NHS
University Hospitals of North Midlands
NHS Trust

AGENDA

Trust Board (Open)

Meeting held on Wednesday 6th November 2024 at 9.30 am to 12.00 pm
Trust Boardroom, Third Floor, Springfield, Royal Stoke

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Staff Story	Information	Mrs J Haire	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 9th October 2024	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
10 mins	**6.**	Chief Executive's Report – October 2024	Information	Dr S Constable	Enclosure	
15 mins	**7.**	Board Assurance Framework – Q2	Assurance	Mrs C Cotton	Enclosure	**ALL**
10:20	**HIGH QUALITY**	**RESPONSIVE** / **PEOPLE**	**IMPROVING & INNOVATING**	**SYSTEM & PARTNERS**		**RESPONSIVE**
	8.	Integrated Performance Report – Month 6 and Committee Assurance Reports:				
10 mins	**8a.**	• Quality Governance Committee Assurance Report (31-10-24) • High Quality Dashboard	Assurance	Prof A Hassall Mrs AM Riley Dr M Lewis	Enclosure	**1**
10 mins	**8b.**	• Performance & Finance Committee Assurance Report (29-10-24) • Responsive Dashboard	Assurance	Prof G Crowe Mrs K Thorpe	Enclosure	**4**
10 mins	**8c.**	• People Dashboard	Assurance	Mrs J Haire	Enclosure	**2**
10:50 – 11:05 COMFORT BREAK						
10 mins	**8d.**	• Strategy & Transformation Committee Assurance Report (30-10-24) • Improving & Innovating Dashboard • System & Partners Dashboard	Assurance	Ms T Bowen Dr M Lewis Ms H Ashley	Enclosure	**9** **3**
10 mins	**8e.**	• Audit Committee Assurance Report (31-10-24) • Resources Dashboard	Assurance	Mrs M Monckton Mr M Oldham	Enclosure	**5, 6, 7, 8**
11:25		**RESPONSIVE**				
10 mins	**9.**	Emergency Preparedness Annual Assurance Statement	Assurance	Mrs K Thorpe	Enclosure	
11:35	**GOVERNANCE**					
5 mins	**10.**	Board Development Programme Update	Assurance	Mrs C Cotton	Enclosure	
5 mins	**11.**	Calendar of Business 2025/26	Approval	Mrs C Cotton	Enclosure	
5 mins	**12.**	RM02 Handling Complaints and Concerns	Approval	Mrs AM Riley	Enclosure	
11:50	**CLOSING MATTERS**					
10 mins	**13.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
	14.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 4th November to** nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:00	**DATE AND TIME OF NEXT MEETING**					
	15.	**Wednesday 8th January 2025, 9.30 am, via MS Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 9th October 2024 at 9.30 am to 12.00 pm
Via MS Teams

MINUTES OF MEETING

			Attended	Apologies / Deputy Sent	Apologies

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

In Attendance:	
Mrs N Hassall	Deputy Director of Governance (minutes)
Mrs F Fraser	Senior Orthodontic Nurse (item 1)
Ms L Harris	Patient (item 1)
Miss K Juggins	Consultant Orthodontist (item 1)
Mr C Pearce	OMFS Surgeon (item 1)
Mrs R Pilling	Head of Patient Experience (item 1)

Members of Staff and Public: 6

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
140/2024	Miss Juggins provided a presentation to the Board members and highlighted the following: • The creation of Keep Stoke Smiling which was aimed at reducing tooth decay	

	and providing education to children about the dangers of fizzy drinks • Media campaigns were created which resulted in further publicity and the Trust subsequently joined Stoke Community Trust, providing dental health workshops to schools • By the end of 2022, 100 schools had signed up to the pledge to become fizz free • Following the success, similar projects had been created across the country including links with the Premier League Primary Stars Programme An overview of orthognathic surgery was provided by Mr Pearce, and Ms Harris highlighted that she shared her story of surgery on Instagram which encouraged more patients to share their story. She added that the subsequently created an orthognathic buddy systema and had since created her own podcast to highlight her and other's journeys in order to provide patients with support and advice. Dr Constable welcomed the transformational work undertaken and improvement in outcomes and stated that this needed to feed into the wider health and wellbeing strategy. Mrs Nicholson commented on the return on investment and cost savings seen through prevention and suggested that work be considered in terms of educating maternity patients as well as focusing on those in the under 5 pathway. Mr Wakefield thanked the team for the presentation and commented on the positive partnerships which had been created. He welcomed the use of social media and the use of technology within the team and thanked Ms Harris for sharing her patient journey. **The Trust Board noted the story.** Mrs Fraser, Ms Harris, Miss Juggins, Mr Pearce and Mrs Pilling left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
141/2024	Mr Wakefield welcomed members to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate. Mr Wakefield welcomed Ms Nicholson and Mrs Monckton to the meeting.	
3.	**Declarations of Interest**	
142/2024	There were no declarations of interest raised.	
4.	**Minutes of the Meeting held 7th August 2024**	
143/2024	The minutes of the meeting held 7th August 2024 were approved as a true and accurate record.	
5.	**Matters Arising via the Post Meeting Action Log**	
144/2024	PTB/605 - Mr Wakefield referred to the action regarding the Board Development Programme and highlighted that Public Board meetings were to move to bi-monthly after November's meeting to create capacity for Executives and Non-Executives, including additional time for Board Development. Mrs Cotton added that the Calendar of Business for 2025/26 was being revised and would be brought to the Board for approval.	

6.	**Chief Executive's Report - September 2024**	
145/2024	Mr Wakefield referred to the 'my health, my way' campaign, and queried the level of uptake. Dr Constable stated that this related to an initiative led by the system which would be measured through the system rather than by UHNM. **The Trust Board received and noted the update.**	
SYSTEM AND PARTNERS		
7.	**Joint Stoke on Trent Health and Wellbeing Strategy 2025-28**	
146/2024	Ms Ashley highlighted the following: • Comments were being requested on the strategy; a number of Executives had already provided their input including Mathew Missen, Public Health Consultant • A number of areas aligned with the Trust's health and wellbeing strategy • Some areas required further consideration in terms of how the Trust could be an active partner in delivering the strategy Professor Maddock commented on the difficulty in identifying actions which were applicable to the Trust and added that some actions also needed to be refined. Professor Hassell welcomed the strategy, the priority target outcomes and guiding principles. He stated that the document required a proofread and some of the images were not clear. He agreed with Professor Maddock in that some targets required refinement to make these easier to measure. Professor Crowe queried how this linked to the work of the Staffordshire Health and Wellbeing Board and Ms Ashley explained that it was a challenge to align work across to the two counties, given the different levels of deprivation but this would be coordinated via the Integrated Care Partnership (ICP) strategy. Mr Wakefield welcomed sight of the document and summarised that further refinement was required. **The Trust Board received and noted the strategy and agreed to provide further comments and feedback by 16th October 2024 so that these could be collated and shared with the City of Stoke on Trent Council by the deadline of 18th October 2024.**	
PEOPLE		
8.	**Appraisal and Revalidation Annual Report**	
147/2024	Dr Lewis highlighted the following: • Once agreed the document was to be shared with NHS England • There had been a change of roles since the previous Responsible Officer, Nick Coleman had stepped down and Dr Lewis had taken over responsibility. He highlighted that Dr Large was due to take over the role of Responsible Officer from November 2024 • The lead appraiser had stepped down and an appointment was to be made • Due to the gap identified in support provided to locally employed doctors and international medical graduates, two Consultants had been appointed for one session a week, to provide oversight for that cohort Ms Bowen referred to pre-employment checks and queried whether assurance was available for international pre-employment checks. Mrs Haire stated that the	

	Trust followed national guidance in terms of the checks undertaken and that this was regularly audited. Professor Hassell referred to the number of unapproved missed appraisals which seemed higher than the previous year and Dr Lewis stated that nationally the General Medical Council (GMC) reported a rate of 20% compared to the Trust rate of 25%. He stated that the new lead appraiser would be responsible for leading the review of the current framework to ensure a more structured approach in in contacting those who were due an appraisal as well as providing them with suitable support. Mr Wakefield referred to the quarter of doctors who were not revalidated and queried how this impacted on the Trust's clinical governance. Dr Lewis stated that as well as the appraisals which were undertaken, incidents and complaints were reviewed. He added that in terms of the number of deferrals, doctors were provided with the support to complete their appraisals and usually the deferral was not due to lack of engagement. Mr Wakefield referred to section 4 where the Board was required to confirm that it was content that the Trust was compliant, and queried how the Trust could be compliant due to the number of appraisals not undertaken. Dr Constable stated that the Trust was compliant due to the process undertaken to complete the report and the supporting processes. He stated that revalidation was required once every 5 years and in terms of deferrals these related to genuine reasons for deferral. He added that the Trust would also be subject to an assurance process undertaken by NHS England. It was agreed to provide further information to the People, Culture and Inclusion (PCI) Committee, in terms of when the outstanding appraisals were due to be undertaken. **The Trust Board received the report and approved the findings.**	**ML**
9.	**2024 Workforce Race (WRES) and Workforce Disability Equality Standard (WDES) Reports**	
148/2024	Mrs Haire highlighted the following: • The improved trend of responses within the National Staff Survey from colleagues in relation to WRES and WDES indicators, although nationally the equality, diversity and inclusion indicators had remained static • The Trust had seen an improvement in 9 / 10 indicators for the WDES and 6 / 10 indicators for the WRES • There had been a notable improvement in colleagues feeling able to report bullying and harassment although this continued to be behind peers • Colleagues were reporting more long term conditions and disabilities • There was disparity in recruitment and career progression for black and ethnic minority (BME) colleagues, and a static position in terms of the experience of colleagues from BME backgrounds who had experienced discrimination from colleagues and line managers • Actions were to focus on debiasing recruitment and selection processes, improving equity in career development and promotion and tackling harassment, bullying and abuse from all sources • In terms of behaviours and cultural awareness there were some challenges in terms of the societal and deep rooted issues and these were being discussed with the Freedom to Speak Up Guardian and People team to analyse any themes	

	• A number of future campaigns had been planned to address race equality • The work of staff networks were to focus on influencing and shaping the agenda with a focus on accountability and driving sustainable change Dr Lewis referred to the bi-annual leadership events held for doctors which an opportunity to provide them with the skills and training required for future roles and stated that the sessions needed to ensure attendees were representative of the workforce. Ms Bowen commented on the importance of creating flexible working options for colleagues requiring reasonable adjustments as well as communicating the importance of providing staff with sufficient support. Professor Crowe referred to the discussion at People, Culture and Inclusion Committee in terms of the actions taken and added that the Committee challenged whether the Trust was being bold enough in certain areas. He stated that the Committee welcomed the desire to tackle potential bias in recruitment processes and the steps to create development opportunities for future medical leaders. Professor Hassell referred to the discrepancy between the number of staff with long term conditions on the Electronic Staff Record (ESR) as opposed to that stated in the National Staff Survey and queried the difference. Mrs Haire explained that whilst efforts were made to obtain this information from staff, including regular cleansing of data, the Staff Survey was anonymous and therefore she felt it related to trust and what the information would be used for. She added that the Trust continues to build staff with the confidence in declaring any disabilities and how we protect this personal information/data. Mr Wakefield suggested that the Staff Networks should be invited back to the Trust Board so that members could hear directly from them. Mrs Cotton stated that this had been highlighted by the well led developmental review and an annual session was to be incorporated into the Board Development Programme. **The Trust Board received and noted the report and agreed to the partial assurance rating. The Trust Board noted the associated action plans, and the priorities identified to improve the workplace experiences of ethnically diverse colleagues and those with a disability and long-term health condition.**	
RESPONSIVE		
10.	**Integrated Performance Report – Month 5 & Committee Assurance Reports**	
149/2024	Quality Governance Committee – 3rd October 2024 Professor Hassell highlighted the following: • The Trust was scored as compliant for 2 / 6 areas for the NHS England Urgent and Emergency Care (UEC) assurance request. It was noted that further consideration was required as to increasing the opportunity for Non-Executive Directors to speak to patients in emergency portals • Partial assurance was provided for the readmissions analysis due to the scope for improved coding • In terms of the patient waiting list backlog, the key priority was to ensure no patients waiting a long time were coming to harm, however progress continued to be slow due to resource constraints • Significant assurance was provided in relation to the medical examiners service, which had been recognised nationally. However, challenges had been identified in terms of the number of community deaths being higher than	

anticipated

Mr Wakefield referred to the breakdown of long wait patients by ethnicity and demographic and queried whether this had been completed. Ms Ashley stated that this had been provided and agreed to discuss this with Executives to identify where this should be considered. **HA**

Mr Wakefield queried what assurance was available in terms of whether the Trust's coding was as good as it should be. Mr Oldham referred to the clinical coding quality audits and external assessments which were undertaken and were generally positive. He stated that these were considered by the Executive Business Intelligence Group which reported to the Performance and Finance Committee (PAF). He added that IQVIA had also been engaged to review the Trust's coding compared with peers.

Mrs Thorpe referred to the readmission rates and coding issue and stated that there were some specific pathways where patients were going home to recover and coming back in for checks which were being incorrectly coded as a readmission. Mrs Freeman added that there remained complexities of coding due to the 406 systems which were in use across the Trust, 300 of which included clinical information. She added that the coders only had access to some of the systems therefore this created problems in not having a full view of the patient journey. She stated that the EPR business case included benefits to coding and added that if a new EPR was introduced, this would reduce the number of systems to 48.

<u>High Quality</u>

Mrs Riley highlighted the following:

- There were zero midwifery vacancies and 0.2 for nursing
- There continued to be an improvement across a broad range of metrics
- Two further never events had been reported in month
- Written duty of candour had not been achieved
- In terms of infection prevention, the annual covid and flu vaccination campaign had commenced with 604 flu vaccines provided and 461 covid vaccines to staff
- In terms of antibiotic resistant organisms, robust processes were in place to isolate patients, with any contacts screened and prevention and cleaning practices implemented.
- The number of covid inpatients was 42 which was slightly higher than previously reported and an increase had been seen across the region
- NHS England and the UK Health Security Agency had issued new healthcare associated infection objectives and targets, therefore reports were to be updated to include the new targets. It was noted that if the rate of c-difficile infections continued on the same trajectory it was likely that the Trust would meet the target although some criteria had changed.

Mr Wakefield queried what worried Mrs Riley the most in terms of quality performance. Mrs Riley referred to the consistency of achieving fundamental standards which was measured by the Care Excellence Framework, and whilst there remained bronze areas this would continue to be an area of focus. In addition, she stated that infection prevention was also a concern.

Ms Bowen referred to the number of patient safety incidents of moderate harm and above and queried how this linked to the five falls incidents with moderate harm. It was noted that the overall breakdown related to the number of incidents as a whole and not just falls.

Performance and Finance Committee – 30th September 2024

Professor Crowe provided the following update:

- In terms of performance to date the Trust was behind its current plan and the focus of the Committee was on understanding the future trajectory of cost improvements, working through potential savings with the Turnaround Director and learning lessons on productivity and efficiency
- The finance and activity group continued to meet and the reporting from the group into the Committee was to be considered
- There were areas where the Trust was able to make improvements although there remained challenges in terms of emergency care portals and addressing the 65 week backlog
- Historically a lot of reports had provided a 'look back' and the focus of the Committee was to look forward to the trajectories in place with assurance provided on the progress being made

Responsive

Mrs Thorpe highlighted the following:

- 4 hour performance had performed slightly better than trajectory, but was presently at 69% due to the pressures beginning to be experienced
- The AMRA unit had opened which had created a benefit in the reduction of 12 hour waits as well as a reduction in Discharge to Assess patients
- Further work in relation to 45 minute handover was to be launched and this would be considered further by the Performance and Finance Committee
- The Trust continued with improved performance for the Faster Diagnostic Standard with the trajectory continuing to be above plan
- The 62 day position had deteriorated slightly but was back on track for August
- The 31 day position had improved for August and this was being discussed as part of the Tier 1 conversations
- There had been a continued reduction in the number of 104, 78 and 65 week patients, with weekly conversations being held
- In terms of 65 week waits there were particular specialties causing some delays in treatment such as respiratory and ear, nose and throat, with a slight increase in patient related delays
- The Trust had reported a position of zero 104 week patients, with 11 patients over 78 weeks
- Work in relation to diagnostics had been undertaken and a provider was being used to support non obstetric ultrasound

Mr Wakefield queried whether the colorectal position had improved since the report had been written and Mrs Thorpe confirmed this, stating that this had been discussed as an MDT across the whole pathway.

Mrs Rodwell referred to data quality and queried the progress made in terms of validation. Mrs Thorpe stated that the internal team had continued to validate patients on the live RTT waiting list, for patients waiting over 52 weeks, combined with administrative validation, patient contact and reviewing patients notes. She stated that a partner organisation was supporting the Trust with additional validation of patients on non-live lists to ensure none had been closed in error. In addition, safeguards were being introduced within the internal data quality team to ensure that once validation had been undertaken changes were made to ensure that further validation was not required.

People, Culture and Inclusion Committee – 2nd October 2024

Professor Crowe highlighted the following:

- The Committee noted the improvement in the quality of papers which aided the ability to adequately cover all items on the agenda
- The interim update from the Chief Healthcare Scientist was welcomed in terms of the way in which the teams had been brought together to support and retain the workforce
- A number of positive assurances were provided
- In terms of areas of concern and issues, the Guardian of Safe Working highlighted some areas where exception reports were not receiving oversight and Executives had been tasked with reviewing this
- Some areas of resource challenges were identified such as within the Employee Relations team and Freedom to Speak Up, which were being considered by the Executive

People

Mrs Haire highlighted the following:

- Wellbeing offers continued to be communicated to support colleagues in returning to work and staying in work
- Turnover and vacancies remained low and within the tolerable threshold
- There continued to be a rise in appraisal rates which reflected the trend in supporting colleagues and tailoring these to individual needs
- Agency utilisation had experienced a positive downward trend and the reasons for agency usage continued to be explored

Dr Lewis referred to the role of the Chief Healthcare Scientist and the agreement to make the post substantive.

Ms Bowen referred to employee engagement and the campaigns introduced and queried whether these focused on positives and celebrating successes. Mrs Haire referred to the 'you said, we did' campaign which celebrated positives as well as the colleague spotlights and employee of the month.

Improving and Innovating

Dr Lewis stated that he was continuing to review the two metrics which would be included in future reports.

System and Partners

Ms Ashley stated that the metrics for this priority continued to be developed.

Resources

Mr Oldham highlighted the following in respect of financial performance:

- The Trust reported a deficit of £9.4 m against a planned deficit of £2.1 m, mainly due to cost improvement saving underperformance, the impact of industrial action and ongoing premium costs for medical staffing
- £16.1 m savings had been validated to month 5 of which £13.2 m were non-recurrent
- Meetings continued to be held with Divisions on a fortnightly basis to review cost improvements. Corporate schemes were expected to deliver in full and Surgery had identified a plan to meet the target. The remaining Divisions were finding this challenging and were expecting a shortfall

	• Meetings had been held with procurement to transact further savings although this was not expected to improve the overall position due to activity growth • £24.3 m of capital had been spent which was £0.5 m behind plan, with continued risks of slippage which were being worked through • The cash position remained strong • Interviews for the turnaround team were being held and it was expected that an ex NHS regional director would be identified for additional support Mr Wakefield queried the action being taken to address winter plan funding and Mr Oldham stated that the schemes identified were fully funded. Mr Wakefield queried if PAF could be provided with the past 3 to 4 years data, of the percentage of cost improvements delivered at this point in the year so that this could be used as a comparison. **The Trust Board received and noted the reports.**	**MO**
CLOSING MATTERS		
11.	**Review of Meeting Effectiveness and Review of Business Cycle**	
150/2024	No comments were made.	
12.	**Questions from the Public**	
151/2024	There were no questions received. Mr Wakefield thanked Mrs Rodwell for her time at the Trust, given that it was her last Board meeting.	
DATE AND TIME OF NEXT MEETING		
13.	**Wednesday 6th November 2024, 9.30 am Trust Boardroom, Third Floor, Springfield**	

Trust Board (Open)

Post meeting action log as at **30 October 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/603	08/08/2024	Infection Prevention Board Assurance Framework	To provide the timeline for expected full compliance in relation to criteria 6.	Ann-Marie Riley Jane Holmes	06/11/2024	30/10/2024	Included on November's agenda	B
PTB/605	08/08/2024	Board Development Programme - Schedule of Board Seminars	To consider inclusion of a session in respect of health inequalities and population health, in addition to reviewing the frequency of board meetings to create additional capacity.	Claire Cotton Helen Ashley	06/11/2024	30/10/2024	Suggested that a session on health inequalities / population health is held with members of Strategy and Transformation / People, Culture and Inclusion Committee at the next deep dive scheduled for 5th March 2025. Proposal for	B
PTB/606	09/10/2024	Appraisal and Revalidation Annual Report	It was agreed to provide further information to the People, Culture and Inclusion (PCI) Committee, in terms of when the outstanding appraisals were due to be undertaken.	Matthew Lewis	18/12/2024		Action not yet due.	GA
PTB/607	09/10/2024	Integrated Performance Report	To provide PAF with an update on data from the past 3 to 4 years, demonstrating the percentage of cost improvements delivered at this point in the year so that this could be used as a comparison.	Mark Oldham	26/11/2024		Action not yet due.	GA
PTB/608	09/10/2024	Integrated Performance Report	To agree where to report the breakdown of long wait patients by ethnicity and demographic after discussion with the Executive	Helen Ashley	08/01/2025		Action not yet due.	GA

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

October 2024

Part 1: Highlight Report

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last meeting on 9th October 2024, some of which are not covered elsewhere on the agenda for this meeting.

1. National and Regional Context

I attended the NHS England Midlands Leadership Call on 23 October 2024. The agenda items were as follows:

- Mental Health
- Agency Price Cap Compliance
- Perinatal Improvement Programme
- Vaccination Update
- Service Delivery

2. Disruption to iPortal

Our main clinical IT system, iPortal, has experienced intermittent periods of unavailability over the last few weeks and this has caused significant disruption to services and the delivery of patient care.

The problem is multi-faceted, involving up to 400 systems on shared hardware, and we are reviewing all systems to determine which are contributing to the performance spikes. Our IM&T team, together with partners CDW and Aire Logic, have been rigorously investigating the relationships between all the systems to identify the rogue processes and server performance issues that have been contributing to the outages. Once these problematic processes have been found, we have either stopped them or repaired them to restore smooth operation across the board.

One of the issues we have identified with iPortal is the speed that the server can write temporary files to the storage disks on the shared storage area network. New hardware has been put online that consists of new locally attached disks so the server can write these temporary files quicker without the delay of the storage area network. It is hoped that this makes an immediate difference to performance and availability.

In addition, we have specified a new hardware platform, and this has been ordered. Once the new hardware is in place, we plan to migrate iPortal to this platform. This move will allow the iPortal databases to operate independently from other systems, which is expected to significantly improve performance and stability.

Whilst these improvements are being developed, we will continue to focus on identifying and resolving poorly performing servers and processes. Until then, our teams are working tirelessly to manage and mitigate the impact of any ongoing disruptions.

I would like to put on record my thanks to Amy Freeman, Chief Digital Information Officer, and the whole IM&T Team for their diligence and attention to detail in managing events over the last few weeks. I would also like to thank clinical teams for their patience and understanding during the period of difficulty. We

persist with our objective for a new, supported, Electronic Patient Record/Patient Administration System, as an important clinical tool for our day-to-day operations. Arguably this is a higher priority than ever. We will manage the risk through our usual governance processes.

3. Ambulance Handover Delays

One area for an immediate focus of attention this side of winter is in the handover of patients to our Emergency Departments from ambulance services. As an organisation we need to behave in a way that recognises our obligations to the whole 'system', including that to patients not yet in our care (but need to be), in that we must enable and prioritise swift ambulance handover in our Emergency Departments.

There is a strong correlation between ambulance handover delays at emergency departments and ambulance Category 2 response delays, meaning longer handovers increase the chances that those in need will wait longer for an ambulance. It is vital that we have a whole system approach to risk across the urgent and emergency care pathway to provide the best outcomes for our patients. This includes deployment of actions (including Your Next Patient) within our hospitals to help improve flow and reduce pressure on the Emergency Department. We know these things work but they do need to be deployed consistently and rigorously.

I attended the NHS England Midlands Winter Risk meeting on 14 October 2024 with Katy Thorpe, Chief Operating Officer, alongside ICB colleagues and system partners. Our Winter Assurance Visit from NHS England took place on 25 October 2024.

4. Becoming smokefree

Smoking remains the number one cause of preventable ill health nationally. For us, smoking prevalence in Staffordshire and Stoke-on-Trent remains exceptionally high, contributing towards preventable ill health and premature death locally and it has a profound effect on us at UHNM and in our hospitals.

This is why during this last month, Stoptober, our Tobacco Dependency Service has been asking colleagues to take the Very Brief Advice + (VBA+) pledge. VBA+ is a 30-second intervention that can be delivered by all healthcare professionals in almost every consultation with patients who smoke. It involves asking patients about their current smoking, advising them on the best methods of stopping smoking available to them and helping them access evidence-based stop smoking support. Patients at UHNM can receive stop smoking support with referrals made via CareFlow 'Smoking Cessation'.

Support is also available for anyone working at UHNM who wishes to quit also through services in the community and Everyone Health. As well as the benefits on our own health and those of our patients taking up all this offer of support, this will help us in the steps we are taking to ensure our hospitals are smokefree by January 2026.

We know that we have serious problems with people smoking at the entrances to our buildings despite clear signage. We are looking at ways to help colleagues not only quit themselves but to be able to approach smokers who are outside our buildings and offer support and signposting. At the very least, until we are totally smokefree, both staff and patients should be using the smoking shelters available to them if they do want to smoke or vape.

We are restarting the important conversation we need to have about being totally smokefree at UHNM. The status quo is not consistent with our stated aims as an acute trust in our community in the 21st century.

Being smokefree is very easy to say, much harder to do. We do need to do more by way of the prevention agenda and provision of support for smokers. However, it is something we must do as if we are to deliver on our responsibilities, both in terms of treating illness as well as preventing it in the first place.

5. Being anti-racist

Anti-racism is more than a statement. Being an anti-racist organisation means that we will actively target, challenge, and remove systemic barriers that enable racism.

Our awareness and understanding of the issues that face people from Black, Asian and Minority Ethnic backgrounds – as patients, as colleagues and as members of society has increased, with the disproportionate adverse impact of COVID-19, the murder of George Floyd in the United States, and the Black Lives Movement. We also recognise the different experiences of discrimination and access to opportunities between white and ethnically diverse colleagues highlighted in the NHS Workforce Race Equality Standards, alongside the recent racially motivated civil unrest. They all demonstrate that we must all do more.

All of this has held up a huge mirror and compelled all of us to appreciate, probably more than ever before, that racial injustice has not disappeared, nor is it isolated to other parts of the world, or indeed other parts of our own country. It is a genuine and lived experience for countless people across the globe. And for all that many of us believe we have worked very hard to create a fairer and more equal society, here, events over the summer makes it apparent that racism is not a historical phenomenon. Rather, and very sadly, it is alive and kicking around us.

So, I believe it remains important that UHNM adds its collective voice to the many voices around the world calling out injustice, prejudice and discrimination.

But we also need to be honest that this is not a matter for everyone else. Within our own organisation there is plenty of work to do and we will not shy away from this reality. Our staff survey tells us that too many people have experienced bullying and harassment across the whole Trust, which is bad enough; but, on top of this, too many Black, Asian and Minority Ethnic (BAME) colleagues have experienced discrimination.

We now, more than ever, must come back to first principles about equality of opportunity, fairness, diversity and inclusion.

This is a journey, as individuals and as an organisation. Becoming anti-racist can involve some feelings of discomfort as it challenges the way things are done, as well as our own assumptions, but we need to be honest about racism, its existence in our society and our institutions and its impact on our people and communities.

Over a quarter of our UHNM workforce are ethnically diverse, yet their experiences in the workplace can be markedly less positive than our white colleagues. We are committed to taking bold and effective action to identify and challenge racism, and you can read what this looks like in our anti-racism statement.

I hereby restate our commitment to eradicating discrimination and injustice, and we will take decisive action. Our Ethnic Diversity Staff Network will have an ever-stronger voice in us leading change together. We also now understand better than ever that the necessary culture change will only become embedded if we can underpin it through collective leadership at all levels of the Trust.

As part of Black History Month, I participated in a podcast/conversation with our Ethnic Diversity Network about black health champions like Mary Seacole, and the contributions made by colleagues in UHNM and NHS services more widely, their experiences, and challenges. This took place on 21 October 2024. Another similar event was held with Professor Sunita Toor, Non-Executive Director, on 30 October 2024.

6. West Midlands Imaging Network

I am delighted to have taken up the role as the new Chair of the West Midlands Imaging Network. It is an honour to step into this role and join such a dedicated and innovative community.

There is tremendous potential for growth and development to improve the services in imaging for the whole of the region, both for our patients and for those who look after them. We can foster stronger partnerships,

enabling, influencing and enhancing professional development opportunities, whilst driving forward initiatives that will set new standards in this field. Together, we can achieve more together than we can alone and thus have a significant impact on our healthcare landscape.

I will feedback on the work of this Network through these regular Board reports.

7. Nursing Times Awards

UHNM Older Adults Diversional Therapists have been announced as the winners of the 'The Care of Older People' category at the prestigious 2024 Nursing Times Awards.

Following a rigorous judging process, The Diversional Therapist Team at UHNM emerged as the winner of Nursing Times' 'The Care of Older People Award' in recognition of their work providing bespoke activities aimed at maintaining the mobility of patients on the Royal Stoke University Hospital's older adult wards.

UHNM's six diversional therapists work on the elderly care wards and have one-on-one time with a patient to help keep them mobile. The therapists encourage patients to get out of bed to play board games, watch a TV programme, go for a coffee and have a walk.

8. Fracture Clinic at County Hospital

The Fracture Clinic at County Hospital has been awarded the prestigious 'platinum award' in the Care Excellence Framework (CEF).

The internally-developed CEF accreditation system evaluates the areas of caring, safety, effectiveness, responsiveness and leadership, helping staff achieve and maintain high standards of care at UHNM. The CEF is delivered in a supportive style fostering a culture of learning, sharing and improving, as well as reward and recognition for achievement. We are able to demonstrate improvements and trends over time which help to benchmark and spread excellence across the organisation.

Wards are assessed every year and are graded from bronze to platinum, with the Fracture Clinic the only recipients of the platinum award in 2024 so far.

9. NHS Parliamentary Awards

The Staffordshire Lung Health Checks team from UHNM attended the NHS Parliamentary Awards in Westminster, London, as regional winners nominated for a national 'Health Equity Award'.

Although the team did not win the national award, attending the event proved to be a fantastic experience, listening to speakers such as Chief Executive for NHSE Amanada Pritchard and Wes Streeting MP, Secretary of State for Health and Social Care. There was also a special recorded message from the Prime Minister, Sir Kier Starmer.

10. Employee and Team Recognition

i) Employee of the Month – Isabel Roberts, Lead Pharmacist for Oncology

Isabel Roberts, Lead Pharmacist for Oncology, has dedicated her own time, missing family engagements, to make sure a new system, used to ensure safe and up-to-date treatment for cancer patients, was ready to be used on time.

She was nominated by colleague and friend Marie Carter, Oncology Pharmacist, who describes Isabel as, "*the most modest person you'll ever meet*".

Ben Jones, Directorate Manager said: "*The way Isabel has conducted the upgrade has been exemplary. To her, no task is too big or too small, she is a total team player and very humble. She typifies the Trust Values and what really makes the Pharmacy Directorate a great place to work. She's one of the key leaders in the team, and without her dedication, this essential upgrade probably wouldn't have come off.*"

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

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

- Lisa Underwood, Head of Nursing - Surgery
- Dr Chris Thompson, Consultant in Renal and Intensive Care Medicine
- Coronary Care Unit, Network Services
- Wendy Hawkins, Theatre Nurse - Maternity Theatres, Women's & Children's
- Dr Melissa Hubbard, Consultant Paediatrician
- Dr Julia Uffindell, Consultant Paediatrician and Clinical Lead, NNU
- Mark Caplice, Healthcare Assistant, SDU (Ward 126)
- Dr Mark Poulson, Deputy Chief Medical Officer
- Amy Freeman, Chief Digital Information Officer
- Mr Saurabh Mehta, Consultant Orthopaedic Surgeon

Part 2: Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Breast Radiologist	Vacancy	Yes	TBC
Consultant O&G (Endo)	Newly created	TBC	TBC
Cardiothoracic Radiologist Consultant	Vacancy	TBC	TBC

The following table provides a summary of medical staff who have taken up positions in the Trust during October 2024.

Post Title	Reason for advertising	Start Date
Consultant Ophthalmologist with interest in Medical Retina	Newly created	10/10/2024
Consultant in General Medicine with Specialist Interest in Diabetes	Newly created	07/10/2024

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

Post Title	Closing Date	Notes
Consultant Dermatologist	21/10/2024	No applicants

Medical Management Appointments – October 2024

No medical management interviews have taken place during October 2024 and no medical management have taken up positions in the Trust. No medical management vacancies closed without applications / candidates during October 2024.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th November 2024
Report Title:	Q2 Board Assurance Framework	**Agenda Item:**	7.
Author:	Claire Cotton, Director of Governance and Nicola Hassall, Deputy Director of Governance		
Executive Lead:	Claire Cotton, Director of Governance		

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

	Please refer to BAF	

Executive Summary

Situation

The Board Assurance Framework (BAF) has been updated by Executive Leads for Q2 2024/25 and presented in full to each Committee; with the enclosed Summary BAF being provided to the Board.

Background

The strategic risks contained within the 2023/24 BAF were refreshed by the Executive Team and agreed by the Board in March 2024 in line with our annual review process. The Q2 BAF has also been updated following the discussions held at the BAF Deep Dives in August 2024.

Assessment

	The 'most threatened' of our Strategic Priorities is 'Quality', with all 9 Strategic Risks posing a threat to its achievement. This is followed by 'Responsive' and 'People', each with 8 Strategic Risks posing a threat.
	The most significant Strategic Risks are 'Digital Transformation', 'Financial In Year Delivery' and 'Financial Sustainability', which have the highest risk score of Extreme 16, above the tolerance of 8 - 12.
	'Digital Transformation' has increased in risk score during the quarter and 'Improving Workforce Sustainability and Culture has slightly decreased in the quarter, although the date to reduce this risk to its target has been delayed to March 2026. In addition, 'Delivering Responsive Patient Care has reduced in risk score.
	Fit for Purpose Estate remains in line with its risk tolerance score, with all remaining risks being above the tolerated risk appetite score.
	The number of linked risks in the quarter have increased for 8 / 9 risks, with the most linked risks affecting 'Delivering Positive Patient Outcomes'.
	5 actions have moved to 'complete / BAU' during Quarter 2, and 7 / 9 risks have identified problematic actions. In addition, actions have been identified to address particular areas of concerns raised within Committee discussions during the quarter.
	There are a number of sources of assurance which have not been seen in line with business cycles and where possible, these are or have been rescheduled.

Key Recommendations

The Trust Board is asked to approve or amend the BAF and to consider whether risk scores and assurance assessments are an accurate reflection of the position

NHS
University Hospitals of North Midlands
NHS Trust

Summary Board Assurance Framework

Quarter 2 2024/2025

Delivering Exceptional Care with Exceptional People

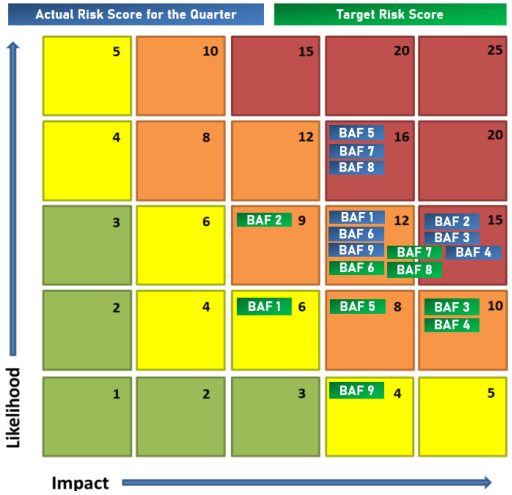
High Level Overview

University Hospitals of North Midlands NHS Trust

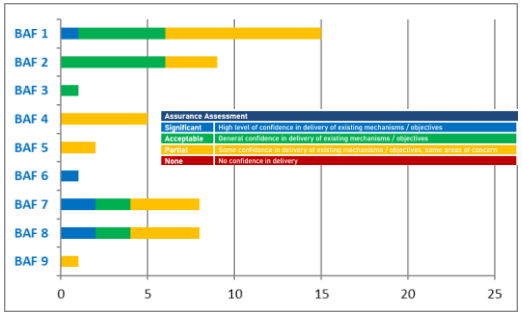
Strategic Risk Summary

Assurance Committee	BAF No.	BAF Risk Title	Risk Score and Assurance Q1	Q2	Q3 Plan	Q4 Plan	Target	Appetite / Tolerance	Linked Risks	Longer Term Risk Actual v Trajectory	Action BRAG	Strategic Priorities
Quality Governance Committee	BAF 1	Delivering Positive Patient Outcomes	High 12	High 12	High 8	High 8	Mod 6	Minimal	174 ↑		1, 11	
							31/03/26	↑ Above Tolerance (4 - 6)				
People, Culture & Inclusion Committee	BAF 2	Improving Workforce Sustainability & Culture	Ext 16	Ext 15	High 12	High 9	High 10	Open	122 ↑		1, 5	
							~~31/03/25~~ 31/03/26	↑ Above Tolerance (8-12)				
Strategy & Transformation Committee	BAF 3	Improving the Health of our Population	Ext 15	Ext 15	Ext 15	High 10	High 10	Open	0		2	
							31/03/25	↑ Above Tolerance (8-12)	Graph not available as no linked risks identified			
	BAF 5	Digital Transformation	High 12	Ext 16	High 12	High 8	High 8	Open	77 ↑		1, 2, 5	
							31/03/25	↑ Above Tolerance (8-12)				
	BAF 9	Research & Innovation	High 12	High 12	High 12	High 12	High 8	Cautious	4 ↑		1, 2, 2	
							30/09/25	↑ Above Tolerance (4 - 6)				
Performance & Finance Committee	BAF 4	Delivering Responsive Patient Care	Ext 20	Ext 15	Ext 15	Ext 20	High 10	Open	59 ↑		2, 2, 4	
							30/09/25	↑ Above Tolerance (8-12)				
	BAF 6	Fit for Purpose Estate	High 12	High 12	High 12	High 12	High 12	Open	72 ↑		2, 5	
							31/03/29	➔➔ At Tolerance (8-12)				
	BAF 7	Financial In Year Delivery	Ext 16	Ext 16	High 12	High 12	High 12	Open	33 ↑		1, 3	
							31/03/25	↑ Above Tolerance (8-12)				
	BAF 8	Financial Sustainability	Ext 16	Ext 16	High 12	High 12	High 12	Open	3 ↑		2	
							31/03/25	↑ Above Tolerance (8-12)				

Strategic Risk Heat Map



Assurance Outcomes Overview



Positive Assurances to Note

- 2 / 9 (➔) risks identified as providing acceptable assurance
- 90% (↑) of assurances were seen compared to the plan during the quarter
- 12% (↓) assurances were rated as significant assurance and 32% (↑) as acceptable assurance
- 9% (↑) of actions have been completed with the remaining 72% on track and 19% delayed

Matters of Concern

- 7 / 9 (➔) risks identified as providing partial assurance
- 10% (↓) of assurance were not seen during Q2
- 56% (↓) assurances were rated as partial assurance and 0% (↓) identified as having no assurance
- 8 / 9 (↑) target risk scores are above the tolerance

BAF 1: Delivering Positive Patient Outcomes

Chief Nurse & Chief Medical Officer | Quality Governance Committee | Threat to:

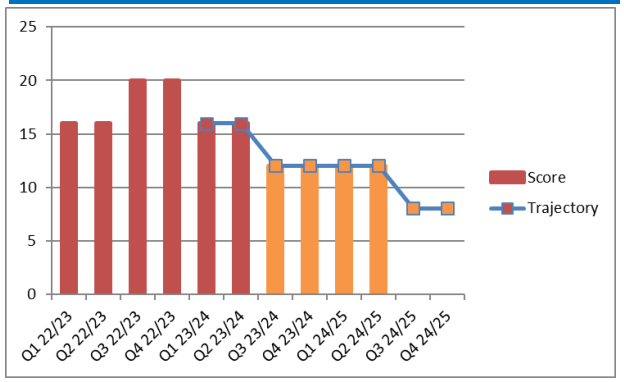
University Hospitals of North Midlands NHS Trust

If we do not consistently maintain evidence based, safe and effective care, then we may see an increased incidence of avoidable harm, poor patient experience and suboptimal patient outcomes, resulting in unnecessary reductions in the quality of treatment, failure to deliver statutory and regulatory compliance, increased complaints and litigation, reputational damage and poor staff morale

Assurance, Risk Ratings & Target

Partial Assurance	High 12	High 12	Q3	Q4	Mod 6 31/3/26

Risk Movement and Risk Reduction Trajectory

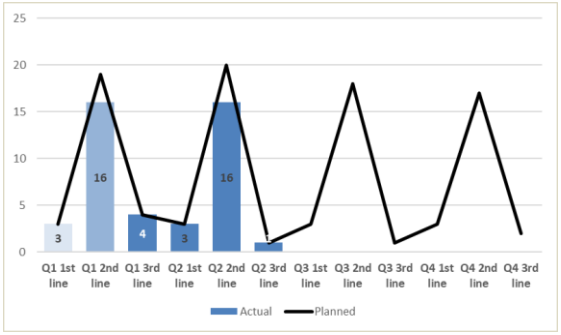


Heat Map Risk Matrix

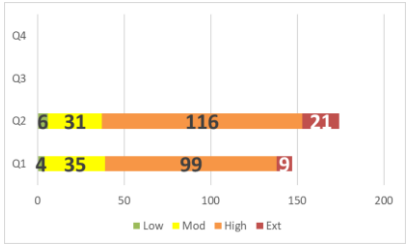
Rationale for Risk Level

The risk score has stayed the same as Q1, although the risk description, current controls and assurances have been reviewed. Main gaps in control continue to relate to clinical effectiveness delivery and introduction of ePMA with further assurance required in terms of Section 29a notice for maternity, and the need for a robust system to be identified to evaluate harm associated with long waits.

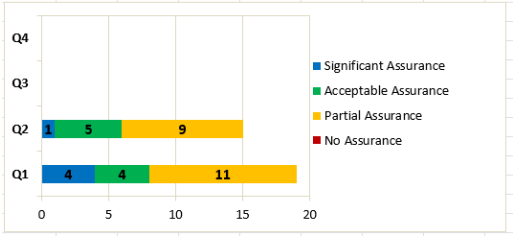
2024 / 2025 Assurance Plan



Linked Risks on Register



Committee Assassurance Outcomes



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Support delivery of Non-Elective Improvement Prog	31/03/2025				
2	Enhance harm review process	31/12/2024				
3	Reduce / eliminate CEF bronze rated areas	31/03/2025				
4	Continue improvements in meeting S29a Notices	01/04/2025				
5	Embed clinical effectiveness processes	31/12/2024				
6	Continue rollout of Improving Together	31/03/2025				
7	Understand root cause of increased HAI rates	31/03/2025				
8	Develop delivery plan for Oliver McGowan full day training	31/05/2025				
9	Review visiting guidance in view of changes in legislation	30/09/2024				
10	Implement Martha's Rule	31/03/2025				
11	Deliver ePMA programme	31/12/2025				
12	Improve complaints response times to target	01/09/2025	N/A			

Overview

- Risk score reviewed and the same as Q1 in line with planned trajectory
- Risk score expected to be above agreed tolerance until 2026
- Continues to have the highest number of 'linked risks' on the risk register, and this has increased to 174 at Q2 from 147 at Q1, with 21 linked risks rated as Extreme
- 9 / 23 assurances for the quarter were rated as having partial assurance; 5 sources of assurance were not rated
- 20 / 23 assurances were seen as planned during the quarter

BAF 2: Sustainable Workforce

Chief People Officer | People, Culture & Inclusion Committee | Threat to:

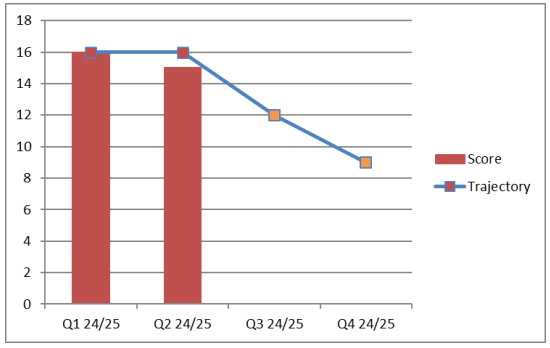
University Hospitals of North Midlands NHS Trust

If we are unable to achieve workforce (people) sustainability through an effective long term workforce strategy and delivery plan which is underpinned by a positive, inclusive organisational culture, then, we may face significant challenges in ensuring we have colleagues with the right skills, values and behaviours in the right place at the right time, resulting in an adverse impact on colleague experience, voice, wellbeing, recruitment, development and retention, with the potential to compromise quality of care for our patients, inability to deliver operational targets and increased premium costs negatively affecting the financial position.

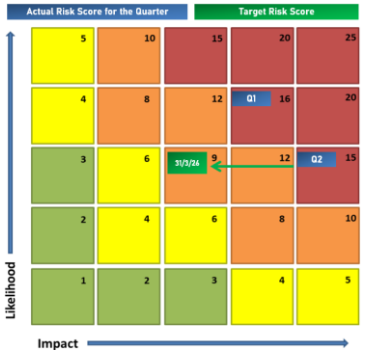
Assurance, Risk Ratings & Target

Acceptable Assurance	Ext 16	Ext 15	Q3	Q4	High 10 31/3/26

Risk Movement and Risk Reduction Trajectory



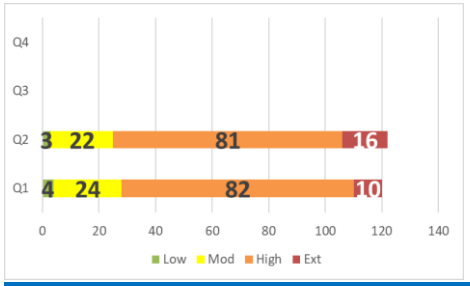
Heat Map Risk Matrix



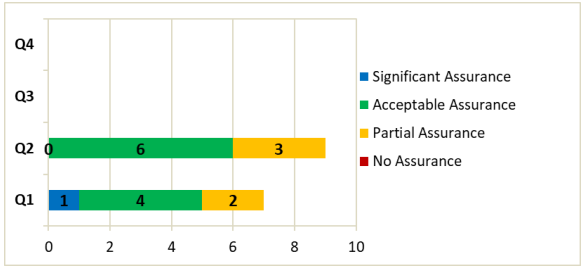
Rationale for Risk Level

- After the People, Culture and Inclusion (PCI) Committee deep session in July, the risk consequence score has been revised to 5, and the target date has been updated to 31/03/2026. Given our current financial challenges, it will not be possible to achieve our target risk score by 31/03/2025
- However, good progress has continued to be made during Q2 2024/25 and PCI agreed to a positive assurance rating in October 2024.

Linked Risks on Register



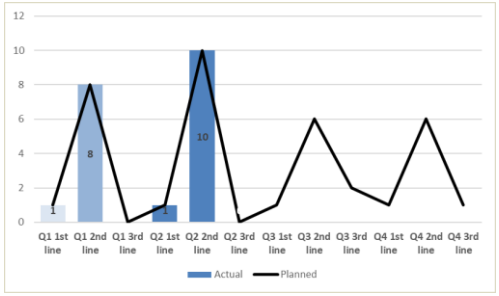
Committee Assurance Outcomes



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Strengthen flexible working opportunities, focus on providing a safe and healthy work environment and continue to support wellbeing of our staff	31/03/2025				
2	Widen career pathways for disadvantaged groups, strengthen mechanisms to demonstrate tangible recognition and appreciation and increase employee knowledge and confidence in raising concerns	31/03/2025				
3	Continue to deliver on our retention plan, develop and launch succession planning framework, scale up new roles to tackle key staff shortages and increase pipeline for school and college leavers	31/03/2025				
4	Embed further remote working opportunities and review, adapt and amend processes in line with national ESR guidance	31/03/2025				
5	Review Guardian of Safe Working exception reporting via Medical Workforce Assurance Group	31/12/2024	N/A			
6	Review of 'no case to answer' outcomes to be undertaken within Employee Relations	31/12/2024	N/A			

2024 / 2025 Assurance Plan



Overview

- Risk score lower than initial trajectory, but this has been revised for the remainder of the year and is expected to be above the agreed tolerance until 2025/26
- Second highest number of 'linked risks' on the risk register at 122 at Q2, compared to 120 at Q1
- 3 / 11 assurances for the quarter were rated as having partial assurance; 2 sources of assurance were not rated
- All 11 assurances were seen as planned during the quarter

BAF 3: Improving the Health of our Population

Director of Strategy & Transformation | Strategy & Transformation Committee | Threat to:

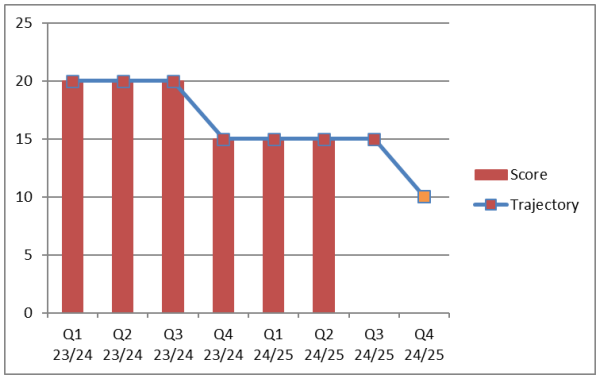
University Hospitals of North Midlands NHS Trust

If we are unable to work together with system partners across organisation and sector boundaries, then we will have minimal impact on the long-term elements of improving population health, the wider determinants of health and addressing health inequalities for the population we serve, resulting in missed opportunities to improve the health of our population and sustained or improved health inequalities and potentially increased pressure on health care services.

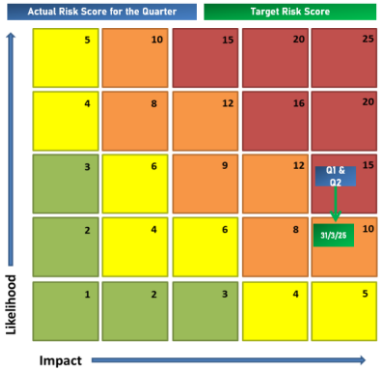
Assurance, Risk Ratings & Target

Partial Assurance	Ext 15	Ext 15	Q3	Q4	High 10 31/3/25

Risk Movement and Risk Reduction Trajectory



Heat Map Risk Matrix



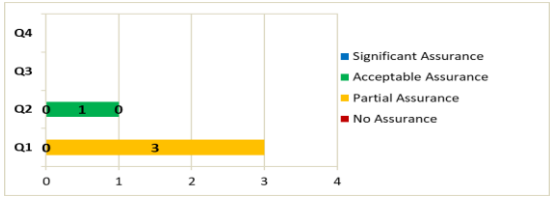
Rationale for Risk Level

- Risk likelihood remained the same as Q1 with work ongoing to embed action plans.
- Main gaps in assurance relate to sight of the strategic action plans which will be delivered during 2024/25

Linked Risks on Register

Graph not available as no linked risks identified

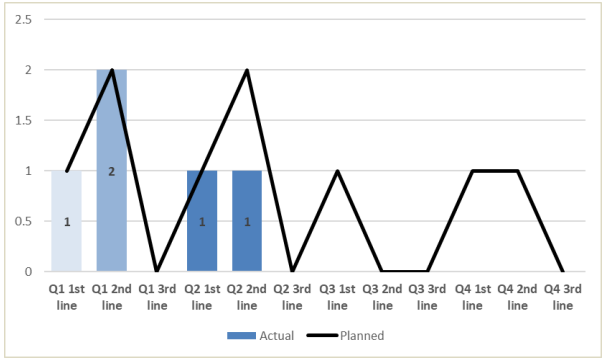
Committee Assurance Outcomes



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Development of metrics to measure progress and delivery	21/03/2025				
2	Develop detailed action plans to support delivery of the strategy	21/03/2025				

2024 / 2025 Assurance Plan



Overview

- Risk score is in line with trajectory although expected to be above agreed tolerance until end of 2024/25
- There continue to be no linked risks identified on the risk register
- Limited sources of assurance identified;, 2 / 3 assurances seen as planned although 1 source of assurance was not rated
- No third line assurances identified

BAF 4: Delivering Responsive Patient Care

Chief Operating Officer | Performance & Finance Committee | Threat to:

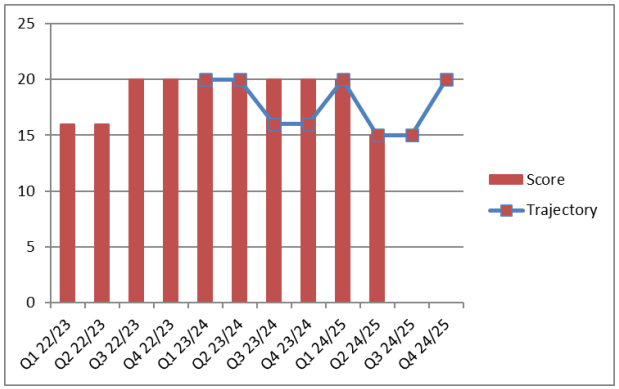
NHS University Hospitals of North Midlands NHS Trust

If we are unable to create sufficient capacity to deal with service demand, then we may be unable to treat patients in a timely manner, resulting in poor patient outcomes, potential patient harm, impact on staff wellbeing, continued regulatory control and negative impact on the financial position

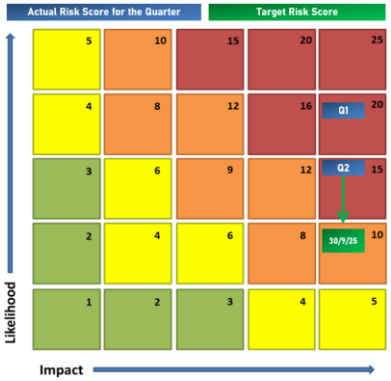
Assurance, Risk Ratings & Target

Partial Assurance	Ext 20	Ext 15	Q3	Q4	High 10 30/9/25

Risk Movement and Risk Reduction Trajectory



Heat Map Risk Matrix

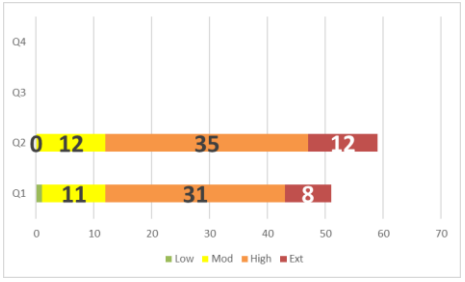


Rationale for Risk Level

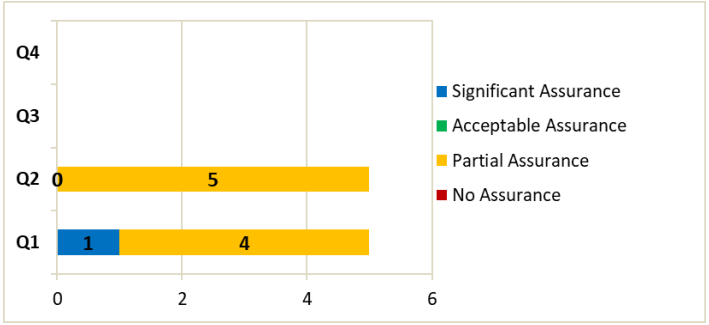
Despite some improvements we remain below the national 4 hour performance trajectory and corridor care is continuing to be used. The Trust is on trajectory for cancer recovery and the backlog of patients is reducing. Intermittent iPortal downtime is having an impact on operational effectiveness.

