighted and was subject to further discussion

Major Actions Commissioned / Work Underway

- To reflect the risk in relation to availability of capital in future years, and impact on addressing the backlog, within the Estates strategic risk
- An update was provided on the ongoing actions taken in relation to the EPRR core standards assessment, in line with the ambition to move to partial compliance by August 2024
- To continue taking forward actions in relation to inventory management and provide further updates within future quarterly procurement updates
- To provide an update in terms of annual planning at the next meeting

Positive Assurances to Provide

- The colorectal pathway redesign business case review highlighted improvements in triage to test, time to turnaround and reduction of the number of patients on the colorectal patient tracking list in addition the positive impact
- Month 11 financial performance delivered a £3.3 m deficit which despite being £4 m behind plan, was ahead of forecast and the Trust was continuing to project a break-even position. An update in relation to Elective Recovery Fund (ERF) income was provided which demonstrated positive performance. In addition, a reduction in agency spend was highlighted
- Planned care demonstrated positive performance in relation to 78 weeks which was on trajectory and the Trust aimed to reduce the number of patients waiting to single figures by the end of April. In addition, there had been positive performance in relation to the Faster Diagnostic Standard and cancer backlog
- The business case review into neonatal nursing demonstrated an improvement in Qualified in Speciality (QIS) Standards whereby the Trust was on trajectory to achieve 70% compliance by December 2024
- The quarterly procurement update highlighted bottom line savings of £8.17 m, continuing collaboration across the Integrated Care System and potential expansion of the Black Country Target Operating Model.

Decisions Made

- The Committee approved the indicative capital income and expenditure plan for 2024/25, accepting that any significant changes would be represented to the Committee in due course
- The Committee supported taking forward further conversations and seeking approval outside of the Committee in relation to signing the Community Diagnostic Centre Lease, after obtaining assurance from the national team regarding the associated financials and profiling of capital
- The Committee approved the following e-REAFs; Franking Machine Postage Charges (13250), Off-Site Storage for Health Records (13299), Oncotype DX Breast Recurrence Score Test - Specialised Diagnostic Testing for Early Invasive Breast Cancers (13328), Salary Sacrifice Vehicle Leasing - Additional Funds (13386), Supply of IV Fluids (13488), Lease of MRI Mobile Scanner to Support CDC Delivery (13694), Cardiology Consumables, Balloon Catheters & Stents (13705) and Day-Case Unit at County Hospital (13737). It was agreed to delay awarding a contract regarding North Stoke Community Diagnostic Centre (13739) until confirmation of funding had been received

Comments on the Effectiveness of the Meeting

- Committee members welcomed the discussion held and the items of business covered

Summary Agenda

No.	Agenda Item	BAF Mapping: BAF No.	BAF Mapping: Risk	BAF Mapping: Assurance	Purpose	No.	Agenda Item	BAF Mapping: BAF No.	BAF Mapping: Risk	BAF Mapping: Assurance	Purpose
1.	BC-0398 Colorectal Pathway Redesign – 12 Month Update	BAF 5	Ext 20		Assurance	6.	Business Case Review: BC-0477 Neonatal Nursing Workforce	BAF 1	High 12		Assurance
2.	Finance Report – Month 11 2023/24	BAF 8	High 9		Assurance	7.	Stoke on Trent Community Diagnostic Centre (CDC)	BAF 4 BAF 5 /	Ext 20		Approval
3.	Capital Income and Expenditure Plan 2024/25	BAF 8	High 9	-	Approval	8.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	BAF 8	High 9	-	Approval
4.	Performance Report – Month 11 2023/24	BAF 5	Ext 20		Assurance	9.	Quarterly Procurement Update Report	BAF 8	High 9		Assurance
5.	EPRR Core Standards Assurance	-		-	Assurance	10.	Annual Planning			-	Information

Attendance Matrix

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

Attended | Apologies & Deputy Sent | Apologies

Highlight Report

Transformation and People Committee 27th March 2024 to Trust Board

● Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • A higher number of unresolved reports were highlighted in the Guardian of Safe Working Report in part due to Industrial Action. It was agreed to discuss the actions required to address the issue of overnight rest facilities for junior doctors at the Medical Workforce Group • The formal disciplinary report highlighted an increase in cases in relation to sexual misconduct, as anticipated following the Sexual Safety campaign. In addition, the majority of allegations related to unauthorised absence and a number of police investigations as a result of external incidents • The talent and succession planning update highlighted some delays in progressing various workstreams due to the impact of Industrial Action although a work programme was in place for the next 6 months. The impact of various workstreams, in particular career conversations was to be captured in future reports • An update on agency controls was provided which highlighted 1 / 4 area of non-compliance; adherence to price caps and a regional cluster rate was being considered. In addition, it was noted that the Trust was not expecting to meet the national agency target of 3.7%, and this would continue to be a challenge for 2024/25 given the revised 3.2% target. A further area of challenge was highlighted, in relation to reducing the number of top 10 high cost/long term locums • The Chief People Officer report highlighted low completion of the Staff Voice survey and this was to move to a quarterly frequency to prevent survey fatigue, improve survey response rate, and time to respond to issues highlighted through the survey • The Health and Safety report highlighted areas of challenge in respect of compliance with manual handling training in addition to measles immunity checks for members of staff	• To triangulate other sources of information with the Guardian of Safe Working, such as National Education and Training Survey (NETS) survey and Staff Survey • To highlight the impact/outcomes of the actions taken, as well as identifying how success was to be measured, within the 2024/25 positive and inclusive culture programme • To provide further assurance to Performance and Finance Committee, in terms of the actions being taken, and expected impact of these, on achieving the 3.2% agency target • To consider a stretch target for vacancies • An action plan had been identified to address the areas identified within the Health and Safety Executive (HSE) Letter of Contravention
● Positive Assurances to Provide	**Decisions Made**
• The Guardian of Safe Working highlighted that all immediate safety concerns were responded to within an hour, all of which related to workload • Formal disciplinary activity highlighted that 14 / 18 investigations were completed within the 28 day timeframe, in line with the Disciplinary Policy • There had been improvements in 5 / 6 metrics within the Gender Pay Gap Report. The only metric which did not improve was related to the mean bonus pay gap which related to national Clinical Excellence Awards and reforms to this framework were being consulted on, in light of the Mend The Gap recommendations • The Health and Wellbeing review highlighted an improvement in the staff engagement score within the national staff survey, with a future focus on delivering people promise 4 'we are safe and healthy' • Positive progress had been made on reducing the number of vacancies within the Trust and this was to be removed as a driver metric due to the progress made • The Health and Safety report highlighted confirmation of compliance following the previous HSE inspection of the containment laboratory in addition to positive progress made on identifying unsafe sharps within the Trust	• The Committee supported the updated plan for 2024/25 in relation to positive and inclusive culture, which was to be submitted to NHS England as part of the Trust's undertakings • In terms of the Chief People Officer report, the Committee agreed to move the assurance assessment from partial to acceptable assurance, due to positive progress made in respect of the People Plan for 2023/24

Comments on the Effectiveness of the Meeting

- Members welcomed the discussion held in particular, having a quarterly focus on all people related matters

Summary Agenda

No.	Agenda Item	BAF Mapping: BAF No.	BAF Mapping: Risk	BAF Mapping: Assurance	Purpose
1.	Guardian of Safe Working Report Q3	BAF 2	ID28655 ID24272 ID18842	● ●	Assurance
2.	Formal Disciplinary Activity Report Q3	BAF 3	High 12	● ●	Assurance
3.	Gender Pay Gap Report	BAF 2 BAF 3	Ext 16 High 12	●	Assurance
4.	Talent and Succession Planning Update	BAF 2	Ext 16	●	Assurance
5.	Health & Wellbeing Review	BAF 2 BAF 3	Ext 16 High 12	●	Assurance
6.	Positive and Inclusive Culture Programme Updated Plan 2024-25	BAF 3	High 12	-	Assurance
7.	Agency Controls	BAF 2	Ext 16	●	Assurance
8.	Chief People Officer Report M11	BAF 2 BAF 3	Ext 16 High 12	● ●	Assurance
9.	Q3 Health & Safety Report		ID18673 ID22876	● ●	Assurance
10.	Executive Health & Safety Group Highlight Report			-	Assurance

Attendance Matrix

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

Attended | Apologies & Deputy Sent | Apologies

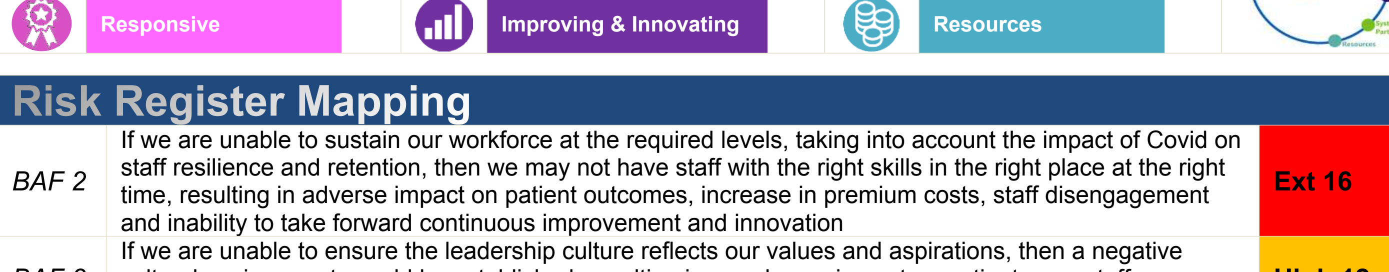
Executive Summary

Meeting:	Trust Board	Date:	3rd April 2024
Report Title:	2023 NHS Annual Staff Survey Report	Agenda Item:	11.
Author:	Priscilla Handley, Assistant Director of OD, Culture & Inclusion Lucy Corbett, OD Service Manager Donna Bailey, OD Consultant, Lead for Employee Experience		
Executive Lead:	*Jane Haire, Chief People 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	X		Systems & Partners	
	Responsive			Improving & Innovating			Resources	

Risk Register Mapping

BAF 2	If we are unable to sustain our workforce at the required levels, taking into account the impact of Covid on staff resilience and retention, then we may not have staff with the right skills in the right place at the right time, resulting in adverse impact on patient outcomes, increase in premium costs, staff disengagement and inability to take forward continuous improvement and innovation	Ext 16
BAF 3	If we are unable to ensure the leadership culture reflects our values and aspirations, then a negative cultural environments could be established, resulting in an adverse impact on patient care, staff disengagement and ineffective performance	High 12

Executive Summary

Situation

Each year NHS staff are invited to take part in the NHS Staff Survey, the largest survey of staff opinion in the UK. The purpose of this report is to provide an update on the 2023 results for our organisation alongside the national comparative data.

Background

The national staff survey measures staff engagement and morale as well as mapping the whole result set against the 7 national people promises. Measuring staff engagement is important for the following reasons:

- One of the key parts of the NHS Long Term Plan is **"Supporting our staff."** The National Staff Survey can be used to assess Trust performance against this goal.
- This supports immediate collective challenge to **improve staff retention** through a **systematic focus** on all elements of the **NHS People Promise**.
- High turnover means that we **lose talent and organisational memory** and **incur costs for recruitment and training**.
- There is a body of evidence that engaged staff deliver better healthcare in terms of **patient experience, safety,** and **outcomes.**
- Engagement is linked to the health and wellbeing of the workforce: scores for the people promise **"We are safe and healthy"** and particularly questions about burnout, correlate with and impact all other people promises.

This year we invited **11,895** substantive staff and **1,659** bank workers to participate in the national staff survey. Considerable efforts were made corporately and divisionally to encourage all staff members to complete the staff survey in 2023. Lessons were learnt from the 2022 survey and extensive work was

completed to ensure the staff data set was as accurate. As a result of the detailed work programme, we achieved a response rate of 45% which is in line with the benchmark group.

The table below shows participation information compared to the benchmark group over the past 5 years.

Year	Number of participants	Response rate	Benchmark Group Response rate
2019	4596	45%	47%
2020	4699	44%	45%
2021	4749	43%	46%
2022	3685	33%	44%
2023	5337	45%	45%

Assessment

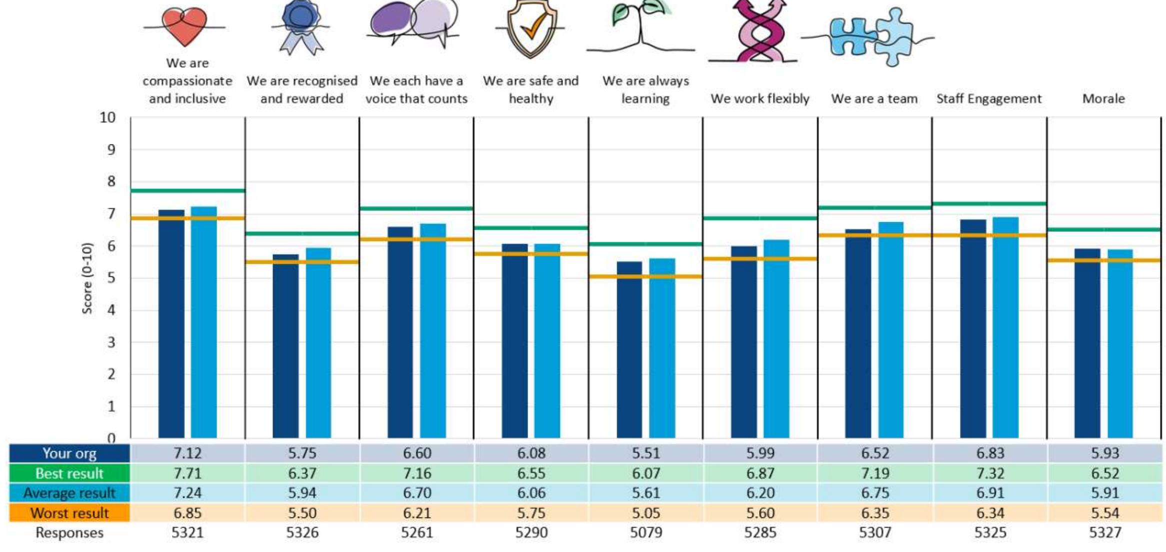
What does the headline data demonstrate?

Our response rates are now in line with the benchmark group at 45%.

The overall Staff Engagement score for the organisation is **6.8** (improving from 6.6 in 2022) and the score for Morale is **5.92** (improving from 5.5 in 2022).

Whilst 2022 was a low year for the staff survey results, we can see improvements from the 2021 results across all the people promises and the results show that the movement is statistically significant.

Chart: National Benchmark Comparison



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.12	5.75	6.60	6.08	5.51	5.99	6.52	6.83	5.93
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	5321	5326	5261	5290	5079	5285	5307	5325	5327

What are the key successes to celebrate?

- Response rates have improved, showing significantly more staff are engaged with the survey and the action the Trust is taking.
- The Trust has made significant improvements in Staff Engagement and Morale scores as well as 5 of the 7 People Promises and we must continue to build on these improvements.
- When comparing the UHNM results from 2022 to 2023 of the 107 question areas, we have improved in 73 questions, remained static on 33 questions, and declined on only 1 question.
- 14 question scores are ahead of the sector benchmark, including staff recommending the organisation as a place for friends and family to receive care.
- The change from 2022 to 2023 staff survey scores for UHNM has shown a statistically significant change.
- Bank staff scores are broadly in line with substantive scores. Bank staff are engaged and enjoy working with their colleagues, but score questions about line management and being involved in changes lower than substantive staff.

What are the areas of focus for 2024?

When compared to the 2023 benchmark group out of the 107 question areas, in 53% (57 questions) are worse than the benchmark group.

We will concentrate on the following areas of focus:
- Continue to build on our work from 2022 aligned to our *culture improvement programme* to understand how we can continue to foster a culture of kindness and respect, strengthening communication around the compassion strand of the Trust values **(People Promise 1: We are compassionate and inclusive)**
- Providing a safe and healthy work climate, identifying actions to address workload pressures and improve wellbeing, as well as reducing violence and aggression, harassment, bullying or abuse in the workplace (by colleagues and service users). **(People Promise 4: We are safe and healthy)**
- Continue to improve the opportunities for staff to share ideas for improvements to processes and systems. Gain commitment from leaders to respond to these proposals constructively and empower staff to implement changes through the Improving Together programmes. **(People Promise 5: We are always learning)**
- We will build on the work that started in 2022 by reviewing flexible working policies and encourage managers to have open conversation with employees about flexible working patterns and promote a healthy work life balance. (**People Promise 6: We work flexibly)**

A review of the workforce race equality indicators demonstrates an improvement in the experience of our colleagues from other ethnic groups in 2 of the 4 questions, but this is still not showing improvement at the rate we would aim to see and is not yet line with our peer average. There is clear improvement requirement and working with our staff networks we will continue to focus our equality, diversity and inclusion programme using the data from the staff survey to help direct the work.

A review of the workforce disability equality indicators demonstrates an improvement in 7 of the 9 questions but this is still not showing improvement at the rate we would aim to see and is not yet line with our peer average. There is clear improvement requirement and working with our staff networks we will continue to focus our equality, diversity and inclusion programme using the data from the staff survey to help direct the work.

What are the next steps?

Step 1 – Detailed review the data
Detailed review of the data at an organisational, divisional and directorate level to understand the issues that are prevalent in certain areas. We will review the free text comments to gain further in-depth into the issues and undertake a thematic analysis of the comments.

Step 2 – Share the findings and discuss widely to uncover the issues
Through our divisional leaders, we will encourage teams to discuss the results and share their understanding of the issues. Divisions are producing a refreshed driver report (A3) using the insight form the staff survey to inform their key areas of focus. These will be reported at the monthly divisional performance reviews.

We will facilitate discussions with our staff representatives and staff networks on the issues arising from the staff survey to collaborate on improvement ideas. We will also undertake deeper dives into any specific areas arising from the data.

We will communicate the 2023 staff survey results widely across the organisation, recapping on the *You Said / We Did* (delivered during 2023) as well as *You Said/We Will* focus for 2024).

Step 3 – Action Planning
We have reviewed the action plans from 2023 to assess for impact and will continue to discuss this with our staff networks to gain an even greater understanding of what has worked well/what has worked less well. Our initial assessment is detailed in the body of this report.

As set out above we have prioritised our 4 areas of organisational focus. A detailed overview of the activities has been received and considered at the Trust Transformation and People Committee (March 2024).

Step 4 – Implementation
We will create and publicise opportunities for employees to get involved in our initiatives and actions. We will work with external organisations and partners to maximise the resource available. We have been successful in securing funding from NHS England for a People Promise Manager and are on part of a national cohort that is focusing on flexible working. During 2024 we will be undertaking a Trust wide engagement campaign to inform the next People Strategy (2025-2028) and the staff survey results and our engagement work will be key to shaping this.

We will identify ways to measure impact of our actions and share regular updates with all staff on the progress we are making throughout the year.

Conclusion

In conclusion, we are pleased overall with our progress (scoring significantly better than last year) yet acknowledge that we have still further to go in comparison to peer average and will continue to focus on embedding the people promise across our organisation through key programmes of activity and engagement. Through our collective work at a corporate and a divisional level we aim to improve beyond the average and ensure that UHNM is a great place to work for everyone.

Key Recommendations

The Trust Board is asked to note the 2023 National Staff Survey report and results along with corporate priorities planned for 2024/25 aimed at creating a great place to work for everyone by improving organisational culture, behaviours and maximising the potential of our people to improve patient outcomes.

NHS Annual Staff Survey 2023 - Findings

February 2024

1. Introduction

The 2023 NHS Annual Staff Survey was carried out between September and November 2023.

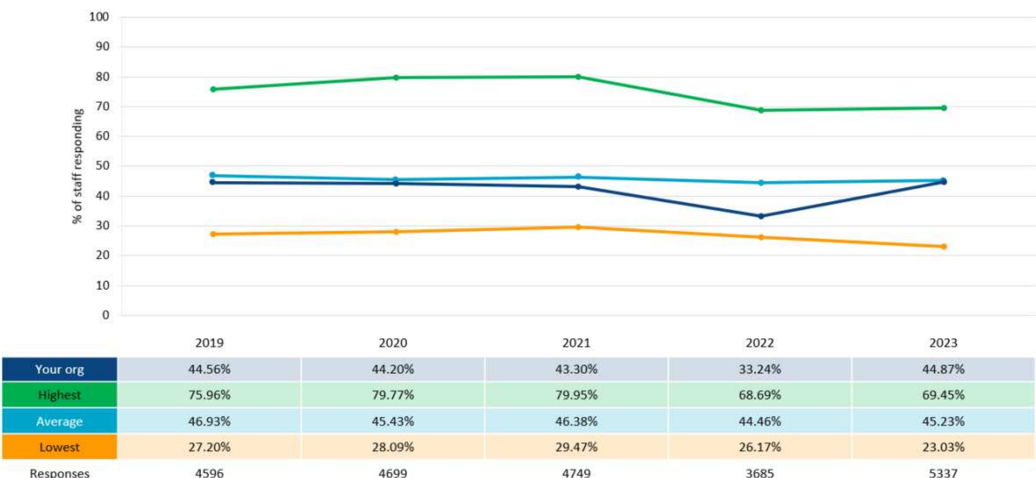
The NHS Staff Survey results are aligned to the People Promise and the two themes of 'Staff Engagement' and 'Morale. The People Promise sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of the following seven elements:

This year we invited **11,895** substantive staff and **1,659** bank workers to participate in the national staff survey. Considerable efforts were made corporately and divisionally to encourage all staff members to complete the staff survey in 2023. Lessons were learnt from the 2022 survey and extensive work was completed to ensure the staff data submitted to the staff survey supplier, IQVIA, was as accurate. As a result of the detailed work programme, we achieved a response rate of 45% which is in line with the benchmark group.

The table below shows participation information compared to the benchmark group over the past 5 years.

Year	Number of participants	Response rate	Benchmark Group Response rate
2019	4596	45%	47%
2020	4699	44%	45%
2021	4749	43%	46%
2022	3685	33%	44%
2023	5337	45%	45%

The graph below shows that in 2022 UHNM's response rate dropped at the same rate as the best organisation and although UHNM has recovered this ground and is now achieving an average response rate, the best response rate has not seen the same improvement.



	2019	2020	2021	2022	2023
Your org	44.56%	44.20%	43.30%	33.24%	44.87%
Highest	75.96%	79.77%	79.95%	68.69%	69.45%
Average	46.93%	45.43%	46.38%	44.46%	45.23%
Lowest	27.20%	28.09%	29.47%	26.17%	23.03%
Responses	4596	4699	4749	3685	5337

2. National Trends

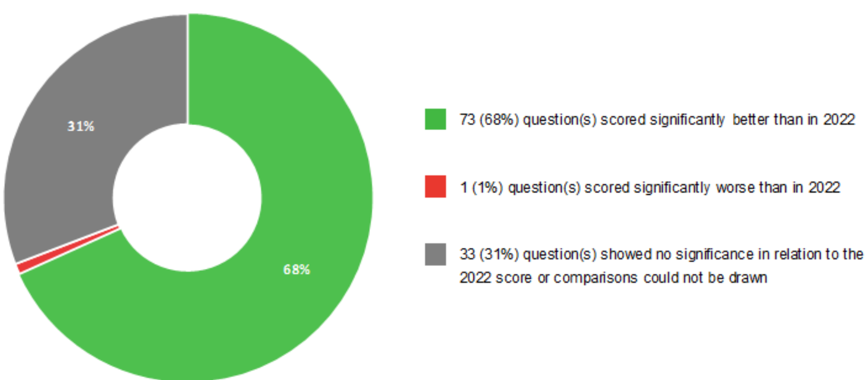
As the 2023 Staff Survey Results are under embargo until 7th March 2024, the National Results Briefing has not yet been communicated. However, the results of our benchmark group (Acute and Acute & Community Trusts) indicate an overall improvement in staff survey outcomes. UHNM's results mirror this pattern, with certain areas demonstrating a more significant increase compared to the average.

3. Understanding the 2023 Staff Survey Results

3.0. Successes

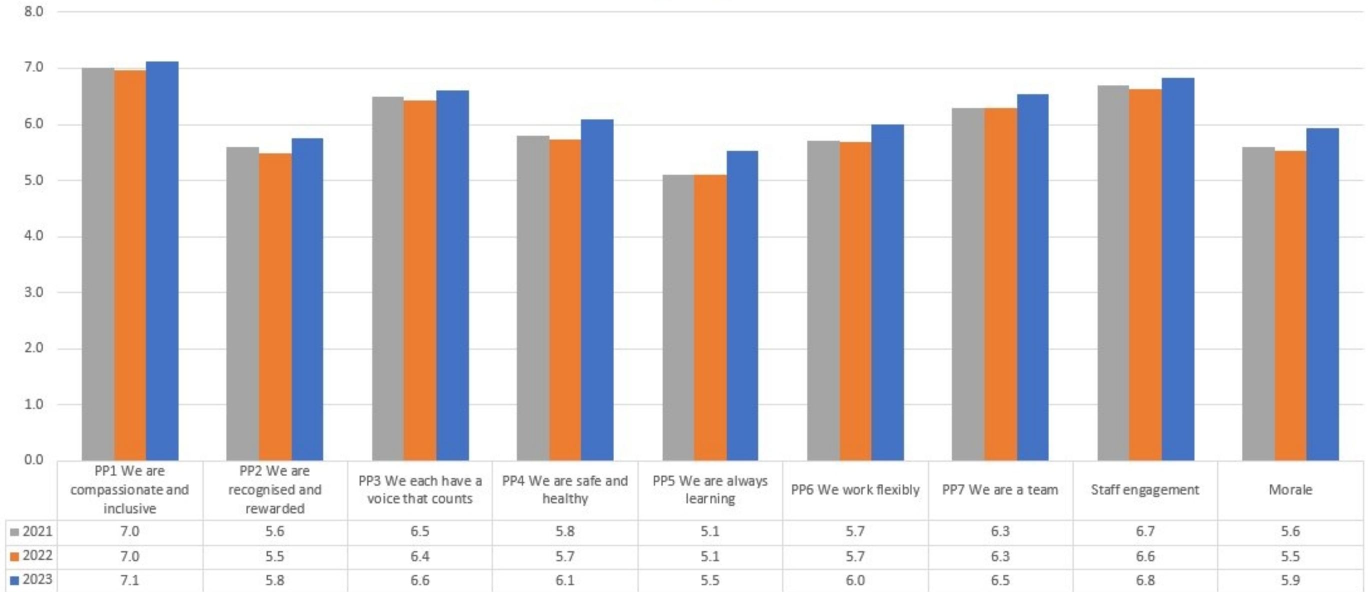
Compared to last year, we scored significantly better across most questions. There was only one question where we scored significantly worse, and this was "this organisation offers me challenging work."

<u>Chart 1 Headline Findings – Question Local Changes</u>



In 2022 UHNM had an unusually low response rate (33%) and overall, the results painted a declining picture compared to the previous year. The 2023 results indicate that this has been reversed as scores have increased for all the people promises and themes, achieving higher scores than in 2021 (see graph below).

<u>Chart 2 – Staff Survey Results 2021-2023</u>



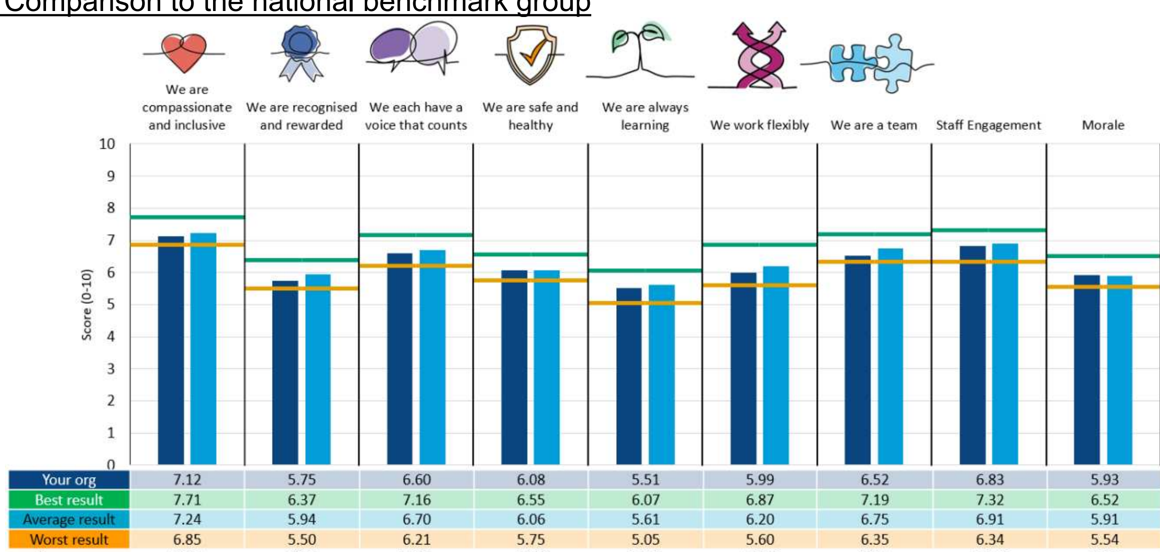
	PP1 We are compassionate and inclusive	PP2 We are recognised and rewarded	PP3 We each have a voice that counts	PP4 We are safe and healthy	PP5 We are always learning	PP6 We work flexibly	PP7 We are a team	Staff engagement	Morale
2021	7.0	5.6	6.5	5.8	5.1	5.7	6.3	6.7	5.6
2022	7.0	5.5	6.4	5.7	5.1	5.7	6.3	6.6	5.5
2023	7.1	5.8	6.6	6.1	5.5	6.0	6.5	6.8	5.9

Comparison to the national benchmark group

The following table presents an overview of the 7 People Promise elements and two themes of staff engagement and morale. It compares this Trust's results to the average for our benchmark group as well as the scores of the best and worst performing trusts in the benchmark group.

UHNM's scores for morale and "we are safe and healthy" are in line with the benchmark group. However, despite improvements, the trusts scores remain lower than those of the benchmark group across six of the people promises and staff engagement.

Chart 3: Comparison to the national benchmark group



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.12	5.75	6.60	6.08	5.51	5.99	6.52	6.83	5.93
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	5321	5326	5261	5290	5079	5285	5307	5325	5327

Staff Survey for bank only workers

Results from the Bank Staff Survey are in line with the substantive scores. The survey results suggest that bank staff are engaged and enjoy working with their colleagues. It is pleasing to see that bank staff report higher scores for feelings of being respected by colleagues, and enjoying working with their teams, as it could easily be expected that non-substantive staff may feel left out or undervalued. There is plenty of room for improvement and it is key that we encourage a higher participation rate so that we can be assured that our results are reflective of our bank colleagues experience of working at UHNM.

3.1. Areas of focus during 2023 * based on the NSS 2022 results

From the 2022 data we chose to focus on the 3 People Promises (PP1, PP6, PP7) where we scored closest to the worst trust within the benchmark group; we were within 0-0.2 of the worst score. Chart 1 above shows that we are no longer in the same position with most of our People Promise scores now closer to the average result. Below we describe the progress made.

Promise 1 – We are compassionate and inclusive

During the year we continued to focus on improving culture via our Enable Programme and our culture improvement programme. We also invested in

- Continued focus on living our Being Kind Compact and embedding the Being Kind approach to the early and lasting resolution of issues.
- Task and Finish approach to addressing bullying, harassment and abuse from patients, relatives, and members of the public.
- Demonstrate organisational commitment to anti-racism and the elimination of race discrimination and embed this into our leadership development (ENABLE and Connects) and people practices.
- Refreshed PDR policy and paperwork with a focus on talent management and equality, diversity, and inclusion.
- Launched the Reasonable Adjustments Policy.

The impact of which is reflected in our scores primarily compassionate culture and compassionate leadership which have both significantly improved. In 2022 the question that most negatively impacted the score for Promise 1 was “my immediate manager takes effective action to help me with any problems I face”. This question is still the lowest scoring, but it had the largest increase (up by 5.5%) out of all the immediate manager questions.

Promise 6 – We work flexibly

UHNM’s score for this promise was 0.1 above the worst score and 0.3 below the average of our benchmark group. Our position has improved against both targets, and we are now only 0.2 below the average.

A lot of effort has gone into reviewing our current understanding and arrangements for flexible and agile working. The benefit of this can be seen in our scores for flexible working which improved significantly across the board.

Complementing our improved immediate manager scores in promise 1, the highest scoring item in promise 6 was “I can approach my immediate manager to talk openly about flexible working”. 64.7% of colleagues agreed with this statement.

Although improved, some scores are still quite low, for example “my organisation is committed to helping me balance my work and homelife” was one of our most improved scores (up by 7.6 percentage points) but only 44.9% of our colleagues agreed with the statement. This is why it is important for the Trust to continue to focus on this promise and drive forward the programme of work already under way.

Promise 7 – We are a team

UHNM’s score for this promise was equal to the worst score and 0.3 below the average. Our 2023 results show we have improved and are now closer to the average score within our benchmark group.

Throughout the year, there has been a focused effort across all divisions and directorates to improve the “we are a team” promise has held significant importance in fostering a cohesive and collaborative organisational culture. By targeting efforts at this local level, teams have been able to address specific challenges and capitalise on unique strengths within their respective areas. This approach has allowed for a more tailored understanding of team dynamics, communication patterns and workflow processes promoting a sense of ownership and accountability among team members as they are directly involved in identifying areas for improvement and implementing solutions. This focused effort has contributed to the overall success of the culture enhancing morale and driving collective achievement towards shard goals.

The biggest contributing factor to our low score within this promise for 2022 was “teams work well together to achieve their objectives” which had fallen by 6 percentage points. This is now one of our most improved scores in this year’s results (up by 7.8 percentage points)

Staff engagement

The staff engagement score increased from 6.6 to 6.8 and is now just below the score for the benchmark group at 6.9. UHNM made progress within each of the 3 sub-scores, most significantly with “advocacy” and “motivation” which are now on par with the benchmark group. Within the advocacy sub-score there is a question about whether colleagues would be happy with the standard of care if a friend/relative needed treatment and UHNM scored significantly higher than average on this.

Motivation

	2019	2020	2021	2022	2023
Your org	7.24	7.14	6.86	6.85	7.00
Best result	7.66	7.61	7.43	7.45	7.39
Average result	7.34	7.23	6.96	6.95	7.04
Worst result	6.90	6.98	6.56	6.49	6.63
Responses	4527	4655	4668	3643	5245

Involvement

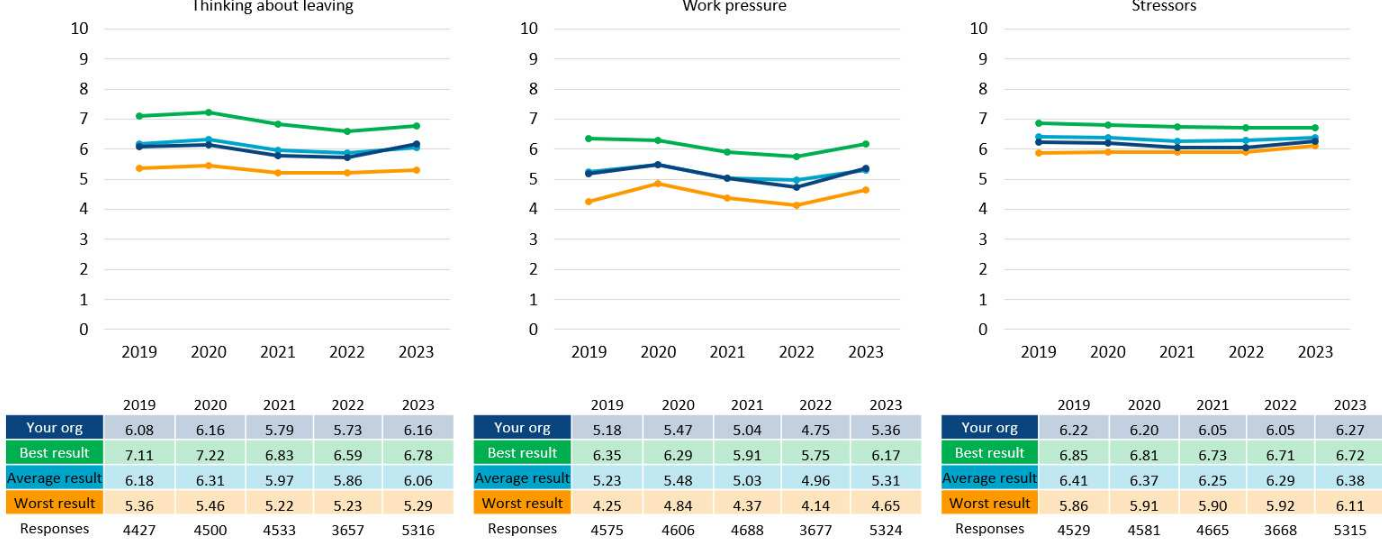
	2019	2020	2021	2022	2023
Your org	6.62	6.57	6.55	6.56	6.71
Best result	7.32	7.13	7.22	7.29	7.21
Average result	6.83	6.76	6.75	6.79	6.86
Worst result	6.15	6.28	6.32	6.29	6.44
Responses	4580	4610	4687	3676	5324

Advocacy

	2019	2020	2021	2022	2023
Your org	6.90	7.09	6.70	6.43	6.77
Best result	7.99	8.15	7.86	7.70	7.78
Average result	6.98	7.10	6.78	6.60	6.74
Worst result	5.23	6.02	5.68	5.60	5.73
Responses	4431	4495	4540	3664	5307

Staff morale

The benchmark group results increased by 0.2 whilst the Trust's score increased by 0.4 bringing it up to 5.93 which is equivalent to the Acute Trust average. UHNM has less staff than average who are considering leaving, and scores for "work pressure" questions have improved. Scores around work stressors have improved but continue to have the biggest negative impact on morale. These include unrealistic time pressures and lack of encouragement from immediate manager.



Thinking about leaving

	2019	2020	2021	2022	2023
Your org	6.08	6.16	5.79	5.73	6.16
Best result	7.11	7.22	6.83	6.59	6.78
Average result	6.18	6.31	5.97	5.86	6.06
Worst result	5.36	5.46	5.22	5.23	5.29
Responses	4427	4500	4533	3657	5316

Work pressure

	2019	2020	2021	2022	2023
Your org	5.18	5.47	5.04	4.75	5.36
Best result	6.35	6.29	5.91	5.75	6.17
Average result	5.23	5.48	5.03	4.96	5.31
Worst result	4.25	4.84	4.37	4.14	4.65
Responses	4575	4606	4688	3677	5324

Stressors

	2019	2020	2021	2022	2023
Your org	6.22	6.20	6.05	6.05	6.27
Best result	6.85	6.81	6.73	6.71	6.72
Average result	6.41	6.37	6.25	6.29	6.38
Worst result	5.86	5.91	5.90	5.92	6.11
Responses	4529	4581	4665	3668	5315

3.2. Areas of focus for 2024 * based on the NSS 2023 results.

Following review of the data we have highlighted areas where the Trust has performed less well and propose these are the areas of focus to achieve improvements.

We will enhance opportunities for staff to contribute ideas for improving processes and systems whilst securing commitment from leaders to respond constructively to any proposals and empower staff to implement change through our improving together programmes. This will be key to our culture improvement programme.

In deciding which promises and themes to focus on we took into consideration our raw scores and how UHNM compares to the benchmark group. At present it would be unrealistic to aim to be "the best" and therefore it was agreed that we would focus on improving some of our poorest scores where meaningful actions could be taken to create the biggest possible impact.

We have decided to continue our focus on People Promise 6 to demonstrate our ongoing commitment to prioritising flexible work arrangements and to integrate flexible working practices within UHNM and promote a healthy work-life balance.

Promise 1 – We are compassionate and inclusive

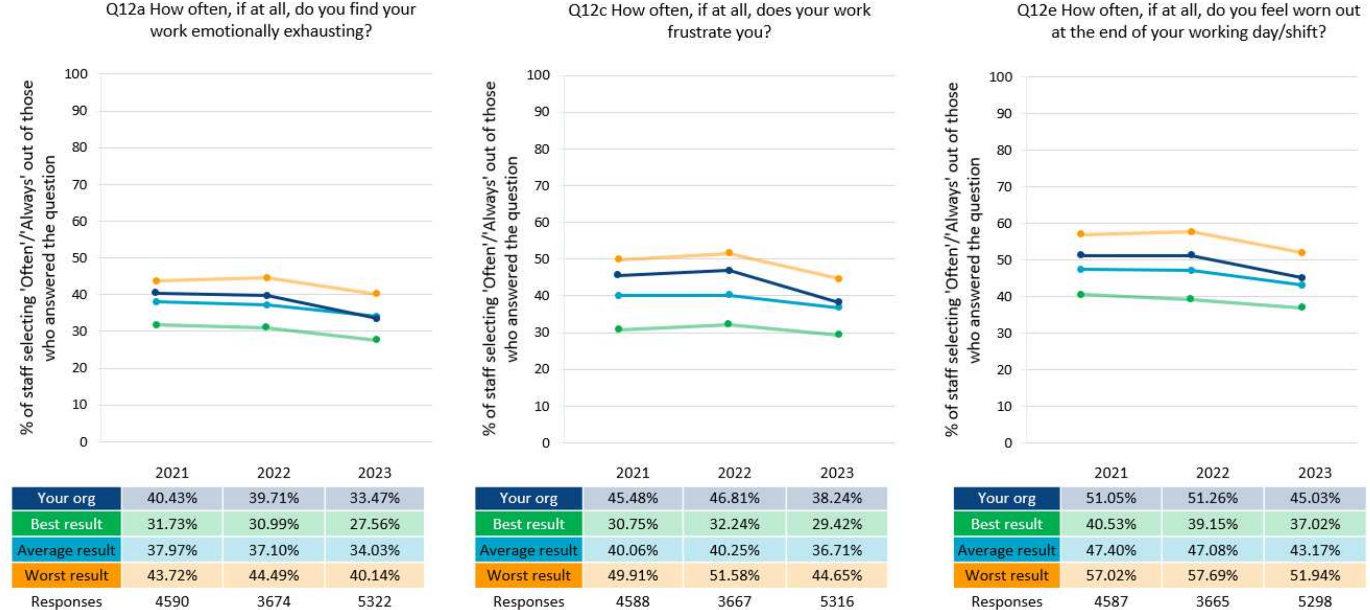
We will continue to focus our culture improvement programme, building on the plan as set out above to ensure a sustained year on year improvement.

A review of the workforce race equality indicators demonstrates an improvement in the experience of our colleagues from other ethnic groups in 2 of the 4 questions, but this is still not showing improvement at the rate we would aim to see and is not yet line with our peer average. There is clear improvement requirement and working with our staff networks we will continue to focus our equality, diversity and inclusion programme using the data from the staff survey to help direct the work.

A review of the workforce disability equality indicators demonstrates an improvement in 7 of the 9 questions but this is still not showing improvement at the rate we would aim to see and is not yet line with our peer average. There is clear improvement requirement and working with our staff networks we will continue to focus our equality, diversity and inclusion programme using the data from the staff survey to help direct the work.

Promise 4: We are safe and healthy

This is a wide-reaching element consisting of 23 questions spread over 3 sub-scores: health and safety climate, burnout, and negative experiences. Our overall score and the sub-scores are all equal to or higher than the benchmark average, however it contains some of the questions on which we have the lowest scores overall (see graphs below). Please note that a low score is better on these questions as they are measuring negative aspects of experience.



Q12a How often, if at all, do you find your work emotionally exhausting?

	2021	2022	2023
Your org	40.43%	39.71%	33.47%
Best result	31.73%	30.99%	27.56%
Average result	37.97%	37.10%	34.03%
Worst result	43.72%	44.49%	40.14%
Responses	4590	3674	5322

Q12c How often, if at all, does your work frustrate you?

	2021	2022	2023
Your org	45.48%	46.81%	38.24%
Best result	30.75%	32.24%	29.42%
Average result	40.06%	40.25%	36.71%
Worst result	49.91%	51.58%	44.65%
Responses	4588	3667	5316

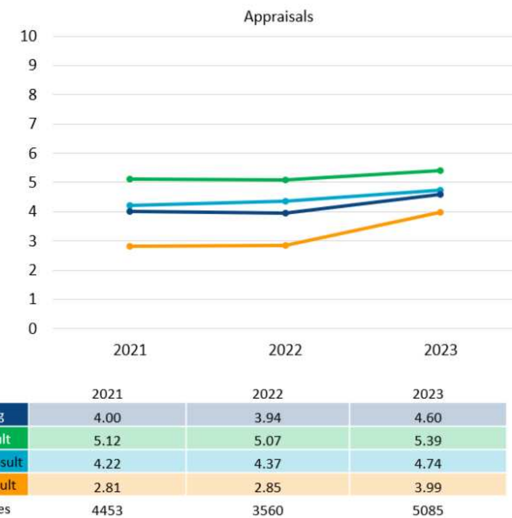
Q12e How often, if at all, do you feel worn out at the end of your working day/shift?

	2021	2022	2023
Your org	51.05%	51.26%	45.03%
Best result	40.53%	39.15%	37.02%
Average result	47.40%	47.08%	43.17%
Worst result	57.02%	57.69%	51.94%
Responses	4587	3665	5298

Promise 5: We are always learning

This element split into two sub-scores. The charts show that on both sub-scores UHNM has improved with scores now being closer to the average than the worst scores. Appraisals is the sub-score that requires the most improvement.

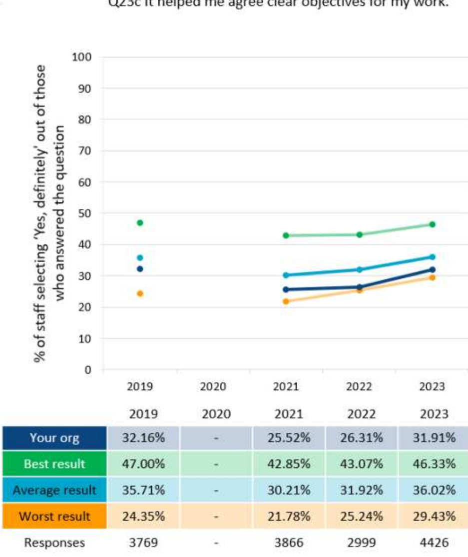
	2021	2022	2023
Your org	6.13	6.19	6.40
Best result	6.86	6.84	6.86
Average result	6.26	6.32	6.44
Worst result	5.68	5.86	6.10
Responses	4565	3666	5312



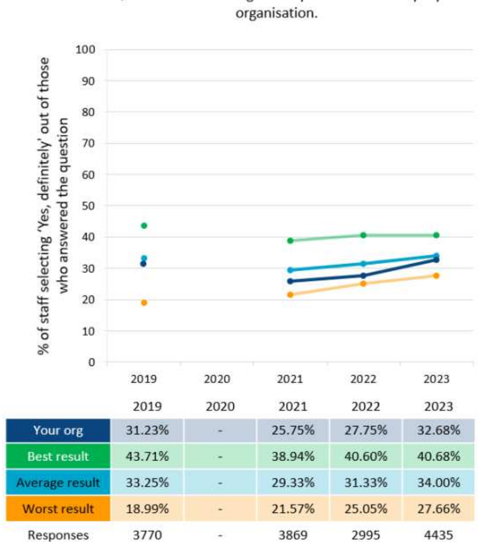
	2021	2022	2023
Your org	4.00	3.94	4.60
Best result	5.12	5.07	5.39
Average result	4.22	4.37	4.74
Worst result	2.81	2.85	3.99
Responses	4453	3560	5085

Within the “development” sub-score sits the only item on which UHNM had a significantly decreased score: “this organisation offers me challenging work” (67.2% down from 69.9%). It is worth noting that the best scoring trust within the benchmark group also followed this trend whilst the average was stable.

There are opportunities for development within several of the question areas especially appraisals resulting in clear objectives and making colleagues feel valued by the organisation (see charts below) where UHNM is below average and quite a way from the best performing trust in the benchmark group.



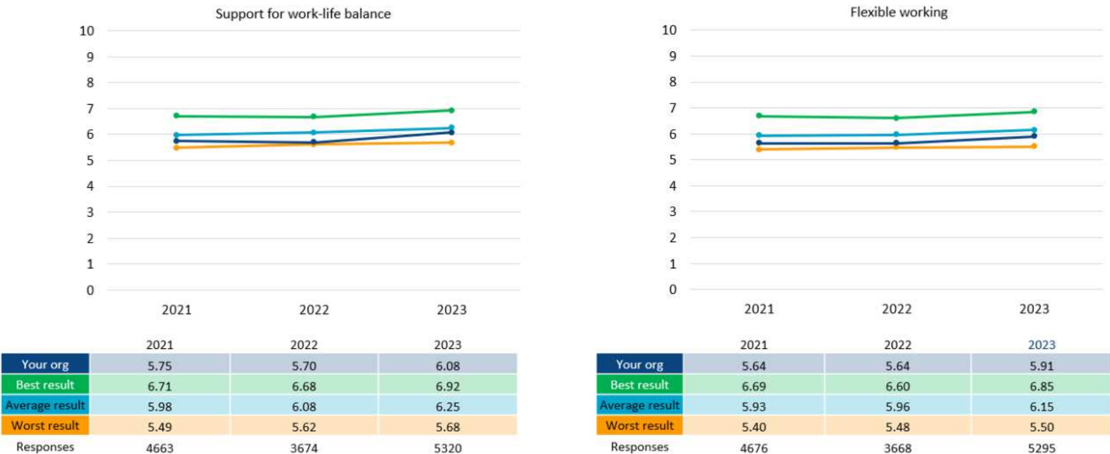
	2019	2020	2021	2022	2023
Your org	32.16%	-	25.52%	26.31%	31.91%
Best result	47.00%	-	42.85%	43.07%	46.33%
Average result	35.71%	-	30.21%	31.92%	36.02%
Worst result	24.35%	-	21.78%	25.24%	29.43%
Responses	3769	-	3866	2999	4426



	2019	2020	2021	2022	2023
Your org	31.23%	-	25.75%	27.75%	32.68%
Best result	43.71%	-	38.94%	40.60%	40.68%
Average result	33.25%	-	29.33%	31.33%	34.00%
Worst result	18.99%	-	21.57%	25.05%	27.66%
Responses	3770	-	3869	2995	4435

Promise 6: We Work Flexibly

As referenced above we have already improved this score and are committed to continuing the programme of work to increase scores further. This element is made up of two sub-scores: work-life balance and flexible working, calculated from 4 questions.



Support for work-life balance

	2021	2022	2023
Your org	5.75	5.70	6.08
Best result	6.71	6.68	6.92
Average result	5.98	6.08	6.25
Worst result	5.49	5.62	5.68
Responses	4663	3674	5320

Flexible working

	2021	2022	2023
Your org	5.64	5.64	5.91
Best result	6.69	6.60	6.85
Average result	5.93	5.96	6.15
Worst result	5.40	5.48	5.50
Responses	4676	3668	5295

Flexible working is based on just one question: “how satisfied are you with the opportunities for flexible working patterns.” Satisfaction levels dropped as we came out of the pandemic and has continued to slowly improve.

We will continue to review our flexible working practices and encourage our managers to have open conversations with employees about flexible working patterns and achieving home and work life balance.

3.4 Alignment to our Culture Improvement Programme

Over the last two years we have been working on a Culture Improvement Programme, stemming from a Culture Review in 2021. The primary focus areas have included race equality, improving diversity and inclusion, civility at work, resolution of problems and grievances at the earliest stage, kindness, and compassion.

To address specific improvement needs, Executive Directors have taken sponsorship of specific areas within the programme. Across the majority of people promises we can see an improvement from 2022 to 2023. We will use this new information to inform the improvement plans for these areas.

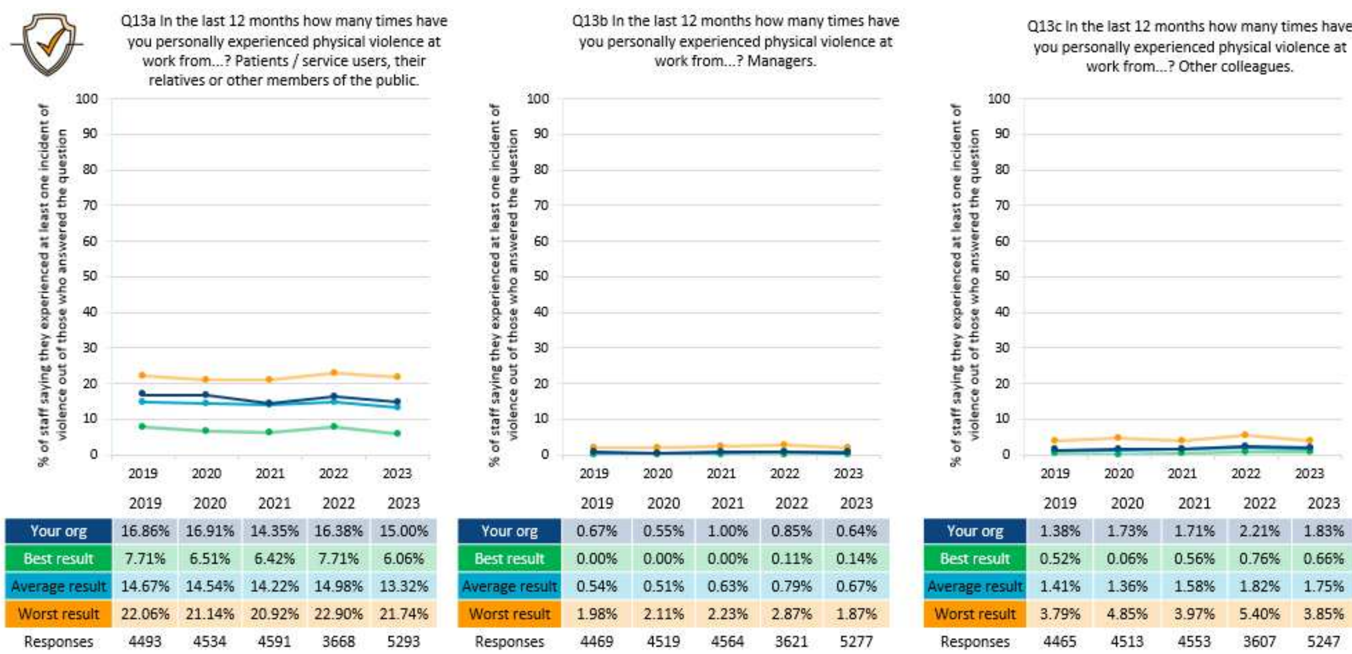
A significant investment has been made in mandatory training sessions aimed at fostering kindness and compassion (Being Kind). This focus on training has been strategically woven as a "golden thread" throughout the broader culture improvement efforts.

The multifaceted approach, involving both targeted executive sponsorship and comprehensive training, demonstrates our commitment to creating a workplace culture that is not only diverse and respectful but also emphasises kindness and compassion in all aspects of work life. This initiative aligns with the broader strategic goal of fostering a positive and inclusive work environment.

This next section of the report highlights some of the important areas of the staff survey.

3.4.1 Violence & Aggression

The survey shows that physical violence is mainly experienced from patients/service users (15%) with very small numbers of colleauges stating they have been subject to physical violence from their manager (0.64%) or another colleague (1.83%) which is similar to the benchmark group average. There has been a slight improvement in scores. There has been a small improvement in the percentage of colleagues stating that they or a colleague reported their last experience of physical violence which is indicated in the graph below, however this change is not statistically significant.



Q13a

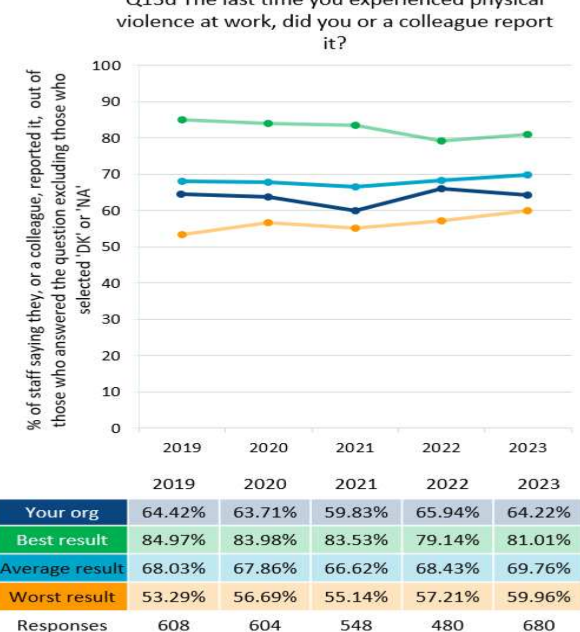
	2019	2020	2021	2022	2023
Your org	16.86%	16.91%	14.35%	16.38%	15.00%
Best result	7.71%	6.51%	6.42%	7.71%	6.06%
Average result	14.67%	14.54%	14.22%	14.98%	13.32%
Worst result	22.06%	21.14%	20.92%	22.90%	21.74%
Responses	4493	4534	4591	3668	5293

Q13b

	2019	2020	2021	2022	2023
Your org	0.67%	0.55%	1.00%	0.85%	0.64%
Best result	0.00%	0.00%	0.00%	0.11%	0.14%
Average result	0.54%	0.51%	0.63%	0.79%	0.67%
Worst result	1.98%	2.11%	2.23%	2.87%	1.87%
Responses	4469	4519	4564	3621	5277

Q13c

	2019	2020	2021	2022	2023
Your org	1.38%	1.73%	1.71%	2.21%	1.83%
Best result	0.52%	0.06%	0.56%	0.76%	0.66%
Average result	1.41%	1.36%	1.58%	1.82%	1.75%
Worst result	3.79%	4.85%	3.97%	5.40%	3.85%
Responses	4465	4513	4553	3607	5247

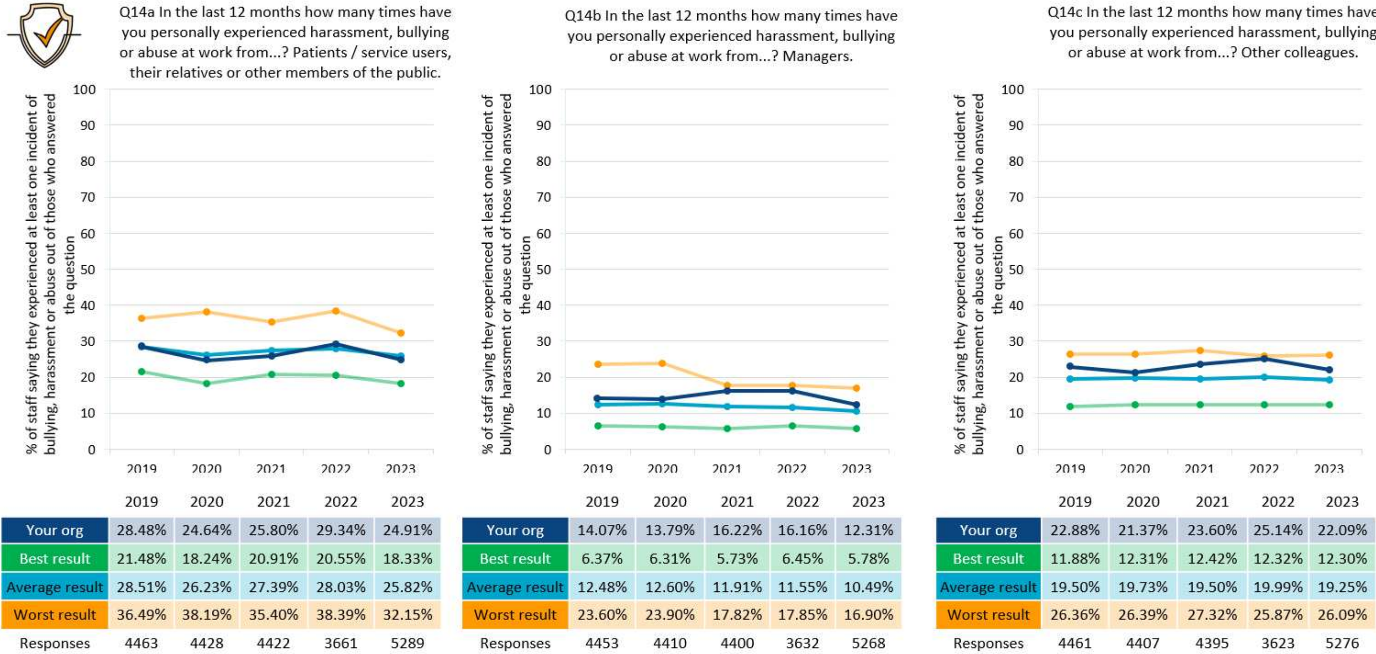


	2019	2020	2021	2022	2023
Your org	64.42%	63.71%	59.83%	65.94%	64.22%
Best result	84.97%	83.98%	83.53%	79.14%	81.01%
Average result	68.03%	67.86%	66.62%	68.43%	69.76%
Worst result	53.29%	56.69%	55.14%	57.21%	59.96%
Responses	608	604	548	480	680

3.4.2 Harassment, bullying and abuse

The percentage of colleagues stating they have experienced harassment, bullying or abuse at work has improved over the main indicators. Most instances of harassment, bullying or abuse are from patients/ service users (24.9%) with 22.1% experiencing this behaviour from colleagues and 12.3% from managers.

UHNM's scores have all significantly improved since 2022, however scores are worse than those of the benchmark group. These are some of the indicators that negatively impact our "we are safe and healthy" people promise score. Instances of reporting have decreased slightly contrary to the trend within the benchmark group.



Q14a

	2019	2020	2021	2022	2023
Your org	28.48%	24.64%	25.80%	29.34%	24.91%
Best result	21.48%	18.24%	20.91%	20.55%	18.33%
Average result	28.51%	26.23%	27.39%	28.03%	25.82%
Worst result	36.49%	38.19%	35.40%	38.39%	32.15%
Responses	4463	4428	4422	3661	5289

Q14b

	2019	2020	2021	2022	2023
Your org	14.07%	13.79%	16.22%	16.16%	12.31%
Best result	6.37%	6.31%	5.73%	6.45%	5.78%
Average result	12.48%	12.60%	11.91%	11.55%	10.49%
Worst result	23.60%	23.90%	17.82%	17.85%	16.90%
Responses	4453	4410	4400	3632	5268

Q14c

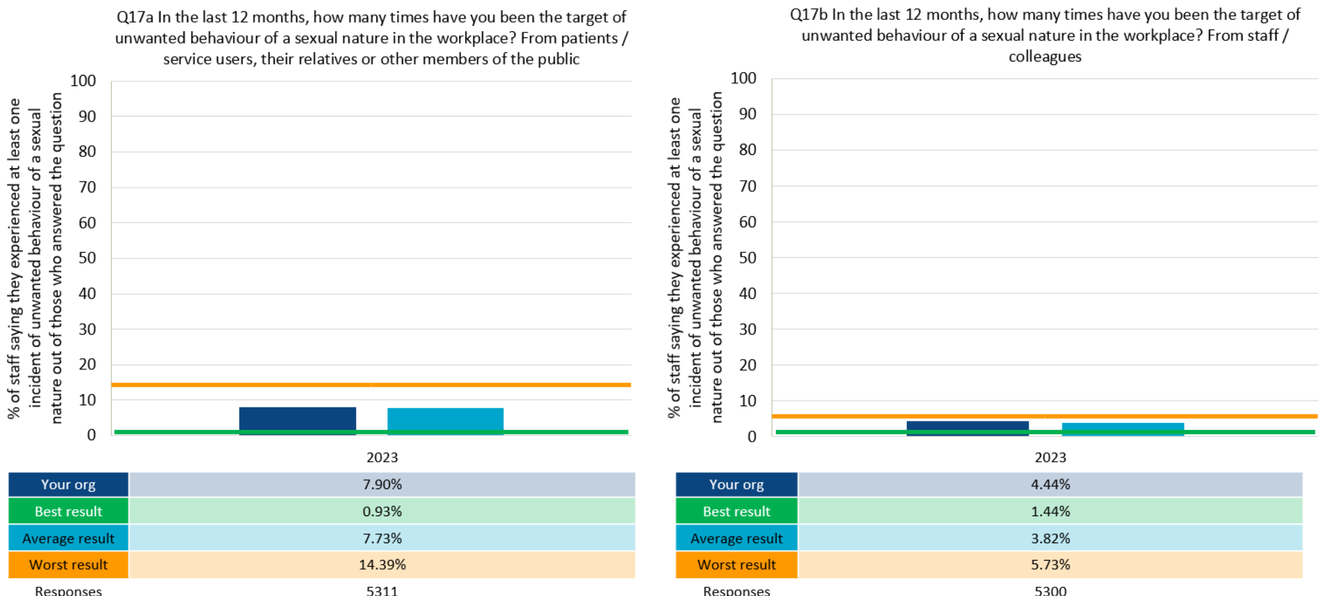
	2019	2020	2021	2022	2023
Your org	22.88%	21.37%	23.60%	25.14%	22.09%
Best result	11.88%	12.31%	12.42%	12.32%	12.30%
Average result	19.50%	19.73%	19.50%	19.99%	19.25%
Worst result	26.36%	26.39%	27.32%	25.87%	26.09%
Responses	4461	4407	4395	3623	5276

3.4.3 Discrimination

With regards to discrimination there are low levels from patients/service users (7.5%) and manager/colleagues (10.3%). These scores have remained static since 2022 and are like those of the benchmark group. The survey does not ask whether colleagues reported these instances.

3.4.4 Sexual Safety

The 2023 survey included two questions regarding sexual safety asking staff to indicate if they have been the target of unwanted behaviour of a sexual nature. Responses can be seen in the charts below.



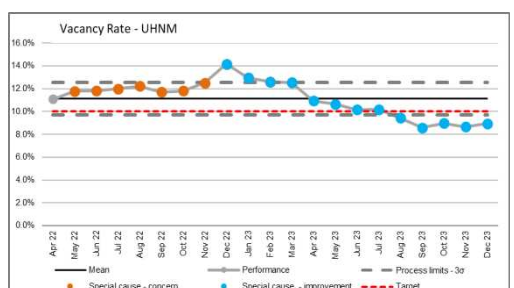
In terms of unwanted behaviour from patients/service users (Q17a) the trust is in line with the average score. However, in terms of unwanted behaviour from colleagues (Q17b) we have a higher-than-average score, albeit the variance between best and worst is much smaller for this question than Q17a.

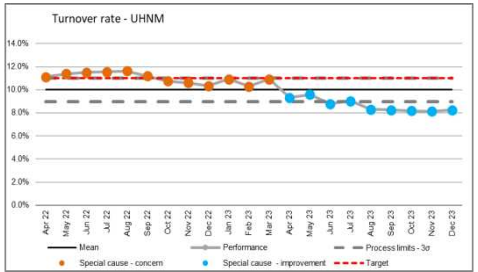
This data will form a baseline for our programme of work to improve sexual safety at UHNM. It is expected that we may see these figures get worse before they get better due to colleagues being more aware of what counts as unwanted behaviour of a sexual nature and hopefully being more willing to report it. We are already focusing our efforts on sexual safety with our programme of work to highlight the issues, the expected behaviours, and the routes to raise concerns.

3.5 Triangulation of the data with other key sources

The national staff survey data doesn't sit in isolation and must be seen in the context the wider people metrics.

We have seen a clear progress during 2023 on our vacancy and turnover rates which will have a significant impact on our staff survey results if our people feel that there is sufficient resource to undertake their roles.





4 Divisional Plans

Divisions will be asked to produce an effective and tailored communication plan to celebrate their successes with their teams sharing the positive impact of them participating in this year's survey. Each division will review their current employee engagement plans to identify areas of focus.

Through the Executive Workforce Assurance Group, we will hold conversations with Divisions to seek further assurance on delivery and to share ideas on improving employee experience and team engagement overall and we will track progress through the divisional performance review framework.

5 Next Steps

Step 1 – Detailed review the data
Detailed review of the data at an organisational, divisional and directorate level to understand the issues that are prevalent in certain areas. We will review the free text comments to gain further in-depth into the issues and undertake a thematic analysis of the comments.

Step 2 – Share the findings and discuss widely to uncover the issues
Through our divisional leaders, we will encourage teams to discuss the results and share their understanding of the issues. Divisions are producing a refreshed driver report (A3) using the insight form the staff survey to inform their key areas of focus. These will be reported at the monthly divisional performance reviews.

We will facilitate discussions with our staff representatives and staff networks on the issues arising from the staff survey to collaborate on improvement ideas. We will also undertake deeper dives into any specific areas arising from the data.

We will communicate the 2023 staff survey results widely across the organisation, recapping on the *You Said / We Did* (delivered during 2023) as well as *You Said/We Will* focus for 2024).

Step 3 – Action Planning
We have reviewed the action plans from 2023 to assess for impact and will continue to discuss this with our staff networks to gain an even greater understanding of what has worked well/what has worked less well. Our initial assessment is detailed in the body of this report.

As set out above we have prioritised our 4 areas of organisational focus.

Step 4 – Implementation
We will create and publicise opportunities for employees to get involved in our initiatives and actions. We will work with external organisations and partners to maximise the resource available. We have been successful in securing funding from NHS England for a People Promise Manager and are on part of a national cohort that is focusing on flexible working. During 2024 we will be undertaking a Trust wide engagement campaign to inform the next People Strategy (2025-2028) and the staff survey results and our engagement work will be key to shaping this.

We will identify ways to measure impact of our actions and share regular updates with all staff on the progress we are making throughout the year.

6 Measuring progress

Progress will be measured in terms of the People Promise, Staff Engagement and Morale scores within the 2024 National Staff Survey.

We will track the overarching staff engagement score throughout the year via our Staff Voice survey. We will use the quality improvement methodology to track delivery of the People Strategy delivery plan and the key performance metrics.

7 Recommendations

The Trust Board is asked to note the National Staff Survey Report and the corporate priorities planned for 2024/25 aimed at creating a great place to work for everyone by improving organisational culture, behaviours and maximising the potential of our people to improve patient outcomes.

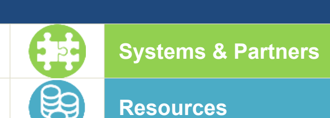
Executive Summary

Meeting:	Trust Board (Open)	Date:	3rd April 2024
Report Title:	Gender Pay Gap Report	Agenda Item:	12
Author:	Charlotte Lees, OD, Culture & Inclusion Business Partner		
Executive Lead:	Jane Haire, Chief People Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

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

Executive Summary

Situation UK organisations employing 250 or more employees are required to publicly report on their gender pay gap in six different ways:

- the mean gender pay gap
- the median gender pay gap
- the mean gender bonus gap
- the median gender bonus gap
- the proportion of men and women who received bonuses, and
- the number of men and women according to quartile pay bands

Background The gender pay gap is a measure that shows the difference in average earnings between men and women across an organisation. It is expressed as a percentage of men's earnings. It is important to recognise that the gender pay gap differs to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value, which is unlawful.

The issues that surround the gender pay gap are complex and the causes are a mix of work, family and societal influences. As employers we will only be able to influence those factors associated with the workplace. The NHS People Plan recognises that to become a modern and model employer the NHS should place a strong emphasis on taking steps to expand opportunities for colleagues to work more flexibly so that they can achieve a better work-life balance. These are key enablers to increasing the representation of women and removing barriers to progression. Our UHNM People Strategy focuses on developing our culture and supporting all that we do to attract, recruit, develop, retain, support and reward our diverse workforce.

Assessment The 2023 Gender Pay Gap shows an improvement in five of the six metrics. There has been a 6.6% reduction in the median pay gap and a 2.5% reduction in the mean pay gap. This improvement has been driven by an increase in the female representation in the upper-middle and upper pay quartiles, and an increase in male representation in the lower-middle and lower pay quartiles.

The main factor in our gender pay gap is that there is a higher proportion of males in higher pay quartile roles. Females represent 77% of the UHNM workforce, and yet represent only 64.5% of the upper pay quartile. Men represent 23% of the workforce but are over-represented in the upper pay quartile at 35.5%.

On the basis of the above, our proposed assurance assessment is:

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

Key Recommendations

Trust Board is asked to note the contents of this report and the recommended actions to improve the Gender Pay Gap at UHNM.

OD, Culture & Inclusion

Gender Pay Gap

Introduction

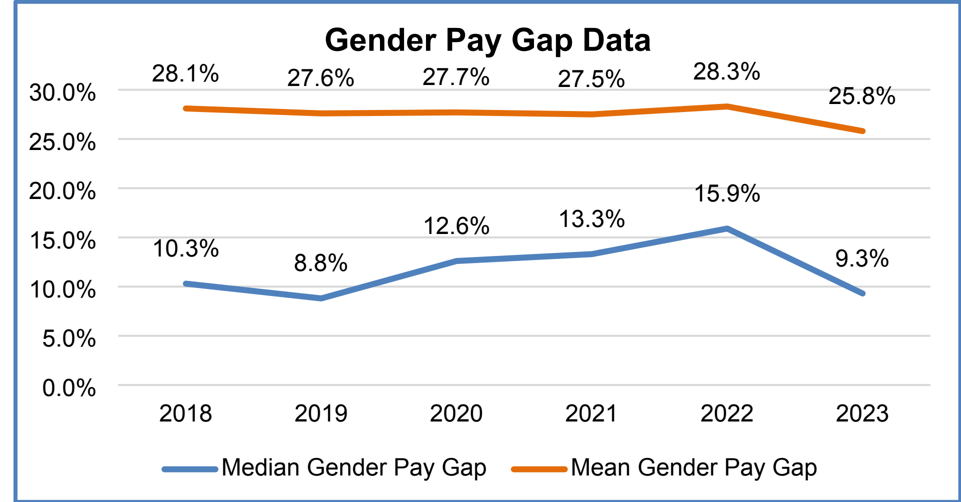
All organisations with 250 or more employees are mandated by the government to report annually on their gender pay gap. The gender pay gap is calculated as the percentage difference between average hourly earnings for men and women. The gender pay gap is different to equal pay, which relates to men and women performing equal work and must receive equal pay, as set out in the Equality Act 2010. This report fulfils the Trust's reporting requirements to publish information relating to six measures and explains why we have a gender pay gap. The six measures are:

Median gender pay gap	Difference between the median hourly rate of pay for female and male employees. Median is the middle value in a sorted list of values such that 50% of employees earn more than the median and 50% earn less than the median.
Mean gender pay gap	Difference between the mean hourly rate for female and male employees. Mean is the sum of the values divided by the number of values.
Median bonus gender pay gap	Difference between the median bonus pay for female and male employees. Median is the middle value in a sorted list of values such that 50% of employees earn more than the median and 50% earn less than the median.
Mean bonus gender pay gap	Difference between the mean bonus pay paid to female and male employees. Mean is the sum of the values divided by the number of values.
Proportion of males and females receiving a bonus	The proportions of male and female employees paid a bonus payment. For UHNM this refers to local and national clinical excellence awards.
Proportion of males and females in each quartile	The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper pay quartile pay bands.

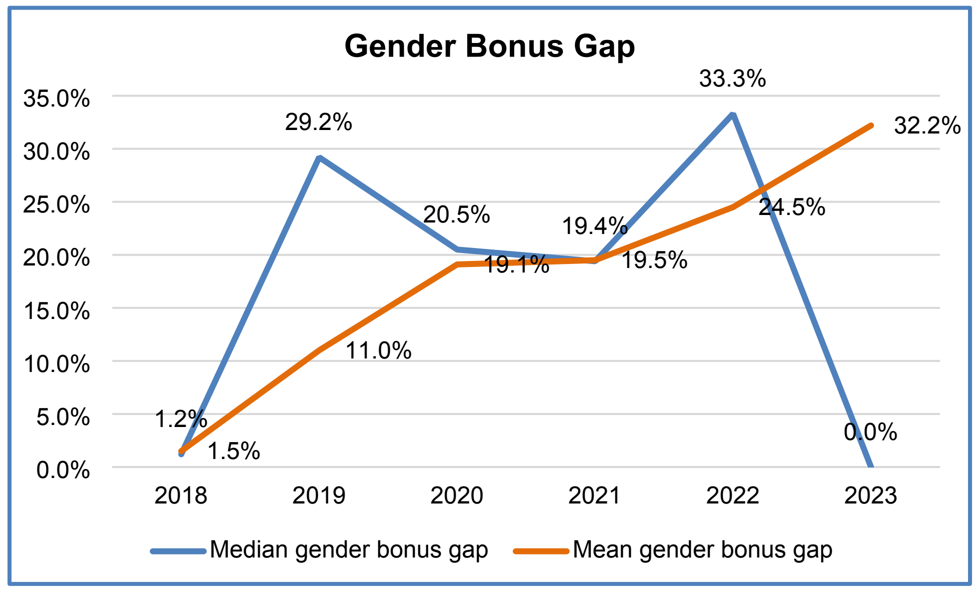
Note: From a statistical perspective the median is considered to be a more accurate measure as it is not skewed by very low or very high hourly pay. However, we know that our gender pay gap is driven by an over representation of men in the upper pay quartile compared to the overall workforce, notably within the Medical and Dental professional group. Therefore the mean is also useful in analysing a pay gap.

Our Gender Pay Gap Data

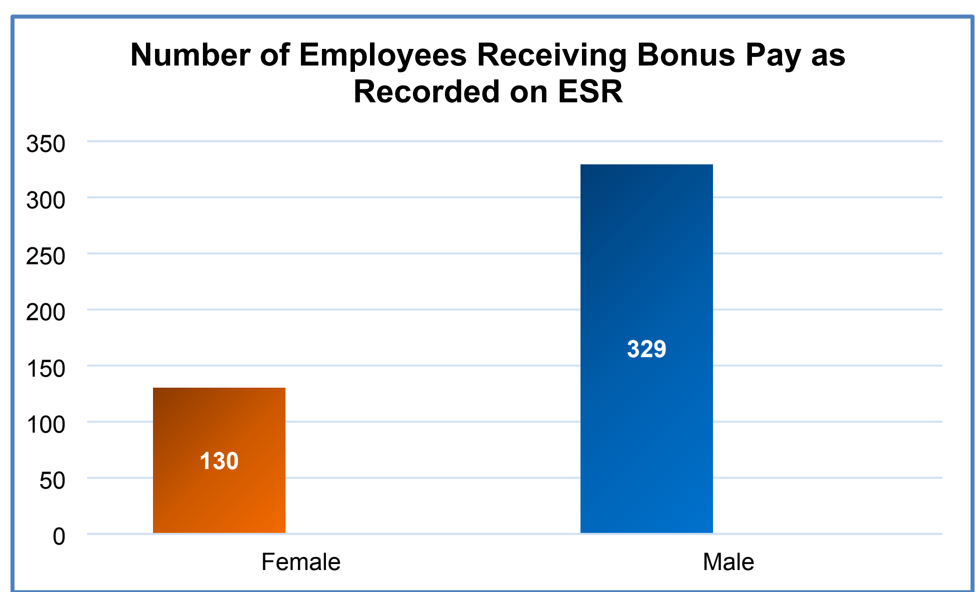
The gender pay data is a snapshot of pay taken on 31st March each year:



The Mean and Median pay gaps have improved in 2023. This is because we have seen an increase in the percentage of women in the upper pay quartiles while at the same time the percentage of men has increased in the lower pay quartiles which has resulted in the pay gap getting smaller.



The Median bonus pay gap has reduced to 0.0%. A median bonus pay gap of 0.0 indicates that the median (middle in the ranked list of individuals receiving bonus pay) woman and the median man in receipt of a bonus (CEA) have both received exactly the same amount.



1.3% of all female employees in the organisation are in receipt of bonus pay, compared to 10.4% of all male employees in the organisation. 100% of all eligible consultants received an internal CEA regardless of gender. However there are more men employed in the Medical and Dental professional group compared to women. The number of men and women in receipt of a CEA has improved on last year.

At UHNM bonus payments relate only to Clinical Excellence Award (CEA) payments made to eligible medical consultant colleagues. CEAs recognise and reward NHS consultant medical staff who perform ‘over and above’ the standard expected of their role and who can demonstrate achievements in developing and delivering high quality care, and commitment to the continuous improvement of the NHS.

CEA’s are not a one off annual performance payment, rather they relate to a nationally agreed contractual payment which forms part of the salary package for consultant medical staff. Eligible individuals can apply for a national CEA (known as Clinical Impact Awards, which last for 5 years) or a locally awarded CEA which are recorded as bonus pay on ESR.

The national awards are prescribed by the British Medical Association and NHS Employers. Many of the CEAs are historic and will be maintained until the recipient’s retirement.

For the 2022-2023 year we continued with an amended internal scheme, introduced due to the Covid-19 pandemic whereby an automatic allocation of the local award has been paid to all eligible consultants regardless of whether they are full or part time.

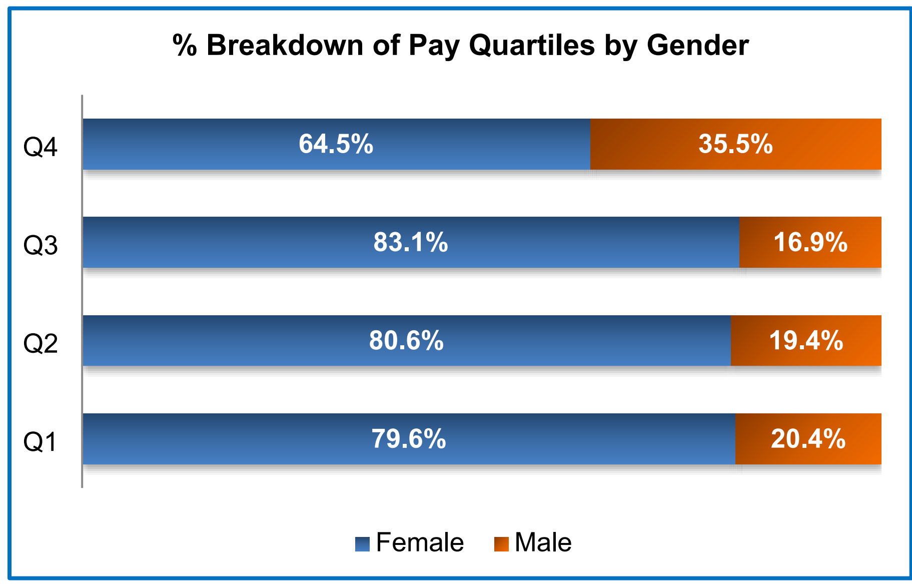
The publication of Mend the Gap – the independent review into gender pay gaps in medicine in England in December 2020 found that CEAs, both national and local, are a contributory factor of the overall gender pay gap in medicine. It highlighted a number of reasons why women are less likely to hold a CEA. For example, female consultants are more likely to be younger and are more likely to work in under-represented specialisms. They are also more likely to take career breaks, making it harder to compile 5 years' worth of CEA evidence. The Department of Health & Social Care is looking to reform the CEA process (currently under consultation), with a number of proposed changes that fall under 3 overarching themes:

- broadening access to the scheme
- making the application process simpler, fairer and more inclusive
- ensuring the scheme rewards and incentivises excellence across a broader range of work and behaviours

The aim of a reformed scheme is to modernise CEAs and take account of new ways of working, including improved recognition of those who are working less than full time (LTFT), and recognise and reward excellence across a broader range of clinical, academic and leadership contributions. Should these reforms be accepted, this should positively impact on the number of women being recognised through the clinical excellence scheme.

The proportion of male and female workforce in each pay quartile at 31st March 2023:

Quartile 1: Percentage of employees in the lower pay quartile
Quartile 2: Percentage of employees in the lower middle pay quartile
Quartile 3: Percentage of employees in the upper middle pay quartile
Quartile 4: Percentage of employees in the upper pay quartile



This data shows that the percentage of women in the most highly paid roles has increased with representation in Quartile 4 increasing by 0.9% and Quartile 3 by 0.8%. At the same time male representation has increased in both Quartile 1 (by 2.2%) and Quartile 2 (by 0.6%). A greater proportion of the male workforce continues to be employed in the upper pay quartile, which drives our gender pay gap.

Our workforce is 77 per cent female; therefore ideally women should make up 77 per cent of each pay quartile. Women are least represented in our medical and dental staff group, (which is within the upper pay quartile) and is where men are most represented.

The percentage of women in the medical and dental staff group has increased by 4.4% compared to the previous year, but whilst overall numbers of women have increased, women are under-represented at Consultant level, at just 28.7% but have greater representation in specialty doctor/registrar roles at 42%; and 47% at Trust Grade Registrar. Furthermore women make up 56.2% of Foundation Year 1 and 48.7% of Foundation Year 2 doctors.

It is important for us to understand how we can support and enable women in non-consultant roles to translate into proportional Consultant postholders. We will be engaging with our medical workforce to help inform our actions in this area.

Having a majority female workforce means that even small fluctuations in the proportion of male to female employees in each quartile, or in receipt of bonus pay will have a significant impact on our gender pay gap.

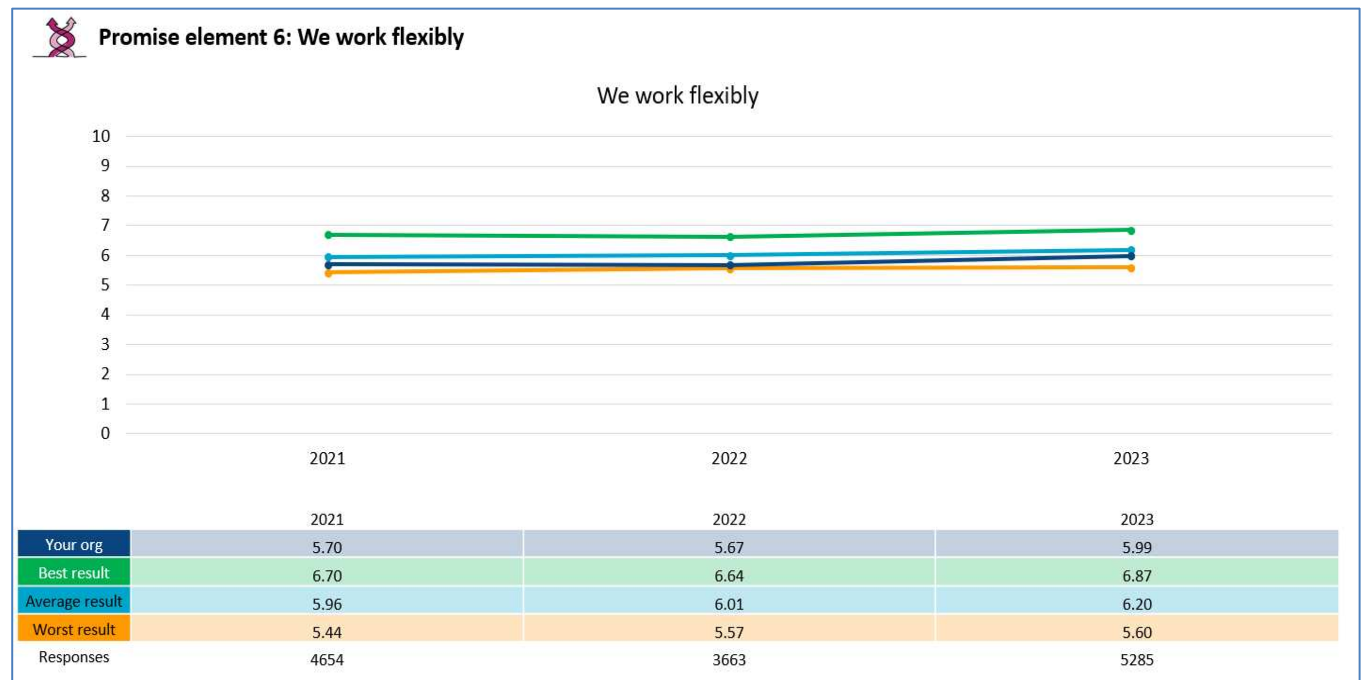
What frameworks do we have in place to ensure gender equality at UHNM?

We are confident that our gender pay gap is a result of the workforce distribution, rather than an equal pay issue. This is because we adhere to the Agenda for Change system, national terms and conditions of service for Medical staff and, for very senior managers (VSMs), there is a specific VSM pay framework.

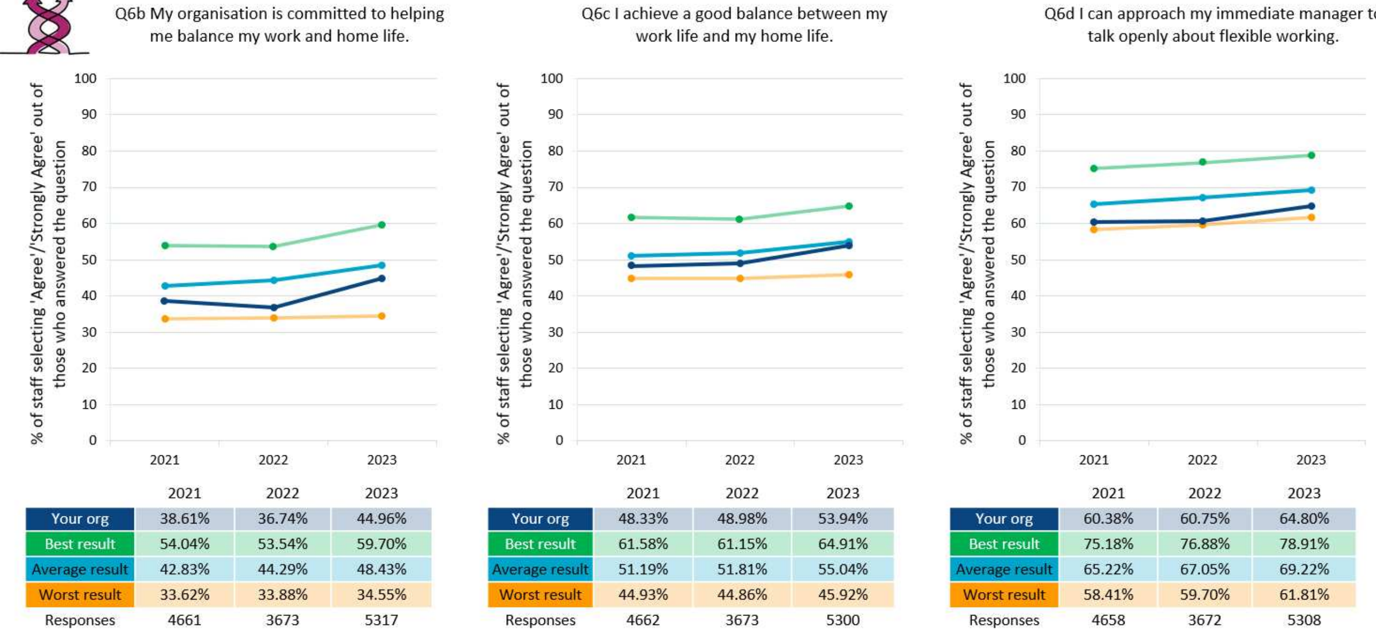
- We ensure the consistent application of Agenda for Change job evaluation rules through the job evaluation process including consistency panels
- We use a transparent structured approach to shortlisting and interviews with agreed criteria to reduce bias in the recruitment process and we provide recruitment training to our managers
- UHNM promotes careers and roles within the organisation and the wider NHS through our Widening Participation strategy, and this includes breaking down traditional stereotypes
- We actively promote and publicise our commitment to flexible working and agile working options for all colleagues and through the provision of a range of family friendly policies and benefits including shared parental leave, paternity leave and self rostering practices, salary sacrifice for childcare vouchers etc.
- We promote our internal and system leadership development programmes to all colleagues and monitor applications to ensure all protected groups including women are represented
- We ensure all staff have a Personal Development Review and can access independent career coaching
- We have a quarterly Leaders Network sessions and dedicated Women's Network
- Our Executive board membership is 70% female

What is our Staff Survey telling us?

The following information demonstrates UHNM responses to the People Promise element – we work flexibly and the work-life balance questions in the NHS National Staff Survey. It tells us that there has been a positive upward trend and a notable improvement on each of the questions compared to the previous survey. It also tells us that there is no significant difference between the responses of women and men in our organisation, but that UHNM positive scores are below the comparator average.



	2021	2022	2023
Your org	5.70	5.67	5.99
Best result	6.70	6.64	6.87
Average result	5.96	6.01	6.20
Worst result	5.44	5.57	5.60
Responses	4654	3663	5285



Q6b	2021	2022	2023
Your org	38.61%	36.74%	44.96%
Best result	54.04%	53.54%	59.70%
Average result	42.83%	44.29%	48.43%
Worst result	33.62%	33.88%	34.55%
Responses	4661	3673	5317

Q6c	2021	2022	2023
Your org	48.33%	48.98%	53.94%
Best result	61.58%	61.15%	64.91%
Average result	51.19%	51.81%	55.04%
Worst result	44.93%	44.86%	45.92%
Responses	4662	3673	5300

Q6d	2021	2022	2023
Your org	60.38%	60.75%	64.80%
Best result	75.18%	76.88%	78.91%
Average result	65.22%	67.05%	69.22%
Worst result	58.41%	59.70%	61.81%
Responses	4658	3672	5308

The following questions are a breakdown of the work-life balance, flexible working and fair opportunities for career progression and promotion questions by gender.

NSS Question	Female		Male	
	2022	2023	2022	2023
Achieve a good balance between work and home life	49.7%	54.8%	47.8%	53.1%
Can approach immediate manager to talk openly about flexible working	61.2%	65.8%	61.3%	65.6%
Organisation acts fairly: career progression	57.4%	57.9%	53.4%	53.4%

Data extracted from raw unweighted NSS report

Progress from our previous Gender Pay Gap report

We have made good progress against a number of the actions we set ourselves in our last report:

Action / Recommendation	Progress
1. Launch the UHNM Menopause Guidance and continue with Menopause Café.	Menopause Guidance launched with a webinar open to all colleagues.
2. Progress implementation of the UHNM revised inclusive talent management approach and begin inclusive recruitment work.	Succession planning commenced with tiers 1 – 3 (VSM) followed by the remainder of the workforce. Talent management Personal Development Review to launch in January 2024 with new paperwork and training along with the Scope for Growth career conversation.
3. Focus on increasing line manager understanding and application of our flexible and agile working policies via bitesize webinar sessions.	Webinars have been held during 2023 about our: - flexible and agile working policies - new reasonable adjustments policy - menopause support - carer's passport awareness during Carers Week

Action / Recommendation	Progress
4. Undertake targeted work to understand specific barriers to women in the medical and dental professional group.	Data analysis of medical and dental responses to the national Staff Survey undertaken. Applying Improving Together methodology to identify root causes and collaborating with the Women's Network on actions during 2024.
5. Establish a UHNM Women's Network to ensure that women have a voice in the organisation.	Women's Network established. Chaired by Deputy Medical Director, with Chief People Officer as Executive Sponsor.

In addition, we have also:

- Established a Flexible Working Task & Finish Group and flexible working project which has included a trust wide flexible working questionnaire
- Commenced Stay Conversations with colleagues in high turnover/difficult to recruit areas
- UHNM is a signatory to the NHS Sexual Safety Charter and established a Sexual Safety Task & Finish Group
- Introduced a Carer's Passport for colleagues with caring responsibilities
- Created EDI Dashboards for our divisions to monitor key performance indicators including flexible working metrics
- Created an Employee Experience Network of champions across the organisation

Summary and proposed actions to reduce the Gender Pay Gap:

Our gender pay gap is not due to the under representation of women in the workplace. Like the majority of NHS providers our workforce is predominately female; however, the smaller proportion of men working at UHNM are more likely to be employed in higher paying roles, most notably in the medical and dental professional group. It is this that influences our negative gender pay gap.

Nationally the NHS pay gap is relatively small for the 88% of NHS staff employed on Agenda for Change (AfC) terms and conditions. However, it is 47% for the 12% of NHS staff who are not, essentially doctors and senior leaders (Source: NHS Equality, Diversity, and Inclusion Improvement Plan 2023)

At UHNM there has been a positive increase in 2023 of female representation in the upper-middle and upper pay quartiles, in addition to an increase in female representation in the medical and dental professional group, which is where women are under-represented compared to their wider organisational representation.

We will use our gender pay gap data to help understand underlying causes for the gender pay gap so that the Trust can take suitable steps to minimise it. Whilst structural changes to the NHS workforce will take time to work through, for example seeing the impact of the recommendations from the Mend The Gap report and reforms of clinical excellence awards. We are prioritising the following areas that will support the NHS People Plan and UHNM People Strategy aspirations of making flexible working and inclusive talent management a reality for our workforce:

Action / Recommendation	Owner	Time scale	Desired Outcome/success criteria
1. Analyse our staff survey data from a gender perspective by comparing the experiences of our male and female staff, particularly around the themes of equality, diversity and inclusion, line management and appraisals.	EDI Lead	Q1	Identify areas of good practice, and areas where targeted action may be required.