Main gaps in control relate to the schemes needing to be identified to create additional capacity for challenged specialties. Gaps in assurance relate to the improvement in discharge profile.

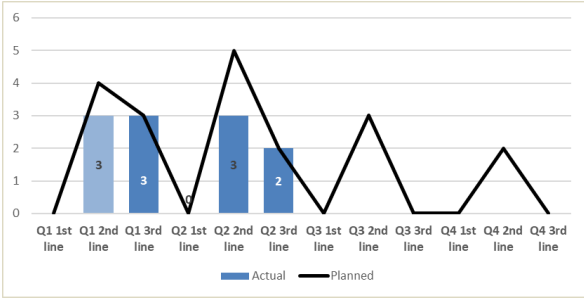
Linked Risks on Register



Committee Assurance Outcomes



2024 / 2025 Assurance Plan



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Increase capacity - County Hospital Elective Care Centre	31/03/2025				
2	Explore/develop data and technology to support services	31/03/2025				
3	Deliver objectives in non-elective improvement programme	31/03/2025				
4	Deliver objectives in elective improvement programme	30/20/2024				
5	Two phased rightsizing work looking at best use of capacity	31/10/2024				
6	Harm review process for patients waiting for elective care	31/07/2024				
7	Introduction of finance, activity and productivity meeting	01/05/2024				
8	Consideration of expanded capacity through ERF	30/07/20204				

Overview

- Whilst the risk score is in line with trajectory it is expected to be above tolerance until September 2025
- 59 linked risks on the Risk Register, a decrease from 51 at Q1
- 7 / 7 assurances seen as planned, 5 of which rated as partial assurance; 2 sources of assurance not rated

BAF 5: Digital Transformation

Chief Digital Information Officer | Strategy & Transformation Committee | Threat to:

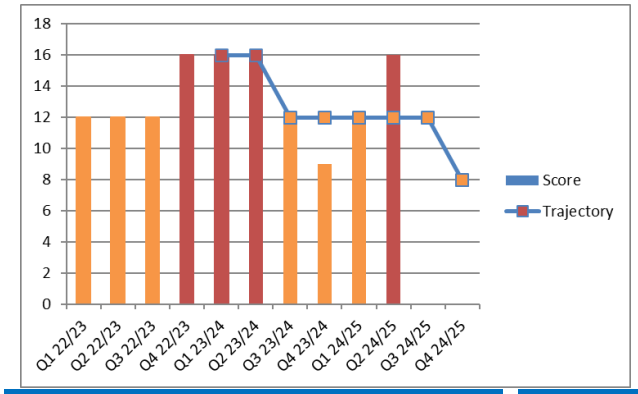
University Hospitals of North Midlands NHS Trust

If our digital solutions and services do not stay in step with modern practice, capabilities, and standards, then the opportunity to transform and improve services to support safety, quality or productivity are limited and UHNM may be unable to meet mandated national standards, resulting in compromised patient care, staff inefficiencies and geographic disadvantages along with a risk to our operating licence.

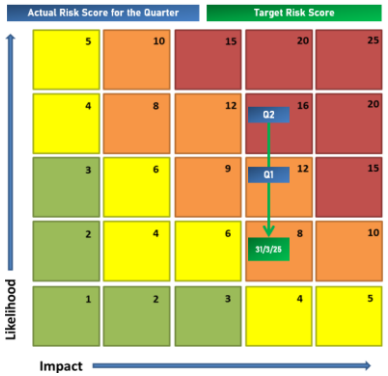
Assurance, Risk Ratings & Target

Acceptable Assurance	High 12	Ext 16	Q3	Q4	High 8 31/3/25

Risk Movement and Risk Reduction Trajectory



Heat Map Risk Matrix

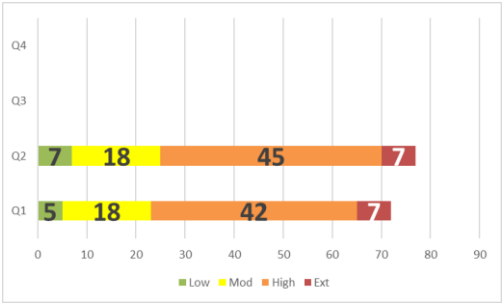


Rationale for Risk Level

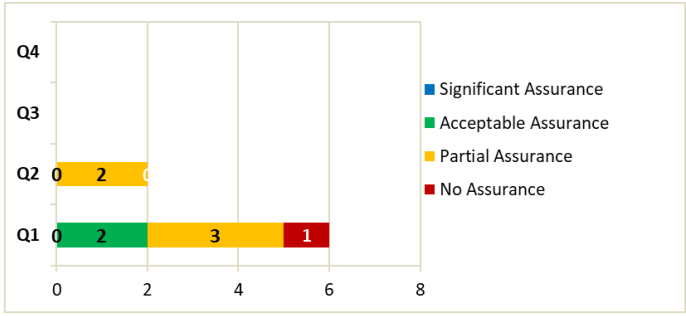
National funding for 25/26 onwards is not yet known so outline business case for the Staffordshire Electronic Patient Record in unable to proceed to Treasury for approval. The need to deliver cost improvement programme is requiring projects to be reprioritised and delayed. Current performance of iPortal is a challenge and having a significant impact of the delivery of clinical services.

Main gaps in control relate to end date of digital strategy, Chief Medical Information Officer vacancy, nationally mandated standards not being met and use of obsolete technology.

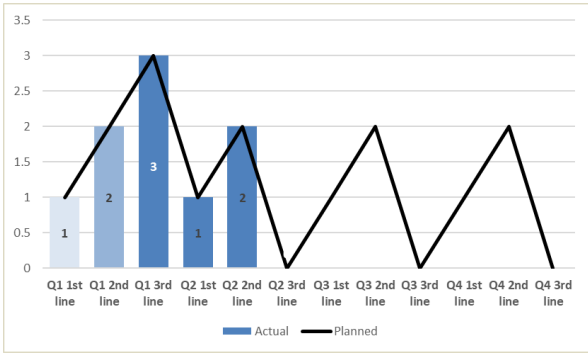
Linked Risks on Register



Committee Assassurance Outcomes



2024 / 2025 Assurance Plan



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	LIMS Go Live	31/10/2024				
2	EPR Outline Business Case	30/09/2024				
3	ePMA pilot	31/11/2024				
4	Business case for AI team	01/03/2025	N/A			
5	Update EPR OBC for UHNM	01/12/2024	N/A			
6	Review KLAS survey results	01/01/2025	N/A			
7	Deploy digital accountability framework	01/01/2025	N/A			
8	Move iPortal onto own infrastructure	01/12/2024	N/A			

Overview

- Risk score has increased above the trajectory and above the risk score tolerance
- Number of linked risks on the Risk Register slightly increased to 77 from 72 at Q1
- All 3 assurances seen as planned during the quarter, with one receiving a rating of no assurance

BAF 6: Fit for Purpose Estate

Director of Estates, Facilities & PFI | Performance & Finance Committee | Threat to:

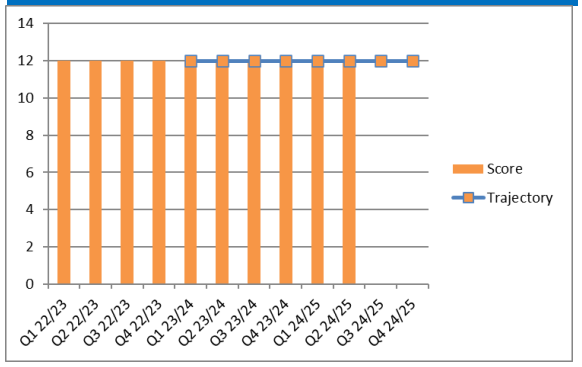
NHS University Hospitals of North Midlands NHS Trust

If we are unable to obtain sufficient investment to develop our estate infrastructure and workforce, then we may be unable to deliver high quality, responsive services in a safe, compliant and sustainable environment, resulting in the inability to achieve national standards, manage backlog maintenance, achieve Value for Money and deliver strong performance against Estates, Facilities and PFI Divisional objectives / KPIs

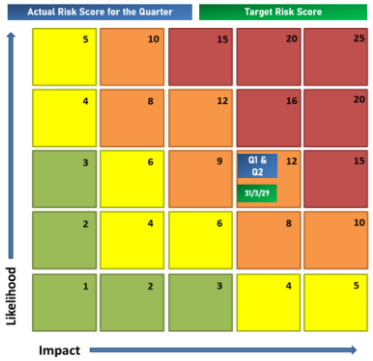
Assurance, Risk Ratings & Target

Acceptable Assurance	High 12	High 12	Q3	Q4	High 12 31/3/29

Risk Movement and Risk Reduction Trajectory



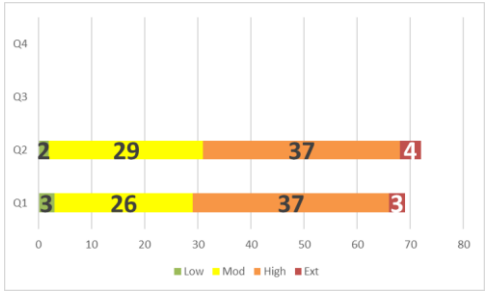
Heat Map Risk Matrix



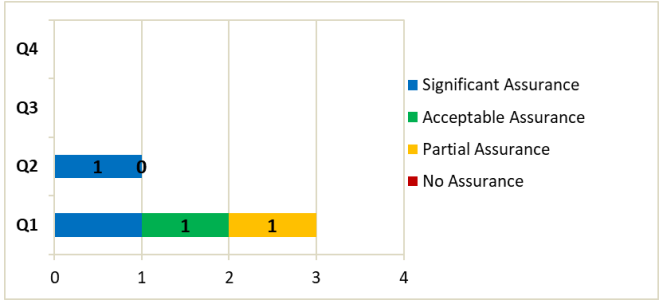
Rationale for Risk Level

- Insufficient capital allocation for 2024/25 and funding constraints
- Supply chain issues and external market influence on number of suppliers available to deliver large capital schemes
- Lack of worked up clinical / demand management plans
- Aging workforce profile and failure to recruit to key estates craftsmen roles
- PFI partners / lenders issues with agreeing formal variations to the Trust's changing requirements

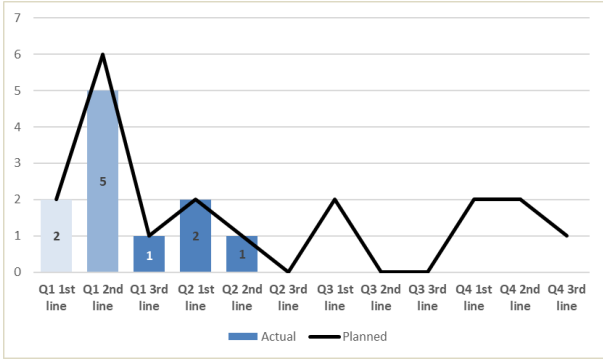
Linked Risks on Register



Committee Assassurance Outcomes



2024 / 2025 Assassurance Plan



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Funding allocation	31/12/2024				
2	Strategy preparation for future bids	31/03/2025				
3	Supply chain partners	31/03/2025				
4	Adapting to a changing climate	31/03/2025				
5	Sustainability/net zero carbon	31/03/2025				
6	Workforce	27/12/2024				
7	PFI partners / lender issues	31/03/2025				

Overview

- Risk score remains in line with trajectory and in line with tolerance
- Number of linked risks on the Risk Register has increase to 72 from 69 at Q1
- 3 / 3 assurances seen as planned; 2 sources of assurance not rated

BAF 7: Financial In Year Delivery

Chief Finance Officer | Performance & Finance Committee | Threat to:

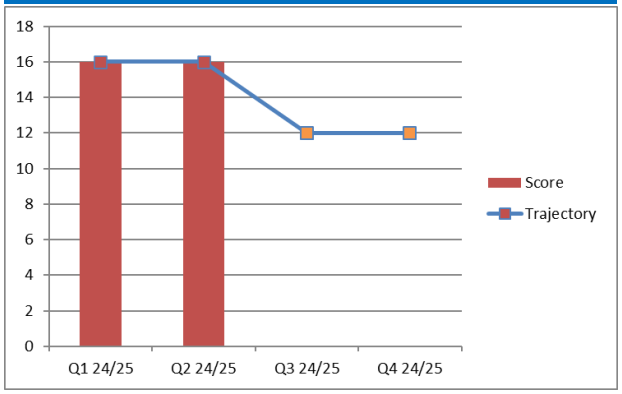
NHS University Hospitals of North Midlands NHS Trust

If we, or system partners, are unable to manage within the assumptions made in the financial plan for 2024/25, then we will be unable to meet our financial plan for 2024/25, resulting in an increased level of external scrutiny and intervention with a loss of control over investment decision making within the Trust

Assurance, Risk Ratings & Target

Partial Assurance	Ext 16	Ext 16	Q3	Q4	High 12 31/3/25

Risk Movement and Risk Reduction Trajectory

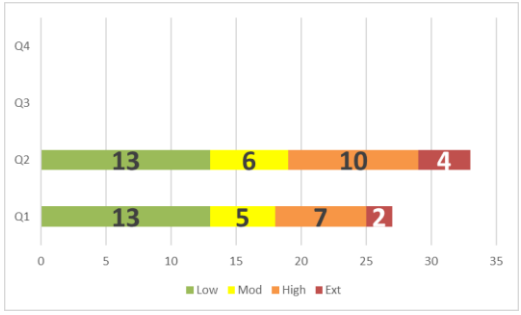


Heat Map Risk Matrix

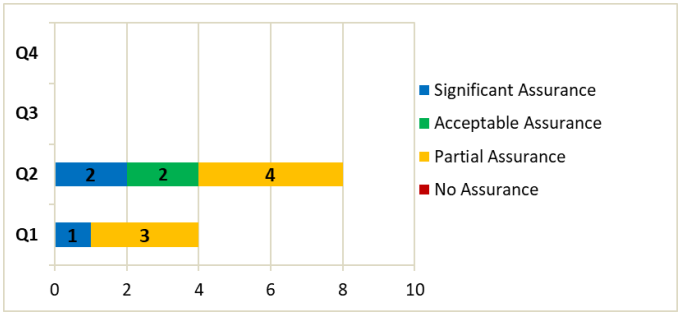
Rationale for Risk Level

- Financial plan has been signed off by the Board and a paper outlining key assumptions and risks has been provided
- Divisions have submitted their high-level cost improvement plans and are finalising Project Initiation Documents (PIDs)
- Systemwide Recovery Director in place leading on development of recovery plan
- Main gaps in control relate to a fully signed off CIP plan and the amount of recurrent versus non-recurrent savings in addition to the risk around Band 2 to 3 funding and temporary staffing spend

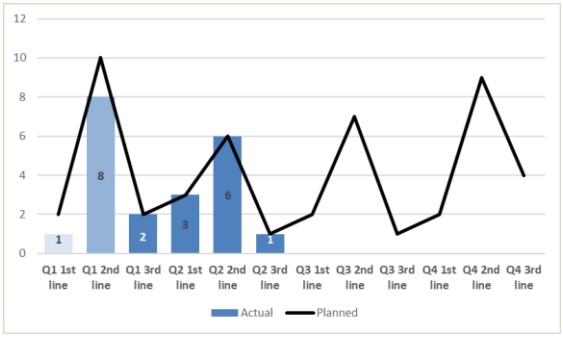
Linked Risks on Register



Committee Assurance Outcomes



2024 / 2025 Assurance Plan



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Identification of recurrent CIP	31/12/2024				
2	Ensure delivery of elective targets	31/03/2025				
3	Identification of non-recurrent mitigations to support the 2024/25 financial position	31/12/2025				
4	Work with Recovery Director to identify further mitigations	31/10/2024	N/A			

Overview

- Risk score in line with trajectory and expected to be above tolerance until Q4 2024/25
- Linked risks on the Risk Register has increased to 33 from 27 at Q1
- 10 /104 assurances seen as planned; 2 assurances not rated

BAF 8: Financial Sustainability

Chief Finance Officer | Performance & Finance Committee | Threat to:

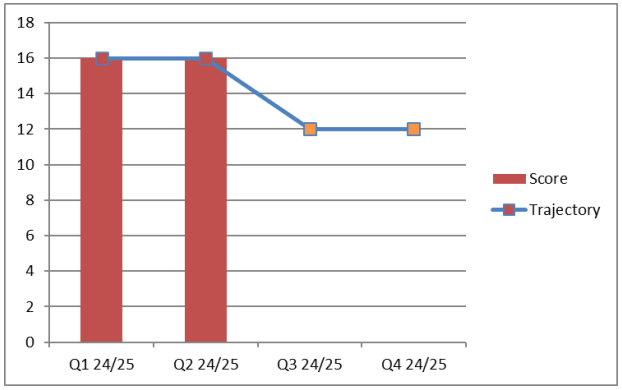
NHS University Hospitals of North Midlands NHS Trust

If we, or system partners, are unable to manage within the assumptions made within the financial plan for 2024/25, then our underlying financial position will deteriorate further, resulting in less funding being available for investments and an increased level of external scrutiny and intervention with a loss of control over investment decision making within the Trust

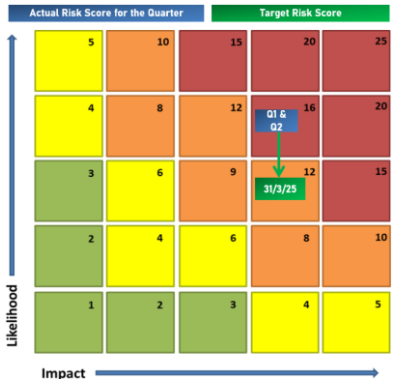
Assurance, Risk Ratings & Target

Partial Assurance	Ext 16	Ext 16	Q3	Q4	High 12 31/3/25

Risk Movement and Risk Reduction Trajectory



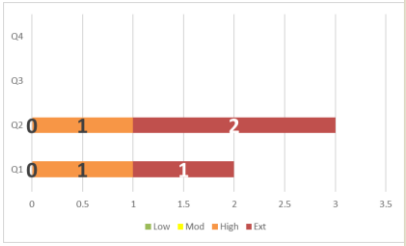
Heat Map Risk Matrix



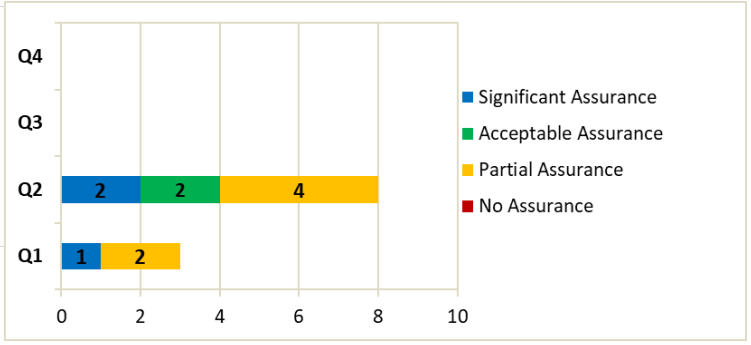
Rationale for Risk Level

- Financial plan for 2024/25 set with an underlying deficit of £58.7m; at month 5 we have reassessed this in light of actual performance during 2024/25 with the underlying deficit worsening by £27.2m to £85.9m as a result of under delivery of recurrent CIPs and in year recurrent non pay expenditure growth.
- Main gaps in control relate to a fully signed off CIP plan and the amount of recurrent versus non-recurrent savings in addition to the risk around Band 2 to 3 funding and business case sign off for winter and AMRAU

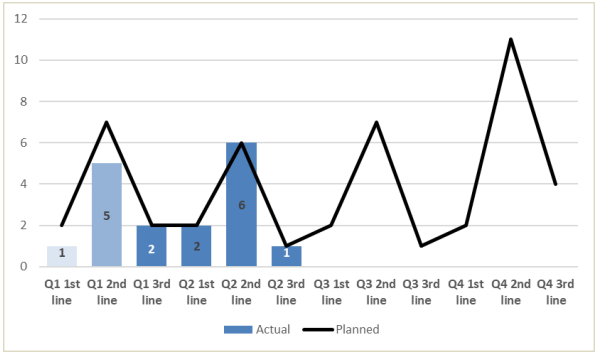
Linked Risks on Register



Committee Assurance Outcomes



2024 / 2025 Assurance Plan



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Identification and delivery of in-year CIP target	31/07/2025				
2	Review the opportunity to recurrently increase elective activity targets	30/09/2025				

Overview

- Risk score in line with trajectory and expected to be above tolerance until Q4 2024/25
- Second lowest number of linked risks on the Risk Register (3)
- 10 / 10 assurances seen as planned; 2 assurances not rated

BAF 9: Research and Innovation

Chief Medical Officer | Strategy & Transformation Committee | Threat to:

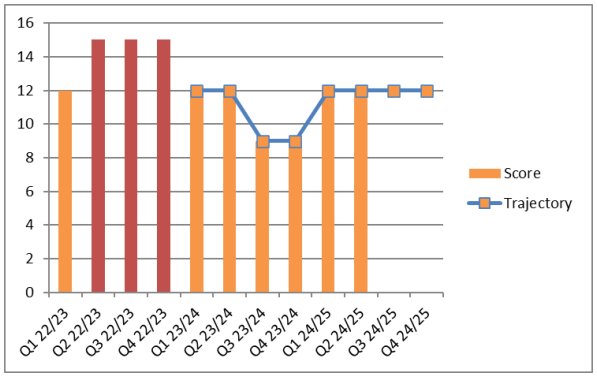
University Hospitals of North Midlands NHS Trust

If we are unable to secure sufficient capacity, resource and skills needed, then we may be unable to deliver the Research and Innovation Strategy, resulting in a failure to maintain our reputation as a successful researching University Hospital, offer patients the opportunity to participate in research, provide high quality innovative care, and attract and retain highly skilled staff, due to our research profile

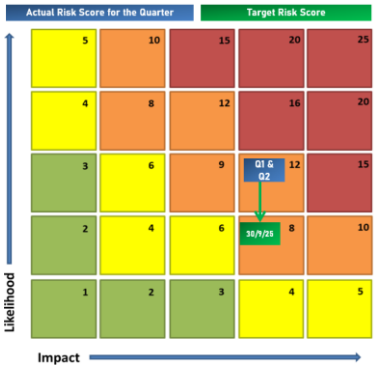
Assurance, Risk Ratings & Target

Partial Assurance	High 12	High 12	Q3	Q4	High 8 30/9/25

Risk Movement and Risk Reduction Trajectory



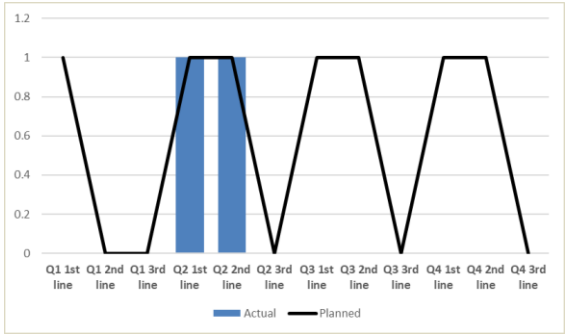
Heat Map Risk Matrix



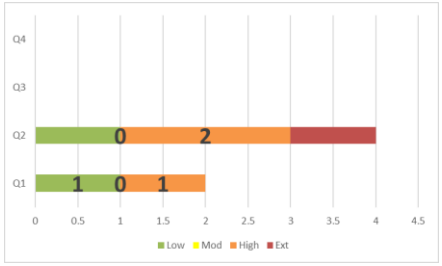
Rationale for Risk Level

- Risk score remained the same since Q1 and whilst positive progress has been made, research output continues to be below comparator Trusts
- Main gaps in control relate to determining the criteria for assessing joint appointments and research active staff, lack of mandatory GCP training and no dedicated research facility. Gaps in assurance relate to lack of reporting from CeNREE and research and innovation into Committees

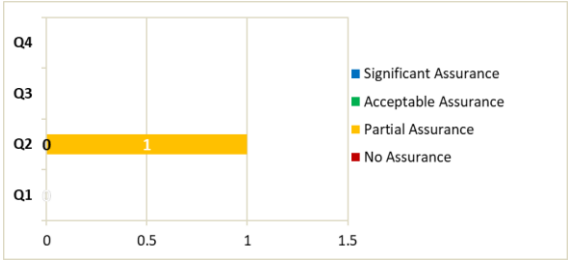
2024 / 2025 Assurance Plan



Linked Risks on Register



Committee Assassurance Outcomes



Summary Action Plan

No	Summary Action	Due	Q1	Q2	Q3	Q4
1	Research to form part of Divisional Performance Reviews	30/09/2024				
2	Research to form part of Divisional Board Agendas	31/12/2024				
3	Commissioning an external specialist to review QMS prior to MHRA inspection	31/12/2024				
4	Introduce CeNREE report to S&T Committee	31/12/2024	N/A			
4	Increasing patient and public involvement in developing research strategy	31/03/2025				

Overview

- Risk score remains in line with trajectory but expected to be above tolerance until 2025/26
- Third lowest number of linked risks (4)
- Very few items of assurance identified within the assurance map. 2 sources of assurance seen within the quarter, 1 rated as partial assurance and 1 not rated

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report (IPR)

Month 6 Performance 2024/2025

Delivering Exceptional Care with Exceptional People

Contents

NHS
University Hospitals of North Midlands
NHS Trust

Data Quality & Statistical Process Control

University Hospitals of North Midlands NHS Trust

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:

	Good level of assurance for the domain
	Reasonable Assurance with an action plan to move into Good
	Limited or No Assurance for the domain with an action plan to move into Good

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

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

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

Assurance Grid

Failing

Strategic Priority Domain Metrics Key

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

Assurance / Variation Key

Assurance

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

Variation

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

Aiming Here

Worsening

VARIATION

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

High Quality | Overview

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Overview from the Chief Nurse and Chief Medical Officer

How are we doing against our trajectories and expected standards?

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

We have met the required targets across a range of metrics including induction of labour, midiwfery triage, falls per 1000 bed days, pressure ulcers developed under UHNM, FFT inpatients, and sepsis inpatients.

Some metrics, whilst not at target, are seeing improvement in month including medication incidents with harm and ED sepsis. We failed to meet the required target for sepsis in maternity and children. We are also reporting 1 never event this month relating to wrong site surgery. Due to this inconsistency there is limited assurance.

ED transition to the new NICE Sepsis guidance was previously agreed however the team no longer want to pursue this as they introduce Vitals in ED . We had a CQC inspection in relation to the S29a at County on 4th July. We received confirmation from the CQC that we did meet the S29a requirements. The AMR Core Contract metrics have been provided for Q1 24/25. We are one of only 17% of Trust regionally (22% nationally) achieving a reduction in line with the target reduction in Watch and Reserve Antimicrobials

Our NICU has received the Baby Bliss Charter Bronze Award and our maternity team have maintained Silver and are now working to Gold status (which we hope to achieve within the next 2 years)

What is driving this?

Falls with harm reducing overall since peak in April 2022 however in month there were 7 incidents of falls with moderate harm or above.

Pressure Ulcers developed under the care of UHNM are reducing overall since peak in April 2022 and lapses in care continue on a downward trajectory since peak in Oct 2022

VTE assessment performance is predominantly poor due to the date and time not being recorded on the assessment form by the prescribers who carry out the assessment. This is required so we can demonstrate that an assessment has been done within 12 hrs of admission which is the metric we are required to report nationally. It should be noted that the numbers of hospital associated thrombosis (HAT) events is within expected values. Investigations into HAT cases demonstrate additional areas that need to improve, including missed doses of prophylactic heparin and inconsistent recording of mechanical thromboprophylaxis.

Processes for monitoring clinical outcomes through specialist teams (clinical effectiveness) remain immature and a high risk (16) persists on the risk register. Further work is currently being undertaken by the Transformation Office to evaluate existing processes and produce a gap analysis against best practice.

Sepsis is a directorate driver metrics and performance is monitored at both IPCC and the Divisional Performance Meeting

High Quality | Overview

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Overview from the Chief Nurse and Chief Medical Officer

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

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

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

UHNM are participating in regional work focusing on C-Diff to consider root causes of increased rates and any learning for organisations.

The never events thematic review was presented to QGC with key learning points identified

Intensive corporate support to Bronze CEF wards continues

What can we expect in future reports?

We will share the learning from the thematic review and infection prevention work as these are completed.

UHNM are in the first wave of Trusts implementing Martha's Rule. This work is progressing well and we are working proactively with our regional patient safety collaborative team. Communications about the initiative have commenced across the Trust

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

We have received a notification of concern from NMSI relating to a maternal death which has been shared with the ICB, NHSE and the CQC for transparency. This is under investigation and a summary report will be presented to QGC once completed.

We are monitoring the medical review element of MAU triage via the Divisional Performance meetings and will add narrative around this in future reports

High Quality | Dashboard

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Induction of Labour	95.0%	97.7%	98.0%						
Maternity Triage	85.0%	92.3%	90.5%						
Patient Safety Incidents rate per 1000 bed days	50.7	48.6	49.3						
Patient Safety Incidents with moderate harm and above per 1000 bed days	0.6	0.8	1.1						
Patient falls with harm per 1000 bed days	1.5	1.4	2.0						
Medication Incidents per 1000 bed days	6.0	5.6	5.9						
Medication Incidents % with moderate harm or above	0.5%	1.7%	1.6%						
Patient Safety Incident Investigation (PSII's) instigated	0.0	2.0	1.0						
Never Events per month	0.0	2.0	1.0						
Pressure ulcers developed under UHNM per 1000 bed days	1.6	1.5	1.3						
Family & Friends Test - Inpatient	95.0%	95.7%	95.9%						
Family & Friends Test - ED	85.0%	77.1%	70.8%						
Family & Friends Test - Maternity	95.0%	86.7%	83.3%						
Sepsis - Adult Inpatient Screening	90.0%	94.2%	96.8%						
Sepsis - Adult Inpatient IVAB	90.0%	100.0%	100.0%						
Sepsis - ED Portals Screening	90.0%	84.7%	87.0%						
Sepsis - ED Portals IVAB	90.0%	82.1%	87.1%						
Sepsis - Childrens Screening	90.0%	85.7%	82.9%						
Sepsis - Childrens IVAB	90.0%	n/a	0.0%						
Sepsis - Maternity Screening	90.0%	78.9%							
Sepsis - Maternity IVAB	90.0%	0.0%	33.3%						

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

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

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

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

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

Related Strategy and Board Assurance Framework (BAF)

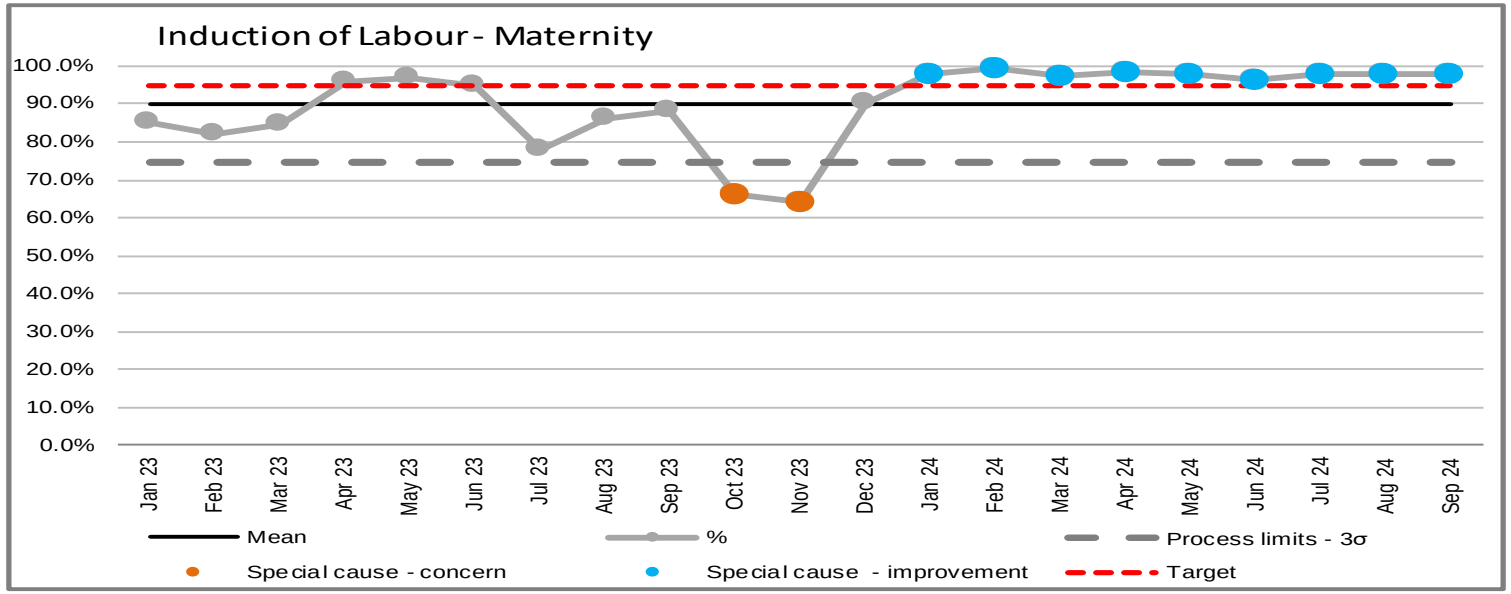
Quality Strategy

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

High Quality | [Induction of Labour]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	P

Target	Jul 24	Aug 24	Sep 24
95%	98.0%	97.7%	98.0%

Background

Induction of Labour Compliance

What is the data telling us?

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

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

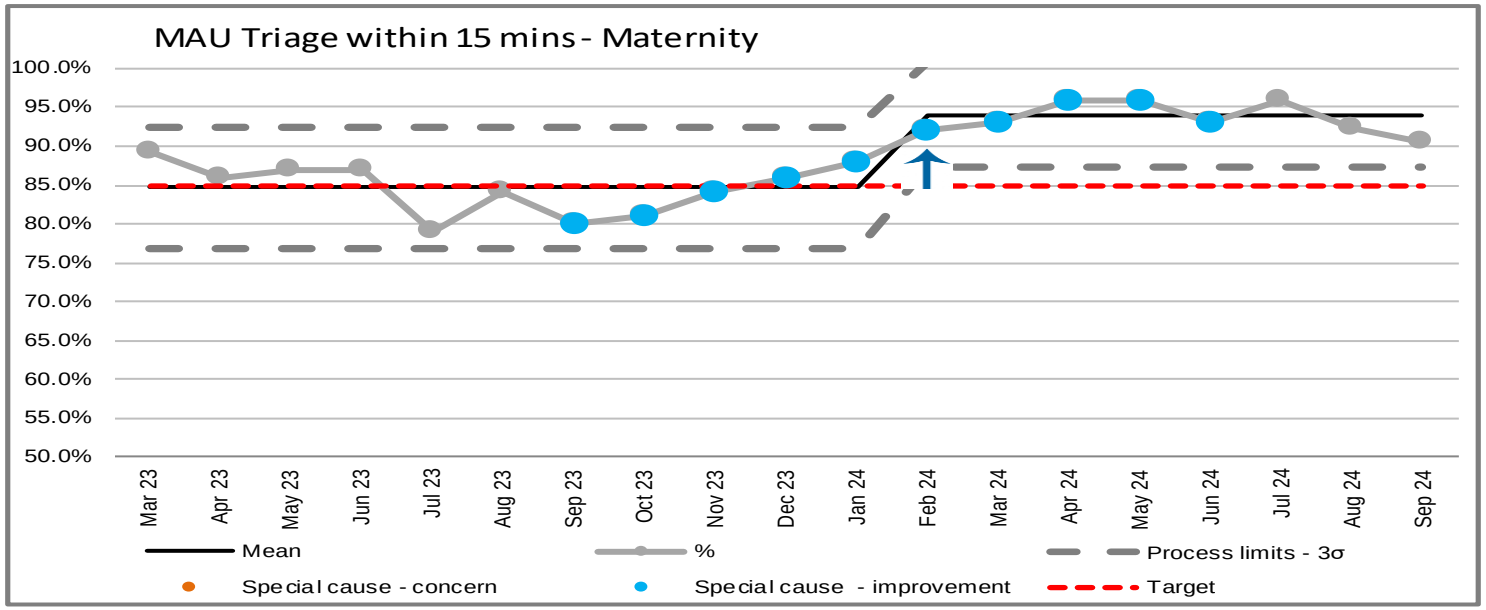
What are we doing about it?

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

High Quality | [Maternity Triage]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
85%	96.0%	92.3%	90.5%

Background

Maternity patients triaged within 15 minutes.

What is the data telling us?

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

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

The MAU improvement group will continue to monitor the numbers of patient triage in 15 minutes and will review the drop in September.

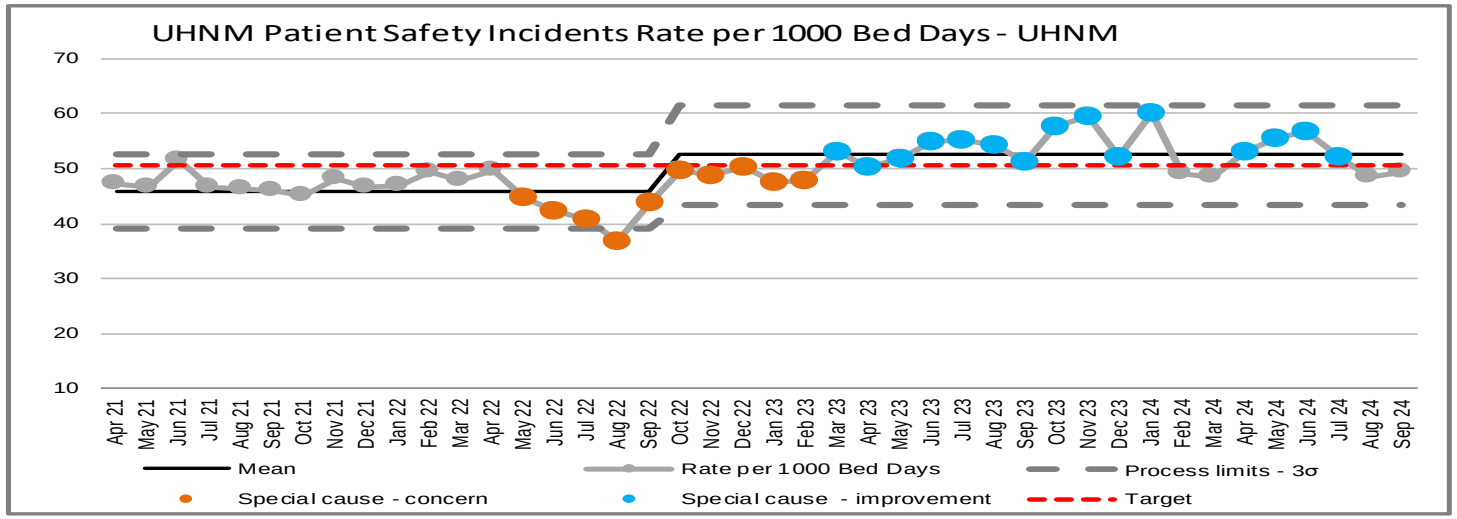
What are we doing about it?

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

High Quality | [PSIs per 1000 bed days]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

NRLS Mean	Jul 24	Aug 24	Sep 24
50.70	52.11	48.56	49.27

Background

Patient Safety Incidents rate per 1,000 bed days

What is the data telling us?

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

September 2024 is lower than 2023 with 49.3 compared to 51.5.

There is no significant variation in reporting rates although the rate has this month is slightly below the previously published NRLS average for Acute Trusts (new national LFPSE data publication is awaited)

What are we doing about it?

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

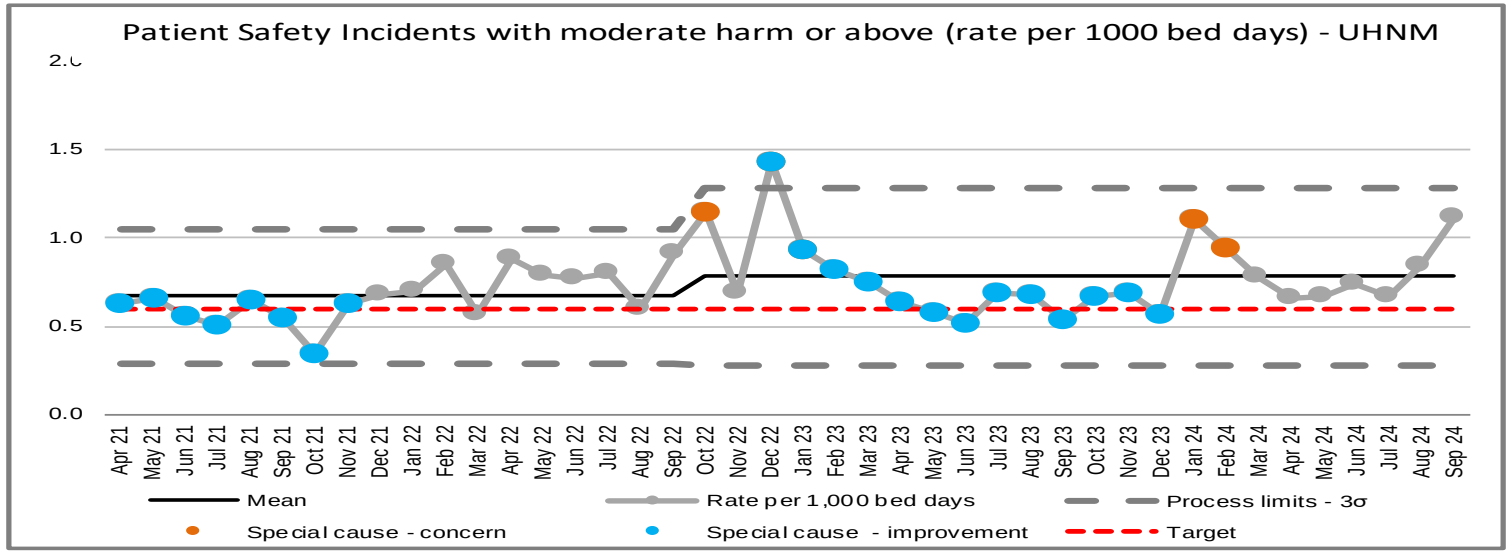
Will continue to monitor the internal reporting rates and identify if there are any specific reasons for reduced rate per 1000 bed days.

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

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
0.60	0.67	0.85	1.11

Background

Patient safety incidents reported with moderate harm and above rate per 1,000 bed days

What is the data telling us?

The rate of PSIs reported with moderate harm or above has increased during September 2024 but remains within normal variation.

What are we doing about it?

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

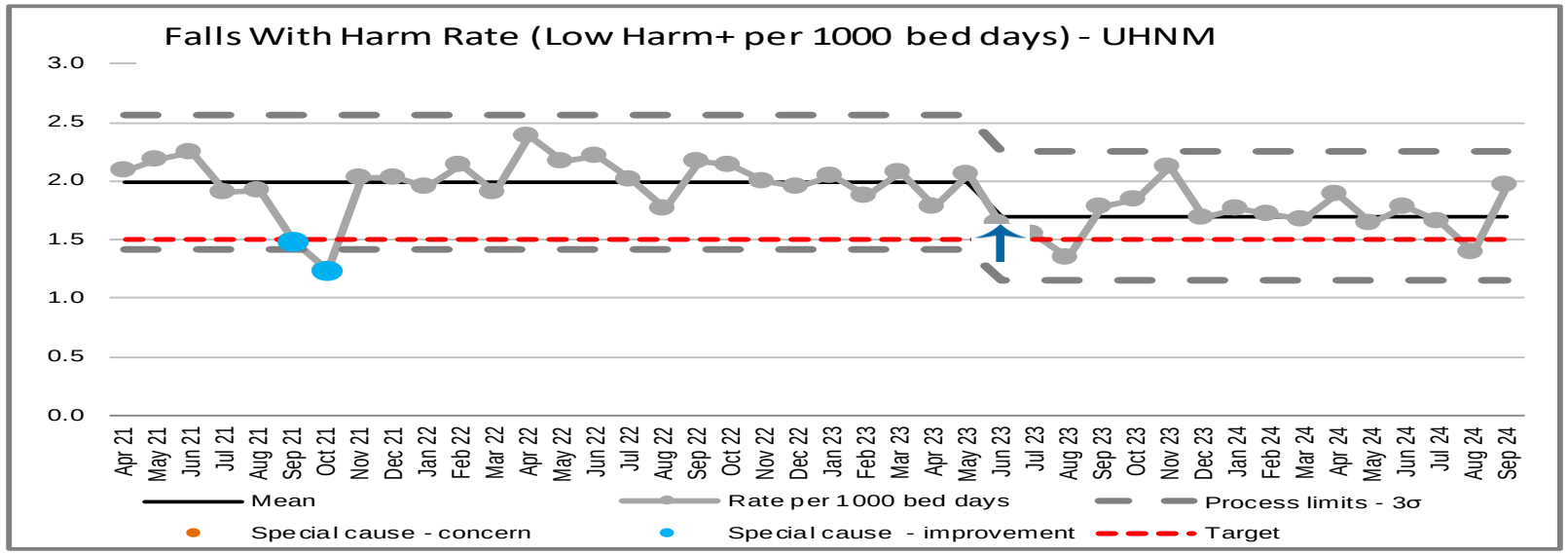
To support PSIRF principles we are reviewing learning and proportionate responses to incident reviews with formal review scheduled in October 2024.

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

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jul 24	Aug 24	Sep 24
1.5	1.7	1.4	2.0

Background

The rate of patient falls reported with low harm or above per 1000 bed days. Excludes collapses and managed falls

What is the data telling us?

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

7 wards have reported falls resulting in serious injuries in September (7 incidents)

What are we doing about it?

The wards listed have been visited and the falls toolkits have been completed with the staff. Investigations to the 7 injuries showed that in all cases the call bell had been a cause for concern.

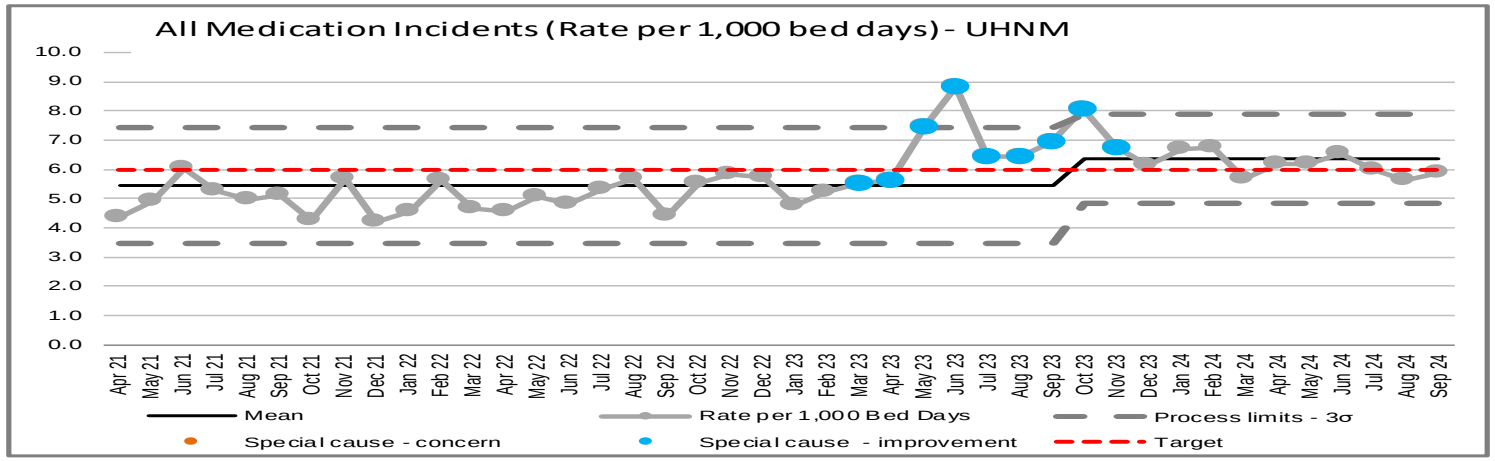
A global e-mail has been sent to encourage the use of the call don't fall posters to be displayed in all areas. The new call bell poster is currently being printed and then will be shared with all wards.

A call bell audit has been completed and learning has been shared with the wards:

High Quality | [Medication Incidents per 1000 bed days]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

NRLS Mean	Jul 24	Aug 24	Sep 24
6.0	6.0	5.6	5.9

Background

Reported Medication incidents rate per 1,000 bed days

What is the data telling us?

The longer-term trend is still showing improvement/increased reporting compared 2021 and 2022.

Recent themes includes insulin, anticoagulants.

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

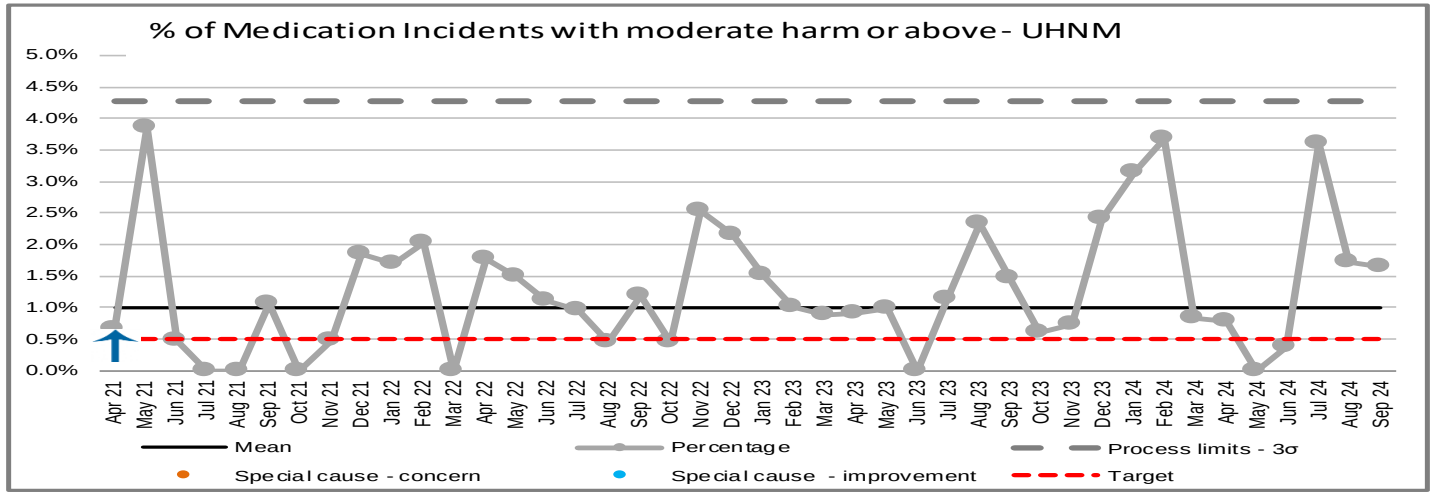
What are we doing about it?

- Insulin themed review group has started led by Q & S Team with MDT attendance, data analysis first step. To work with Insulin Safety Group as a number of workstreams in progress.
- Insulin Themed Review drafted and under review.
- Ward CD Audit (Q1 & 2) has been completed – results to be discussed at Meds Opt & Safety next week & shared via nursing / equivalent forums.
- Annual Medicine Storage Audit started 23/9/24
- Safety Alert for SGLT2 inhibitors approved via Medicines Optimisation & Safety Group.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
0.5%	0.39%	3.48%	1.35%

Background

The percentage of medication incidents reported as causing moderate harm or above

What is the data telling us?

The September results equates to 4 incidents

ID	Directorate	Location (exact)	Sub category	Actual Impact
343284	Maternity & Neonatal services	NICU	Administration to patient	Moderate Harm
342353	Oncology, Haematology & Medical Physics	Chemo Day Unit (County)	Adverse Drug Reaction	Moderate Harm
343863	General Surgery & Urology	SAU (RSUH)	Prescribing	Moderate Harm
344575	Oncology, Haematology & Medical Physics	Chemo Day Unit (County)	Adverse Drug Reaction	Moderate Harm

What are we doing about it?