Action / Recommendation	Owner	Time scale	Desired Outcome/success criteria
2. Monitor our progress against the NHS Equality, Diversity, and Inclusion Improvement Plan High Impact Action 3 – 'Eliminate Pay Gaps'.	EDI Lead	Q1	Year on year reduction in the gender pay gap. Our progress will be documented in the Trust's Annual Equality, Diversity and Inclusion Report.
3. Extend the Scope for Growth career conversation tool for personal development following the System pilot.	Assist. Director of OD	Q2	Colleagues receive a tailored conversation about career aspirations and create a development plan. Measured by improvement in the NHS National Staff Survey (NSS) metrics relating to appraisal and fair opportunities for career progression.
4. Continue with the Flexible Working Task & Finish Group including analysing the flexible working project outputs and make recommendations.	Head of Employee Relations	Q4	Implementation of the recommendations of the Task & Finish Group with evaluation through year on year improvement on the flexible working metrics of the NSS.
5. Take forward the recommendations from the UHNM's Women's Network sub-group into the gender pay gap in medicine once they have been made.	EDI Lead	Q4	Co-creation of actions designed to balance gender representation in medicine across all pay bands and clinical excellence awards.
6. Continue with the work around sexual safety, led by the UHNM Sexual Safety Task & Finish Group	Chief People Officer	Q4	UHNM colleagues feel safe from sexual misconduct at work, measured by improvement of the NSS questions 'in the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives, or other members of the public? or from staff or other colleagues?

This report must be published on the UHNM website, and the data reported on a designated government website at www.gov.uk/genderpaygap by 31st March 2024.

Appendix 1 Explaining the Gender Pay gap:

Our gender pay gap is influenced by the make-up of our workforce which has:

- A greater proportion of male employees in the upper pay quartile compared to middle and lower quartiles and;
- A greater proportion of female employees in the lower and middle pay quartiles compared to the upper quartile

Having a predominantly female workforce means that even small fluctuations in the proportion of male to female employees in each quartile will have a significant impact on our gender pay gap.

An example of how a Gender Pay Gap can come about:

- ~ *An organisation comprises 10 staff and 1 manager*
- ~ *The 10 staff are 9 females and 1 male and they all earn exactly £50,000 per year so they are all on equal pay*
- ~ *The manager, who is a man, earns £100,000 per year*
- ~ *The average salary for women in this organisation is £50,000*
- ~ *The average salary for men is (£50,000 + £100,000 / 2) = £75,000*
- ~ *The gender pay gap is therefore £25,000 or 50%*

How our workforce was made up (as at 31st March 2023)

UHNM is typical of any NHS Trust in that it has a higher number of females than males in its workforce. 77% of our workforce are female compared to 23% men.

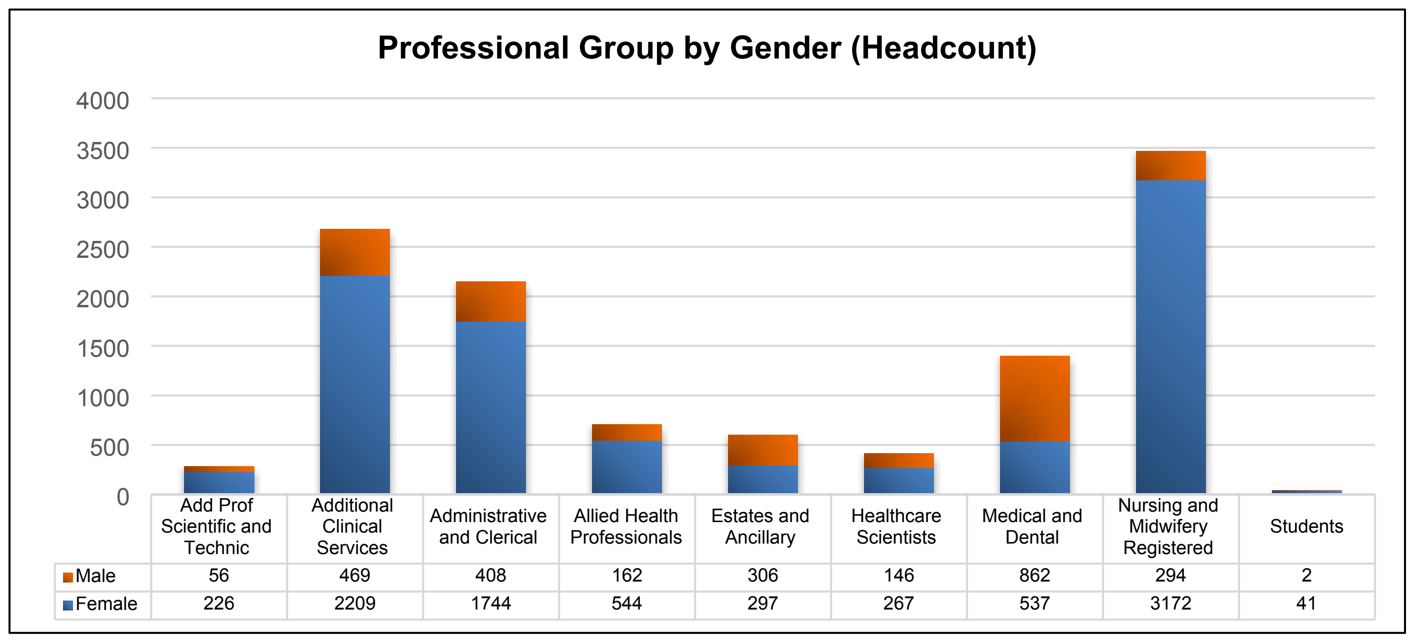
Staff Group	Female	Male
Add Prof Scientific and Technical	80.1%	19.9%
Additional Clinical Services	82.5%	17.5%
Administrative and Clerical	81.0%	19.0%
Allied Health Professionals	77.1%	22.9%
Estates and Ancillary	49.3%	50.7%
Healthcare Scientists	64.6%	35.4%
Medical and Dental	38.4%	61.6%
Nursing and Midwifery Registered	91.5%	8.5%
Students	95.3%	4.7%
Trust Total	77%	23.0%

AfC Pay Band	Female	Male
Band 2	78.9%	21.1%
Band 3	84.8%	15.2%
Band 4	82.1%	17.9%
Band 5	87.4%	12.6%
Band 6	83.9%	16.1%
Band 7	81.4%	18.6%
Band 8a	74.5%	25.5%
Band 8b	64.6%	35.4%
Band 8c	60.6%	39.4%
Band 8d	45.5%	54.5%
Band 9	73.3%	26.7%

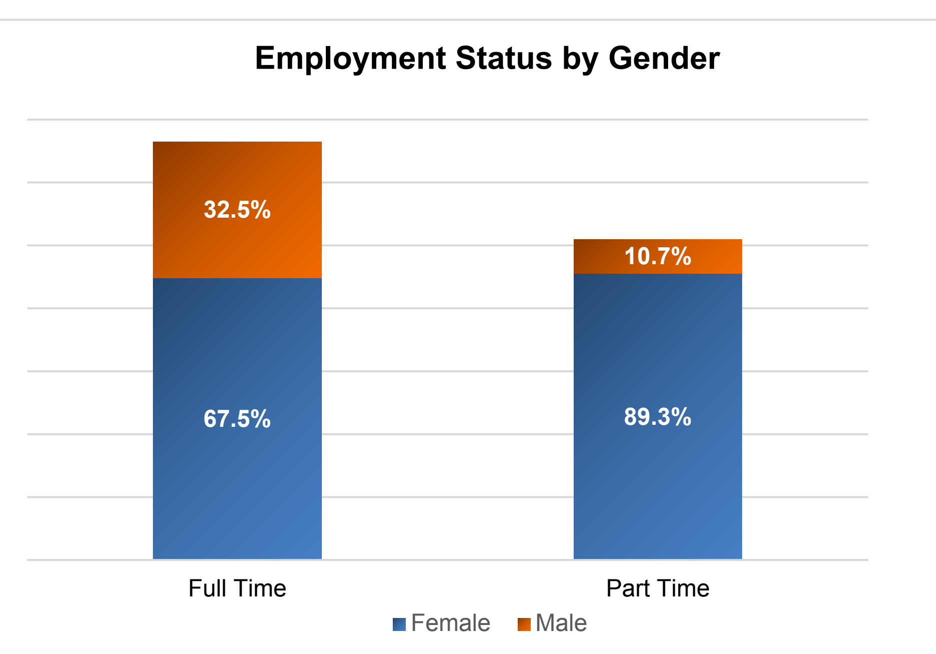
The percentage of women in the medical and dental staff group has increased by 4.4% compared to the previous year.

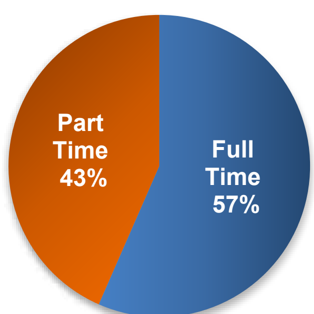
Whilst overall numbers of women have increased, they are under-represented at Consultant level, at just 28.7% but have greater representation in trust grade specialty doctor roles at 47%. Furthermore women make up 56.2% of Foundation Year 1 and 48.7% of Foundation Year 2 doctors.

It is important for us to understand how we can support and enable women in non-consultant roles to translate into proportional Consultant postholders. We will be engaging with our medical workforce to help inform our actions in this area.



	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students
Male	56	469	408	162	306	146	862	294	2
Female	226	2209	1744	544	297	267	537	3172	41





A greater proportion of women are in part time roles, which in comparison with full time jobs, tend to have a lower hourly median pay.

% of Employees Working Part Time by Agenda for Change Pay Band

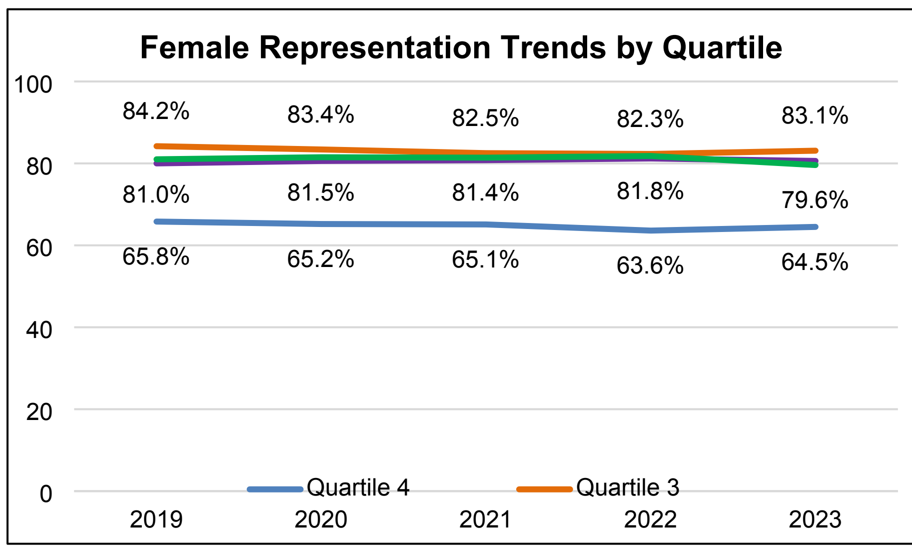
100
90
80
70
60
50
40
30
20
10
0

AfC Pay Band	2	3	4	5	6	7	8a	8b	8c	8d	9
%	66.2%	44.1%	30.8%	47.4%	47.4%	30.6%	23.6%	16.8%	6.1%	0%	0%

AfC Pay Band

The amount of colleagues (male or female) working part time decreases as pay bands increase.

12.6% of doctors work less than full time (16.9% of female doctors and 9.9% of male doctors)



There has been an increase of 0.9% female representation in Quartile 4 (upper pay) and 0.8% in Quartile 3 (middle to upper pay) compared to the previous year. The Medical and Dental professional group has seen the most notable movement in gender representation, with females increasing by a headcount of 75, while male representation has reduced by a headcount of 37.

% of Employees by Quartile and Gender 2019-2023

	Quartile 1	Quartile 2	Quartile 3	Quartile 4
Female 19	81.0%	80.0%	84.2%	65.8%
Male 19	19.0%	20.0%	15.8%	34.2%
Female 20	81.5%	80.6%	83.4%	65.2%
Male 20	18.5%	19.4%	16.6%	34.4%
Female 21	81.4%	80.8%	82.5%	65.1%
Male 21	18.6%	19.2%	17.5%	34.9%
Female 22	81.8%	81.2%	82.3%	63.6%
Male 22	18.2%	18.8%	17.7%	36.4%
Female 23	79.6%	80.6%	83.1%	64.5%
Male 23	20.4%	19.4%	16.9%	35.5%

How do we compare with other similar organisations?

We can compare our gender pay performance against our Model Hospital recommended peers using the gender pay gap data from the last report (**31st March 2022** snapshot), which is available from the NHS Model Hospital website.

Pay Gap Metrics	Data period	Provider value	Peer average	National value	National value method	Chart
Average gender hourly pay gap	2022/23	28.3%	24.8%	20.5%	Provider median	
Median gender hourly pay gap	2022/23	15.9%	13.3%	9.3%	Provider median	
Proportion of males in lower quartile of hourly pay	2022/23	18.2%	15.5%	19.4%	Provider median	
Proportion of females in lower quartile of hourly pay	2022/23	81.8%	84.5%	80.6%	Provider median	
Proportion of males in top quartile of hourly pay	2022/23	36.4%	29.3%	32.3%	Provider median	
Proportion of females in top quartile of hourly pay	2022/23	63.6%	70.7%	67.7%	Provider median	

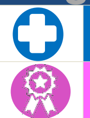
Executive Summary

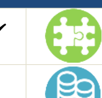
Meeting:	Trust Board (Open)	Date:	3rd April 2024
Report Title:	Leadership Competency Framework	Agenda Item:	13.
Author:	Nicola Hassall, Deputy Associate Director of Corporate Governance		
Non-Executive / Executive Leads:	David Wakefield, Chair / Tracy Bullock, Chief Executive		

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

No associated risks identified

Executive Summary:

Situation

This paper provides the Board with an update on the actions required to implement the new Leadership Competency Framework (LCF), published by NHS England in March 2024. The framework was developed following the 2019 Kark review of the Fit and Proper Person test, whereby it was recommended for ‘the design of a set of specific core elements of competence, which all directors should be able to meet and against which they can be assessed’. This paper is also provided as assurance in respect of Care Quality Commission Well-led Key Line of Enquiry 1.1 “Do leaders have the skills, knowledge, experience, and integrity that they need – both when they are appointed and on an ongoing basis?”.

Background

Updates in relation to implementation of the revised Fit and Proper Person Test (FPPT) Framework have been provided to the Nomination and Remuneration Committee, and revised checks have been undertaken on all Board Members. The LCF is to be used when recruiting and appraising Board Members and the Board Member Appraisal Framework will be published by autumn 2024.

Assessment

The LCF is designed to:

- support the appointment of diverse, skilled and proficient leaders
- support the delivery of high-quality, equitable care and the best outcomes for patients, service users, communities and our workforce
- help organisations to develop and appraise all board members
- support individual board members to self-assess against the six competency domains and identify development needs

Six leadership competency domains have been identified as follows:

Driving high-quality and sustainable outcomes	The skills, knowledge and behaviours needed to deliver and bring about high quality and safe care and lasting change and improvement – from ensuring all staff are trained and well led, to fostering improvement and innovation which leads to better health and care outcomes.

Setting strategy and delivering long-term transformation	The skills that need to be employed in strategy development and planning, and ensuring a system wide view, along with using intelligence from quality, performance, finance and workforce measures to feed into strategy development
Promoting equality and inclusion, and reducing health and workforce inequalities	The importance of continually reviewing plans and strategies to ensure their delivery leads to improved services and outcomes for all communities, narrows health and workforce inequalities, and promotes inclusion.
Providing robust governance and assurance	The system of leadership accountability and the behaviours, values and standards that underpin our work as leaders. This domain also covers the principles of evaluation, the significance of evidence and assurance in decision making and ensuring patient safety, and the vital importance of collaboration on the board to drive delivery and improvement.
Creating a compassionate, just and positive culture	The skills and behaviours needed to develop great team and organisation cultures. This includes ensuring all staff and service users are listened to and heard, being respectful and challenging inappropriate behaviours.
Building a trusted relationship with partners and communities	The need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities, and our workforce. Strengthening relationships and developing collaborative behaviours are key to the integrated care environment.

The above competency domains will be incorporated into all future Board Member job descriptions and recruitment processes, as well as being used to help evaluate applications and identify questions to explore skills and behaviours. It is expected that any relevant information in respect of the competencies will also be included in future Board Member References. In addition, the competencies will form part of Board Member appraisals for 2024/25 and the appraisal document will be reviewed again once the new Board Member Appraisal Framework has been published. A revised Chair Appraisal Framework has been published and will therefore be utilised for the Chairs 2023/24 appraisal.

Prior to their 2023/24 appraisals, all Board Members will be required to self-assess themselves against the competency domains. In addition, Board Members (and other Stakeholders for the Chair) will be invited to provide a response to each of the statements within the assessment (i.e. strongly agree, agree, disagree, or strongly disagree). The Chair (for Non-Executive Directors), Chief Executive (for Executive Directors) and Senior Independent Director (for the Chair), will subsequently assure themselves that Board Members can demonstrate evidence of achievement across all 6 domains, and where this is not the case, will ensure that appropriate development is identified.

Key Recommendations:

The Trust Board is asked to approve the following:

- Incorporation of the competency domains into all future Board Member job descriptions and recruitment processes, as well as being used to help evaluate applications and identify questions to explore skills and behaviours
- Incorporating the competency domains as part of Board Member appraisals undertaken in 2024, noting that the Trust templates will be reviewed again once the new Board Member Appraisal Framework has been published

The Trust Board is asked to note the following:

- That the outputs of the appraisal process and implementation of the LCF will be included within existing reports to the Nominations and Remuneration Committee
- That the competency domains are expected to be built into national leadership programmes and support offers for Board Directors and Aspiring Board Directors.

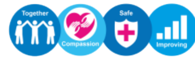
Leadership Competency Framework Board Member Self-Assessment

Domain 1: Driving High Quality, Sustainable Outcomes

What does good look like?

I am a member of a unitary board which is committed to ensuring excellence in the delivery of high quality and safe care within our limited resources, including our workforce. I seek to ensure that my organisation demonstrates continual improvement and that we strive to meet the standards expected by our patients and communities, as well as by our commissioners and regulators, by increasing productivity and bringing about better health and care outcomes with lasting change and improvement.

Competency	Almost Always	Frequently	Occasionally	Rarely or Never	No Chance to Demonstrate
1. I contribute as a leader:					
1a. to ensure that my organisation delivers the best possible care for patients					
1b. to ensure that my organisation creates the culture, capability and approach for continuous improvement, applied systematically across the organisation					
2. I assess and understand:					
2a. the performance of my organisation and ensure that, where required, actions are taken to improve					
2b. the importance of efficient use of limited resources and seek to maximise productivity and value for money and delivery of high quality and safe services at population level					
2c. the need for a balanced and evidence-based approach in the context of the board's risk appetite when considering innovative solutions and improvements					
3. I recognise and champion the importance of:					
3a. attracting, developing and retaining an excellent and motivated workforce					
3b. building diverse talent pipelines and ensuring appropriate succession plans are in place for critical roles					
3c. retaining staff with key skills and experience in the NHS, supporting flexible working options as appropriate					
4. I personally:					
4a. seek out and act on performance feedback and review, and continually build my own skills and capability					
4b. model behaviours that demonstrate my willingness to learn and improve, including undertaking relevant training					



Domain 2: Setting Strategy and Delivering Long Term Transformation

What does good look like?

I am a member of a unitary board leading the development of strategies which deliver against the needs of people using our services, as well as statutory duties and national and local system priorities. We set strategies for long term transformation that benefits the whole system and reflects best practice, including maximising the opportunities offered by digital technology. We use relevant data and take quality, performance, finance, workforce intelligence and proven innovation and improvement processes into account when setting strategy.

Competency	Almost Always	Frequently	Occasionally	Rarely or Never	No Chance to Demonstrate
1. I contribute as a leader to:					
1a. the development of strategy that meets the needs of patients and communities, as well as statutory duties, national and local system priorities					
1b. ensure there is a long-term strategic focus while delivering short-term objectives					
1c. ensure that our strategies are informed by the political, economic, social and technological environment in which the organisation operates					
1d. ensure effective prioritisation within the resources available when setting strategy and help others to do the same					
2. I assess and understand:					
2a. the importance of continually understanding the impact of the delivery of strategic plans, including through quality and inequalities impact assessments					
2b. the need to include evaluation and monitoring arrangements for key financial, quality and performance indicators as part of developing strategy					
2c. clinical best practice, regulation, national and local priorities, risk and financial implications when developing strategies and delivery plans					
3. I recognise and champion the importance of long-term transformation that:					
3a. benefits the whole system					
3b. promotes workforce reform					
3c. incorporates the adoption of proven improvement and safety approaches					
3d. takes data and digital innovation and other technology developments into account					
4. I personally:					
4a. listen with care to the views of the public, staff and people who use services, and support the organisation to develop the appropriate engagement skills to do the same					
4b. seek out and use new insights on current and future trends and use evidence, research and innovation to help inform strategies					

Domain 3: Promoting Equality and Inclusion, and Reducing Health Inequalities

What does good look like?
I am a member of a unitary board which identifies, understands and addresses variation and inequalities in the quality of care and outcomes to ensure there are improved services and outcomes for all patients and communities, including our workforce, and continued improvements to health and workforce inequalities.

Competency	Almost Always	Frequently	Occasionally	Rarely or Never	No Chance to Demonstrate
1. I contribute as a leader to:					
1a. improve population health outcomes and reduce health inequalities by improving access, experience and the quality of care					
1b. ensure that resource development takes account of the need to improve equity of health outcomes with measurable impact and identifiable outcomes					
1c. reduce workforce inequalities and promote inclusive and compassionate leadership across all staff groups					
2. I assess and understand:					
2a. the need to work in partnership with other boards and organisations across the system to improve population health and reduce health inequalities (link to Domain 6)					
3. I recognise and champion:					
3a. the need for the Board to consider population health risks as well as organisational and system risks					
4. I personally:					
4a. demonstrate social and cultural awareness and work professionally and thoughtfully with people from all backgrounds					
4b. encourage challenge to the way I lead and use this to continually improve my approaches to equality, diversity and inclusion and reducing health and workforce inequalities					

Domain 4: Providing Robust Governance and Assurance

What does good look like?

I understand my responsibilities as a board member and how we work together as a unitary board to reach collective agreement on our approach and decisions. We use a variety of information sources and data to assure our financial performance, quality and safety frameworks, workforce arrangements and operational delivery. We are visible throughout the organisation and our leadership is underpinned by the organisation's behaviours, values and standards. We are seen as a Well Led organisation and we understand the vital importance of working collaboratively.

Competency	Almost Always	Frequently	Occasionally	Rarely or Never	No Chance to Demonstrate
1. I contribute as a leader by:					
1a. working collaboratively on the implementation of agreed strategies					
1b. participating in robust and respectful debate and constructive challenge to other Board Members					
1c. being bound by collective decisions based on objective evaluation of research, evidence, risks and options					
1d. contributing to effective governance and risk management arrangements					
1e. contributing to evaluation and development of board effectiveness					
2. I understand Board Member responsibilities and my individual contribution in relation to:					
2a. financial performance					
2b. establishing and maintaining arrangements to meet statutory duties, national and local system priorities					
2c. delivery of high quality and safe care					
2d. continuous, measurable improvement					
3. I assess and understand:					
3a. the level and quality of assurance from the Board's Committees and other sources					
3b. where I need to challenge other Board Members to provide evidence and assurance on risks and how they impact decision making					
3c. how to proactively monitor my organisation's risks through the use of the Board Assurance Framework, the risk management strategy and risk appetite statements					
3d. the use of intelligence and data from a variety of sources to recognise and identify early warning signals and risks					
4. I recognise and champion:					
4a. the need to triangulate observations from direct engagement with staff, patients and service users, and engagement with stakeholders					
4b. working across systems, particularly in responding to patient safety incidents, and an understanding of how this links with continuous quality improvement					
5. I personally:					
5a. understand the individual and collective strengths of the Board, and I use my personal and professional knowledge and experience to contribute at the Board and support others to do the same					

Domain 5: Creating a Compassionate, Just and Positive Culture

What does good look like?

As a board member I contribute to the development and ongoing maintenance of a compassionate and just learning culture, where staff are empowered to be involved in decision making and work effectively for their patients, communities and colleagues. As a member of the board, we are each committed to continually improving our approach to quality improvement, including taking a proactive approach and culture.

Competency	Almost Always	Frequently	Occasionally	Rarely or Never	No Chance to Demonstrate
1. I contribute as a leader to:					
1a. develop a supportive, just and positive culture across the organisation (and system) to enable all staff to work effectively for the benefit of patients, communities and colleagues					
1b. ensure that all staff can take ownership of their work and contribute to meaningful decision making and improvement					
1c. improve staff engagement, experience and wellbeing in line with our NHS People Promise					
1d. ensure there is a safe culture of speaking up for our workforce					
2. I assess and understand:					
2a. My role in leading the organisation's approach to improving quality, from immediate safety responses to creating a proactive and improvement-focused culture					
3. I recognise and champion:					
3a. being respectful and I promote diversity and inclusion in my work					
3b. the ability to respond effectively in times of crisis or uncertainty					
4. I personally:					
4a. demonstrate visible, compassionate and inclusive leadership					
4b. speak up against any form of racism, discrimination, bullying, aggression, sexual misconduct or violence, even when I might be the only voice					
4c. challenge constructively, speaking up when I see actions and behaviours which are inappropriate and lead to staff or people using services feeling unsafe, or staff or people being excluded in any way or treated unfairly					
4d. promote flexible working where possible and use data at board level to monitor impact on staff wellbeing and retention					

Domain 6: Building Trusted Relationships with Partners and Communities

What does good look like?
I am part of a board that recognises the need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities and our workforce. We are seen as leading an organisation that proactively works to strengthen relationships and develop collaborative behaviours to support working together effectively in an integrated care environment.

Competency	Almost Always	Frequently	Occasionally	Rarely or Never	No Chance to Demonstrate
1. I contribute as a leader by:					
1a. fostering productive partnerships and harnessing opportunities to build and strengthen collaborative working, including with regulators and external partners					
1b. identifying and communicating the priorities for financial, access and quality improvement, working with system partners to align our efforts where the need for improvement is greatest					
2. I assess and understand:					
2a. the need to demonstrate continued curiosity and develop knowledge to understand and learn about the different parts of my own and other systems					
2b. the need to seek insight from patient, carer, staff and public groups across different parts of the system, including Patient Safety Partners					
3. I recognise and champion:					
3a. management and transparent sharing, of organisational and system level information about financial and other risks, concerns and issues					
3b. open and constructive communication with all system partners to share a common purpose, vision and strategy					

NHS Chair Appraisal Reporting Template

This template should be used to formally record the summary of the key outcomes from the appraisal discussion between chairs and appraisal facilitators.

Name of Organisation:	
Name of Chair:	
Name and Role of Appraisal Facilitator:	
Appraisal Period:	
Date of Appraisal:	

Part 1: Multisource Stakeholder Assessment Outcomes (for completion by appraisal facilitator)

A. Summary of significant emergent themes from stakeholder assessments:

B. Highlighted areas of strength:

C. Identified opportunities to increase impact and effectiveness:

Part 2: Self-Reflection (for completion by the chair)

Summary of self-reflection on multisource stakeholder assessment outcomes in light of own self-assessment:

Part 3: Personal Development and Support (for completion by the chair and appraisal facilitator)

Personal development and/or support needs identified:			
Description	**Proposed Intervention**	**Indicative Timescale**	**Anticipated Benefit / Measure of Success**

Part 4: Principal Objectives (for completion by chair and appraisal facilitator)

Summary of self-reflection on multisource stakeholder assessment outcomes:		
Objective	**Anticipated Benefit / Measure of Success**	**Anticipated Constraints / Barriers to Achievement**
1.		
2.		
3.		

Part 5: Suitability for Appointment (for completion by the chair and appraisal facilitator)

The appraisee has been assessed in the last 12 months under the NHS England FPPT Framework and it is confirmed that they continue to be a 'fit and proper person' as outlined in Regulation 5 and there are no pending proceedings or other matters which may affect their suitability for appointment.
YES / NO – If NO please provide details:

Part 6: Overall Assessment Rating and Confirmation

Explanation of Assessment Ratings	
1. **Satisfactory** – they are meeting their formal expectations	2. **Cause for concern** (they are not meeting their formal expectations and will be formally logged and addressed)

Confirmation of overall assessment rating: (please circle and sign below)		
1. Satisfactory	**2. Cause for concern**	
Confirmed by	**Signature**	**Date**
Chair		
Senior Independent Director		

Part 7: Confirmation

Confirmation of key outcomes of appraisal discussion:		
Confirmed by	**Signature**	**Date**
Chair		
Appraisal Facilitator		

Part 8: Submission

a. Copy submitted to england.chairsappraisal@nhs.net who will forward to your Regional Director for review

Name of Regional Director	Date

b. Endorsement by NHS England Chief Operating Officer (NHS England to action)

Name	Date
Name	**Date**

Non-Executive Director Appraisal Summary

This template should be used to formally record the summary of the key outcomes from the appraisal discussion between Chairs and Non-Executive Directors.

Name of Organisation:	
Name of Non-Executive Director:	
Name of Chairman:	
Appraisal period:	
Date of appraisal:	

1. Overall Assessment of Performance

The performance of the individual has been assessed as (please indicate with an 'x')

Strong Performance	Fully Competent	Needs Development	Poor Performance

2. Summary of Stakeholder Outcomes (for completion by the Chair)

3. Summary of Self-Reflection on Leadership Competency Framework Self-Assessment in light of Stakeholder Assessment Outcomes (for completion by the Non-Executive Director)

4. Assessment of Performance Against Agreed Objectives

5. Specific Strengths and Aspirations

6. Learning and Development Needs

Personal development and/or support needs identified:			
Description	**Proposed Intervention**	**Indicative Timescale**	**Anticipated Benefit / Measure of Success**

7. Any Further Comments, including any actions to improve performance

8. Suitability for Appointment (for completion by the chair and appraisal facilitator)

The appraisee has been assessed in the last 12 months under the NHS England FPPT Framework and it is confirmed that they continue to be a 'fit and proper person' as outlined in Regulation 5 and there are no pending proceedings or other matters which may affect their suitability for appointment.
YES / NO – If NO please provide details:

9. Confirmation

Confirmation of key outcomes of appraisal discussion:		
Confirmed by	**Signature**	**Date**
Chair (appraiser)		
Non-Executive Director (appraisee)		

10. Submission

Copy submitted to NHS England

Executive Director Objective Setting & Performance and Development Review (PDR) Record

Name of Executive Director:	
Job Title:	
Appraisal Period:	
Date of Appraisal:	

1. Summary of Stakeholder Outcomes (for completion by the Chief Executive)

2. Summary of Self-Reflection on Leadership Competency Framework Self-Assessment in light of Stakeholder Assessment Outcomes (for completion by the Executive Director)

3. Assessment of Performance in the Past Year Against Objectives

Please provide a brief overview of whether or not you have achieved the objectives which were set in your previous appraisal.

Objectives	Action Taken	Completed?	Comments

4. Statutory and Mandatory Training

Please confirm your compliance in terms of core and essential to role training and any timescales to complete outstanding training modules.

5. Reflection on What Went Well, What Could Have Gone Better and How I Have Met the Trust Values

Please describe any aspects of your performance in the past year that went well, along with any aspects which could have gone better, and you might do differently in the future.

6. Objectives for Current Year, Aligned to Strategic Priorities

Please identify below, your objectives for the forthcoming year and identify against each, which of the Strategic Priorities these are aligned to.

Objective	Strategic Priority						Action Required	Date of Completion
	●							

7. Wellbeing

Is there any update to your health risk assessment or any point you wish to note regarding your health & wellbeing.

8. Personal Development Plan

Is there is any additional study / courses you would like to include for your own personal development.

Description	Proposed Intervention	Indicative Timescale	Anticipated Benefit / Measure of Success

9. Additional Comments

If there is anything further you would like to include that has not been captured above, please record here

9. Fit and Proper Persons Declaration

The appraisee has been assessed in the last 12 months under the NHS England FPPT Framework and it is confirmed that they continue to be a 'fit and proper person' as outlined in Regulation 5 and there are no pending proceedings or other matters which may affect their suitability for appointment.

YES / NO – If NO please provide details:

10. Confirmation

Confirmed by	Signature	Date
Chief Executive (appraiser)		
Executive Director (appraisee)		

Date Inputted onto ESR	

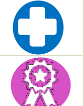
Executive Summary

Meeting:	Trust Board	Date:	3rd April 2024
Report Title:	Integrated Performance Report, Month 11 2023/24	Agenda Item:	
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & Safety; Operational Performance: Warren Shaw, Strategic Director of Performance & Information; Matt Hadfield, Associate Director of Performance & Information. Workforce: Jason Ahern, Assistant Director of Workforce Information; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Simon Evans: Chief Operating Officer Jane Haire: Chief People Officer Mark Oldham: Chief Finance Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

	High Quality			People			Systems & Partners
	Responsive			Improving & Innovating			Resources

Risk Register Mapping

Executive Summary

Situation

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

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

Quality & Safety

The report provides latest (February 2024) update on the different Quality Indicators. There have been updates to the report to include, where possible, peer benchmarking against various quality indicators. These indicators, where applicable, utilise SPC charts and to allow for comparisons allowing for activity and benchmarking, the rate per 1000 bed days. The use of rates per 1000 bed days allows comparison between organisation and national targets/benchmarking by allowing for different activity levels and not just the comparison of raw total numbers. The charts/indicators with only raw total numbers are used to provide internal analysis of the indicators so can also compare different months to set target totals i.e. C Diff Cases, E Coli cases, MRSA which have set target per month already calculated and set nationally for the organisation.

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

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

The report includes the Assurance Matrix and reordered indicators and dashboard so that indicators are grouped together appropriately.

Assessment

The number of reported patient safety incidents has decreased this month as well as the rate per 1000 bed days. However, both are continuing to show positive trends and remain within normal variation limits. Total incidents reported is showing significant high variation and positive reporting. It should be noted that an increase in reported incidents and near misses should not be seen as negative hence positive rating for variation indicator) but can reflect a positive reporting culture. The breakdown of incidents by harm reflects this and that there have been increases in reported incidents with no harm and near misses.

Moderate harm or above incidents, both raw numbers and rate per 1000 bed days have also shown an initial in month reduction in February 2024 but last 2 months have shown increases compared to reducing trends in previous 12 months.

During February 2024 there have been 0 ‘Your Next Patient’ related incidents reported with moderate harm and that there had been reductions overall as the Trust continued to face increased operational pressures during February 2024.

The largest categories for reported PSIs excluding Non-Hospital Acquired Pressure Ulcers continue to be Patient Falls, Medication, Patient Flow, Clinical Assessment and Treatment related incidents. Patient Falls incidents remain the largest category after Tissue Viability in February 2024 and there were no significant changes in these categories compared to previous months.

Patient falls rate has continued to show longer term positive trend, and February 2024 has noted a decrease to 5.0 and there was also a slight decrease in falls with harm rate of 1.7 during February compared to 1.8 in January and but is also lower than same period in 2023.

Medication related incidents have decreased this month but continue to be higher than same period last year as part of the ongoing drive to improve reporting of medication errors/incidents. There has been a decrease in February (at time of the report) in the percentage of these incidents that have been reported as resulted in moderate harm or above for overall medication related incidents but when patient related only there has been increase from 2.93% to 3.32%. These incidents will be reviewed at Medicines Optimisation & safety Group to assess the impact on patients and also identify and share learning.

As noted previously, since December 2023 the Trust no longer reported incidents via the Serious Incident Framework following the introduction of the new national Patient safety Incident Review Framework (PSIRF). However, the Trust has logged and notified the ICB of 1 incident during February 2024 on STEIS but under the PSII response.

There has been 1 new Never Event reported during February 2024. This incident related to wrong site surgery (incorrect lesion) and is the second in recent months. This new incident will have a PSII completed but in addition a thematic review of the previously reported and investigated incorrect lesion removals will also be undertaken to assess and compare any differences or similarities between the incidents. The outcomes of these reviews will be formally reported to QSOG and QGC.

Duty of Candour compliance during February for verbal notification at has remained at 100% but there was also a decrease in compliance with the internally set 10-day target with 75%. There were 15 cases recorded as formally triggering duty of candour. 12 of the 15 cases have recorded written follow up being provided within the 10-day target but 3 other not complying with the timeframe. It is noted however that all of the cases have subsequently completed the written follow up and the Trust is compliant with the statutory duty of candour regulations.

The current position for received patient Safety Alerts shows that there is 1 overdue Patient Safety Alert (at time of report). There was 1 new alert received during February and the 1 overdue alert has been actioned and is being led by the ICB on behalf of the wider ICS.

Pressure Ulcer developed under UHNM care have decreased as well as the pressure ulcers with lapses in care during February 2024 and remains below the long-term mean. Category 2 pressure ulcer with lapses in care continue to be the largest category with Category 3 and Unstageable showing reductions during February 2024. There has been slight increase in number of Deep Tissue Injuries identified with lapses in care but these remain in normal variation and below the long term mean. The new PSIRF Tissue Viability toolkit is in use and allows more involvement in clinical areas for developing responses and embedding of learning and sustained improvement.

Friends & Family Test for A&E remains below the 85% target of patients recommending the service and following previous months improvements, February has seen lower score of 65% with response rate of 10% which is an improvement from previously reported 8% response rate. UHNM is 40th out of 124 Trusts nationally for response rate, previously noted to be 33rd. However, UHNM is 84th for the percentage pf positive results, previously reported 87th. To promote and increase the response rate the FFT questionnaires are continuing to be handed out to all patients on arrival to ED and the QR codes have been made more visible throughout the department. In addition, a 'You said, we did' board has been put up in the Waiting Area to demonstrate changes to patient/relatives' comments in a bid to further promote and increase the responses received.

Inpatient FFT results have decreased below the 95% target with 94.1%. The response rate has also reduced in February with 20% compared to 22% in January, December with19% and 21% in November 2023. UHNM have the 20th highest response rate out of the 154 acute trusts reporting FFT for inpatient areas which is an improvement from previously reported 17th. There are key improvement initiatives identified previously are continuing and focus on key priorities identified within the FFT returns.

Maternity FFT is above the 95% target at 95.3%. February 2024 saw improvement with 127 (110 in January , 104 in December, 85 in November and 97 in October) completed surveys returned with 21 (40 in January, 37 in December, 25 in November and 21 in October) completed from the Birth touchpoint. The antenatal touchpoint scored 83% recommendation and post natal 97% recommendation. Compared to the latest national data available (December 2023) out of 113 Trusts, UHNM were 73rd for number of responses for antenatal, 41st for number of responses for birth, 37th for post-natal ward and 57th for post-natal community which shows improvement in all areas. FFT Task & Finish Group for post-natal care established and work is ongoing with the Maternity Voices for improving feedback.

Complaints rate remains below the target/benchmark rate of 35 and within normal variation. Complaints Team are continuing to review the complaints triage process to ensure that it is effective and that the number of PALS escalated to formal complaints does not rise. This is included in the quarterly Patient Experience Reports along with detailed reviews of trends and themes from received complaints. The average monthly response times for February 2024 recording median response time of 64 working days (against target of 40 working days).

Mortality indices remain within expected ranges and compare well with our peers and other acute trusts. SHMI is showing significant improvement with 9 consecutive months of reductions. HSMR has also reduced for third month in succession.

VTE Risk assessment compliance has declined during February and is below the 95% target at 91.5%. The new VTE Risk assessment has been introduced across surgical wards.

Hospital Associated Thrombosis rate remains below the long term mean in February 2024 with a rate of 0.63per 10,000 admissions.

Timely Observations are continuing to improve across the Trust with current performance at 73.5%. Fir the first time since reporting/monitoring there are 0 wards with less than 50% of patients having timely observations recorded on VitalPack. As previously noted, Medicine, Surgery and Network Services have all now included Timely Observations as Driver Metrics and focussing as priority to improve compliance.

C Diff numbers have increased during February but remains lower than February 2023 with 13 cases confirmed. There have been number of key actions taken during the past month including the addition of the CUR-95 score has now been added to the CAP antimicrobial Microguide to support clinicians in treatment decisions.

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

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

All data used in this report is as recorded on 8th March 2024 and figures may change following further review/investigation/update

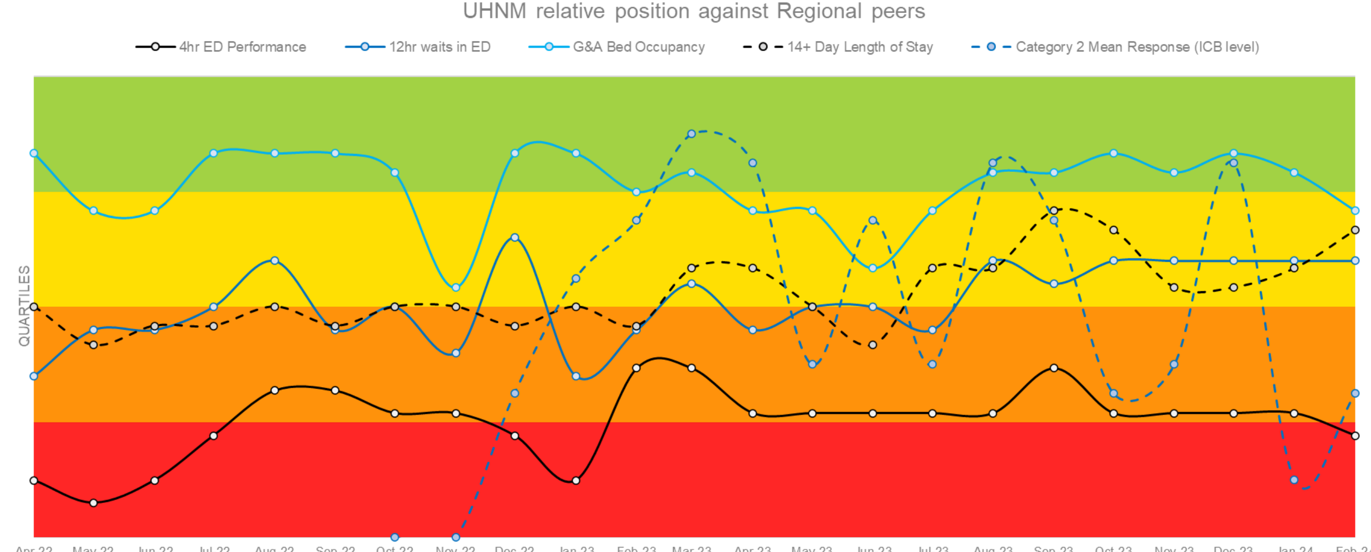
Operational Performance

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

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

How are we doing against our trajectories and expected standards?

12 Hour trolley wait delays in the Emergency Departments improved overall in February and the 4 hour standard remained largely static (0.3% reduction) The Ambulance handover in within 60 min indicator also improved although all of these below the target range desired. During the month of February the 76% 4-hour standard was increasing in its priority having been deprioritised in order to focus on ambulance handover and safety measures. This strategy is in keeping with the Trusts zero tolerance approach to extreme handover delays and both were expected to improve as they did.



In relative performance when compared to regional peers the 14+Day length of stay indicator showed improvement as well as the Category 2 mean time for ambulance response. However, in relative terms the 4 hour performance for February deteriorated along with bed occupancy reflecting the high utilisation of both Stafford County and Royal Stoke sites.

Whilst figures show the overall month position a look at weekly performance during February showed a week on week improvement. From the week commencing 5h of February, 4-hour performance, ambulance handover delays and 12 hour trolley waits all showed a week on week improvement. For example 4-hour performance improvement moved from 59% on the 5th of February through to 69.1% 26th February.

What is driving this?

February 2024 forecast anticipated a challenging suite of demands on services with further BMA Industrial Action taking place across a weekend Saturday 24th Feb to Wednesday 28th Feb.

In addition to this on the 13th February inpatient capacity was exceeded and with increased demands in emergency departments a Critical Incident was declared. The incident response lasted until the 15th February whereby access to

Emergency Care was restored to more normal operating parameters. On review of this incident alongside the winter surge response, it was evident that this was one of 3 points over winter where the demand for inpatient care was greater than capacity for a period of up to 4 days. This then led to overcrowding and reduced access in excess of safe parameters.

Multiple organisations faced similar demands at this time across the region and it is likely that the original peak demand model that was anticipated in planning for the 15th January, revised for February half term in fact peaked on the 14th February.

A review of both surge plan actions and subsequent command and control interventions put in place to respond to deterioration in emergency access took place on the 22nd February 2024. This pulls together intelligence on both the initial planning for winter period as well as additional responses and improvement schemes in order to aid recovery in March and to better plan for holiday periods and winter going forward.

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

Throughout February additional measures were put in place to protect non-admitted pathways and build resilience in admitted pathways to support the achievement of the 4-hour standard. This was managed whilst balancing the demands on inpatient care and ambulance handovers. These activities will continue into March.

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

In January and February 2024, considering increased Industrial Action and winter pressures, additional focus has been put into a smaller range of improvement activities with the expectation of more sustainable progress than the previous much broader programme of work. Once Industrial Action activities cease in March the full range of improvement programme will restart.

Specific areas of feedback:

Admission Avoidance and Length of Stay reduction through Acute Care at Home

- The service still operates with a large vacancy rate and recruitment continues alongside elements of mutual aid to maximise capacity.
- Development of the Call Before Convey services continues with reenforced communication strategies; recent evaluation has been shown to be one of the most successful/well used call before convey services available to benchmark.
- Agreement on the next stage of Call Before Convey to include Category 2 Ambulance Calls has been established and work is commencing on protocol and resourcing to intervene in this important cohort of patients conveyed to hospital.

Non-Admitted Performance (RSUH)

- Conscious decisions to use non-admitted capacity to support ambulance handover will now reduce unless in the most extreme days of pressure.
- County Hospital increased demand with diverts and increased intelligent conveyance will be used less in order to support RSUH site.

Winter Preparation

- Winter/surge plan actions continued through February and are expected to be in place until mid-April before any services reduce to pre-winter levels. Bed bases will not reduce until April when works on the Stafford County Site will require the closure of a ward.
- The review of actions taken and winter measures took place in February and have been used to form the Easter holiday plan alongside mainstreaming of elements of the seasonal plan.

Workstream Priority – Workstream 2 Standard Work (RSUH)

- Improvement in ward discharges on Simple and Timely discharges has a potential to free up to 70 beds
- Use of the SAFER Care bundle Red to Green and Reason to Reside tools will reduce constraints to discharge and reduce unwarranted variation in discharge behaviours.
- KPMG support will continue until the end of March 2024 to enable intensive improvement cycles whilst using the Trusts Improving Together Methodology.

What can we expect in future reports?

The mitigation and improvement actions being undertaken in January and into February are likely to result in positive impact in March 2024 where there is still ambition to achieve sizable improvement in ambulance handover delays, trolley waits within in ED and against the 4-hour standard.

Previous planning on the urgent delivery of a discharge lounge has made way for a refocus of effort on ward discharge practice. Early March success of Workstream 2 has resulted in the additional allocation of resources to help expand this in both increasing scope and pace.

In previous months reports there was reference to a contingency action in the event of the emergency pathway continuing to operate over capacity. This was the cancellation of elective surgery for all patients that require inpatient admission and do not have suspected cancer or have very long waits would enable an increase in capacity for medical specialties. This is unlikely to be utilised now in the Month of March.

At Month end of March 2024 it is unlikely that the 4-hout 76% target will be met in full. It is expected that a marked improvement will be made and it is still expected that March will be one of if not the best performance in the last 12 months.

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

How are we doing against our trajectories and expected standards?

Diagnostic performance in February was above 19/20 levels, however DM01 performance remained largely static in comparison with January. The largest contribution to this coming from Endoscopy delays.

The number of patients waiting 78 weeks or more post validation ended at 159 and the predictions in month increased because of Industrial Action. As a Tier 1 trust NHSE region and national and regional teams have weekly oversight of improvement trajectories. Trajectories originally had factored in a reduction of capacity in January with the ambition of 0 patients waiting by March. As further Industrial Action occurred in February this trajectory has been updated to reflect a reduction down to 0 patients waiting by April 2024. There remained 3 patients waiting over 104 weeks for treatment at the end of February with an expectation that this reduces back to 0 by the end of March 2024.

Cancer treatment backlog numbers have continued to reduce in line with trajectory and latest performance at the close of February have numbers better than trajectory. This performance reflects an improvement in several tumour sites however the most notable and with greatest impact is lower GI (Colorectal) which has seen an improvement to better than trajectory performance. The focus now is on maintaining the position to begin to support overall cancer performance % against the standard. There is a significant amount of cancer alliance funding supporting this position which is currently in discussion for Q1 24/25.

Cancer diagnostic performance is expected in February to meet the 75% standard. SPC charts show a sustained improvement from August and further improvement is still required in specific tumour sites.

What is driving this?

As previously reported Endoscopy performance is contributing to both planned care and cancer standards. Backlogs in cancer are now reducing and the service is increasing its capacity however the recovery period will be staged initially recovering cancer 28 day faster diagnostics standard and then planned care 6 weeks standard. Additional capacity has been secured in Q4 2024 and this will be required throughout 2024/25 with business cases being developed to right size the service permanently.

Industrial Action has reduced capacity during December, January, and February, which combined with increased numbers of patients choosing not to have treatments in the early new year has resulted in a deterioration of waiting times for patients waiting 78 weeks or more. This capacity has been replanned and initial performance expectations was complete reduction down to 0 patients waiting by March. This will now be April.

Cancer treatment backlog reduction (62 day) continue at high levels and capacity has been protected above all other areas of elective care. Increases in capacity supported by West Midlands Cancer Alliance (Lower GI Surgery in particular) have seen a significantly positive impact.

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

Endoscopy services continue their three part improvement plan for the resolution of demand versus capacity. Having completed a recent high level of demand and capacity review it is possible to quantify some of the impact of these schemes.
In Q4 the additional funding to support additional capacity will be fully deployed using support from independent sector insourcing. This is approximately 50% increase in overall capacity moving from 54 funded lists to 72+. This is being used to expand capacity and is the final funding position available to us this financial year. The second part of

the plan uses external support brought into endoscopy to help improve utilisation and productivity. It is anticipated this improvement could lead to 15% more capacity although requires several months to fully deliver. This will also include work with the leadership teams to fully mobilise the digital system now implemented and to improve processes and booking practice. This final element will ensure that the service is sustainable into 2025 and will be the longer term recruitment and workforce strategy to deliver a permanent service that responds to patients needs across SSOT. It is expected that the number of lists to address demand and to clear backlog of patients down within the next 12 months is approximately 104 lists per week. That would represent an increase in endoscopist capacity of approximately 95%, although currently theatre physical and nursing capacity appear to be able to accommodate that increase.

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

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

What can we expect in future reports?

As discussed in previous months IPR narrative diagnostics and planned care will not be met by March 2024. The full impact of this is still being analysed however the timing of the action is such that it is unlikely any suitable alternatives for the lost capacity will be available when required and Q1 will be the earliest these targets will be met.

Cancer services have the greatest protection of services (including cancer diagnostic services) and recovery trajectories are still expected to be delivered. Currently they remain on trajectory in early March however a record increase in referrals as a result of national celebrities and members of the royal family are likely to put unplanned stress on services. Ongoing discussions are taking place with regulators on both undertakings and NOF3 exit criteria which now must be considered in relation to the Industrial Action.

Workforce

How are we doing against our trajectories and expected standards?

- **Turnover** and **vacancy** metrics continue to perform well against our expected standards. The turnover rate in February 2024 has shown a small improvement to 7.9% and this remains well below the Trust's 11% target. The vacancy metric has also improved to 8.10% which also remains within our expected standard of 10%. The main driver of the vacancy % is due to an increase in the total FTE for actual people in post.
- **Sickness absence** continues to be above the Trust expected standard of 3.39%. In month we have seen a 0.51% decrease to 5.33%. The 12-month cumulative rate has increased fractionally to 5.24% from 5.22%. The main driver of this continues to be stress and anxiety, which has seen a 4.3% increase, when compared to the reductions seen in the previous two months. Chest and respiratory conditions remain the second reason for absence, but saw a 6.6% decline resulting from a significant reduction in the reporting of covid cases.
- **Performance Development Reviews (PDR's)** continue to be below the Trust target of 95%. In month we have seen a slight improvement from 82.1% to 83.5%. The refreshed PDR paperwork, to support colleagues in achieving their potential, was published in January 2024, with twelve drop-in sessions taking place, to complement the new guides and electronic training materials which have been made available on the Intranet.
- **Statutory and Mandatory Training** (core for all subjects) remains just below the Trust target of 95% and improved by 0.2% to 93.7% in February 2024 from 93.5% in January.

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

- Divisional and Directorate Management Teams continue to manage sickness absence in line with the Trust Policy.
- The refreshed PDR paperwork was released, as planned, in January 2024, supported by multiple drop-in sessions, as mentioned above. Divisions are also undertaking weekly PDR compliance reviews.

- We are continuing to watch the statutory and mandatory training performance to ensure that we maintain the strong position on this metric.

What can we expect in future reports?

- The local Staff Voice Survey achieved an engagement score of 6.40, with 478 responses, which is 473 less responses than January's results.
- Key themes from the NHS National Staff Survey have been shared with the Divisions and key lines of enquiry have started, to celebrate the improvements, while understanding where improvements can be made ahead of this year's survey.
- We should anticipate that sickness absence in month may continue to incrementally improve, now that we are heading into Spring, with less Covid-19 related cases experienced.

Finance

Key elements of the financial performance for the year to date are:

- For Month 11 the Trust has delivered a year-to-date deficit of £3.3m against a planned surplus of £0.7m; this adverse variance of £4.0 is primarily driven by underperformance against the Trust's in year CIP target and unfunded additional winter escalation capacity that remained open through the year.
- The Trust has received an additional £1.5m funding towards the cost of industrial actions for January and February. This takes the total funding for industrial actions and cost pressures to £10.5m for the year.
- The Trust has incurred £5.0m of costs relating to winter escalation capacity remaining open to Month 7 partially funded by £2.1m of additional funding from the local ICB. Winter and escalation costs from Month 8 are funded as part of the Trust's winter plan.
- To date the Trust has validated £40.9m of CIP savings to Month 11 against a plan of £50.4m. The Trust has recognised £4.7m of CIP due to an assumed reduction in the annual leave provision delivering 50% of the NR ICB stretch CIP target; the balance is expected to be delivered from a further reduction in the provision.
- The Month 11 actual position indicates that the Trust is on track to deliver a break-even position for the year.
- There has been £59.7m of Capital expenditure which is £6.1m below plan.
- The cash balance at Month 11 is £65.3m which is £4.7m lower than plan.

Key Recommendations

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

Integrated Performance Report

Month 11 2023/24

Delivering Exceptional Care with Exceptional People

Contents

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2	Quality	5
3	Operational Performance	31
4	Workforce	73
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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

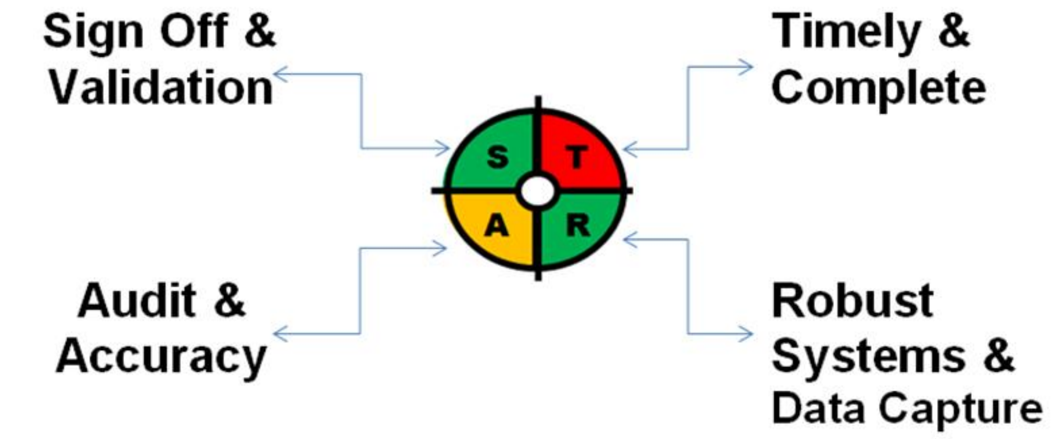
Assurance - how assured of consistently meeting the target can we be?

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

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

A note on Data Quality

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

2025 Vision “Provide safe, effective, caring and responsive services”

Quality Spotlight Report

The Trust achieved the following standards in February 2024:

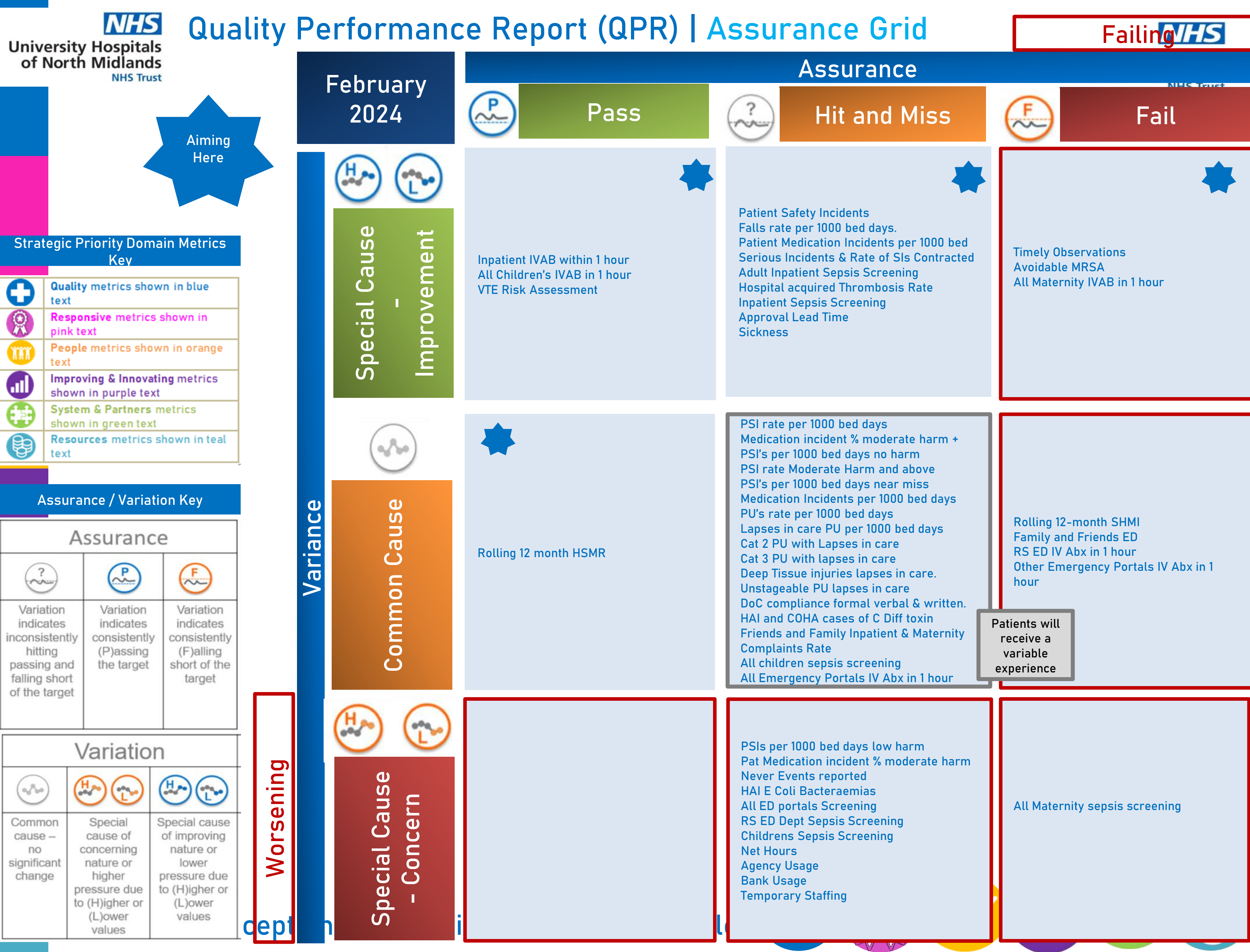
- Falls rate was 5.0 per 1000 bed days for January 2024 and below benchmark rate.
- Rate of falls reported that have resulted in harm to patients currently at 1.7 per 1000 bed days and continues to be within the control limits and normal variation.
- Hospital Associated Thrombosis has continued to remain below the mean rate and is within normal variation and cases are under review.
- 100% verbal Duty of Candour compliance recorded in Datix.
- Trust rolling 12-month HSMR continues to be within expected range at 97.91
- Trust rolling 12-month SHMI 98.44 and is Band 2 – as expected. There has been continued improvement in SHMI
- Zero avoidable MRSA Bacteraemia cases reported.
- Pressure Ulcers per 1000 bed days with lapses in care developed under UHNM care is now 0.39 and below the target rate 0.5
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- E. Coli Bacteraemia cases on trajectory with 16 in February compared to target of 16.
- Inpatient sepsis Screening and Sepsis IVAB within 1 hour achieved 94.8% and 100% respectively and meeting the 90% target rate
- Children's Sepsis Screening compliance achieved the 90% target with 94.1% during February.
- Maternity IVAB compliance improved from 40% and above the 90% target for audited patients with 100%
- Friend & Family (Maternity) 95.3% and above 95% target.
- The rate of complaints per 10,000 spells is 26.69 and remains below the target of 35 and long term mean rate but within normal variation.

The Trust did not achieve the set standards for:

- 75% compliance with Duty of Candour 10 working day letter performance following formal verbal notification and under review for completion and upload of letter on Datix
- There were 17 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 1 Never Event – incorrect lesion removed
- 1 overdue Patient Safety Alerts which is awaiting final approval and sign off (as at end of February 2024 and this is continuing to be led by the ICB)
- Timely Observations remain below the 90% target but has seen further improvement during February 2024 with 73.5%.
- VTE Risk Assessment completed during admission has decline and below 95% target with 91.5% recorded in February (via Tendable)
- C Diff YTD figures above trajectory with 13 against a target of 8.
- Friend & Family (Inpatients) 94.1% and dipped below 95% target.
- Friend & Family (A&E) remains below 85% target at 65%
- Sepsis Screening compliance in Emergency Portals declined to 78% and below the target 90%.
- Emergency Portals Sepsis IVAB improved to 89.8% but remains below the 90% target for audited patients.
- Maternity Sepsis Screening compliance has improved from 45.5% in January 2024 but remain below 90% target at 70%

During February 2024, the following quality highlights are to be noted:

- Total number and rate of Patient Safety Incidents decreased in month but continues to show increased reporting over longer term trend
- Total incidents with moderate harm or above and the rate of these incidents within normal variation levels during January and noted increase in month (incidents are currently under review)
- Medication related incidents rate per 1000 bed days is 6.1 which above the target and the long term mean rate as is patient related at 5.7. The monthly variation is within the normal expected variation and above the NRLS national rates. The % of medication incidents reported with moderate harm or above has decreased for February 2024 and incidents remains under review.
- PSIRF adopted and therefore no Serious Incidents reported. 1 new PSII reported in February 2024 and under review using Patient Safety Incident Investigation (PSII) process
- Largest reason / category of complaints in February 2024 continue to relate to clinical treatment with 36% of complaints received relating to issues with clinical treatment.



University Hospitals of North Midlands NHS Trust
Quality Performance Report (QPR) | Assurance Grid
Failing
February 2024
Assurance
Pass
Hit and Miss
Fail
Aiming Here
Strategic Priority Domain Metrics Key
Quality metrics shown in blue text
Responsive metrics shown in pink text
People metrics shown in orange text
Improving & Innovating metrics shown in purple text
System & Partners metrics shown in green text
Resources metrics shown in teal text
Variance
Special Cause - Improvement
Inpatient IVAB within 1 hour
All Children's IVAB in 1 hour
VTE Risk Assessment
Patient Safety Incidents
Falls rate per 1000 bed days.
Patient Medication Incidents per 1000 bed
Serious Incidents & Rate of SIs Contracted
Adult Inpatient Sepsis Screening
Hospital acquired Thrombosis Rate
Inpatient Sepsis Screening
Approval Lead Time
Sickness
Timely Observations
Avoidable MRSA
All Maternity IVAB in 1 hour
Common Cause
Rolling 12 month HSMR
PSI rate per 1000 bed days
Medication incident % moderate harm +
PSI's per 1000 bed days no harm
PSI rate Moderate Harm and above
PSI's per 1000 bed days near miss
Medication Incidents per 1000 bed days
PU's rate per 1000 bed days
Lapses in care PU per 1000 bed days
Cat 2 PU with Lapses in care
Cat 3 PU with lapses in care
Deep Tissue injuries lapses in care.
Unstageable PU lapses in care
DoC compliance formal verbal & written.
HAI and COHA cases of C Diff toxin
Friends and Family Inpatient & Maternity
Complaints Rate
All children sepsis screening
All Emergency Portals IV Abx in 1 hour
Patients will receive a variable experience
Rolling 12-month SHMI
Family and Friends ED
RS ED IV Abx in 1 hour
Other Emergency Portals IV Abx in 1 hour
Assurance / Variation Key
Assurance
Variation indicates inconsistently hitting passing and falling short of the target
Variation indicates consistently (P)assing the target
Variation indicates consistently (F)alling short of the target
Variation
Common cause – no significant change
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values
Special cause of improving nature or lower pressure due to (H)igher or (L)ower values
Worsening
Special Cause - Concern
PSIs per 1000 bed days low harm
Pat Medication incident % moderate harm
Never Events reported
HAI E Coli Bacteraemias
All ED portals Screening
RS ED Dept Sepsis Screening
Childrens Sepsis Screening
Net Hours
Agency Usage
Bank Usage
Temporary Staffing
All Maternity sepsis screening

Quality Dashboard

Metric	Benchmark	Previous	Latest	Variation	Assurance
Patient Safety Incidents	2000	2480	1851		
Patient Safety Incidents per 1000 bed days	50.70	58.20	45.96		
Patient Safety Incidents per 1000 bed days with no harm	34	38.77	31.01		
Patient Safety Incidents per 1000 bed days with low harm	13	15.98	12.51		
Patient Safety Incidents per 1000 bed days reported as Near Miss	2	2.39	1.64		
Patient Safety Incidents with moderate harm +	20	44	16		
Patient Safety Incidents with moderate harm + per 1000 bed days	0.60	1.03	0.79		
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		
Patient Falls per 1000 bed days	5.6	5.5	5.0		
Patient Falls with harm per 1000 bed days	1.5	1.9	1.6		
Medication Incidents per 1000 bed days	6	6.4	6.1		
Medication Incidents % with moderate harm or above	0.50%	3.32%	2.03%		
Patient Medication Incidents per 1000 bed days	6	5.6	5.2		
Patient Medication Incidents % with moderate harm or above	0.50%	2.93%	3.32%		

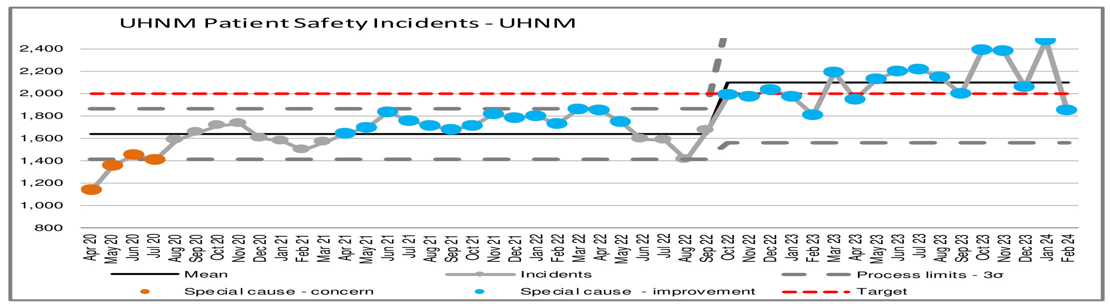
Metric	Benchmark	Previous	Latest	Variation	Assurance
Serious Incidents / PSIIs reported per month	0	4	1		
Serious Incidents / PSIIs Rate per 1000 bed days	0	0.09	0.02		
Never Events reported per month	0	2	1		
Duty of Candour - Verbal/Formal Notification	100%	100.0%	100.0%		
Duty of Candour - Written	100%	88%	75.0%		
All Pressure ulcers developed under UHNM Care	60	86	76		
All Pressure ulcers developed under UHNM Care per 1000 bed days	1.6	2.13	1.88		
All Pressure ulcers developed under UHNM Care lapses in care	12	20	16		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.49	0.39		
Category 2 Pressure Ulcers with lapses in Care	8	10	5		
Category 3 Pressure Ulcers with lapse in care	4	1	2		
Deep Tissue Injury with lapses in care	0	7	9		
Unstageable Pressure Ulcers with lapses in care	0	4	3		

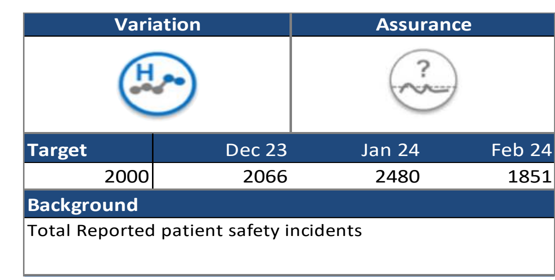
Quality Dashboard

Metric	Benchmark	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	67.4%	65.0%		
Friends & Family Test - Inpatient	95%	95.7%	94.1%		
Friends & Family Test - Maternity	95%	91%	95.3%		
Written Complaints per 10,000 spells	35	26.26	28.43		
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	95.74	94.15		
Rolling 12 Month SHMI (4 month time lag)	100	101.60	101.44		
VTE Risk Assessment Compliance	95%	96.6%	91.5%		
Hospital Associated Thrombosis Rate per 10,000 Admissions	N/A	0.88	0.63		
Timely Observations	90%	71.0%	73.5%		
Reported C Diff Cases per month	8	12	13		
Avoidable MRSA Bacteraemia Cases per month	0	1	0		
HAI E. Coli Bacteraemia Cases per month	16	19	16		

Metric	Benchmark	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	100.0%	94.8%		
Inpatient IVAB within 1hr (Contracted)	90%	89%	100.0%		
Children Sepsis Screening Compliance (All)	90%	100%	94.1%		
Children IVAB within 1hr (All)	90%	N/A	N/A		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	83.0%	78.0%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	80.00%	89.8%		
Maternity Sepsis Screening (All)	90%	45%	70.0%		
Maternity IVAB within 1 hr (All)	90%	40%	100.0%		

Reported Patient Safety Incidents





Variation		Assurance	
Target	**Dec 23**	**Jan 24**	**Feb 24**
2000	2066	2480	1851
Background			
Total Reported patient safety incidents			

UHNM Patient Safety Incidents Rate per 1000 Bed Days - UHNM

COVID-19 Pandemic

Mean — Rate per 1000 Bed Days — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Variation		Assurance	
NRLS Mean	**Dec 23**	**Jan 24**	**Feb 24**
50.70	51.08	58.20	45.96

What is the data telling us:

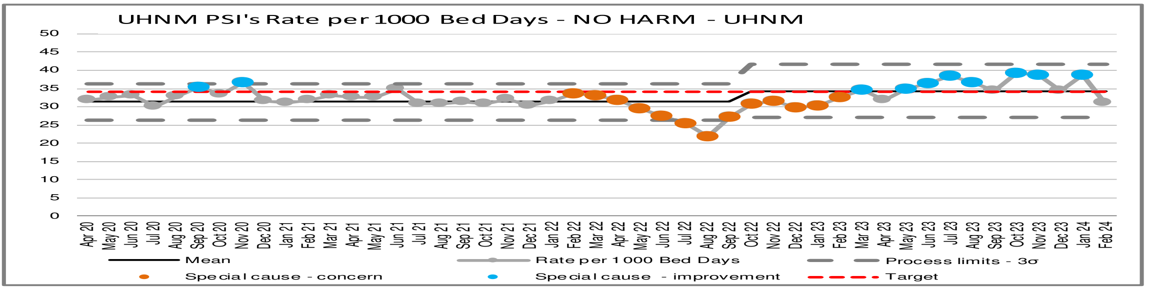
The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The February 2024 total is below the mean total but above total for same period in 2023. The rate per 1000 bed days has also decreased and below the NRLS mean rate but above the same period in 2023.

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.

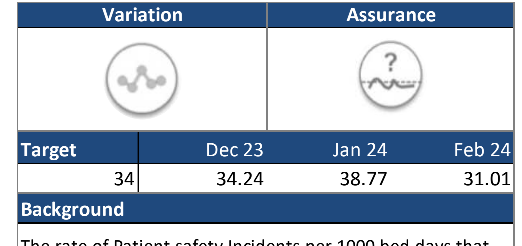
The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers are Patient Falls, Medication, Patient Flow, Treatment related and Clinical assessment incidents. Falls related incidents are the largest category after Tissue Viability in February 2024.

There has been increase in the number of incidents relating to 'Your Next Patient' with 22 during February reflecting continued operational pressures including Critical incident (23 in January, 14 during December, November and October, 34 during September 2023, 76 in August, 110 in July, 102 in June, 97 in May, 117 in April, 157 in March, 170 in February and 228 in January 2023) which accounts for 0.01% of total patient safety incidents. The February 2024 YNP related incidents are significantly lower than February 2023. There continues to be significant reduction in the number of reported incident relating to the YNP processes. 6 of the 22 incidents were directly patient flow related and where patients were being moved to AMU or wards

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



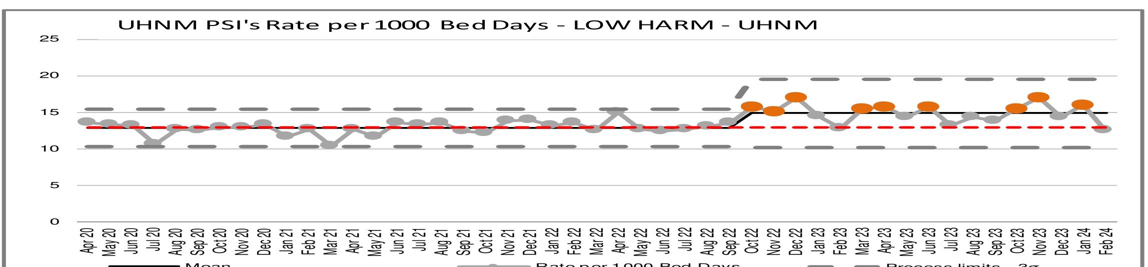
Variation	Assurance



Target	Dec 23	Jan 24	Feb 24
34	34.24	38.77	31.01

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	Dec 23	Jan 24	Feb 24
13	14.36	15.98	12.51

Background

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

UHNM PSI's Rate per 1000 Bed Days - NEAR MISSES - UHNM

Variation	Assurance

Target	Dec 23	Jan 24	Feb 24
2.0	2.03	2.39	1.64

Background

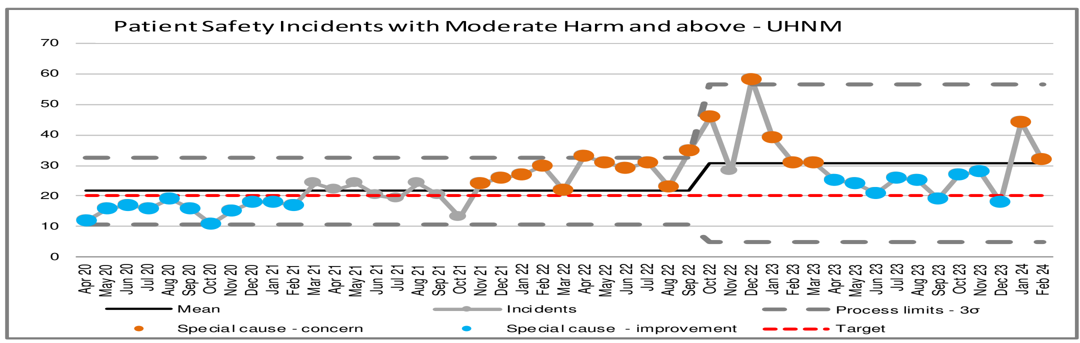
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

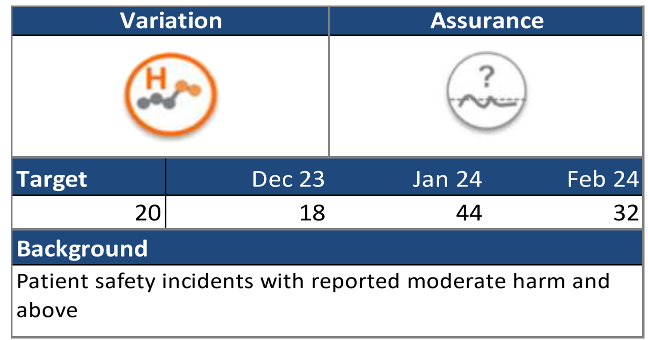
What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm and near misses have seen rates dip below the long term mean and target rates during February 2024. Low harm also decreased in month and is below the mean rate.

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

Reported Patient Safety Incidents with Moderate Harm or above

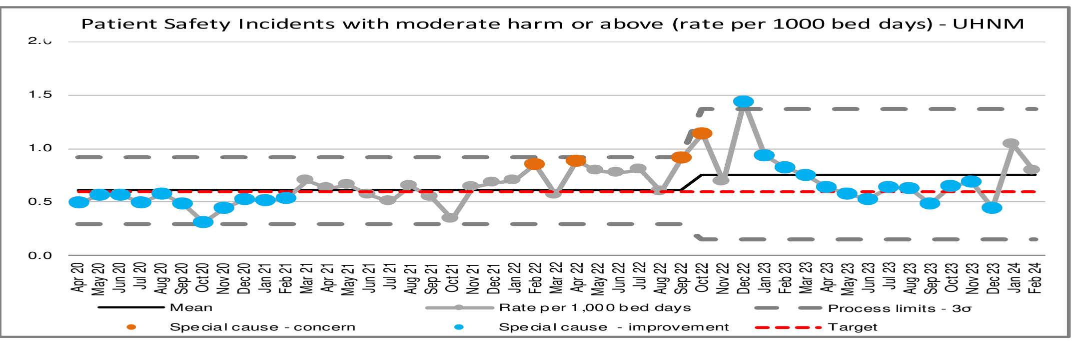




Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
20	18	44	32

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
0.60	0.45	1.03	0.79

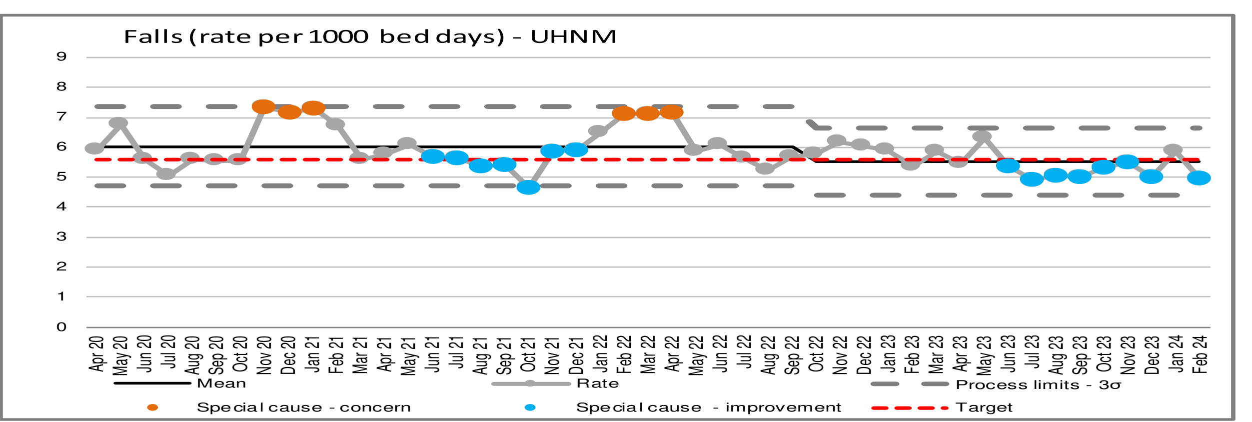
What is the data telling us:

The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within normal control limits but has shown decrease total numbers and rate for February 2024 but these remain under review and may alter following completion of the reviews. The last 14 months had seen reducing trends and below the mean rate which was recalculated in October 2022.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with Medication (7), Falls and Tissue Viability (5) and Treatment/Procedure (4) related incidents.

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

Patient Falls Rate per 1000 bed days



Variation		Assurance	
Target	Dec 23	Jan 24	Feb 24
5.6	5.0	5.9	5.0

Background
The number of falls per 1000 occupied bed days

What is the data telling us:

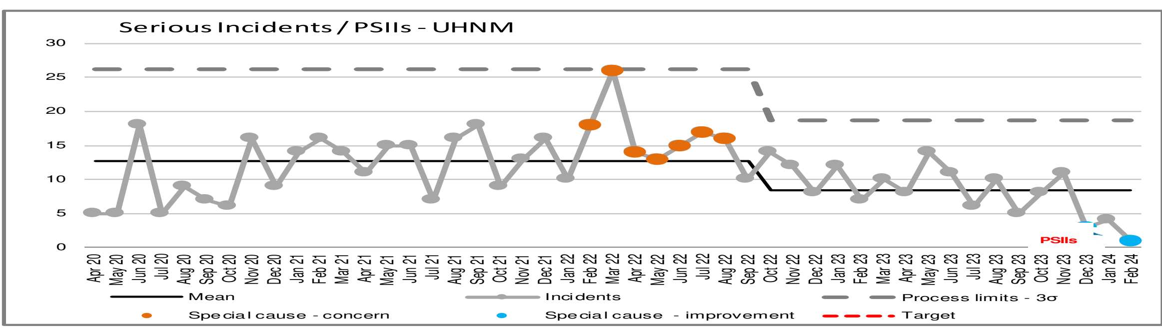
The Trust's rate of reported patient falls per 1000 bed days was within expected range in February.

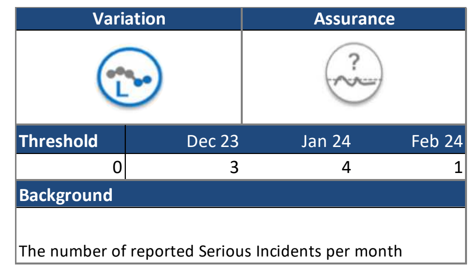
The areas reporting the highest numbers of falls in February 2024 were:-
Royal Stoke ECC – 16 falls, Royal Stoke AMU – 13 falls, Ward 228 – 8 falls, Ward 120 – 8 falls , Ward 225 – 8 falls, Ward 15 – 8 falls

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

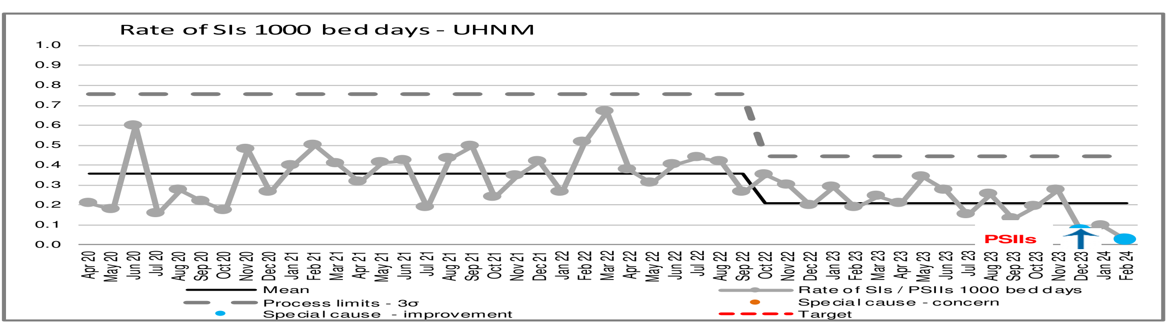
- From the 61 falls across the 6 areas there were 3 injury's which were from ECC, AMU and ward 15. PSIRF toolkits were completed in conjunction with the ward and improvements and actions were discussed.
- Education is currently being provided on a 1:1 basis in ECC to ensure documentation and mitigation for risks are in place.
- Discussions regarding falls have taken place with the fall's links in ECC and AMU.
- A meeting is taking place with the education team in ECC to update the presentations and to discuss themes that are occurring in ECC
- Falls audits have been completed on the above wards and areas of good practice were noted. Areas of improvements were fedback and discussed.
- New N/A induction training has taken place.
- New falls champion training and existing refresher training has been advertised to both Royal Stoke and County sites.
- Ward 15 had a multiple faller in February.

Serious Incidents / PSIIs per month





Variation		Assurance	
Threshold	**Dec 23**	**Jan 24**	**Feb 24**
0	3	4	1
Background			
The number of reported Serious Incidents per month			



Variation		Assurance	
Target	**Dec 23**	**Jan 24**	**Feb 24**
0	0.07	0.09	0.02
Background			
The rate of Serious Incidents / PSIIs Reported per 1000 bed days			

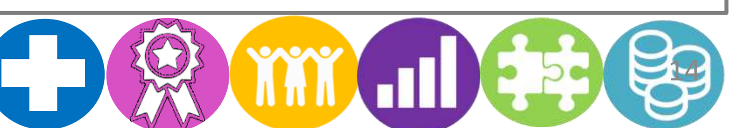
What is the data telling us:

In December 2023, UHNM stopped reporting incidents under the Serious Incidents Framework and adopted the new Patient Safety Incident response Framework (PSIRF). Whilst UHNM moves towards LFPSE implementation, the interim arrangement is to report on STEIS incidents that previously noted as SIs. During February 2024, UHNM reported 1 incident that is being reviewed using the new Patient Safety Incident Investigation (PSII) methodology

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. February 2024* saw 1 incident reported:

- 1 Treatment related (Dermatology)

The rate of SIs / PSIIs per 1000 bed days has varied consistently within confidence limits but have shown significant improvement with rate below the previous long term mean of 0.4. The confidence limits have been recalculated from October 2022 to reflect the significant changes. The current rate is 0.02.



Maternity related Serious Incidents / PSIIs Summary

Summary of new Maternity Serious Incidents

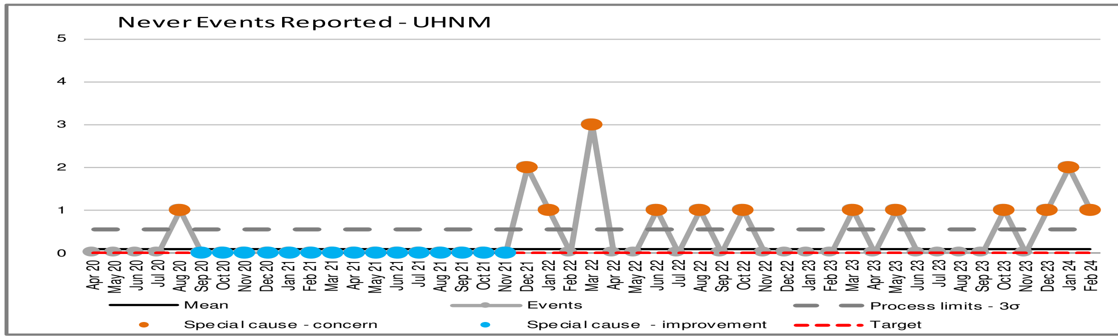
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during December 2023. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

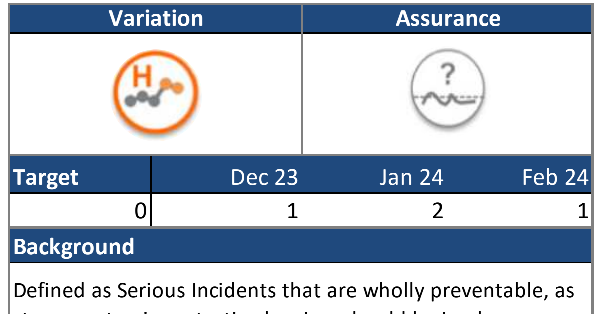
All Serious Incidents / PSIIs will continue to be are reported and investigated and the final Root Cause Analysis / PSII Report presented at Divisional meetings and Risk Management Panel for review and agreement prior to sharing with CCGs for closure.

There were 0 Maternity related PSIIs reported during February 2024

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

Never Events





Variation	Assurance

Target	Dec 23	Jan 24	Feb 24
0	1	2	1

Background

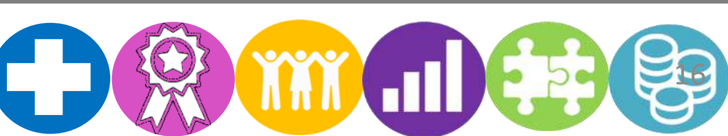
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

There have been 1 new Never Event reported in February 2024. The target is to have 0 Never Events.

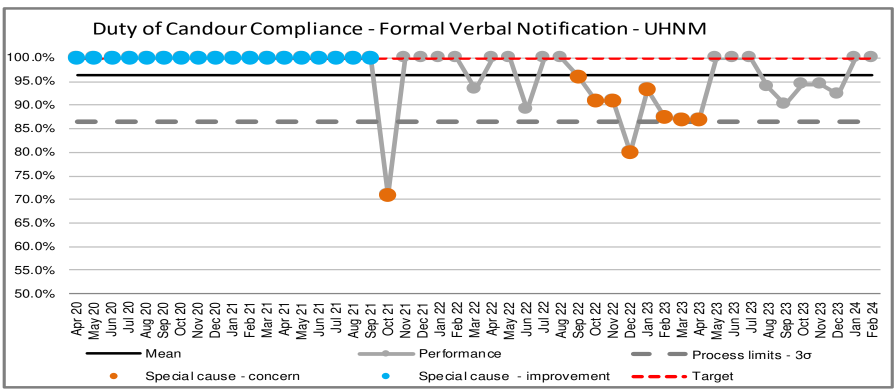
Whilst these are Never Event Category it is now reported via the PSIRF approach and will have a PSII undertaken.

Log No.	Never Event Category	Description
327323	Wong site surgery (incorrect lesion)	Patient seen in outpatients Dermatology 2 week wait clinic originally 29/11/23. Patient operated on under plastic surgery on 11/01/24. Histology results seen 02/02/24 – benign therefore patient discharged. Informed by secretary that patient had contacted them stating that he was concerned that the wrong lesion had been biopsied.

The latest Never Event is related to incorrect lesion and is second in recent months. These incidents will have PSIIs completed and also review previous actions and complete thematic review to assess / compare differences and similarities between the incidents and share the wider learning.



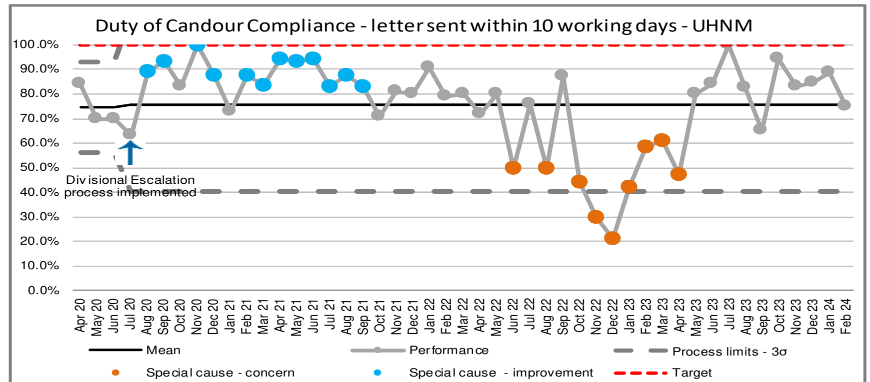
Duty of Candour Compliance



Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
100%	92.3%	100.0%	100.0%

Background

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



Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
100%	84.6%	88.5%	75.0%

Background

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

What is the data telling us:

During February there were 15 incidents reported and identified that have formally triggered the Duty of Candour. 100% (15 out of 15) have recorded that the patient/relatives been formally notified of the incident in Datix and within normal variation.

Confirmed Follow up Written Duty of Candour compliance* (i.e. receiving the letter within 10 working days of verbal notification **and recorded in Datix**) during February 2024 is 75% as of 8th March 2024 including those letters that are completed within timescale and not yet exceeded the timeframe. 3 cases were outside the 10-day timeframe have had the letter forwarded and completed..

100% of the identified cases have had Duty of Candour completed.

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

Actions taken:

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

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

Head of QSC has been undertaking additional sessions at Directorate & Specialty Meetings to discuss Duty of Candour and staff responsibilities.

Patient Safety Alerts

New Patient Safety Alerts received:

During February 2024 there has been 1 new alert received through the Central Alert System (CAS) – national web based cascading system for issuing patient safety alerts and other safety critical information and guidance to the NHS. Alerts available on the CAS website include NHS England and NHS Improvement Patient Safety Alerts (PSA) and Estates Alerts, MHRA Dear Doctor letters, Medical Device Alerts (MDA) and Drug Alerts, Chief Medical Officer (CMO) Alerts, and Department of Health & Social Care Supply Disruption alerts.

Alert Type	CAS Status	Alert Reference Number	Alert Title	Date Issued	Date Completed	Deadline Date
NHS PSA	**Open**	Nat/PSA 2024 003 DHSC MVA	Shortage of Salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials	26/02/2024		08/03/2024

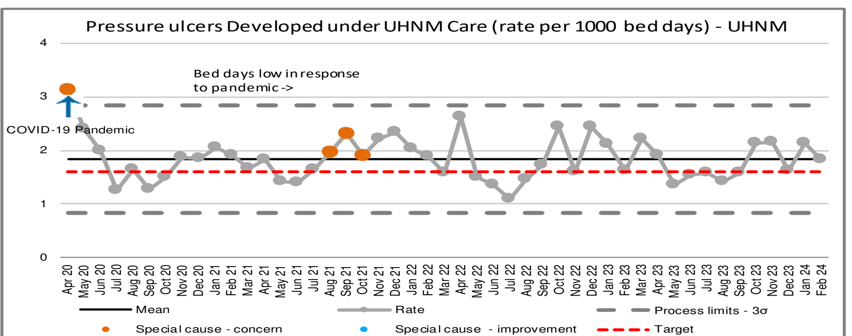
Currently there are 5 open alerts on the CAS system for UHNM

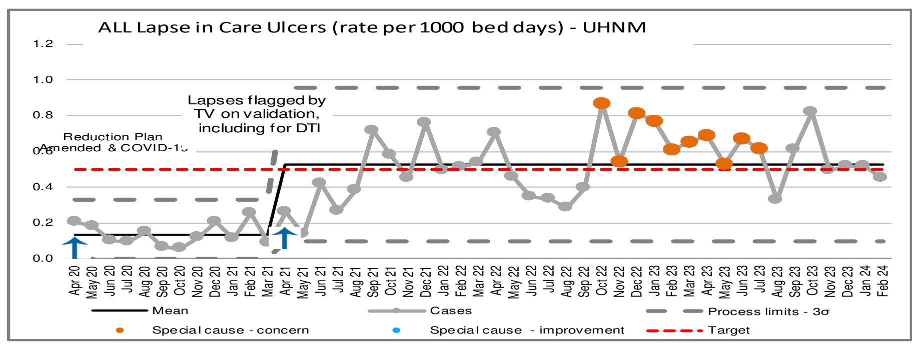
Alert Type	CAS Status	Alert Reference Number	Executive Lead	Alert Title	Date Issued	Deadline Date
NHS PSA	**Open**	Nat/PSA/2023/010/MHRA	Chief Nurse	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls	31/08/2023	01/03/2024
NHS PSA	**Open**	Nat/PSA/2023/013/MHRA	ICB Lead	Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients.	28/11/2023	31/01/2024
NHS PSA	**Open**	Nat/PSA/2023/014/MHRA	Chief Nurse	Identified safety risks with the Euroking maternity information system.	07/12/2023	07/06/2024
NHS PSA	**Open**	Nat/PSA 2024 002 NHSPS	Medical Director / Deputy MD	Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks.	31/01/2024	31/01/2025
NHS PSA	**Open**	Nat/PSA 2024 003 DHSC MVA	Medical Director	Shortage of Salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials	26/02/2024	08/03/2024

Overdue Patient Safety Alerts: There is currently 1 overdue alert.

Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Deadline Date	Comments
NHS PSA	**Open**	Nat/PSA/2023/013/MHRA	Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients.	31/01/2024	Meetings between UHNM and ICB regarding pregnancy prevention programme and a system wide meeting of the valproate group. ICB will lead on response to this alert. Feedback/responses being collated at ICB level, going through Meds Safety Group once completed by the ICB lead, awaiting feedback as deadline date has now passed.

Pressure Ulcers developed under care of UHNM per 1000 bed days

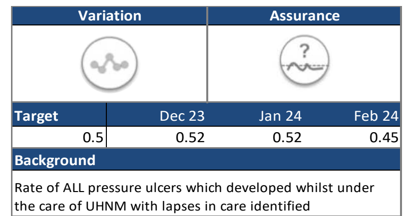




Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
1.6	1.63	2.14	1.84

Background

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



Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
0.5	0.52	0.52	0.45

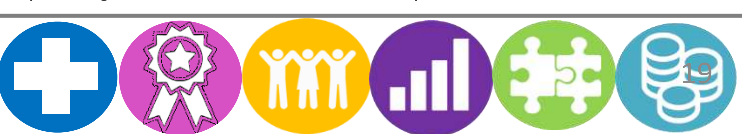
Background

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

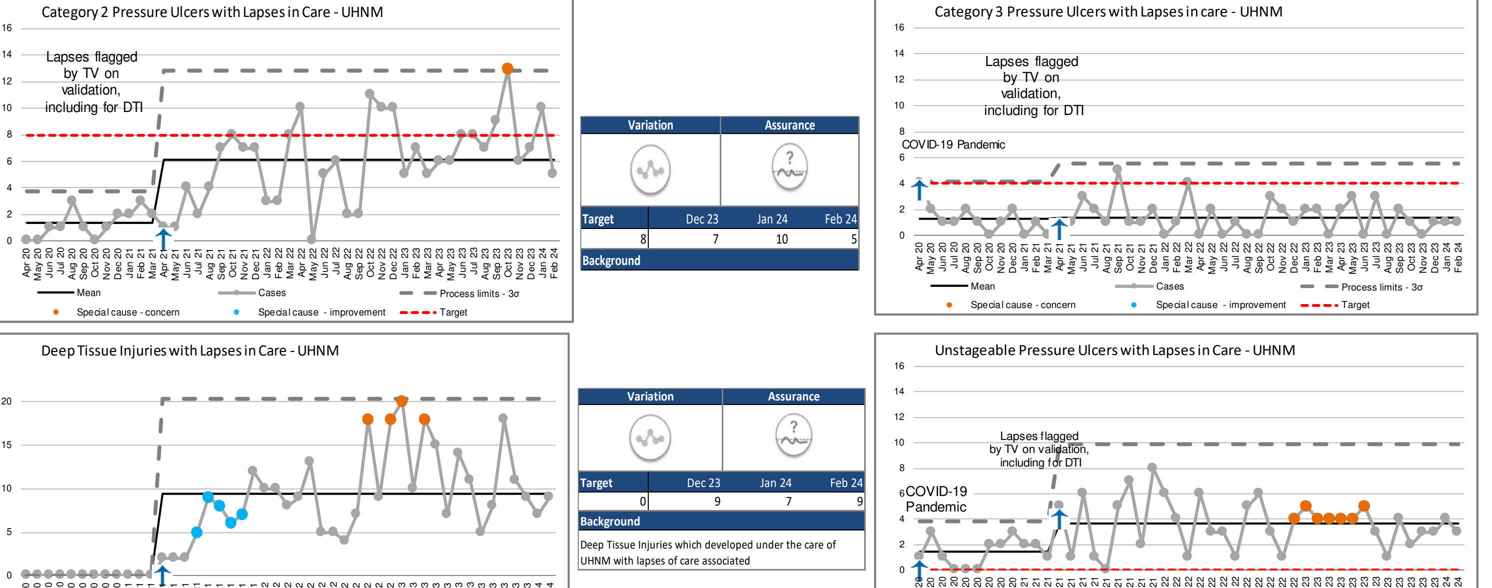
What the data is telling us The rate of pressures ulcers reported as developed under UHNM care was within expected limits in February. The rate of cases with lapses in care identified was also within expected range in February.
Where a patient cannot be repositioned due to acuity, this must be documented, otherwise a potential lapse in care may be identified.
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.

Actions

- Training delivered for NA induction, Preceptorship days, and ED new starters. Have now delivered training to student paramedics.
- Education plan for 2024 which will include pressure prevention, categorization, continence, lower limb, wound care, and negative pressure. Conference arranged for March 2024.
- ESR approved by Statutory & Mandatory Training group has been approved and being developed. The guidelines for categorisation have been released from the NWCS, just awaiting the resources which will hopefully be February / March 2024.
- Stakeholder group for patient seating have approved standard patient chair and will now look at recliner chairs and bariatric options.
- Discussions with procurement to have all alternating mattresses in the Trust and develop a recycling scheme.
- Increase in clinical caseload leading to longer wait times. This has been added to the risk register.
- Concerns that pressure damage reported has been incorrectly reported (miscategorisation). Updating the referral to be able to capture more details.



Pressure Ulcers with lapses in care



Category 2 Pressure Ulcers with Lapses in Care - UHNM

Target	Dec 23	Jan 24	Feb 24
8	7	10	5

Background

Category 3 Pressure Ulcers with Lapses in care - UHNM

Target	Dec 23	Jan 24	Feb 24
4	1	1	1

Background

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

Deep Tissue Injuries with Lapses in Care - UHNM

Target	Dec 23	Jan 24	Feb 24
0	9	7	9

Background

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

Unstageable Pressure Ulcers with Lapses in Care - UHNM

Target	Dec 23	Jan 24	Feb 24
0	3	4	3

Background

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

What is the data telling us:

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

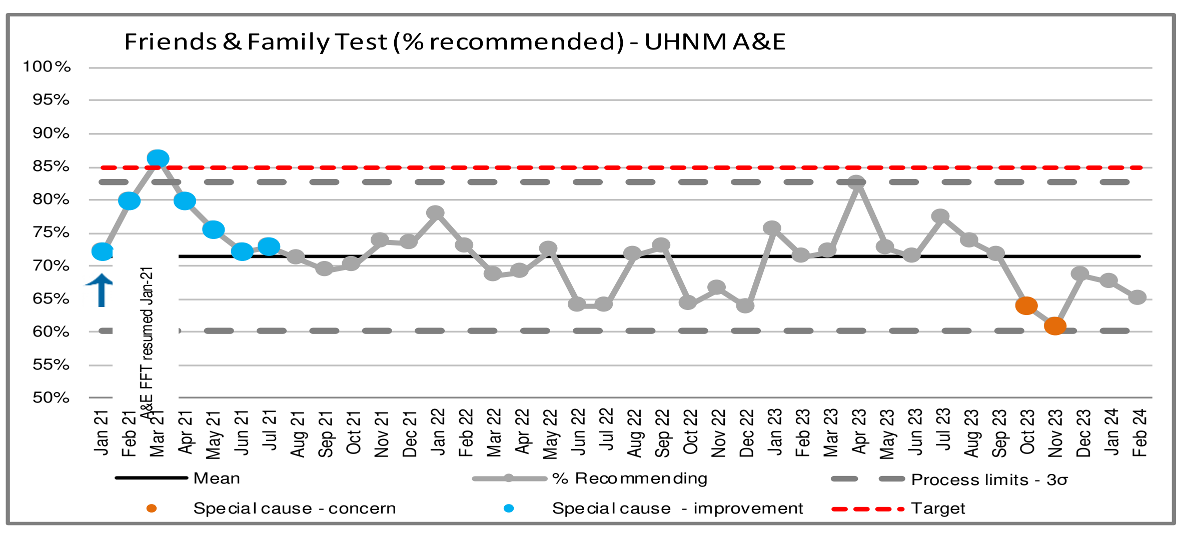
Locations with more than 1 lapse in February 2024 were: **Ward 1 (3), County AMU (2), Ward 111 (2), Ward 226 (2)**

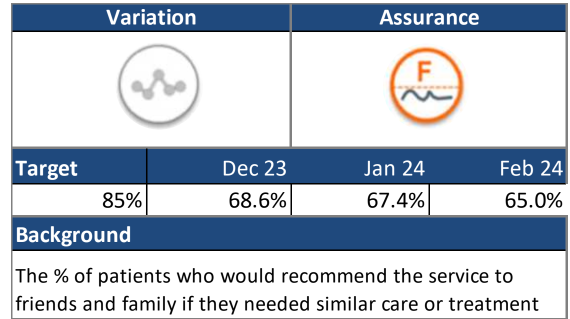
Root Cause(s) of damage - Lapses - Feb 2024	Total
Management of repositioning	8
Management of device	7
Management of heel offloading	3

Actions:

- PSIRF toolkit completed for DTI, Category 3, and unstageable. Category 2's will be investigated at ward level and a thematic review will be completed quarterly. Completion of action plans will be checked by Quality and Safety and Governance teams prior to the closure of incidents.
- Multiple reporting wards are invited to assurance meetings and to be offered support with improvements.
- Quality and Safety team to visit multiple reporting areas to help with improvements and deliver ad hoc training.
- Tendable support with completion of pressure prevention audit due to discrepancies. This has been escalated to Tendable steering group and patient safety.
- Patient safety partner to start attending steering groups.
- Protocol for matrons and senior nurses has been developed for management of category 2 at ward level and this go through a trail.
- Re-fresh of ward audits completed for nursing assistants to be more involved in learning from incidents.

Friends & Family Test (FFT) – A&E





Variation		Assurance	
Target	Dec 23	Jan 24	Feb 24
85%	68.6%	67.4%	65.0%

Background

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

- The overall satisfaction rate for our EDs was within expected limits in February 2024.
- The Trust received 1420 responses which is an increase on the previous month and the response rate percentage 10% overall. The Trust's overall satisfaction rate is lower than the national average of 78% (NHS England December 23- latest figures) at 65% which is a further decrease on previous months. UHNM is 40th out of 122 Trusts for the number of responses in ED (NHS England December 2023), and 84th out of 122 Trusts for the percentage positive results.
- Feedback from patient experience of using 111First and the kiosks continues to be monitored. 21% of respondents in February 2024 reported to have used 111First prior to attending ED, which is equal to the previous few months. Key themes from February 2024 continue are around poor communication, patients feeling abandoned, staff attitude, long waits, pain relief especially related to Royal Stoke.

Actions :

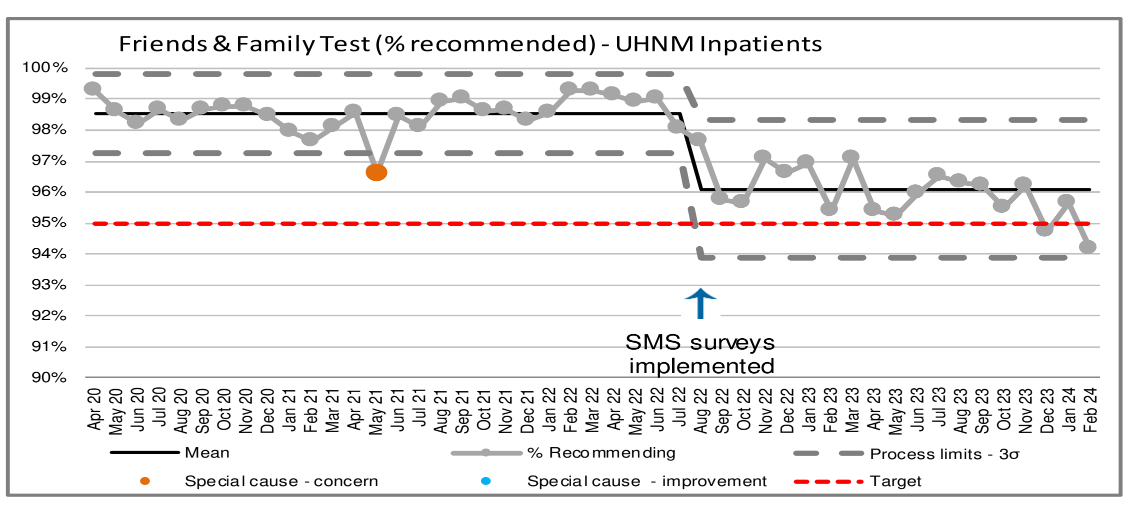
FFT push – handed out to all patients on arrival to ED.

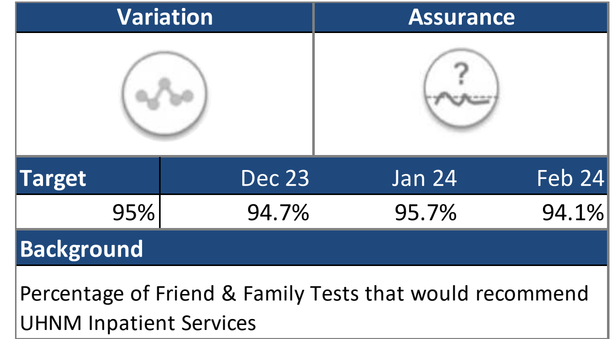
QR code made visible throughout the department.

QR code put onto all future FFTs.

You said we did board in waiting room.

Friends & Family Test (FFT) - Inpatient





Variation	Assurance

Target	Dec 23	Jan 24	Feb 24
95%	94.7%	95.7%	94.1%

Background

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

What do the results tell us?

- The monthly satisfaction rate for inpatient areas was within expected limits in February and remains above the national average of 94% (December 2023 NHS England).
- In February 2024 a total of 2320 responses were collected from 68 inpatient and day case areas (11470 discharges) equating to a 20% return rate which is lower than last month and lower than the internal target of 30%. UHNM have the 20th highest response rate for all reporting Trusts in the country (151)and are 84th for percentage positive responses (NHS England December 2023- latest data)

Actions:

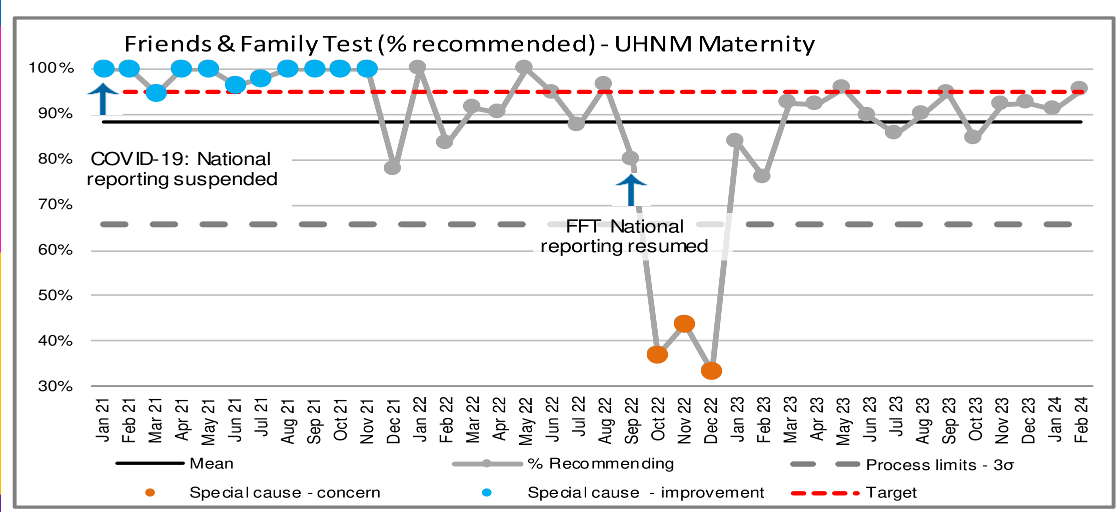
- Support individual areas to ensure they're using the most up to date version of the surveys.
- Continue to focus on Medicine and Surgery to increase response rate.

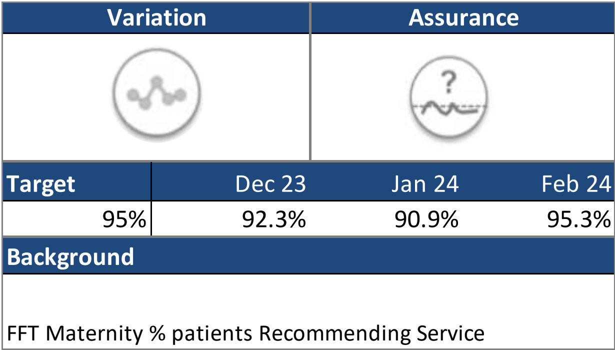
Work continues around a suite of patient priorities based on patient feedback:

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

Delivering Exceptional Care with Exceptional People

Friends & Family Test (FFT) - Maternity





Variation		Assurance	
Target	**Dec 23**	**Jan 24**	**Feb 24**
95%	92.3%	90.9%	95.3%

Background

FFT Maternity % patients Recommending Service

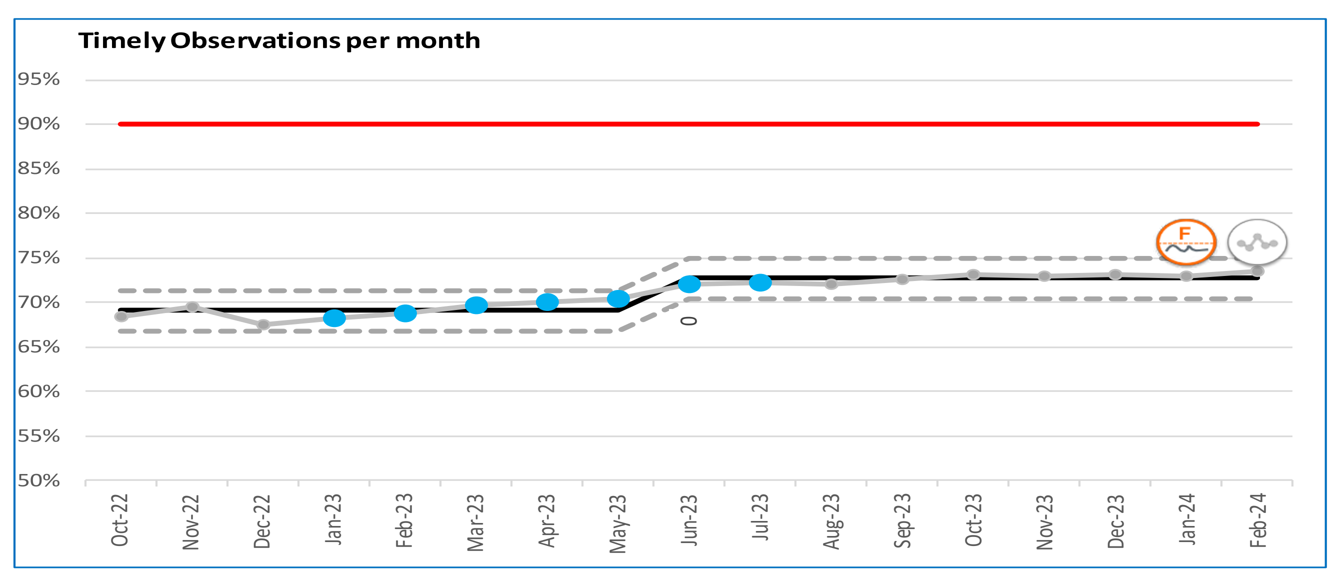
What do these results tell us?

- There were a total of 127 surveys were received in February 2024 across all 4 touch-points (ante-natal, birth, post natal ward; post natal community) with 21 of these being collected for the "Birth" touch-point, providing an 4% response rate (based on number of live births) and 100% satisfaction score which is an increase on the previous month's figures.
- The Antenatal touch point scored 83% recommendation (23 surveys) which is a decrease on the previous month (93%). The post-natal ward touch point scored 97% satisfaction rate (64 surveys) which is an increase in both response rate and satisfaction percentage from the previous month.
- Compared to the latest national data available (December 2023) out of 111 Trusts, UHNM were 73rd for number of responses for antenatal, 41st for number of responses for birth, 37th for post-natal ward and 57th for post-natal community.

Actions:

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

Timely Observations



What do these results tell us?
Compliance remains well below the 90% target in February 2024. A small improvement has been sustained since mid 2023, but little further progress has been since. Compliance for February 2024 was 73.5%.

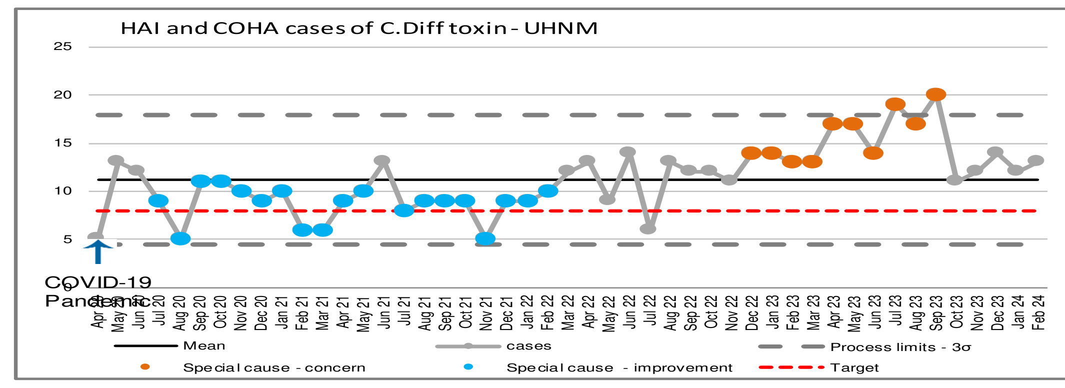
Individual Wards and Departments continue to be reviewed and monitored as part of the monthly Performance Review process and actions are identified to improve compliance.

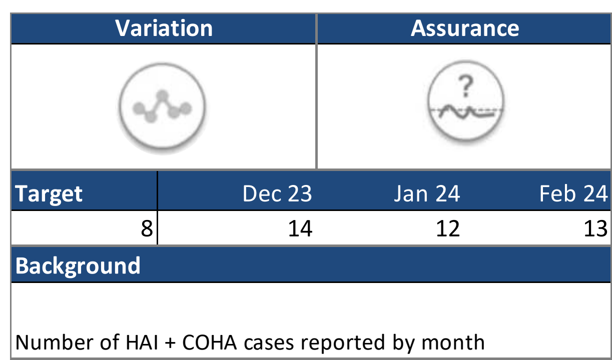
Medicine, Surgery and Network Divisions have timely observations as a Driver metric and there is a corporate A3 Improvement Project underway considering additional actions required to improve overall compliance/performance. This is being led by the Deputy Chief Nurse and CNIO.

No wards had Timely Observations recorded at 50% or less during February.

4 wards had compliance between 50 – 60%: Ward 230, Ward 113, Ward 128, Ward 78.

Reported C Diff Cases per month





Variation	Assurance

Target	Dec 23	Jan 24	Feb 24
8	14	12	13

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

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

There have been 13 reported C diff cases in February 2024. 9 x HAI and 4 COHA

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

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

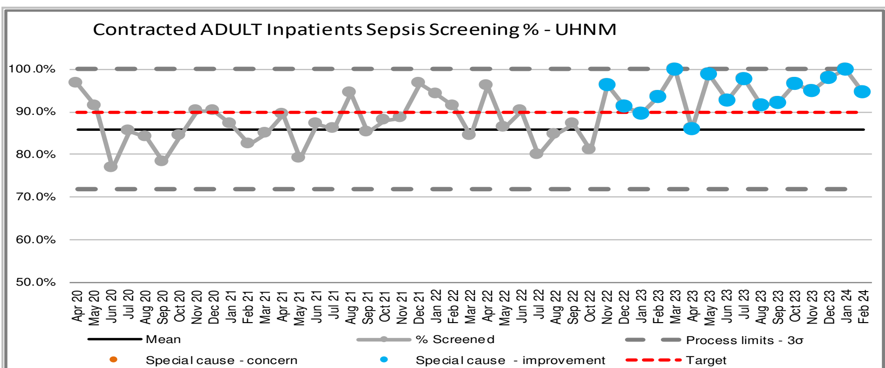
There has been three clinical areas with more than one Clostridium *difficile* case within in a 28 day period which triggered in February . Where ribotypes are different person to person transmission is unlikely.

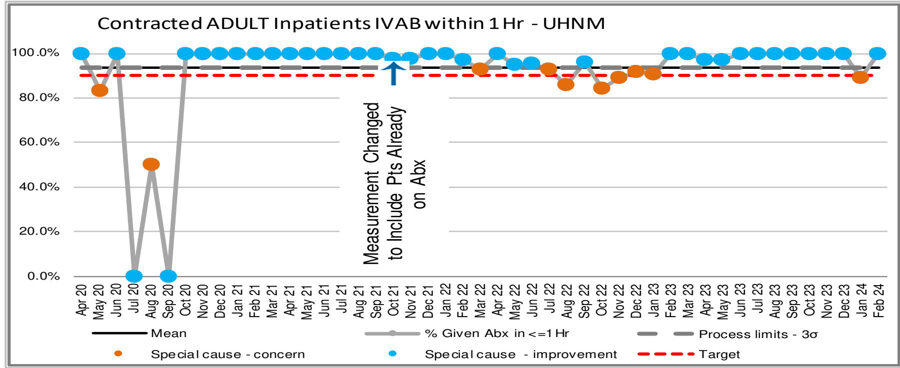
- AMU Royal – Awaiting ribotype results
- 102 - Awaiting ribotype results
- Ward 14 – different ribotypes

Actions:

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- Task and Finish Group for West Building in place
- CURB -95 score added to CAP antimicrobial Microguide
- Campaign commenced in West Buildings to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- AMU and FEAU also targeted as antibiotics are generally started in the admission portals
- Additional oversight of C-Diff cases is being implemented where there is potential learning in terms of antibiotic use
- Consultant Microbiologist presented to ED and Elderly Care Doctors on Cdiff and antibiotic guidelines
- Consultant Microbiologist continues rounds on the Elderly care wards in West Building
- IP review of emergency portal environment
- CDI bench marking to comparative Trusts to commence in March

Sepsis Screening Compliance (Inpatients)





Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
90%	98.0%	100.0%	94.8%

Background

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

Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
90%	100.0%	88.9%	100.0%

Background

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

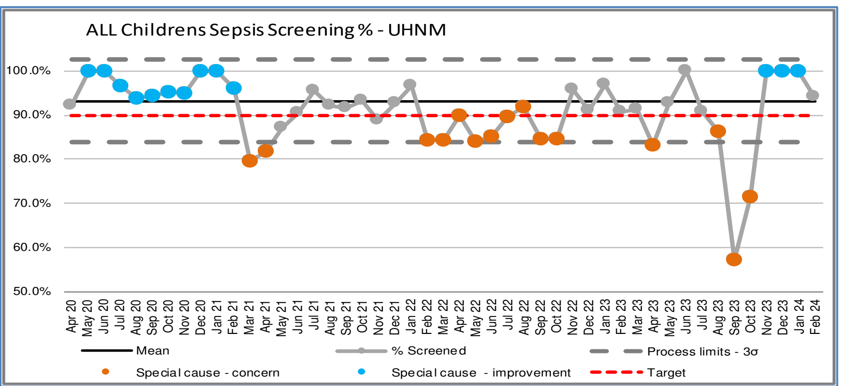
What is the data telling us:

Inpatient areas achieved the screening and the IVAB within 1 hour target for February 2024. There were 115 cases audited with 6 missed screenings. Out of 115 cases audited, 72 cases were identified as red flags sepsis with 43 cases having alternative diagnosis and 26 were already on IVAB treatment, all true red flags patient received IVAB within 1 hour.

Actions:

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

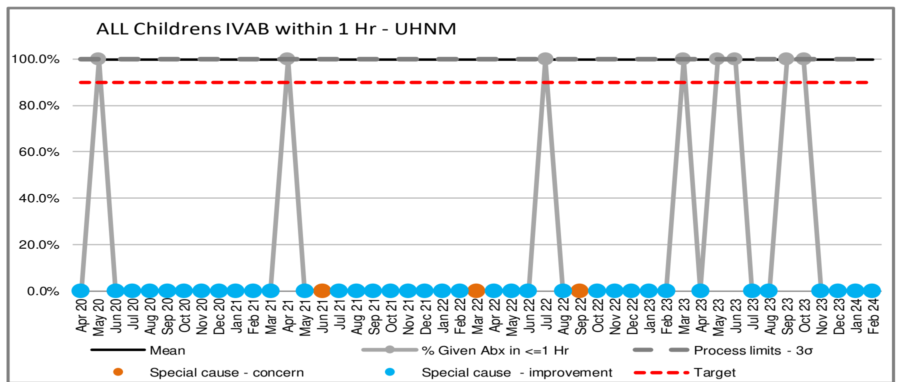
Sepsis Screening Compliance ALL Children



Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
90%	100.0%	100.0%	94.1%

Background

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



Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
90%	N/A	N/A	N/A

Background

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

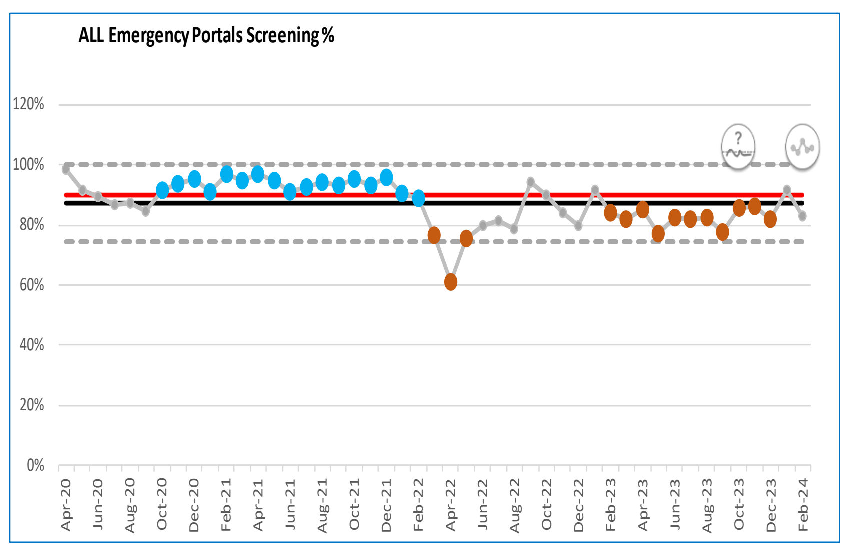
What is the data telling us:

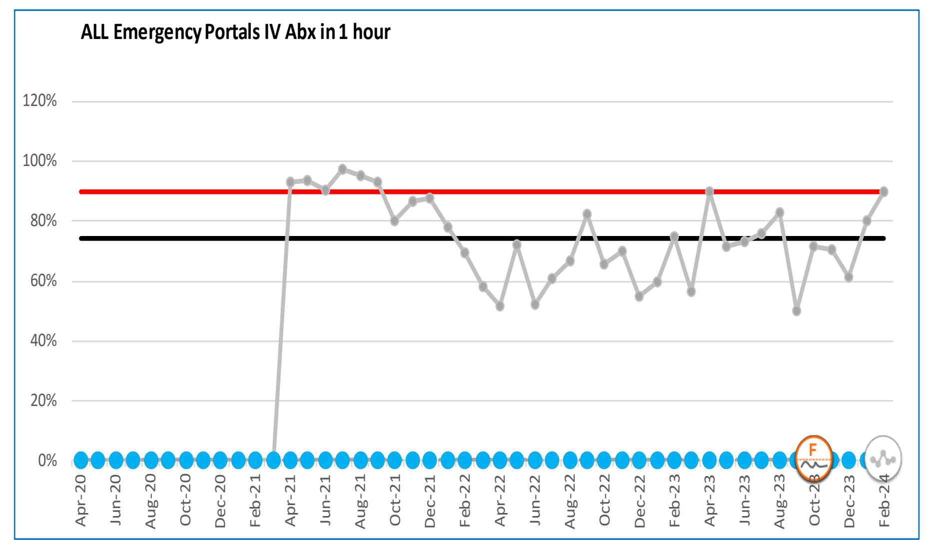
Children's Services target rate of > 90% was achieved for February 2024. We are still seeing a small numbers of children trigger with PEWS > 5 & above in Inpatients areas. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks). There were 32 cases audited for emergency portals with 2 missed screening. No true red flag sepsis was identified from the randomised audits in inpatients and emergency portals. A slight decrease in screening compliance in comparison to previous months.

Actions:

- Children emergency portal sepsis screening and documentation is now available electronically
- The Sepsis Team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective; on-going
- Plan of collaborative work with Children education lead and aiming to deliver Induction training when required: on-going
- The children department is aiming to implement the new National PEWS chart and sepsis screening tool guidelines in the coming weeks/months which will be supported by the sepsis team.

Sepsis Screening Compliance (Emergency Portals Contract)





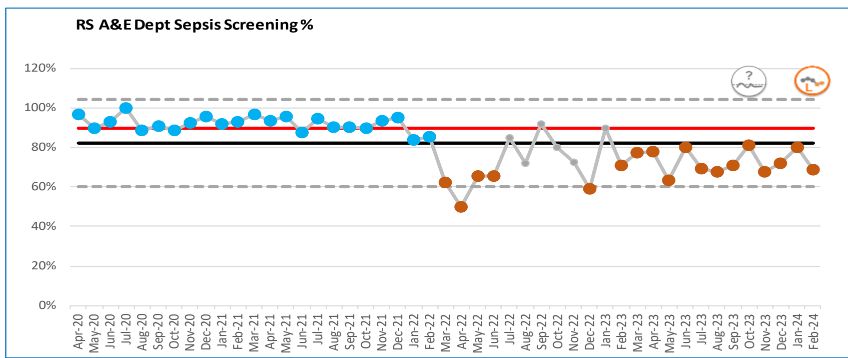
What is the data telling us:

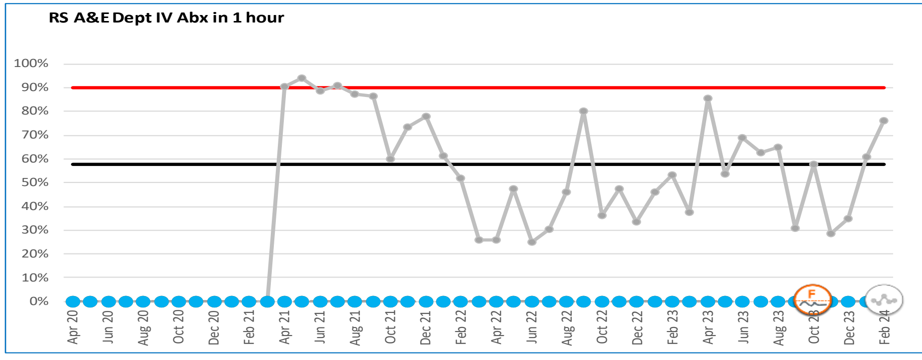
Adult Emergency Portals screening did not meet the target rate for February 2024. There were 82 cases audited with 14 missed screening (patients are escalated but no documentation available in the screening tool) in total from the emergency portals. The performance for IVAB within 1 hour achieved 89.8 %, which is a very good improvement from previous months. Out of 82 cases, there were 66 red flags sepsis in which the 19 cases already on IVAB, 49 cases were newly identified sepsis, and 17 cases have alternative diagnosis. There were 3 delayed IVAB by ED Royal Stoke. Missed screening contributed by ED & AMU Royal Stoke and SAU.

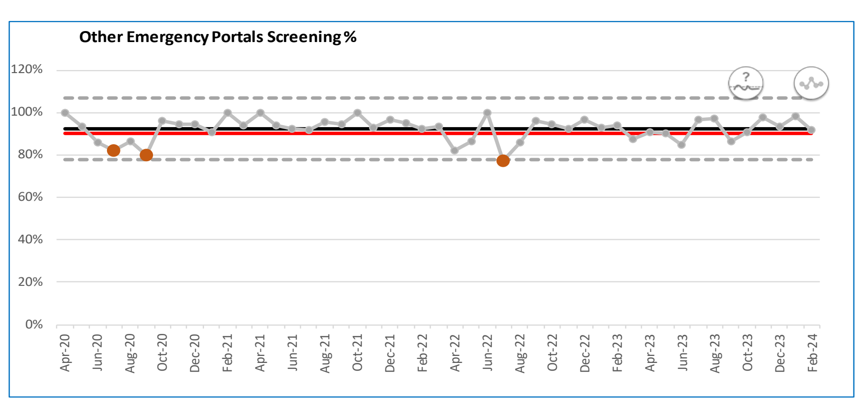
Actions:

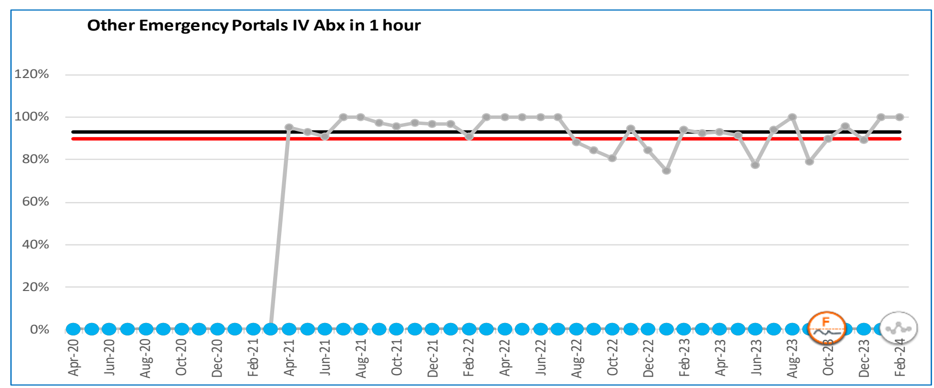
- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E regularly. Provide sepsis session when staffing and acuity allows.
- Face to face A&E sepsis induction/ training for new nursing staff, nursing assistant and medical staff will continue
- Monitoring impact of long ambulance waits on timely assessment and treatment of sepsis; on-going
- Sepsis Champion Day training is organised for both ED sites with good attendance from Jan 2024 and this will carry on monthly or bi-monhtly as planned
- Good emphasis of Deteriorating Patient Reviewer (DPR) Vocera in ED, enable the assigned clinician to review and provide timely assessment, treatment and escalation of patients whose condition meeting the NEWS2 medium to high-risk sepsis triggers.
- Working towards implementation of electronic screening
- There is an on-going plan implementation of the new Sepsis NICE & AoRMC guidelines once the update is available in the sepsis vitalpacs (digital system)

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







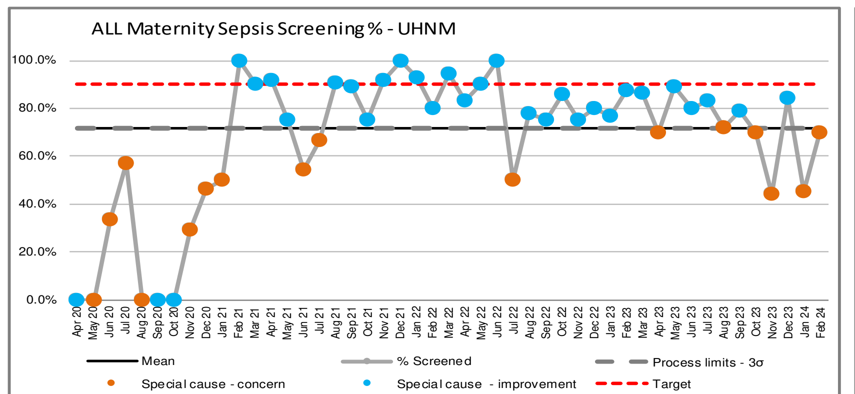


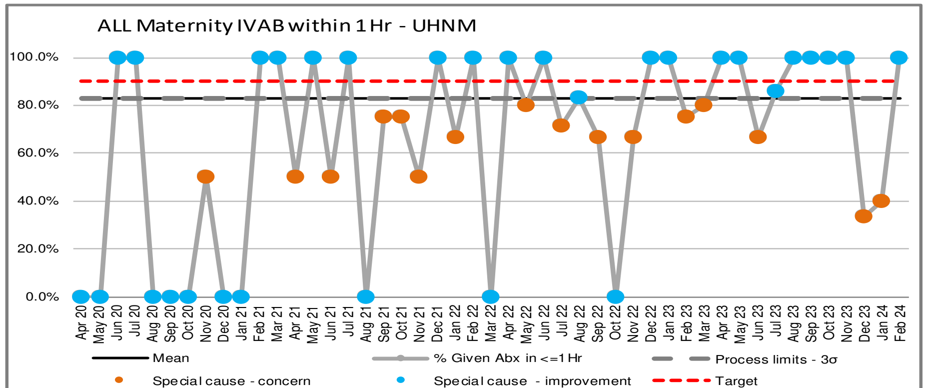
What is the data telling us:
The Emergency Department at RSUH remain below target rate for both screening and IVAB within the 1 hour for February 2024.

Actions:

- To provide short sessions in ED staff during the winter months focusing the importance of sepsis screening documentation and urgent escalation for true red flag sepsis triggers
- Deteriorating Patient Reviewer (DPR) is currently in place and managed by Emergency Physician in Charge in ED. There will be a specific clinician assigned and dedicated to log in DPR VOCERA device at the beginning of their shift to review and provide timely assessment, treatment and escalation of patients who triggers for medium to high-risk sepsis.
- Colleagues from the ICS visited ED on 30th November 2023 to review practice in terms of sepsis screening and verbal feedback has been positive and the written report is awaited.

Sepsis Screening Compliance ALL Maternity

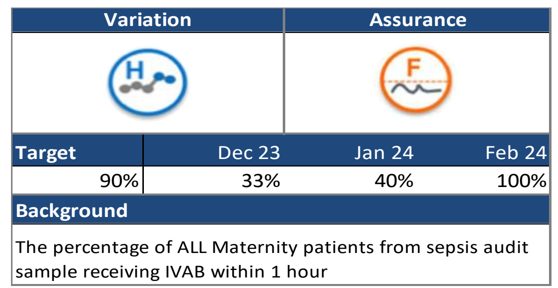




Variation		Assurance	
Target	Dec 23	Jan 24	Feb 24
90%	84.2%	45.5%	70.0%

Background

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



Variation		Assurance	
Target	Dec 23	Jan 24	Feb 24
90%	33%	40%	100%

Background

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

What is the data telling us:

Maternity audits in screening compliance is below target this month for emergency portals. Inpatient areas are also well below target for screening. The compliance was above target for IVAB within 1 hour. This compliance score is based on a very small number (cases).

There were 12 cases audited from emergency portal (MAU) and 8 cases from inpatients with total of 6 missed screening (has been escalated but no documentation in the screening tool).

Actions:

- Maternity antibiotic PGD has been drafted and is currently under review by the Pharmacy Team; still awaiting finalisation
- Monthly Maternity sepsis skills drill is now replaced with ad hoc sepsis sessions in each clinical areas; on-going
- Sepsis sessions will focus and highlight the importance of screening documentation
- The sepsis team will create further awareness and plan collaborative work with maternity educators and senior team

Operational Performance

2025 Vision “Achieve NHS Constitutional patient access standards”

Spotlight Report from Chief Operating Officer

Urgent and Emergency Care Performance (Non-Elective Care)

- Context
  - 12 Hour Trolley Waits improved from 1263 in January to 943 in February.
  - Type 1 A&E Attendances reduced from 13561 in January to 13020 in February.
- Driver Metrics
  - Four Hour Performance broadly maintained from 64.2% in January to 63.9% in February.
  - 12+ Hours In ED improved from 2325 in January to 1943 in February.
  - Ambulance Handovers <60 Minutes also improved from 63.3% in January to 72.8% in February.

Planned Care, Cancer and Diagnostic Performance (Elective Care)

Diagnostics Summary

- DM01 activity in February was above 19/20 levels, however data is unvalidated.
- DM01 performance was 76.8% overall in February, a drop of 0.2% from January (77%).
- Endoscopy performance is the main contributor to this performance being below the national target of 99%

Endoscopy:

- Insourced weekend service continued alongside an additional locum in the service, following external funding from WMCA.
- Routine, urgent, surveillance and planned patients continue to wait longer than expected. Maximising in week sessions and use of CNS TI's, additional support from surgeons and 18 Weeks Insourcing to support these cohorts
- Long term trajectory and resource requirement submitted but funding not currently available to further drive non-cancer cohorts
- Request to Proceed being drafted to request funding for recovery and BAU activity and ERF paper drafted.
- Management team continuing to work on demand management strategies and productivity measures to improve utilisation and appropriateness (including admin and clinical validation). Demand and Capacity model reworked.
- Sustained improved booking performance for lower cancer PTL patients – now 3-4wks notice (was 3 days)
- Improvement plan ongoing and workstream leads progressing actions
- Four Eyes Insight on to Week 9 of their Improving Efficiency Programme within the Endoscopy service. Proposal going to Execs to move to Phase 2 and embark on a 24-week FEI led programme.

Spotlight Report from Chief Operating Officer

Referral to treatment (RTT Planned Care and Elective Recovery)

- 104ww - three patients were waiting in February – identified through validation of waiting lists. Both patients have a TCI date in March.
- 78ww February was 159 as the final validated position
- 78ww March prediction is 71 for UHNM. The overall Referral To Treatment (RTT) Waiting has increased this month to 81,226 (unvalidated), down from 81,352 in December.
- Day case as a % of all elective work is currently 88.5%.

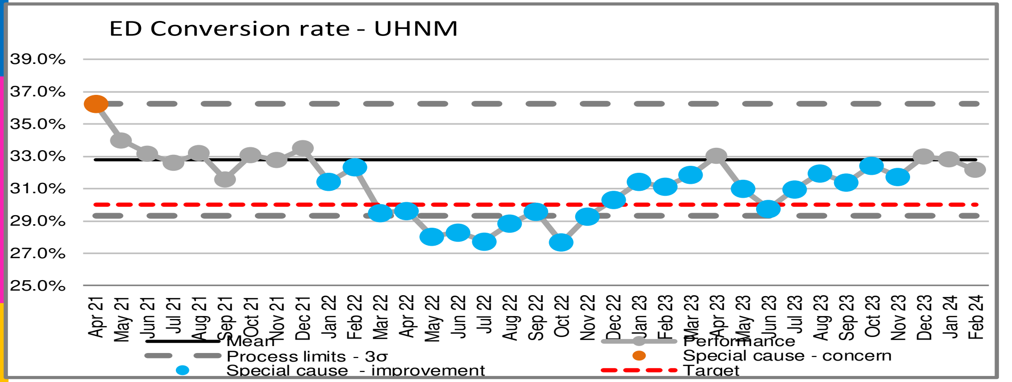
Cancer

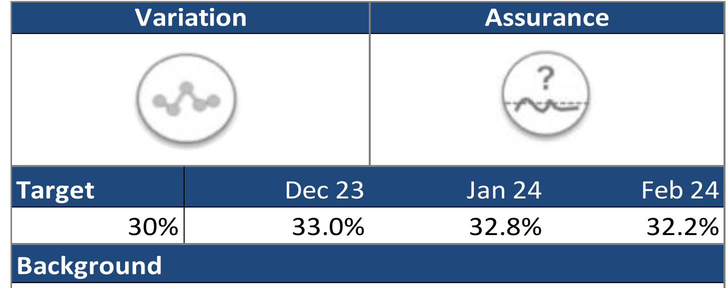
- Cancer Waiting Times standards have been amalgamated in to three simplified metrics; 28 Day Faster Diagnosis set at 75%, 31 Day Decision to Treat to Treatment set at a 96%, and 62 Day Referral to Treatment set at 85%.
- Combined 62 Day Standard achieved 56.1% in January. The current provisional position for February is 57%.
- The combined 31 Day Standard achieved 81.4% in January. It is predicted to land at 87.9% in February.
- The combined Faster Diagnosis Standard achieved 67% in January. It is predicted to land at around 75.03% in February.
- The total GP referred suspected cancer PTL sits around 3300 in total currently; reflecting higher than usual demand.
- UHNM has achieved the 62 day backlog recovery trajectory to return the number of patients waiting over 62 days to pre-pandemic levels by March 24. The 'fair share' aim was to have a backlog of no more than 273, the backlog at the week ending 10.03.24 was 263, achieving the fair shares position.
- UHNM continues to receive and see a high volume of GP suspected cancer referrals, more than usual seasonal demand plus the predicted growth, with some weeks exceeding 1000 referrals received. Referral optimisation support is being sought from the ICB.