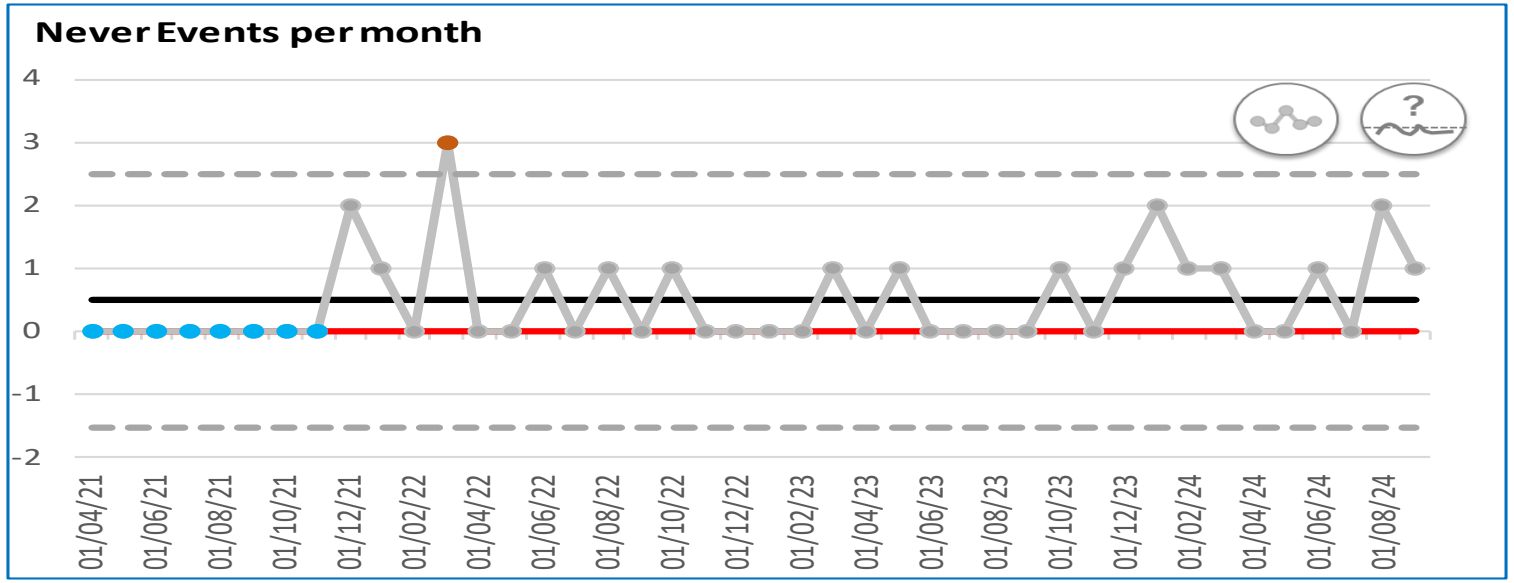
The reported incidents are reviewed and assessed via the Pharmacy Safe Medications Team along with input from the relevant clinical areas to share learning and actions

Review of Adverse Drug Reaction related incidents within Oncology & Haematology is being undertaken to identify any potential themes or issues in relation to reported adverse drug reaction related incidents.

High Quality | [Never Events per month]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



What is the data telling us?

There has been 1 reported Never Events during September 2024.

Latest incident related to wrong site surgery which occurred at start of September 2024.

- Incorrect skin lesion on patient's scalp removed for biopsy.

What are we doing about it?

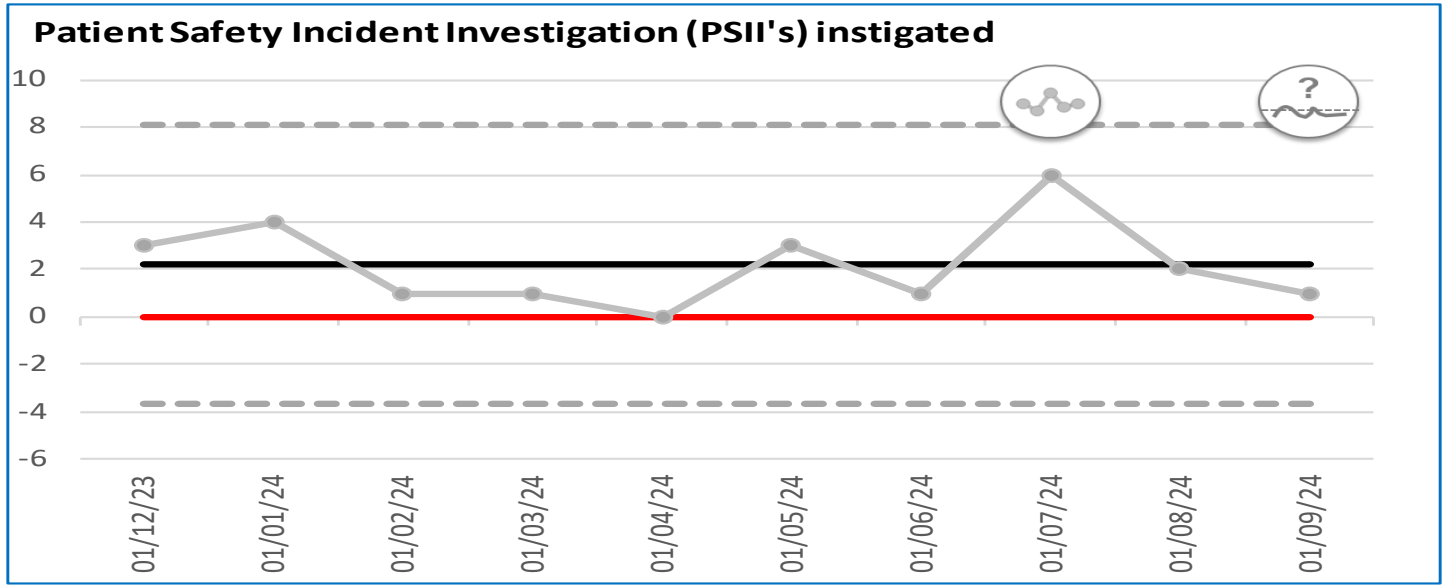
The Never Events reported during 2024 which relate to Wrong site surgery (incorrect lesions removed or biopsy) are under review within Specialised Surgery services utilising PSIRF Patient Safety Incident Investigation along with thematic review of these new incidents and previously reported wrong site surgery / incorrect lesion removed from previous years to assess the actions and system solutions to mitigate these type of incidents. Actions and new processes to be approved at Skin Away Day in September 2024 and reported at RMP.

Benchmarking against national reporting of Never Events and assessing national best practice.

High Quality | [PSIIs per month]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



What is the data telling us?

We have agreed 1 new PSII being undertaken, and reported on STEIS as agreed with ICB, during September 2024. This PSII is for the reported Never Event noted for incorrect lesion as per national requirement for Never Events to have full individual PSII response under PSIRF.

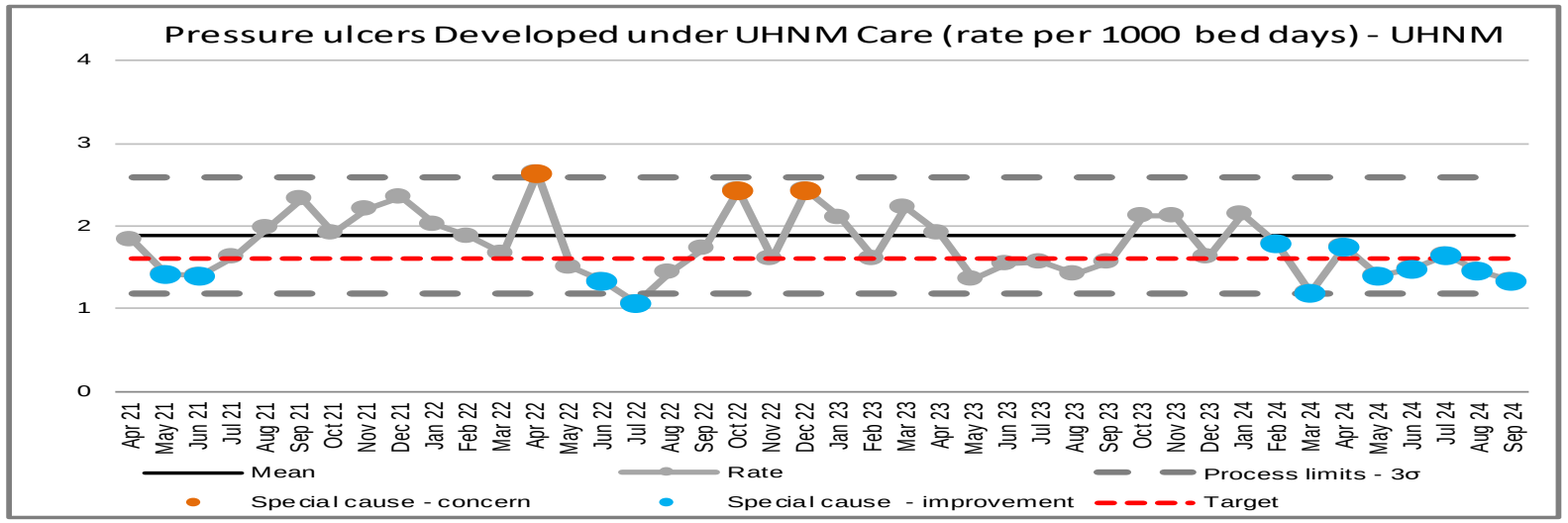
What are we doing about it?

PSII continue to be responded to under PSIRF and system-based learning identified where possible. PSIIs are reviewed at Trust Risk Management Panel chaired by Deputy CMO with other senior medical and nursing representatives.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
1.6	1.66	1.47	1.33

Background

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

What is the data telling us?

The rate of pressures ulcers reported as developed under UHNM care was has been below the average for the past 8 months which may indicate significant change.

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

As well as pressure ulcers, 4 urethral splits were reported in September, 2 with lapses identified. This is significantly below the average for a second month.

What are we doing about it?

Education available for pressure prevention, continence, wound assessment, and lower limb.

Stop the pressure in November to focus on Inclusivity, including skin tone and end of life care. To launch the ESR package and Tissue Viability Champions

Consultant Connects to be trialled in AMU with full training to be delivered.

Focus of the month has been shared focusing on assessments and Purpose T

Company creating prompt cards to include supporting pressure prevention, categorisation, and appropriate pathways

Wound assessment and skin health booklet is going through final approval and then be available to order

Chair evaluations taking place in critical care and the west building. Annual mattress audit to be completed in October.

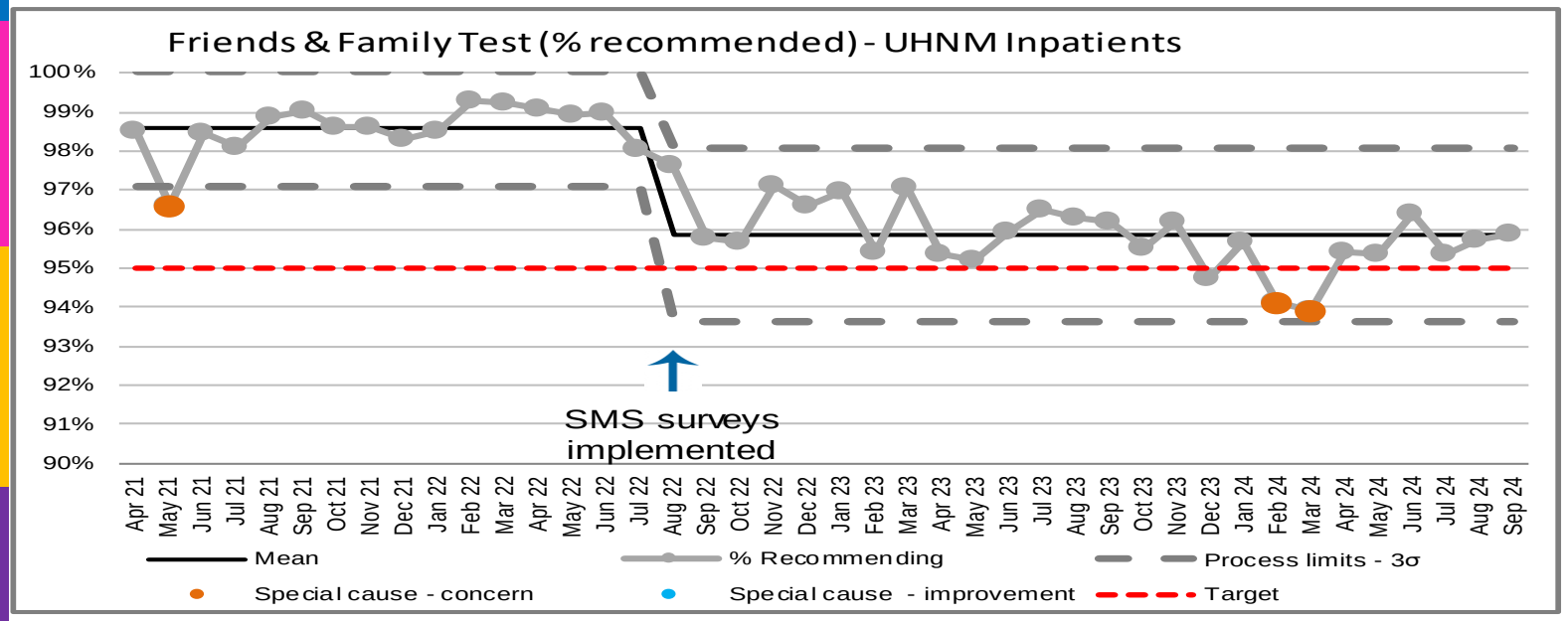
Evaluation of the Trezzo mattress has been completed in ED with positive feedback

To look at stop using Datix for referrals and areas to use the referral service if specialist input required.

High Quality | [Friends & Family Test - Inpatients]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
95%	95.4%	95.7%	95.9%

Background

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

What is the data telling us?

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

In September 2024, a total of 3044 responses were collected from 67 inpatient and day case areas (11638 discharges) equating to a 26% return rate. NHS England data was updated in August 24 and UHNM had the 10th highest response rate for all reporting Trusts in the country (154) and are 78th for percentage positive responses.

- Scores split by Division:
- Network- 27% response rate 97% satisfaction score
- Surgery- 26% response rate 94% satisfaction score
- Medicine- 29% response rate 95% satisfaction score

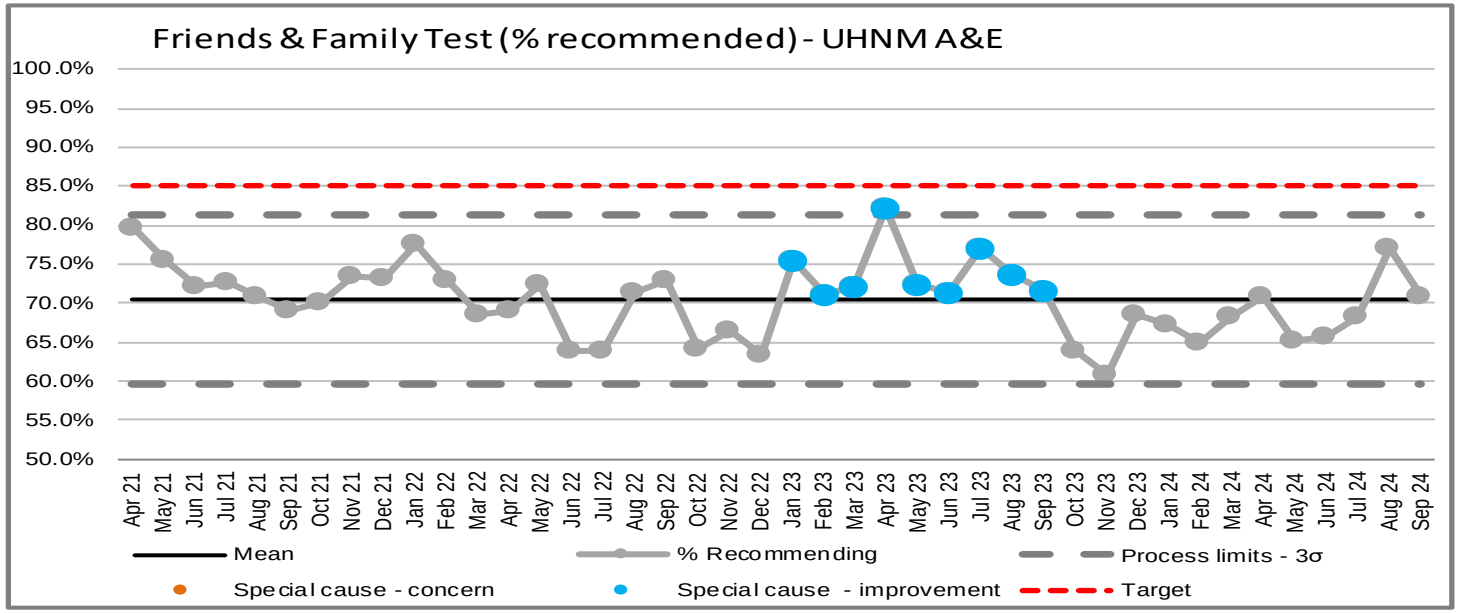
What are we doing about it?

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

High Quality | [Friends & Family Test - ED]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
85%	68.2%	77.1%	70.8%

Background

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

What is the data telling us?

The overall satisfaction rate for our EDs was within the usual range in September 2024, some way below the target.
The Trust received 1129 responses which was 8% and remains the same as the previous few months. The Trust's overall satisfaction rate is 76% while the national average is 83% UHNM is 45th out of 125 Trusts for the number of responses in ED (NHS England August 24), and 73rd out of 125 Trusts for the percentage positive results (NHS England August 24- latest figures)

Feedback from patient experience of using 111First and the kiosks continues to be monitored with 21% of respondents in September 2024 reported to have used 111First prior to attending ED, which is a slight decrease on the previous few months. Key themes from September 2024 continue to be long waits for both sites. Cleanliness was highlighted at RSED alongside staff attitude, while wait times and communication were key themes at County.

What are we doing about it?

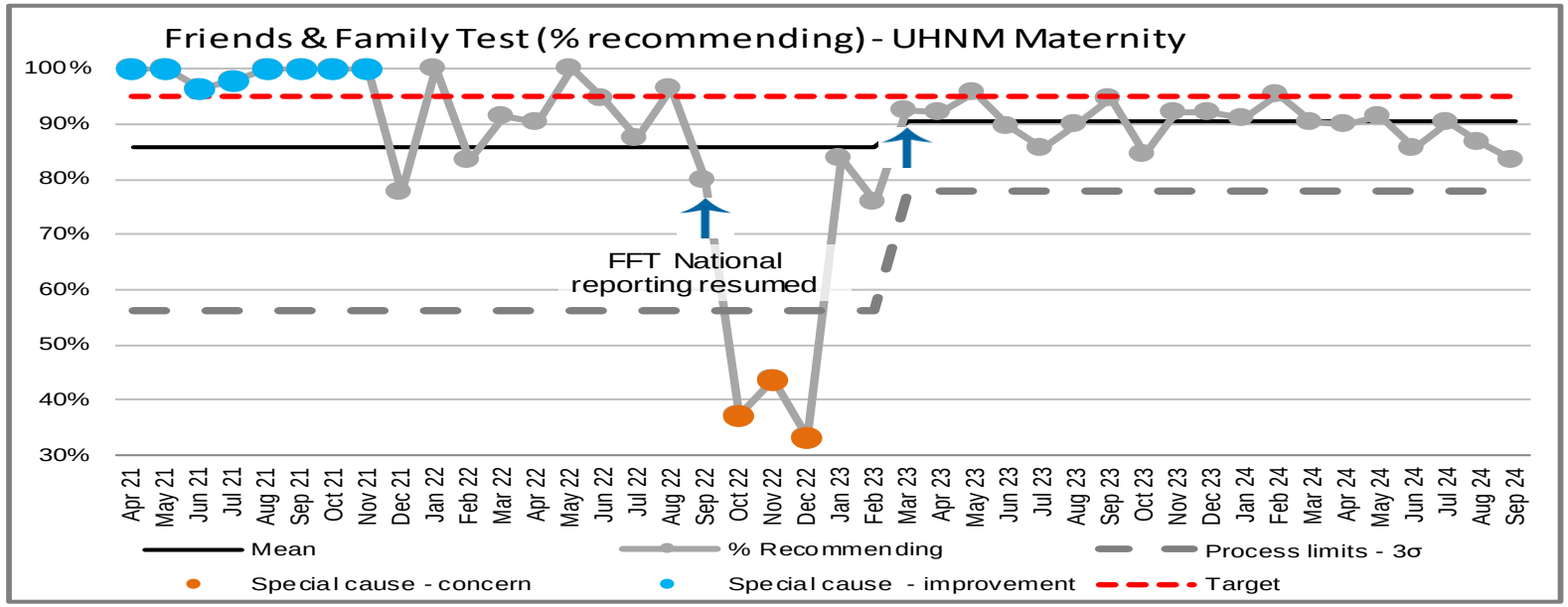
QR code made visible throughout the department.
Consideration to alternative methods of sharing QR code such as "business cards" available on reception and throughout the department.
Discuss with Dept Leads regarding ensuring mobile phone numbers are recorded in the "mobile" phone part of Iportal (not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

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

High Quality | [Friends & Family Test - Maternity]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
95%	90.4%	86.7%	83.3%

Background

FFT Maternity % patients Recommending Service

What is the data telling us?

The average % recommending has been stable at around 90% since 2023, a little below the 95% target.
There were a total of 204 surveys received in Sept 2024 across all 4 touch-points (ante-natal, birth, post-natal ward; post-natal community) with 52 of these being collected for the "Birth" touch-point, providing a 10% response rate (based on number of live births) and a 88% satisfaction score which is a decrease on the previous month.
The Antenatal touch point scored 63% satisfaction (63 surveys) which is a significant decrease in satisfaction. The post-natal ward touch point scored 94% satisfaction rate (89 surveys) which is a big increase in both volumes of surveys and satisfaction.
Compared to the latest national data available (August 24) out of 111 reporting Trusts, UHNM were 46th for number of responses for antenatal & 100th for percentage positive; 17th for number of responses for birth & 95th for percentage positive, 60th for post-natal ward. No data was submitted for post-natal community in Sept 24.

What are we doing about it?

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

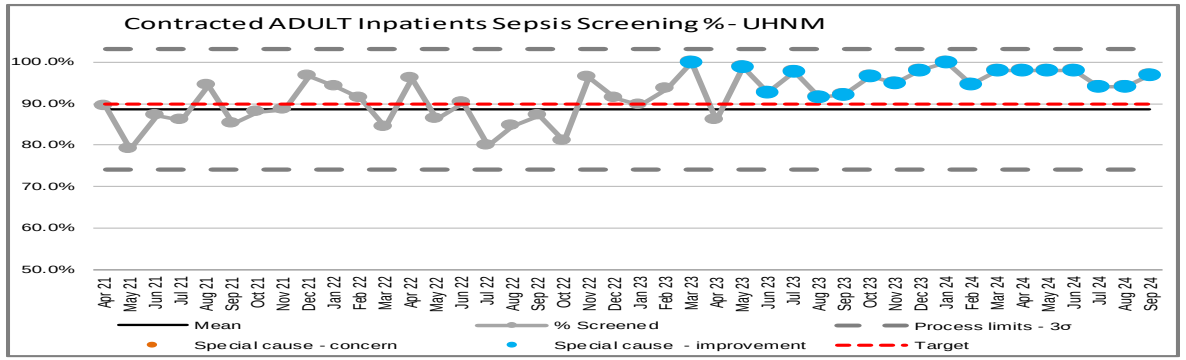
Look at incorporating the questions from the National Maternity Survey which requires the most improvement into the FFT survey.

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

High Quality | [Sepsis – Adult Inpatient]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

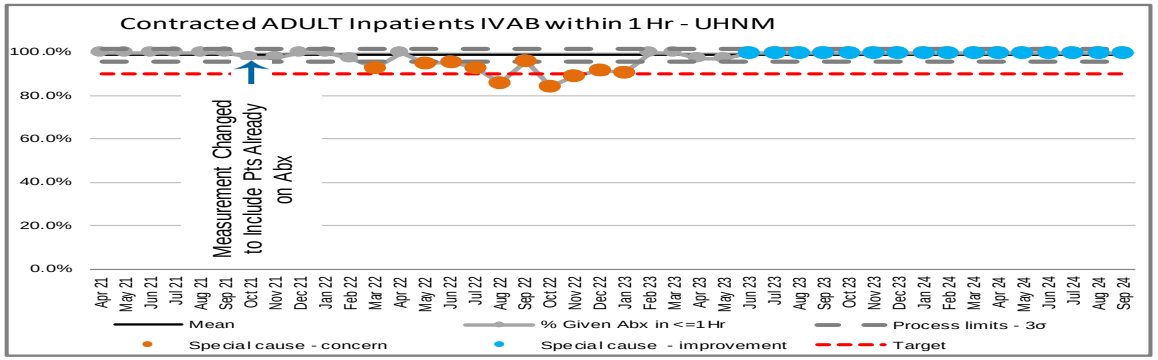


Variation	Assurance
H	?

Target	Jul 24	Aug 24	Sep 24
90%	94.1%	94.2%	96.8%

Background

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



Variation	Assurance
H	P

Target	Jul 24	Aug 24	Sep 24
90%	100.0%	100.0%	100.0%

Background

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

What is the data telling us?

Inpatient areas achieved the screening and IVAB within the 1-hour target for September 2024.

There were 94 cases audited with 3 missed screenings. Out of 94 cases audited 61 were identified as red flag sepsis with 40 having alternative diagnosis. 20 patients were already on IVAB treatment.

All true red flag sepsis patients received IVAB within 1 hour

What are we doing about it?

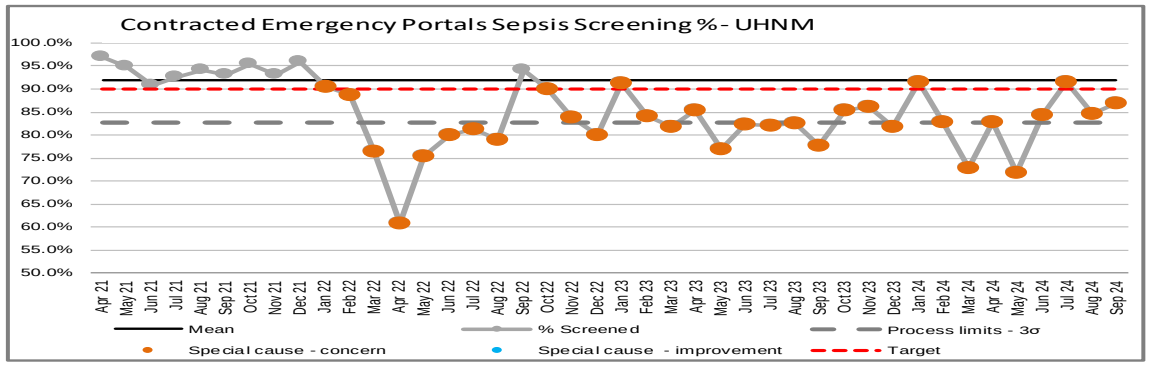
Sepsis sessions / kiosks continue to all levels of staff in the clinical areas that require immediate support.

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

High Quality | [Sepsis – Emergency Portals]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

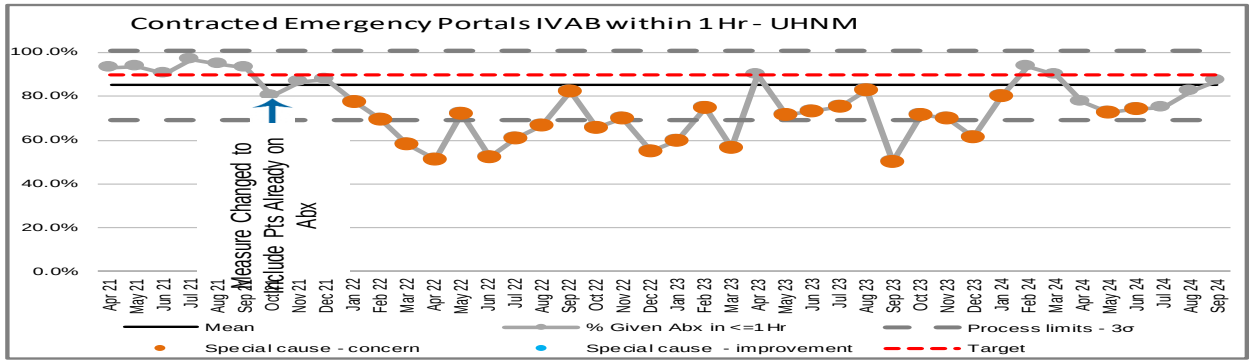


Variation	Assurance
	

Target	Jul 24	Aug 24	Sep 24
90%	91%	85%	87%

Background

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



Variation	Assurance
	

Target	Jul 24	Aug 24	Sep 24
90%	75%	82%	87%

Background

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

What is the data telling us?

Adult Emergency portals screening is failing the target for September 2024 with 87%. Contributed to ED at Royal Stoke, SAU and AMU at County . There were 69 cases audited with 9 missed screening in total from the emergency portals. The performance for IVAB within 1 hour improved to 87%

Out of 69 cases there were 58 red flag sepsis in which 13 patients were already on IVAB. 27 patients had an alternative diagnosis leaving 18 newly identified sepsis 4 patients received IVAB outside the target 1 hour window.

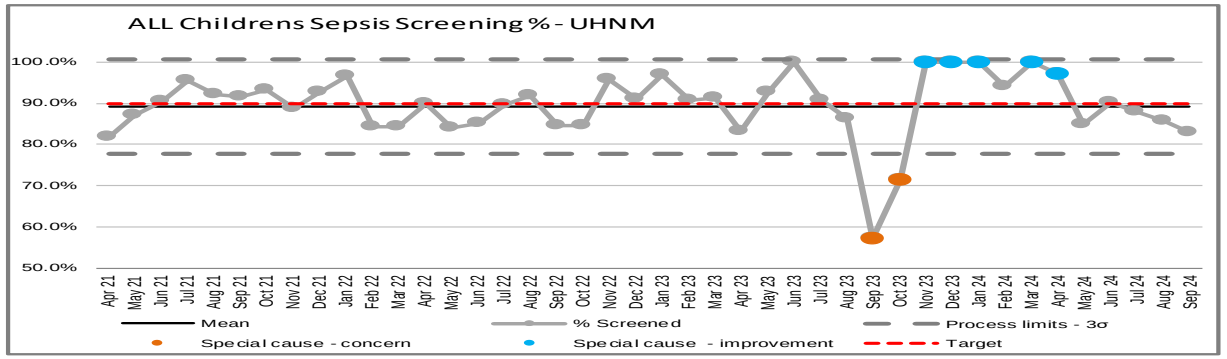
What are we doing about it?

- The sepsis team continue by closely monitor compliance by visiting and auditing ED regularly.
- Regular meetings with ED senior team with robust actions in place.
- Face to face sepsis induction / training for new nursing staff, nursing assistant and medical staff continue.
- ED at County have moved to Vitals on 30th September and ED Royal are planned for the 4th November.

High Quality | [Sepsis – Children]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

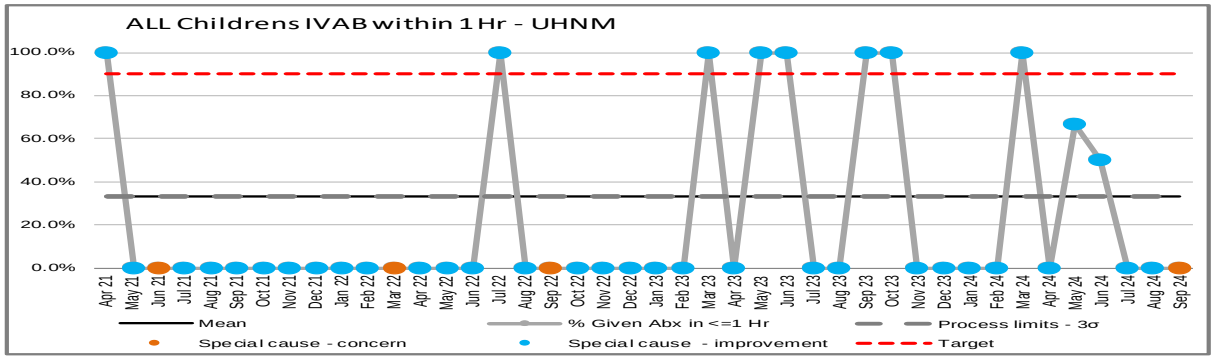


Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
90%	88.0%	85.7%	82.9%

Background

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



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
90%	n/a	n/a	0.0%

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?

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

There were 36 cases audited for emergency portals with 1 missed screening.
1 true red flag sepsis was identified from the randomised however they received IV antibiotics outside of the 1 hour window.

What are we doing about it?

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

Work ongoing for the implementation of the national PEWS chart and sepsis screening tool guidelines.

High Quality | [Sepsis – Maternity]

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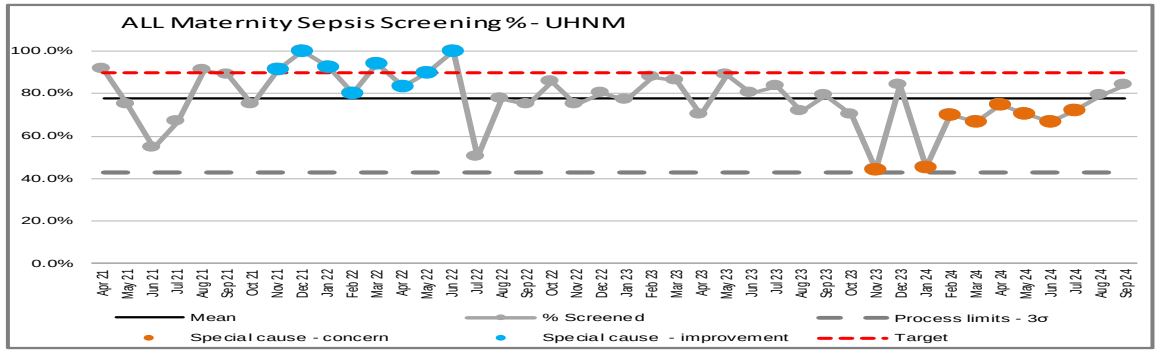
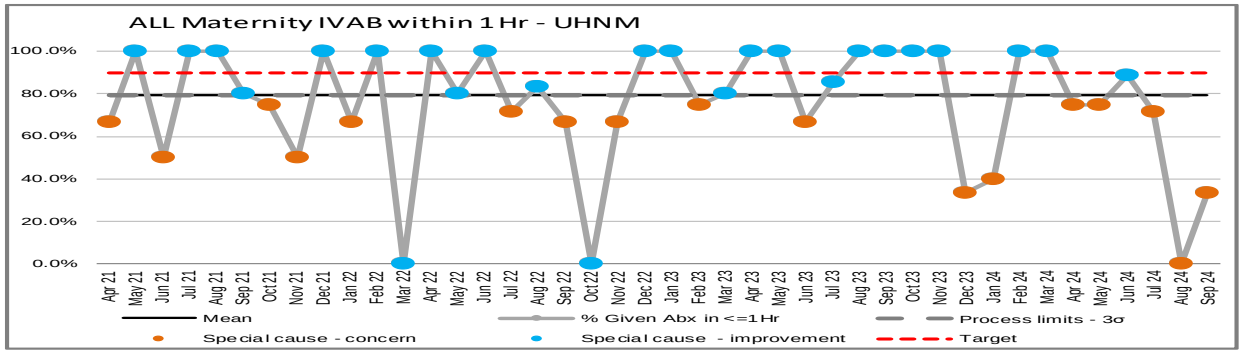


Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
90%	72.2%	78.9%	84.2%

Background

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



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
90%	71%	0%	33%

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

There were 10 cases audited from emergency portal MAU with 1 missed screenings. Inpatient had 9 cases audited with 2 missed screenings.

What are we doing about it?

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

Regular collaborative work with maternity educators and senior team, to discuss the audit findings and plan of improvement.

Responsive | Overview

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive

Overview from the Chief Operating Officer

How are we doing against our trajectories and expected standards?

Non-Elective

The 4-hr performance standard is 76% climbing to 78% in March 2025. September validated position is 69.2% which is 3.8% below the August outturn and is 2.9% below our improvement trajectory. This is first time in 7 months that we have not achieved greater than 70%.This however, this is higher than 2020. Our relative performance is now in the lower 3rdquartile of Trusts regionally and nationally. We have also seen deterioration in our 12hour performance but remain in the 2nd quartile.

September has seen an increase in our number of patients spending more than 12 hrs from arrival in ED. This has moved from 1,221 validated to 1,799, a 32.13% increase.

The data provided by West Midlands Ambulance Service (WMAS) is provided a month in arrears.
Ambulance Cat 2 mean time has continued to reduce since January 2024 where the average Cat 2 mean was 43.34 minutes. The most current reportable data we have suggests the mean time was 26.24 minutes

Elective

We overachieved against the Cancer 75% 28-day standard for 4 months from May to August. The combined 62-day performance was reported at 66% in August and UHNM have met the trajectory for 4 out of 5 months of the year. September is incomplete and still being validated, the current position of 57% is predicted to improve. Wait for colonoscopy reduced from 47.6 days in August 2023 to 15.9 in Sept 2024 as a result of the significant increase in endoscopy capacity, including the mobile unit.

The September diagnostic DM01 performance data is unvalidated at time of writing this report. however current performance is at 54.5% against the 95% six week standard. This is a continuation of the monthly deterioration over the last 5 months (August 57.5%), largely as a result of Non Obstetric USS, which reduced to 40.09% in August, a 5% deterioration on previous month. The deterioration has been due to a 44% vacancy factor in this team and a delay in identifying an independent sector partner to provide additional in-sourcing capacity, now expected to commence from 24/10. Performance in Endoscopy at is 45.32% an increase of 8.5% compared to August. At the end of September there were 376 patients that had waiting >6weeks for their planned or surveillance endoscopy v the 419 trajectory, in April there were 4094 patients waiting. This has been possible due to investment in the mobile endoscopy unit and insourcing to ensure 100% of Trust capacity was used.
Echocardiogram performance has deteriorated from 50.28% in July to 47.55% in August, however a locum commenced in post in late September and performance in October is expected to improve as a result.

The number of patients waiting over 65 weeks for their treatment reduced from 609 in August to 206 in September. We are expecting c109 breaches of the 65 week standard in October against the national zero target, due in the main to ENT in common with several other Trusts regionally. The number of patients waiting 78 weeks or more for their treatment ended at 11 for September which was 1 less than August. There is 1 reportable 104 week breach in September, which was again related to data quality error at the start of the patients pathway. As a Tier 1 Trust, NHSE national and regional teams have weekly oversight of improvement trajectories and associated actions.

The number of patients over 52 weeks reduced to 2765 September, 554 less than August. Plans to achieve a maximum 52 weeks waiting time by March 2025 have now largely been developed by Divisional teams with a number of ERF bids approved. The proportion of patients waiting 52+ weeks who have reached a decision to admit is currently 36%. Our national ranking improved from 145th to 136th in August

A temporary increase in validation capacity commenced in August and it is expected to be completed by the end of October, over which time 12k patient pathways across RTT and Endoscopy will be validated. Patient cohorts being validated are from within a number of high-risk / failsafe groups. We are working with NHSE to ensure that all patients identified are treated within 4 weeks.

We achieved 56.08% performance against the 92% incomplete trajectory in September, an improvement for the 6th consecutive month

Responsive | Overview

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University Hospitals of North Midlands NHS Trust

Responsive

Overview from the Chief Operating Officer

What is driving this?

Non-Elective

4-hour performance is in line with trajectory and is, because of the improvements in County Hospital and the improved usage of the Clinical Decisions unit as well as the Workstream 1 (non-admitted) at Royal Stoke Hospital.

We remain within our expected trajectory for Emergency Department attendances - September activity out turned at 22,796 verse August out turn at 23,661 attendances which equates to a 3.77% decrease. Flow for our patients in our Emergency Departments requiring inpatient treatment has also deteriorated and is still below the daily requirement to hit the end of year standard. Both admitted and non-admitted pathway, during September, has been problematic in core hours and out of hours due to a continues cycle of 'doing yesterday's work today'.

The number of patients waiting an aggregated time of arrival greater than 12 hours increased in September. September demonstrated an increase of 578 patients. An overall increase of 32.13% compared with August; the availability of medical inpatient beds and timeliness of accessing has continued to be the primary issue even with the new AMRAU. The expectation and standard associated with Clinically Ready to Proceed is within 60 minutes of final intervention by the emergency department and is set at 95%. September achieved 39.67% of our patients accessing their onward pathway.

Both the capacity of Emergency Departments (overcrowding) and the profile of ambulance arrivals (variation can be up to 22 ambulances/hours) has impacted on the ability to offload in a timely manner. There are improvement opportunities identified where handover reporting, and release process can reduce the amount of time patients wait to be handed over and ambulance crews wait in our departments. We are now in a detailed planning phase to enable an infrastructure whereby no crews breach a 45-minute handover. This is being monitored very closely.

Elective

The increase in capacity funded through ERF bids, NHSE, Cancer Alliance has supported the reduction in the number of patients over 65weeks. The mobile endoscopy unit which opened in August has continued to routinely see 28 patients per day (c727 per month), supporting a significant reduction in patients waiting for planned and surveillance endoscopies. ENT, Respiratory and Gastro have all increased their capacity using independent sector in-sourcing contracts.

NOUS performance deteriorated further, and this is likely to continue whist the IS partner that has now been contracted commences in late October.

Our 1 patient that breached the 104-week standards was identified following consultant validation. The patient had attended in 2022 but had not been added to a waiting list following clinician to clinician advice being sought. An investigation is currently underway to identify any similar patients affected.

Responsive | Overview

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

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

Non-Elective

Work continues within workstreams 1, 2, 3 and 4 to improve our non-elective flow and responsiveness to meet demand, improve patient experience and safety.

The Trust had agreed to go live in the first wave of Trusts for the Midlands with early handover of ambulances. This was intended to start with a pilot on the 30th September, however an assessment of the site position mean this did not take place and we retain a risk based approach to rapid handover.

The Deputy Chief Officer for Delivery and PMO Transformation Lead for Non-elective are evaluating the effectiveness of all 4 Non-Elective workstreams and metrics.

The new Same Day Emergency Care Unit at Royal Stoke hospital site was 'handed over' and confirmed to become operational on 2 August 2024 and is now fully functional by the end of August, initial indications of its impact are very positive.

Elective

Endoscopy services continue their three-part improvement plan for the resolution of demand versus capacity. A mobile unit became operational from mid-August 2024. 727 patients will have their tests through the unit each month - this has helped to significantly reduce our surveillance/planned backlog and support diagnostic recovery ahead of agreed trajectory. In addition to this we will continue to insource additional capacity funded by cancer alliance and ERF funding throughout Q1-4. The 3rd element is the development of a sustainability business case for endoscopy to provide recurrent staffing which is expected to be presented to the Executive Team in late October.

Whilst there was an initial delay in mobilising the approved ERF bid for ENT, as expected this improved in September as our insourcing provider identified a larger cohort of consultants available. Following extensive efforts and with support from NHSE, we have been able to identify a potential IS partner (Nuffield Hospital Chester), who are equipped to operate on our patient case mix. Unfortunately, due to higher IS tariff costs there will be an overall financial loss accompanied with delivery of the c50 patient cohort. This ERF bid will be discussed at Executive Team in October. To date there has been little appetite amongst consultants to undertake additional sessions due to the rate of pay offered. However, following agreement in September to an enhanced rate, there are consultants in a number of specialties, most notably General Surgery, that are willing to undertake additional sessions. As a result from November there will be weekly weekend lists at County which will support the additional activity associated with the County Hub Business Case.

In October we agreed a contract with Hassan Diagnostics to deliver c300 NOUS scans per week from the last week in October. A number of initiatives to reduce demand to the modality are now in place or being explored, including introduction of Radiographer rejection SOP which was introduced in September and has safely rejected c430 referrals. There is a 44% vacancy factor in NOUS, to create additional capacity funding has been agreed to support Registrar training. In September a locum Echocardiographer came into post to support delivery of the 13 and 6ww DM01 targets. The modality appointed 2 overseas candidates recently and they are coming into post in December and January, at which point capacity will meet demand. The Diagnostic Cell was re-established in August through which performance is monitored.

From October, the Patient Access Team will undertake validation in-month as opposed to month end. This will reduce the risk of month end breaches and should lead to a reduction in patients entering pathways at a late stage. A business case is in development to provide a IA solution to validation of the entire c700k patient waiting list. There has been a commitment from NHSE to fund this. When in place this will significantly reduce risk and potential patient harm due to unmonitored patient waiting times.

Responsive | Overview

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive

Overview from the Chief Operating Officer

What can we expect in future reports?

Non-Elective

We expected our performance to follow our trajectory which considers the pressures over the summer months translating into the Autumn and winter months alongside the incremental improvement as part of our Non-Elective Improvement Programme. We expected September to be challenged as we feel the impact of an earlier than planned for winter pressure. We will reinvigorate our use of key policies and SOP's to support this expected pressure.

Going forward, improvements in 4-hour performance we expect 12 hour and ambulance handover delays will be tracked and monitored very closely to improve from this point. We have seen the correlation between improvements in flow and these indicators. The impact of the implementation of the new HALO model will also be visible within the next report.

Elective

For RTT/Planned Care we should expect to see a further reduction in the number of patients >65 weeks in October with a forecast of c109 patients from predominantly ENT breaching at month end. In line with NHSE expectations, the Trust will aim to achieve a zero 65w position at end of November, it is recognised however that this will be exceptionally challenging especially for ENT. ERF bids to support a further reduction in waiting times to 52 weeks by the end of March are currently being developed and will be reviewed for approval in October. For Children and Young People, we would expect to see zero patients breaching 52w at the end of March 2025 and for adults this number should also be minimal (pending ERF bids being agreed). All patients that are at risk of breaching 52weeks at the end of March will have their 1st OPA by the end of December, currently 31% of patients are booked leaving c3400 to book in Quarter 3.

NOUS performance will continue to deteriorate until our insourcing provider is in place and this will impact upon the Trust DM01 position overall in October. It is expected that the 13w position will improve from November onwards. The number of patients waiting surveillance or planned endoscopy will continue to reduce and it is expected that this will be zero at the end of November, 2 months ahead of the agreed trajectory.

Cancer performance and the number of patients >62 days and in backlog and not diagnosed, is a concern with ongoing focus required in terms of "good news letters" , pathology and imaging turnaround times. From January it is likely that the 31 day target will return as an operational planning target.

Post validation of the 12k pathways we will reflect upon lessons learnt from this exercise and build this into the training program for our Teams.

Responsive | Dashboard

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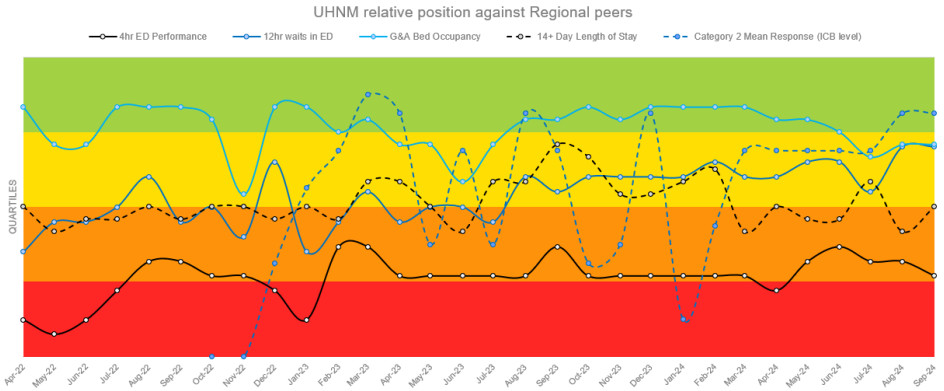
University Hospitals of North Midlands NHS Trust

Responsive

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
UEC 4 Hour Target	76%	73.0%	69.2%						
Over 12 hours in ED	0	1,221	1,799						
UEC Cat 2 Handover Average Time	00:18:00	00:22:59	00:16:36						
Cancer 28 Day FDS	75%	75.1%	72.4%						
Cancer 31 Day Combined	96%	92.9%	90.1%						
Cancer 62 Day Combined	85%	66.6%	57.6%						
Diagnostics DM01 Performance	99%	57.5%	54.5%						
RTT No. of Patients Waiting >52 Weeks	0	3,211	2,765						
RTT No. of Patients Waiting >65 Weeks	0	593	222						
RTT No. of Patients Waiting >78 Weeks	0	15	17						
RTT No. of Patients Waiting >104 Weeks	0	3	3						
Treating patients in a timely manner (Hospital Combined Performance Score)	7,000	3,997	3,994						

Relative position against Midlands Trusts

For 4hr ED Performance, 12hr waiting in ED, G&A Bed Occupancy, 14+ day Length of Stay and WMAS Category 2 Mean Response*



*Monthly Category 2 Mean Response is a comparison between the 11 ICBs served by WMAS & EMAS and is extrapolated from weekly data which is only available from October 2022

Related Strategy and Board Assurance Framework (BAF)

Quality Strategy

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

Responsive | UEC 4 hour Target

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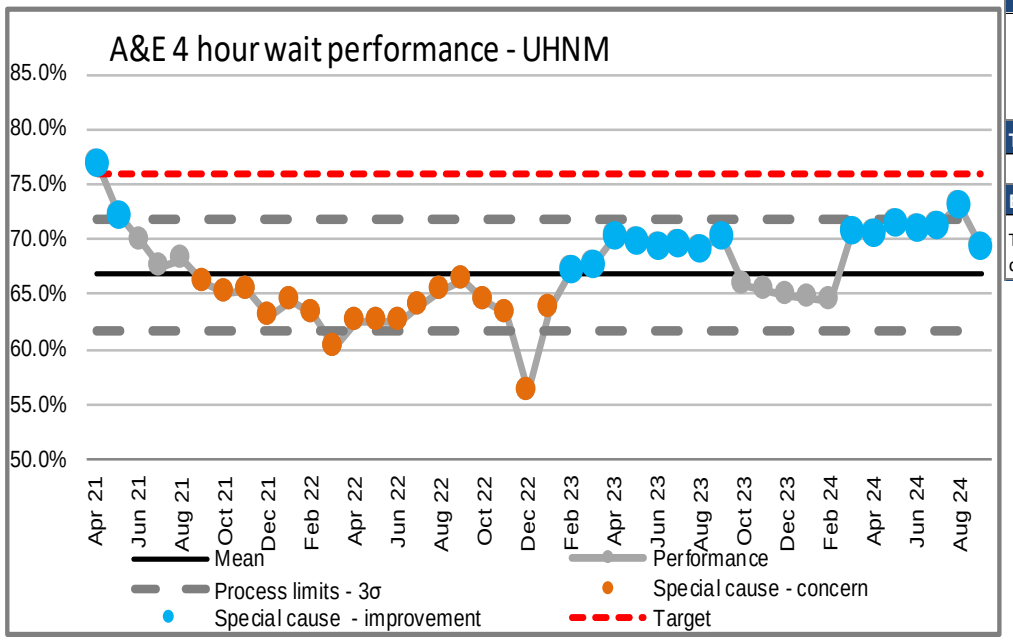
University Hospitals of North Midlands NHS Trust

Responsive

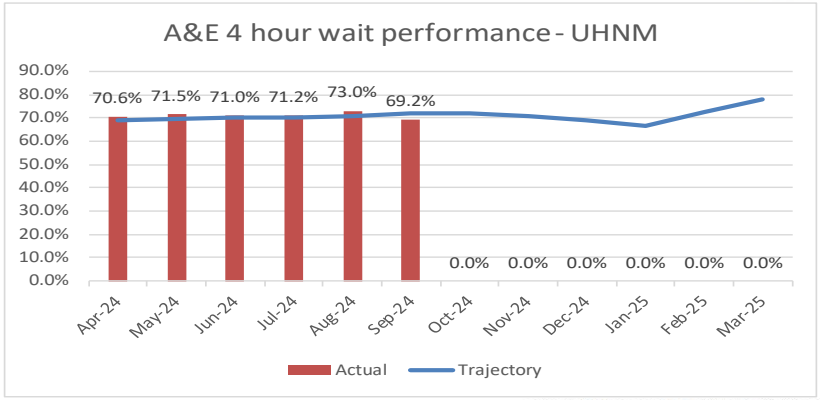


Variation	Assurance
H	F

Target	Jul 24	Aug 24	Sep 24
76%	71.2%	73.0%	69.2%

Background

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



What is the data telling us?

Validated Performance is 69.2% for September which has decreased since last month by 3.8% and noting the average over the last 3 months has reduced slightly at 71.13%.

The submitted improvement trajectory against the 4hr standard set for September has not been met (72.1% vs 69.2%) and is 6.8% adverse to the national target of 76% until February 2025 and then 78% for March 2025 onward.

The teams ongoing work to improve this performance metric is evidenced in maintaining and demonstrating an increasing trend since March albeit it a reduction in last month's performance.

Type 1 4hr performance for Royal Stoke was 41.3% which is 5.4% lower than last month at 46.7%, however of note performance since March there has been an average of 45.39% compared to the preceding 6 months at 39.68% which demonstrates a marked improvement of 5.71% during this 6-month period.

Type 1 4hr performance for County was 71.1% which has reduced by 8.4% from last month's performance of 79.5%, and notably, apart from last month has seen an increasing trend in performance since January.

As a trust, there were zero days in September where we achieved greater than 78%, The highest recorded type 1 performance for September was 75.9% on 11th September

We are ranked 93rd out of 142 Acute Trusts for August which is negative shift of 7 ranking positions.

What are we doing about it?

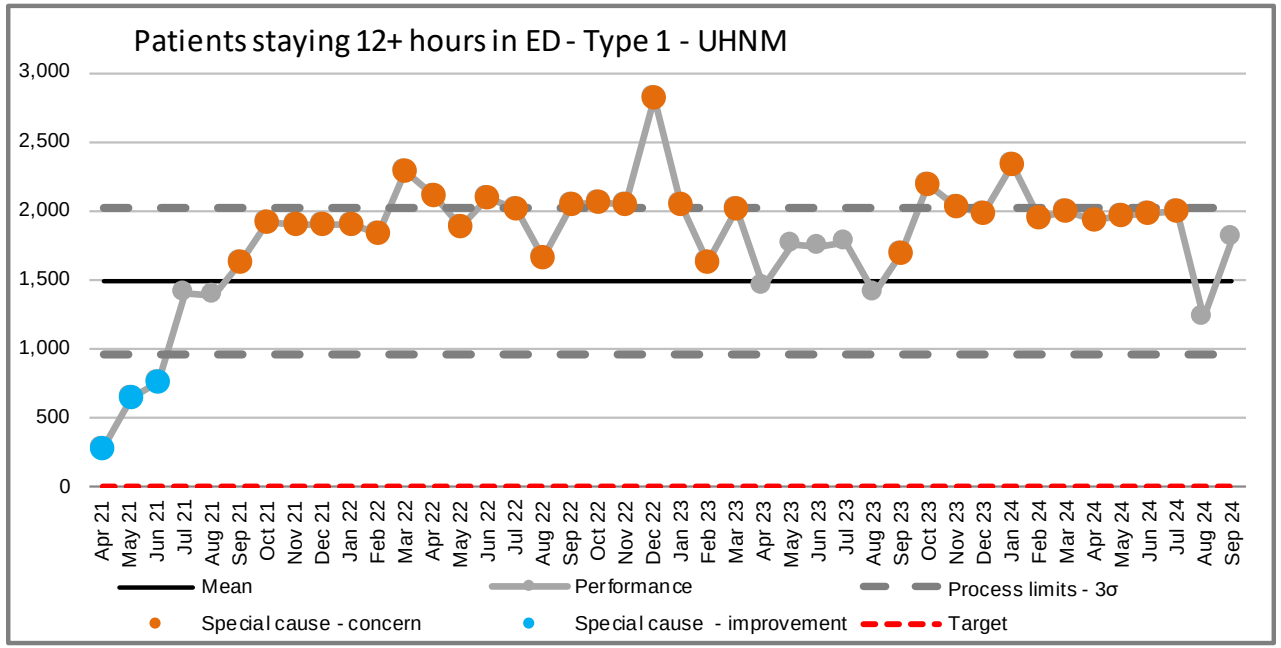
- Focus on streaming from ED to alternative pathways to support patient care.
- Review of escalation and triggers to support reduction in ambulance handover delays.
- CDU utilisation work continues on both sites to ensure consistent processes.
- EhPC chest pain pathway agreed, and trial is due to commence.
- Revised process for management of cubicles in Ambulatory area, trial commenced.
- SDEC: AEC task and finish in place to work through potential opportunities
- The new AMRA unit (opened on 2nd August) which provided an increase in capacity continues to positively support management of flow through the Emergency Department.