Section 1: Non-Elective Care

Headline Metrics

Non-Elective Care – monthly *(context)*

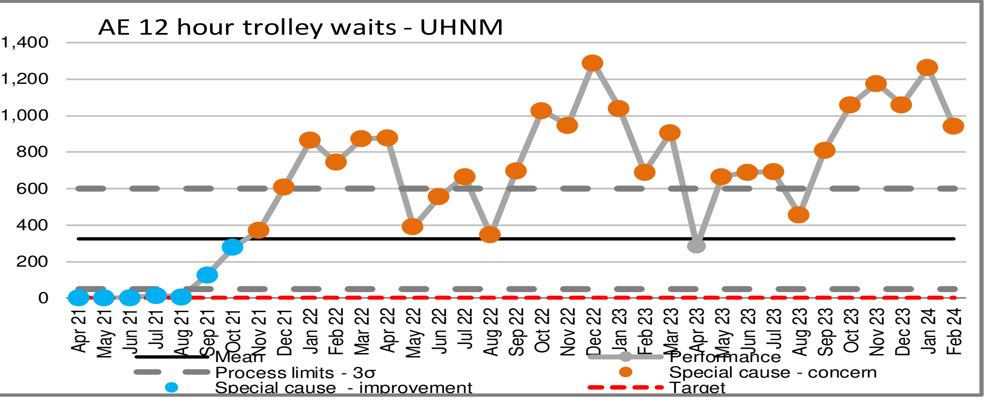




Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
30%	33.0%	32.8%	32.2%

Background

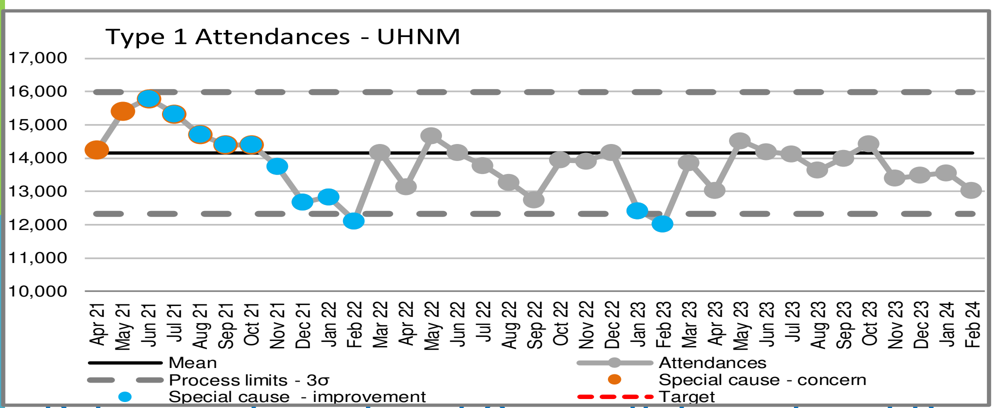
The percentage of patients who having attended the ED are admitted.



Variation	Assurance		
H	F		
Target	Dec 23	Jan 24	Feb 24
0	1059	1263	943

Background

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

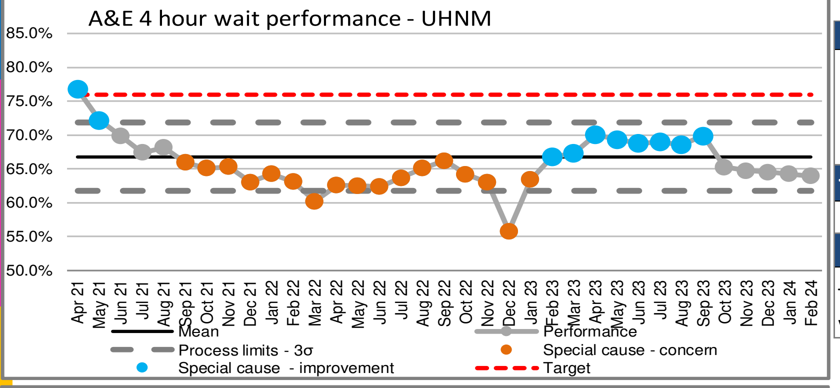


Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
N/A	13491	13561	13020

Background

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

Non-Elective Care – Headline Metrics

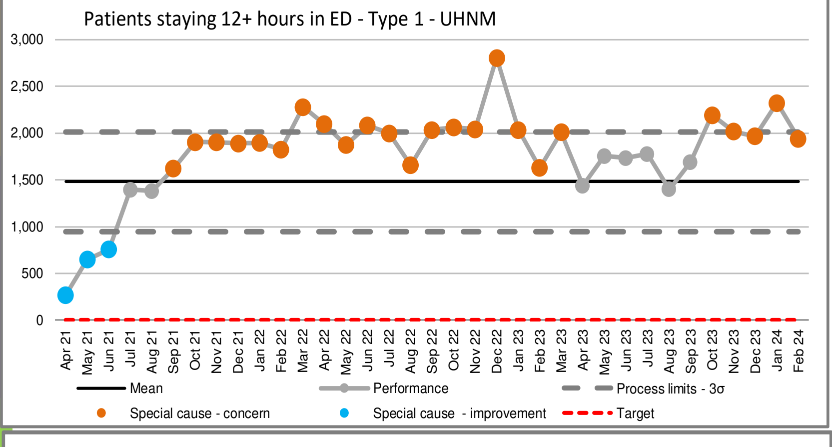


Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
76%	64.5%	64.2%	63.9%

Background

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

4 hour performance remains below the 76% target. Despite performance being below target, this has plateaued at 64%.



Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
0	1968	2325	1943

Background

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

What is the data telling us?

Patients waiting over 12 hours in ED reduced by 16% in February.

Ambulance Handovers within 60 minutes - UHNM

Mean · Performance · Process limits - 3σ · Special cause - concern · Special cause - improvement · Target

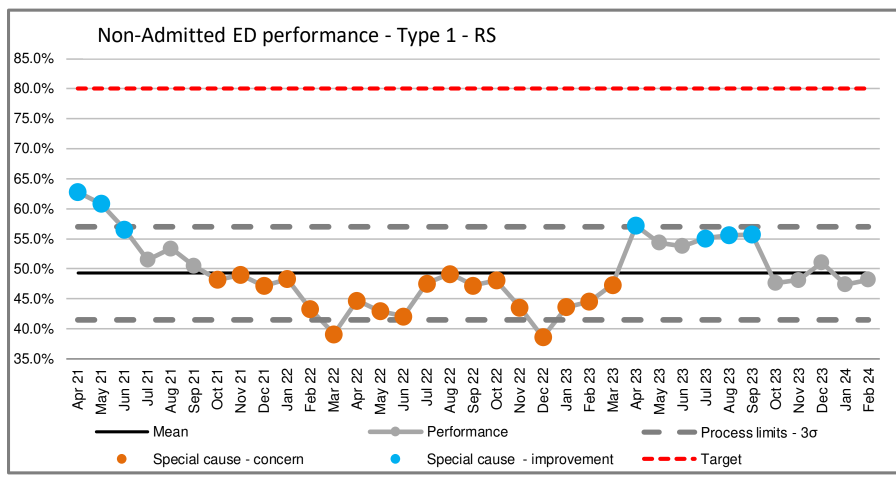
Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
95.0%	78.1%	63.3%	72.8%

Background

The percentage of ambulance handovers completed within 60 minutes.

Ambulance handovers within 60 minutes improved in February but continues to be below the lower control limit and considerably below the same period last year.

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



Variation	Assurance

Target	Dec 23	Jan 24	Feb 24
80%	51.0%	47.4%	48.2%

Summary

Workstream 1 driver metric 4-hour non-admitted performance was 48.2% for February. Governance for the workstream has been reviewed, ToR agreed, triumvirate leads for each countermeasure and A3 updated. Continuing to monitor the new dashboard and identifying additional actions to support achieving the combined performance of 76%.

Actions

Additional Senior Decision maker allocated in the ambulatory stream which has indicated a slight and consistent improvement in performance continues to be monitored daily using the new dashboard.

Children's ED subgroup focusing on reviewing patients earlier in the journey. EhPC utilisation, particularly in the morning to create flow, senior leadership reviewing rotas, navigation, creation of a navigation shift focusing on standard work.

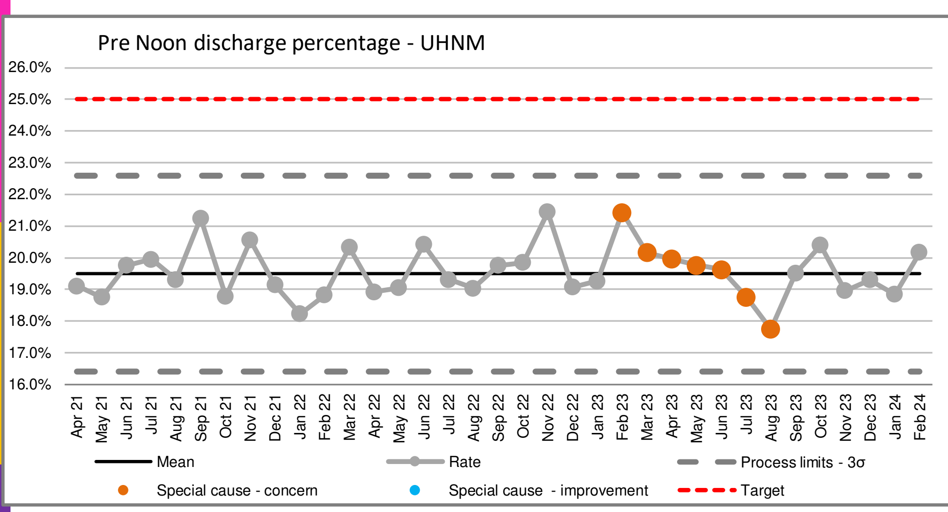
CDU has been consistently open since the 20th February. Actions include undertaking a live clinical audit on criteria to increase utilisation, review will have been undertaken by the next NELIG to understand missed opportunities.

Ambulatory standard work, reviewing and enhancing previous work undertaken. Data review of DTA's in ambulatory (over the last 12 months) to determine potential gains to support 4-hour performance. In the meantime, proactive management of DTA's through the ED Huddles.

Data review of deflections from the ED to support increase in SDEC utilisation.

EhPC had an additional 718 patients have been seen within the extended hours of the service since it was opened on 9th January. Action: Standard work for the navigator to have a view of EhPC and ED numbers to ensure proactive management of demand is undertaken.

Workstream 2; Standard Work
Pre-Noon Discharges



Variation		Assurance	
Target	**Dec 23**	**Jan 24**	**Feb 24**
25%	19.3%	18.8%	20.2%

Background

The percentage of discharges complete before 12 noon.

Summary

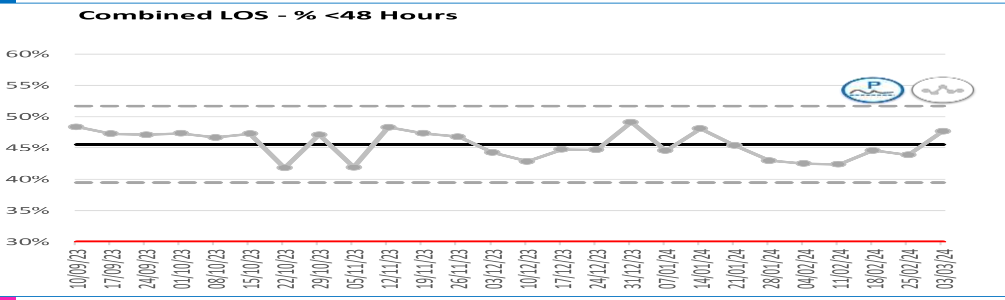
The overall Trust performance against pre-noon discharges for non-elective wards for February was 15.2%, for Royal 15.8% and County 11.4%. The current ToC which aims to ensure adherence to standard work is undertaking a learning session to agree a plan to review the next wards to continue this work and will be monitored through Workstream 2; County to be included in this process and has been proposed as one of the countermeasures.

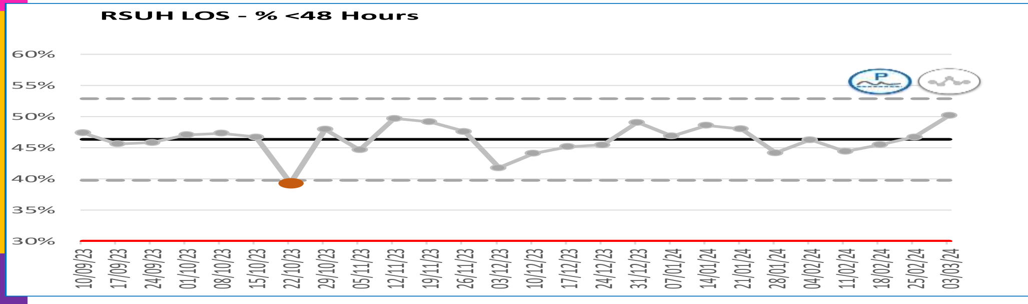
Actions

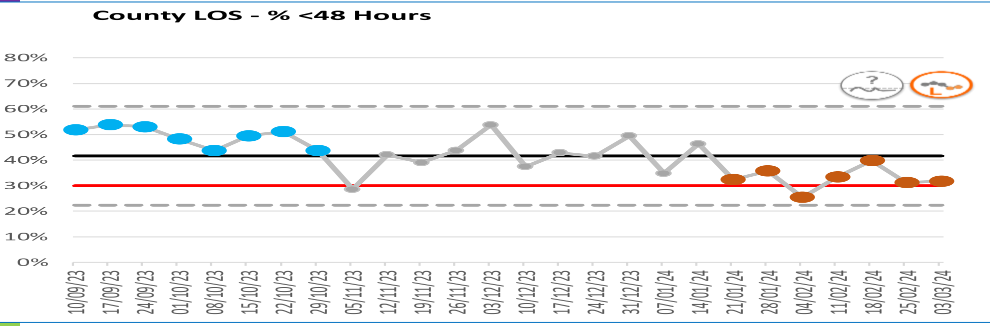
The A3 is still in development and a couple of sessions have been completed to undertake the root cause to identify the countermeasures. However, the Test of Change (ToC) is also being used to identify further root causes and this will be ongoing through the ToC. The top contributors are being identified and draft countermeasures will be circulated to the group for consideration at the next meeting. The group continue to meet weekly.

The ToC summary for the 4 identified wards (76b, 120, 128 and 230) stated that over the week there was a reduction in patients waiting over 12 hours by 5.8% on average. This was facilitated by increase in discharges across the medicine division by 20.3% with an average of 2.2 per day length of stay reduction across the 4 wards. The ToC continues to focus on developing a product Standard work detailing how to adhere to SAFER principles, which will be iterated and spread to different wards.

Workstream 3; Frailty
75+ Patients with LOS <48 Hours







Summary

February combined performance against the driver metric of 75% frail patients with a LoS < 48 hours was 45.6%. A review of the data is being completed to identify a phased target which will be agreed at the next workstream meeting.

The group have completed the countermeasures and a proposed set of actions for each of the 3 subgroups have been developed, which the leads are reviewing to confirm at the next meeting.

Actions

Proposed actions to achieve Goal 1

- Develop the pathways in the Acute Care at Home team to support the deflection from ED.
- Home Care is Best Care Programme – Incorporating a risk and benefit assessment against potential admission.
- Evaluation of the ambulance service conveyancing review.
- Education piece to WMAS on safeguarding v safety.
- Test of Change (4 weeks) in ED at County for extended day therapy service.
- Test of Change IDH in-reach to ED to explore opportunities.
- Alignment of front of house service across both sites.

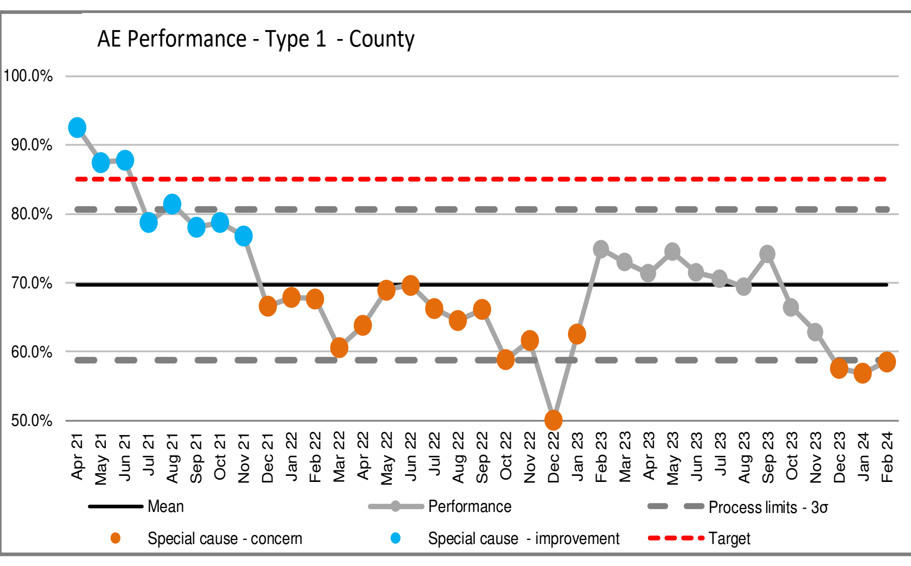
Proposed actions to achieve Goal 2

- Single pathway document incorporating CGA and admission document together with a plan to roll out across both sites. CGA workshop planned.
- Ensure RESPECT documentation is mandatory for all appropriate frail patients, with a focus on quality documentation.
- Deconditioning strategy.
- Increasing utilisation of virtual ward for frail complex patients.

Proposed actions to achieve Goal 3

- Education - discharge pathways and understanding of community pathways.
- Transforming the discharge facilitation model to reduce the length of stay for patients (against the discharge ready date) for complex frail patients (IDH).
- End of life pathway – to reduce the length of stay and improve discharge pathway.
- Early supported discharge for patients with therapy needs.

Workstream 4; County Hospital UEC
County Hospital Four Hour Performance



Variation	Assurance		
Target	Dec 23	Jan 24	Feb 24
85%	57.6%	56.9%	58.6%

Summary

Workstream 4 driver metric of 4-hour performance for County site achieved 58.6% in February. Ongoing monitoring of March performance is in place with the aim to achieve the combined performance of 76% by reviewing and understanding urgent actions required to support a return to recent high performance at County.

Patrick Wilkinson will be taking over as lead for this workstream during March.

Actions

Workforce: Workforce modelling in ED being undertaken to determine senior medical support requirements against demand profile.

Ambulatory: Ambulatory standard work and review of the MRU (SDEC) model to explore further opportunities and ensuring alignment with future model.

Review of radiology and pathology support to prevent delays and support performance.

Triage: Continue with staffing review for triage, however this may require a business case if uplift is identified.

To support surges in attendances, a potential area for an additional triage room as been identified, a feasibility study with IP support is being undertaken.

AMU standard work: Aligning to ToC objectives currently being undertaken at the Royal site (refer to WS2 detail).

TTO's: avoiding delays due to errors – education piece being undertaken for junior doctors.

Length of stay reviews continue for long waiters and a score card has been developed to monitor progress.

AMU medical staffing review: Consultant vacancies out of advert, medical staffing demand profile review against rotas to support earlier discharges, ACP resource review across both sites to align resources to demand (new lead ACP will be leading on this review).

Urgent Care - 4 hour standard

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Jan 24	1.0%	**17.1%**	
A&E - 4 Hour Standard	Jan 24	76.00%	**64.2%**	
A&E - 4 Hour Standard (Type 1)	Jan 24	76.0%	**42.9%**	
A&E - 4 Hour Standard (Type 2 or 3)	Jan 24	95.0%	97.2%	
A&E - Conversion Rate	Jan 24	25.0%	**27.6%**	
A&E - DTA to Admission >12 Hours	Jan 24	0.0%	**19.6%**	
A&E - DTA to Admission >12 Hours#	Jan 24	0.0	**1,209.0**	
A&E - DTA to Admission >4 Hours	Jan 24	10.00%	**32.7%**	
A&E - Left Without Being Seen	Dec 23	5.00%	**6.3%**	
A&E - Reattendance Rate	Dec 23	5.0%	**9.0%**	
A&E - Time to Initial Assessment	Dec 23	15.0	8.0	
A&E - Time to Treatment	Dec 23	60.0	**85.0**	
A&E - Total Time in A&E	Dec 23	160.0	**188.0**	
A&E - Total Time in A&E (Admitted)	Dec 23	180.0	**406.0**	
A&E - Total Time in A&E (Non-Admitted)	Dec 23	140.0	**164.0**	

- 4 hour performance over the latest two months has remained statis at 64%.
- UHNM have been consistently below all peers during this period.
- UHNM remain in the third quartile.

Urgent Care - 12 hour standard

A&E - 12 Hour Standard

Jan 24 Performance: 17.1% | Rank: 99th of 124

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

A&E - 12 Hour Standard (0.0%–18.0%; % Rank 0–100), Feb 23 – Jan 24, with Target line.

Legend: University Hospitals North Midlands, Recommended, Requires Improvement, Region, Teaching, % Rank

- All peer groups have followed a similar trend since February.
- UHNM have continued to have the highest % of 12 hour breaches compared to peer groups.
- UHNM remain in the lowest quartile.

Key Performance Indicator	Period	Target		SPC
A&E - 12 Hour Standard	Jan 24	1.0%	17.1%	
A&E - 4 Hour Standard	Jan 24	76.00%	64.2%	
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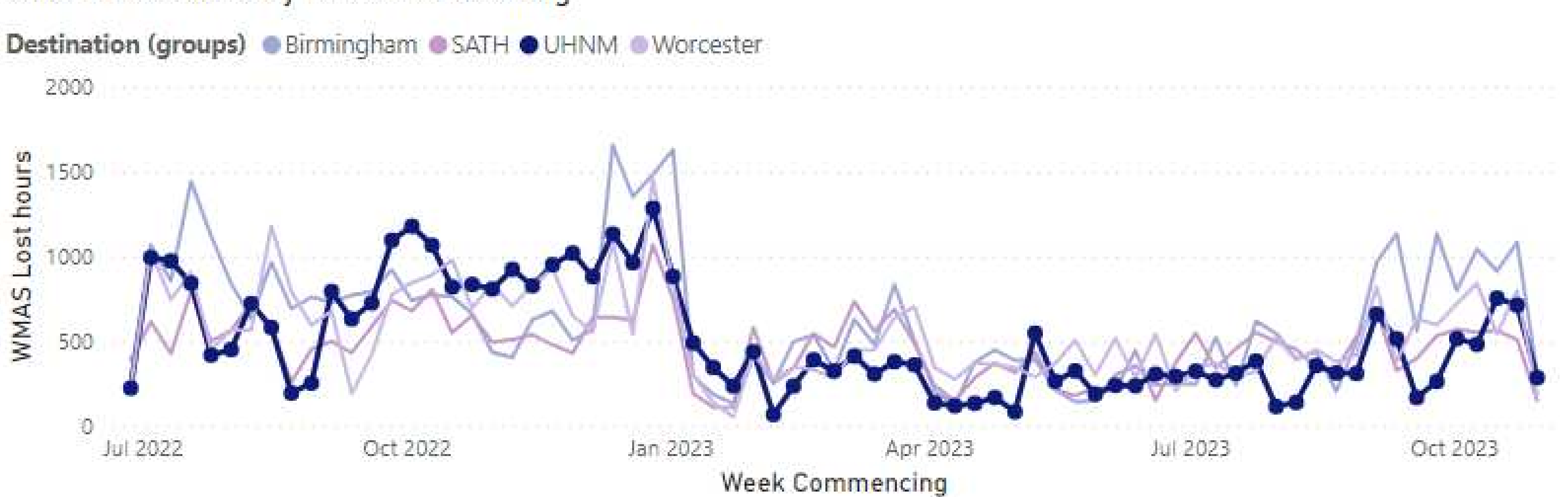
Urgent Care – Ambulance Handover Delays



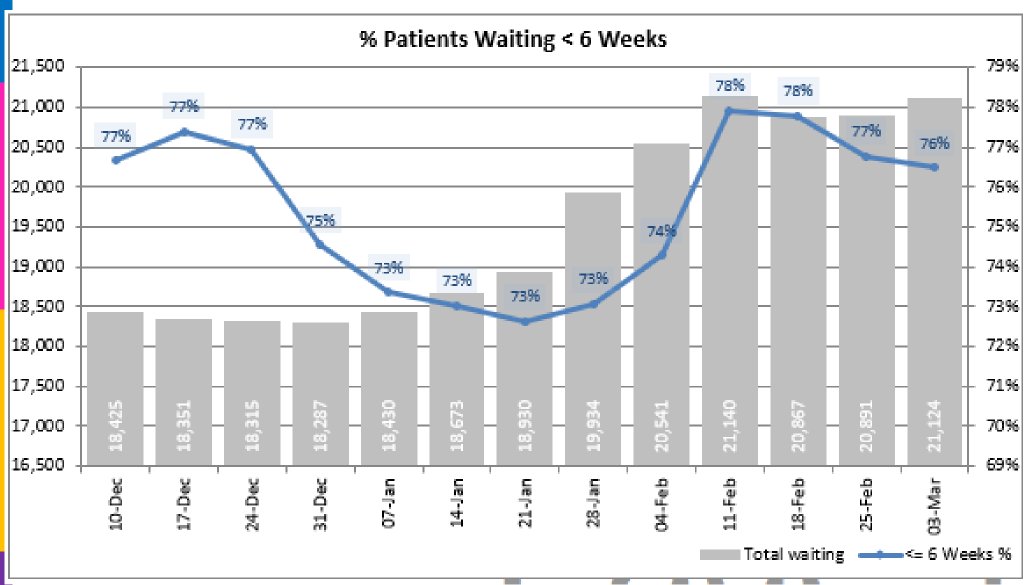
- WMAS Ambulance handover delays over 60 minutes apportioned to four Trusts.
- During October UHNM have seen a worsening trend, but remain below/within peer trusts.

NB. Data not updated due to a data feed issue from WMAS which is being investigated.

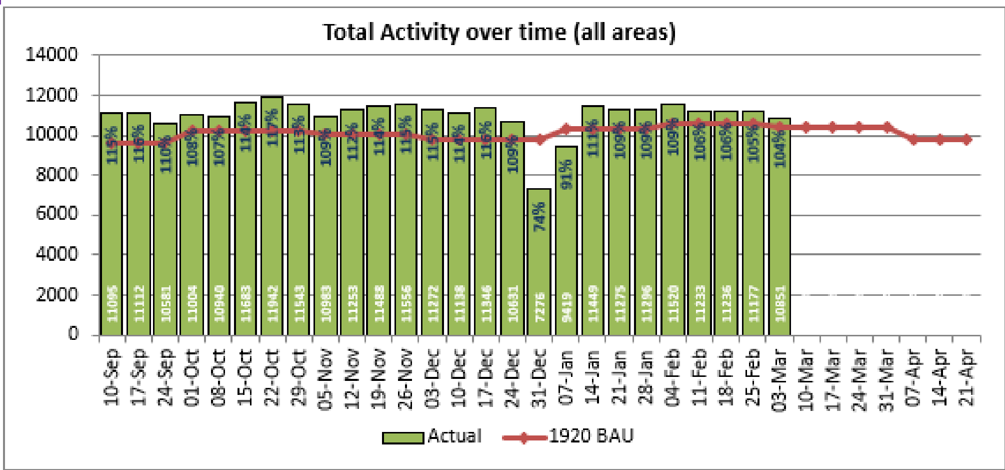
Data source: WMAS 09/11/23

Section 2: ELECTIVE CARE

Planned Care - *Diagnostics*



Test	<=6	6-9	10-12	13+ Wks	Total	% <6Wks
Magnetic Resonance Imaging	3,464	173	7	1	3,645	95.0%
Computed Tomography	3,541	28	7	4	3,580	98.9%
Non-obstetric Ultrasound	5,595	1,422	37	2	7,056	79.3%
DEXA Scan	0	0	0	0	0	
Cardiology - Echocardiography	1,419	382	61	60	1,922	73.8%
Cardiology - Electrophysiology	0	0	0	0	0	
Colonoscopy	372	104	85	979	1,540	24.2%
Flexible sigmoidoscopy	233	71	52	763	1,119	20.8%
Cystoscopy	149	21	8	62	240	62.1%
Gastroscopy	401	129	93	285	908	44.2%
Neurophysiology	481	54	26	2	563	85.4%
Respiratory physiology	503	36	7	5	551	91.3%
Urodynamics	0	0	0	0	0	
Total	**16,158**	**2,420**	**383**	**2,163**	**21,124**	**76%**



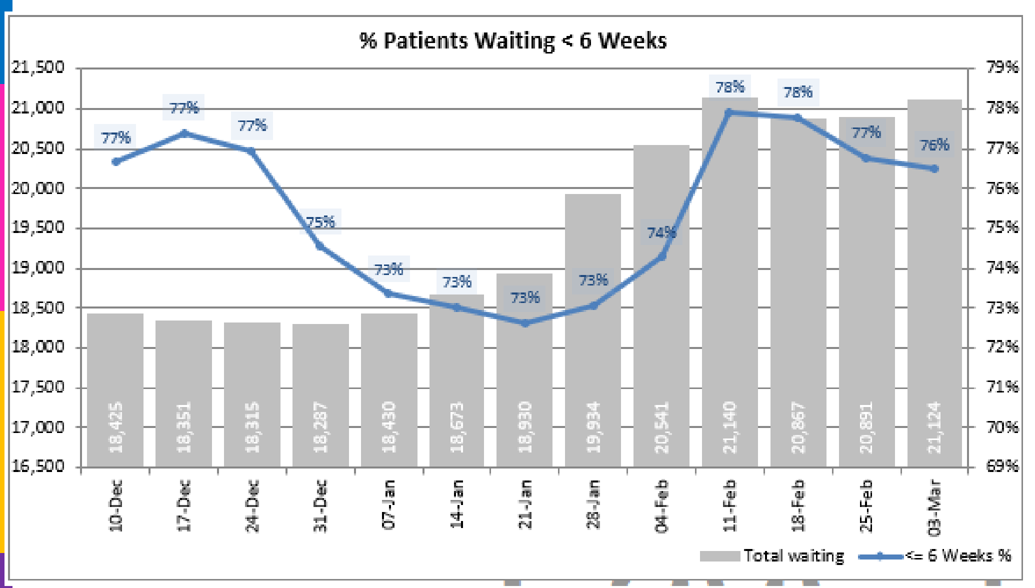
Pathology*:*

The following represents performance as at 26th February 2024;

- Urgent (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day 16 (previously Day 18), with 80% of cases reported by Day 10 (Previously Day 11)
- Accelerated (include all Cancer Resections): 95% reported at Day 23 (Previously Day 25) with 80% of cases reported by Day 16 (Previously Day 14)
- Routine (all Specimens not in above categories): 95% Day reported at 27 (No Change) 80% of cases reported by Day 17 (Previously Day 18)

Our 7 day reporting turnaround time (TAT) for Urgent cases is at 54% against the Royal College of Pathologists' target of 80% within 7 days (previously 55%)

Planned Care - *Diagnostics*



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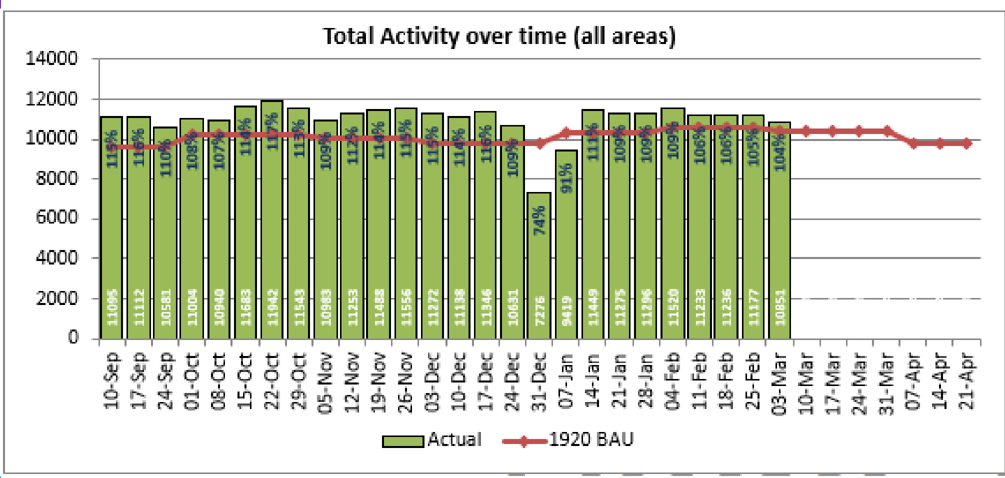

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Our 7 day reporting turnaround time (TAT) for Urgent cases is at 54% against the Royal College of Pathologists' target of 80% within 7 days (previously 55%)

Delivering Exceptional Care with Exceptional People

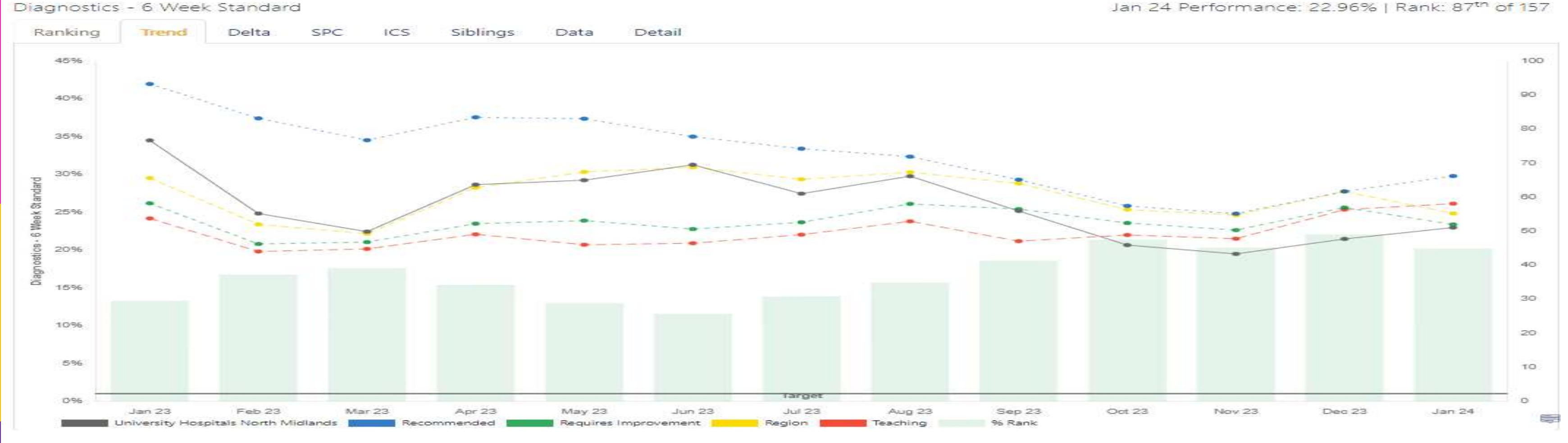
Diagnostics Summary

- DM01 activity in February was above 19/20 levels, however data is unvalidated.
- DM01 performance was 76.8% overall in February, a drop of 0.2% from January (77%). Endoscopy performance is the main contributor to this performance being below the national target of 99%
- In pathology 7 day reporting turnaround time (TAT) for Urgent cases is at 54% against the Royal College of Pathologists' target of 80% within 7 days (previously 55%)

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

- Insourced weekend service continues until end March 2024 and from February extending into County site, following external funding from WMCA. This resource is specifically to support reducing cancer wait time but March capacity will support 78ww position
- Concerns raised by surgical/gastro pathways that delays are hindering their ability to deliver 65wks by end of September although these patients have now all had their endo appointment confirmed
- Routine, urgent, surveillance and planned patients continue to have wait more than their target date. Maximising in week sessions and use of CNS TI's, additional support from surgeons and 18 Weeks to support these cohorts
- Capacity and Demand model now reworked, showing a significant gap between funded capacity and sessions available through current estate
- Request to Proceed and ERF Papers drafted to request funding for recovery and BAU activity
- Service team continuing to work on demand management strategies and productivity measures to improve utilisation and appropriateness (including admin and clinical validation)
- Sustained improved booking performance for lower cancer PTL patients
- Improvement plan ongoing and workstream leads progressing actions
- Four Eyes Insight on to Week 9 of their Improving Efficiency Programme within the Endoscopy service. Proposal going to Execs to move to Phase 2 and embark on a 24-week FEI led programme.

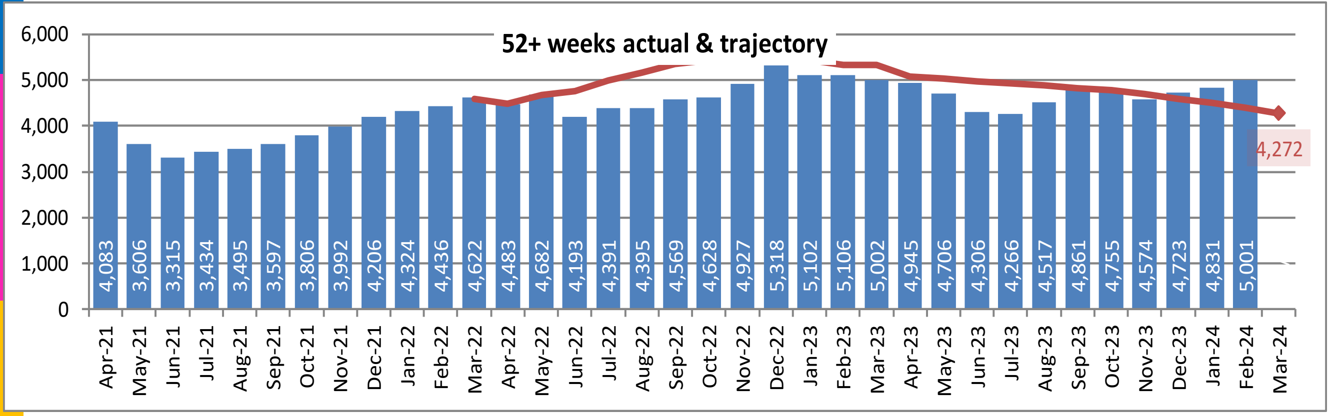
Diagnostics

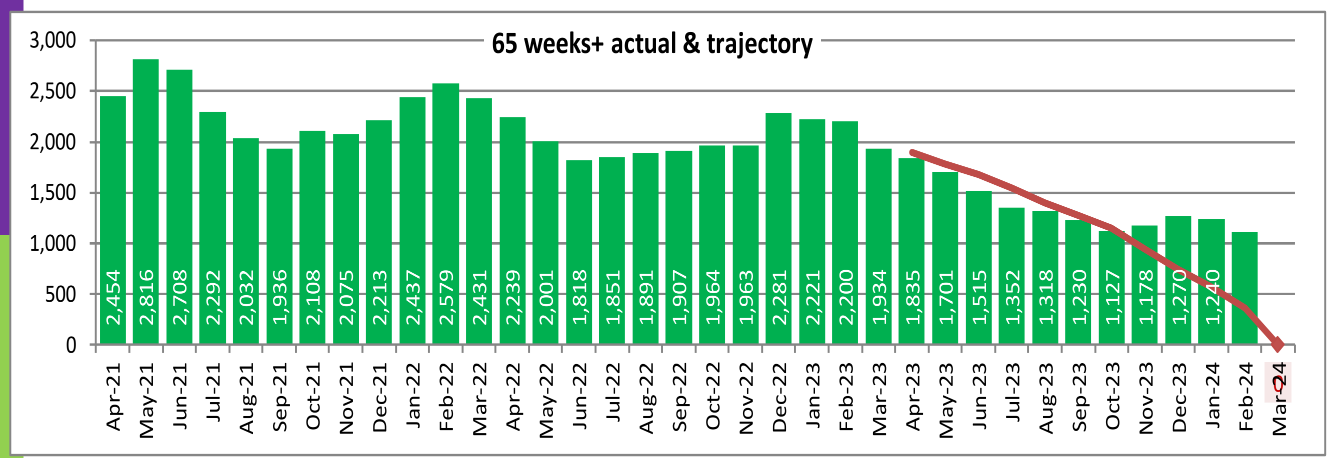


	Key Performance Indicator	Period	Target		SPC
	Audiology	Jan 24	1.00%	3.9%	
	Colonoscopy	Jan 24	1.00%	72.8%	
	Computed Tomography	Jan 24	1.00%	0.7%	
	Cystoscopy	Jan 24	1.00%	5.7%	
	DM01 Waiting <13 Weeks	Jan 24	100.00%	90.5%	
	Diagnostics - 6 Week Standard	Jan 24	1.00%	23.0%	
	Diagnostics - 6 Week Standard Reversed	Jan 24	99.00%	77.0%	
	Echocardiography	Jan 24	1.00%	36.0%	
	Electrophysiology	Jan 24	1.00%	-	
	Flexi Sigmoidoscopy	Jan 24	1.00%	76.2%	
	Gastroscopy	Jan 24	1.00%	47.3%	
	Magnetic Resonance Imaging	Jan 24	1.00%	9.7%	
	Neurophysiology	Jan 24	1.00%	32.0%	
	Non-obstetric Ultrasound	Jan 24	1.00%	12.9%	
	Sleep Studies	Jan 24	1.00%	20.5%	
	Urodynamics	Jan 24	1.00%	0.0%	

- All peer groups are performing at a similar level.
- UHNM continue to perform better than all peer groups, despite a slight deterioration over the last two months.
- All groups including UHNM remain significantly above the 1% national target.
- MRI, Non Obstetric Ultrasound and Colonoscopy saw the biggest deterioration in performance in January.
- UHNM remain in the 3rd Quartile.

Planned Care – *RTT*

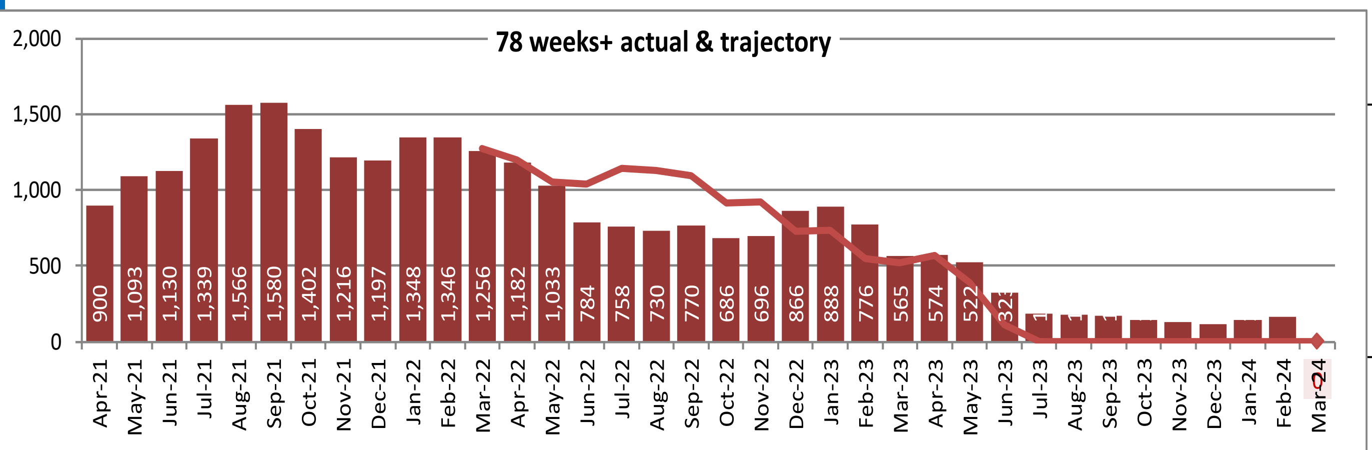




Patients waiting 52+ weeks has seen growth each month since November 2023.

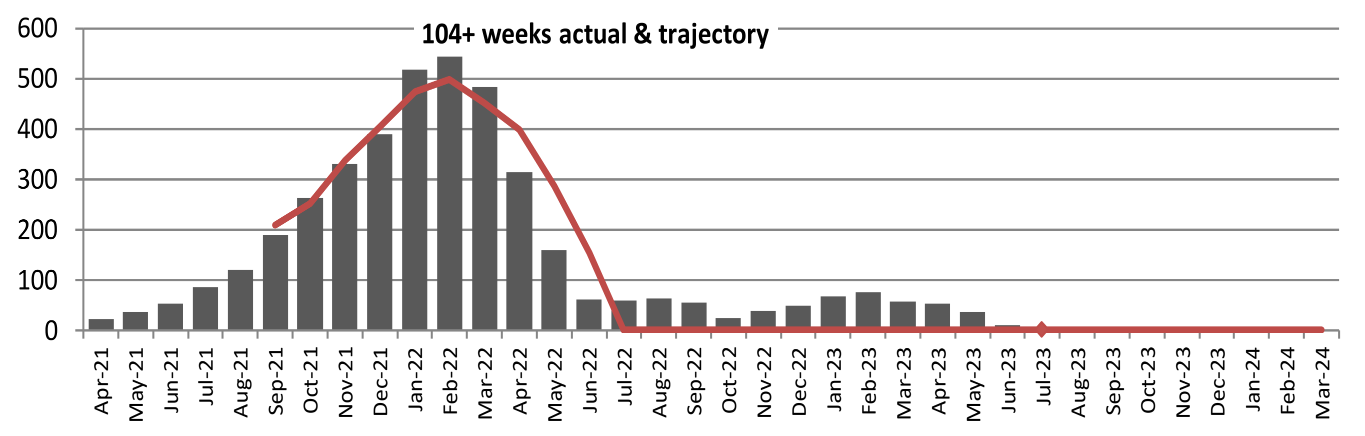
65+ week waiters reduced for the first time in the last four months.

Planned Care – *RTT Long Waiters*



The number of patients waiting over 78 weeks was validated as 159.

January data is unvalidated and is likely to reduce marginally.



There are three patients who have been waiting 104+ weeks in February.

Planned care - *RTT*

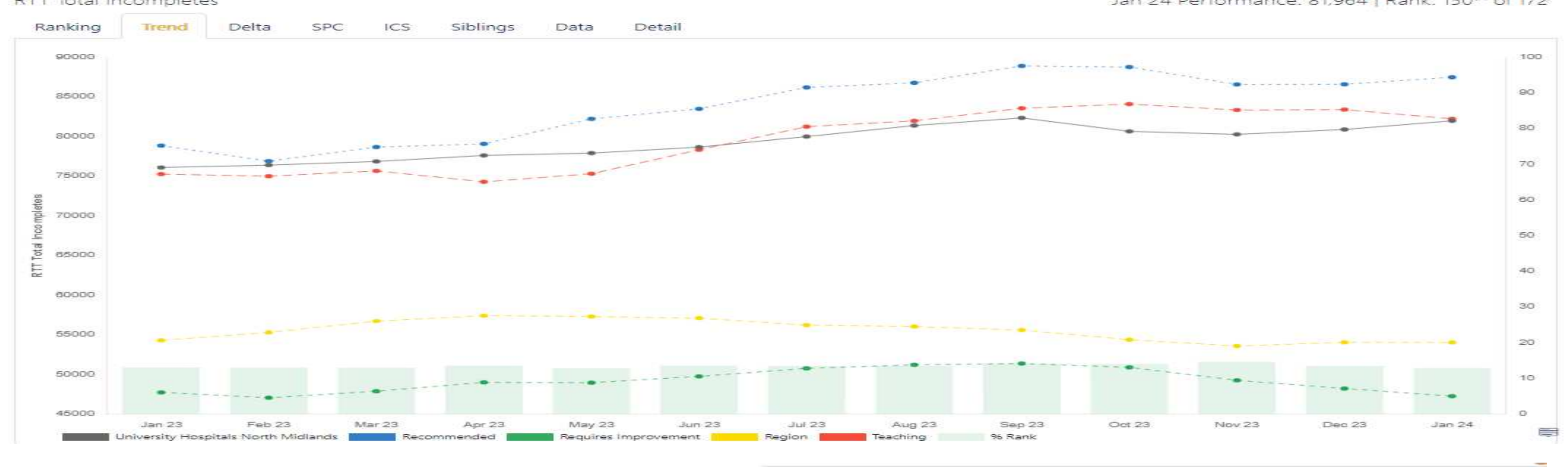
Summary

- 52+ week patients increased during February to 5,001 (unvalidated).
- 78+ patients have been gradually reducing, Dec was 117. However, due to winter pressures and IA the number has now increased to 159 (validated)
- The overall Referral To Treatment (RTT) Waiting list now sits 81,226 end of February (unvalidated).
- The focus continues on 78w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 65 week+ patients with the introduction of a weekly elective management oversight group.
- At the end of February the number of > 104 weeks was 3.
- The IS have taken over 1000 patients from Orthopaedics & Spinal (out of over 1000 considered), with a further 60 patients being worked through to contact & transfer.