Responsive | Over 12 hours in ED From Arrival

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive



Variation	Assurance
	F

Target	Jul 24	Aug 24	Sep 24
0	1992	1221	1799

What is the data telling us?

This metric has changed from 12-hour trolleys waits to aggregated time of arrival greater than 12 hours.

September experienced 1799 patients with a greater than 12-hour length of stay compared with 1221 patients in August This represents a 32.13% increase (578 patients).

Our overall ranking deteriorated from 78th out of 124 Acute Trusts in August to 90th out of 124 Acute Trust in September. A shift of 12 ranking positions.

Mean time in the emergency department varies in and out of hours. Overall mean time in the Emergency Department for September, Type 1 only 7.43hrs for September compared to 5.78hrs in August. There remains an in hours and out of hours issue in terms of responsiveness. Type 1 in hours was 6.77hrs verses 8.70hrs

What the chart does not tell us is percentage compliance against the Clinically Ready to Proceed (CRTP) target of no greater than 60 minutes. September demonstrated 39.67% compliance verses 54.96% in August, which a deterioration of 15.29%. The compliance target is 95%.

What are we doing about it?

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

Responsive | UEC Cat 2 Handover Average

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University Hospitals of North Midlands NHS Trust

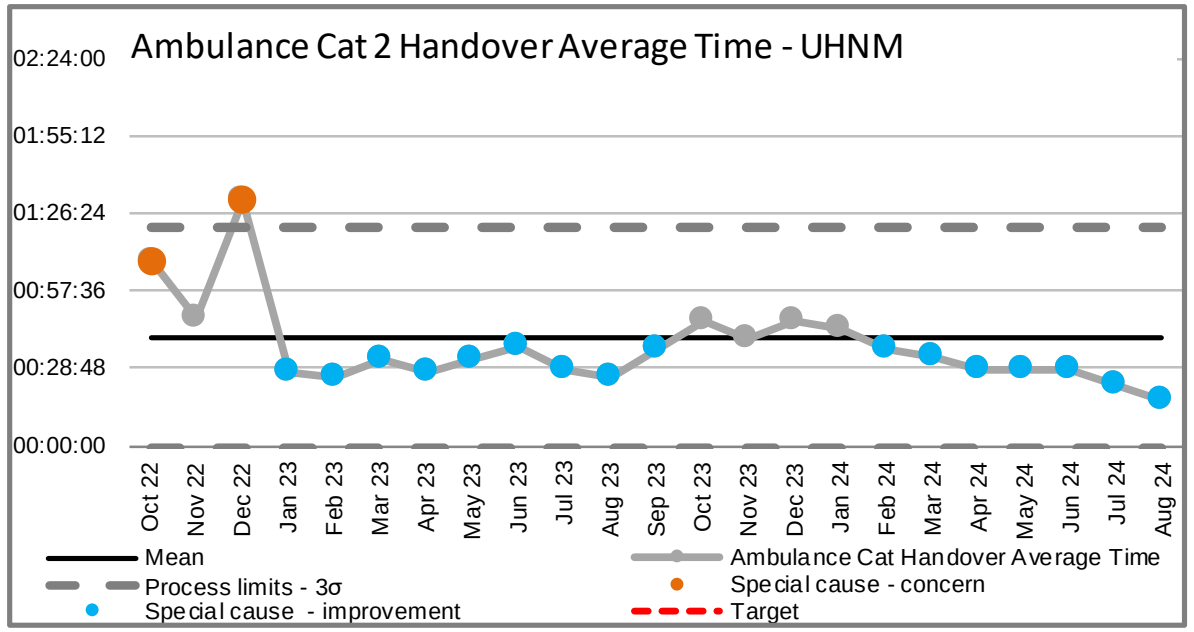
Responsive

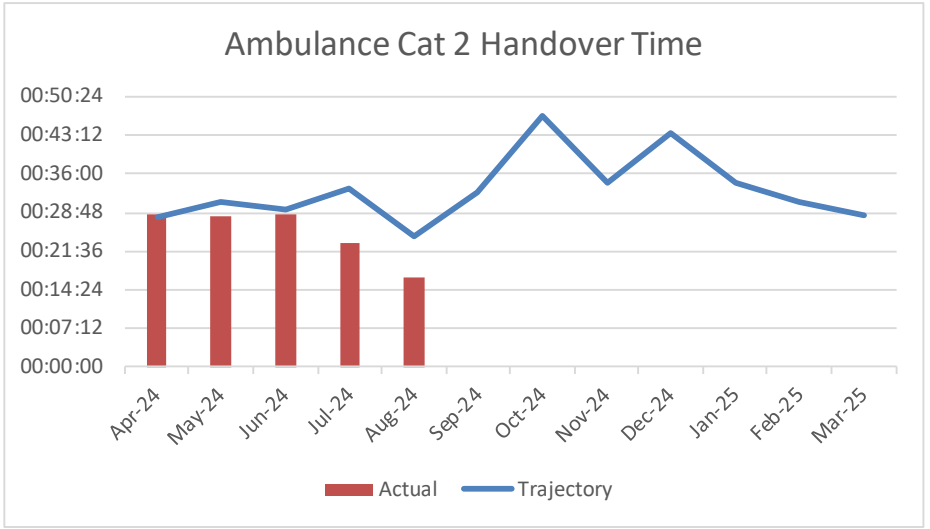
Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
00:00:00	00:28:30	00:22:59	00:16:36

Background

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





What is the data telling us?

The data provided by West Midlands Ambulance Service (WMAS) is provided a month in arrears. Ambulance Cat 2 mean time has continued to reduce since January 2024, January saw an average Cat 2 mean of 43.34 minutes compared to our current position for September at 29.54 minutes. However, August position was 16.36 minutes, which is an adverse position of 12.88 minutes..

Handover within 15 minutes of arrivals in September demonstrated a 26.24% compliance compared to 32.35% compliance in August. A deterioration of 6.11%.

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

What are we doing about it?

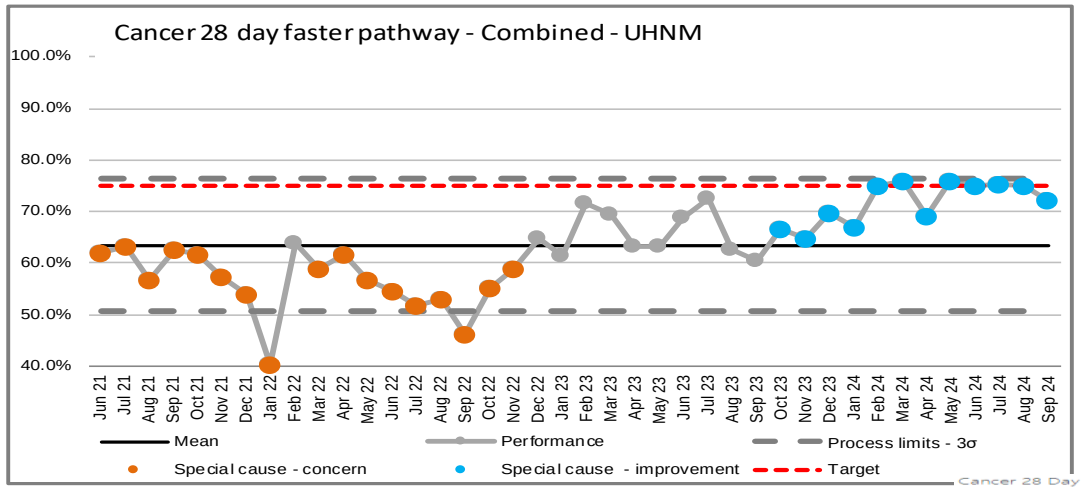
We have instigated an internal rapid handover process, which when triggered and enacted, drives the off load of 2 ambulances every 30 minutes until the pressure is reduced and the risk removed.
A review of escalation and triggers to support reduction in ambulance handover delays in partnership with WMAS is in train to replicate the London Ambulance Service model of no greater than 45minutes to offload. .
The 'corridor' in the emergency department is utilised to support the risk of reducing the waiting ambulances.
A revised HALO provision to cover 24/7 has been approved by The Urgent and Emergency Care Board and a 12-week test of change is in train and will complete at the end of October 2024.
'Your Next Patient' protocol is enacted to decompress the emergency department to further support flow and off load capability. This process is currently under review.
Regular daily contact with WMAS is in place to ensure confidence in actions taken and where possible deflects or diverts to County or Burton are agreed to support timely ambulance release.

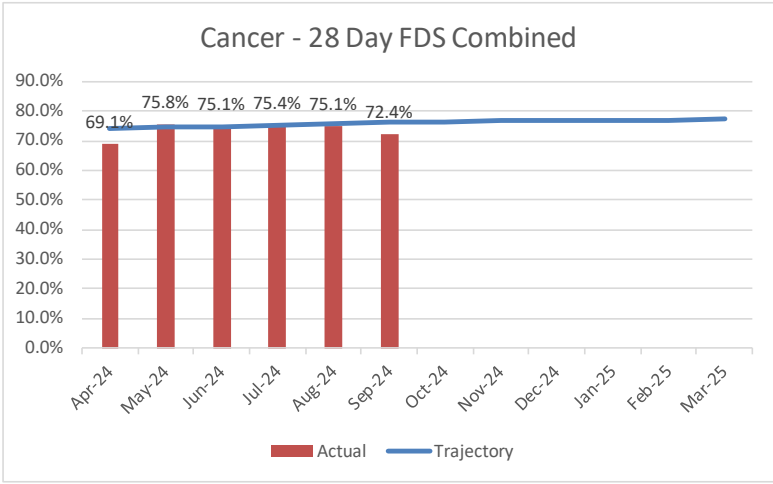
Responsive | Cancer 28 Day FDS

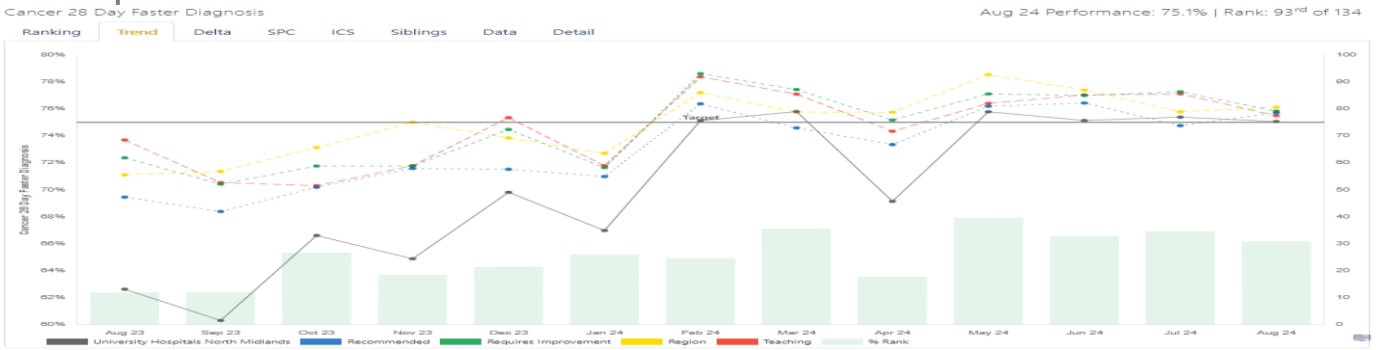
Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive







What is the data telling us?

The combined faster diagnosis standard performance has demonstrated a special cause improvement over the past year. UHNM achieved the 75% national standard and the submitted trajectory for the past 4 months and is predicted to report a further improved position in September. Data is not final yet.

When broken down at tumour site level, some pathways perform better than others; Upper GI, Skin and Breast being consistent and high achievers.

Pathways that require a higher number of investigations such as Gynaecology and Urology perform lower than the standard.

Pathology is a major delay factor in being able to tell patients they have cancer within 28 days.

What are we doing about it?

Improvement plans for lower performing pathways are in place; Gynae and Urology. Best practice from better performing providers is being implemented, such as referral vetting and speedy booking of 1st OPAs. Teams have implemented national priorities such as Cancer Navigators who expedite patient pathways. Referral optimisation plans will support faster timelines for patients receiving diagnosis or all clear for cancer.

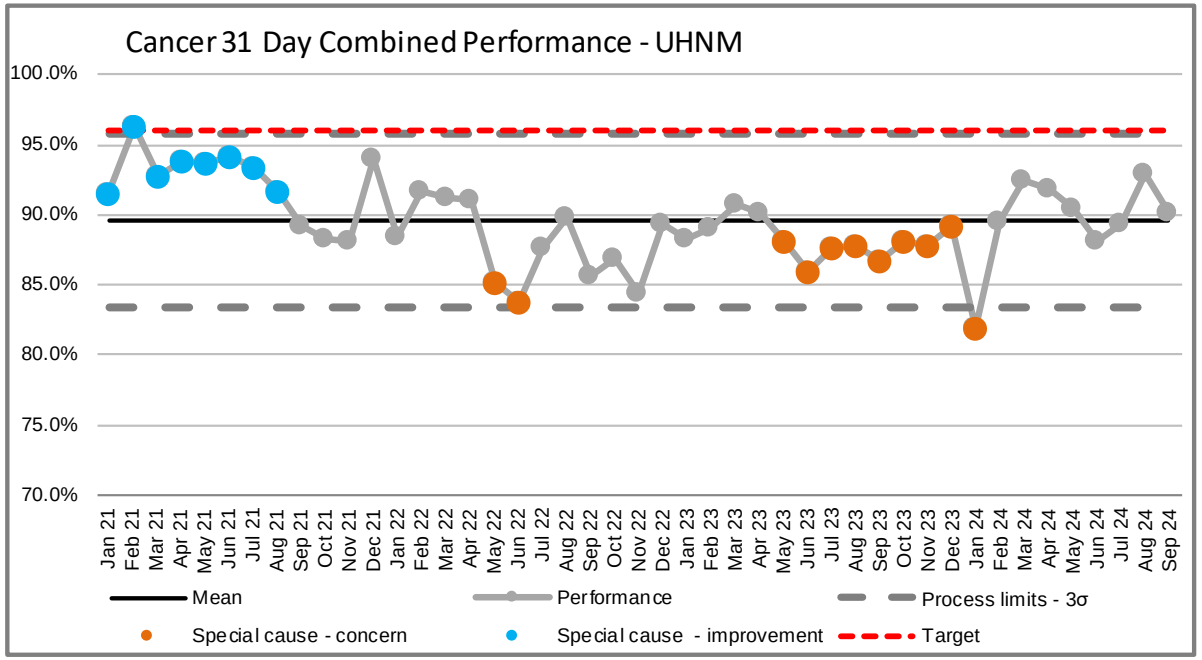
West Midlands Cancer Alliance funding is being used to support faster turnaround times in diagnostics, particularly in Endoscopy, Radiology and Pathology.

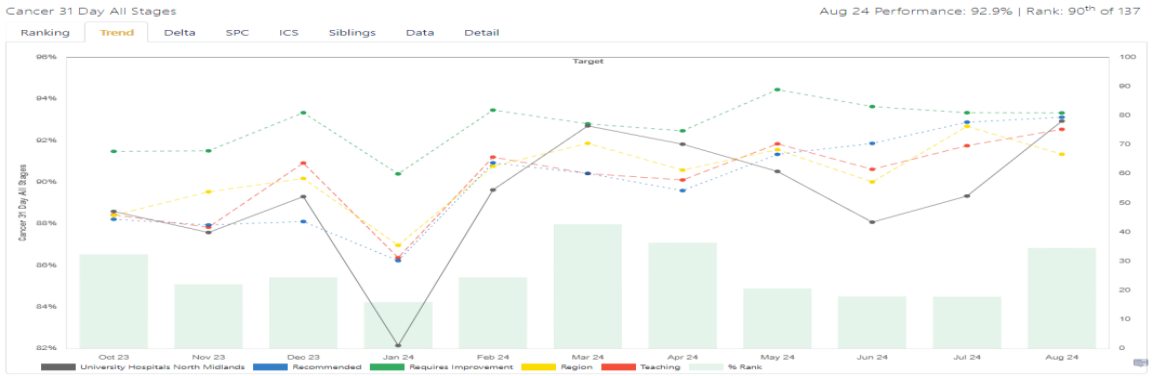
Responsive | Cancer 31 Day Combined

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive





What is the data telling us?

The 31-day combined cancer treatment standard achieved 93% in August, the highest performance so far this year. September is currently incomplete and unvalidated. There is varying performance when broken down by tumour site. Consistent and high achievers are Breast, Skin and Upper GI. However, the most challenged tumour sites are Urology and Colorectal. Urology reported the longest waits due to access to surgical capacity. This was mainly for Kidney patients waiting for a Partial Nephrectomy.
The longer waits on the Colorectal pathway were either due to access to surgery or therapeutic endoscopy procedures.

What are we doing about it?

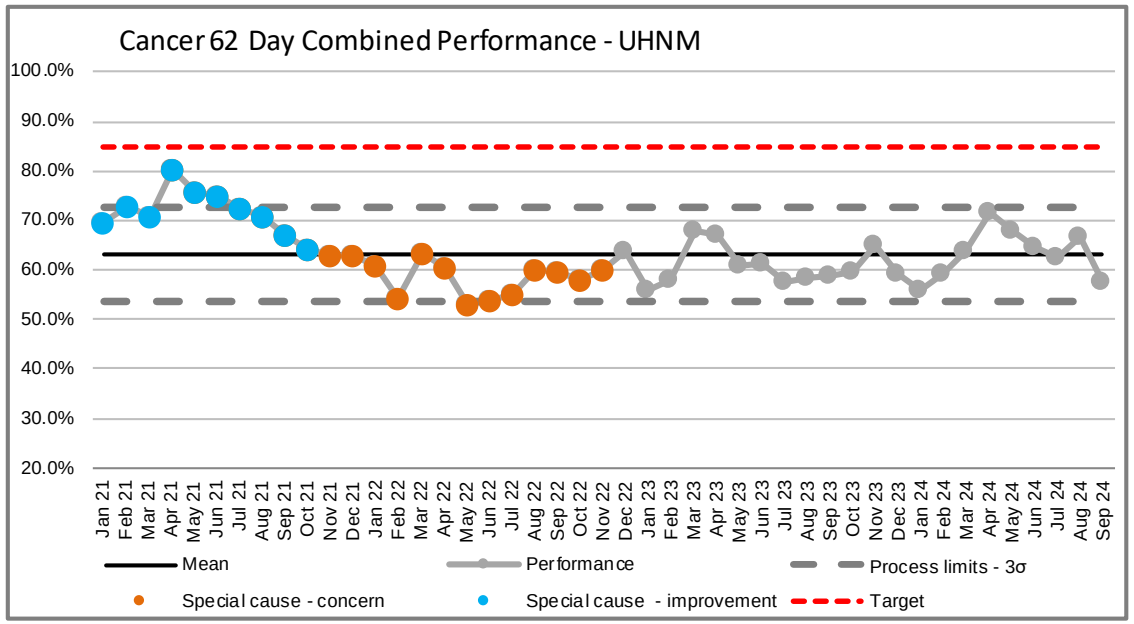
Access to robotic procedures are prioritised through the oversight group.
Partial Nephrectomy capacity has been escalated through the Tier 1 route with a request for mutual aid.
The endoscopy improvement plan is being enacted that will clear backlog and create sufficient capacity to meet therapeutic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

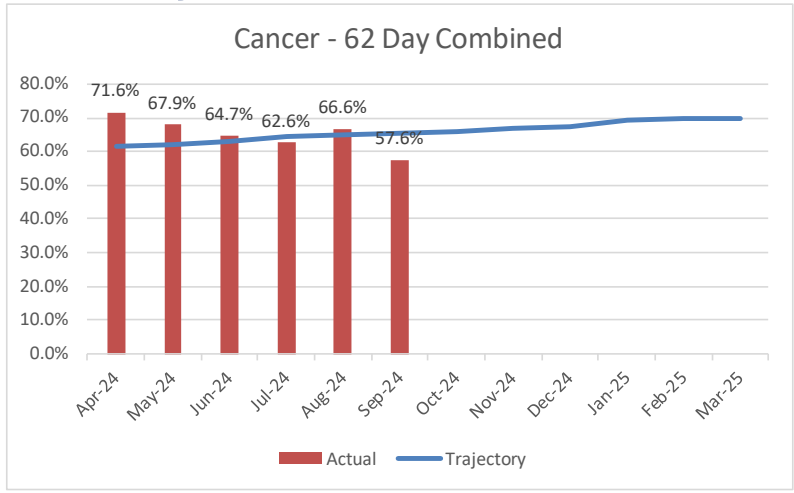
Responsive

Responsive | Cancer 62 Day Combined

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust





What is the data telling us?

The combined 62-day performance was reported at 66% in August. UHNM have met the trajectory for 4 out of 5 months of the year. September is currently incomplete and still being validated, the current position of 57% is predicted to improve.
When broken down by tumour site, there are no consistent achievers however pathways with better performance than most include Breast and Skin.
Pathways with the most challenged performance are Gynae, H&N, Lung and Colorectal.
Contributing factors include delay to diagnostics particularly pathology reporting which impacts significantly for Gynae and Lung. Oncology capacity also impacts timely treatment.

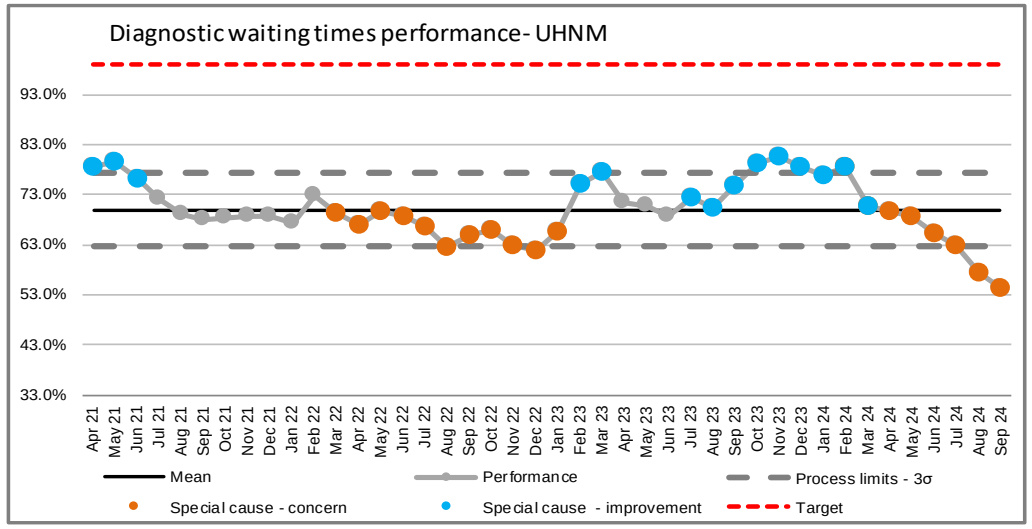
What are we doing about it?

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

Responsive | Diagnostics DM01 Performance

Provide efficient and responsive services

Responsive

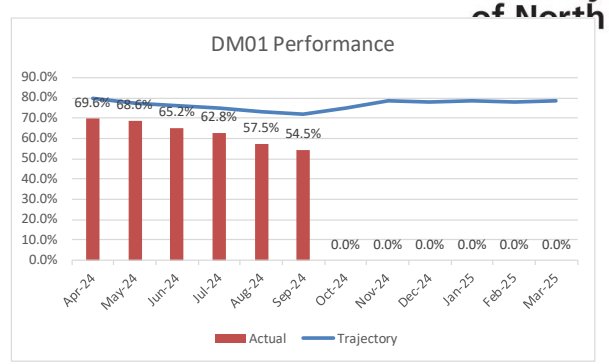


Variation	Assurance
L	F

Target	Jul 24	Aug 24	Sep 24
99%	62.8%	57.5%	54.5%

Background

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



What is the data telling us?

September DM01 data is unvalidated at time of writing this report however current performance was at 54.5% against the 95% six week standard. This is a continuation of the monthly deterioration over the last 5 months (August 57.5%).

The main contributing modalities are:

- Endoscopy: Performance for Endoscopy at is 45.32%. Performance has increased 8.5% from August. Total WL size has reduced by 251 patients.
- Non obstetric ultrasound performance has deteriorated from 45.5% in July to 40.09% in August. If Hassan can come online in August, performance should improve for September
- Echocardiogram performance has deteriorated from 50.28% in July to 47.55% in August. From October additional capacity is coming online which will improve performance

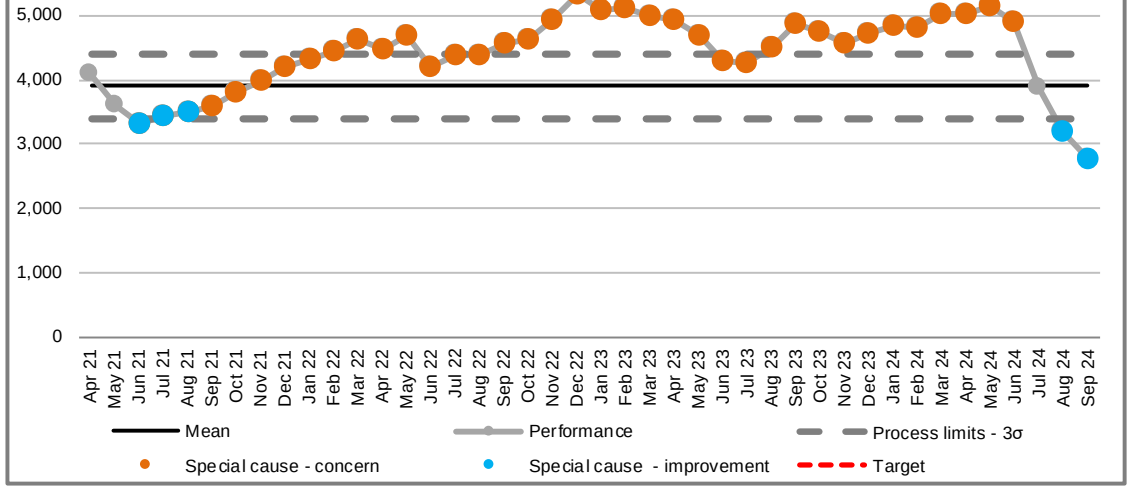
What are we doing about it?

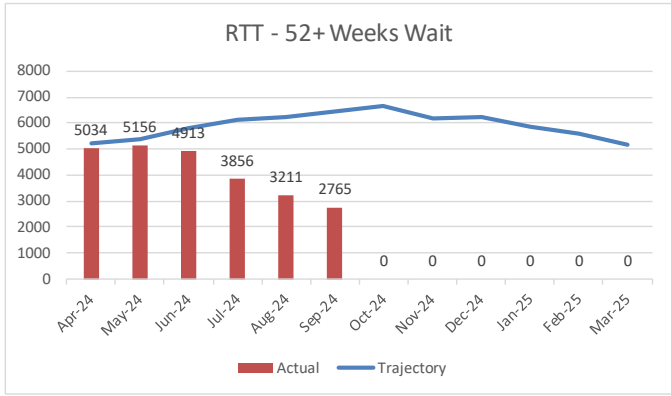
- Endoscopy: Q2-4 ERF funding in place enabling the service to continue to insource to cover all vacant sessions to increase capacity. The mobile unit is operational and scoping an average of 29 patients per day, 7 days per week. All additional capacity is supporting diagnostic recovery in line with trajectory.
- The surveillance and planned backlog has been cleared in line with NHSE ask.
- The 3rd element of the business cases for endoscopy recurrent staffing is currently in progress through governance structures.
- Non obstetric Ultrasound: Hassan have been approved in an off-framework capacity and we are in the final stages of commissioning. Imaging are anticipating a start date of 24th October, from which point the TATs for NOUS patients will begin to improve
- Additional work being undertaken to validate the waiting list to remove patient who do not wish to attend for their appointment has commenced. Additional capacity is also being worked up via booked registrar lists. Active recruitment is taking place to fill substantive posts and a business case for the growth of trainees is being developed
- Echo: Capacity continues to be supported by an external agency whilst we await recruitment to posts expected to commence in December 24. Echo have also secured 1 x additional agency Locum Sonographer to bolster the number of patients we can treat each month (156 from October 24 – March 25) to support an earlier recovery of the position

Responsive | RTT No. of Patients Waiting Over 52 Weeks

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust





Variation	Assurance
L	F

Target	Jul 24	Aug 24	Sep 24
0	3856	3211	2765

Background

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

What is the data telling us?

There has been a significant reduction in 52+ week waits due to a targeted validation exercise undertaken largely by the Trust Patient Access Team. The largest reductions have been seen in Respiratory & Gastroenterology.

The proportion of patients waiting 52+ weeks who have reached a decision to admit is currently 36%. Our ranking has improved from 145th to 136th in August largely as a result of the validation exercise that has been in place since July.

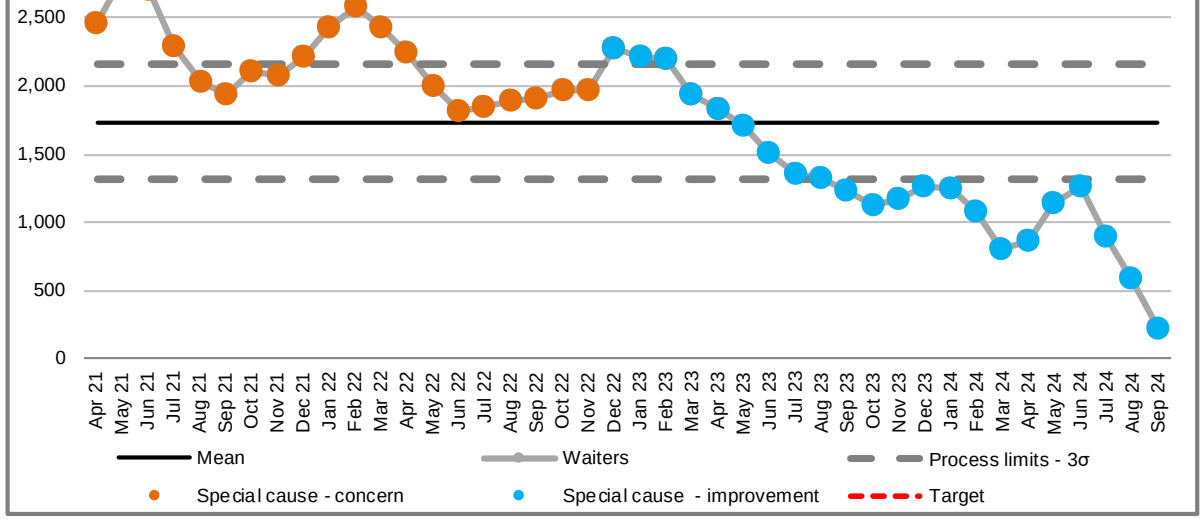
What are we doing about it?

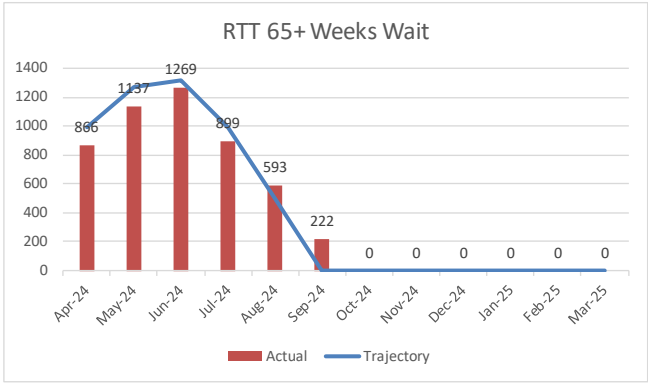
- Revamped RTT & Planned Care training offering now available, including Intermediate Training. RTT training performance will be monitored through Planned Care Board from August
- Clinician training now available combined with Clinic Outcome Form training. Available as eLearning now
- Exploring utilisation of digital tools (Palantir's CCS) to focus validation to pathways with DQ issues and/or missing pathway milestones
- Further Patient Validation Texts have been sent, with 66% response rate and 8,101 patients wishing to be removed from the waiting list.
- Divisions supported with tracking and admin process improvements where resource allows.
- All patients on a 52w pathway at end of March will have their 1st OPA by end of Dec (currently 31%)
- ERF bids to achieve 52w standard are in the process of being approved and will provide additional capacity across a number of specialties

Responsive | RTT No. of Patients Waiting Over 65 Weeks

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust





Variation	Assurance
L	F

Target	Jul 24	Aug 24	Sep 24
0	899	593	222

Background

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

What is the data telling us?

The volume of patients waiting 65 weeks reduced to 206 in September, a reduction of 387patients compared to August. This is due to an increase in capacity in particular in Endoscopy, Gastro, ENT and Respiratory funded through a variety of cancer alliance, ERF and NHSE funds along with an increased focus on validation.

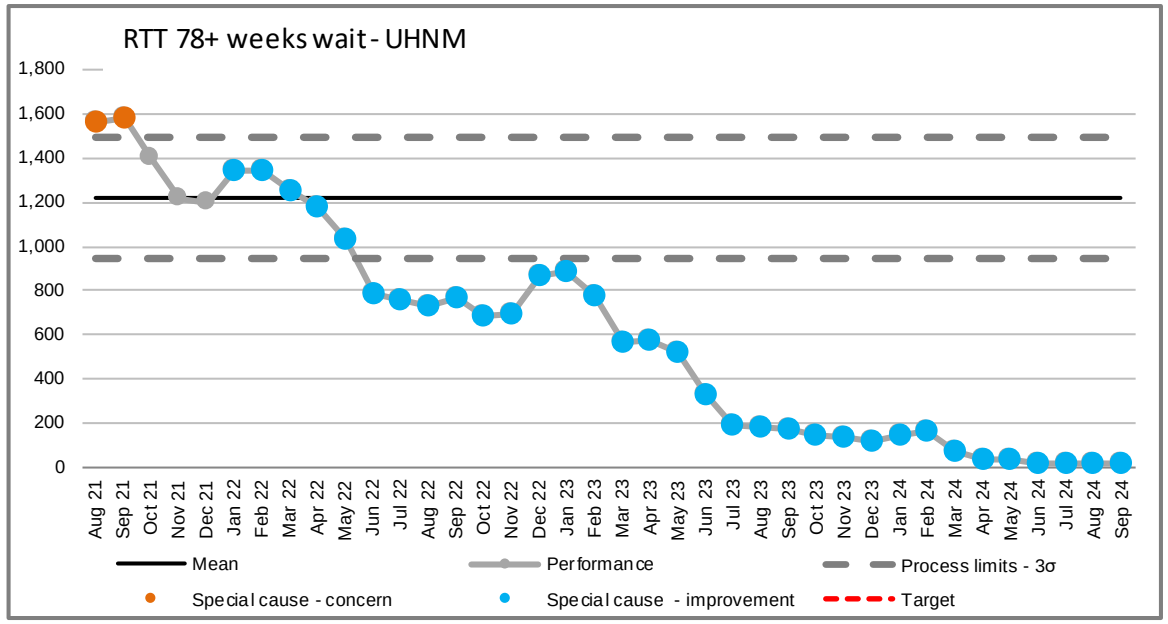
What are we doing about it?

- ERF business cases for extra capacity through insourcing & WLIs approved
- Focus on utilisation and productivity in theatres and outpatients
- Targeted validation on Respiratory, Gastro & ENT pathways
- Detailed plans and trajectories to illustrate the route to 65weeks have been developed and are formally monitored weekly through Elective Oversight Group and PTL meetings between Corporate Ops and Divisions
- Aiming for zero patients >65w at end of November in line with NHSE request, though it is recognised that this will be challenging

Responsive | RTT No. of Patients Waiting Over 78 Weeks

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

Target	Jul 24	Aug 24	Sep 24
0	11	15	17

Background

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

What is the data telling us?

78-week waits have decreased in September (11, from 15 in August).

What are we doing about it?

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

Responsive | RTT No. of Patients Waiting Over 104 Weeks

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

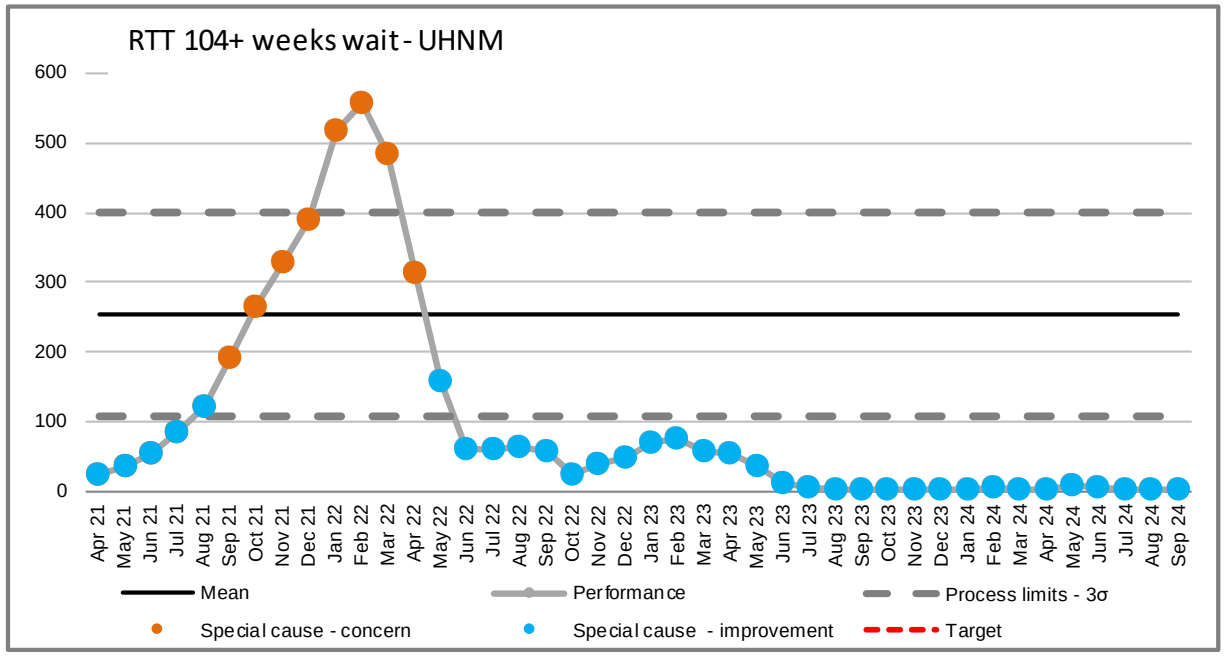
Responsive

Variation	Assurance
	

Target	Jul 24	Aug 24	Sep 24
0	1	3	3

Background

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



What is the data telling us?

The Trust reported one 104-week breaches for September. The patient was identified via consultant validation in October with the delay being due to a clock start date not being applied. Following identification, patient clock start and appropriate clock stop could then be applied,

What are we doing about it?

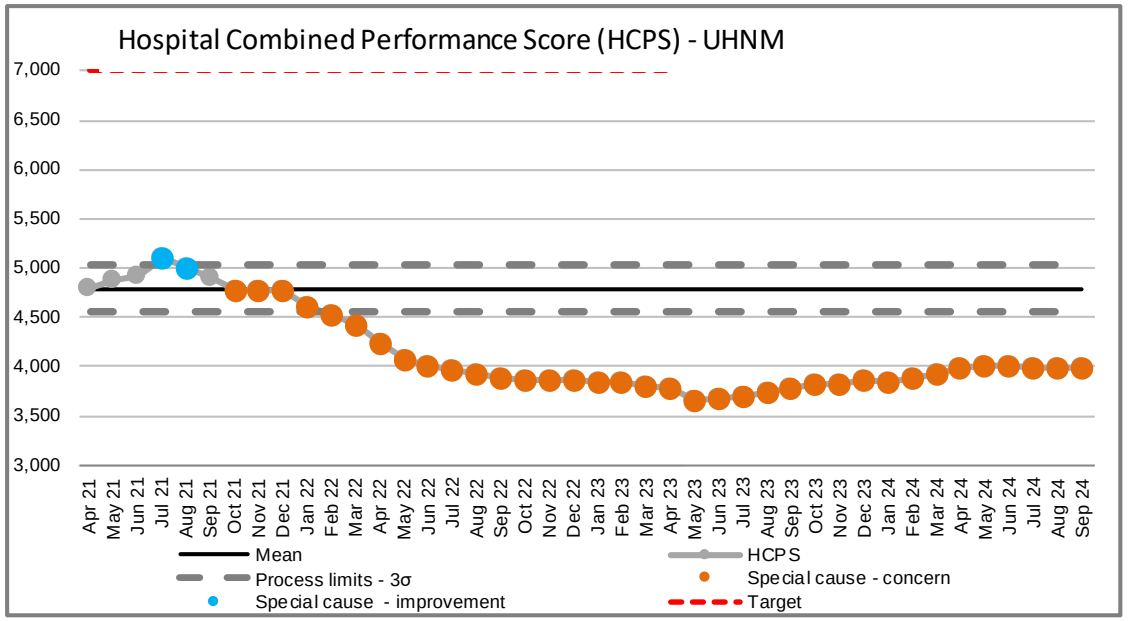
A whole scale review of validation, RTT training and DQ commenced in July. A DQ Task Force has been established and is chaired by the COO. An RTT training plan has been approved at Planned Care Board to ensure all relevant staff are up to date with training by end of December.
MBI are currently validating 12k patient pathways from high risk "fail safe groups" and as a result there is a possibility of "in-month" 104 week breaches. We are working with NHSE in line with NHSE DQ Guidance published in September 2024 to ensure patients that are identified are treated within 4 weeks of that date,

Responsive | Treating Patients in a Timely Manner (HCPS)

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive



Variation	Assurance
L	F

Target	Jul 24	Aug 24	Sep 24
7000	3997	3997	3994

What is the data telling us?

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

What is the data telling us?

The Hospital Combined Performance Score has plateaued May – September
Top concerns and most deteriorated include: DM02 6w diagnostic waits, 104w breaches, RTT 65 weeks (ENT and Resp), 4 hour ED standard, number of patients >12 hours following a DTA,
Most improved include: Friends and Family ED score, reattends to ED, left without being seen in ED, cancer 2ww and FDS, OP DNA rate, staff turnover rates.

What are we doing about it?

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

People | Overview

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust

People

Overview from the Chief People Officer

How are we doing against our trajectories and expected standards?

Our most recent *Staff Engagement* score was 6.56 for July 2024, up from 6.42 for April 2024, against a target of 7.2. The Staff Voice Survey is now collected quarterly, meaning the next scoring will not occur until January 2025, following the National Staff Survey's completion. A total of 486 bank staff have signed up for the Wagestream solution, (450 in August-24) with a further 15 enrolling. There has been a total of 2,333 streams, totalling £355,000 of advances, since Wagestream's launch.

Sickness absence remains above our expected standard of 3.39%. In month we have seen a slight decrease to 4.86%, while the 12-month cumulative rate remains at 5.3% for the fifth consecutive month. The main driver of this continues to be stress and anxiety, followed by other musculoskeletal problems and gastrointestinal problems as the second and third most common reasons.

Turnover and *vacancy* metrics continue to perform well against our expected standards. The turnover rate in September 2024 decreased slightly to 7.8% which remains consistently below our 11% target, for the last 2 Years. Vacancies decreased to 8.2% (8.7% in August-24). The main drivers of this were increases across Registered Nursing (+63.48), AHP's (+36.69), Infrastructure (+10.23) and Medical & Dental (+15.16). These increases were counter-balanced by a 70.22 fte uplift in the total budgeted establishment.

Agency costs decreased to 2.57%, in September 2024, down from 2.97% in August 2024, which is below the threshold set by NHS England. In real-terms, overall agency usage decreased to 138.07 WTE in September 2024 from 206.35 WTE in August 2024.

What is driving this?

Sickness absence is driven by many factors, including stress and anxiety and seasonal changes such as colds, cough and chest & respiratory problems. The gradual sickness absence reductions, which have occurred over the last three months, are most likely influenced by seasonal changes.

Agency expenditure is being driven by vacancies, sickness and additional work related to the elective recovery programme and an increased demand in theatres and endoscopy services. However, the additional scrutiny at executive and divisional level appears to be having the desired effect in reducing overall agency spend, with some agency activity being converted to bank expenditure, as well.

People | Overview

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust

People

Overview from the Chief People Officer

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

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

Sickness absence continues to be monitored at directorate performance reviews. Areas with over 8% or of concern are supported by the People Advisors, focusing on long term sickness cases. Our people are also provided with many online and in-person resources, to improve their personal resiliency when coping with work-related stress.

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

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

What can we expect in future reports?

We may see a slight increase in sickness absence, following the end of the summer holiday period and as a result of seasonal changes.

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

Agency utilisation has fallen below NHS England's 3.2% threshold. We expect agency usage to continue to track close to this threshold, due to on-going elective recovery programme activity, and the continued need for escalation capacity and the additional demand in theatres and endoscopy services.

People | Dashboard

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust

People

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Employee Engagement	7.2	6.6	6.6						
Sickness Absence (In Month)	3.40%	4.92%	4.86%						
Vacancy Rate	8.00%	8.66%	8.20%						
Turnover Rate	11.00%	7.96%	7.76%						
Appraisal Rate	95.00%	88.28%	87.10%						
Agency Utilisation	3.20%	2.97%	2.57%						

Related Strategy and Board Assurance Framework (BAF)

People Strategy

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

People | Employee Engagement

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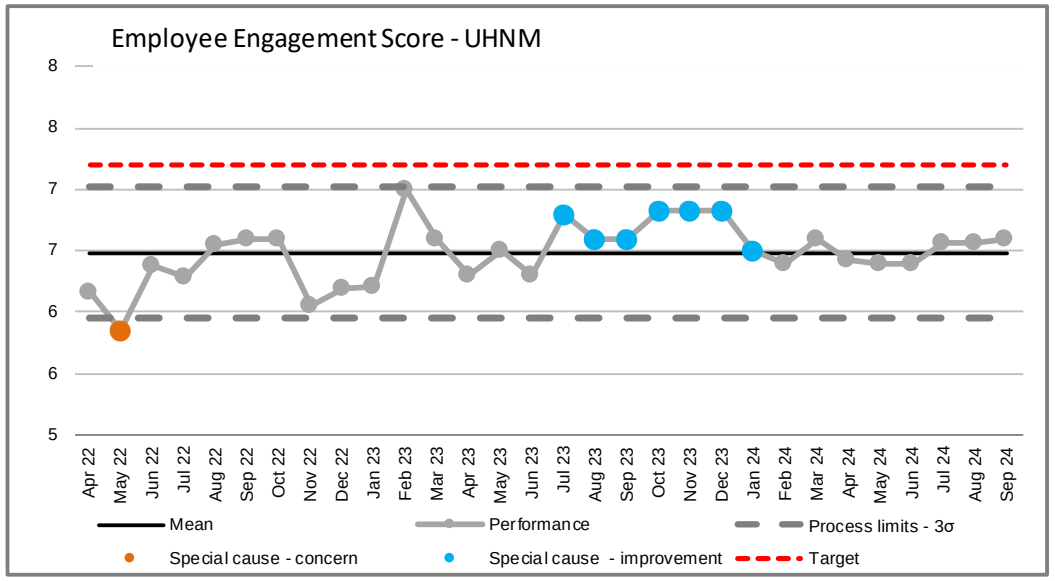
University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Jul 24	Aug 24	Sep 24
7.2	6.6	6.6	6.6

Background

What is the data telling us?

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

The Staff Voice Survey is now collected quarterly, meaning the next scoring will not occur until January 2024, to allow for the National Staff Survey. (The most recent score will be used in the intervening months.)

The National Staff Survey is now live with a response rate of 31.7% effective 20th October, totalling 4,003 responses.

What are we doing about it?

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

Sustained operational pressures continue to impact on overall employee engagement.

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

People | Sickness Absence in Month

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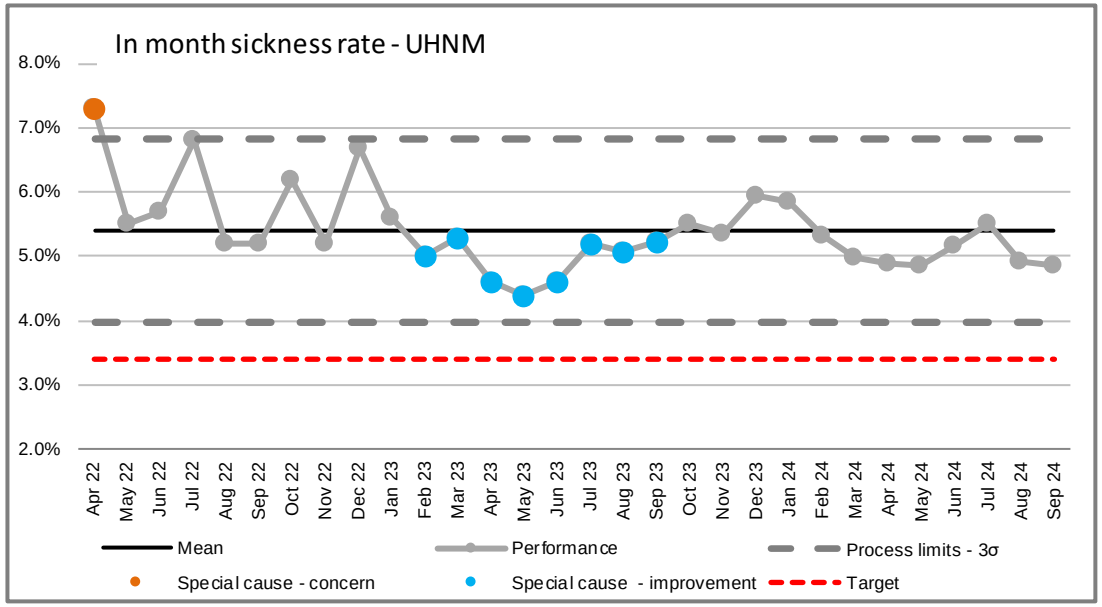
University Hospitals of North Midlands NHS Trust

People



Variation	Assurance
	F

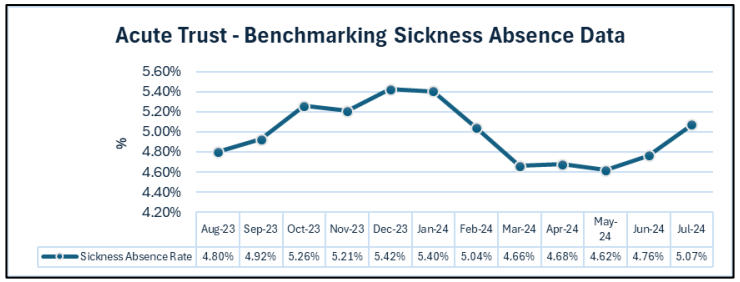
Target	Jul 24	Aug 24	Sep 24
3.4%	5.5%	4.9%	4.9%

Background

Percentage of days lost to staff sickness

Our sickness absence rates are comparable to other Acute Trust's when examining the available benchmarking data.

(Benchmarking data effective July 2024)



What is the data telling us?

The rolling 12-month average sickness absence rate reduced slightly to 5.26% (5.30% in August 2024) against the target of 3.4%.

The in-month sickness absence reduced to 4.86% in September (4.92% in August-24) with Chest & Respiratory Problems seeing the biggest increase, while most other absence reasons saw overall reductions in September 2024.

In rank order (highest first), the top 3 reasons for absences during August were: (1) Anxiety/stress/depression/other psychiatric illnesses, (2) Other Musculoskeletal problems and (3) Gastrointestinal problems.

What are we doing about it?

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

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

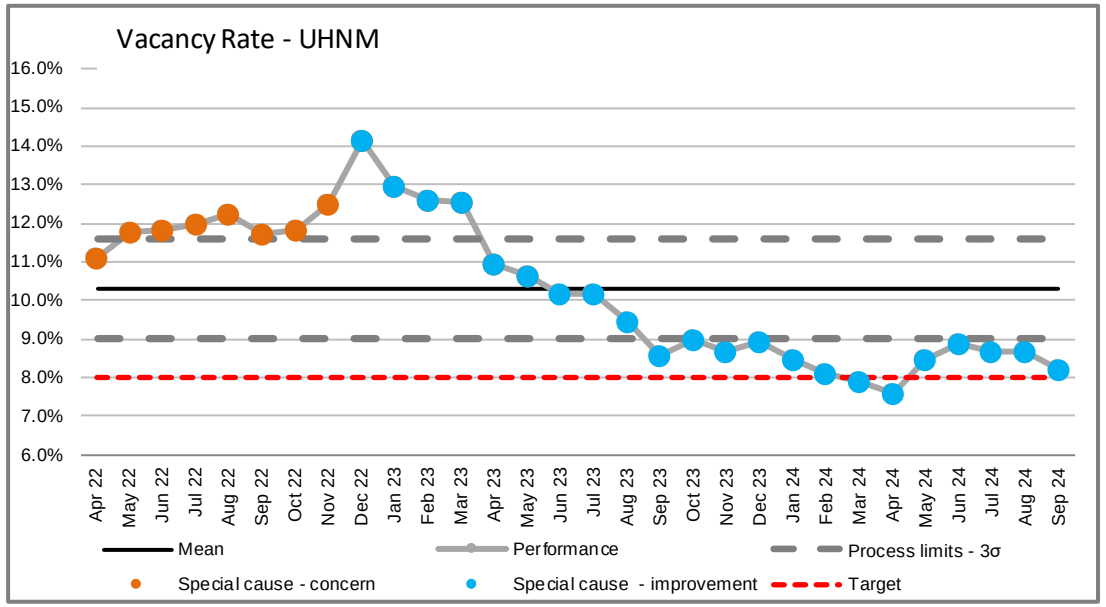
Network Division - commenced sickness assurance meetings.

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

People | Vacancy Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
8%	8.7%	8.7%	8.2%

Background

Based on Full Establishment (Substantive, Bank & Agency)

Vacancies at 30-09-24	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,724.32	1,572.14	152.18	8.83%	9.06%
Registered Nursing	3772.39	3469.61	302.78	8.03%	8.70%
All other Staff Groups	6892.37	6331.84	560.53	8.13%	8.53%
Total	12,389.08	11,373.59	1,015.49	8.20%	8.66%

What is the data telling us?

The summary of vacancies, by staff groupings, highlights a 0.4% decrease in the overall vacancy rate. The reasons for this are explained below.

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

Colleagues in post increased in September 2024 by 120.94 fte, across Registered Nursing (+63.48), AHP's (+36.69), Infrastructure (+10.23) and Medical & Dental (+15.16). Budgeted establishment increased by 70.22 fte, which decreased the vacancy fte by -50.72 FTE overall.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 30/09/24]

What are we doing about it?

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

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

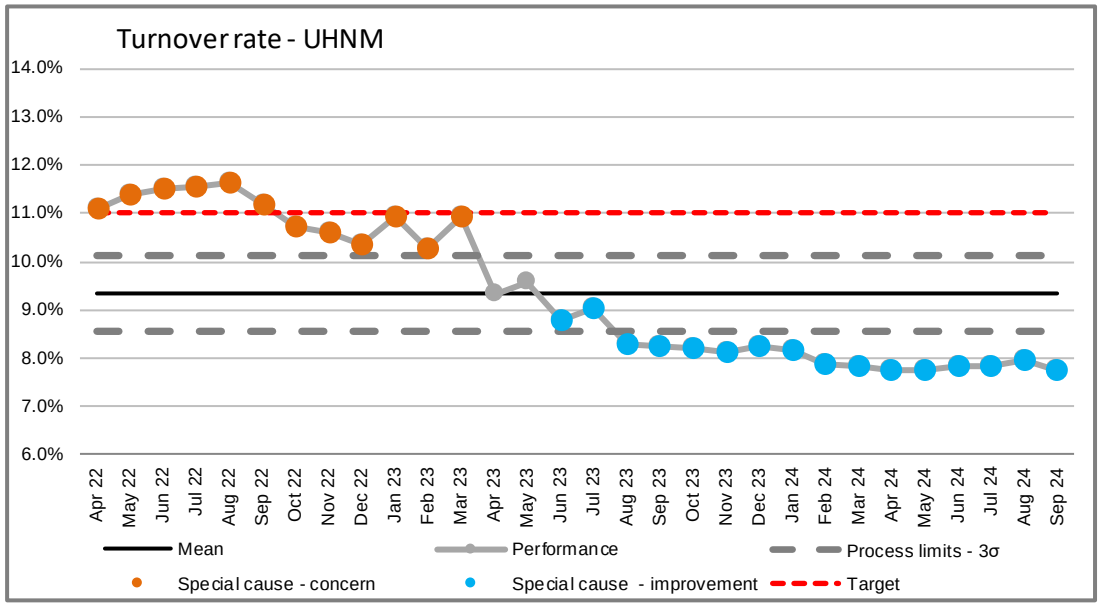
We continue our targeted spotlights on our colleagues, which supplement our recruitment campaigns.

People | Turnover Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust

People



Variation	Assurance
	

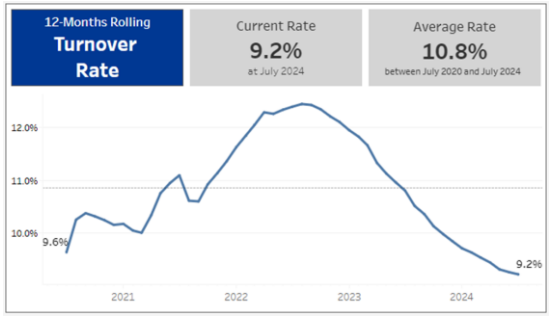
Target	Jul 24	Aug 24	Sep 24
11.0%	7.8%	8.0%	7.8%

Background

Turnover rate.

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

(Benchmarking data effective July 2024)



What is the data telling us?

The turnover rate in September 2024 remains low, at 7.8% (8.0% in August 2024), which is consistently below the Trust's 11% target, for the last 2 Years.

What are we doing about it?

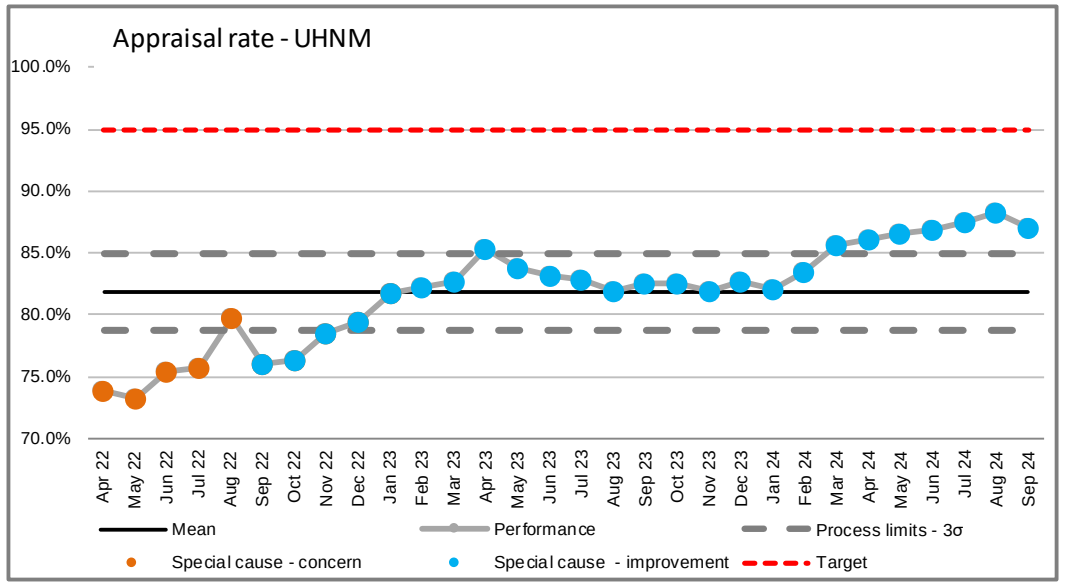
Turnover continues to perform well against our expected standards, reflecting our programmes of work which make this a great place to work. Some recent examples include :

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

People | Appraisal Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Jul 24	Aug 24	Sep 24
95%	87.5%	88.3%	87.1%

Background

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

What is the data telling us?

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

The gradual and incremental improvements in our appraisal rates, between February to August 2024, have stalled slightly in September 2024 at 87.1% (88.3% in August 2024).

The divisions' weekly monitoring, review and assurance meetings appear to be having the desired effect on driving improvements in compliance. WCCS Division's drive to improve overall PDR compliance is now starting to be mirrored within the other divisions as well.

What are we doing about it?

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

Network Division - Weekly PDR compliance hotspot and assurance meetings.

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

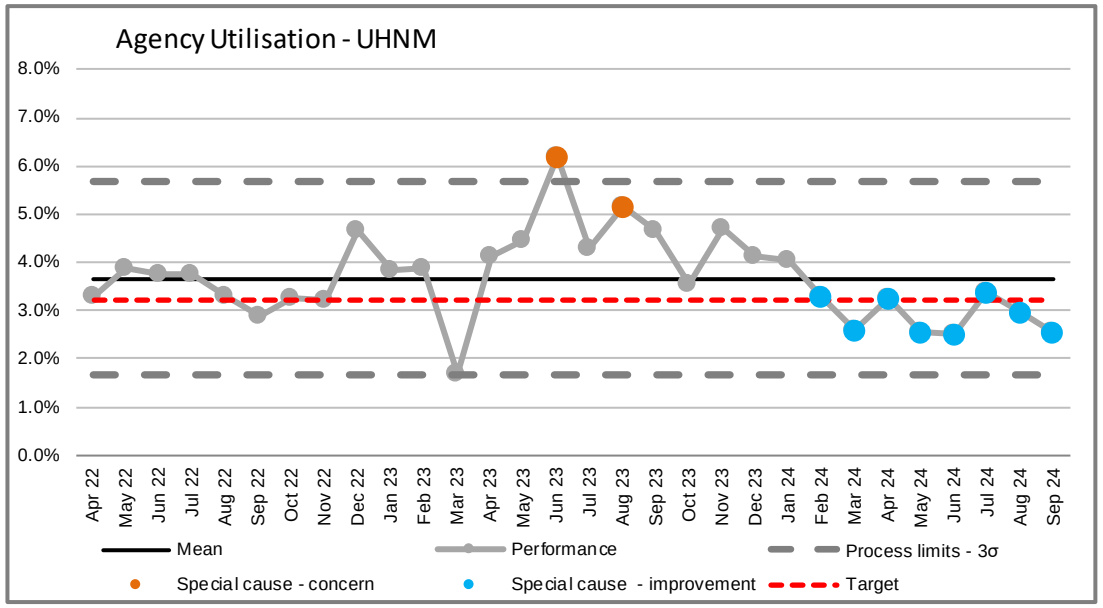
Medicine Division – Weekly updates reports on compliance. With focused assistance on those areas with the lowest compliance.

WCCSS – Weekly performance reports and assurance meetings.

People | Agency Utilisation

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
3.2%	3.4%	3.0%	2.6%

Background

Agency cost as a percentage of total pay cost

What is the data telling us?

Agency cost is calculated as a percentage of the total Pay Costs, which decreased to 2.57% in August 2024, (2.97% in August 2024), which is below the threshold set by NHS England.

In real-terms, overall agency usage decreased to 138.07 WTE in September from 206.35 WTE in August 2024. All staff groups saw decreases in agency usage with Registered Nursing & Midwifery seeing the largest reduction in use of 40.41 WTE, between August and September 2024.

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

What are we doing about it?

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

Improving & Innovating | Overview

Excellence in development and research

University Hospitals of North Midlands NHS Trust

Overview from the Chief Medical Officer and Chief Nurse

How are we doing against our trajectories and expected standards?

Metric 1: Increasing clinical trial participants:.

Research Participants:
23/24 Apr-Sept = 687
24/25 Apr-Aug = 1007

Positive increase on 23/24, but behind regional comparator Trusts, including University Trusts.

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

Metric 3: Increasing research active staff: The A3 and scorecard remain under development. The A3 has shown that we do not know what is meant by 'research active' nor how many research active staff we have in UHNM. The data provided indicate what we know only from those staff who have contacted CeNREE or the R&I department for research support or who are current CIs/PIs. This estimated number is probably increasing in part due to newly active staff but also due to gaining awareness of existing research active staff.

What is driving this?

Metric 1: To achieve the increased number of research participants requires a balanced portfolio of contracted target recruitment numbers. Apr-Sept 24/25 is over 46% higher than recruitment numbers during Apr-Sept 23/24. When benchmarked against regional Trusts our portfolio recruitments puts us behind comparator Trust, currently in 8th place regionally.

Metric 2: The A3 has shown that we do not collect this data in a systematic way. This number therefore remains unchanged.

Metric 3: The A3 has shown that we do not collect this data in a systematic way and that we do not have an agreed definition of 'research active'. The estimated number has increased from 389 to 409 since the last report.

Improving & Innovating | Overview

Excellence in development and research

University Hospitals of North Midlands NHS Trust

Overview from the Chief Medical Officer and Chief Nurse

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

Metric 1: We are monitoring recruitment against recruitment targets monthly through lead practitioner meetings. We have a high target questionnaire study reliant on school participation. We have allocated resources to this. We have identified couple of good high volume low resource requiring studies and waiting for sponsors to approve the site. Balancing the portfolio will take time to attract and run high number/recruitment studies.

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

Metric 3: We have two countermeasures in place: 1) a definition of 'research active' was suggested by stakeholders in the Research and Innovation Strategy Oversight Group (meeting 18th September) and this is now under consideration by selected members of the Executive Research and innovation Group, and 2) we will conduct a Trust wide census followed by a quarterly census via Divisional Leads.

What can we expect in future reports?

Metric 1: We will begin to look at the distribution of targets over the number of studies being set up, we are working towards proportionality in the offer of research activities to our patients. It will take about 12-18 months before we can see significant change in recruitment to allow our reputation to attract high recruiting studies.

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

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

Improving & Innovating | Dashboard

Excellence in development and research

University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Increase Clinical Trial Participation	208.0	187.0	153.0						
Increase Clinical Academic Posts/Honorary Contracts	-	8.0	13.0						
Increase Research Active Employees	-	389.0	409.0						

Improving & Innovating

Related Strategy and Board Assurance Framework (BAF)

Quality Strategy

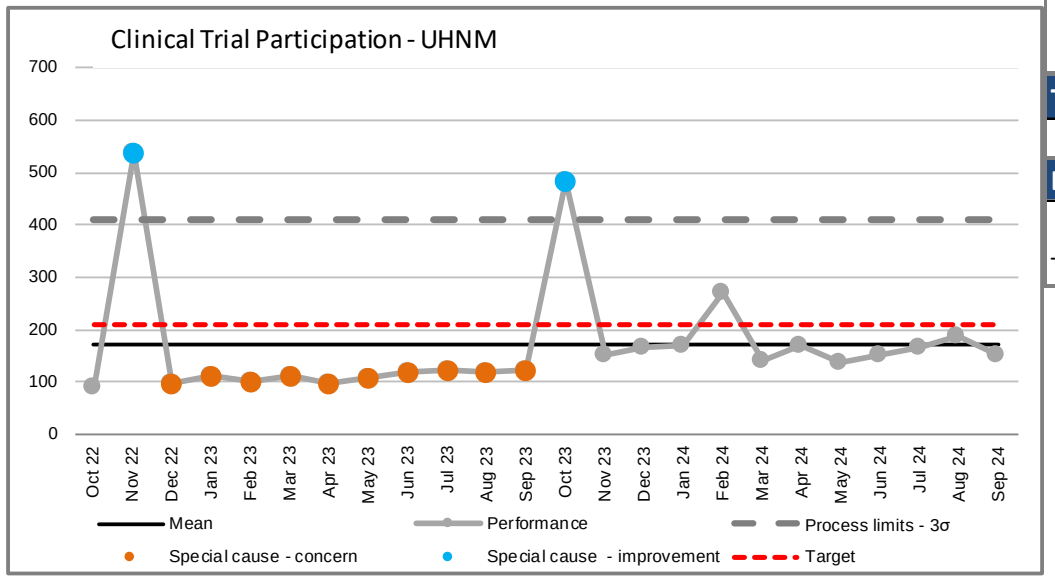
Research Strategy

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

Improving & Innovating | Clinical Trial Participation

Excellence in development and research

University Hospitals of North Midlands NHS Trust

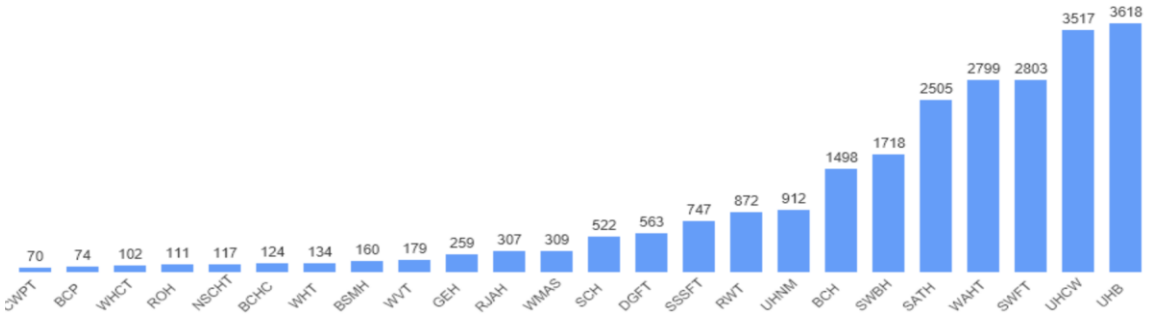


Variation	Assurance
	

Target	Jul 24	Aug 24	Sep 24
208	165	187	153

Background

The number of patients starting Clinical Trials each month.



What is the data telling us?

We benefit from running a variety of studies. The spikes show our quick turnaround studies, which are important and help to increase our numbers, which in turn will increase our reputation regionally.

The data also shows our position within the region for portfolio recruitment

What are we doing about it?

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

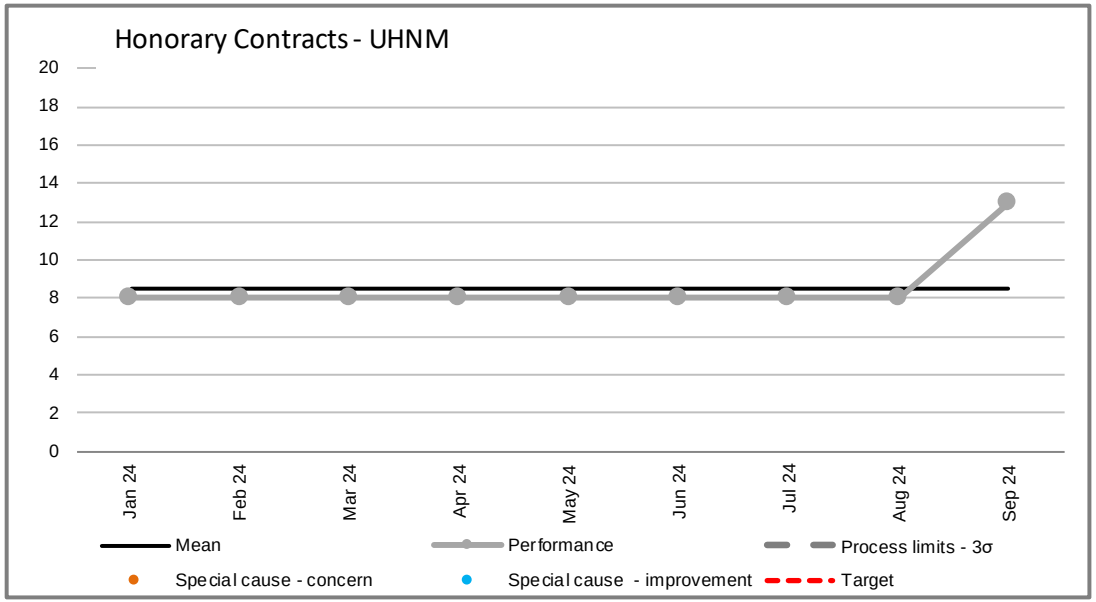
We also see our position within the region and are looking at the facilities and resources offered by the top recruiters to inform our investment direction.

Improving & Innovating

Improving & Innovating | Clinical Academic Posts/Honorary Contracts

Excellence in development and research

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
N/A	8	8	13

Background

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

What is the data telling us?

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

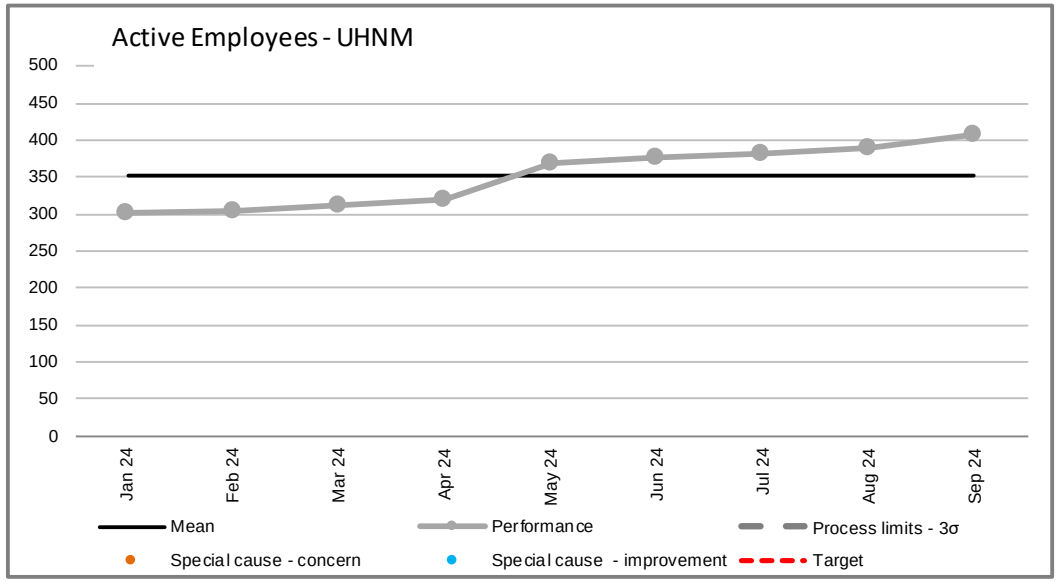
What are we doing about it?

We agreed a suggested definition of type of contract with stakeholders at a meeting on 18th September and this is currently under consideration by selected members of the Executive R&I Group. Once approved, we will conduct a Trust wide census followed by a quarterly census via Divisional leads to obtain more accurate data. This will indicate where we need to prioritise our negotiations with Higher Education Institutions (HEIs).

Improving & Innovating | Research Active Employees

Excellence in development and research

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
N/A	383	389	409

Background

The number of research active employees in UHNM.

What is the data telling us?

We do not have a confirmed definition of 'research-active' or a process for collecting this data, so this number remains smaller than anticipated.

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

What are we doing about it?

We agreed a suggested definition with stakeholders on 18th September which now needs approval from the Executive R&I Group. We will then conduct a Trust wide census followed up with quarterly census via Divisional Leads. This will highlight the areas where there is a shortfall in research activity where we can focus our attentions for development and support.

Divisional research lead posts have been agreed and will be open for applications shortly.

System & Partners | Overview

Working together to improve the health of our population

University Hospitals of North Midlands NHS Trust

Overview from the Director of Strategy & Transformation

How are we doing against our trajectories and expected standards?

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

- Elective activity vs pre-pandemic levels for under 18s and over 18s (completed with waiting list split by gender, deprivation, ethnicity and age) Proposed Annual Report metric
- Emergency admissions for under 18s (completed as part of ICB assessment) Proposed Annual Report metric
- Number of adult inpatients offered tobacco dependency treatment (Submitted monthly to NHSE – showing increasing referrals as the service is embedded) Proposed IPR metric
- Number of maternity patients offered tobacco dependency treatment (Submitted monthly to NHSE – we are increasing referrals as the service is embedded) Proposed IPR metric
- Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (not yet reported)

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

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

What is driving this?

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

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

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

System & Partners | Overview

Working together to improve the health of our population

University Hospitals of North Midlands NHS Trust

Overview from the Director of Strategy & Transformation

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

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

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

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

What can we expect in future reports?

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

System & Partners | Dashboard

Working together to improve the health of our population

University Hospitals of North Midlands NHS Trust

Proposed Metrics

Number of inpatients offered Tobacco Dependency Treatment

Number of maternity patients offered Tobacco Dependency Treatment

Anchor maturity assessment

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Alcohol Dependency	-	0.64%	0.64%						
Tobacco Dependency Treatment (Inpatients)									
Tobacco Dependency Treatment (Maternity)									
Anchor Maturity Assessment									

System & Partners

Related Strategy and Board Assurance Framework (BAF)

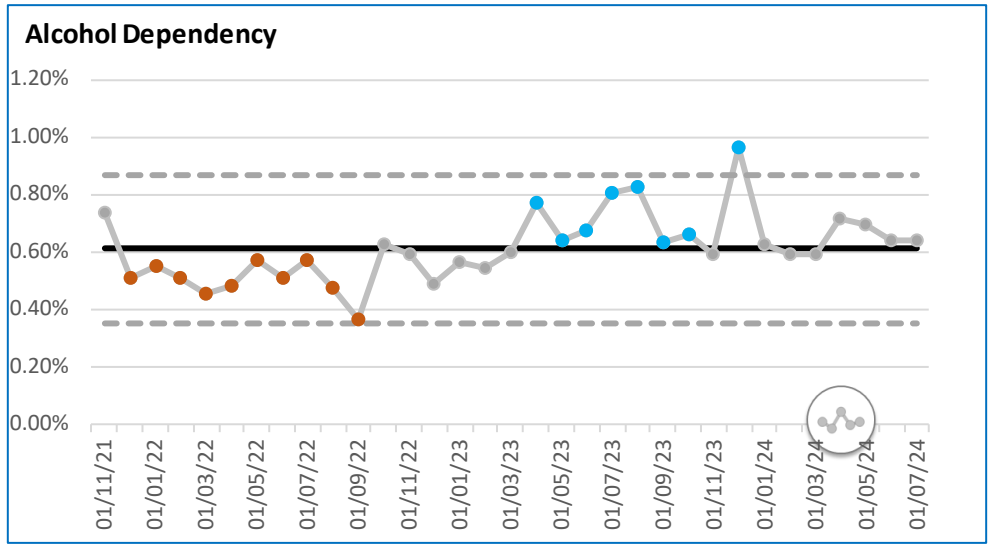
Health & Wellbeing Strategy

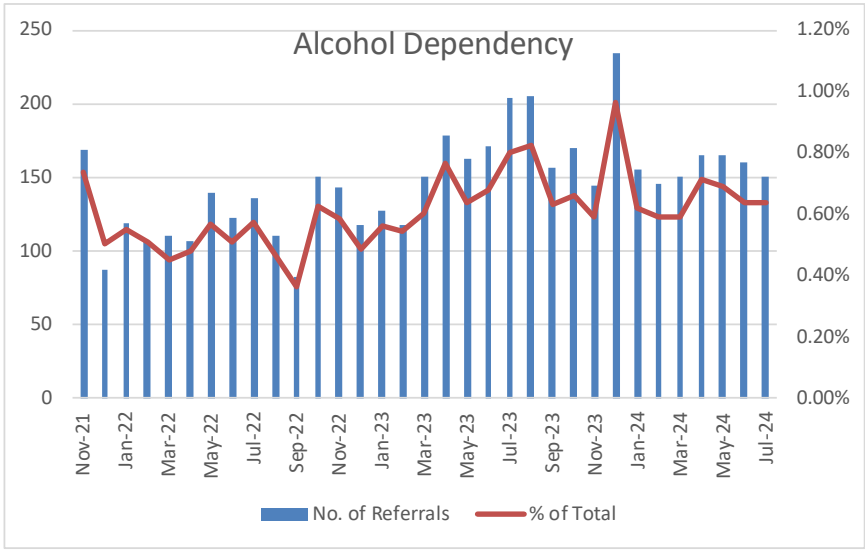
BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 3: Improving the Health of our Population	Ext 15	Partial	Ext 15	Partial				

System & Partners | Alcohol Dependency

Working together to improve the health of our population

University Hospitals of North Midlands NHS Trust





What is the data telling us?

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

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

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

What are we doing about it?

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

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

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

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

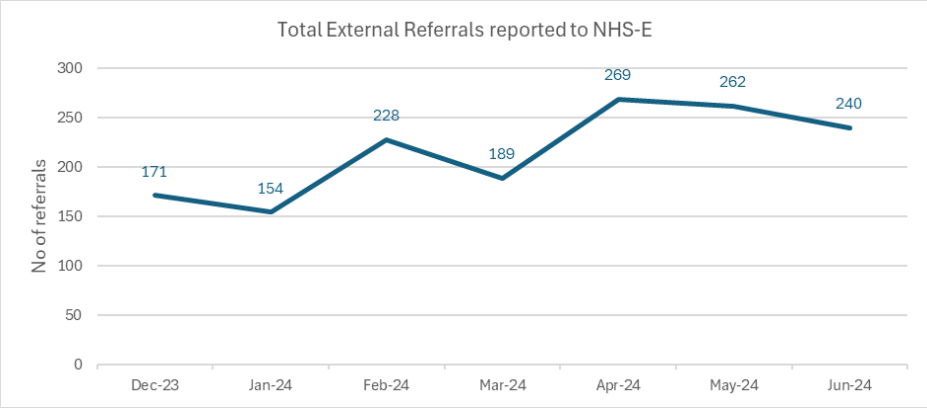
System & Partners

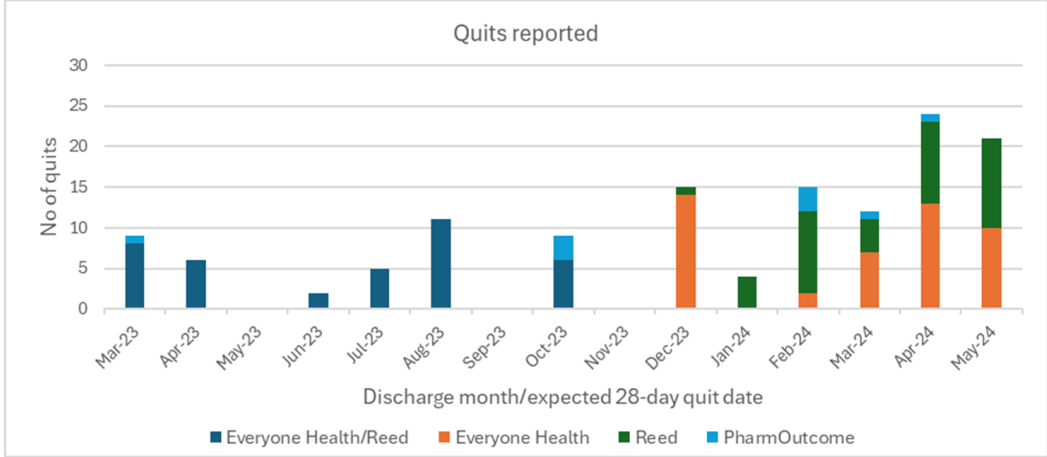
System & Partners | Tobacco Dependency Treatment (Inpatients)

Working together to improve the health of our population

University Hospitals of North Midlands NHS Trust

Referral activity from trust for community smoking cessation





What is the data telling us?

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

What are we doing about it?

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

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

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

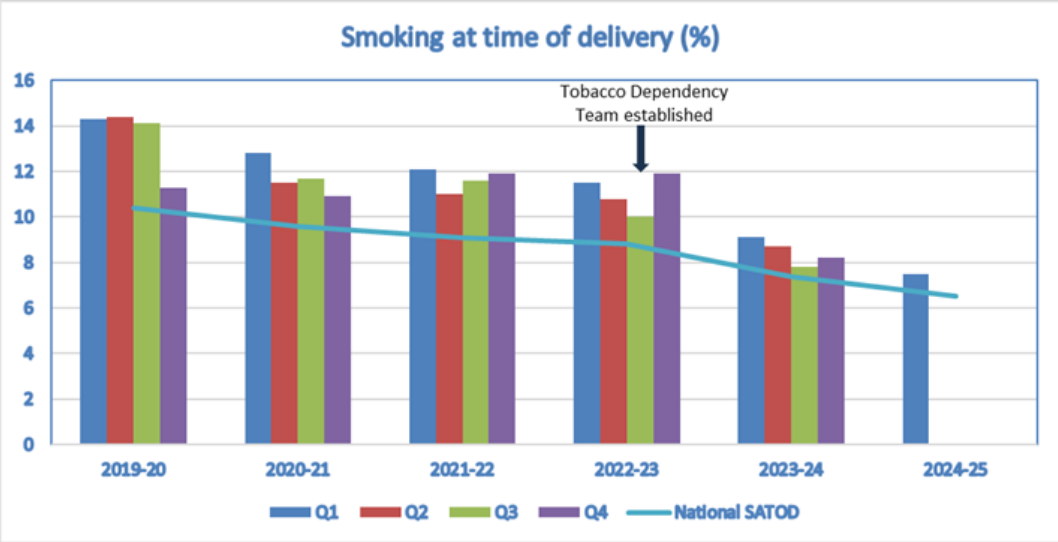
Working with Smoking Control Group to develop new policy for the Trust, aiming for smoke free by 2025.

System & Partners

System & Partners | Tobacco Dependency Treatment (Maternity)

Working together to improve the health of our population

University Hospitals of North Midlands NHS Trust



What is the data telling us?

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

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

What are we doing about it?

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

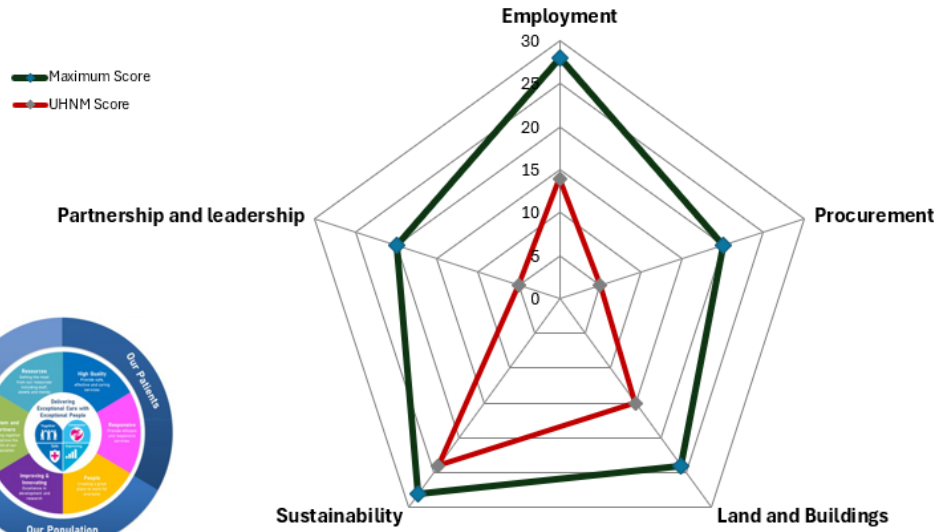
LMNS has submitted an expression of interest for the national maternity incentive scheme to support this evidence based approach to enabling expectant mothers to quit.

System & Partners

System & Partners | Anchor Maturity Assessment

Working together to improve the health of our population

University Hospitals of North Midlands NHS Trust



Our maturity score: 63
Maximum score: 120

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

What is the data telling us?

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

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

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

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

What are we doing about it?

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

Promoting existing sustainability initiatives and exploring opportunities to work with system partners on the warmer homes/beat the cold programme with the Keep Warm Keep Well intervention, NHS netzero agenda and ICS climate adaptation plan.

With unemployment and workplace health significant public health issues locally we are undertaking analysis to understand inequalities in the workforce. Findings will be presented to ICS Staff Health and Wellbeing project to take forward as an ICS partnership project.

System & Partners

Resources | Overview

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer and Chief Digital Information Officer

How are we doing against our trajectories and expected standards?

Non – elective
Non-elective activity continues at high levels although slightly below plan. This continues the general growth over the last 12 months. Plans for this year incorporate a rebase position incorporating growth in the use of Clinical Decision Unit and a continued review is in place.. These were patients who otherwise would wait for excessive periods of time in ED. A review has been undertaken collaboratively with UHNM and the ICB to assess whether an increase in 'walk-ins' can be demonstrated. This undertaking has established that 'walk-ins have more than doubled since April and a subtle connection aligned to the GP Collective action can be seen.

Elective
September activity over delivered against plan for DC however we under delivered against all other PODs
Day case 111.7%
Elective 90.80%
First OP Proc 94.8%
First Outpatient 102.6%
Follow up 99.9%

Freedom of information requests are not being completed against the nationally mandated standard. It is expected that this will improve when the new information management system is introduced in September with results improving from October onwards. Subject Access Requests have seen a small improvement of 2% although this is not a statistically material change.

What is driving this?

Non – elective
Although demand management schemes were in place over winter and past the Easter period this was not necessarily seen through a reduction in admissions, however a formal analytical review is complete and is now demonstrated through our internal Winter Plan and supported by the submitted System Surge Plan.
An important note on admissions is the use of the Clinical Decisions Unit which was, for a period, closed. This resulted in several patients waiting in ED for 24hours+ receiving treatment in an inappropriate environment. Those patients are now accessing the CDU and that will have contributed to the increased admissions shown from October 2023. Indications from the recent opening of AMRAU is positive but needs onward assurance of continuity of delivery..

Elective
The majority of DC overperformance is related to endoscopy procedures which will increase further as the mobile unit reaches full capacity in September (c750 cases per month). Underperformance in all other PODs was due to high levels of AL (in line with Trust policy) and an inability to commence some insourcing until September

The manual management of Freedom and Information Requests make it a challenge to monitor the high volume of complex requests especially where one request is required to be completed by multiple departments this is set to change in October through the deployment of the new FOI management system.

Resources | Overview

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer and Chief Digital Information Officer

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

Non – elective
The System Demand Management Collaborative is tasked with identifying schemes to reduce demand. This programme commenced in April and is likely to have its greatest impact from October 2024 and onward.
The Trust, System Partners and the ICB have reviewed all services, schemes and initiatives that will influence this and preparing for our winter planning and resilience and external and internal additional funding has been agreed and plans are being mobilised.

Elective
There are now monthly executive led FAP meetings with all divisions to review their activity outputs. This sits alongside Outpatient and Theatre improvement workstreams to support improvements in utilisation. The County strategic programme also is looking at the utilisation and development of work across County theatres and its STS facilities. Additional activity has been agreed through ERF bids to achieve 65w with bids to support 52w delivery expected to be approved in October. T and O are currently exploring supporting other centres via mutual aid.

For both FOI and SARs the introduction of a new information management system to help manage the workflow and approvals from October onwards.

What can we expect in future reports?

Non – elective
Impact and outputs will be made available regarding the schemes funded to reduced non-elective admissions. This assessment, alongside a challenge and confirm exercise. Will feed into both our weekly Winter Planning and weekly System Winter Surge meeting.
The newly agreed improvement and recovery trajectories set against the 4hr standard and Cat2 mean will be featured more prominently but work is still ongoing in respect of this.

Elective
Agreement of 52w ERF bids will lead to an increase in activity from November onwards
There is a risk that the gap between plan and actual will grow over Q3/4 due to the delay in approval of the County Surgical Hub business case. Divisions are currently undertaking a gap analysis to identify potential risk and additional further mitigations to close the gap.

An increase in FOI performance is expected from October 2024 onwards.

Resources | Overview

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Daycase / Elective Activity	7,900	10,379	10,678						
Non-Elective Activity	variable	9,304	9,013						
Outpatients' 1st	27,430	32,582	27,890						
Outpatients' Follow Up	41,048	48,071	40,532						
Freedom of Information Performance	90.0%	63.0%	64.0%						
Subject Access Request Performance	100.0%	96.0%	98.0%						
Data Security Breaches	0.0	0.0	0.0						

Related Strategy and Board Assurance Framework (BAF)

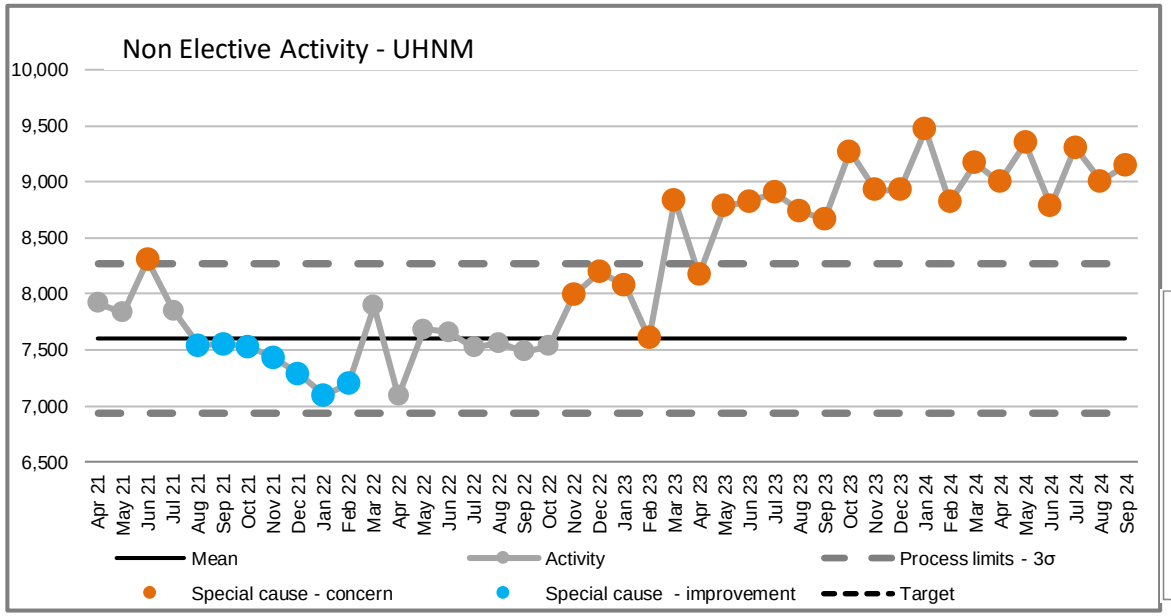
Digital Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 8: Financial Sustainability	Ext 16	Partial	Ext 16	Partial			Low 3	Partial
BAF 5: Digital Transformation	High 12	Partial	Ext 16	Partial			High 9	Acceptable

Resources | Non elective Activity

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

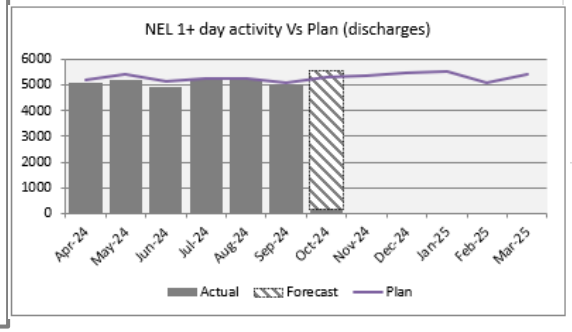


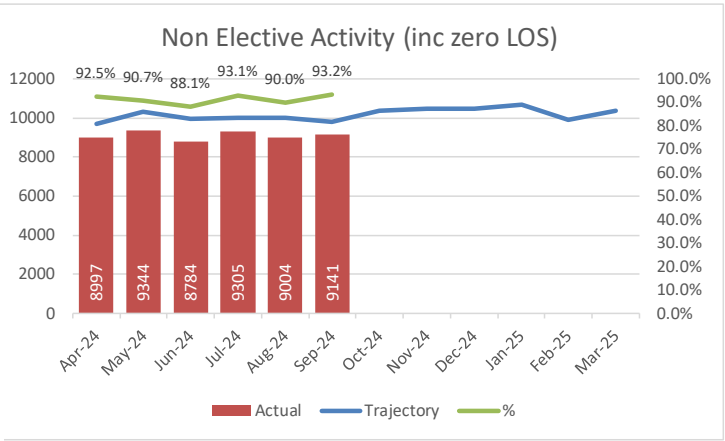
Variation	Assurance
H	P

Target	Jul 24	Aug 24	Sep 24
variable	9,305	9,004	9,141

Background

Non elective discharges following an inpatients spell at the Trust each month (includes zero LOS).





What is the data telling us?

In September we experienced a slightly lower demand in respect of our non-elective activity. September saw a reduced NEL+1 day length of stay and a NEL zero-day length of stay.

Activity verse plan for NEL 0, Year To Date – the plan was 28,410 patients but actual was 23,856 (a reduction of 16.03%). NEL+1 activity verse plan, Year To Date – the plan was 31,402 verses actual outturn was 30,712. A slight reduction of 2.20%.

The associated discharge profile for non-elective NEL zero-day achieved 87.11% against plan for September. NEL +1-day LoS achieved 99% against plan. Total expected discharges were 9,807 verses and actual of 9.136 Representing 671 fewer discharges than expected.

What the data does not tell us is any variation in average length of stay by pathway and the expected daily discharges by pathway. Nor does it describe the increase in Covid or other infectious diseases. Paediatric RSV impacted on length of stay and Covid experienced a higher-than-expected impact on admissions. This is now formally being reviewed at System and Trust level.

What are we doing about it?

The attends and admission profile is not directly within UHNM control; however, we continue to focus on and further develop alternative pathways to admission avoid.

Renewed focus through Acute Care at Home (ACaH), has positively impacted on the utilisation of 'virtual ward' capacity. 2 in reach practitioners are in post to support a 'pull' model. This is now becoming 'Business As Usual' (BAU).

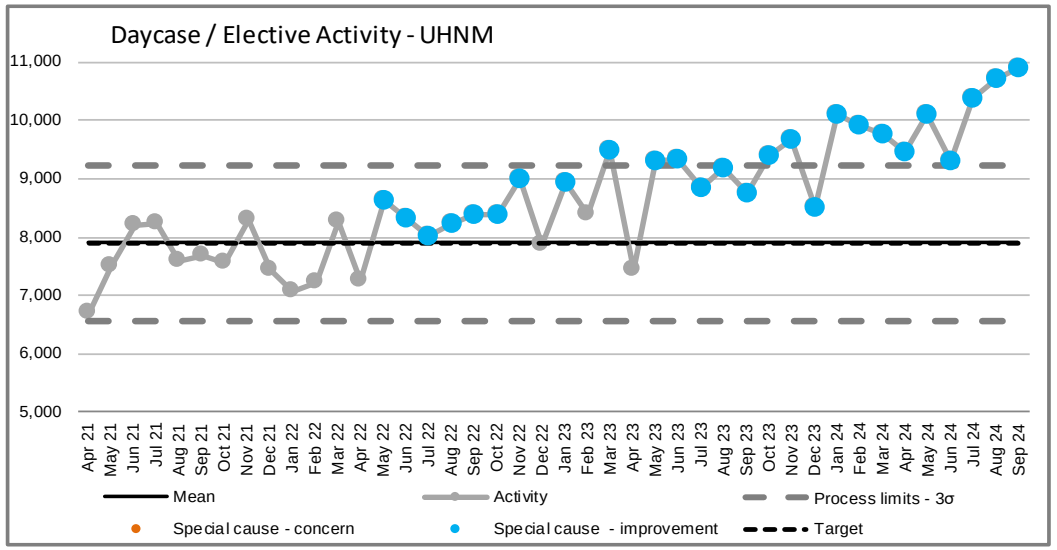
'Call before Convey' does not yet yield the benefit anticipated but is demonstrating month on month improvement.. Through collaboration with key system partners, this agreed process should prevent attend and admission, and work is in train to explore how we maximise this process and fully exploit access to all alternative nonhospital pathways.

Resources

Resources | Daycase/Elective Activity

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

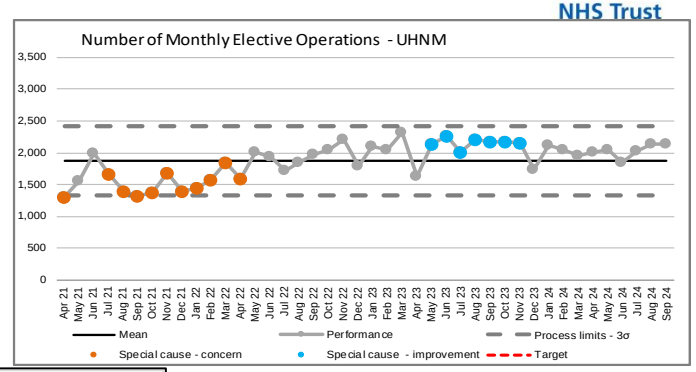


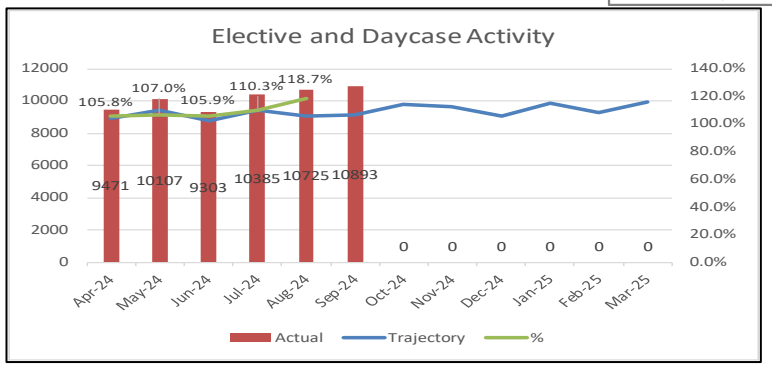
Variation	Assurance
H	?

Target	Jul 24	Aug 24	Sep 24
variable	10,385	10,725	10,893

Background

Daycase and overnight elective activity provided by the Trust each month





What is the data telling us?

There has been a special cause improvement since April 22 across day case and elective activity. Raising in Sept to 10,893 largely as a result of increase in endoscopies. Data above relates to Trust wide Daycase & Elective activity.

Theatres:
Capped utilisation for theatres has improved slightly to 76.9%, however benchmark data from Model Health shows significant and continued improvement with UHNM in Quartile 3 as a provider at 80.8% against national median of 79.8%. Differences in metric output are result of data capture methodology - in process of moving UHNM internal to the MH methodology.

Number of cases across theatres as a subset reduced by 10 to 2137 in Sept 24.

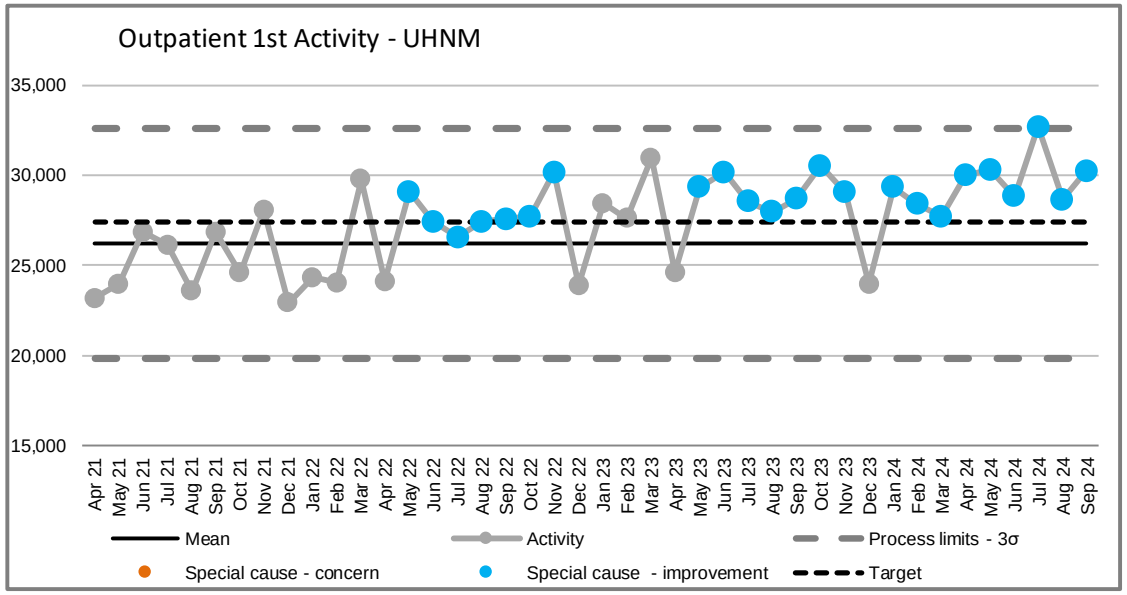
What are we doing about it?

- APOM review with NHSE / GRIFT took place 3rd Oct – awaiting report
- Golden Patient trial with T&O ongoing
- "Perfect week" took place at County w/c 7th October.
- List allocation meeting process continues
- Perioperative Medicine Pathway Transformation – Delivery groups continue to focus on future state pathway and finalising training on the digital screening tool
- Standby Pt pathway continues to evolve – >20 pts x successful cases used to backfill OTD cancellations and GA Pts have been treated as part of this .

Resources | Outpatient First Appt

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

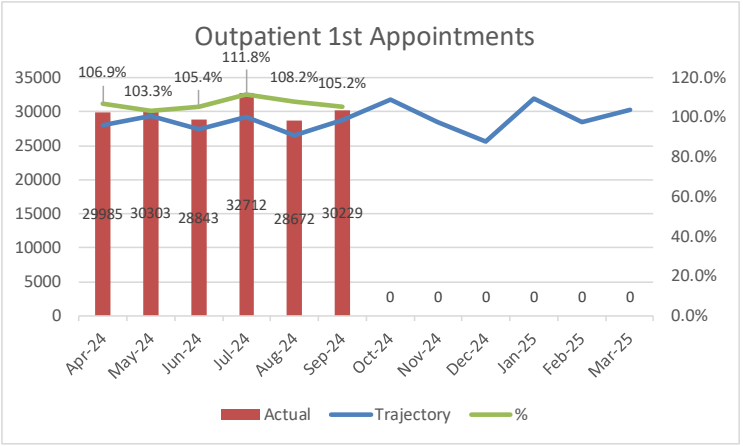


Variation	Assurance
	

Target	Jul 24	Aug 24	Sep 24
variable	32,712	28,672	30,229

Background

The number of 1st Outpatient appointments at the Trust each month



What is the data telling us?

Activity saw a sustained increase vs 3 year mean from May 2023 with all points (apart from Dec 2023) above mean, therefore mean needs recalculating from April 2023 onwards.

Whilst not specifying follow ups with/without procedure, the firsts and follow ups position implies an improvement vs the new OP National Guidance metric: % of all outpatients that are firsts, and follow ups with a procedure.

OP Cell 2024/25:
To "increase proportion of news / follow ups with a procedure", effectively making 'best use of available capacity', the countermeasures will aim to address one or more of the following:

- Increase 1st appointments
- Reduce follow ups without a procedure

Any capacity released should therefore be used for additional new patients, or to address the long waits / backlog.

What are we doing about it?