RTT

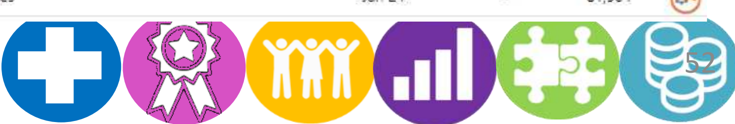
- Validation has increased with some additional resource in the short term. Temporary validation resource will cease by the end of the financial year, decreasing Corporate Validation capacity by 60%.
- RTT Performance sits at 49.8%, a decrease from 50.0% in January.
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.
- The Trust is currently at 69% of all pathways over 52 weeks having been validated within the last 12 weeks. This is an improvement on last month's 66%
- 31,068 eligible patients waiting 12+ weeks were sent a validation form in October 2023, with 1,532 patients confirming they no longer wish to continue their pathway. 2,990 patients said their condition had changed since their referral. These are still being worked through by the clinical divisions. A further validation form invitation is planned to be sent during April.
- Trust wide revamp of validation & training underway, the IST are supporting the Trust with events in September – December to train all admin staff working with RTT. Training programme complete – 525 people attended training.
- Work underway to develop new training courses and add on to Intranet, with courses bookable on ESR. Planned Care Intranet page to be re-launched in April, with updated training materials.
- Active reporting focus on ensuring the right patients (urgent and longest waiters) are the patients booked into all available capacity so that the limited resource available continues to be used for the right patients by clinical need. This is being scrutinised through a divisional weekly meeting with COO/Deputy
- Patient by patient monitoring by each specialty and by the corporate team on the patients at risk of the breaching 104 and 78 weeks by end of month, and month following.
- Key enablers to the continued focus on long waiting patients are ring fencing of beds for Orthopaedics at RSUH, modular theatre at County and improvement in theatre utilisation and booking.
- Increased focus on non-admitted patients and increasing outpatient & diagnostic capacity, improving utilisation and business processes to move patients to a decision to admit.
- Roll-out of Palantir's Foundry platform underway, validation of NON-RTT outpatient referrals commenced 21st November.
- External validation support sought from MBI, commenced 4th October. Work completes 12th January, with final report received & disseminated.

RTT

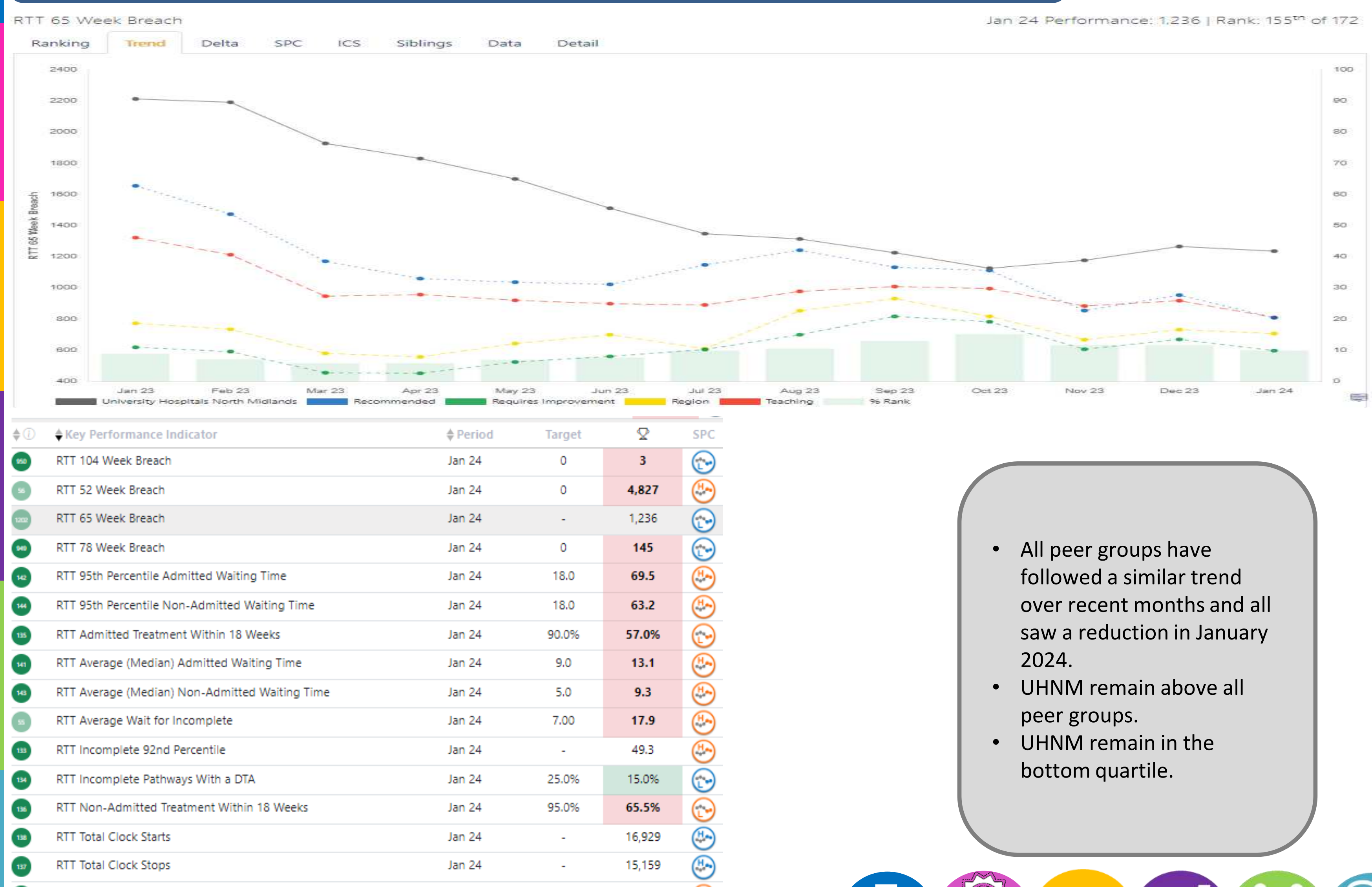


- UHNM and Recommended peer group a showing the same trend over the last 12 months, with an increase in January 2024.
- Other peer groups have seen a reduction in January 2024.
- UHNM remain in the bottom quartile.

	Key Performance Indicator	Period	Target		SPC
	RTT 104 Week Breach	Jan 24	0	3	
	RTT 52 Week Breach	Jan 24	0	4,827	
	RTT 65 Week Breach	Jan 24	-	1,236	
	RTT 78 Week Breach	Jan 24	0	145	
	RTT 95th Percentile Admitted Waiting Time	Jan 24	18.0	69.5	
	RTT 95th Percentile Non-Admitted Waiting Time	Jan 24	18.0	63.2	
	RTT Admitted Treatment Within 18 Weeks	Jan 24	90.0%	57.0%	
	RTT Average (Median) Admitted Waiting Time	Jan 24	9.0	13.1	
	RTT Average (Median) Non-Admitted Waiting Time	Jan 24	5.0	9.3	
	RTT Average Wait for Incomplete	Jan 24	7.00	17.9	
	RTT Incomplete 92nd Percentile	Jan 24	-	49.3	
	RTT Incomplete Pathways With a DTA	Jan 24	25.0%	15.0%	
	RTT Non-Admitted Treatment Within 18 Weeks	Jan 24	95.0%	65.5%	
	RTT Total Clock Starts	Jan 24	-	16,929	
	RTT Total Clock Stops	Jan 24	-	15,159	
	RTT Total Incompletes	Jan 24	-	81,964	



RTT



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- All peer groups have followed a similar trend over recent months and all saw a reduction in January 2024.
- UHNM remain above all peer groups.
- UHNM remain in the bottom quartile.

NHS University Hospitals of North Midlands NHS Trust

RTT

RTT Average (Median) Admitted Waiting Time

Jan 24 Performance: 13.1 | Rank: 52nd of 139

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

Legend: University Hospitals North Midlands, Recommended, Requires Improvement, Region, Teaching, % Rank

RTT Average (Median) Non-Admitted Waiting Time

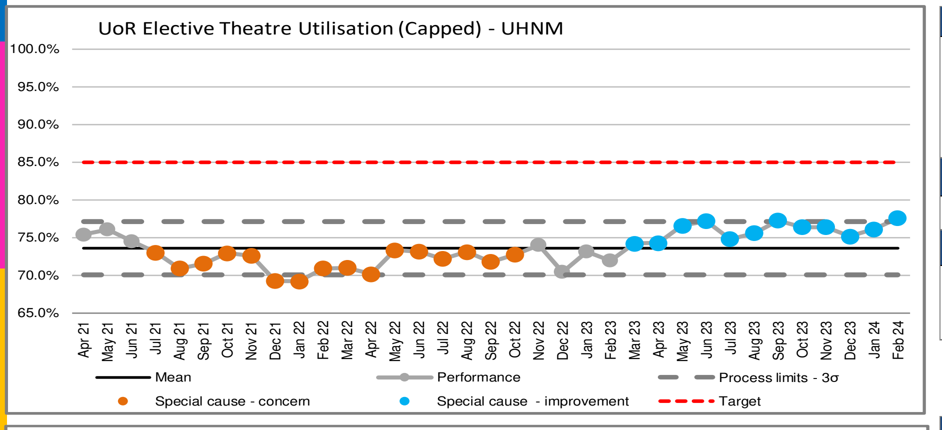
Jan 24 Performance: 9.3 | Rank: 64th of 166

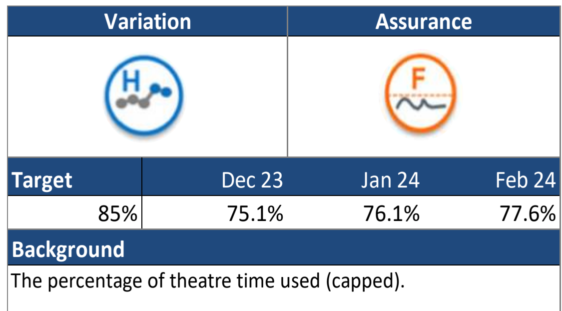
Ranking | Trend | Delta | SPC | ICS | Siblings | Data | Detail

Legend: University Hospitals North Midlands, Recommended, Requires Improvement, Region, Teaching, % Rank

- The average wait (median) for patients at UHNM on an RTT admitted pathway, has reduced since November 23 despite all peer groups seeing an increase.
- All peer groups including UHNM for those patients on a non admitted RTT pathway have increased in January 2024, following a reducing trend at the end of 2023.

Planned Care – *Theatres*



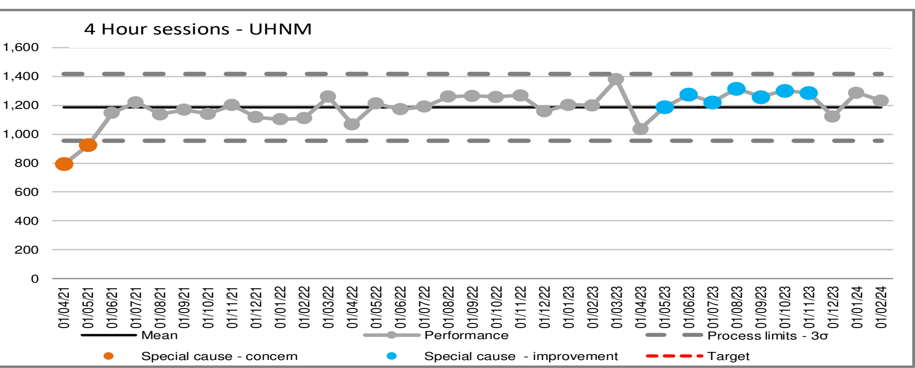


Variation	Assurance		
Target	**Dec 23**	**Jan 24**	**Feb 24**
85%	75.1%	76.1%	77.6%

Background

The percentage of theatre time used (capped).

Capped Utilisation performance has improved further and has exceeded the upper control limit in February.



Variation	Assurance		
Target	**01/12/23**	**01/01/24**	**01/02/24**
N/A	1124	1287	1233

Background

The number of 4 hour sessions during the month.

The number of 4 hour sessions continues to see normal variation.

Number of Monthly Elective Operations - UHNM

Mean · Performance · Process limits - 3σ · Special cause - concern · Special cause - improvement · Target

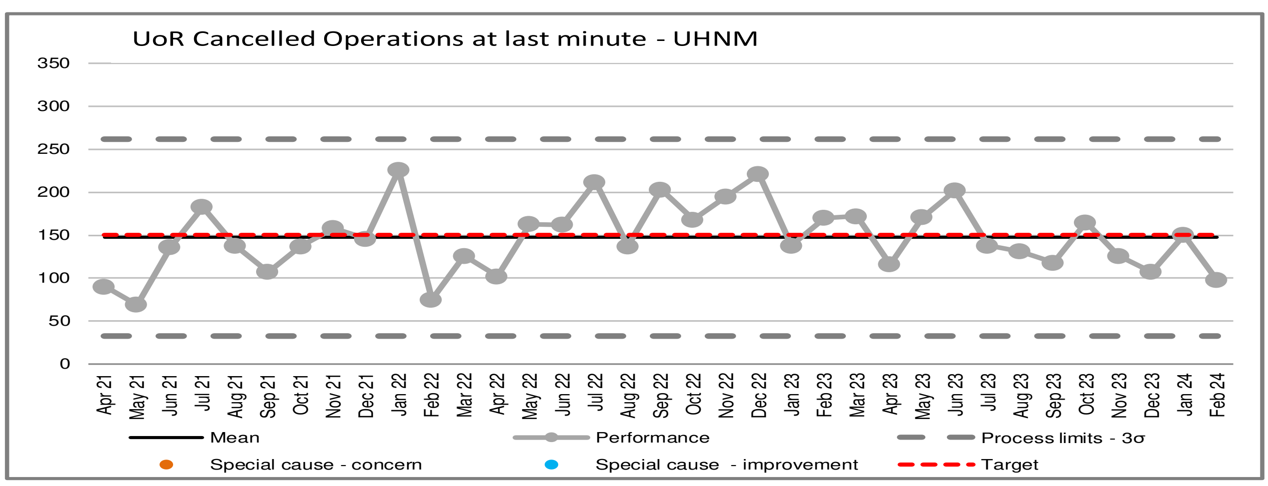
Variation	Assurance		
Target	**01/12/23**	**01/01/24**	**01/02/24**
N/A	1746	2112	2048

Background

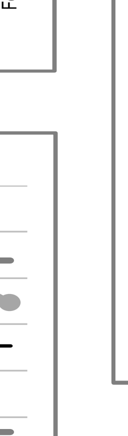
The total number of elective operations during the month.

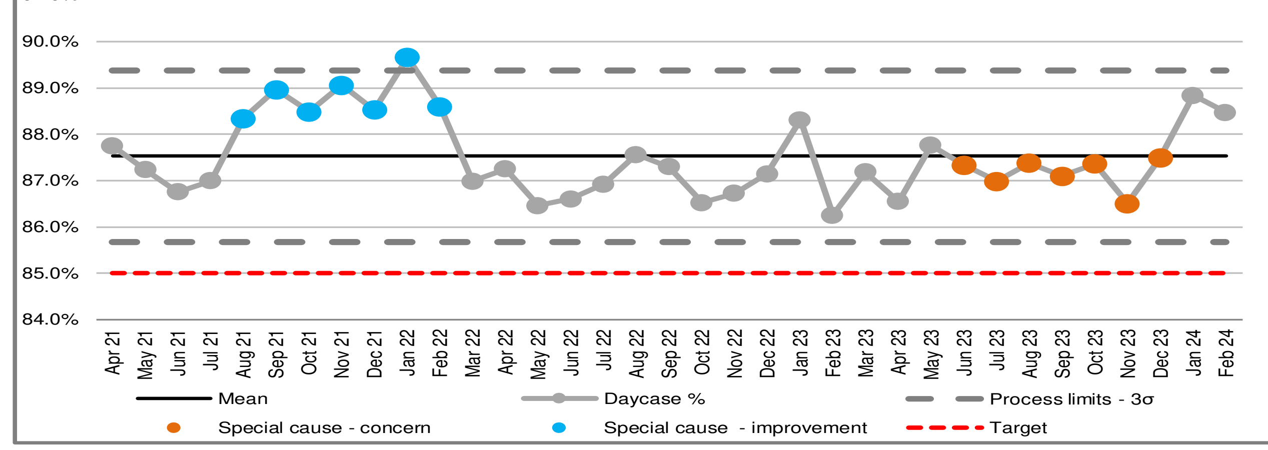
Following a dip in December, Elective Operations are back to normal levels.

Planned Care – *Theatres*



February saw a reduction in the number of Cancelled Operations, but remains within normal variation.





Following an increase in the proportion of Daycase activity since November 2023, February saw a marginal reduction.

Planned Care - *Theatres*

Elective inpatients Summary

- Capped utilisation Increased further in month to 77.6%.
- Cancelled operations decreased to 8%
- Perioperative Pathway transformation commenced with the Perioperative Care Working Group Sub delivery Groups starting their meetings and work. ERF proposal submitted to seek investment for 12month resource to support transformation.
- Cardiac Theatre Business Continuity Incident as result of Aspergillus Niger contamination led to loss of Cardiac Elective Capacity for 1 week – BAU resumed 11th March.

Actions

- Decontamination of Theatres 31 & 32 and Perfusion equipment an rooms due to Apspergillus Niger. BC incident conducted and closed
- CYP-Pre-Ams Business case presented at Pre-Execs, further responses required before re-submission to next pre-exec meeting
- Dashboard reporting stabilised with validation process in place
- Ophthalmology meeting with HOO, DM & Clinical Lead to determine actions required to improve "start time". Actions agreed
- Further supported Performance week in planning stages
- Robotic Assisted Surgery strategy continues to develop through workshops

Theatres - Benchmarked

University Hospitals of North Midlands NHS Trust

Include independent provider data? Chart View Table View

Select level: Provider

Select scope: National

Highlight system providers

Select chart type: Variation Chart

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

Download

University Hospitals of North Midlands NHS Trust (My Provider)

Capped Theatre Utilisation %: Touch time within planned session vs planned session time : 75.7%

Provider Quartile 4 - Highest 25%

Capped Theatre Utilisation %: Touch time within planned session vs planned session time

100.0% 75.0% 50.0% 25.0% 0.0%

In order of Capped Theatre Utilisation %: Touch time within planned session vs planned session time (n=120)

My Provider
Non-Peer Providers
Provider Top/Best Decile (83.4%)
My Peers
Peers (Recommended Peers) Median (78.2%)
Provider Median (77.8%)

- Issue raised with NHSE regards inaccuracy of ongoing Model Health Data since change of submission data set to County Elective Hub. Awaiting response from Model Health Data lead

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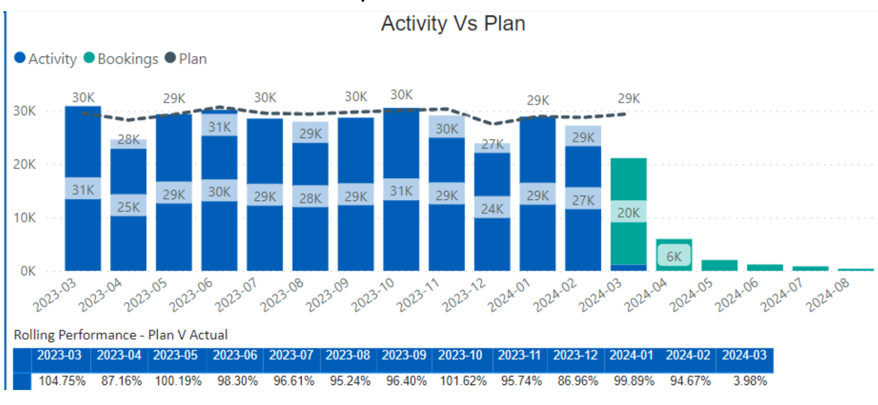
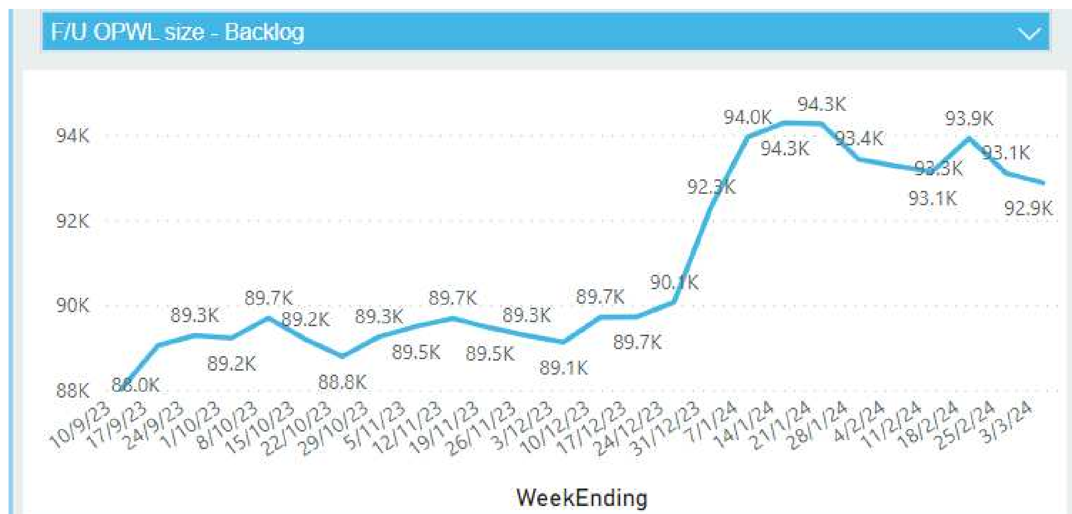
Planned Care – *Outpatients*



2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2024-01	2024-02	2024-03
104.75%	87.16%	100.19%	98.30%	96.61%	95.24%	96.40%	101.62%	95.74%	86.96%	99.89%	94.67%	3.98%

2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2024-01	2024-02	2024-03
104.33%	97.88%	111.55%	105.60%	100.64%	103.12%	102.22%	109.02%	106.88%	97.04%	111.35%	101.33%	2.95%



New Outpatient activity performance was 95% of plan in February and 96% YTD.
Outpatient Follow Up performance was 101% in February with YTD at 104%.

The Follow Up Backlog was on a downward trend throughout February, despite the spike during w/e 18th Feb.

Planned care – *Outpatients*

Actions

- **OP Cell Programme Structure** - Reframed on reducing follow ups without a procedure by 25%, reflecting the 23/24 Elective Recovery Guidance ambition. Regular
- meetings with NHSE have confirmed alignment of approach and main elements covered. OP Cell A3 format, monitoring identified countermeasures. Key actions from Elective Care Review incorporated, updates reported to the Elective Steering group. Awaiting 24/25 Planning Guidance.

  Risks: - Business plans signed off for 23/24 include increase in follow ups, in part to clear follow up backlog
  - Clinically Led challenge required to facilitate clinical conversations and encourage engagement
  - Lack of pace on schemes linked to System Partners, previously escalated at Planned Care Improvement Board
  - PKB functionality to support waiting list validation & 2way SMS: timeline risk, (revisiting 2 way SMS targeting DNAs)
  - Impact of further Industrial Action (IA) on cancelled OP sessions / attendances, impact on improvement work
  - CIP impact on admin vacancies process – admin resource remains critical for transformation & sustained performance
- **Referral Management / Variation**

  Advice & Guidance - Advice & refer 'triage by default': scoping internal /external support. Presentation shared at OP Cell and Planned Care, plan to present to System Groups for review & discussion ahead of decision on pilot. Specialties provisionally identified for pilot.

  E-referral worklist reports - Reports revised to reflect workflow, with filters to support oversight of urgent & 2ww triage position.

- **Activity Management / Variation**

  PIFU - Feb 2024 (provisional): 4.9% Benchmarking vs national median January – UHNM: 30th of 142 providers (4.9% vs 3.0%).

  'PIFU by Default' initiative – with NHSE support; clinical workshop Nov 7th with Medical Director & Clinical Leads, well attended, updated UHNM comms. Presented at Midlands OP Board in February. Linking in with 4 initial priority specialties (with NHSE clinical support). Proving difficult to schedule regular contact with clinical teams due to competing priorities. Helpful clinician to clinician meeting held for two specialties with next steps.

  Outcomes – Tail broadly cleared, continuing progress on backlog (cohorts not high risk). Following iportal directive, new report views to target improvement actions effectively (eg unoutcomed where iportal outcome captured and/or letter completed). >45% of outcomes initially recorded on Careflow. Review of reporting and associated operational processes underway with DQ and specialty input.

  RPA OP Outcomes - Scoping specialty pilot with UHNM BI, agreement in principle for pilot in a specialty using available robot capacity.

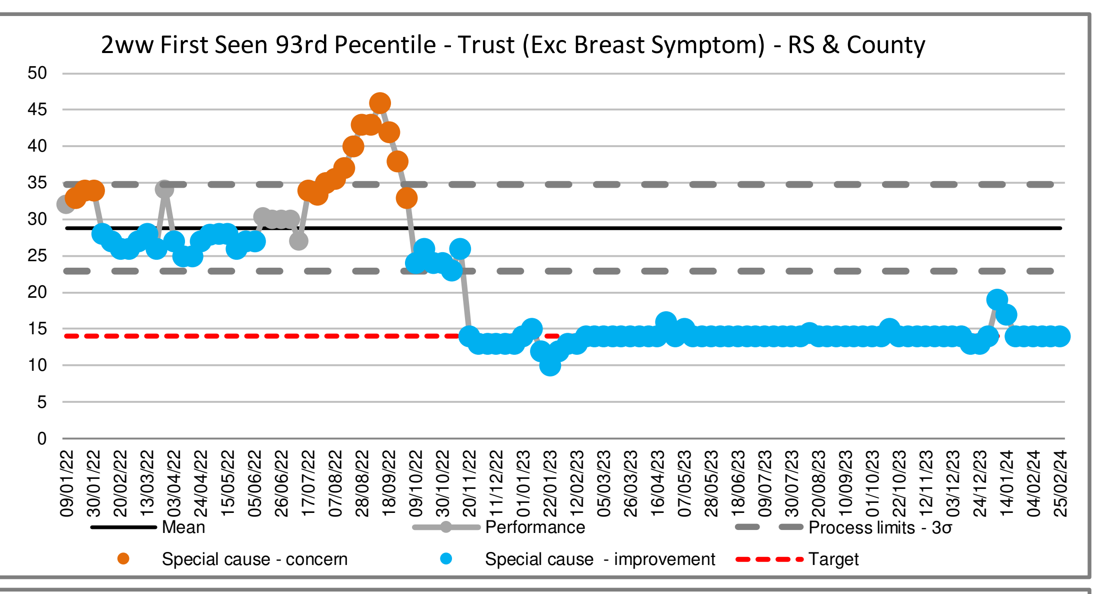
  OP Productivity; Utilisation – Feb 2024 (provisional): Clinic Utilisation: 90.4% vs 90.0% (plan); Booking rate: 96.6% (vs 96.3%) DNA rate: 6.5% (vs 6.5%), review of bookings by TFC to understand under-utilised slots. **Missed Appointments -** overbooking to compensate, **2-way messaging –** paper approved in principle at IM&T SMT, meeting held with supplier, funding identified, potential go live May/June. **Health inequalities Audits -** HED DNA benchmarking specialties vs national position identifies outliers. Linking with NHSE & Public Health consultant around approaches. Initial analysis complete, scoping meetings with specialty ahead of pilot. Proposal to be drafted.

- **Key Enablers**

  GIRFT Further, Faster – key programme, UHNM a cohort 2 Trust. Handbooks shared; monitoring onboarding (15/17) & follow on meetings with clinical & mgt specialty teams. Many outpatient actions similar to OP GIRFT Guidance. Specialty Checklists being reviewed with clinicians (68.3% updated). February Midlands Monthly OP Transformation Network dedicated to Further Faster.

  PIFU RPA – Discharge Letters (at Review Date),with UHNM BI; Urology & paeds live, rolling out vs plan for other specialties. Lymphoedema & gynae next.

Cancer – Headline metrics



Variation	Assurance

Target	11/02/2024	18/02/2024	25/02/2024
14	14	14	14

Background

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

What is the data telling us?

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

Cancer 28 day faster pathway - Combined - UHNM

100.0%, 90.0%, 80.0%, 70.0%, 60.0%, 50.0%, 40.0%

Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22, Apr 22, May 22, Jun 22, Jul 22, Aug 22, Sep 22, Oct 22, Nov 22, Dec 22, Jan 23, Feb 23, Mar 23, Apr 23, May 23, Jun 23, Jul 23, Aug 23, Sep 23, Oct 23, Nov 23, Dec 23, Jan 24, Feb 24

Mean — Performance — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Variation	Assurance

Target	Dec 23	Jan 24	Feb 24
75%	69.7%	67.0%	76.8%

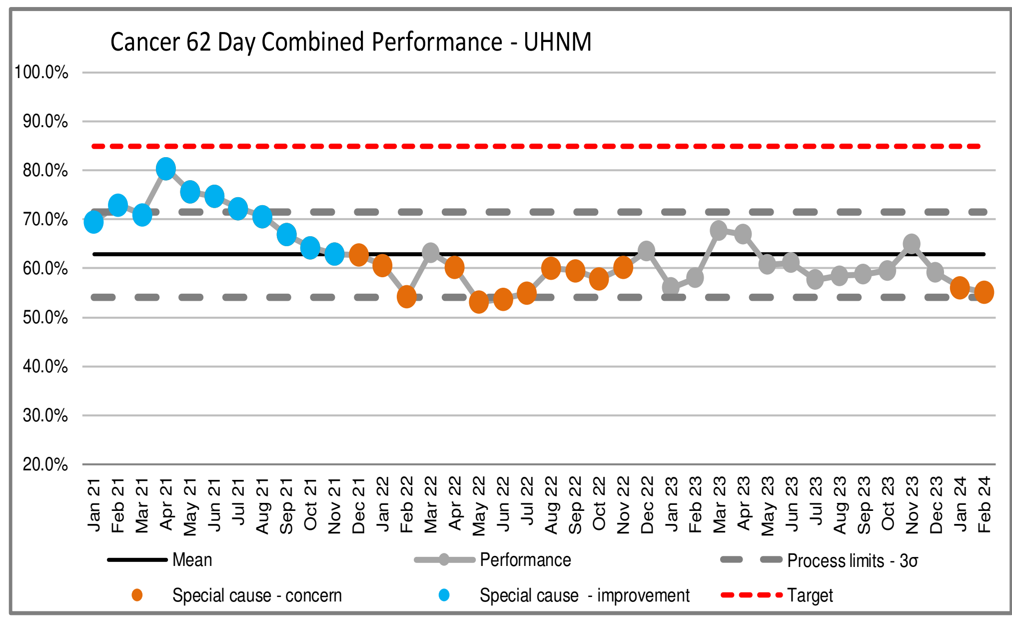
Background

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

What is the data telling us?

The FDS performance is continuing to improve, with pockets of good practice. E.g. Breast, Lung and Upper GI all achieve the standard . The combined Faster Diagnosis Standard achieved 67% in January. It is predicted achieve the standard in February, however validation is ongoing.

Cancer – Headline metrics



Variation	Assurance

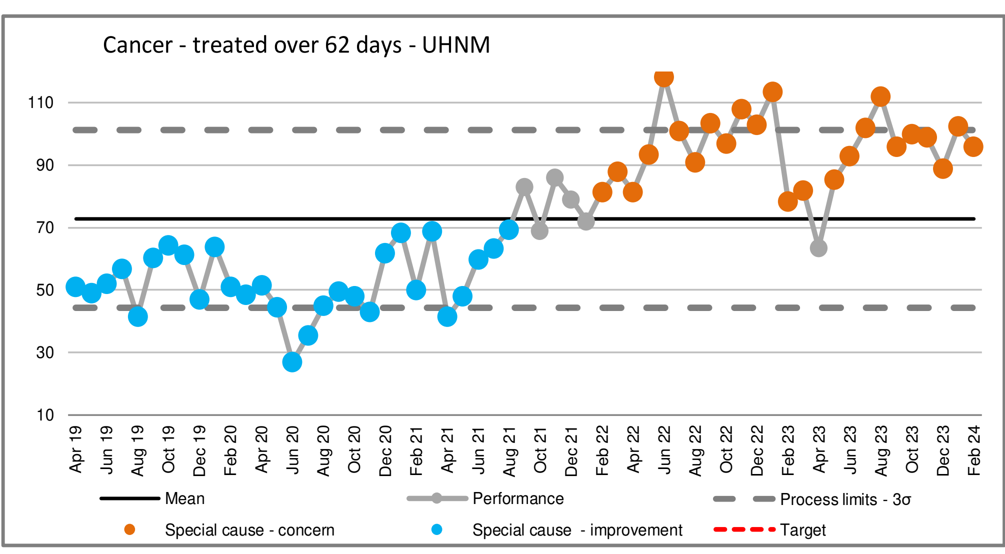
Target	Dec 23	Jan 24	Feb 24
85%	59.1%	56.1%	55.1%

Background

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

What is the data telling us?

Performance significantly challenged and below standard for the past 2 years. Performance remains between 50 – 60% for Oct, Nov, Dec & Jan. The February 24 position is incomplete and still being validated.



Variation	Assurance

Target	Dec 23	Jan 24	Feb 24
N/A	89.0	102.5	96.0

Background

The number of patients treated over 62 days

What is the data telling us?

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

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Cancer Actions

- The Faster Diagnosis Standard has improved over the past few months for most challenged tumour sites Gynae, Urol, LGI and Skin.
- The 62 day and 104 day backlogs have reduced ahead of trajectory for the past 4 months, with Colorectal and Skin ahead of trajectory. UHNM has achieved the 'fair shares' aim to return the backlog to pre-pandemic levels, ahead of the March 24 target.
- 25% of referrals received on the lower GI suspected cancer pathway are FIT negative however are within the exclusion criteria agreed with commissioners (IDA, Rectal Bleeding), demonstrating appropriate use of the pathway and endoscopy capacity.
- During a regional audit of 3 months worth of data, UHNM completed colonoscopies for just 0.3% of FIT negative patients who were on a suspected cancer LGI pathway – this is the lowest in the region when benchmarked against providers within the West Midlands.

Most Challenged Areas

LGI:

- Surgical capacity has been released through additional activity delivered by SHS supporting recovery of the LGI cancer pathway backlog of patients waiting for diagnosis and treatment. This is enabled by using a mixture of OPAs and, Day Case capacity and has resulted in an improvement of the 62+ backlog position in LGI. In addition, the LGI FDS performance has improved over the past 3 months and is expected to continue to recover.

Skin:

- Extra minor ops and OPA capacity is being provided through weekend activity. TIs are also supporting the position including insourcing. The 62+ day backlog position is ahead of trajectory and the FDS has achieved for the past 2 months and is predicted to achieve again in Feb.

UROL:

- An escalation for support has been submitted to the system, to explore expansion of referral optimisation hub to include all suspected cancer referrals. This is expected to improve FDS performance due to improved quality of referrals. Timescales for the completed review of the Choice and Referral centre which began last year are still TBC. The UROL Expert Advisory Group of the west midlands is focusing on targeted case finding in primary care.

Pathology:

- Pathologists are prioritising reporting into Urgent and Accelerated streams, particularly for high volume pathways such as Skin and Colorectal. One locum consultant, 2 fixed term Band 4's and one locum BMS were recruited using recovery funds in November 23. TATs for Urgent (Diagnostic Cancer) specimens: 95% are reported at Day 16 – an improvement of 2 days since last month.

Endoscopy:

- Recovery plans are being enacted to increase internal capacity using a combination of clinical Endoscopists, consultants/middle grades to improve utilisation. Locums are supporting diagnostic and surveillance waits. Insourced management support has been commissioned. Turn around times from request to test for Colonoscopy patients on a GP referred LGI cancer pathway have reduced in February.

Radiology:

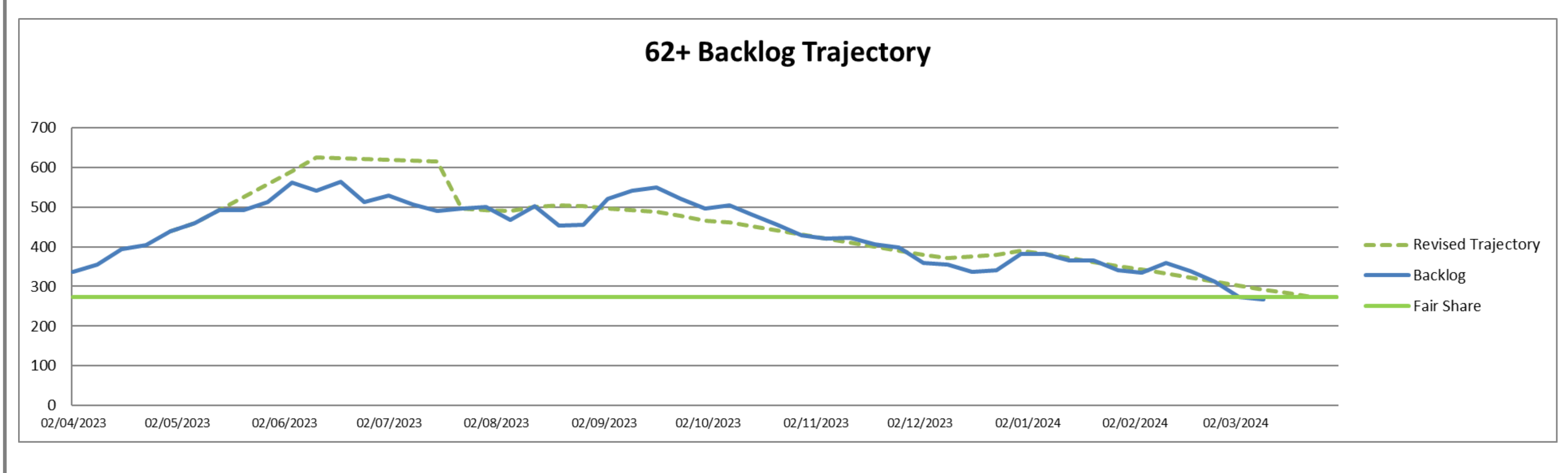
- For increased Radiology reporting capacity to support cancer pathways, TIs are being offered, in addition recruitment is underway for an additional fellow, plus a review of outstanding reports and allocation / escalation is continuous.

Escalations:

- There are a growing number of patients waiting for surgical treatment on the Urology pathway. Surgical capacity for RALPs at SaTH is being utilised. Further to this mutual aid and internal theatres solutions such as reallocation are being explored.
- An audit of referral quality is underway, making note of errors and omissions on GP cancer referrals. This will be shared with ICS colleagues to highlight themes of sub-optimal referrals and to support targeted improvement actions, such as an expansion of the referral optimisation hub.

Cancer Trajectories

- National planning guidance 23/ 24 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. This was based on a fair share total allocated to Trusts, with UHNM target being 273. An internal PTL Backlog trajectory for UHNM is shown by the green dotted line below, which was revised and modelled to bring us back in line with the fair share target by March 24, taking into account the unpredicted workforce challenges in Endoscopy. For the week ending 10/03/24 UHNM achieved this aim reporting a backlog of 268.
- The actual total of patients waiting over 62 days on a 2WW pathway are shown in blue below, and are a snap shot in time of the PTL position. This is for the week ending 10.03.24
- UHNM provide assurance to the regional NHSEI team, with detailed plans on a weekly basis. Tiered Progress to date:
    - The 62 day backlog has reduced by 67 patients since last month to a current position of 268.
    - The number of days waited for 1st OPA (93rd Percentile) has reduced to within target of 14 days.
    - The total PTL has reduced to a current position of around 3300.
    - The number of patients waiting over 104+ has reduced by 17 patients since last month to a current position of 67.
    - The combined Faster Diagnosis Standard was submitted at a final January 23 position of 67%.
    - The combined Faster Diagnosis Standard for February is still incomplete and being validated, however is predicted to achieve the standard.



Cancer

Cancer - 28 Day Faster Diagnosis

Jan 24 Performance: 67.0% | Rank: 101st of 135

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

Cancer - 28 Day Faster Diagnosis

Target

Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24

University Hospitals North Midlands | Recommended | Requires Improvement | Region | Teaching | % Rank

Key Performance Indicator	Period	Target		SPC
Cancer - 28 Day Faster Diagnosis	Jan 24	75.0%	67.0%	
FDS Acute Leukaemia	Jan 24	75.0%	-	
FDS Brain Tumours	Jan 24	75.0%	50.0%	
FDS Breast Cancer	Jan 24	75.0%	88.0%	
FDS Breast Symptoms	Jan 24	75.0%	92.3%	
FDS Children's Cancer	Jan 24	75.0%	91.7%	
FDS Gynaecological Cancer	Jan 24	75.0%	48.6%	
FDS Haematological Malignancies	Jan 24	75.0%	50.0%	
FDS Head & Neck Cancer	Jan 24	75.0%	68.4%	
FDS Lower Gastrointestinal Cancer	Jan 24	75.0%	41.7%	
FDS Lung Cancer	Jan 24	75.0%	72.1%	
FDS Missing or Invalid	Jan 24	75.0%	-	
FDS Other Cancer	Jan 24	75.0%	-	
FDS Sarcoma	Jan 24	75.0%	40.0%	
FDS Skin Cancer	Jan 24	75.0%	79.5%	
FDS Testicular Cancer	Jan 24	75.0%	85.7%	
FDS Upper Gastrointestinal Cancer	Jan 24	75.0%	83.0%	
FDS Urological Malignancies	Jan 24	75.0%	44.9%	

- All peer groups including UHNM remain below target, with all seeing a drop in performance apart from the Recommended peer.
- UHNM remain below all peer groups, despite seeing an improving trend since September 2023.
- Head & Neck and Lung have dropped below target in January.
- UHNM have moved into the third quartile from the bottom quartile.

Cancer

Cancer 31 Day First Treatment

Jan 24 Performance: 83.55% | Rank: 112th of 139

Ranking Trend Delta SPC ICS Siblings Data Detail

Target

Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24

University Hospitals North Midlands | Recommended | Requires Improvement | Region | Teaching | % Rank

- All peer groups saw a drop in performance in January.
- UHNM saw a greater drop than other peer groups, whereby they are now performing below all peer groups.
- UHNM have moved into the bottom quartile from the third quartile last month.

Cancer 31 Day First Treatment	Jan 24	96.00%	83.6%	
Key Performance Indicator	Period	Target		SPC
Cancer 2 Week Wait	Jan 24	93.00%	92.7%	
Cancer 2 Week Wait Breast Symptomatic	Jan 24	93.0%	88.7%	
Cancer 31 Day First Treatment	Jan 24	96.00%	83.6%	
Cancer 31 Day Subsequent Treatment	Jan 24	96.0%	80.3%	
Cancer 62 Day All Sources	Jan 24	85.00%	59.3%	
Cancer 62 Day Consultant Upgrade	Jan 24	85.0%	65.4%	
Cancer 62 Day Screening	Jan 24	90.0%	73.9%	
Cancer Sub Treat Drugs	Jan 24	96.0%	87.4%	
Cancer Sub Treat Radiotherapy	Jan 24	96.0%	93.2%	

Cancer

Cancer 62 Day All Sources

Jan 24 Performance: 59.30% | Rank: 99th of 139

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

Target

Cancer 62 Day All Sources

85% 80% 75% 70% 65% 60% 55% 50%

100 90 80 70 60 50 40 30 20 10 0

Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24

University Hospitals North Midlands | Recommended | Requires Improvement | Region | Teaching | % Rank

- All peer groups are currently performing at similar levels.
- UHNM are at the midpoint between all peer groups.
- UHNM have moved into the third quartile from the bottom quartile last month.