Countermeasure	Update / Next Steps
Advice & Guidance (A&G)	Advice & refer (triage by default) –scoping external support at System A&G Group –proposed A&G standards circulated widely for comments. **Potential impact of GP Collective Action unclear.**
Patient initiated Follow Ups (PIFU)	• >10 specialties live with RPA for PIFU Discharge letters. Gynae & Lymphoedema latest to go live with RPA. • UHNM volunteered to support PIFU Discovery Wayfinder Programme led by NHSE re PIFU & NHS App, awaiting date from NHSE.
Missed Appointments: - 2 Way messaging - Health Inequalities Audits	• **2 Way Messaging;** IM&T & supplier technical testing for implementation. Planned go live October with test specialty • **Health Inequalities Audits** – dashboard developed, aligning with wider health inequalities approach, closely linking with public health consultant. Pilot started July, now complete. Trying to identify resource for a pilot contacting patient cohorts prospectively. • **Missed Appointment NHSE Community of Practice** – UHNM shared audit approach & key learning points at NHSE Midlands Missed Appointments Community of Practice in October
Clinic Utilisation	See Missed Appointments Also, Clinic Process Flow in shared OP Areas, initial findings reported to OP Cell Sep, focus agreed for 2 specialties.
Results Waiting List review	Trust wide: Detailed analysis complete. Audit of neurosurgery and child health completed with 4 categories of outcomes. Improving Together event 19/06, current process mapped. Good engagement from various teams, further session held 24th July. Targeted validation request to each Division for overdue patients starting with the longest overdue. Reviewing reporting. Event Planned end of October.
Outcomes process review	Scoping approach; targeting those outstanding from previous months initially, outliers in limited number of medical specialties. Still challenges in clearing backlog, reviewing approach. Clinic outcome training actions being identified, form being re-reviewed.

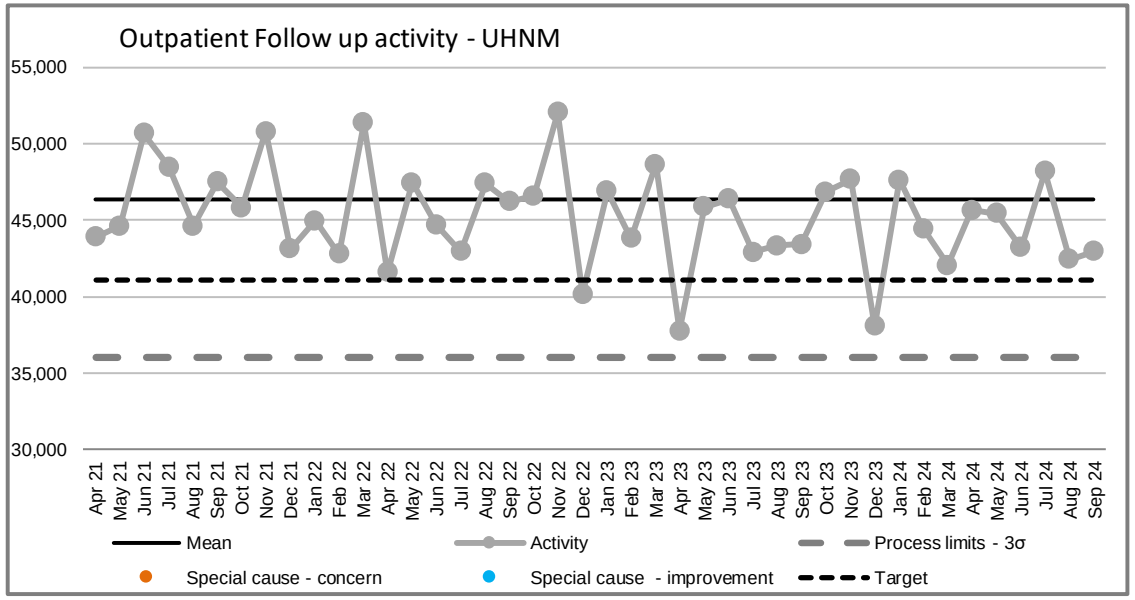
Resources

Delivering Exceptional Care with Exceptional People

Resources | Outpatient Follow Up Appts

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

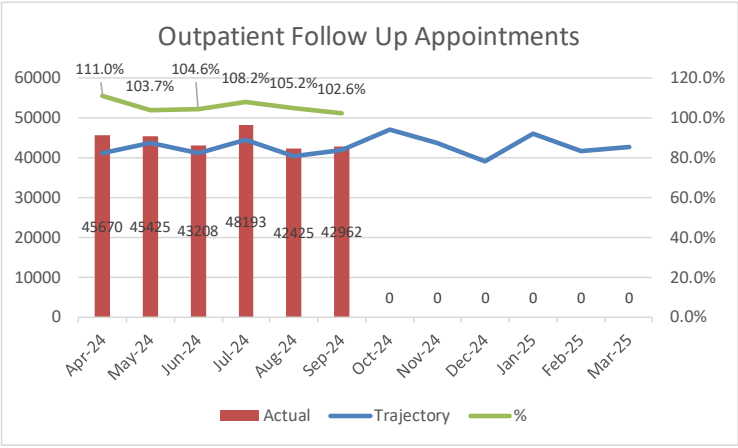


Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
variable	48,193	42,425	42,962

Background

The number of follow up outpatient appointments at the Trust each month



What is the data telling us?

No significant change at this level; however from Jan to Aug 7 points of 9 below mean.

Whilst not specifying follow ups with/without procedure, the firsts and follow ups position implies an improvement vs the new OP National Guidance metric: % of all outpatients that are firsts and follow ups with a procedure.

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What are we doing about it?

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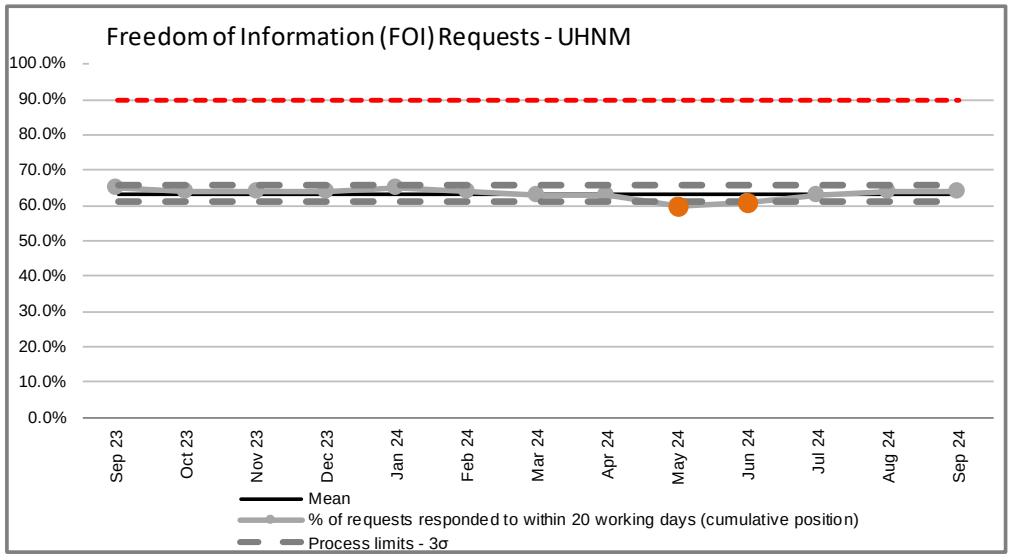
Resources

Resources | Freedom of Information Performance

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Jul 24	Aug 24	Sep 24
90%	63%	64%	64%

Background

Freedom of Information Act requires 90% of requests to be responded within 20 working days

What is the data telling us?

The turnaround time is set at 20 working days as per the FOI Act.

The turnaround times for responding to Freedom of Information (FOI) requests is below the 90% target.

The data shows improvement for the past two consecutive months but is still below the target.

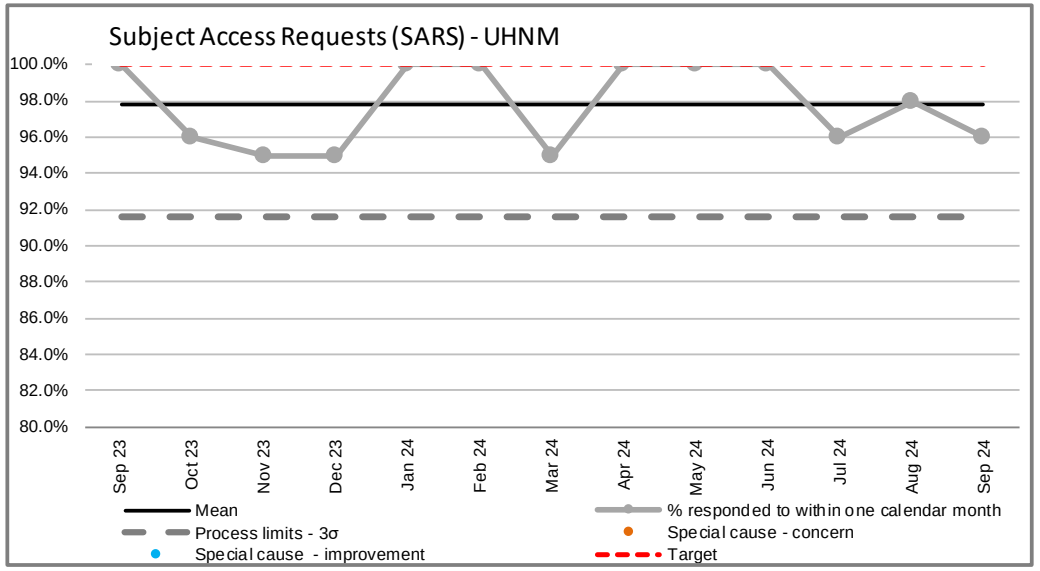
What are we doing about it?

- A digital system has been procured following consultation with key stakeholders.
- The disclosure log work stream is complete which will make the disclosure log more intuitive for the requestor
- The system is currently undergoing final testing:
  - New templates have been loaded and working as expected,
  - Training sessions have been undertaken,
  - Accounts have been created for users,
  - Access controls established and users have confirmed they can access the system.
- Final steps are underway to make the portal and disclosure log live

Resources | Subject Access Request Performance

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
100.0%	96.0%	98.0%	96.0%

Background

Data Protection Act requires subject access requests (SARs) to be responded within one calendar month. The figure includes Health Records/ CCTV/ Staff records plus information contained within emails

What is the data telling us?

The Data Protection Act states all SARs must be responded to within one calendar month unless an extension is agreed with the requestor (for more complex requests).

September saw a dip in the response times due to annual leave and sickness absence.

What are we doing about it?

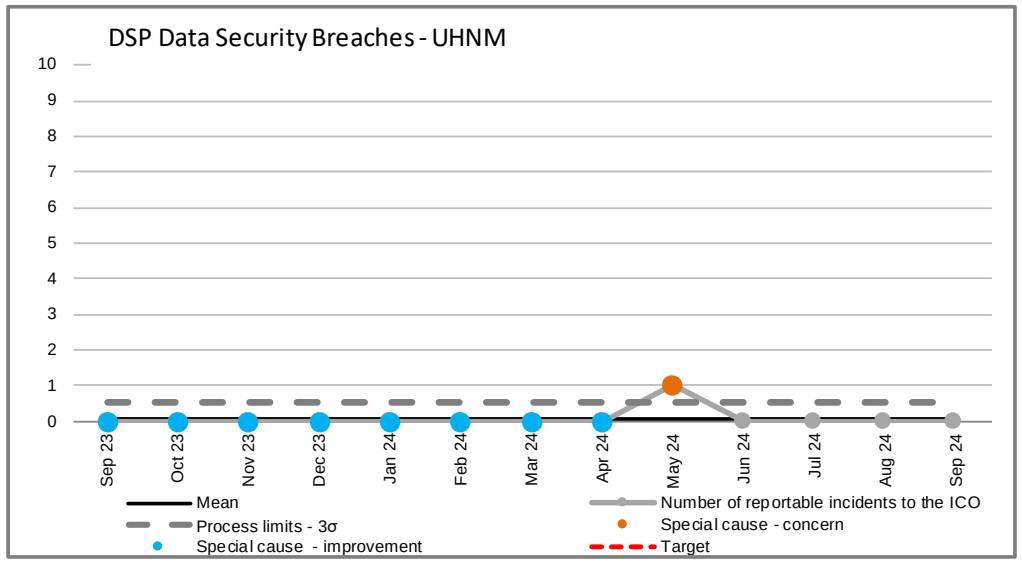
The Data, Security & Protection team are implementing a digital system for Freedom of Information Requests. This will also support the management of SARs. The People Directorate have agreed to move to the digital solution. This will facilitate a review of practice across DSP/Health Records and People Directorate in the management of SARs with the aim of standardising practice across the Trust. A project plan is being developed (as per the detail outlined on the FOI slide). The SAR module will be rolled out once the FOI module has been embedded across the Trust.

Monitoring of performance continues and additional support will be provided where appropriate.

Resources | Data Security Breaches

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jul 24	Aug 24	Sep 24
0	0	0	0

Background

What is the data telling us?

A data security breach must be reported to the Supervisory Authority; the Information Commissioner's Office (ICO), if it meets the ICO criteria threshold.

No serious breaches have been reported this month.

What are we doing about it?

A governance and assurance programme is in place to support staff in understanding Data, Security & Protection (DSP) and hence minimise a data security breach:

- Policies and Standard Operating Procedures are reviewed in line with latest/best practice.
- Statutory and Mandatory training is undertaken on a yearly basis
- DSP manual in place to support staff in their day-to-day duties.
- Training awareness survey to identify staffs understanding of DSP.
- Dedicated training material, for example Information Asset Owners, responsible for the management of digital systems.
- A meeting has taken place with the ICO to discuss the incident reported in May. Discussions are ongoing with the ICO.

Resources | Digital Project Delivery Lifecycle

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

	Progress Status						
Project Priority	COMPLETE	IN PROGRESS	MOVED TO BAU	NOT STARTED	ON HOLD	MOVED TO 25_26	Grand Total
Essential	3	14	1	4	1		**23**
Essential – Proof of Concept (PoC)			1	2		1	**4**
Mandated	1	18	2	22	6	2	**51**
Other - High Priority		5		9			**14**
Other - Medium Priority		4		5		1	**10**
Other - Low Priority	1	2	1	9	1	2	**16**
Parked				1			**1**
PoC				1			**1**
TBC							
Grand Total	**5**	**43**	**5**	**53**	**8**	**6**	**120**

Variation		Assurance	
Target	Jul 24	Aug 24	Sept 24
N/A	121	119	104

Background

There is no specific overarching target for the Digital Project Delivery Lifecycle however the count provided above identifies the number of projects presently on the IM&T project pipeline with a status of In Progress, Not Started or On Hold. The adjacent table and associated narrative describes the status and priority of all IM&T projects for 2024_25.

What is the data telling us?

There are currently 43 IM&T projects that are in progress (a reduction of 8 from last month). This is through project completion or work being transitioned to BAU. 5 projects have been completed during September 2024. 61 projects have either not started or are currently on hold (a decrease of 7 from last month) as some projects have now been moved to start next financial year (see table above). As noted in the last report, there continues to be a large volume of IM&T projects slated for delivery during 2024_25 however there has been an overall decrease due to the rescheduling to 2025_26, project consolidation or projects no longer required.

What are we doing about it?

To ensure that projects are prioritised correctly, IM&T will periodically undertake a review of priorities utilising a defined scoring mechanism based on criteria such as alignment to national/local strategy, benefits and risk reduction. IM&T have also introduced a new project request process and will also be developing a new Project Management tool to provide a centralised view and oversight of IM&T projects in addition to associated standardised project management processes. We will continue to review projects that have not started with a view to transfer these to the 2025_26 IM&T project pipeline.

Resources | Financial Summary

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

This report presents the financial performance of the Trust for September 2024 (Month 6).

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

- For Month 6 the Trust has delivered a year-to-date deficit of £11.9m against a planned deficit of £2.5m; this adverse variance of £9.4m is primarily driven by underperformance against the Trust's in year CIP, Purchase of Healthcare from external bodies and pay costs above funded establishment to respond to service pressure and patient acuity in Medical and Support to Clinical staff groups.
- There is a difference between the budget profile of the Trust's financial plan and the final plan submitted to NHSE; the Trust will continue to monitor performance against its financial plan and inform the committee of the position reported externally. It should be noted that this issue only effects the budget profile not the actual position and is neutral across the year.
- The Trust has a CIP target of £56.6m in 2024/25. The Trust has validated £19.6m of CIP savings to Month 6 against a plan of £24.9m. Of the £19.6m saving delivered, £15.8m are non-recurrent.
- The full year forecast at Month 6 indicates that the most likely position remains a £23.1m deficit; this includes the expected impact of a series of agreed actions across the system which are incorporated into a draft system wide recovery plan.
- There has been £30.2m of Capital expenditure to Month 6. This is £0.6m below planned expenditure to Month 6.
- The cash balance at Month 6 is £80.4m which is £8.9m higher than plan mainly due to the profile of cash payments from the ICB; the forecast for the year is for a reduction of £20m due to non-cash elements, a requirement of £7.7m of Trust cash to be used for the 2024/25 capital programme and the payment in 2024/25 of capital payables at 31 March 2024.

Resources | Income and Expenditure

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

The Trust has delivered an £11.9m deficit at Month 6 which is a £9.4m adverse variance from the planned deficit of £2.5m. The table below summarises the I&E position at Month 6.

Income & Expenditure Summary Month 06 2024/25	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,083.7	91.4	92.3	0.9	539.3	543.2	3.8
Other Operating Income	91.0	8.6	7.4	(1.2)	46.5	45.1	(1.4)
Total Income	1,174.7	100.0	99.7	(0.3)	585.8	588.3	2.5
Pay Expenditure	(706.2)	(59.4)	(59.0)	0.5	(349.2)	(351.6)	(2.4)
Non Pay Expenditure	(435.3)	(38.3)	(40.5)	(2.2)	(222.6)	(232.5)	(9.9)
Total Operational Costs	(1,141.5)	(97.7)	(99.4)	(1.7)	(571.8)	(584.1)	(12.3)
EBITDA	33.2	2.3	0.2	(2.1)	14.1	4.2	(9.8)
Interest Receivable	4.0	0.3	0.5	0.2	2.0	3.3	1.3
PDC	(2.0)	(0.2)	(0.3)	(0.2)	(1.0)	(1.8)	(0.8)
Finance Cost	(35.2)	(2.9)	(2.9)	(0.0)	(17.6)	(17.7)	(0.1)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	0.0	(0)	(2.5)	(2.0)	(2.5)	(11.9)	(9.4)
Plan phasing adjustment	0.0	1.0	0.0	(1.0)	5.1	0.0	(5.1)
Surplus / (Deficit) reported to NHSE	0.0	0.5	(2.5)	(3.0)	2.5	(11.9)	(14.4)

Key issues to note within the Month 6 position include the following.

The year-to-date adverse variance of £9.4m is mainly driven by an under achievement of CIP £5.3m, pay costs above funded establishment to respond to service pressure and patient acuity in Medical and Support to Clinical staff groups £4m and the purchase of healthcare from other bodies (mainly relating to external reporting in Radiology and Pathology) £2.5m. Income is over recovered by £2.5m mainly due to additional excluded drugs and devices income; this is offset by non-pay overspends. The Month 6 position includes an additional £1.1m of income to cover the costs of industrial action earlier in the year.

Resources | CIP

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

The Trust has a £56.6m CIP target for 2024/25. To Month 6, the Trust is reporting £19.6m savings in year, of which £15.8m relates to non-recurrent schemes. The in-month under-delivery of £0.5m is driven by the under-achievement of recurrent CIP delivery in the clinical divisions below the planned level.

The table below summarises the Month 6 position:

CIP Savings Month 6 2024/25	Annual Target	In Month			Year to Date		
		Budget	Actual	Variance	Budget	Actual	Variance
Divisional position							
Medicine & Urgent care	3.9	0.3	0.1	(0.2)	1.9	0.4	(1.6)
Surgery, Theatres & Critical Care	3.6	0.3	0.1	(0.2)	1.8	0.2	(1.6)
Network services	2.8	0.2	0.1	(0.1)	1.4	0.3	(1.1)
Womens, Childrens & Clinical Support Services	2.6	0.2	0.1	(0.1)	1.3	0.4	(0.9)
Central functions	1.6	0.1	0.1	(0.1)	0.8	0.3	(0.5)
Estates, Facilities & PFI	1.0	0.1	0.1	(0.0)	0.5	0.5	(0.0)
North Midlands & Cheshire Pathology Services	1.2	0.1	0.0	(0.1)	0.6	0.1	(0.5)
Recovery actions - divisional CIP to be identified							
Divisional CIP	16.7	1.4	0.6	(0.8)	8.3	2.2	(6.1)
Pay Underspend	6.0	0.5	0.5	-	3.0	3.0	-
Bank interest	2.0	0.2	0.4	0.2	1.0	2.3	1.3
Energy savings	3.2	0.3	0.3	-	1.6	1.6	-
Investment slippage	5.0	0.6	0.6	-	4.2	4.2	-
Other non recurrent	7.3	0.6	0.7	0.1	3.6	3.1	(0.5)
Additional CIP to 4% of cost base	6.3	0.5	0.5	-	3.2	3.2	-
Additional CIP to achieve breakeven	10.2		-	-			-
Recovery action - non recurrent mitigation							
Recovery actions - balance sheet							
Recovery actions - discretionary expenditure							
Recovery action - pay controls							
Total CIP	56.6	4.0	3.5	(0.5)	24.9	19.6	(5.3)

The table below summarises the recurrent and non-recurrent CIP delivery.

2024/25 CIP target	Annual Target	In Month			Year to Date		
		Budget	Actual	Variance	Budget	Actual	Variance
Recurrent	25.0	1.7	0.9	(0.8)	9.9	3.8	(6.1)
Non Recurrent	31.7	2.4	2.6	0.3	15.0	15.8	0.8
Total CIP target	56.6	4.0	3.5	(0.5)	24.9	19.6	(5.3)

Resources | Capital

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

UHNM Capital Plan	2024/25 Plan £000	2024/25 Forecast £000	YTD Plan M6 £000	YTD Actual M6 £000	Variance M6 £000
Capital funding					
PFI & Loan Commitments	31.5	31.5	14.2	14.2	-
Base STP allocation	22.1	22.1	11.1	11.1	-
ICB fair share reduction	(0.5)	(0.5)	(0.3)	(0.3)	-
ICB brokerage	(3.1)	(3.1)	(1.5)	(1.5)	-
ICB IFRS16 CDC lease funding	5.0	5.0	-	-	-
ICB IFRS16 incremental increase allocation	4.4	4.4	0.5	0.5	-
Public Dividend Capital funding	40.9	41.8	8.1	8.1	-
Donated, granted other capital funding	7.0	6.7	2.2	2.2	-
Internal funding source (including capital receipts)	1.8	2.3	-	-	-
Total Capital funding	109.2	110.2	34.4	34.4	-
Capital expenditure					
PFI & Loan Commitments	(31.5)	(31.5)	(14.2)	(14.2)	-
Pre-committed investment items (ICB allocation)					
PFI enabling costs	(0.2)	(0.2)	(0.2)	(0.1)	0.1
Network & Comms BC525	(1.3)	(1.3)	(1.3)	(1.2)	0.1
IM&T computer hardware refresh programme	(5.2)	(2.3)	-	-	-
LED lighting BC546	(0.2)	(0.2)	-	-	-
Pharmacy Robot BC487 -	(0.0)	(0.0)	-	-	-
Investment funding	(0.5)	(0.5)	(0.1)	(0.1)	-
Central Contingency & risk	(0.3)	(0.2)	-	-	-
Project Star - car park completion/RI remedial work	(0.7)	(0.7)	(0.3)	(0.3)	-
Emergency Department (restatement costs)	(0.2)	(0.2)	-	-	-
Air heat boiler replacement Trust Contribution	(0.8)	(0.8)	-	-	-
EPMA (Electronic Prescribing) BC	(0.4)	(0.4)	(0.2)	(0.2)	(0.1)
Patient Portal roll out costs (BC 462)	(0.1)	(0.1)	(0.0)	(0.0)	0.0
ED ambulance off - enabling ward moves	(0.3)	(0.1)	(0.1)	(0.1)	-
Endoscopy works 7th room - PDC ICB allocation	(0.4)	(0.0)	-	-	-
County theatre holding bay	(0.3)	(0.3)	-	-	-
Omnicell Cabinet for AMU	(0.3)	-	-	-	-
Car park barriers BC550	(0.8)	(0.8)	-	-	-
Electronic Patients records BC/specification	(0.1)	(0.1)	(0.1)	(0.0)	0.0
Approved minor investments	(0.2)	(0.2)	(0.2)	(0.2)	0.0
Purchase of County Medical Records building	-	(1.4)	-	-	-
Spinal Navigation BC	-	(0.8)	-	-	-
Omnicell Cabinet replacement ED	-	(0.2)	-	-	-
County CTS2 Equipment	-	(0.4)	-	-	-
County mammography equipment (brought fwd)	-	(0.7)	-	-	-
Medical devices additional allocation	-	(1.0)	-	-	-
Investments provisionally approved by Oct CIG	-	(0.2)	-	-	-
Funding to be (allocated)/shortfall	(2.5)	-	-	-	-
Total Pre committed Investment items	(14.6)	(13.0)	(2.3)	(2.2)	0.2
IMT Sub Group Funding	(3.5)	(2.1)	(0.7)	(0.5)	0.2
IM&T lap top replacement top-slice	1.3	-	-	-	-
Medical Devices Sub Group Total Funding	(3.6)	(3.6)	(1.4)	(1.8)	(0.4)
Medical Devices Sub Group brought forward	-	(1.0)	-	-	-
Estates Sub Group Total Funding	(4.3)	(4.3)	(1.3)	(0.6)	0.7
Health & Safety compliance	(0.2)	(0.2)	-	-	-
Net zero carbon (sustainability) initiatives	(0.1)	(0.1)	-	-	-
Total Sub Groups	(10.3)	(11.3)	(3.3)	(2.9)	0.4
Lease liability re-measurement	(0.4)	0.2	0.1	0.1	-
IFRS16 - lap top extension	(0.1)	(0.5)	(0.5)	(0.5)	-
IFRS16 CDC building lease	(5.0)	(4.1)	-	-	-
IFRS16 - cancer digital pathology	-	(0.6)	-	-	-
IFRS16 - hardware refresh	-	(3.0)	-	-	-
IFRS16 - pathology extension	-	(0.3)	-	-	-
IFRS16 new lease/lease extension	(0.5)	(0.7)	(0.2)	(0.2)	-
IFRS16 efficiency requirement	0.9	-	-	-	-
Total IFRS16 leases	(5.1)	(8.9)	(0.5)	(0.5)	-
Total Internal Capital Expenditure programme	(61.5)	(64.6)	(20.4)	(19.8)	0.6
Additional CRL / Externally Funded PDC					
CDC phase 2 endoscopy - 24/25 PDC	(6.2)	(6.6)	-	-	-
CDC phase 2 endoscopy - 24/25 IM&T	(0.5)	(0.5)	-	-	-
CDC phase 1 estates enabling - 24/25	(14.5)	(4.4)	(0.9)	(0.9)	-
ICB brokerage allocated to CDC slippage	3.1	-	-	-	-
TIF 2 PDC (Breast care unit)	(7.5)	(4.5)	(0.8)	(0.8)	-
TIF 2 PDC (Day Case Unit) -	(8.7)	(8.1)	(3.4)	(3.4)	-
PDC - UEC modular build (AMRA) 23/24 PDC	(2.9)	(2.9)	(2.6)	(2.6)	-
Digital - EPR 2023/24 PDC	(2.1)	(2.1)	(0.4)	(0.4)	-
Digital - EPR 2024/25 PDC	(1.4)	(1.4)	-	-	-
Pathology cancer reporting PDC	-	(0.4)	-	-	-
Mobile breast screening PDC	-	(0.5)	-	-	-
Air heat boiler replacement PSDS Grant BC 510	(2.5)	(2.5)	(0.0)	(0.0)	-
Equipment - endoscopy CDEL	(1.0)	(1.0)	-	-	-
Charitable funded expenditure	(3.5)	(3.1)	(2.2)	(2.2)	-
Total Additional CRL / PDC Funded expenditure	(47.8)	(37.9)	(10.3)	(10.3)	-
Total Capital Expenditure	(109.2)	(102.6)	(30.8)	(30.2)	0.6
Planned under/(over) spend	(0.0)	7.7	3.6	4.2	0.6

At Month 6 the forecast year-end expenditure against plan has shown a deterioration of £7.7m compared to the previous month due to unmitigated underspends on the PDC funded CDC enabling works (£4.7m) and TIF County Breast Unit (£3m).

For CDC and TIF County Breast Unit the latest forecast expenditure would require a brokerage of PDC funding between 2024/25 and 2025/26 of £17.55m, of which £9.87m was included within the approved capital plan. As per the forecast above the remaining £7.7m of PDC brokerage required cannot be accommodated within the forecast. The position on both PDC funded schemes above is currently being discussed with the relevant NHSE National Programme teams however no indication has been given that there will be a further rephasing of the PDC funding for either scheme. As a result, this currently represents a £7.7m unfunded risk to the 2025/26 capital programme.

The Trust has potentially identified a further £3.8m of mitigating actions in respect of VAT refunds and the CDC landlord works however the accounting implications and risks of these need to be fully discussed and agreed prior to being included.

At Month 6 capital funding is in line with plan and capital expenditure is £0.6m lower than plan. Of the £30.2m expenditure, £14.2m relates to pre-committed items for the repayment of PFI and IFRS16 lease liabilities and PFI lifecycle expenditure.

For capital expenditure the main variance from plan is on capital sub-groups where expenditure overall is £0.6m behind plan. The estates sub-group is £0.7m behind plan mainly due to minor slippage in the boiler shell replacement and endoscopy wash replacement schemes. This is partly offset by the medical devices sub-group being £0.4m ahead of plan due to the early procurement of a number of items. The IM&T sub-group is £0.2m behind plan at month 6. It is expected that all capital sub-group schemes will be completed by the year end.

The planned underspend of £3.6m at Month 6 relates to the difference between capital funding through depreciation and planned expenditure. The depreciation charge is generally phased equally over the course of the financial year however capital expenditure is phased largely in the second half of the financial year.

Resources | Balance Sheet

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

Balance sheet as at Month 6	31/03/2024	30/09/2024			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	686.3	690.7	690.1	(0.6)	
Right of Use Assets	18.1	18.5	16.0	(2.5)	Note 1
Intangible Assets	16.3	13.3	13.0	(0.3)	
Trade and other Receivables	1.1	1.1	1.1	0.0	
Total Non Current Assets	721.7	723.6	720.2	(3.5)	
Inventories	17.7	17.7	18.3	0.6	
Trade and other Receivables	44.4	47.4	57.4	10.0	Note 2
Cash and Cash Equivalents	82.0	71.5	80.4	8.9	Note 3
Total Current Assets	144.1	136.6	156.1	19.5	
Trade and other payables	(125.6)	(114.3)	(146.6)	(32.3)	Note 4
Borrowings	(25.7)	(25.7)	(25.7)	(0.1)	
Provisions	(5.7)	(5.7)	(5.5)	0.2	
Total Current Liabilities	(156.9)	(145.7)	(177.8)	(32.2)	
Borrowings	(477.1)	(477.6)	(476.1)	1.5	Note 1
Provisions	(2.3)	(2.3)	(2.3)	0.0	
Total Non Current Liabilities	(479.4)	(479.9)	(478.4)	1.5	
Total Assets Employed	229.5	234.7	220.0	(14.6)	
Financed By:				-	
Public Dividend Capital	693.9	693.9	693.9	-	
Retained Earnings	(669.1)	(663.9)	(678.5)	(14.7)	Note 5
Revaluation Reserve	204.7	204.7	204.7	-	
Total Taxpayers Equity	229.5	234.7	220.0	(14.7)	

Note 1. Right of use assets are £2.5m behind plan and borrowings are £1.5m below plan. This is mainly due to the IM&T hardware refresh lease starting later than planned. The Business Case has now been approved and the assets and liability will be shown once assets are available for use to the Trust.

Note 2. Trade and other receivables are £10m higher than plan. This is mainly due to prepayments of £13.2m being higher than expected, the prepayments mainly relate to managed service contracts and annual licences which are paid for the 12-month period. NHS accrued income is also higher than plan at £21.2m. Included within this is a balance with the ICB of £8.1m, which includes accruals relating to industrial action income and the impact of accounting for the PFI under IFRS. Accrued income of £6.6m with NHS England includes £3.7m relating to drugs costs and £1.8m variable growth funding.

Note 3. At Month 6 the cash balance was £80.4m, which is £8.9m higher than the plan of £71.5m. Cash received is £17.3m higher than plan overall. The Staffordshire and Stoke ICB block mandate is £17.4m higher than plan, of which £10.6m relates to the upfront payments of ERF funding. Payments are £8.4m ahead of plan at the year end of which £7.8m relates to general payments. This overspend reflects the revenue overspend to Month 6 and the higher than planned level of prepayments in 2024/25. Capital payments are £2.4m ahead of plan.

Note 4. Trade and other payables are £32.3m higher than plan. This is mainly due to deferred income of £44.7m at Month 6 being significantly higher than plan. Of this balance £24.2m relates to Staffordshire and Stoke ICB due to the upfront payments of ERF funding £10.6m, 2024/25 block contract £4.9m and West Midlands Cancer Alliance funding £1.7m. At Month 6 the deferred income balance also included £6.6m from NHSE relating to high-cost devices, £1.9m in relation to the specialised block contract from NHS England, and £1.1m for Digital Pathology.

The overall increase in deferred income is partly offset by the reduction in capital payables compared to the year end due to the payment of invoices and reduced level of capital spend in the early months of the financial year compared to the year end.

Note 5. Retained earnings are showing a £14.7m variance from plan which reflects the Month 6 financial performance deficit of £11.9m and adjustments relating to.

- donated income and donated depreciation £1.3m.
- adjust PFI revenue costs to a UK GAAP basis £1.1m.

Resources | Forecast revenue outturn

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

The Trusts forecast for the year is for a £23.1m deficit; this includes the impact of additional actions that have been agreed by Chairs and CEOs. At a system level this forecast is for a £146m deficit which has not been accepted by NHSE. The detail of the additional actions were reported to the Committee last month with a request that a profiled forecast be included in the report along with the actual performance against this profile; the table below provides the profile of the £23.1m deficit over the remainder of the year.

2024/25 I&E forecast surplus/(deficit) £m	YTD Mn 5	Mn 6	Mn 7	Mn 8	Mn 9	Mn 10	Mn 11	Mn 12	Total
Base forecast	(9.4)	(2.6)	(2.9)	(3.0)	(3.1)	(4.2)	(3.5)	(3.5)	(32.2)
Divisional CIP schemes above base forecast			0.5	0.5	0.5	0.5	0.5	0.5	3.0
Divisional risk bias		0.3	0.3	0.3	0.3	0.3	0.3	0.3	2.1
Non recurrent mitigations								5.0	5.0
I&E forecast surplus/(deficit)	(9.4)	(2.3)	(2.1)	(2.2)	(2.3)	(3.4)	(2.7)	2.3	(22.1)
Band 2 to 3 mitigation								(15.0)	(15.0)
System recovery plan									
Band 2 to 3 mitigation								7.0	7.0
Additional balance sheet flexibility						1.2	1.2	1.2	3.6
Further CIP/Mitigation discretionary expenditure				0.1	0.1	0.1	0.1	0.1	0.7
Further CIP/Mitigation pay controls				0.3	0.3	0.3	0.3	0.3	1.4
Additional Education funding for junior medical staff		0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4
Industrial action funding					0.9				0.9
In month I&E forecast surplus/(deficit)	(9.4)	(2.3)	(2.1)	(1.7)	(0.9)	(1.7)	(1.1)	(4.0)	(23.1)
Cummulative I&E forecast surplus/(deficit)	(9.4)	(11.6)	(13.7)	(15.4)	(16.3)	(18.0)	(19.1)	(23.1)	

The Month 6 actual deficit of £2.5m is a £0.2m deterioration on the forecasted position for a £2.3m deficit; the table below summarises the main movements from the forecast

		£m	
Month 6 I&E forecast surplus/(deficit)		(2.3)	Note
Additional Education funding for junior medical staff		(0.1)	1
Industrial action funding		1.1	2
Variance to base forecast		(1.3)	3
Month 6 I&E surplus/(deficit)		(2.5)	

Notes

1. Confirmation of the additional Health Education England funding for junior medical staff was received after the Month 6 accounts were closed and so was not included within the position; the additional income will be included in the Month 7 position
2. The additional income to fund the impact of industrial action earlier in the year has been received earlier than forecast and therefore has been reflected in the Month 6 position (the actual value was £0.2m than the forecast).
3. The base divisional position at Month 6 was a £1.3m deterioration on the forecast. The main driver for this was additional costs relating to purchase of healthcare from other bodies in Imaging, Pathology and Skin Services. The additional £200k costs in Skin Services are due to the ERF scheme being ahead of plan and therefore the costs are expected to come into line with the forecast

The realistic full year forecast has not changed significantly from the £23.1m with the additional non pay costs seen in Month 6 expected to be offset by additional income from HEE.

Resources | Conclusion

Getting the most from our resources including staff, assets and money

University Hospitals of North Midlands NHS Trust

The Trust has recorded an actual year to date deficit of £11.9m at Month 6 against a planned deficit of £2.5m, resulting in an adverse variance year to date of £9.4m. This is primarily driven by the non-delivery of CIP, non-pay pressures and pay costs for Medical and Support to Clinical staff groups. A series of actions incorporated into a system recovery plan result in a forecast deficit for the year of £23.1m (including the impact of the Band 2-3 rebanding); this is unlikely to be accepted by NHSE and so further actions are required to deliver the Trust's financial plan for the year.

Highlight Report

Quality Governance Committee | 31st October 2024

Matters of Concern / Key Risks to Escalate

For information:

- The Committee noted the inadequacy of assurance for completion of **Venous Thromboembolism (VTE) assessment** which was not expected to be addressed until the implementation of an Electronic Prescribing and Medicines Administration (EPMA) system
- Initial feedback from the **Major Trauma Peer Review** highlighted 4 areas of concern out of the 81 standards, and it was noted that an action plan had been developed to address these areas. The Committee agreed that it was not able to rate the level of assurance provided until the full report had been received
- The **Infection Prevention Hospital Acquired Infection** report highlighted ongoing actions being taken to prepare and inform staff of the actions required in treating potential m pox cases. The Commtitee agreed with the partial assurance rating due to the work required to further reduce the number of c-difficile and e-coli cases as well as increasing training compliance
- The **annual report for vulnerable patients** provided partial assurance due to the actions required to address the gap in staffing to deal with the increase in referrals, the requirement to increase training compliance and the further assurance required to consider any differences in compliance between sites. The size and complexity of the vulnerable patients agenda was noted and discussed
- The **child safeguarding annual report** highlighted particular risks with actions being identified to address the separation of maternity safeguarding, and requirements to increase level 3 training compliance for safeguarding children which provided partial assurance
- The **safeguarding adults annual report** provided partial assurance and highlighted an increase in the need for the team to contribute to external reviews, gaps in supporting domestic abuse patients and the contribution to the PREVENT agenda
- An update was provided on the 14 actions taken following the review into **wrong site surgery never events** and a partial assurance level was suggested by the Committee with this moving to acceptable assurance once it had been confirmed that all actions had been completed
- The risk in relation to **clinical effectiveness** continued to be rated as Extreme 16 although some progress was being made and assistance from the Project Management Office was being utilised to undertake a gap analysis

Major Actions Commissioned / Work Underway

- To articulate the lack of assurance on staffing levels for other staff as a gap within **BAF 1** in addition to revisiting the target risk score trajectories for Q3 and Q4 given current performance
- To provide further assurance to the Committee in terms of the reasons for the continued challenges with **timely observation** compliance
- To obtain further information from the region in terms of the root causes and learning associated with the national increase in **e-coli** rates
- To include further assurance in terms of intra uterine transfers within future **maternity dashboard** reports in addition to including the plans for continuity of carer, medical triage data and triangulation of data regarding patient experience
- Given the Trust's position within the regional heatmap for **neonatal and perinatal deaths**, a paper was to be provided to Quality and Safety Oversight Group and escalated as required to the Committee
- To provide a further update on the **Major Trauma Peer Review** to the Committee once the full report had been received
- To confirm the increase in the number of **child attendances** to Emergency portals compared to 2021
- To provide further assurance in future reports in relation to closing the loop on actions taken as a result of a **PSII** as well as expanding on the information provided in terms of patient involvement
- Further assurance was required to be provided in relation to **Perinatal Mortality** and use of interpreters

Positive Assurances to Provide

- The Committee considered **BAF 1 Delivering Positive Patient Outcomes** and welcomed the work undertaken to articulate the risk more clearly as well as the refinement of controls, assurances and actions.
- The **quality performance report** highlighted continued improvement in a range of metrics with actions being focussed on addressing friends and family test compliance
- The **maternity dashboard** highlighted that the Trust was on target to achieve the training trajectory for PROMPT and fetal monitoring. Induction of labour rates had also been maintained and good progress was noted with the saving babies lives care bundle. A particular positive improvement in reducing the number of mothers smoking at the time of delivery was highlighted and the Committee agreed with the rating of acceptable assurance
- The **maternity workforce report** highlighted that recruitment had been made to all midwifery and nursing vacancies alongside positive retention rates and the Committee agreed with the rating of acceptable assurance
- Acceptable assurance was provided in relation to the overview of the key findings from the **Infected Blood Inquiry**
- A revised format of the **infection Prevention Board Assurance Framework (BAF)** was provided which provided acceptable assurance and highlighted the key risks to the four areas of non-compliance as well as the outstanding actions to be taken
- The **Patient Safety Incident Investigation (PSII)** highlight report for Quarter 2 provided acceptable assurance, due to the process in place to report and investigate incidents
- The **Organ Donation and Transplantation bi-annual report** was provided and highlighted an increase in the number of donors and transplants taking place. An update was also provided on the eye and tissue service which had commenced, and the Committee welcomed the significant assurance provided

Decisions Made

- The Committee agreed that updates on the **Infection Prevention BAF** should continue to be received by the Committee with any escalations included within the highlight report rather than being provided separately to the Trust Board.
- The Committee agreed to continue to receive the **quality performance** report on a monthly basis but to receive this for discussion on a bi-monthly basis

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Despite a full agenda, members felt all items received due consideration	• To consider how instances affecting patient safety as a result of delays could be reported to the Committee given this is included within the performance report

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Quarter 2, 2024/25 Board Assurance Framework (BAF)	All		Not applicable	Approval	9.	Vulnerable Patients (Mental Health, Dementia/Learning disabilities and Autism) Annual Report 2023-2024	1	High 12	Partial	Assurance
2.	Quality Performance Report - Month 6 24/25	1	High 12	Not rated	Assurance	10.	Safeguarding Children Annual Report 23/24	1	High 12	Partial	Assurance
3.	Maternity Dashboard Q2 & September 2024	1	High 12	Acceptable	Assurance	11.	Safeguarding Adults Annual Report 23/24	1	High 12	Partial	Assurance
4.	Maternity & Neonatal Workforce Report Q1 & Q2 2024/25	1/2	High 12	Acceptable	Assurance	12.	Patient Safety Incident Investigation Highlight Report Q2	1	High 12	Acceptable	Assurance
5.	Major Trauma Peer Review	1	High 12	Not rated	Assurance	13.	Never Event Summary Report (Wrong Site Surgery)	1	High 12	Partial	Assurance
6.	Infected Blood Inquiry (IBI) Report Summary	1	High 12	Acceptable	Assurance	14.	Executive Clinical Effectiveness Group Highlight Report	1	High 12	Not applicable	Assurance
						15.	Organ Donation and Transplantation Bi-Annual Report	1	High 12	Significant	Assurance
7.	Infection Prevention Hospital Acquired Infection (HAI) Report Q2	1	High 12	Partial	Assurance	16.	Executive Quality & Safety Oversight Group Highlight Report	1	High 12	Not applicable	Assurance
8.	Infection Prevention Board Assurance Framework 24/25	1	High 12	Acceptable	Assurance	17.	Perinatal Mortality Report Tool Report Q1 24/25	1	High 12	Not rated	Information

Attendance Matrix

Members:		M	J	J	A	S	O	N	D	J	F	M
Andrew Hassell	Non-Executive Director (Chair)											
Claire Cotton	Director of Governance	NH	NH	NH			NH					
Matthew Lewis	Chief Medical Officer		AMM									
Katie Maddock	Non-Executive Director											
Jamie Maxwell	Head of Quality, Safety & Compliance											
Wendy Nicholson	Associate Non-Executive Director											
Ann-Marie Riley	Chief Nurse											
Sunita Toor	Non-Executive Director											

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th November 2024
Report Title:	Maternity & Neonatal Workforce Report Q1 & Q2 - October 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, and Maternity Safety Champion		

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

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	**6**

Executive Summary

Situation

This paper represents the maternity and neonatal workforce position for Q1 & Q2 (Apr-Sep 2024). Maternity providers are required to present this report as assurance of maternity safety to the Trust Board every 6 months, during the NHS Resolution, CNST Maternity Incentive Scheme year six reporting period up to 30th November 2024. Since January 2022, UHNM have provided additional assurance every quarter, whilst we worked towards becoming fully established in nursing and midwifery. This report will now return to 6 monthly in line with national recommendations.

Background

Safe maternity and neonatal staffing has featured in many significant national publications over the last 10 years; including:

- Birthrate Plus® (the only calculating tool endorsed by NICE)
- NICE Safe Midwifery Staffing for Maternity Settings (NICE guidance 2015; NICE pathway 2021)
- Better Births 2016
- NHS England National Quality Board Safe Staffing documents (2018)
- Delivering Midwifery Continuity of Carer (MCoC) at full scale (2021) which acknowledges the need to undertake a Birthrate Plus assessment to understand the current standard-model midwifery workforce required and following this through with recruitment
- Strengthening midwifery leadership: a manifesto for better maternity care (RCM, 2019)
- NHS England Maternity Business assurance Framework (revised July 2021)
- Safe midwifery staffing was also at the forefront of 'the safety of maternity services in England Parliamentary Business July 2021

- HSIB (2020) (now MNSI) published a National Patient Safety, 'Delays to intrapartum intervention once fetal compromise is suspected' and recommended the introduction of a flow coordinator. UHNM also contributed towards the report
- Ockenden the Final Report 2022
- East Kent 'Reading the Signals' report 2022
- APPG Birth Trauma Report 2024
- Thirlwall Inquiry 2024
- CQC National Review of Maternity Services 2024

Assessment

The business case for midwifery staffing to meet birthrate plus recommendations was approved in November 2022, following a full review in February 2022.

With the support of the Trust, maternity and neonatal teams have led a sustained recruitment campaign which has led to the drop in vacancies from 68.23 wte midwife posts to the current position of 0 vacancies. The Neonatal Nursing team is now fully recruited to. This is due to a sustained workforce development and improvement programme over the last 3 years.

To ensure the sustainability of safe midwifery staffing a package of support and retention work has been developed and continues, this has meant that UHNM is in the lowest quartile of Trusts for midwifery attrition. At the time of writing this report we have maintained 100 % of our newly qualified midwives in both year 1 (2022) and year 2 (2023) and our new cohort of newly qualified midwives commenced in post on the 7th October, taking us to full midwifery establishment in line with Birthrate Plus 2022. In line with Ockenden the Birthrate Plus assessment will take place again from February 2025, reporting approximately at the end of Q1 2025. The funding for this assessment has been secured from ICB/LMNS funding.

The increased midwifery and nursing staffing has supported the quality improvement work around induction of labour and maternity assessment unit triage, amongst many other quality improvement programmes with associated improved outcomes. Amongst nursing staffing for our neonatal unit, the increase has and continues to support our aim to increase the number of QIS (Qualified in Speciality) trained nurses in line with BAPM Standards.
In midwifery, one to one care in labour and the supernumerary status of the delivery suite coordinator has been maintained throughout.

Key Recommendations

- The Trust Board is asked to receive the report.

University Hospitals of North Midlands NHS Trust

UHNM Maternity & Neonatal Workforce Paper

Date: October 2024

1. Introduction

Safe midwifery and neonatal nurse staffing features in many national documents relating to safe maternity care.
Midwifery staffing was at the forefront of 'the safety of maternity services in England Parliamentary Business' July 2021. Since that time maternity staffing has featured in many significant inquiries into maternity and neonatal services; Ockenden, East Kent, Thirlwall and most recently the Birth Trauma and CQC National Maternity reports. Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm.

Safe midwifery and nursing staffing continues to be one of the safety actions within the NHS Resolution CNST maternity incentive scheme year 6, it features within the three-year delivery plan for maternity and neonatal services and is recognised by NICE as being vital to safety in maternity units (NICE guidance 2015; NICE pathway 2021).

2. The historic position

A Full Birthrate Plus® review was undertaken in 2022. Birthrate Plus®, is a national tool that gives the intelligence and insights and informs decision making about safe and sustainable services needed to be able to model midwifery numbers, skill mix and deployment across all maternity services based on the complexity risk rating of our patients.
This review identified that UHNM had a deficit of 68.13 WTE clinical midwives, 6.28 WTE Maternity Support Workers (MSW). There was also a deficit of 9.2 WTE specialist midwives. In line with Ockenden recommendations, a full review of midwifery staffing should take place every 3 years, therefore we have secured funding from the ICB/LMNS and have commissioned a full Birthrate Plus review to commence in February 2025.

Birthrate Plus® recommendations for UHNM

There is a requirement that all midwifery workforce uplift is now in line with Ockenden, the Final Report (2022). This uplift should be 'locally calculated' over the most recent three-year period. UHNM completed their locally calculated uplift immediately following the publication of Ockenden (2022). Prior to our review planned for 2025 we will again calculate our uplift using our local data over the last 3 years.

Based on 25.99% uplift the workforce requirements are as shown in the table below:

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

Neonatal Nursing

Neonatal Nursing Workforce is calculated to meet BAPM compliance, and align with local and national recommendations from NHSE, LMNS (Local Maternity & Neonatal Service), ICB (Integrated Care Board), WMNODN (West Midlands Neonatal Network and GIRFT (Getting it Right First Time). A quarterly report:

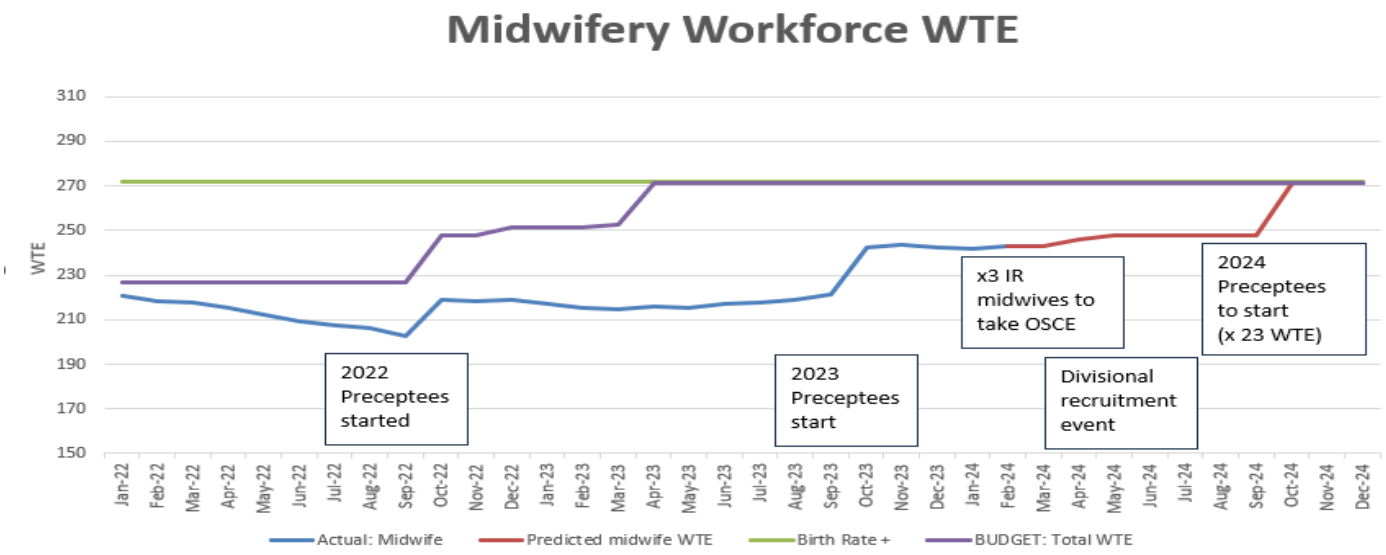
Neonatal Nursing Workforce Calculator (2020) is completed and delivered to the Workforce & Education Team within the WMODN and the LMNS.

3. The journey

A business case for midwifery staffing was presented to recruit to the full vacancy position, this was approved in November 2022.

- 20 newly qualified midwives were recruited in 2022 following Ockenden funding (£1,678,601) and 2.14 WTE band 6 midwives were recruited; this enabled the opening of the maternity assessment area 24 hours a day. However, this still left a significant gap in the midwifery workforce.
- In March 2023 offers were made to all the third-year student midwives on placement at UHNM, they were then appointed and commenced practice in October 2023.
- Ongoing recruitment continued and a series of recruitment events took place.
- In March 2023 a maternity and neonatal recruitment event took place at a hotel in central Stoke on Trent. This was held in a large conference room and smaller board rooms were made available for interviews on the day. A hot buffet lunch was provided, and we had representatives from all areas of maternity and the neonatal unit. Stalls were set up to give attendees the opportunities to talk to staff and local attractions such as Trentham gardens and the local tourist board. A promotional video was running throughout the day and the trust recruitment team were available to process any applications in real time.
- 200 delegates attended the event, 50 people were interviewed.
- 11 midwives were recruited, 14 MSW's and 10 neonatal nurses.
- In November 2023 a second event took place within the Antenatal clinic in Maternity, 20 delegates attended, 1 midwife 3 neonatal nurses were appointed.
- Ongoing recruitment has continued with area specific advertisements, we have recruited 5 WTE midwives to the community setting.
- Maternity attended the pan divisional recruitment event on April 17th 2024.
- 4 midwives were appointed.
- Visits were made to our 2024 3rd year midwifery students and 27 applied for positions at UHNM.
- UHNM has been part of the regional project for the recruitment of internationally trained midwives, The initial target was 5 midwives, this was extended to 7 when a further offer was made. An overseas midwife previously working in another part of the Trust has joined maternity, and was supported to undertake her OSCE.
- 5 Midwifery Apprentice midwives commenced training in September 2023 and another 5 positions commenced in September 2024. Thus, ensuring that as well as midwifery students from both Keele and Staffordshire Universities, UHNM have supported 10 internal maternity support workers to apprenticeships intended to result in an extra 5 qualified midwives in years 2025 and 2026.

The results of this recruitment have maintained the trajectory of full recruitment by October 2024 and this has been achieved.
At the time of writing this report there are no vacancies for clinical midwifery staffing.



4. Retention

Recognising the need to retain and develop our current workforce Rachel Topping – Recruitment & Retention Lead Midwife, was appointed in March 2022.

She has worked with both cohorts of preceptorship midwives to support them with on boarding, settling in and clinical practice. This post is also pivotal to understanding why people leave and offering all leavers exit interviews. Funding for this position was secured for a second year and subsequent funding has now been confirmed by NHSE as baseline funding going forward.

A bespoke and supportive preceptorship programme was developed. When benchmarked against the national preceptorship standards upon their launch the programme met all core and the majority of gold standards in year 1. Development of the programme for year two ensured that all core and gold standards have been met. The programme has seen great success with a 100% retention of the 2022 and 2023 cohorts. Some of the initiatives built into the preceptorship programme include*:*

- Strong onboarding process including afternoon tea, nights out and what's app group.
- Two-week induction including team building and orientation to the service.
- 6 weeks supernumerary time on top of induction.
- 4 protected nonclinical days for training and pastoral support.
- Allocated preceptor.
- Orange lanyard to identify preceptees. A successful way of ensuring good support.
- Opportunity to participate in Director of Midwifery fellowship.
- Enhanced financial package.
- Supportive package for preceptorship graduates with the Acorn scheme; new band 6's have an Acorn pin to identify them as junior staff members.

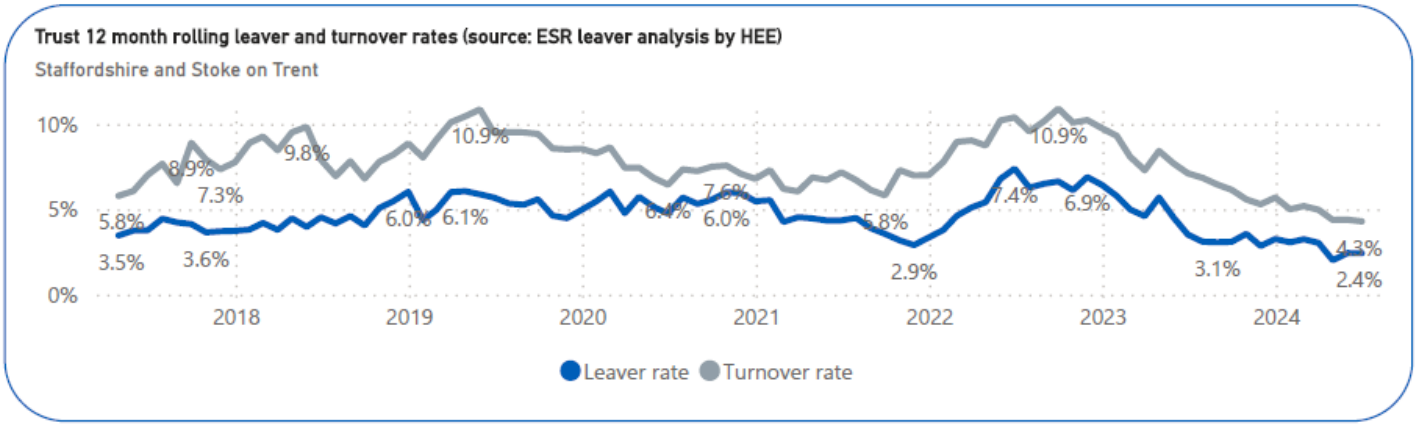
We have held individual meetings with midwives who have suggested that they may wish to leave the service, issues such as flexibility, contracted hours and family issues have been addressed and 4 WTE experienced midwives have remained at UHNM. At the time of writing this report, we have secured a further 2 experienced midwives by offering flexibility of working hours.

5. Attrition – leaver and turnover rates - midwifery

UHNM is in the lowest quartile of peer Trusts for midwife attrition. Our midwifery leaver rate at UHNM is 2.4%, whilst regionally this is 4.4% and nationally 4.7%. Our turnover rate is 4.3%, whilst regionally this is 7.9% and nationally 9.8%.

	UHNM	Regional	National
Midwife Leaver Rate	2.4%	4.4%	4.7%
Midwife Turnover	4.3%	7.9%	9.8%
Midwife vacancy	0%	8.54%	7.8%
MSW vacancy B2	0%	12.07%	14.1%

Rolling leaver and turnover rates – midwifery



6. Exit interviews

Exit interviews conducted have shown no themes or trends.

1 person retired

1 person moved to a different area for promotion
- This was to pursue personal goals and development

1 person left to care for children as wanted a break of over 5 years

1 person left for personal goals and development
- This person has now applied for two of our currently advertised specialist roles (not clinical)

7. The current position – midwifery staffing

The midwifery staffing vacancy position is reported through PWR (provider workforce return) each month. The data for this is pulled from ESR based on the budgeted establishment. However, it includes data for all budgeted midwives throughout the organisation, not just those working clinically. Therefore, the figure quoted (in PWR) will not always be representative of the actual clinical midwifery vacancy.
It does accurately represent the vacancies within the band 2, 3 and 4 roles.

To ensure an accurate vacancy position, the senior team, ward managers and retention leads meet regularly with the Divisional finance lead to look at midwifery, nursing and support worker establishments numbers in every area. We are then able to produce an accurate up to date position on a regular basis.

October 2024

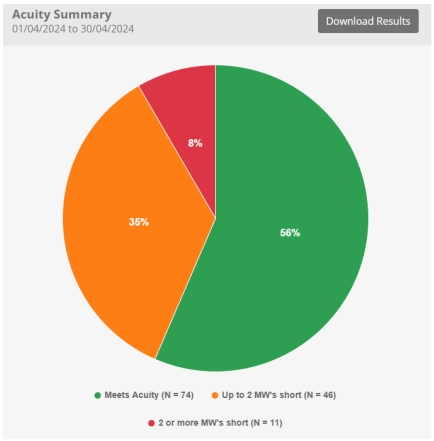
Position	Vacancy
Midwife band 6	0 WTE
Maternity Support worker band 2	0 WTE
Maternity Support worker band 3	3.59 WTE (advertised)
Maternity Support worker band 4	1.0 WTE (advertised)
Nursing	0 WTE

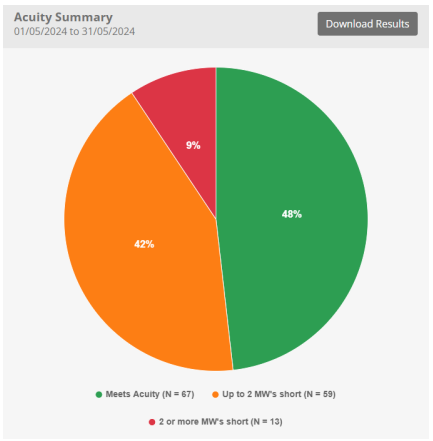
8. Maternity unit acuity

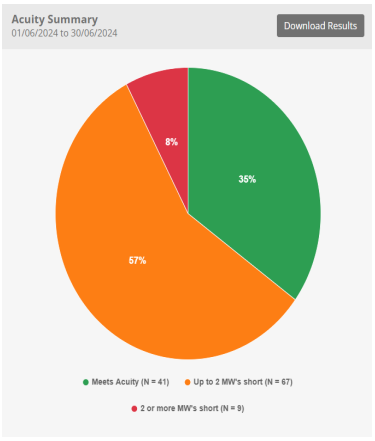
Acuity in maternity is measured using the birth rate plus acuity tool. This is reliant on 4 hourly data entries which identify any midwifery staffing needs. To be confident that data can be reliably interpreted, the tool requires an 85% confidence factor. The following demonstrates that we are not meeting the confidence factor target, therefore we are working with both Birthrate Plus associates and our Inpatient Midwifery Matrons to ensure that our confidence factor improves.

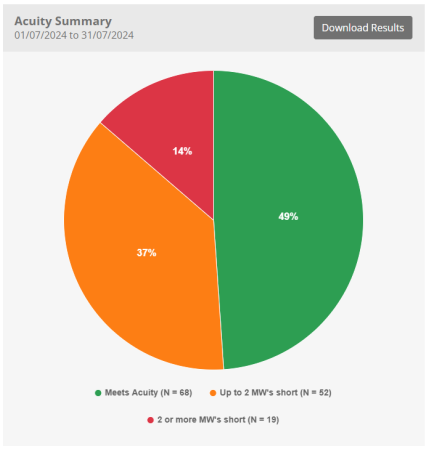
Compliance confidence factor:
Sep 60.5% confidence factor
Aug 60.7% confidence factor
Jul 66.1% confidence factor
Jun 56.6% confidence factor
May 66.1% confidence factor
Apr 65.5% confidence factor

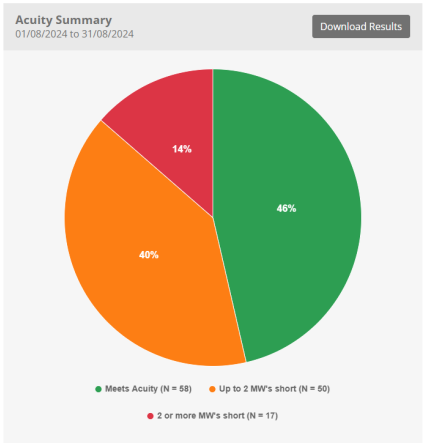
The following represents our acuity per month for delivery suite only, over a six-month period – Q1 & 2. Red indicates that there are 2 or more midwives short, however as discussed above the confidence in this data is not where it should be and we are addressing this through internal measures with our midwifery teams.

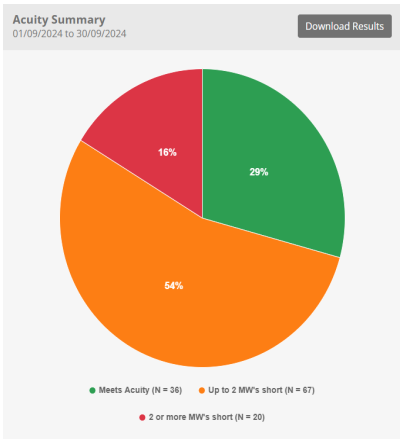












9. Specialist Midwives

We have continued to support the service with specialist midwives, recruitment over the last 3 years has made a positive impact on patient care, safety, and outcomes.

Specialist midwives in post 2022	Specialist midwives in post 2024	Specialist midwives in post/planned 2025
Bereavement Lead Midwife	Bereavement Lead Midwife Bereavement Lead Midwife PMRT Lead Midwife	All funding now secured through NHSE/ICB/LMNS funding – all posts now substantive
Clinical Education Midwife band 7	Clinical Education Midwife band 7 Clinical Education Midwife band 6 Fetal Monitoring Lead Midwife	Substantive funding now secured for existing posts Plus additional Clinical Education Midwife band 6
Recruitment and Retention Lead Midwife	Recruitment and Retention Lead Midwife Recruitment and Retention Lead MSW band 4	Substantive funding now secured
Consultant Midwife for Public Health band 8	Consultant Midwife for Public Health band 8	Public Health Lead Midwife post advertised to back fill 0.4 wte of Consultant Midwife who is seconded in NIHR Senior Nursing & Midwifery post – 3 years
Saving Babies Lives Lead Midwife	Saving Babies Lives Lead Midwife	Substantive funding now secured
Digital Lead Midwife band 7	Digital Lead Midwife band 7 Digital Lead Midwife band 6	Substantive funding now secured
Named Midwife for Safeguarding band 7	Named Midwife for Safeguarding band 7 Safeguarding midwife band 6	Substantive funding now secured
Mental Health Specialist band 6	Mental Health Specialist band 7 Mental Health Specialist Midwife band 6	Substantive funding now secured
Professional Midwifery Advocate band 7	Professional Midwifery Advocate band 7 Professional Midwifery Advocate band 6 x 5 on a sessional basis	Ongoing
Infant Feeding Specialist band 7 Infant Feeding Specialist band 6	Infant Feeding Specialist band 7 Infant Feeding Specialist band 6 Infant Feeding Specialist band 6 Infant Feeding Specialist MSW band 3	Ongoing
Diabetic Specialist Midwife	Diabetic Specialist Midwife	
	Induction of Labour Lead Midwife	Substantive funding now secured
	Pelvic Health Lead Midwife	Substantive funding now secured
	Preterm Birth Lead Midwife	Substantive funding now secured
	Clinical Placement facilitator	Funding to continue being sought for 2025-2026
	Advanced Midwifery Practitioners x 2 (in training)	Complete in 2025
	Guidelines Lead Midwife	Substantive funding now secured
	Senior Project Manager band 8	Funding to continue being sought for 2025-2026

	CNST/Ockenden Lead Midwife band 7	
	Governance Lead Midwife band 8	
Director of Midwifery	Director of Midwifery	Seconded 0.5wte to National Maternity Improvement Advisor role – backfilled – succession planning
Deputy Director of Midwifery – Workforce	Deputy Director of Midwifery – Workforce	
	Deputy Director of Midwifery – Governance	Substantive funding now secured
Maternity Inpatient Matron	Maternity Inpatient Matron (DS, MAU, Triage)	
Maternity Outpatient Matron	Maternity Outpatient Matron	
	Neonatal Matron	Substantive funding now secured
	Maternity Inpatient Matron (205, 206, MBC, Blossom Suite) (12 months test of concept)	
	EDI Lead Midwife band 8 (to be recruited)	Now recruited – commences in post November 24
	Legacy mentors under development	
Clinical Psychologist to support the maternity and neonatal team		New post for this year

10. Training and development

2022-2023	Update 2024 & planned
Bespoke Vitality training focusing on the 5 behaviours of a cohesive team. Provided to the whole midwifery workforce including Everything DiSC profiling for every member of the midwifery team.	This bespoke training was commissioned externally from 2022, 2023 and finished in 2024. To ensure that we continue this we have secured funding for 5 Everything DiSC Trainers who will ensure this training is delivered to every new starter, including our preceptees, nursing and medical staff.
Connects leadership course available for all leaders and future leaders	We have 2 of our team leaders doing this year's GOLD connects.
ENABLE training mandated for all leaders and specialists (bands 7 and above) as part of their Leadership Toolkit	Ongoing
Being Kind training for all UHNM staff	On-going via ESR and included in 'Leadership Toolkit' for all band 7's and above
Coaching and mentoring available to all leaders	Via the West Midlands network for all band 7's & above Plus 18 people have been supported to have 1:1 coaching (identified via selection following the Vitality Programme)
Development of preceptorship programme in line with national standards	Ongoing
UHNM presence at each university with each cohort	Ongoing
International recruitment programme	Completed – 7 in post
Development of MSW workforce (Foundation degree and apprenticeships)	This year we have supported another 5 MSW's to train as midwives
Appointment of retention leads (B7 & B4)	Substantive funding now secured
Commencement of exit interviews and stay conversations	Ongoing
Promotion of Trust opportunities such as Values awards, annual awards, Freedom to speak up champions, access staff good causes funds	Our 'Rise Together' Awards in 2024 were a huge success with over 500 nominations received and 300 attendees, this event will be repeated in 2025 – as we continue to focus on valuing and appreciating our staff
Aspirant programme including Director of Midwifery Fellowships	This year we are supporting 4 more Director of Midwifery fellowships
Implementation of Legacy mentors	This is now planned for 2025
Development of the PMA service	We now have some sessional PMA's – NHSE funded
Offering places for Advanced Midwifery practitioners	Two Advanced Midwifery practitioners due to qualify in 2025 (the first for UHNM)
Investment in leadership development programme – 'Leadership Toolkit'	We have now added the 'Talent & Succession Planning' conversations to our leadership toolkit and 'Report Writing'
Student midwives (Staffs) now undertaking development in leadership & governance – year 3	Keele University have now taken up this initiative meaning all of our students now receive this
QUAD Perinatal Cultural Leadership Programme – cohort 2	The QUAD is now fully operational – NHSE are planning updates to this programme nationally
Continue aspiring leaders programmes x 2 matrons	Completed for 2 matrons, this year we are also supporting our Deputy Director of Midwifery through her Aspirant Director of Midwifery Programme with NHSE
HDU training for midwives x 5	This year we are training another 10 midwives
Human Factors for Healthcare Train the Trainers programme (22 maternity leaders)	Now included on our annual multidisciplinary training
Succession Plan – underpinned by workforce plan, leadership toolkit & aspirant programme (requirement of Ockenden)	We have now added the 'Talent & Succession Planning' conversations to our leadership toolkit

10.1 Support worker Training and development

UHNM believe that the development of the maternity support worker workforce is key to the retention of MSW's and the improvement of maternity services. There are several opportunities available for support workers to progress their career from entry level positions to entry on the NMC midwifery register. These include:

- Opportunities to take functional skills (Maths and English), NVQ level 2, & NVQ level 3
- Support of foundation degrees with a midwifery pathway to develop MSW's into B4 positions in the community, infant feeding, and education
- Midwifery apprenticeships developing MSWs into midwives
- Implementation of specialist MSW roles including:
    - Infant feeding
    - Substance misuse
    - Safeguarding
    - Bereavement
    - B4 community MSW's
    - Lead MSW for recruitment and retention
- Celebration of MSW successes
- Planned bespoke MSW training day to upskill the MSW workforce

11. Medical/Other Workforce

Following the successful approval of the recent Obstetrics and Gynaecology Workforce Business Case, the recruitment update is summarised below:

- X4 WTE Consultant posts (Specialising in Perinatal Mental Health, Fetal Medicine, Ambulatory care and Endometriosis) – awaiting recruitment **
- X3 WTE Advanced Training Fellows – awaiting recruitment **
- X2 WTE Research Fellows – will be filled by the Deanery – awaiting recruitment **
- 0.5 WTE Sonographer – advertised numerous times however, unable to recruit into due to the national shortage of sonographers therefore currently using bank staff until permanent appointment
- 0.5WTE Imaging Department Assistant – To be filled once the Sonographer is appointed
- Surgical/Robotic First Assistant – awaiting recruitment
- 1 WTE Medical Secretary – currently filled with bank member of staff until permanent appointment recruited to **
- 5.6 WTE Maternity Support Worker – Posts recruited into, awaiting starts dates
- 3.1 WTE Ward Clerk – Post recruited into, awaiting start dates

** Due to the timing of the report, there may be an update position on these posts which can be given verbally at the time of the meeting.

The recruitment of these posts will help support the following:

- Reduce the number of clinical risks, relating to lack of workforce that is highlighted in the risk register and Maternity services CQC Sections 29a notice
- Reduce Maternity Assessment Unit (MAU) Triage times as it will allow Medical Staffing dedicated cover and a 24/7 ward clerk/maternity support worker to be on duty
- Registrar cover specifically for acute gynaecology during night shifts. The current impact of having no dedicated gynae registrar cover during the night and weekend means that the current team comprising of 1x senior registrar, 1x junior registrar & 1x SHO is required to cover 11 clinical areas including maternity: MAU and triage, wards and theatres, SAU, ED referrals and gynae inpatients
- To have appropriate staffing levels to be able to cope with the increase in gynae non-elective (NEL) activity – in last 5 years 74% increase in NEL activity on a monthly basis
- Dedicated sonographer and imaging assistant to support Uterine Artery Doppler scanner as part of Saving Babies Lives
- Dedicated surgical first assistant to release senior medical staff to support acute areas

12. Neonatal workforce

A separate and comprehensive neonatal workforce report has been submitted:

Summary:

Recently recruited: Q2
- WTE 8a ANNP Advanced Neonatal Nurse Practitioner (starts 1.12.24)
- 4.00 WTE Band 5 – Newly Qualified Nurse

Current Establishment
- Band 7 5.76 WTE
- Band 6 31.93 WTE
- Band 5 44.33 WTE
- Band 4 1.78 WTE
- Band 2 14.65 WTE
- Admin 3.0 WTE

Current Vacancy:

Network Workforce Report for Q2 to be submitted 18.10.24
- Band 7 <1.53 WTE (out to advert)
- Band 6 <4.00 WTE (please see NB)
- Band 5 >2.31 WTE (please see NB)
- Band 4 < 2.85 WTE (out to advert)

NB: Establishment ratio of band 5 and band 6 will change once cohort of developmental band 5 nurses complete QIS training July 2024 and are promoted to Band 6 as per job description.

Current roles to advert:

- 1.0 WTE Band 8a ANNP Advanced Neonatal Nurse Practitioner (as per business case)
- 3.0 Band 4 nurse Associate
- 1.53 WTE Band 7 Sister – Interviews 14.10.24 (6 candidates)

The plan to enhance QIS ratio is in place as follows:-

- 3.6 WTE nurses completed June 2023
- 4.92 WTE nurses have commenced the course for January 2024 – complete Oct 2024
- 3.38 WTE nurses will be enrolled for June 2024 – complete Mar 2025
- Candidates identified for subsequent courses

The QIS course is a specialist module and delivered at degree/master's level, to provide speciality training in neonatal care. The duration of the course is 9 months.

Transitional Care Unit

In response to extreme Neonatal Nursing staffing pressures and challenges, the decision was made to close the Transitional Care Unit in 2022. The Transitional Care Unit has successfully re-opened and has a core nursing team. The unit is functioning well, and positive working relationships have been established between all clinical areas. Transitional care is a 10 bedded unit, staffed by neonatal nursing teams, supported by midwifery teams, enabling mothers to stay with their babies when additional support is required for the neonate.

13. Home birth and free-standing midwife led unit

The home birth service was paused in 2021 due to staffing pressures and the need to maintain a safe equitable service for all. In April 2024 we commenced a package of training for our community midwives, this involves training with our WMAS colleagues, and it has been very well received by all who have attended. On 1st April 2024 we recommenced booking service users for planned home births. At the time of this report there are 3 home births booked for this month.

Intrapartum care at the Freestanding Midwifery Birthing Unit, County has remained suspended since 2020. It was recognised within our birthrate plus report that over 60% of service users in this area were in the highest 2 categories of care need, this is higher than the national average which is 58%.
The report includes a casemix review of service users and their outcomes, they then fall into categories 1,2,3,4 or 5. As an example, category 1 service users are those with the most normal and healthy outcome possible. i.e. the pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less, they achieve a normal birth with an intact perineum. The baby is born in good condition and weighs over 2.5kg. Category 4 is more complicated cases affecting the service user and/or their baby, such as caesarean section, pre-term births, low Apgar score or birthweight.

The report shows that in 2018 the generic casemix in categories 1 and 2 was 23.3%, however in 2021 that percentage had fallen to 16.8%. The report identifies that there will be a correlation between the casemix, and maternity stats recorded on the dashboard especially in relation to induction rates, delivery method, post-delivery problems, obstetric and medical conditions. Only service users in categories 1 and 2 can have their babies on a low-risk unit due to their risk factors and interventions required. In view of the reduced activity in the free-standing birthing unit a Stafford hospital, a service change project is in progress. A clinical senate took place earlier this year, the decision was supportive of the ICB to proceed to a business case that recommends the favoured option for the removal of birthing services in this unit.

14. Next steps

- **All clinical midwifery vacancies are now filled**
- Active recruitment of any specialist midwife roles and band 3 & 4 MSW roles continues
- Active recruitment to any specialist neonatal nurse posts continues
- We will be repeating our celebration event; the ‘Rise Together Awards’ in 2025; the purpose is to celebrate the work of all staff who support our newly qualified, new recruits and internationally recruited midwives. We are extremely proud of our teams and the positive way in which they have approached the changes in maternity and neonatal services over the last three years. A system of nomination is used to recognise those who have made a positive impact across all teams

The categories are:

- Admin support of the year
- Doctor of the year
- Leader of the year
- Best team player
- Most compassionate person
- Midwife of the year
- Most innovative staff member
- MSW of the year
- Most supportive person
- Rising Star
- Safest pair of hands
- Sodexo person of the year
- Midwife of the year
- Unsung hero

15. Recommendations

Maternity and Neonatal Divisional Quality and Safety Forum is asked to receive the report.

Highlight Report

Performance and Finance Committee | 29th October 2024

Matters of Concern / Key Risks to Escalate

For information:

- The Committee considered the **Quarter 2 Board Assurance Framework**, in particular risks 4, 6, 7 and 8. The Committee agreed that further updates should focus on the key controls and actions which expected to reduce the risk score, as well as highlighting the changes made in the quarter so that the progress made could be clearly identified. The Committee noted that whilst the target risk score for the financial risks had been initially identified as High 12, it was unlikely that these would be able to be achieved, and this would be reflected within the next update.
- The **finance report** at month 6 provided **partial assurance**, with the main drivers of the in-year deficit of £11.9 highlighted as underperformance against the Trust's cost improvement programme (CIP) and an overspend on healthcare assistants which had been driven by an increase in 1-1 nursing requirements. However, a positive reduction in agency spend was noted
- An update on the **financial outlook** was provided which described the size of the challenge in developing a medium-term financial plan. The Committee felt unable to provide an assurance rating in relation to this item due to the work which remained ongoing to identify workstreams which supported the development of a sustainable financial model.
- The progress on **CIP** schemes was provided which highlighted an improvement in the total number of 'green' schemes, although **partial assurance** was provided given the scale of challenge in the ability to identify recurrent savings. The need to finalise the identification of savings for 2024/25 was noted, given the need to commence the identification of savings for 2025/26
- **Partial assurance** was provided in respect of **urgent care**, whereby the Trust's 4 hour performance had deteriorated to 69.2% compared to 72.1% in August which was below the improvement trajectory. In addition, it was highlighted that it was also not expected to be achieved in October, due to the winter profile arriving earlier than planned which included an increase in covid cases.
- Whilst the number of **ambulance attendances** had slightly reduced, work remained ongoing to ensure timely offload which was difficult at times due to the pattern of attendances. The Trust continued to focus on offloads within 45 minutes, whereby a model was being piloted and working well in hours, although was challenging out of hours. In addition, a number of further actions were being taken such as a relaunch of the Internal Professional Standards, a test of change for the Hospital Ambulance Liaison Officer (HALO) and rolling out actions within workstream 2 to throughout the Trust.
- Whilst the Committee was **partially assured** in respect of the annual **Emergency Preparedness, Resilience and Response (EPRR) core standards assessment**, compliance had improved from 34% in 2023 to 78%. It was noted that the assessment had also been subject to independent confirm and challenge with the Integrated Care Board and NHS England
- **Partial assurance** was determined in respect of **pharmacy procurement**, in the main due to the risks in relation to the novation from Lloyds Pharmacy and delay in replacement of the automated dispensing system. However, the Committee welcomed the £930,000 savings identified for 2024/25.
- The ongoing clinical coding backlog was highlighted by the **Executive Business Intelligence Group**, whereby elective cases were being prioritised and solutions were being identified to address the non-elective backlog

Major Actions / Work Underway

- To update **BAF 4** to clarify expectations and the pace of change expected with clear specific actions
- Whilst **capital** remained on track to date, some slippage had been identified and required mitigation and it was agreed to provide a paper to the Committee / Trust Board on the sale of the Royal Infirmary
- It was agreed that a roadmap needed to be identified, setting out the timescales for the creation of a **medium / long term system financial plan**. It was agreed to discuss this further at December's meeting, in addition to considering whether an update from the System Recovery Director could be provided
- It was agreed to consider the **business case review for** the Staffordshire Treatment Suite Phase 1 at the meeting in December
- A review of the **four urgent care workstreams** was being undertaken, which included the review of performance metrics and delivery targets
- Future **pharmacy procurement** updates to provide further assurance on how the programme aligns with CIP schemes, the process for improvement and productivity, and the long term strategy on reducing wastage and mitigating supply chain risks

Positive Assurances to Provide

- Whilst the Committee was partially assured in terms of operational performance, it noted the good progress made in **planned care** with improvements in cancer and referral to treatment (RTT) performance. There continued to be challenges within **diagnostics**, and a gap in non-obstetric ultrasound but the Trust had since identified a partner to work with and as such an improvement was expected in October. In addition, the Committee welcomed the improvements within **endoscopy** whereby the waiting time was now in line with the national waiting list guidance.
- The update on **sustainability and net zero carbon** provided **acceptable assurance**, highlighting the particular increase in engagement into key digital workstreams. Updates were also provided in relation to additional actions which had been taken to address key areas of risk such as addressing workforce capacity and receiving NHS England approval of the District Heat Network business case
- **The Executive Business Intelligence Group** highlighted the positive progress made in rolling out data quality assurance indicators

Decisions Made

- The Committee approved the **business case** in relation to Staffordshire Treatment Suite Phase 2
- The Committee approved the following **Request for Executive Approvals (e-REAF);** Reporting of the Targeted Lung Health Check (14995), Home Delivery of Darbepoetin – Contract Extension (14967), Home Delivered Haemodialysis (14931), Arthroscopy & Sports Medicine Contract (14844), CDC - Endoscopy Keymed Olympus Scopes (14976), Enhanced Primary Care – GP Federation Service Extension (14406)
- The Committee approved the **business case** in relation to Interventional Radiology

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• No further comments were made	• The Committee noted the reliance on the Strategy and Transformation Committee to receive updates in relation to improvement such as transformation, quality improvement and innovation although there were cross cutting themes which potentially required the Committees to come to together. It was noted that this would be further discussed at the Trust Board Time Out in November • It was agreed to consider how performance could be reported in terms of the Children's Hospital via the strategy refresh considered by the Strategy and Transformation Committee

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Quarter 2, 2024/25 Board Assurance Framework (BAF)	All		Not applicable	Approval	7.	Performance Report – Month 6 2024/25	4	Ext 15	Partial	Assurance
2.	Finance Report – Month 6 2024/25	7, 8	Ext 16	Partial	Assurance	8.	EPRR Core Standards Assurance	-		Partial	Assurance
3.	Financial Outlook	8	Ext 16	Not rated	Information	9.	Investment Request to Support Patient Safety and Sustainability of the Interventional Radiology Service	1, 2	ID 33746 ID 32961	Not applicable	Approval
4.	CIP Report	7	Ext 16	Partial	Assurance	10.	Pharmacy Directorate Medicines Finance, Procurement and Supplies Report Months 1-6 2024-25	7	ID 33484 ID 33483 ID 32550 ID 32552 ID 32551	Partial	Assurance
5.	BC-0569 STS (Staffordshire Treatment Suite) Phase 2	4	Ext 15	Not applicable	Approval	11.	Sustainability and Net Zero Carbon (NZC) Bi-annual Performance Report	6	High 12	Acceptable	Assurance
6.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-		Not applicable	Approval	12.	Executive Business Intelligence Group Highlight Report (27-09-24)			Not applicable	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)												
2.	Ms H Ashley	Director of Strategy												
3.	Ms T Bowen	Non-Executive Director												
4.	Dr S Constable	Chief Executive	TB	TB										
5.	Mrs C Cotton	Director of Governance	NH		NH	NH		NH	NH					
6.	Mrs K Thorpe	Acting Chief Operating Officer	SE	SE	SE	SE	SE		MH					
7.	Dr L Griffin	Non-Executive Director	Chair	Chair										
8.	Ms A Gohil	Non-Executive Director												
	Mrs M Monckton	Non-Executive Director												
9.	Mr M Oldham	Chief Finance Officer												
10.	Mrs S Preston	Strategic Director of Finance												
11.	Mrs A Rodwell	Non-Executive Director												
12.	Mr J Tringham	Director of Operational Finance												

Attended | Apologies & Deputy Sent | Apologies

Since 14th September to 14th October 2024, 1 contract award over £1.5 m was made, as follows:

- **Steam Supply for Central Sterile Service Department,** supplied by F Blaize Plumbing Heating Pipework Ltd, at a total cost of £2,740,893.71, approved on 9th October 2024

Highlight Report

Strategy & Transformation Committee | 30 October 2024

Matters of Concern / Key Risks to Escalate

For information:

- The Committee received the **Board Assurance Framework (BAF)** for Quarter 2 and considered risks 3, 5 and 9. The Committee noted that the risk in relation to Digital Transformation had been broadened following discussion at the previous deep dive and this had also increased in risk score given the current financial climate and ongoing iPortal challenges.
- The update on the **transformation programme** highlighted the maturity and performance of four specific programmes of work as well as providing an update on six major change programmes. The Committee agreed with the rating of **partial assurance** given the further progress required, in particular the work required to review and understand partnerships
- An update on **international commercial opportunities** was provided, highlighting the engagement with the Healthcare UK Export Catalyst Programme. A rating of **partial assurance** was provided due to the further work required to strengthen the Trust's organisational readiness to secure commercial opportunities and create collaborative partnerships. The Committee challenged the need to ensure that work on further developments did not impact on the ability to deliver UHNM core business given the current operational pressures
- The **Improving Together** update highlighted **partial assurance** in respect of the impact of continuous improvement on performance, as there was a need to reaffirm the expectation of using improvement methodology throughout the Trust by reinforcing the culture of continuous improvement. A peer review of current improving together utilisation was suggested to be undertaken
- **Partial assurance** was provided for the **data, security and protection (DSP) toolkit** due to the ongoing challenges with DSP training compliance which was below the 95% target and the Committee noted the action being considered, to identify a solution to remove system access where staff have not completed the training within the past 12 months after having 3 warnings

Major Actions Commissioned / Work Underway

- To develop the **BAF risk radar** further, particularly addressing the gaps in relation to the commercial and technological sections
- To expand on the third line assurances identified for **Improving the Health of our Population BAF 3**
- To review the target risk score for **Digital Transformation BAF 5** to ensure this was reflective of the current financial climate
- To expand on the controls and assurances articulated **for Research and Innovation BAF 9** to include those specific to innovation
- Further updates on the **Trust Population Health and Wellbeing Strategy** to include a number of key targets and metrics for measurement
- Further updates on **international commercial opportunities** to clearly identify the mission, vision and associated framework as well as clarifying how potential returns for the Trust could be measured, whilst providing assurance that this would not adversely impact on operational business as usual
- Further assurance to be provided in future reports on **data, security and protection** to expand on the actions being taken with regards to multi factor authentication (MFA)
- Ongoing actions continuing to be taken in respect of addressing the **iPortal issues** and it was agreed to provide further assurance of the action taken including circulating the outcome of the Root Cause Analysis (RCA) to members for information once available
- Pilot of **Electronic Prescribing and Medicines Administration (EPMA)** to be undertaken at County Hospital in January as opposed to October

Positive Assurances to Provide

- The Committee noted the infrastructure being put into place to enable delivery of the three programmes for the **Trust Population Health and Wellbeing Strategy** which provided **acceptable assurance** to the Committee. This included an increase in resources and an update on workstreams was provided
- **Acceptable assurance** was agreed for the **innovation programme update** which recognised the current levels of innovation within the Trust with key actions focussed on the development of an innovation strategy and associated framework, clarification of oversight and improvements in peer to peer support
- **Acceptable assurance** was provided in relation to the **Improving Together** update for the progress made against NHS Impact principles and the capability and capacity build for improvement skills

Decisions Made

- No decisions were required to be made

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Welcomed the papers provided	• The Committee considered what it could do to help drive forward a credible transformation plan to assist in addressing the current financial challenges. A discussion was held as to how this could be undertaken and it was suggested to refresh the Committee's Terms of Reference in light of the change in direction, and noted that further discussions were to be held on aligning the remit of Committees with the refreshed strategy

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Quarter 2, 2024/25 Board Assurance Framework (BAF)	All		Not applicable	Approval	5.	Innovation Programme Update	9	High 12	Acceptable	Assurance
2.	Population Health and Wellbeing Strategy Update	3	Ext 15	Acceptable	Assurance	6.	Improving Together Assurance Report		ID 27153	Acceptable / Partial	Assurance
3.	UHNM Transformation Programme			Partial	Assurance	7.	Data, Security & Protection (DSP) Toolkit Position	5	ID 21784	Partial	Assurance
4.	International Commercial Opportunities Update	9	High 12	Partial	Assurance	8.	Executive Digital and Data Security Protection Group Highlight Report (18-09-24)	5	Ext 16	Not applicable	Assurance

Attendance Matrix

Members:		A	J (DD)	J	O	J
Tanya Bowen	Non-Executive Director (Chair)					
Helen Ashley	Director of Strategy					
Claire Cotton	Director of Governance				NH	
Gary Crowe	Non-Executive Director (Vice-Chair)					
Amy Freeman	Chief Digital Information Officer				HP	
Arvinda Gohil	Non-Executive Director					
Matthew Lewis	Chief Medical Officer			AMM		
Ann-Marie Riley	Chief Nurse					
Lisa Thomson	Director of Communications					
Sunita Toor	Non-Executive Director					
Lorraine Whitehead	Director of Estates, Facilities & PFI					

Highlight Report

Audit Committee | 31st October 2024

Matters of Concern / Key Risks to Escalate

For information:

- The Committee received a newly developed **cyber security report** which provided **partial assurance** in relation to compliance with the Cyber Assessment Framework, due to challenges with training, management of shadow IT and the capacity and resource available to implement projects. It was agreed to provide quarterly updates on progress going forwards, to include an assessment and impact of the actions being taken to reduce identified risks
- A rating of **partial assurance** was provided in respect of the **Corporate Governance Report**, which recognised the ongoing actions being taken in respect of commencing the review of out of date policies, although the inclusion of the assessment of risk was expected to move the assurance level to acceptable in January
- **Partial assurance** was provided in terms of the completion of **internal audit recommendations**, due to the 3 delayed and 15 problematic actions. A specific update was provided in relation to a problematic action for job planning and the system which was required to be developed in order to be able to confirm the number of sessions planned for each clinician versus those delivered. The Committee supported a recommendation to consider taking forward a case to address this point, including consideration of interim spot checks and implementation of Get It Right First Time (GIRFT) best practice

Major Actions Commissioned / Work Underway

- Whilst work had been completed on the **Nurse E-Rostering** internal audit report this was to be approved by the Chief Nurse before being finally presented to the Committee
- To review the process for Executive sign off of **completed internal audits** to ensure these are presented to the Committee in a timely fashion following completion
- To consider whether the next meeting in January should be extended or moved to accommodate the additional internal audit reports which were expected
- To consider how further assurance could be provided on **new policies** in development including how long these take to be developed and ratified
- To update the risk radar within the **Board Assurance Framework** to ensure this reflected the updated information available from RSM
- Further assurance to be provided in relation to **pharmacy stock write offs** at a future meeting
- To obtain further assurance in relation to **Single Tender Waivers** and the number per Department versus size of spend to identify any outliers. It was agreed to invite a representative from the Procurement team to the next meeting to assist with this update

Positive Assurances to Provide

- The Committee welcomed the introduction of a specific report into **cyber security**, which highlighted areas of progress, risk and further action which would continue to be developed in future quarters
- The **annual declaration of interest response rate** for 2023/24 concluded at 98% and the 2024/25 process had commenced
- The Committee agreed with the suggested **significant assurance** rating for the Board Assurance Framework (BAF) due to the process undertaken to update and consider the BAF at Committees, which included quarterly deep dives and reflected the assurance rating from previous internal audits. However, it was recognised that as the BAF was a live document, this required further update following the deep dives in addition to reflecting the discussions held at recent Committees
- **Losses and special payments** for the quarter provided **acceptable assurance** and highlighted total losses of £1,772,131 for the year
- 8 **Single Tender Waivers** were highlighted for the quarter in addition to 113 late purchase orders and the Committee agreed with the **acceptable assurance** rating in respect of the procedures and processes in place
- The Committee noted that there had been 89 **salary overpayments** during the quarter and agreed with a rating of **acceptable assurance** given these were being managed appropriately to ensure repayment whilst recognising the actions required to follow up overpayments at divisional performance reviews
- **Acceptable assurance** was provided in relation to the update provided in terms of the **disposal of land** at the Royal Infirmary and Central Outpatients Department whereby a paper for Trust Board consideration was being prepared
- The **counter fraud progress report** highlighted that a number of risks had reduced in relation to fraud and bribery and the preventative actions implemented since the previous review, in addition to receiving an update on reactive work

Decisions Made

- The Committee recommended the Board Assurance Framework for consideration at the next Trust Board to be held in November

Comments on the Effectiveness of the Meeting

- No specific comments were made

Cross Committee Considerations

- Information was provided by the counter fraud team in terms of the proposed move to 3 yearly data security and protection training and it was agreed to discuss this further with the Strategy and Transformation Committee
- It was agreed to consider referring the issues identified in relation to HR processes with the People, Culture and Inclusion Committee

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Internal Audit Progress Report	2	Ext 16	Not rated	Assurance	6.	Losses and Special Payments Update Q2 2024/25	7, 8	Ext 16	Acceptable	Assurance
2.	H1 Cyber Security Report 2024/25	5	Ext 16	Partial	Assurance	7.	SFI Breaches and Single Tender Waivers Q2 2024/25	7, 8	Ext 16	Acceptable	Assurance
3.	Internal Audit Action Tracker			Partial	Assurance	8.	SFI Breaches related to Late Termination and Change Forms - Quarter 2 2024/25	7, 8	Ext 16	Acceptable	Assurance
4.	Corporate Governance Report			Partial	Assurance	9.	Update on the disposal of land at the former RI and COPD sites			Acceptable	Assurance
5.	Quarter 2, 2024/25 Board Assurance Framework (BAF) • Summary BAF Q2 24/25 • BAF Deep Dive Outcome Summaries			Significant	Approval	10.	Counter Fraud Progress Report			Not assessed	Assurance

Attendance Matrix

Members:		May	June	August	October	January
Alison Rodwell	Non-Executive Director (Chair)					
Tanya Bowen	Non-Executive Director					
Gary Crowe	Non-Executive Director					
Leigh Griffin	Non-Executive Director					
Andrew Hassell	Associate Non-Executive Director					
Margaret Monckton	Non-Executive Director					

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th November 2024
Report Title:	EPRR Core Standards Assurance	**Agenda Item:**	9
Author:	J Dodds Head of EPRR		
Executive Lead:	Katy Thorpe COO / Michelle Harris DCOO		

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

- As part of ensuring how compliant a Trust is in delivering their Emergency Preparedness, Resilience and Response (EPRR), a set of core standards has been developed and each Trust is asked to self-assess against the annual NHS Core Standards for EPRR.
- UHNM is required to submit Annual Assurance to the Integrated Care Board and NHS England against the NHS England Core Standards for EPRR.
- Core standards Assessments were required to be submitted by 30th August 2024, and UHNM met this deadline.
- A further request for additional evidence was requested by NHSE / ICB on 3rd October, with a 10 calendar day turnaround, and again this deadline was met.
- A confirm and challenge meeting was held with NHSE regional EPRR, ICB EPRR Strategic Lead, and UHNM COO, Deputy COO, and Head of EPRR on 21st October 2024, with a final submission required for 25th October 2024.

Background

- The assessment document for EPRR is a total of 62 individual core standards, split over 10 Domains:
  Governance
  Duty to Assess Risk
  Duty to maintain plans
  Command and Control
  Training and Exercising
  Response
  Warning and Informing
  Cooperation
  Business Continuity
  Hazmat / CBRN

The compliance level for each standard is defined as:

Compliance Level	Definition
Fully Compliant	Fully compliant with the Core Standard
Partially Compliant	Not compliant with the Core Standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-Compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Following the 2024 Confirm and Challenge process, UHNM reported position was 48/62 (78%) (Partially Compliant /)

2024 Partially Compliant	77% - 88% -	48/62 Core Standards (78%)
2023 Non-compliant	Below 76% -	21/ 62 Core Standards (34%)

2024 process

- Once the Core Standards assessment is submitted, ICB and NHS England review the submission, together with supporting evidence.
- ICB & NHS England may request additional supporting evidence during October (note only documents produced prior to 30th August (the deadline for submission) can be used as further evidence).
- A check and challenge process with the Trust, ICB and NHS England took place October 21st 2024
- A final, agreed, report is submitted from the Trust to the ICB and NHS during November, for ratification at the Local Health Resilience Partnership (LHRP).

Assessment

- NHS England and the ICB undertake a rigorous assessment against each core standard, and require detailed evidence to support each position that the trust submits.
- The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards (62/62 Core Standards)
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS Core Standards (55 – 61 of 62 Core Standards)
Partial	The organisation is fully compliant against 77-88% of the relevant NHS Core Standards (47 – 54 of 65 Core Standards)
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS Core Standards (less than 47 of 65 Core Standards)

What are the key conclusions (positive or negative)?

- UHNM EPRR have been undertaking a comprehensive review of the core standards submission for 2024, which will be subject to an in depth Confirm and Challenge process with ICB and NHSE.
- The EPRR team had recruited a Band 7 EPPR Officer2, but unfortunately the individual was head hunted and left the trust after 2 months in employment, subsequently causing delays and re-evaluation of his work plan, centred around training and exercising, and causing that work plan to be reconfigured.

- UHNM is submitting a self assessment of Partial Compliance rating, with 48/62 (78%) core standards being assessed as fully compliant, with 14/62 (22%) requiring some further work to ensure full compliance.

2024 Reporting

Partially Compliant	77% - 88% -	48/62 Core Standards (78%)

In addition, there are 11 Deep Dive Questions, based on Cyber Security, that require a self assessment, but these have no impact on overall scores with the core standards. Working with IMT and Head of Cyber Security, 6/11 Deep Dive questions were reported as fully compliant.

- *What are the solutions?*
- Based on the above, EPRR are reporting a self assessment of Partially Complaint(>76%), with some further work required to confirm compliance in the following areas:
- The Local Resilience Forum has produced a data sharing agreement, which is in the process of being signed off by the COO.
- There are several areas within the Business Continuity Cycle that need addressing, and this will be the focus of work in the near future
- On Call arrangements need agreement and sign off.
- Training and exercising – we require further work to develop EPRR specific PDP records.
- Further work is ongoing with Police casualty Bureau and ED / Caldicott Guardian to establish appropriate data sharing principles in a major Incident.
- Incident specific plans are in the final stages of approval by EPRG (Emergency Planning Resilience Group) and EIG.
- We need to undertake training to ensure the trust has a suitable cadre of loggists.
- Mass Casualty Plans (although ongoing work is taking place), and requires some additional work with Regional and ICB partners
- Pandemic Flu – needs updating to New and Emerging Pandemics, and requires lessons learnt from COVID adding
- Evacuation and Shelter planning requires an update, but work is ongoing, and requires some additional work with Regional and ICB partners
- Mass Countermeasures requires further work on how countermeasures are received and distributed by the trust
- Data Protection and Security Toolkit requires IMT reporting of compliance, and they will be reporting as non compliant, therefore affecting our rating for this Core Standard.

Based on the above, EPRR can report they will be aiming to report 78%Partially Compliant (albeit greatly improved from 34% submitted for 2023) Compliance with Core Standards for 2024/25.

NHS England Midlands

EPRR annual assurance 2024/25: Confirm and challenge summary.

1 Summary position

NHS England and ICB have undertaken a review of the evidence submitted by each organisation to understand their self-assessment position. Additional information was sought where the assessment evidence was not sufficient to make an assessment. NHS England and ICB are assured of the compliance against the NHS Core Standards for EPRR where no further challenge or observations have been made (see below) and confirms it will report on these items nationally.

Although it is down to individual organisations to reassess their scores, it should be noted where an organisation has been told of an issue in their arrangements this could result in significant interest at an inquiry or subsequent investigation, especially where full compliance continues to be asserted.

In addition, NHS England and ICB undertook to provide feedback outside of the process on areas which while not affecting compliance against the standard impacted on the way the plans and policies might be used. This was based on the guidance, learning from incidents and examples in other documents. These should be considered and acted upon by the organisation.

NHS England and ICB remains committed to ensuring the EPRR assurance process drives improvements across the NHS whilst identifying weaknesses in arrangements which may result in the challenges during or after an incident response.

1.1 Compliance levels/RAG:

- Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.
- Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.
- Green (fully compliant) = Fully compliant with core standard.

Colour shown behind number is self-assessment reported position.

2 Organisation specific challenges and observations

Situation

- As part of ensuring how compliant a Trust is in delivering their Emergency Preparedness, Resilience and Response (EPRR), a set of core standards has been developed and each Trust is asked to self-assess against the annual NHS Core Standards for EPRR.
- UHNM is required to submit Annual Assurance to the Integrated Care Board and NHS England against the NHS England Core Standards for EPRR.
- Core standards Assessments were required to be submitted by 30th August 2024, and UHNM met this deadline.
- A further request for additional evidence was received from NHSE & the ICB on 3rd October
- A confirm and challenge meeting was undertaken with ICB, NHSE, and UHNM COO, DCOO, and Head of EPRR on 21st October, and a final assessment position was submitted on 25th October.
- UHNM EPRR team consists of a Head of EPRR, EPRR Manager and an EPRR Support Officer, who report to the Deputy Chief Operating Officer, and are overseen by the Chief Operating Officer, in their role as EPRR Accountable Emergency Officer.
- The trust has responded to multiple Business Continuity, Critical and Major Incidents within the last 12 months, including:
- Multiple Business Continuity incidents, including floods, theatre contamination
- Multiple Critical Incidents due to capacity
- Network Outages
- Public Disorder
- Hazmat Incident
- Blood Transfusion Amber Alert
- The EPRR team has undertaken a programme of training for the Strategic and Tactical rota, and also the site matron rota. In addition, both Eds undertake comprehensive Major Incident and CBRN training.
- In addition, the trust has undertaken exercises both internally and with multi agency partners, including cyber, evacuation and shelter, and testing the health coordination roles in response to major incidents, alongside multiagency partners at Fire service HQ, Stone.
- In response to these incidents and exercises, Incident Response plans, Hazmat / CBRN plans have been reviewed and updated, and all incidents have been debriefed to ensure lessons are identified, and appropriate

Background

- The assessment document for EPRR is a total of 62 individual core standards, split over 10 Domains:
  Governance
  Duty to Assess Risk
  Duty to maintain plans
  Command and Control
  Training and Exercising
  Response
  Warning and Informing
  Cooperation
  Business Continuity

Hazmat / CBRN

- The compliance level for each standard is defined as:

Compliance Level	Definition
Fully Compliant	Fully compliant with the Core Standard
Partially Compliant	Not compliant with the Core Standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-Compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

- Following the **2023** Confirm and Challenge process, UHNM against 5/62 (8%) of Core Standards (Non-Compliant), initial reported position was 5/62 (8%) of Core Standards (Non-Compliant), but subsequently upgraded to 21/62 (34%) (Non-Compliant)

Non-compliant	Below 76% -	21 / 62 Core Standards (34%)

2024 process

- Once the Core Standards assessment is submitted, ICB and NHS England review the submission, together with supporting evidence.
- ICB & NHS England requested additional supporting evidence during October (note only documents produced prior to 30th August (the deadline for submission) can be used as further evidence).
- A check and challenge process with the Trust, ICB and NHS England took place towards the end of October (21st October).
- A final, agreed, report is submitted from the Trust to the ICB and NHS during November, for ratification at the Local Health Resilience Partnership (LHRP).

Assessment

- NHS England and the ICB undertake a rigorous assessment against each core standard, and require detailed evidence to support each position that the trust submits.
- The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with:

Organisational rating	Criteria

Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards (62/62 Core Standards)
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS Core Standards (55 – 61 of 62 Core Standards)
Partial	The organisation is fully compliant against 77-88% of the relevant NHS Core Standards (47 – 54 of 65 Core Standards)
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS Core Standards (less than 47 of 65 Core Standards)

- *What are the key conclusions (positive or negative)?*
- UHNM EPRR have been undertaking a comprehensive review of the core standards submission for 2024, which has been subject to an in depth Confirm and Challenge process with ICB and NHSE.
- The EPRR team had recruited a Band 7 EPPR Officer, but unfortunately the individual was head hunted and left the trust after 2 months in employment, subsequently causing delays and re-evaluation of his work plan, centred around training and exercising, and causing that work plan to be reconfigured.
- UHNM EPRR are on track to achieve a Partial Compliance rating, with 48/62 (78%) core standards being assessed as fully compliant, with 14/62 (22%) requiring some further work to ensure full compliance.
-

2024 Reporting

Partial Compliance	>76%	48/62 Core Standards (78%)

In addition, there are 11 Deep Dive Questions, based on Cyber Security, that require a self assessment, but these have no impact on overall scores with the core standards. Working with IMT and Head of Cyber Security, we expect at least 6/11 Deep Dive questions to be reported as fully compliant.

- *What are the solutions?*

- Based on the above, EPRR are on track to met Partial compliance (>76%), with some further work required to confirm compliance in the following areas:
- The Local Resilience Forum has produced a data sharing agreement, which is in the process of being signed off by the COO.
- There are several areas within the Business Continuity Cycle that need addressing, and this will be the focus of work in the near future
- On Call arrangements need agreement and sign off.
- Training and exercising – we require further work to develop EPRR specific PDP records.
- Further work is ongoing with Police casualty Bureau and ED / Caldicott Guardian to establish appropriate data sharing principles in a major Incident.
- Incident specific plans are in the final stages of approval by EPRG (Emergency Planning Resilience Group) and EIG.
- We need to undertake training to ensure the trust has a suitable cadre of loggists.
- Mass Casualty Plans (although ongoing work is taking place), and requires some additional work with Regional and ICB partners
- Pandemic Flu – needs updating to New and Emerging Pandemics, and requires lessons learnt from COVID adding
- Evacuation and Shelter planning requires an update, but work is ongoing, and requires some additional work with Regional and ICB partners
- Mass Countermeasures requires further work on how countermeasures are received and distributed by the trust
- Data Protection and Security Toolkit requires IMT reporting of compliance, and they will be reporting as non compliant, therefore affecting our rating for this Core Standard.

Based on the above, EPRR can report they will be aiming to report Partial Compliance with Core Standards for 2024/25.