	Key Performance Indicator	Period	Target		SPC
[illegible]	Cancer 2 Week Wait	Jan 24	93.00%	92.7%	
[illegible]	Cancer 2 Week Wait Breast Symptomatic	Jan 24	93.0%	88.7%	
[illegible]	Cancer 31 Day First Treatment	Jan 24	96.00%	83.6%	
120	Cancer 31 Day Subsequent Treatment	Jan 24	96.0%	80.3%	
[illegible]	Cancer 62 Day All Sources	Jan 24	85.00%	59.3%	
100	Cancer 62 Day Consultant Upgrade	Jan 24	85.0%	65.4%	
[illegible]	Cancer 62 Day Screening	Jan 24	90.0%	73.9%	
118	Cancer Sub Treat Drugs	Jan 24	96.0%	87.4%	
119	Cancer Sub Treat Radiotherapy	Jan 24	96.0%	93.2%	

Inpatient and Outpatient Decile & Ethnicity

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

Inpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.19%	9.80%	8.95%	7.95%	7.80%	11.04%	11.77%	10.48%	13.17%	7.30%	0.55%
Weeks Waited- 78-104	12.33%	10.56%	10.93%	10.04%	7.46%	12.63%	9.45%	10.19%	10.12%	4.80%	1.48%
Weeks Waited- 52-77	14.01%	11.84%	10.35%	9.03%	7.77%	10.69%	9.67%	9.26%	11.40%	4.85%	1.12%
Weeks Waited- Under 52	13.64%	11.25%	10.03%	9.28%	7.45%	10.69%	10.87%	8.95%	10.95%	5.43%	1.47%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	10.75%	9.95%	9.25%	8.85%	7.76%	11.04%	11.42%	10.37%	12.92%	6.57%	1.11%
Weeks Waited- 78-104	11.21%	10.44%	9.83%	8.66%	7.73%	11.07%	10.94%	9.91%	12.33%	6.55%	1.35%
Weeks Waited- 52-77	13.08%	11.17%	10.02%	9.47%	7.18%	10.66%	10.46%	9.04%	11.26%	6.29%	1.35%
Weeks Waited- Under 52	13.44%	11.43%	10.08%	8.80%	7.58%	10.50%	10.46%	9.09%	11.22%	5.88%	1.52%

Inpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.16%	0.47%	0.08%	0.42%	0.40%	0.66%	0.03%	0.11%	0.26%	0.42%	0.42%	0.16%	0.03%	93.05%	0.37%	0.87%	1.66%	0.42%
Weeks Waited- 78-104	0.44%	0.44%	0.30%	0.81%	0.30%	1.40%		0.15%	0.07%	0.44%	1.11%	0.37%		89.00%	0.37%	2.07%	1.40%	1.11%
Weeks Waited- 52-77	0.54%	0.61%	0.24%	1.09%	0.58%	1.26%	0.20%	0.07%	0.14%	0.54%	1.26%	0.41%	0.27%	85.31%	0.54%	2.21%	2.04%	
Weeks Waited- Under 52	0.44%	0.73%	0.26%	0.67%	0.53%	1.68%	0.13%	0.18%	0.15%	0.55%	1.57%	0.30%	0.21%	83.87%	0.35%	2.64%	2.21%	3.28%

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	0.33%	0.38%	0.23%	0.43%	0.48%	0.88%	0.08%	0.15%	0.19%	0.55%	1.44%	0.33%	0.16%	0.23%	87.89%	0.34%	2.53%	1.89%	1.47%
Weeks Waited- 78-104	0.40%	0.76%	0.19%	0.64%	0.62%	1.04%	0.16%	0.13%	0.16%	0.69%	1.43%	0.33%	0.08%	0.22%	84.36%	0.32%	3.09%	2.63%	2.75%
Weeks Waited- 52-77	0.33%	0.75%	0.26%	0.61%	0.56%	1.28%	0.16%	0.21%	0.14%	0.61%	1.58%	0.29%	0.15%	0.21%	83.60%	0.30%	3.14%	2.37%	
Weeks Waited- Under 52	0.79%	0.74%	0.23%	0.66%	0.61%	1.33%	0.18%	0.16%	0.16%	0.78%	1.93%	0.35%	0.19%	0.23%	82.04%	0.30%	3.14%	2.50%	

APPENDIX 1

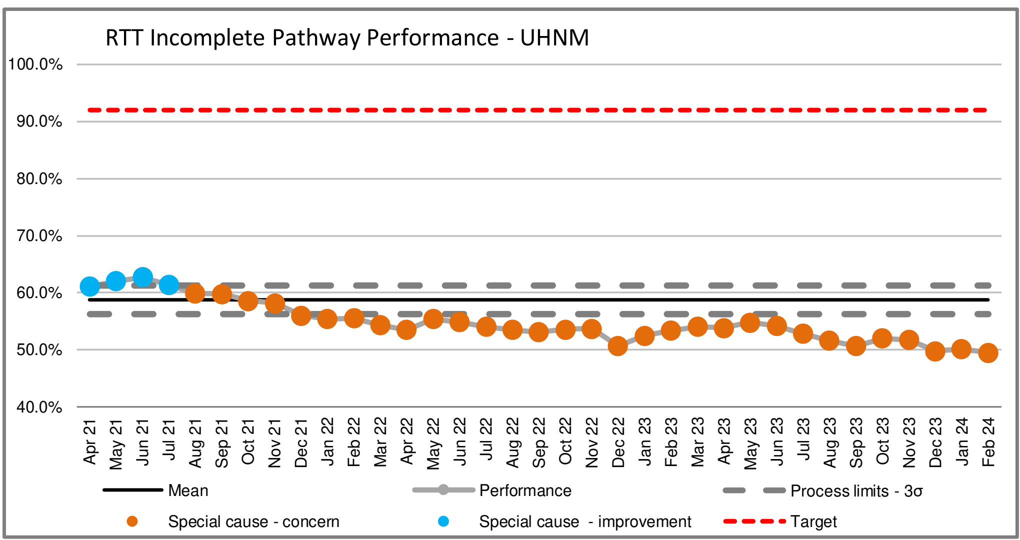
Operational Performance

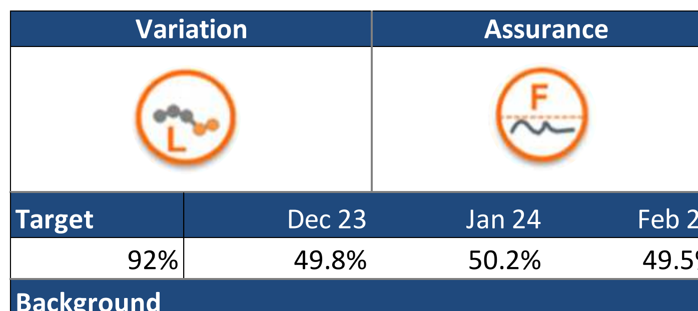
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	Percentage of Ambulance Handovers within 15 minutes	0%	25.03%	L		
	Ambulance handovers greater than 60 minutes	1	1	L	F	
	Time to Initial Assessment - percentage within 15 minutes	85%	57.59%		F	
	Average (mean) time in Department - non-admitted patients	180	297	H	F	
	Average (mean) time in Department - admitted patients	180	427	H	F	
	Clinically Ready to Proceed	90	531	H	F	
	12 Hour Trolley Waits	0	943	H	F	
	Patients spending more than 12 hours in A&E	0	1943	H	F	
	Median Wait to be seen - Type 1	60	114		F	
	Bed Occupancy	92%	88.86%			
Cancer Care	Cancer 28 day faster pathway	75%	76.83%	H	?	
	Cancer 31 Day Combined	96%	87.14%		F	
	Cancer 62 Day Combined	85%	55.08%	L	F	
	2WW First Seen (exc Breast Symptom)	93%	94.74%		?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	6.5%	L	?	
	Cancelled Ops	150	98		?	
	Theatre Utilisation	85%	81.9%			
Inpatient / Discharge	Same Day Emergency Care	30%	41%	H	?	
	Super Stranded	183	177	L	?	
	MFFD	100	86	L	?	
	Discharges before Midday	25%	20.2%		F	
	Emergency Readmission rate	8%	14.3%		F	
Elective waits	RTT incomplete performance	92%	49.53%	L	F	
	RTT 52+ week waits	0	5001	H	F	
	Diagnostics	99%	76.84%	H	F	

Referral To Treatment



Variation	Assurance
	

Target	Dec 23	Jan 24	Feb 24
92%	49.8%	50.2%	49.5%

Background

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

What is the data telling us?

RTT performance reduced further in February and continues to see a declining trend.

RTT Incomplete Pathways - UHNM

88,000
83,000
78,000
73,000
68,000
63,000
58,000
53,000
48,000
43,000
38,000

Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22, Apr 22, May 22, Jun 22, Jul 22, Aug 22, Sep 22, Oct 22, Nov 22, Dec 22, Jan 23, Feb 23, Mar 23, Apr 23, May 23, Jun 23, Jul 23, Aug 23, Sep 23, Oct 23, Nov 23, Dec 23, Jan 24, Feb 24

Mean — Performance — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Variation	Assurance

Target	Dec 23	Jan 24	Feb 24
N/A	80987	82078	81242

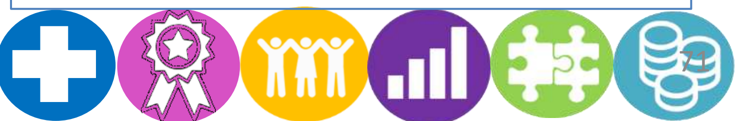
Background

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

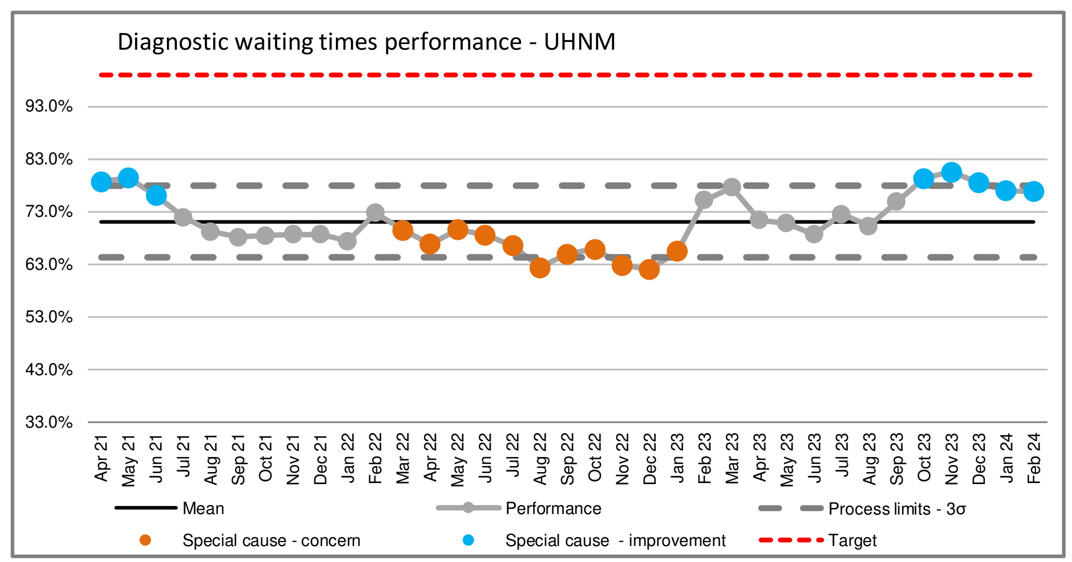
What is the data telling us?

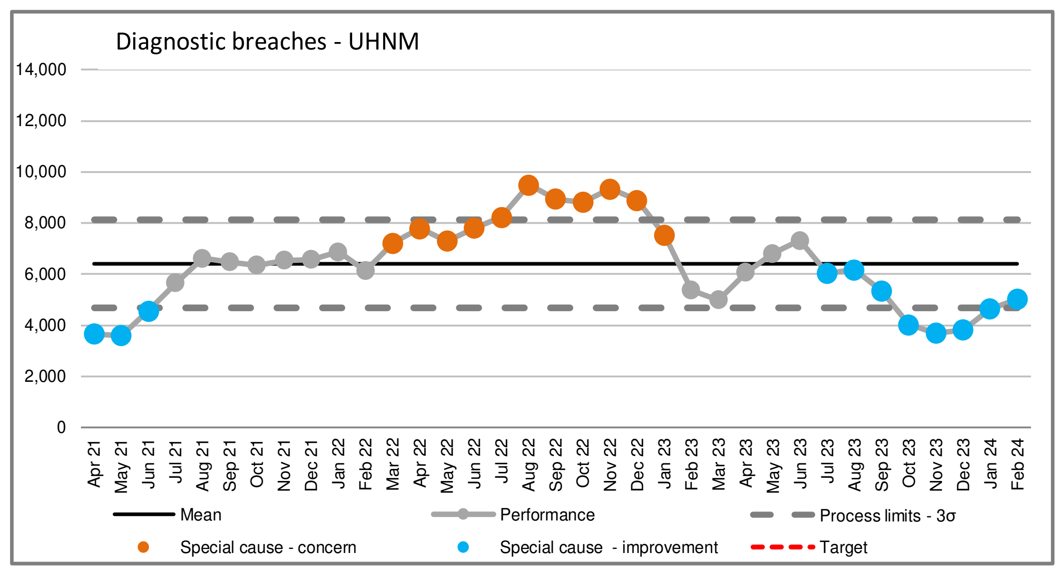
Total number of RTT pathways has plateaued since September 2023, despite performance against the 18 week target deteriorating.

Delivering Exceptional Care with Exceptional People



Diagnostic Standards





Variation	Assurance
H	F

Target	Dec 23	Jan 24	Feb 24
99%	78.6%	77.0%	76.8%

Background

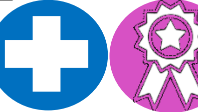
The percentage of patients waiting less than 6 weeks for the diagnostic test.

What is the data telling us?

Waiting time performance saw a deterioration in February, at 77% against the 99% target.

Overall waiting list has continued to see growth since December 2023.

Delivering Exceptional Care with Exceptional People



Workforce

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

Workforce Spotlight Report

Key messages

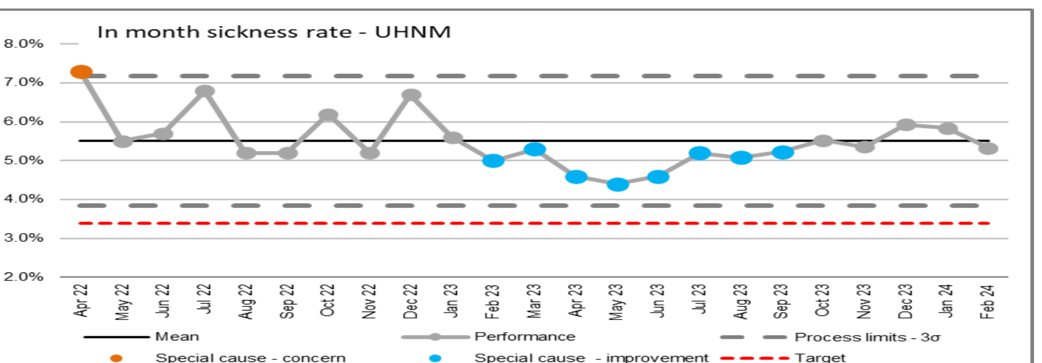
- The 12m Turnover rate in February 2024 improved to 7.9% (8.2% in January 2024) which remains below our 11% target.
- February's vacancies improved to 8.10% (8.46% in January), influenced by a total increase of 107.01 FTE in post, across all staff groups, offset by an 18.09 FTE increase in the budgeted establishment, reducing the vacancy FTE by 88.92 FTE overall.
- February 2024's in-month sickness rate improved by 0.51% to 5.33% (5.84% in January 2024). The 12-month cumulative rate increased fractionally to 5.24% (5.24% in January 2024).
- Stress and Anxiety continues to be the top reason for sickness in February which increased by 4.3% to 27.5% in Feb-24 (23.2% in Jan-24). Chest & Respiratory remains the second most common reason, at 9.1%, followed by Gastrointestinal problems, which pushed Cold, Cough & Flu down to 8.5% in Feb-24 from 10.5% in Jan-24, which reflects February's lower reported numbers of Covid-19 cases.
- Employees may report covid-like symptoms on Empactis, but Managers are then recording this as either chest & respiratory, or cold & flu, on ESR, in the absence of a formal lateral flow test, following the cessation of symptomatic covid testing, since May 2023. During February 2024, the overall number of employees who reported Covid-19 symptoms decreased significantly to 161 episodes, on Empactis, from 342 cases in January 2024. This is reflected in managers only reporting 84 covid-related cases on ESR, for February 2024, which is a decrease from the 198 episodes reporting in January 2024.
- February 2024's PDR Rate improved to 83.5% (82.1% in January 2024). The refreshed PDR paperwork, to support colleagues in achieving their potential, was published in January 2024 and managers were supported in its rollout through drop-in sessions which took place during January 2024, with a renewed focus in the Divisions, on increasing compliance.
- The Statutory and Mandatory training rate on 29th February 2024 improved by 0.2% to 93.7% (93.5% on 31st January 2024). This compliance rate is for the 7 'Core for All' subjects only.

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.33%		F
Staff Turnover	11%	7.87%	L	P
Statutory and Mandatory Training rate	95%	93.65%		F
Appraisal rate	95%	83.53%	H	F
Agency Cost	N/A	3.31%		P

Sickness Absence

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance

Target	Dec 23	Jan 24	Feb 24
3.4%	5.9%	5.8%	5.3%

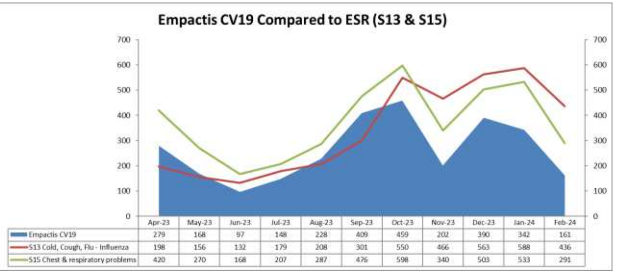
Background

Percentage of days lost to staff sickness

Summary

Org L2	Divisional Trajectory - March 2024	2023 / 03	2023 / 04	2023 / 05	2023 / 06	2023 / 07	2023 / 08	2023 / 09	2023 / 10	2023 / 11	2023 / 12	2024 / 01	2024 / 02	Trajectory
205 Central Functions	3.39%	3.61%	2.80%	2.37%	2.81%	3.54%	3.46%	3.44%	3.82%	3.78%	3.94%	4.32%	3.93%	↓
205 Division of Network Services	5.25%	4.64%	3.91%	3.80%	4.00%	4.35%	4.83%	4.51%	5.32%	5.10%	5.55%	5.60%	5.50%	↓
205 Division of Surgery, Theatres and Critical Care	5.25%	6.47%	5.47%	4.90%	5.24%	6.62%	6.15%	6.12%	6.15%	6.12%	6.83%	7.32%	5.99%	↓
205 Estates, Facilities and PFI Division	5.25%	6.30%	6.00%	5.32%	5.09%	4.69%	5.11%	4.87%	6.13%	5.19%	4.35%	4.01%	3.71%	↓
205 Medicine and Urgent Care	5.25%	5.25%	5.10%	4.88%	4.78%	5.67%	5.35%	6.12%	6.25%	5.79%	6.45%	5.97%	5.34%	↓
205 North Midlands & Cheshire Pathology Service (NMCPS)	4.50%	5.61%	4.71%	4.68%	5.38%	4.71%	4.43%	4.82%	5.65%	5.00%	5.01%	5.53%	4.77%	↓
205 Women's, Children's & Clinical Support Services	5.25%	5.11%	4.63%	4.62%	5.09%	5.08%	5.01%	4.91%	4.94%	5.20%	5.94%	5.69%	5.65%	↓

- For M11, the in-month sickness rate improved to 5.33% (5.84% in Jan-24).
- The 12-month cumulative rate increased fractionally to 5.24% (5.22% in Jan-24).
- Stress and Anxiety continues to be the top reason for sickness in February which increased by 4.3% to 27.5% in Feb-24 (23.2% in Jan-24). Chest & Respiratory remains the second most common reason, at 9.1%, followed by Gastrointestinal problems, which pushed Cold, Cough & Flu down to 8.5% in Feb-24 from 10.5% in Jan-24.
- Covid 19 cases reported on Empactis, by the employee, may be recorded as either chest & respiratory, or cold and flu, on ESR, by the manager, in the absence of a formal lateral flow.
- Both ESR reasons have seen a marked decrease, consistent with Empactis.



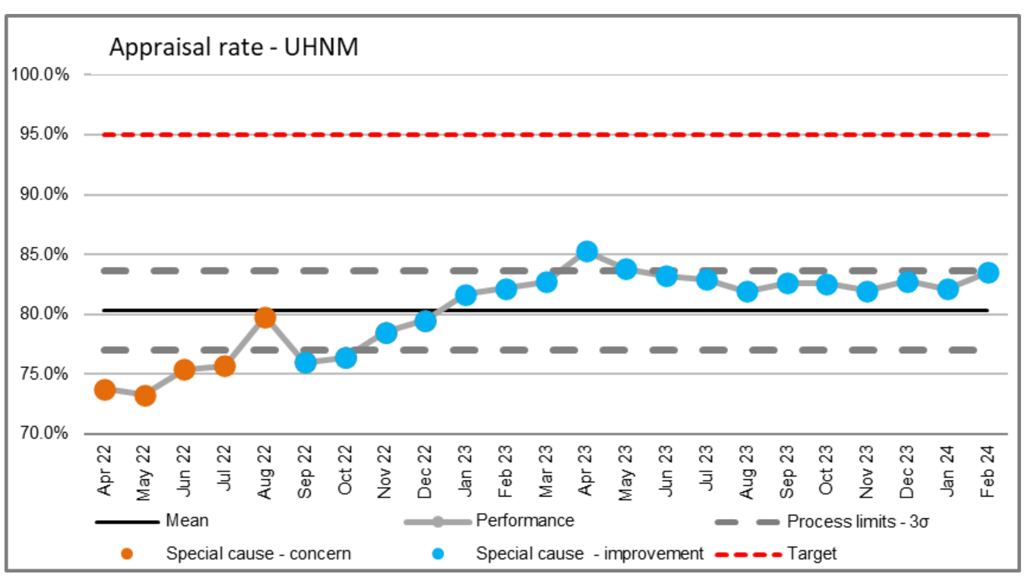
Sickness rate is consistently above the target of 3.4%.

Actions

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

Appraisal/Performance Development Review (PDR)

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Dec 23	Jan 24	Feb 24
95%	82.8%	82.1%	83.5%

Background

Percentage of people 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%. More recently the rate shows special cause variation. There has been a drop below the lower control limit since August 2019.

Summary

- On 29th February 2024, the PDR Rate improved by 1.4% to 83.5%, compared to 82.1% for January 2024.
- This figure remains below the overall target and divisions have been asked to review key issues and actions to work towards meeting target.
- The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance and making the process enhance employee experience.
- The new PDR documentation was published in January 2024, with twelve drop-in sessions taking place, to complement the new guides and electronic training materials which have been made available on the Intranet.

Actions

The focus on ensuring completion of PDRs is continuing with:

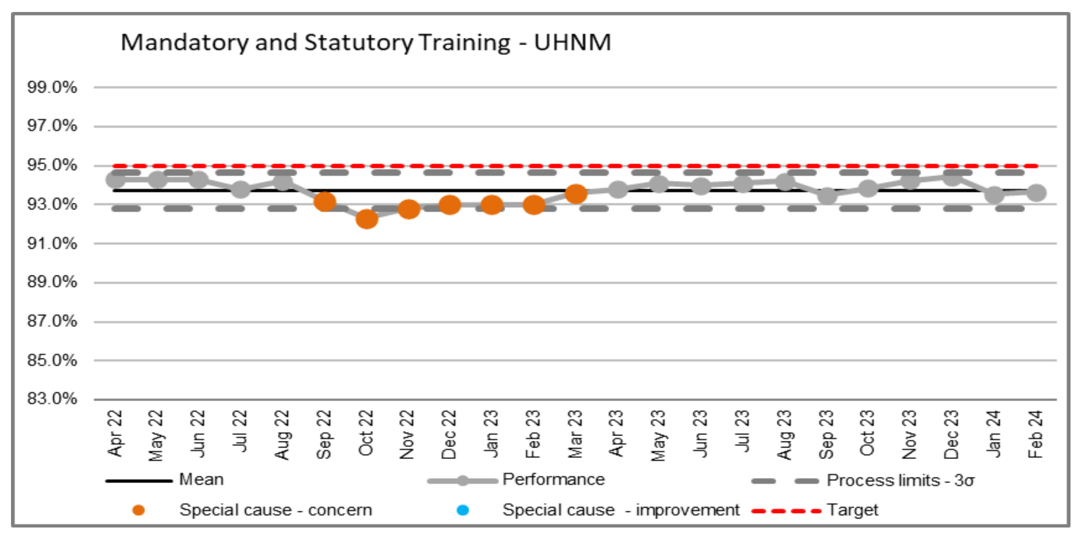
NMCPS - All out of date PDR's to be scheduled with line managers, and ESR hierarchy changes and training gaps to be identified.

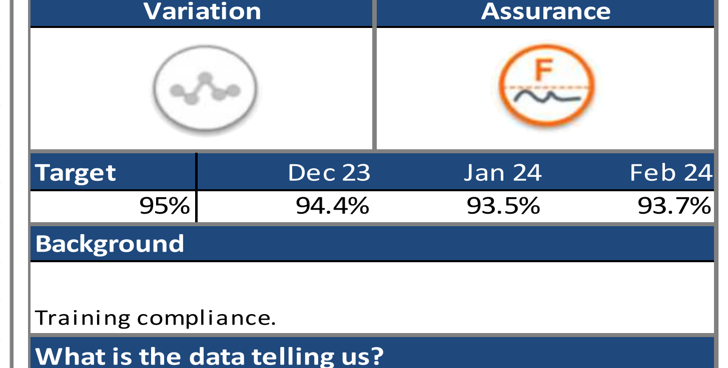
Network Division - Hold a dedicated weekly PDR compliance hotspot and assurance meetings

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

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

Statutory and Mandatory Training





At 93.7%, the Statutory and Mandatory Training rate remains just below the Trust target for the core training modules

Summary

Statutory and Mandatory training rate on 29th February 2024 improved by 0.2% to 93.7% (93.5% on 31st January 2024). This compliance rate is for the 7 'Core for All' subjects only.

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|LOCAL|Security Awareness - 3 Years|	11813	11813	11101	93.97%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years	11813	11813	11234	95.10%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	11813	11813	11167	94.53%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Y	11813	11813	11234	95.10%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	11813	11813	11281	95.50%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Y	11813	11813	11129	94.21%
NHS|MAND|The Oliver McGowan Mandatory Training on	11813	11813	10292	87.12%

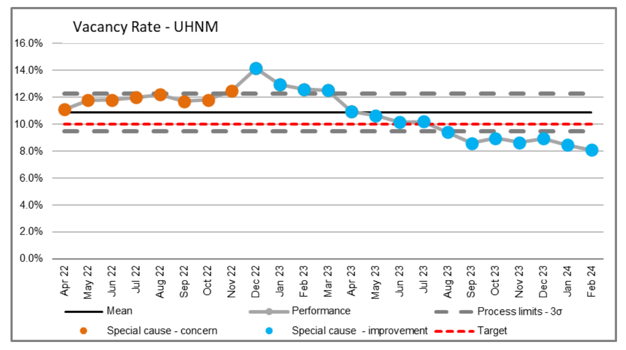
Compliance rates for the Annual competence requirements were as follows:

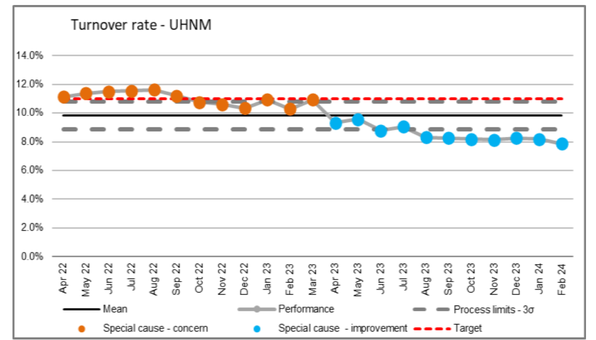
Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	11813	11813	8771	74.25%
NHS|CSTF|Information Governance and Data Security - 1	11813	11813	10514	89.00%

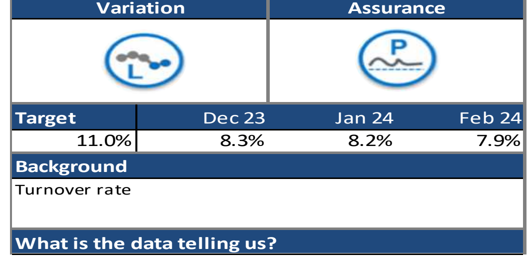
Actions

- We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.
- Compliance is monitored and raised via the Divisional performance review process.
- The Being Kind and Oliver McGowan Training are now reported as part of 'Core for All' subjects.

Workforce Vacancies and Turnover







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.

Summary

- The 12m Turnover rate in February 2024 improved to 7.9% (8.2% in January 2024) which remains below our 11% target.
- The summary of vacancies by staff groupings highlights a 0.35% improvement in the vacancy rate over the previous month.
- February's vacancies improved to 8.10% (8.46% in January). Colleagues in post increased in February 2024 by 107.01 fte, budgeted establishment increased by 18.09 fte, which reduced the vacancy fte by 88.92 FTE overall [*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 29/02/24]

Vacancies at 29-02-24	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,692.88	1,463.59	229.29	13.54%	13.58%
Registered Nursing	3683.27	3335.95	347.32	9.43%	10.41%
All other Staff Groups	6736.23	6331.22	405.01	6.01%	6.09%
Total	12,112.38	11,130.76	981.62	8.10%	8.46%

The turnover rate for February 2024 remains below the trust target of 11%.

Turnover rate when measured against total staff in post improved slightly to 7.9% from 8.2% last month.

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

Actions

- Significant amount of recruitment events targeting specific roles across multiple divisions.
- Continued targeted social media campaign.
- Targeted spotlight on UHNM colleagues continue and supplement the recruitment campaigns

Finance

2025 Vision	"Ensure efficient use of resources"

Delivering Exceptional Care with Exceptional People

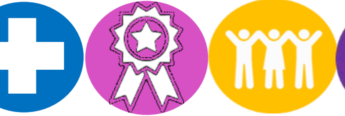
Finance Spotlight Report

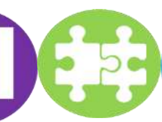
Key elements of the financial performance for the year to date are:

- For Month 11 the Trust has delivered a year-to-date deficit of £3.3m against a planned surplus of £0.7m; this adverse variance of £4.0 is primarily driven by underperformance against the Trust's in year CIP target and unfunded additional winter escalation capacity that remained open through the year.
- The Trust has received an additional £1.5m funding towards the cost of industrial actions for January and February. This takes the total funding for industrial actions and cost pressures to £10.5m for the year.
- The Trust has incurred £5.0m of costs relating to winter escalation capacity remaining open to Month 7 partially funded by £2.1m of additional funding from the local ICB. Winter and escalation costs from Month 8 are funded as part of the Trust's winter plan.
- To date the Trust has validated £40.9m of CIP savings to Month 11 against a plan of £50.4m. The Trust has recognised £4.7m of CIP due to an assumed reduction in the annual leave provision delivering 50% of the NR ICB stretch CIP target; the balance is expected to be delivered from a further reduction in the provision.
- The Month 11 actual position indicates that the Trust is on track to deliver a break-even position for the year.
- There has been £59.7m of Capital expenditure which is £6.1m below plan.
- The cash balance at Month 11 is £65.3m which is £4.7m lower than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	94.9		
	Expenditure - Pay	variable	57.2		
	Expenditure - Non Pay	variable	36.5		
Activity	Daycase/Elective Activity	variable	9,918		
	Non Elective Activity	variable	10,693		
	Outpatients 1st	variable	27,205		
	Outpatients Follow Up	variable	42,103		





Income & Expenditure

Income & Expenditure Summary Month 11 2023/24	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,015.9	85.6	87.9	2.3	931.1	940.0	8.9
Other Operating Income	88.0	7.4	7.0	(0.3)	80.8	82.1	1.3
Total Income	1,103.9	92.9	94.9	2.0	1,011.9	1,022.1	10.2
Pay Expenditure	(674.2)	(58.0)	(57.2)	0.8	(616.8)	(608.8)	8.0
Non Pay Expenditure	(403.4)	(32.8)	(36.5)	(3.8)	(370.2)	(395.1)	(24.9)
Total Operational Costs	(1,077.5)	(90.8)	(93.8)	(3.0)	(987.0)	(1,003.9)	(16.9)
EBITDA	26.3	2.1	1.1	(1.0)	24.9	18.2	(6.7)
Interest Receivable	2.9	0.2	0.5	0.2	2.6	5.3	2.7
PDC	(10.3)	(0.9)	(1.5)	(0.7)	(9.4)	(9.4)	0.0
Finance Cost	(19.0)	(1.6)	(1.6)	0.0	(17.4)	(17.3)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	(0.1)	(1.5)	(1.4)	0.7	(3.3)	(4.0)

The overspend of £4.0m is mainly driven by.

- an under delivery of CIP by £9.5m. The main CIP schemes behind plan at Month 11 are the ICB non-recurrent stretch of £4.7m and the divisional target of £6.9m.
- additional capacity costs of £5.0m have been incurred to Month 7; additional funding of £2.1m has been agreed with the Staffordshire and Stoke on Trent ICB and this has been reflected in the Month 7 position. Additional winter and escalation costs from Month 8 are funded as part of the Trust winter plan.
- The additional £10.5m funding received to cover the costs of Industrial Action and other pressures has been allocated to cover the additional pay costs incurred due to industrial action of £5.6m with the remaining £4.9m allocated against non-pay pressures.

Capital Spend

UHNM Capital Plan	2023/24 Plan/forecast £000	Movement £000	2023/24 Revised Plan/forecast £000	YTD Plan M11 £000	YTD Actual M11 £000	Variance M11 £000
Capital funding						
PFI & Loan Commitments	19.6	-	19.6	16.7	16.7	-
Base STP allocation	22.1	-	22.1	20.3	20.3	-
Share of ICB 2022/23 surplus re-distribution	0.7	5.9	6.6	6.0	6.0	-
Public Dividend Capital funding	19.3	8.2	27.4	-	-	-
Donated, granted other capital funding	5.0	1.0	6.0	3.4	3.4	-
Internal funding source (including capital receipts	2.7	(1.4)	1.3	-	-	-
Total Capital funding	69.5	13.7	83.1	46.4	46.4	-
Capital expenditure						
PFI & Loan Commitments	(19.6)	-	(19.6)	(16.7)	(16.7)	-
Pre-committed investment items (ICB						
Total Pre committed Investment items	(30.0)	1.8	(28.2)	(24.8)	(23.0)	1.8
IMT Sub Group Total Funding	(2.3)	-	(2.3)	(1.9)	(1.6)	0.3
Medical Devices Sub Group Total Funding	(2.4)	-	(2.4)	(2.4)	(2.4)	(0.0)
Estates Sub Group Total Funding	(3.6)	-	(3.6)	(2.6)	(2.5)	0.1
Sub-group brought forward from 2024/25	-	(1.5)	(1.5)	(0.3)	(0.3)	-
Health & Safety compliance	(0.2)	-	(0.2)	(0.1)	(0.1)	0.0
Net zero carbon initiatives	(0.1)	-	(0.1)	(0.1)	(0.0)	0.1
Central funding beds, mattresses, hoists	(0.1)	-	(0.1)	(0.1)	(0.1)	(0.0)
Total Sub Groups	(8.7)	(1.5)	(10.2)	(7.5)	(7.0)	0.5
New IFRS16 leases (previously classified as operating leases and charged to revenue)						
Lease liability re-measurement	(0.2)	(0.1)	(0.4)	(0.4)	(0.4)	-
IFRS 16 leases	(0.9)	(1.5)	(2.4)	(1.4)	(1.4)	-
Community Diagnostic Centre lease	-	-	-	-	-	-
IFRS16 funding offset	1.1	1.6	2.7	1.8	1.8	-
Total Internal Capital Expenditure programme	(58.2)	0.3	(58.0)	(48.9)	(46.7)	2.3
Additional CRL / Externally Funded PDC						
Wave 4b Funding - Lower Trent Wards	(1.6)	0.3	(1.3)	(0.7)	(0.7)	-
TIF 2 PDC CTS phase 1 - enabling slippage	(0.4)	-	(0.4)	(0.4)	(0.4)	-
TIF 2 PDC (Day Case Unit)	(2.7)	1.2	(1.5)	(1.0)	(1.0)	-
TIF 2 PDC (Women's Hospital)	(1.2)	0.6	(0.7)	(0.4)	(0.4)	-
PDC - additional General & Acute beds	(13.4)	2.0	(11.4)	(9.1)	(5.2)	3.9
PDC - Community diagnostic centre phase 1	-	(1.1)	(1.1)	(0.8)	(0.8)	-
PDC - Pathology LIMS	-	(1.3)	(1.3)	(1.0)	(1.0)	-
PDC endoscopy	-	(0.5)	(0.5)	(0.1)	(0.1)	-
PDC - cyber & A&E imaging	-	(0.3)	(0.3)	-	-	-
PDC - Frontline digitalisation EPR	-	(1.5)	(1.5)	-	-	-
Required NHSE plan re-phasing adjustment	7.2	(7.2)	-	-	-	-
Equipment - endoscopy CDEL (transfer from NCA)	-	(1.0)	(1.0)	-	-	-
Air heat boiler replacement PSDS Grant BC 510	(2.9)	-	(2.9)	(1.6)	(1.6)	-
Charitable funded expenditure	(2.1)	-	(2.1)	(1.8)	(1.8)	-
Total Additional CRL / PDC Funded expenditure	(17.1)	(8.8)	(25.9)	(16.9)	(13.0)	3.9
Total Capital Expenditure	(75.3)	(8.5)	(83.9)	(65.8)	(59.7)	6.1
Planned under/(over) spend	(5.9)	5.1	(0.7)			

At Month 11 capital expenditure was £59.7m against a revised plan of £65.8m, an underspend of £6.1m. Of the £59.7m expenditure, £16.7m is related to pre-committed items for the repayment of PFI and IFRS16 lease liabilities and PFI lifecycle expenditure. The main reasons for the underspend of £6.1m relate to the following schemes:

- Project Star is £0.6m behind plan based on costs from the latest statement of works, which showed an underspend in month 11. A review of the forecast for the remainder of the financial year has been undertaken and as part of changes to the capital plan it is anticipated that expenditure will increase by £0.5m in year; and
- ED ambulance drop-off - enabling ward moves is £0.5m behind plan due to delays in finalising costs and the scope of work within the available funding. As part of the changes to the capital plan this scheme will be completed in 2024/25.

The changes to forecast above ensure that there is no overall change to the planned capital expenditure in year.

The IM&T sub-group is showing an underspend of £0.3m at Month 11, a reduction of £0.8m compared to Month 10 position. The remaining under spend is mainly due to delays in the radiation oncology equipment scheme forecast with expenditure expected to be in line with plan at the year end.

The PDC funded scheme for general and acute beds is £3.9m behind plan at Month 11 and reflects the latest certified value of expenditure. Work has been undertaken to bring forward the equipment relating to the scheme from 2024/25 to reduce the level of overall slippage and impact of the additional costs in 2024/25. However additional potential slippage has been identified in terms of the work expected to be carried out in month 12 and mitigation actions are currently being reviewed.

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

Balance sheet

University Hospitals of North Midlands NHS Trust

Balance sheet as at Month 11	31/03/2023 Actual £m	29/02/2024 Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment *	627.6	649.7	647.8	(2.0)	Note 1
Right of Use Assets	18.8	16.0	16.1	0.1	
Intangible Assets	18.4	15.0	15.2	0.2	
Trade and other Receivables	1.4	1.4	1.4	0.0	
Total Non Current Assets	666.1	682.0	680.4	(1.6)	
Inventories	16.8	16.8	18.4	1.6	Note 2
Trade and other Receivables *	57.9	40.3	39.3	(0.9)	
Cash and Cash Equivalents **	84.0	70.0	65.3	(4.7)	Note 3
Total Current Assets	158.7	127.1	123.1	(4.1)	
Trade and other payables **	(134.0)	(125.3)	(126.0)	(0.8)	
Borrowings	(14.0)	(14.0)	(14.5)	(0.5)	
Provisions	(5.6)	(5.6)	(5.6)	0.0	
Total Current Liabilities	(153.5)	(144.8)	(146.1)	(1.3)	
Borrowings	(256.8)	(244.9)	(245.4)	(0.5)	
Provisions	(2.7)	(2.7)	(2.5)	0.1	
Total Non Current Liabilities	(259.5)	(247.5)	(248.0)	(0.4)	
Total Assets Employed	411.7	416.8	409.4	(7.3)	
Financed By:				-	
Public Dividend Capital	665.0	665.0	665.0	-	
Retained Earnings *	(427.5)	(422.5)	(429.0)	(6.5)	Note 4
Revaluation Reserve *	174.2	174.2	173.4	(0.8)	
Total Taxpayers Equity	411.7	416.8	409.4	(7.3)	

Note 4. Retained earnings are showing a £6.5m variance from plan which reflects the revenue variance from plan of £4m at month 11. The remaining variance is due to lower than planned capital donated income (relating to donated capital expenditure) and higher than planned donated depreciation and is set out in the table below.

Variances to the plan at Month 11 are explained below:

Note 1. Property, plant and equipment is £2m lower than plan and reflects the slippage in the capital programme at month 11. The main variances relate to lower than planned expenditure on a number of projects including the multi-storey car park and the PDC funded general and acute beds scheme. Expenditure on Trust funded schemes is expected to be in line with plan at the year-end.

Note 2. The inventory balance has increased by £1.6m in comparison to the balance at 31 March 2023. The main increase is in relation to pharmacy showing an increase of £0.7m which is due to the timing of purchases to ensure stock levels. The interventional radiology balance has increased by £0.4m mainly due to the continued reduction in the balance of zero cost items in 2023/24.

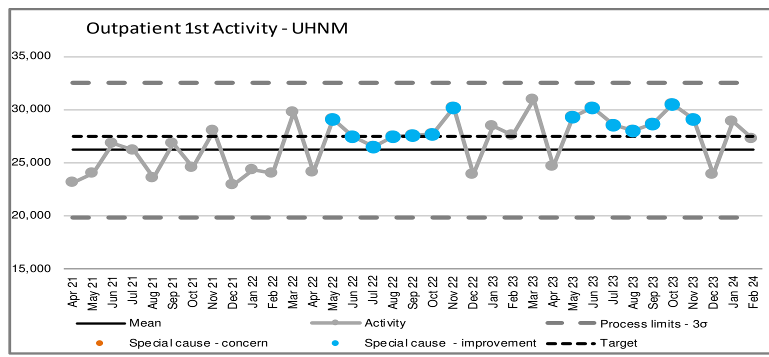
Note 3. At Month 11 our cash balance was £65.3m, which is £4.7m lower than the revised plan of £70m. Cash received is £15.6m higher than plan overall, of which £13.5m relates to the ICB block mandate and includes £9m cash received to cover the additional cost of industrial action, £1.1m winter funding and CDC funding of £1.6m.

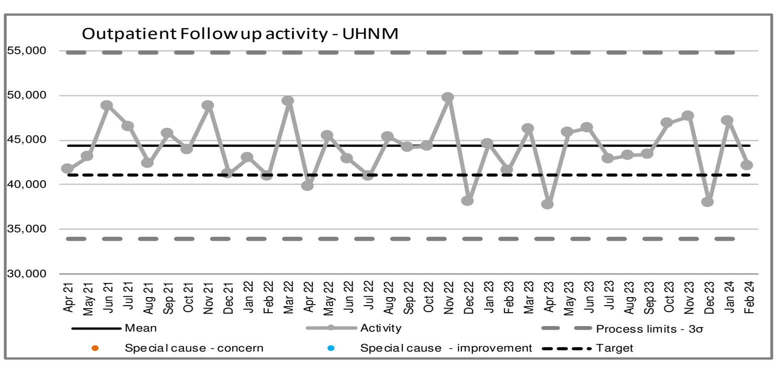
Other income and VAT reimbursements are £6m and £3.5m ahead of plan. Other income includes higher than expected interest received on the daily cash balance and £4.6m funding from West Midlands Cancer Alliance. Higher than planned VAT reimbursements reflect the recovery of VAT on significant capital schemes. Capital funding (PDC Capital) is £10m behind plan as funding cannot be drawn down ahead of need, however cash for all schemes has been received in month 12. Education contract training income is £2m higher than plan and is based on the latest schedule received from NHS England.

Payments are £20.3m ahead of plan at Month 11. General and payroll related payments are £12.2m and £3.5m ahead of plan respectively and reflects the revenue deficit reported in previous months and the cost of covering industrial action.

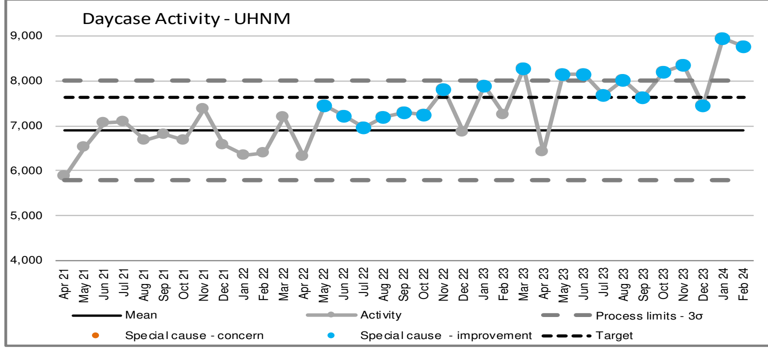
Activity

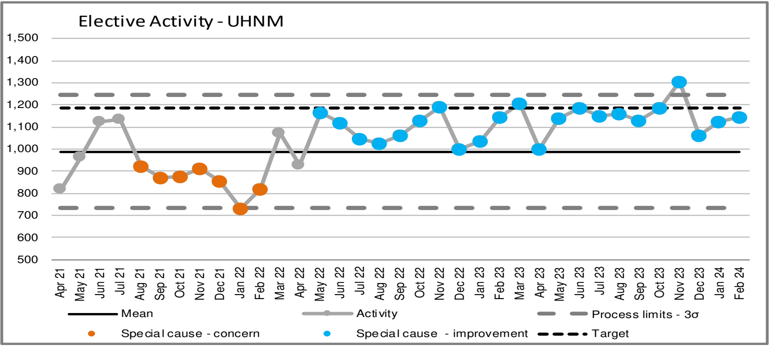
Planned care Outpatient



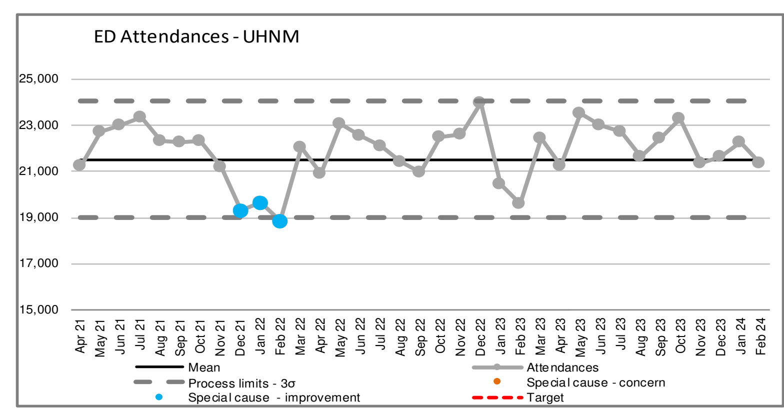


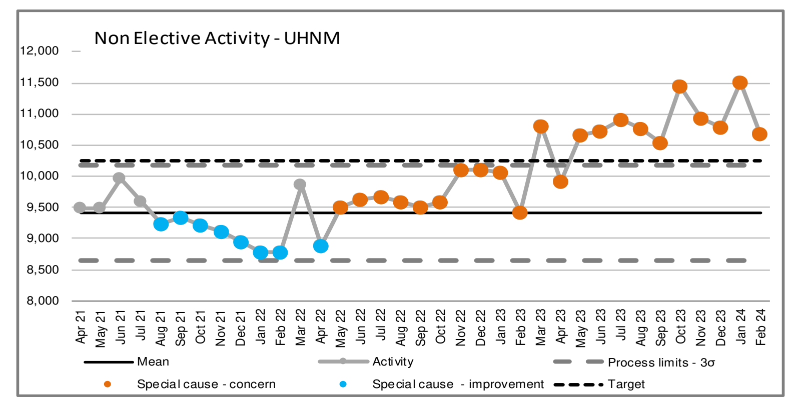
Planned care Inpatient





Urgent Care

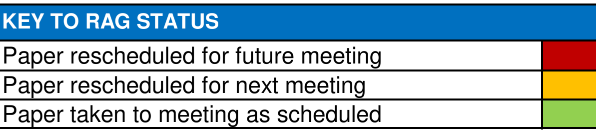




Delivering Exceptional Care with Exceptional People

Trust Board

2024/25 BUSINESS CYCLE



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

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		3	8	5	10	7	4	9	6	4	8	5	12
HIGH QUALITY													
Chief Executives Report	Chief Executive												
Patient Story	Chief Nurse		Staff			Staff			Staff			Staff	
Quality Governance Committee Assurance Report	Director of Governance												
Quality Strategy Update	Chief Nurse / Medical Director												
Care Quality Commission Action Plan	Chief Nurse												
Bi Annual Nurse Staffing Assurance Report	Chief Nurse												
Quality Account	Chief Nurse												
NHS Resolution Maternity Incentive Scheme	Chief Nurse												
Maternity Serious Incident Report	Chief Nurse												
Winter Plan	Chief Operating Officer												
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI												
Infection Prevention Board Assurance Framework	Chief Nurse												
RESPONSIVE													
Integrated Performance Report	Various												
Clinical Strategy Update	Director of Strategy												
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer												
PEOPLE													
Transformation and People Committee Assurance Report	Director of Governance												
People Strategy Update													
Gender Pay Gap Report	Chief People Officer												
Revalidation	Medical Director												
Workforce Disability Equality Report	Chief People Officer												
Workforce Race Equality Standards Report	Chief People Officer												
Staff Survey Report	Chief People Officer												
Raising Concerns Report	Director of Governance												
IMPROVING AND INNOVATING													
Research Strategy Update	Medical Director / Chief Nurse / Director of Strategy												
SYSTEM AND PARTNERS													
System Working Update	Chief Executive / Director of Strategy												
Population Health and Wellbeing Strategy	Director of Strategy												
RESOURCES													
Performance and Finance Committee Assurance Report	Director of Governance												
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above	Director of Strategy	NA											

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		3	8	5	10	7	4	9	6	4	8	5	12
Estates Strategy Update	Director of Estates, Facilities & PFI												
Digital Strategy Update	Chief Digital Information Officer												
Going Concern	Chief Finance Officer												
Annual Plan	Director of Strategy												
Board Approval of Financial Plan	Chief Finance Officer												
Final Plan Sign Off - Narrative/Workforce/Activity/Finance	Chief Finance Officer												
Activity and Narrative Plans	Director of Strategy												
Capital Programme 2022/23	Chief Finance Officer												
Standing Financial Instructions	Chief Finance Officer												
Scheme of Reservation and Delegation of Powers	Chief Finance Officer												
GOVERNANCE													
Nomination and Remuneration Committee Assurance Report	Director of Governance												
Audit Committee Assurance Report	Director of Governance												
Trust Strategy	Director of Strategy												
Board Assurance Framework	Director of Governance												
Annual Evaluation of the Board and its Committees	Director of Governance												
Annual Review of the Rules of Procedure	Director of Governance												
Board Development Programme	Director of Governance												
Well-Led Self Assessment	Director of Governance												
Risk Management Policy	Director of Governance												
Complaints Policy	Chief Nurse												