A detailed breakdown of the reasons for Partial Compliance for each Core Standard is detailed below:

2.1 University Hospitals of North Midlands NHS Trust (acute)

Core Standard Self assessment 2024	Core Standard Self assessment 2023	Domain	Standard	Detail of standard	Reason for challenge/observation from ICB or NHSE – challenge in *Italics* - UHNM response in normal font
1 Fully compliant	Fully Compliant	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Agreed Fully Compliant
2 Fully Compliant	Partially Compliant	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s)	*Requirement for policy to be signed off by the Board – this cannot be delegated as it is a specific requirement.* No specific requirement within standard for full policy to be presented to board – Policy has undergone full UHNM Policy Ratification process via EPRG / EIG / PAF, as well as via the Policy Ratification group Feedback from our Deputy Director of Governance

				• Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	*In line with the Trust's Scheme of Reservation and Delegation of Powers, the Trust Board reserves the power to approve a certain number of policies which does not include those within the remit of EPRR. Therefore, this responsibility is delegated to relevant Executive Groups with oversight provided to respective Committees. This process has been appropriately followed when approving policies OP16 and OP02, via our Executive Infrastructure Group, with subsequent assurance provided to the Performance and Finance Committee, and to the Trust Board via our Committee Highlight Reports."* *"In addition, when re-checking the EPRR Framework and Core Standard, we were unable to find specific reference of the requirement for the Trust Board to approve these policies therefore we continue to consider our approach to be fully compliant with the guidance"*
3 Fully Compliant	Partially Compliant	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements"	EPRR report to board in Nov Now contained in Board annual report p27

4 Fully Compliant	Fully Compliant	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	
5 Fully Compliant	Fully Compliant	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	EPRR resource confirmed in EPRR Policy, and Annual Board Report / Accounts
6 Fully Compliant	Partially Compliant	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Trust has recognised EPRR lessons learnt process, including debriefs from incidents, and updates on incidents by COO to Exec team The trust commissioned a review of all incidents from Oct to May from ICB
7 Fully Compliant	Partially Compliant	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including	EPRR risks now listed on Datix, and EPRR team members of LHRP Risk Group

				community and national risk registers.	
8 Fully Compliant	Partially Compliant	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	EPRR risks are on DATIX, and EPRR team are members of LHRP Risk Assessment Group
9 Fully Compliant	Partially Compliant	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Widespread consultation with NHSE and ICB plus internal stakeholders on plans
10 Fully Compliant	Fully Compliant	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	IRP in place, and reviewed with last 12 months
11 Fully Compliant	Fully compliant	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Severe Weather plan in place, and reviewed in last 12 months
12 Fully Compliant	Partially Compliant	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases	Plan updated and reviewed in last 12 months

				including High Consequence Infectious Diseases.	
13 Partially Compliant	Partially Compliant	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Plan has been updated, and awaiting feedback from IPC group, but not fully signed off Need regional and system guidelines to be provided.
14 Partially Compliant	Partially Compliant	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Need regional and system guidelines to be provided. NHSE Countermeasures Guidance is incorporated into plans. PGDs have been updated and incorporated into plans
15 Partially Compliant	Partially Compliant	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Requires system / regional processes adding (still to be developed) Mass casualty multiagency workshops have taken place to refine plan
16 Partially Compliant	Partially Compliant	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Requires system / regional processes adding (still to be developed) Need to incorporate guidance for full site evacuation plans. Need to incorporate patient tracking guidance
17 Fully Compliant	Fully compliant	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements	Lockdown plan revised and updated in last 12 months

				in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	
18 Fully Compliant	Partially Compliant	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Updated VIP / Protected persons plan has been developed, and ratified in last 12 months
19 Fully Compliant	Partially Compliant	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Requires system / regional processes adding (still to be developed) Internal Plan has been updated and ratified, to include Disaster Victim Identification with escalation process for capacity, and arrangements across the Pathology network. Has been engagement with Local resilience Forum Mass Fatalities process, and have recently received proposed arrangements from them
20 Partially Compliant	Partially Compliant	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to	Ongoing work is being undertaken to review and overhaul the on call policy and procedures

				respond to or escalate notifications to an executive level.	
21 Fully Compliant	Partially Compliant	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Ongoing EPRR training is now provided to on call Strategic and Tactical staff, in addition to Matron on call rota. We have an advisory to collate EPRR specific PDPs in relation to EPRR training and exercising, and incident response, to be addressed over the next 12 months
22 Fully Compliant	Fully Compliant	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	We have an EPRR specific Training Needs Analysis, and undertake a training programme to Strategic and Tactical on call staff in line with the Minimum Occupational Standards
23 Fully Compliant	Partially Compliant	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	The trust has participated in several exercises over the last 12 months, including testing of Cyber arrangements, Tabletop Evacuation ICU exercise, and 2 live play multiagency exercises, based around a large scale industrial fire, with approximately 100 -150 participants in each. The trust has a forward look internal exercise programme, and is liaising with LRF partners in relation to a large scale exercise next year.

24 Partially Compliant		Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Although the trust has training records in place for those that have undertaken Strategic / Tactical training, we do yet have PDPs in place specifically in relation to EPRR training
25 Fully Compliant	Partially Compliant	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Plans and Policies are available on the trust intranet, and general awareness training is undertaken in ED, and on Junior Doctor and Nursing inductions, as well as ad hoc sessions on the CENREE leadership programme
26 Fully Compliant	Fully Compliant	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required.	The trust has an ICC identified and operational in within the trust HQ building, with operational control rooms in Ed, Theatres, Critical care an within divisions. If the main ICC s unavailable, a fall back option can be utilised within the site office, or over at County

				An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	All ICCs have Red “Go bags”, with printed copies of all plans and policies, and equipment and stationary to set up a temporary ICC in a suitable location, including the use of Magic mobile whiteboards We have a dedicated ICC operational guide
27 Fully Compliant	Partially Compliant	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Latest versions are available on the trust intranet, and printed copies are available in ICCs and red “Go Bags”
28 Fully Compliant	Partially Compliant	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	The trust has Business Continuity Plans in place, and has responded to multiple BC disruptions, including multiple rounds of Industrial Action , IT outages, and other disruptions to service
29	Partially Compliant	Response	Decision Logging	To ensure decisions are recorded during business	Insufficient Loggists trained.

Partially Compliant				continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24-hour access to a trained loggist(s) to ensure support to the decision maker	A training programme will be delivered for the Executive PA team in the first instance, with further training being rolled out over the next 12 months. In addition to this, specific Surviving a Public Inquiry training is being provided to those on the strategic rota by a KC specialising in major incident response, as well as
30 Partially Compliant	Partially Compliant	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	The trust has a process in place for the submission of Sitreps, including SBARs, METHANE and Mass Casualty reporting tools, and follow the NHSE reporting process. This has been activated for numerous Business Continuity, and Critical incidents
31 Fully Compliant	Fully Compliant	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidelines available in hard copy in ED & Critical Care, and online in ICC, and on the trust intranet pages
32 Fully Complaint	Fully Compliant	Response	Access to 'CBRN incident: Clinical	Clinical staff have access to the 'CBRN incident: Clinical Management and health	Guidelines available in hard copy in ED & Critical Care, and online in ICC, and on the trust intranet pages

			Management and health protection'	protection' guidance. (Formerly published by PHE)	
33 Fully Compliant	Partially Compliant	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	The trust has an EPRR Media and Communications plan, which has been reviewed in the last 12 months, and communications team are constituent members of the EPRG
34 Fully Compliant	Partially Compliant	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	The trust has an EPRR Media and Communications plan, which has been reviewed in the last 12 months, and actioned within the last 12 months
35 Fully Compliant	Partially Compliant	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	The communications team have process to ensure contact with stakeholders, including LRF partners, elected officials
36 Fully Compliant	Partially Compliant	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	The communication team have robust arrangements with local media, and also multiagency communications groups. Social media is utilised in response to incidents, and also is routinely monitored to enable rapid trust responses to emerging issues

37 Fully Compliant		Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	The trust has effective representation by the AEO on LHRP and constituent sub groups by the Deputy COO & Head of EPRR, as required
38 Fully Compliant		Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	The trust has effective representation by the AEO on LRF and constituent sub groups by the Deputy COO & Head of EPRR, as required
39 Fully Compliant	Partially Compliant	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil	The trust has documented processes for requesting mutual aid, from within the NHS, local partners, and if required Military Aid to the Civil Authority (MACA), and has links into local 4x4 groups to assist with responses to severe weather if required.

				Authorities (MACA) via NHS England.	
CS 40 – 42 not applicable to Acute Trusts					
43 Partially Compliant	Partially Compliant	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	The LRF has produced a Data Sharing agreement, which in the process of being signed off by the AEO.
44 Fully Compliant		Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The Trust has a Business Continuity Policy (OP02) which has been reviewed and ratified in the last 12 months
45 Fully Compliant		Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	The BCMS is outlined within the Business Continuity Policy OP2

46 Fully Compliant	Partially Compliant	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The trust has a BIA template, which is becoming standardised across the trust .
47 Fully Compliant	Partially Compliant	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	The Trust has a BCP template, which is being standardised across the trust
48. Fully Compliant	Partially Compliant	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Business continuity plans have been utilised in response to multiple rounds of Industrial Action, IT Outages, and other BC Incidents over the last 12 months.
49 Partially Compliant	Partially Compliant	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Trust reached 92% compliance – standard is 95% But ICT have an action plan in place

50 Partially Compliant	Partially Compliant	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	KPI need to include whole cycle review and test process KPI need defining for next year, include trajectory year 1 x%, year 2 x %, year 3 90%
51 Partially Compliant	Partially Compliant	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Need to include authority, audit limits, standard interval check, audit stage reviews. BCMS lacks the required information regarding the auditing of the BCMS and needs to be reviewed
52 Partially Compliant	Partially Compliant	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	clear actions from areas, debrief survey and improvement log The section on management review appears to delegate this to the EPRR forum but not completely as it is not clear who has authority – noting changes to the BCMS are required to be signed off by Top management (eg the board).

53 Partially Compliant	Partially Compliant	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Need to include Supplies team awareness of BC training, how are suppliers chosen, what assessment of suppliers is undertaken.
55 Fully Compliant	Partially Compliant	Hazmat/ CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Hazmat / CBRN plan has been reviewed and ratified in last 12 months The plan outlines the governance arrangements for CBRN
56 Fully Compliant	Partially Compliant	Hazmat/ CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	A risk assessment is in place for the trust, and safe systems are work are outlined in the plan
57 Fully compliant		Hazmat/ CBRN	Specialist advice for Hazmat/ CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff has access to Toxbase, and are signposted to UKHSA advice In addition, specialist advice can be obtained from STWA, the Environment Agency, and Staffordshire Fire and Rescue Service HazMat Officers, and

					West Midlands Ambulance Service National Interagency Liaison Officer
58 Fully Compliant	Partially Compliant	Hazmat /CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Hazmat / CBRN plan has been fully revised, and updated following a HazMat incident
59 Fully Compliant	Fully Compliant	Hazmat/ CBRN	Decontaminatio n capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self-presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s)	Equipment is available and there are some good elements in the plan. Tank discharge protocols are clearly documented, as is liaison with STWA and the Environment Agency The trust CBRN capability has been favourably audited by WMAS across both sites, and can provide both dry and wet decontamination processes

				The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	
60 Fully Compliant	Fully Compliant	Hazmat/ CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting	The trust holds more than the required stocks of CBRN equipment in line with the checklist listed in the standard This stock holding has been audited, and confirmed as exceeding the requirements by a WMAS audit

				patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	
61 Fully Compliant	Partially Compliant	Hazmat/ CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor)	A full preventive maintenance programme is in place for all CBRN equipment

				- calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	
62 Fully Compliant	Fully Compliant	Hazmat/ CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	The trust has a well documented, and ratified waste Management policy EF05
63 Fully Compliant	Fully Compliant	Hazmat/ CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	UHNM has a cadre of CBRN Trainers, who undertake CBRN training at both County and UHNM
64 Fully Compliant	Fully Compliant	Hazmat/ CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or	ED staff at both sites undertake a full CBRN training programme, with a cadre of in house CBRN trainers. The training covers dry and wet decontamination processes, and includes safe systems of work for staff.

				over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	
65 Fully Compliant	Partially Compliant	Hazmat/ CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	A full range of PPE is available, and the trust has a regular fit testing and FFP3 training programme, including the donning and doffing of PPE
66	Partially Compliant	Hazmat/ CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN	

Partially Compliant				plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Exercise scheduled at both County and RS within Exercise Timetable already submitted CS23

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th November 2024
Report Title:	Board Development Programme 2024/25 – Update on Schedule of Seminars	**Agenda Item:**	10.
Author:	Nicola Hassall, Deputy Director of Governance		
Executive Lead:	Claire Cotton, Director of Governance		

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	✓	Improving Together		
Responsive	✓	Improving & Innovating	✓	Resources	✓			

Executive Summary

Situation and Background

The outputs of the Board Effectiveness Review were presented to the Trust Board at the Seminar in April 2024. This identified a number of areas of development which subsequently informed the topics within the Board Seminar Schedule for 2024/25. Additional areas of development have also been included within the programme for 2024/25 following the Deloitte Well Led Developmental Review. The schedule of seminars includes a variety of business and developmental topics including 'must dos', emerging developments and operational/strategic challenges, aligned to our Strategic Priorities.

This paper provides the Trust Board with an overview on the progress to date on delivering the topics identified, in addition to confirming the timing of remaining sessions.

Assessment

A review of the Board Seminar Schedule has been undertaken and the attached demonstrates the topics which have been covered as planned, including those which are scheduled for forthcoming Seminars. Sessions have also been scheduled within the time allocated for Closed Board meetings, particularly the sessions in December and February given the opportunity to utilise the time freed up from the move to bi-monthly Public Trust Boards.

The attached demonstrates that all but one of the topics to date have been covered as planned, as the Board Insights training has been deferred from November 2024. In addition, a session with the Chairs of the Staff Networks has been included for February and a number of items to be considered within the programme for 2025/26 have also been included.

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

Rationale

Significant assurance has been provided based on the programme of seminars which has been in place throughout the year and delivered as planned with the exception of deferral.

Key Recommendations

The Trust Board is asked to consider the progress made with the planned activities within the Board Seminar Schedule and to note the timing and activities to be covered for the remaining sessions. In addition, the Board is asked to highlight any further areas of development which they would like to feature within the programme.

Board Development Programme 2024 - 2025

NHS University Hospitals of North Midlands NHS Trust

Topic	Session Lead	Development / Business	Purpose / Outcome	3rd April Closed Bd	12th April Seminar	15th May Seminar	5th June Closed Bd	17th July Seminar	7th Aug Closed Bd	11th Sept Seminar	9th Oct Closed Bd	18th Nov Time Out	4th Dec Closed Bd	15th Jan Seminar	5th Feb Closed Bd	19th March Seminar	Strategic Priorities
Board Development	Director of Governance	Board Development	To consider the findings of our Board Effectiveness Evaluation and agree Board Development for 2024/25														● ● ● ● ● ●
Well Led Self-Assessment	Director of Governance	Strategic	To agree the output of the Board's Self-Assessment														● ● ● ● ● ●
Risk Appetite	Director of Governance	Strategic	To review and agree the Trust's Risk Appetite Statement														● ● ● ● ● ●
Update on Responsiveness, Finance, Workforce & Productivity	Chief Operating Officer / Chief Finance Officer / Chief People Officer / Director of Strategy	Operational / Business Issues	Update in respect of annual planning, associated risks and issues and links to Well Led														● ● ● ● ●
Independent Well-Led Assessment	Director of Governance	Operational / Business Issues	To consider the findings of our External Developmental Review against the Well Led Framework and agree our Development Plan.														● ● ● ● ● ●
Levers of Effectiveness / GIRFT	Chief Medical Officer Chief Operating Officer	Operational / Business Issues	To provide an update in respect of progressing the Clinical Effectiveness divisional programmes of work														● ● ● ●
Innovation	Director of Strategy, Chief Nurse, Chief Digital Information Officer	Operational / Business Issues	To provide an update in respect of progressing the work in relation to innovation														● ●
Counter Fraud Annual Training	Chief Finance Officer	Board Development	RSM to lead the session														●
Enabling Strategies Half Year Update	Director of Strategy plus Executive Leads	Strategic	A review of progress against delivery of our Strategy and supporting Delivery Plans.														● ● ● ● ● ●
Cyber Security & Digital	Chief Digital Information Officer	Operational / Business Issues	Annual training and development on Cyber Security / Risk.														●
Sustainability	Director of Estates, Facilities and PFI	Operational / Business Issues	An update on delivery of the Green Plan and key priorities.														● ●
Research and CeNREE	Chief Nurse & Medical Director	Operational / Business Issues	An update on progress with CeNREE and Research.														● ● ●
UHNM Staff Networks	Chief People Officer	Operational / Business Issues	Annual update on the work and challenges of our Staff Networks														●
Freedom to Speak Up	Director of Governance	Operational / Business Issues	Completion of annual self-assessment														● ●
Strategic Risks - Board Assurance Framework	Director of Governance	Strategic	To agree the Strategic Risks for 2024/25 Board Assurance Framework.														● ● ● ● ● ●
Annual Plan and Focus Confirmation (local priorities)	Director of Strategy and Transformation	Strategic	To agree the Annual Plan, Annual Delivery Plans for Enabling Strategies and to confirm priorities agreed through focussed negotiation.														● ● ● ● ● ●
Digitised Care - the future	Chief Digital Information Officer	Operational / Business Issues	To be considered for 2025/26 programme														● ● ● ● ●
Artificial Intelligence, Genome Sequencing & Robotics	Chief Digital Information Officer	Operational / Business Issues	To be considered for 2025/26 programme														● ●
System Working, Challenges & Working Together	Chief Executive	Strategic	To be considered for 2025/26 programme														● ● ● ● ● ●
Board Insights / Personalities	Chief People Officer	Board Development	To be considered for 2025/26 programme														●

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th November 2024
Report Title:	Calendar of Business 2025/26	**Agenda Item:**	11.
Author:	Nicola Hassall, Deputy Director of Governance		
Executive Lead:	All		

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 and Background

The Calendar of Business provides a forward plan for all Board, Committee and Executive Group meetings, and is designed to ensure that the frequency and scheduling of those core governance meetings is proportionate and allows for effective flows of decision making and assurance. It builds on the outputs of annual effectiveness reviews and ongoing discussion and feedback, to ensure that it remains fit for purpose.

Taking into account the increasing demands on time, a particular area of focus for the 2025/26 calendar has been to streamline the number of meetings where feasible to do so and this builds on the decision to move Public Board meetings to bi-monthly, bringing UHNM in line with partners within and beyond our system.

Assessment

Whilst the Calendar of Business for 2025/26 follows the similar sequencing of meetings as per 2024/25, a number of changes have been made:

- Committees have been scheduled where possible to avoid half term holidays
- Performance and Finance Committee (PAF) will take place on a Monday due to a clash with a system finance meeting
- People, Culture and Inclusion and Strategy and Transformation Committees will take place bi-monthly on an alternating basis
- Maternity Quality Governance Committee (MQGC) has been removed and re-integrated with Quality Governance Committee (QGC) – Executive Maternity Quality and Safety Oversight Group remains in place.
- Executive Research & Innovation Group has been removed and incorporated into Executive Strategy and Transformation Group although work remains ongoing around the role and purpose of this group alongside the development of our revised Strategy
- Performance Review Meetings with Divisions will be held on a bi-monthly basis (previously monthly) allowing greater opportunity for Divisions to take action and make improvement between reviews
- Trust Leadership Forum (previously Trust Executive Committee) has been included and the Terms of Reference for this are under development; this Forum brings together the senior leaders of the organisation and changes made build on the recommendations from the recent Well Led Review

It should be noted that although the scheduling of Committee meetings follows the same pattern as for 2024/25, in December 2025, due to the Christmas period and the fact that data is usually available from the 15th of the month, Committees will be held on different days to provide more time to prepare papers after the release of the data.

Change in Frequency of Public Trust Board Meetings

As announced by the Chairman in October 2024, Public Trust Board meetings will move to every other month from November 2024. The frequency of meetings has not been reviewed for many years and the proposed change not only frees up management capacity in the production of reports but brings UHNM in line with many other organisations both within and beyond our system and creates opportunity for additional leadership development as needed, given the current Board Development Programme is stretched for capacity.

It should be noted that there is no stipulation for NHS Trusts to have a set number of meetings which must take place, although the frequency of meetings should support decision-making processes and submission deadlines. In addition, there should be sufficient opportunity for debate and discussion in Public to provide assurance to stakeholders that the Trust Board is discharging its duties effectively. Other NHS Trusts have already taken the decision to move to less frequent public meetings for the reasons outlined above.

Key points to note are as follows:

- The number of Public Trust Board meetings will reduce from 11 to 6
- Closed Board meetings will continue to be held on a monthly basis to consider any urgent business and items for Board Development will follow
- The Business Cycles for Board and Committees will be revised to reflect the change in timing, ensuring any national submission dates are taken into account

Key Recommendations

The Trust Board is asked to **approve** the Calendar of Business for 2025/26 and to approve the decision to change the frequency of meetings to reduce the time burden on Board members and reduce the regularity of reporting required from senior managers.

Calendar of Business 2025/2026

NHS University Hospitals of North Midlands NHS Trust

	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun
April				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30					
M12 Reporting				TLF	PCIC	QGC						PTB	CEG				EFAP	EHSG	EST	EWAG					PRW	TBS	PRM				PAF	CC	STC					
												CTB					QSOG				BH			BH	PRS		PRN											
May						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
M1 Reporting						QGC					TLF	CTBD		BTO			MQSOG			EIG	EBI			EFAP	EHSG		EWAG										
						AC				BH														QSOG			DSP				BH							
June		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30						
M2 Reporting			PAF	TLF	PCIC	QGC						PTB	CEG					EHSG	EST	EWAG	AC			EPTB	PRW	TBS	PRM				PAF						
				NRC								CTB												EFAP	PRS		PRN										
												CT												QSOG													
July				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
M3 Reporting				TLF	STC	QGC	NED					CTBD	EIG	EBI				EHSG		EWAG				EFAP							PAF	CC	PCIC	QGC			
														NED						DSP				QSOG										AC			
August							1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
M4 Reporting											TLF	PTB					MQSOG			CEG				EFAP	EHSG	EST	EWAG					PRW		PRM			
												CTB												QSOG							BH	PRS		PRN			
September			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30					
M5 Reporting			PAF	TLF	STC	QGC						CTB	EIG	EBI				EHSG	TBS	EWAG				EFAP							PAF						
				NRC								AGM								DSP				QSOG													
October					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
M6 Reporting					PCIC	QGC					TLF	PTB							BTO	CEG					EHSG	EST	EWAG				EFAP	PRW		PRM			
												CTB																			QSOG	PRS		PRN			
November	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30							
M7 Reporting			PAF	TLF	STC	QGC						CTBD	EIG	EBI			MQSOG	EHSG		EWAG				EFAP													
				NRC		AC														DSP				QSOG													
				CC																																	
December			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31				
M8 Reporting			PAF	TLF	PCIC	QGC						PTB	CEG				EFAP	EHSG	EST	EWAG				PAF	STC	QGC											
												CTB					QSOG										BH	BH									
												CT																									
January						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
M9 Reporting						BH					TLF	CTBD								EIG	EBI				EHSG		EWAG				EFAP	PRW		PRM			
											NRC																DSP				QSOG	PRS		PRN			
February		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28								
M10 Reporting			PAF	CC	PCIC	QGC					TLF	PTB	CEG				MQSOG	EHSG	EST	EWAG				EFAP		TBS											
						AC						CTB												QSOG													
March		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3		
M11 Reporting			PAF	NRC	STC	QGC					TLF	CTBD	EIG	EBI				EHSG		EWAG				EFAP	PRW		PRM				PAF			PCIC	QGC		
																				DSP				QSOG	PRS		PRN									

COLOUR KEY		TIME
Public Trust Board	PTB	9:30 - 12.30 pm
Closed Trust Board	CTB	1.00 - 2.00 pm
Closed Trust Board / Board Development Session	CTBD	9.00 - 1.00 pm
Trust Board Seminar	TBS	9.00 - 1.00 pm
Trust Board Time Out	BTO	9.00 - 4.00 pm
Annual General Meeting	AGM	12.30 - 3.00 pm
NED Away Day	NED	9.00 - 4.30 pm
Performance and Finance Committee	PAF	9.00 - 12.00 pm
Executive Infrastructure Group	EIG	11.00 - 12.30 pm
Executive Business Intelligence Group	EBI	9.00 - 10.30 am
Executive Finance, Activity & Productivity Group	EFAP	S - 9.00 - 10.00 am N - 10.15 - 11.15 am M - 11.30 - 12.30 pm W - 1.00 - 2.00 pm
Audit Committee	AC	12.30 3.00 pm
Nomination & Remuneration Committee	NRC	10.30 - 12.00 pm
Trust Leadership Forum	TLF	8.30 - 10.00 am
Corporate Trustee	CT	2.30 - 3.30 pm
Charity Committee	CC	12.30 - 2.00 pm
Quality Governance Committee	QGC	9.30 - 12.30 pm
Executive Quality and Safety Oversight Group	QSOG	2.00 - 4.00 pm
Executive Maternity Quality and Safety Oversight Group	MQSOG	2.00 - 4.00 pm
Executive Clinical Effectiveness Group	CEG	9.30 - 11.00 am
People, Culture & Inclusion Committee	PCIC	9.00 - 12.00 pm
Executive Health and Safety Group	EHSG	10.30 am - 12.00 pm
Executive Workforce Assurance Group	EWAG	9.00 - 11.00 am
Strategy & Transformation Committee	STC	9.00 - 12.00 pm
Executive Data Security and Protection Group	DSP	12.30 pm - 2.00 pm
Executive Strategy and Transformation Group	EST	9.00 - 10.30 am
Performance Management Reviews	PR	W 8.45 - 10.45 am S 11.00 - 1.00 pm M 8.45 - 10.45 am N 11.00 - 1.00 pm
Staffordshire School Holidays		

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th November 2024
Report Title:	RM02 Handling Complaints and Concerns	**Agenda Item:**	12.
Author:	Rebecca Pilling, Head of Patient Experience		
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	✓			

Executive Summary

Situation and Background

The attached policy has been reviewed as part of its 3 yearly cycle and is being presented to the Trust Board for approval, in line with the Trust's Scheme of Delegation to 'approve the arrangements for dealing with complaints'.

Assessment

The policy has been reviewed and the changes made mainly relate to the appendices, in clarifying the sign off and escalation process for complaints. A number of groups have been consulted with, when making the revisions, including the Hospital User Group, Patient Experience Group and Executive Quality and Safety Oversight Group.

Key Recommendations

The Trust Board is asked to approve the revised policy.

Policy Document

Reference: RM02

University Hospitals of North Midlands NHS Trust

Handling Complaints and Concerns

Version:	**12**
Date Ratified:	**October 2024 by the Quality and Safety Oversight Group**
To Be Reviewed Before:	**October 2027**
Policy Author:	**Head of Patient Experience**
Executive Lead:	**Chief Nurse**

Version Control Schedule

Version	Issue Date	Comments
1	January 2004	
2	January 2005	
3	January 2008	
4	March 2009	
5	March 2010	
6	February 2013	Reviewed and approved
7	March 2014	Ratified at Quality and Safety Forum
8	August 2015	Aligned with County
9	January 2018	
10	September 2020	There have been minor amendments to include the DATIX verbal complaint process within the policy, and working groups that have had their titles changed. The timescales for escalation have been made clearer, and some unnecessary appendices have been removed.
11	June 2021	
12	October 2024	There have been significant changes to the policy including the Appendices – Sign off process, Escalation process have been amended

Statement on Trust Policies

The latest version of 'Statement on Trust Policies' applies to this policy and can be accessed here

NHS
University Hospitals of North Midlands
NHS Trust

Review Form / Equality Impact Assessment (EIA)

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Analysis Form is designed to help consider the needs and assess the impact of each policy. To this end, EIAs will be undertaken for all policies.

Policy Reference, Title and Version Number	RM02 Handling Complaints and Concerns V12
Summary of changes made on this review	A new escalation process for delayed responses A new triage for complaint timeframes
Please list which service users, staff or other groups have been consulted with, in relation to this	Hospital User Group Patient Experience Group
Were any amendments made as a result? If yes, please specify	No
Does this policy involve the administration or control of medicines? If yes, have the Safe Meds Group been consulted with?	N/A
Which Executive Director has been consulted on?	Chief Nurse
Does this policy have the potential to affect any of the groups listed below differently - please complete the below. Prompts for consideration are provided, but are not an exhaustive list	

Group	Is there a potential to impact on the group? (Yes/No/Unsure)	Please explain and give examples	**Actions taken to mitigate negative impact** *(e.g. what action has been taken or will be taken, who is responsible for taking a future action, and when it will be completed by – may include adjustment to wording of policy or leaflet to mitigate)*
Age (e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)	No		
Gender (e.g. is gender neutral language used in the way the policy or information leaflet is written?)	No		
Race (e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)	No		
Religion & Belief (e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered)	No		
Sexual orientation (e.g. is inclusive language used? Are there different access/prevalence rates?)	No		

Group	Is there a potential to impact on the group? (Yes/No/Unsure)	Please explain and give examples	**Actions taken to mitigate negative impact** *(e.g. what action has been taken or will be taken, who is responsible for taking a future action, and when it will be completed by – may include adjustment to wording of policy or leaflet to mitigate)*
Pregnancy & Maternity (e.g. are procedures suitable for pregnant and/or breastfeeding women?)	No		
Marital status/civil partnership (e.g. would there be any difference because the individual is/is not married/in a civil partnership?)	No		
Gender Reassignment (e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)	No		
Human Rights (e.g. Does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)	No		
Carers (e.g. is sufficient notice built in so can take time off work to attend appointment?)	No		
Socio/economic (e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)	No		
Disability (e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer.	No		
Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities? (e.g. allow extra time for appointments, allow advocates to be present in the room, having access to visual aids, removing requirement to wait in unsuitable environments, etc.)			**Yes** **Easy read version of patient information leaflet to accompany policy**
Will this policy require a full impact assessment and action plan? (a full impact assessment will be required if you are unsure of the potential to affect a group differently, or if you believe there is a potential for it to affect a group differently and do not know how to mitigate against this - please contact the Corporate Governance Department for further information)			**No**

CONTENTS **Page**

1. INTRODUCTION

Feedback/comments on services provided, suggestions for improvement, and complaints when services fail to satisfy the user, are actively sought by the Trust. They are seen as a means of identifying and rectifying errors or faults and enhancing the quality of the service. Complaints should therefore, be seen in a positive light, as an opportunity for improvement. This Policy has been formulated in order that all Trust staff may be aware of what constitutes a complaint, and the actions which should be taken when a complaint is received.

Prior to 1st April 2009 there were two different processes for handling complaints related to health and social care services. These processes differed in stages and timescales; investigations were also carried out in different ways. Many people use services which cross health and social care boundaries. If problems arose, it was hard for people to know who to go to and difficult for different services to respond jointly.

The Government wished to make it simpler for people to complain about their experiences of using health and social care services. In the White Paper, Our health, our care, our say (January 2006), the Department of Health set out its commitment to develop a single system across health and social care by 2009 that would 'focus on resolving complaints locally with a more personal and comprehensive approach to handling complaints' (Page 160).

In September 2006, the National Health (Complaints) Amendment Regulations 2006 came into force which imposed a reciprocal duty on NHS organisations and local authorities to co-operate and to provide a co-ordinated response to the complaint.

In June 2007 the Department of Health launched a public consultation, 'Making Experiences Count' (MEC) and new regulations were passed by Parliament in February 2009 (Statutory Instrument No 309) to take effect on 1st April 2009.

In December 2009 the Care Quality Commission published their essential standards of Quality and Safety, setting out what Providers should do to comply with section 20 regulations of the Health and Social Care Act 2008. This policy considers the requirements set out within Outcome 17 of the Act.

The policy also considers the minimum standards set out within the NHSLA Risk Management Standards 2010/11 as well as the new guidance set out by the PHSO pilot, "NHS Complaint Standards: the value of good complaints handling, published in 2021 alongside NHS Complaint Standards Model Complaint Handling Procedure for providers of NHS services in England, December 2022 NHS Complaint Standards | Parliamentary and Health Service Ombudsman (PHSO)

In reviewing this policy the Trust has taken into account lessons learnt following the inquiry into the care provided by other healthcare organisations which found that the poor experiences of patients and their families were not taken into account in the delivery of safe and effective services. The University Hospitals of North Midlands is committed to ensuring that feedback from patients, service users and staff are an integral component in the planning, delivery and continuous improvement of its services.

This Policy and Procedures for the handling of complaints is entirely separate from the Trust's Disciplinary Procedures. Its purpose is not to apportion blame amongst staff but to investigate complaints to the complainant's satisfaction while being scrupulously fair to staff. Any matter referred for disciplinary proceedings ceases to be covered by this Policy.

An "Equality Impact Assessment" has been undertaken and no actual or potential discriminatory impact has been identified relating to this document.

2. POLICY STATEMENT

As referenced in the NHS Constitution patients and/or their representatives have the right to:

- have any complaint made about NHS services dealt with efficiently and to have it properly investigated,

- know the outcome of any investigation into their complaint,

- take their complaint to the independent Parliamentary Health Service Ombudsman (PHSO) if they are not satisfied with the way their complaint has been dealt with by the NHS,

- make a claim for judicial review if they think they have been directly affected by an unlawful act or decision of an NHS body.

The NHS commits to:

- ensure the patient/representative is treated with courtesy and receive appropriate support throughout the handling of a complaint and feel assured that the fact that a complaint has been made will not adversely affect the future treatment of the patient,

- when complaints happen, to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively,

- ensure that the organisation learns lessons from complaints and uses these to improve NHS services.

The Policy of the Trust is to ensure:

- that responses to complaints are outcome-based and focus on achieving the best possible results for complainants, by providing the answers and explanations that complainants need to help them understand if, when and how something went wrong or why something happened that they perceived to be wrong. Such investigations allow the Trust an opportunity to address issues and improve services for others.

- that complaints are responded to promptly, avoiding unnecessary delays, keeping the complainant regularly informed about progress,

- that the barriers which could prevent or inhibit service users from expressing dissatisfaction with the service are removed,

- that complainants are aware of their right to refer their complaint to the Parliamentary Health Service Ombudsman (PHSO) if they are not satisfied with the Trust's response to their complaint,

- That all staff are aware of the Trust's Policy and Procedures for the handling of complaints and that these are followed uniformly across the Trust,

- That feedback and lessons learned from complaints are used to improve service design and delivery across the Trust.

3. SCOPE

This policy applies to all disciplines of staff across the Trust, but the degree of responsibility will vary throughout the organisation.

4. DEFINITIONS

Complaints
A complaint can be defined as an expression of discontent which requires a response. It is a generic term for any sort of complaint, raised either verbally, via e-mail or in writing by people using health/social care services.

DATIX
DATIX is the organisation's risk management software which is used for the recording and reporting of Adverse Incidents, Complaints, and Claims, PALS, Inquests and organisational risks.

Patient Advice and Liaison Service (PALS)
PALS provides support to patients, carers and relatives, representing their view and resolving local difficulties on-the-spot by working in partnership with Trust staff. In addition to helping resolve patients' concerns quickly and efficiently, and improving the outcome of care in the process, PALS provide information to patients to help make contact with the NHS as easy as possible. There are Information boards regarding the PALS service in clinical and non-clinical areas throughout the Trust.

Complaints Advocacy Service
Complaints Advocacy Services help individuals to pursue complaints about the NHS, ensuring that complainants have access to the support they need to articulate their concerns and navigate the complaints system, thereby maximising the chances of their complaint being resolved more quickly and effectively at a local level. The Complaints Advocacy Services will determine the level of service required according to complainants' needs. As well as providing advice the service provides advocacy in terms of writing letters and attending meetings to speak on the complainant's behalf.

Patient Information 'Compliments, Concerns and Complaints' is a leaflet, produced by the Trust which encourages patients, relatives and visitors to share their experiences whether positive or negative. The leaflet contains information about how to raise concerns at ward and department level, how to contact PALS and how to escalate complaints if they have not been resolved. Copies of the leaflet should also be available in areas around the Trust for patients/visitors etc. to review, as required.

'Making a Complaint' is a leaflet designed to guide a complainant through the complaints procedure. When enquiring, a complainant should be provided with a copy of this leaflet when a formal complaint is made and acknowledged. This leaflet focuses on what the complainant can expect from the Trust, how to obtain support from the NHS Complaints Advocacy Service and how to contact the Parliamentary Health Service Ombudsman (PHSO).

5. ROLES AND RESPONSIBILITIES

5.1 Chief Executive/Divisional Senior Management Teams

The Chief Executive has overall responsibility for the management of complaints and, together with the Trust Board and Divisional Senior Management Teams, is responsible for ensuring that lessons are learnt, and the standard of care and treatment afforded to patients, carers and relatives is improved following the investigation of a complaint. They are also responsible for ensuring that this policy is implemented in an effective and timely manner across the organisation.

5.2 Executive Responsible for Complaints

The role of the Executive Complaints Manager is fulfilled by the Chief Nurse who reports directly to the Chief Executive in all matters relating to the implementation of the Trust's Policy and Procedures for handling complaints.

5.3 Head of Patient Experience

The role of the Trust's Head of Patient Experience is to;

a. Identify trends.
b. Discuss analysis at Patient Experience and involvement meetings.
c. Supply complaint reports to specific groups e.g., Quality & Safety Oversight Group .
d. Offers support in ensuring complaints are managed appropriately and effectively.

5.4 Divisional Nurse Director/Professional Head of Clinical Service

Divisional Nurse Director/Professional Head of Clinical Service is responsible for ensuring:

a. effective complaints management within their Division and for providing clinical support to investigations,
b. that all nursing/midwifery/AHP staff receive training in complaints management,
c. That a process is in place which encourages patients to provide feedback prior to discharge from hospital.

5.5 Directorate Managers

Directorate Managers are responsible for overseeing and monitoring the management of complaints within their Directorate, nominating leads to liaise with the Corporate Complaints Team in providing information, support and assistance throughout investigations. Directorate Managers must ensure there is a robust system in place for the Directorate Teams to regularly review complaints with the Patient Experience Advisors which will include updates on the status of recommendations.

5.6 Operational Complaints Manager

The Operational Complaints Manager will oversee the complaints process supporting the Head of Patient Experience and manages the day-to-day activity of the Corporate Complaints Team. Ensuring response letters for signature, prepared by the central complaints team; are delivered in a timely and accurate way, ensuring a sensitive and high-quality written response is sent to families/service users. Assists in the processes that ensure the department and the Trust achieve statutory standards such as Care Quality Commission and NHSLA requirements.

5.7 Patient Experience Advisors (Lead Investigating Officers)

Patient Experience Advisors report to the Operational Complaints and PALS Manager and are responsible for investigating complaints in line with Trust policy, ensuring that all appropriate actions are taken to achieve local resolution, which includes the writing of reports, deadlines and completion dates and agreeing recommendations and action plans with the Directorate Teams. The Corporate Complaints Team will ensure that DATIX is updated and all complaint documents are uploaded.

5.8 Complaints Administrator

The Complaints Administrators report to the Operational Complaints Manager and administer the complaints system, in accordance with Trust policy.

5.9 Patient Advice & Liaison Service (PALS) staff

The PALS team report to the Operational Complaints and PALS Manager and are responsible for ensuring that all complaints/concerns/feedback received into the PALS department are dealt with proactively, ensuring fast and effective resolution of patient concerns.

5.10 Front Line Staff

Front line staff have a responsibility to manage, and where possible resolve, verbal complaints, in line with Trust policy and to distinguish those serious issues that, even if raised verbally, need to be brought to the attention of senior managers within the organisation, for example where they raise patient safety issues.

5.11 Independent Reviewers (Internal & External)

In extenuating circumstances and by agreement of the Executive Team an independent review may be considered. Independent Reviewers (internal) have the responsibility of considering a complaint, outside of their own area, where the initial investigation has failed to resolve the complaint to the complainant's satisfaction. Independent review may be undertaken outside of the Trust (external), if it is felt that an internal review would not offer a true independent opinion or if the complainant rejects an internal independent review.

5.12 Senior Clinicians

In line with their GMC professional standards, clinicians have a responsibility to co-operate in the investigation of a complaint relating to treatment provided by them or one of their team, including meeting with complainants, if requested. They also have a responsibility to provide their opinion on treatment provided by a clinician outside their team, if necessary.

5.13 All Employees

All employees have a responsibility to abide by this policy, including procedural guidance in Appendix A and any decisions arising from the implementation of it.

6. TRAINING

In accordance with the Trust's Training Needs and Analysis, training on the management of complaints is delivered, dependent on the needs of each job role (See Policy HR53). All training records should be held in the staff personal record, ideally within ESR.

7. MONITORING AND REVIEW ARRANGEMENTS

The process for monitoring compliance with this policy is as follows:

- Duties, including process for listening and responding to concerns/complaints. The Corporate Complaints Team will monitor compliance with the standards on an ongoing basis. Where concerns with the handling of a complaint are identified, these will be highlighted to the Divisional Nurse Director/Professional Head of Clinical Service and, where appropriate, the Chief Nurse.

- Where joint investigations are undertaken, the process will be monitored by the Complaints Administrator at UHNM, alongside the appropriate Complaints Team in the other organisation(s).

- In addition, a Complaint Survey is sent electronically (Appendix J) will be sent to everyone raising a formal complaint at the Trust. The results of these will be used monthly to monitor how the complaint was handled and responded to. The findings will give a corporate overview of the management of complaints from the complainant's perspective and will be included in the monthly complaints report, shared at the Patient Experience Group. These reports will also support in monitoring the process by which improvements are made as a result of concerns/complaints being made.

- The monthly complaint report will also be used to monitor the timeframes for responding to complaints.

- Where the monitoring identifies deficiencies, divisions are responsible for ensuring that this is included in their local risk register with an action plan to address any shortfalls.

Additional means by which this policy is monitored include the following:

- There must be a record of all complaints made to the Trust. All complaints must be entered onto DATIX which should be maintained both centrally and within each division.

- There should be regular monitoring of the incidence and the handling of complaints both centrally and within the divisions.

- The Chief Executive and/or the Chief Nurse may, at any time, initiate a formal review of the overall investigation, management and outcome of a complaint.

- Divisional Senior Management should ensure that all actions identified from a complaint are implemented, monitored and completion dates achieved.

- Complaints Management will be monitored via the Directorate Monthly Performance reviews.

- A summary of complaints is included in the Quality Report and issues discussed at the Divisional Quality Performance Review Meeting as required.

Information contained in the reports should be anonymised to ensure patient/complainant confidentiality.

RM02 Policy and Procedure for Handling Complaints Monitoring Table					
Aspect of compliance or effectiveness being monitored	Monitoring method	Individual or department responsible for the monitoring	Frequency of the monitoring activity	Group/committee/ forum which will receive the findings/monitoring report	Committee/ individual responsible for ensuring that the actions are completed
duties	Datix	Line Manager	As exception	Divisional Governance Group	Divisional Governance Group
process for listening and responding to concerns/complaints of patients, their relatives and carers	An audit of a random selection of closed complaint files against a number of standards (appendix B)	Complaint Manager/Head of Patient Experience	Quarterly	Patient Experience Group	Patient Experience Team
process for ensuring that patients, their relatives and carers are not treated adversely as a result of raising a concern/complaint	Complaints Satisfaction Surveys	Patient Experience Department	Monthly	Patient Experience Group	Patient Experience Team
process by which the organisation aims to improve as a result of concerns/ complaints being raised	Complaints	Patient Experience Department	Quarterly	Patient Experience Group	Patient Experience Group

The policy will be reviewed in 3 years to ensure that it remains relevant.

8. REFERENCES

Department of Health 'Our health, our care our say: making it happen' (October 2006)
National Health (Complaints) Amendment Regulations 2006
Department of Health 'Making Experiences Count' (February 2008)
Statutory Instrument 2009 No. 309, the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009.
NHS Core Standard C14
NHS Confidentiality Code of Practice (gateway reference 1656)
Freedom of Information Act 2000

The NHS Constitution (21 January 2009)
PHSO, Complaints Standards: “NHS Complaint Standards: the value of good complaints handling (2021)
NHS Complaint Standards Model Complaint Handling Procedure for providers of NHS services in England, December 2022

Appendix A

PROCEDURAL GUIDANCE WHEN MANAGING A COMPLAINT

Time limit on initiating complaints

A complaint should be made as soon as possible after the action giving rise to it. The time limit for making a complaint will be within 12 months from the date the matter occurred or the matter came to the notice of the complainant. There is discretion to investigate beyond this, if there are good reasons for a complaint not having been raised sooner, e.g. bereavement, and it is still possible for the Trust to investigate the complaint effectively and fairly.

Principles on which the policy is based

It is the right of every health service user to bring to the attention of Trust management aspects of their care and treatment about which they are unhappy. All staff must be aware of an individual's right to comment on the standards of service provided by the Trust and must therefore be familiar with the Trust's policy for dealing with complaints.

Any complaints system should be simple, easy to understand and as devoid of bureaucracy as possible, while ensuring that it is effective in responding to the satisfaction of complainants.

Service users, regardless of their position in society, age, race, language, gender, sexuality, literacy level or physical or mental ability should be able to register a complaint.

At all times NHS staff should treat patients, carers and visitors in line with Trust Values. However, violence, racial, sexual or verbal harassment towards staff will not be tolerated. NHS staff will not be expected to tolerate language that is of a personal, abusive or threatening nature.

Staff can seek support via the Complaints Manager or Head of Patient Experience should Policy C74 – Habitual and Vexatious Complainants require consideration of implementation.

All complaints should be taken seriously.

In the case of verbal complaints, front-line staff should be empowered to resolve complaints at source.

Complainants should be involved from the outset and Investigating Officers should seek to determine what complainants are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options for pursuing the complaint and should be kept informed throughout the process.

Both complainant and those involved in the complaint must feel that any investigation carried out has been impartial and that all points of view have been listened to and investigated fairly.

Respondents should be willing to accept the validity of the complainant's point of view, even if they do not share it; to give an explanation of events and apologise if appropriate.

Complainants must be assured that the fact that they have made a complaint will not jeopardise their care or treatment in the future. Concerns regarding discrimination in relation to treatment as a result of raising a concern or complaint will be highlighted to the Trust through the questionnaire which is issued to all complainants following completion of a complaint.

Complaints should be viewed as allowing opportunities for quality enhancement and, therefore, should be responded to positively rather than reacted against negatively.

As per NHS Complaint Standards Model Complaint Handling Procedure for providers of NHS services in England, December 2022, our complaints process should have a strong focus on:

- *Early resolution by empowered and well-trained people*
- *All staff, particularly senior staff, regularly reviewing what learning can be taken from complaints*
- *How all staff, particularly senior staff, should use this learning to improve services.*

It also stipulates that an effective complaint handling system:

Promotes a learning culture by supporting the whole organisation to:

- see complaints as an opportunity to develop and improve its services and people
- set clear expectations to embed an open, non-defensive approach to learning from complaints
- regularly talk to its managers, leaders and service users about what it has learnt from complaints and how it has used learning to improve services for everyone
- give colleagues the support and training they need to deliver best practice in handling complaints.

Welcomes complaints in a positive way and:

- recognises them as important insight into how to improve services
- creates a positive experience by making it easy for service users to make a complaint
- gives colleagues the freedom to resolve issues quickly and to everyone's satisfaction.

Is thorough and fair when looking into complaints and:

- gives an open and honest answer as quickly as possible, considering the complexity of the issues
- makes sure service users who make complaints, and colleagues directly involved in the issues, have their say and are kept updated when they carry out this work
- makes sure service users can see what colleagues are doing to look into the issues in a fair and objective way, based on the facts

Gives fair and accountable responses that:

- set out what happened and whether mistakes were made
- fairly reflect the experiences of everyone involved
- clearly set out how the organisation is accountable • give colleagues the confidence and freedom to offer fair remedies to put things right
- take action to make sure any learning is identified and used to improve services.

General guidelines

All complaints, whether they are received within divisions or centrally, must be checked on receipt

- Ensure the complaint does not indicate that a service user, patient or member of staff is at immediate risk. If the service user, patient or member of staff is at risk, action must be taken without delay to ensure their safety.

- Establish whether consent is required if the complaint is received via a third party.

- Determine if the complaint has been made within the timescale for making complaints.

- Determine if the complaint concerns have been referred to the appropriate Directorates or Trust with responsibility. If this is not the case, the complaint should be returned to the Complaints Administrator for appropriate re-direction.

- To see whether the complaint has been sent by a third party. The actions set out in Section 6.10 must be taken in the case of third-party complaints.

- Ensure response letters for signature, prepared by the central complaints team; are delivered in a timely and accurate way, ensuring a sensitive and high-quality written response is sent to families/service users.

- Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level and the duties of the system to respond to complaints should be regarded as entirely separate from the consideration of litigation. The Centralised Complaints Team will liaise with the Medico-Legal Team as required.

- The principle of confidentiality must be respected throughout.

The staff involved, as well as the complainant, should be kept informed of the progress of complaint investigations and be made aware of the outcome. The final draft response to complainants must be shared with the staff involved.

Complete and accurate records must be kept throughout the investigation of complaints. A complaint file has the same status as any other created by a healthcare organisation. It is a public record; its contents are confidential and should be maintained to an appropriate standard. All records/correspondence must be dated and kept on file electronically, using the Complaints Module of the Trust's Risk Management System (DATIX). Electronic and paper records should be kept separate from the patient's health records, for 10 years after the resolution of the complaint in line with the Information lifecycle and Corporate Records Management Policy.

If investigation of a complaint reveals a possible need for disciplinary action against staff at any point in the investigation, the matter must be referred at once by the appropriate manager to the Employee Relations Team for their review and action required. The complainant and staff involved should be advised accordingly. Relevant information gathered in investigating the complaint may be handed over for the purpose of the disciplinary investigation. However, if any part of the complaint is not the subject of the disciplinary proceedings, proceedings under this Policy may continue for that part of the complaint.

The Complaints Administrator will ensure that a check takes place to establish if there has been a previous Adverse Incident Report or Request for Disclosure, related to the complaint.

If investigation of a complaint reveals an unreported adverse incident, the matter must be referred at once by the appropriate manager to the Quality Safety and Compliance Department.

For complainants who have communication support needs, or for whom English may not be their first language, the Trust has access to a range of services to support this. These can be accessed by contacting

the Complaints and PALS Manager or PALS service.

The fact that a death has been referred to the Coroner's Office does not mean that the Trust cannot carry out a complaint investigation. Any investigations involving the Coroner must be signed off by the Chief Executive. The Complaints Administrator should liaise with the Coroner's Office and forward a copy of the report to the Coroner on completion of the investigation, if requested to do so, and advise the complainant of this.

The NHS complaints procedure does not cover complaints about private medical treatment, provided in an NHS setting but it does cover any complaint made about an NHS body's staff or facilities relating to care in their private pay beds.

The Trust is committed to providing safe and effective care for patients and individual employees have a right and duty to raise any concerns. This policy should be read in conjunction with the Trust's Speaking Up Policy (G26) which has been developed to provide an avenue for staff to raise issues of concern and to protect patients from harm.

The Complaints Team will highlight any concerns to the Complaints and PALS Manager/Head of Patient Experience if there are any concerns arising from a complaint which require referral to professional regulatory bodies, the police, the coroner, or protection agencies (vulnerable adults and children).

IF YOU ARE UNSURE HOW TO DEAL WITH A COMPLAINT, INVOLVE YOUR LINE MANAGER/DIRECTORATE MANAGER.

Stages of Complaint

Stage One (Local Resolution)

When those providing the service are able to resolve the complaint to the complainant's satisfaction, within the Trust's complaints procedures.

Stage Two (Parliamentary Health Service Ombudsman) (PHSO)

When the complaint is not resolved at Stage 1 and the complainant refers the case for review by the PHSO. The Ombudsman is independent of the NHS and the Government and derives their powers from the Health Service Commissioners Act 1993.

1. Stage One – Local Resolution

A complaint may be made verbally or in writing (including electronically).

1.1 Verbal Complaints

Verbal complaints can be made face to face or by telephone. If a telephone complaint is received out of hours this should be referred to the relevant Senior Manager. In the absence of such a manager the complaint should be referred to the Site Manager on duty or on call manager.

The member of staff receiving the complaint should listen courteously to what the complainant has to say and should identify the issues of concern and the outcomes expected by the complainant. These should be recorded on DATIX by completing the verbal complaint form (located in additional forms within the module) If the complainant does not wish to discuss their concerns over the telephone, they should be offered the opportunity of a face-to-face meeting.

The member of staff should seek to resolve the complaint immediately if at all possible. If the complaint is resolved at first contact (by the end of the next working day), the member of staff should update Datix Verbal Complaint Form

In the case of a clinical complaint, the relevant consultant, senior nurse, midwife or allied health professional must be contacted without delay. The offer of a meeting with a clinician at this stage may resolve the complaint.

When a verbal complaint is received by a member of the PALS team, the PALS officer will record the information directly onto DATIX and if resolved at first contact will update and close the DATIX file.

If it is not possible for the PALS officer to feedback to the complainant by the end of the next working day, for example because the member of staff has to obtain information from another source which cannot be provided immediately, the PALS officer will agree a timescale and respond as agreed. This should be no longer than 8 working days, with the Divisional Management having a maximum of 5 working days to respond to PALS. The PALS officer will update the DATIX file and close the complaint. Follow up on implementation of any recommended actions will be undertaken by the Division in which the complaint occurred.

If the PALS officer is unable to resolve the complaint within the maximum agreed 8 working days timescale, they should update DATIX and proceed via the escalation process:

Day 10 – Senior PALS Officer
Day 13 – Complaints and PALS Manager
Day 16 – Head of Patient Experience

who will escalate to the relevant divisional manager for support in obtaining a response. The PALS

officer will inform the complainant of the reasons for the delay and discuss with them whether they are happy for their concern to continue to be managed through the PALS process or whether they would prefer to escalate to a formal complaint. This request must be documented in the progress notes of the case by the PALS officer.

If the complainant is verbally or physically abusive the matter should be escalated to the Complaints and PALS Manager or Head of Patient Experience and a Datix Incident Form completed.

1.2 Written complaints

Written complaints can be received by letter, or electronically. All written complaints should be forwarded to the Corporate Complaints Team who will acknowledge receipt of the complaint and open a file within DATIX.

2. The Investigation

The Patient Experience Advisor (lead investigating officer) should assess the seriousness of the complaint using the Risk Matrix (Appendix C). The complaint should be categorised using the information contained in the written complaint or the information provided as part of the verbal complaint.

The Trust aims to resolve formal complaints within the timescales indicated by the triage process of 15, 40, or 60 working days of receipt. To support the triage process the Patient Experience Advisor should use the investigation timescale scoring matrix (Appendix D) to determine an appropriate timescale, using the information contained in the written complaint or the information provided as part of the verbal complaint.

Unless exceptional circumstances prevent, the Patient Experience Administrators should acknowledge receipt of the complaint in writing within 3 working days. The Patient Experience Advisor should then produce a complaints plan/letter by contacting the complainant within 5 working days and confirming with them the issues of concern and the outcomes expected by them and agree a timescale and preferred format for response, including the offer of face-to-face meeting if preferred by the complainant. The offer of a meeting must be supported by the Trust at all times. This information will be recorded on DATIX on a Complaints Plan letter (Appendix E). On completion of the Complaints Plan, the Patient Experience Advisor should notify the Complaints Administrators who will send a copy of the Complaints Plan to the complainant together with a copy of the Trust's complaints leaflet, Making a Complaint, and consent form, if appropriate. This includes information on the services provided by the NHS Complaints Advocacy Service.

If the complainant does not wish to discuss their concerns over the telephone, they should be offered the opportunity of a face-to-face meeting. If the Patient Experience Advisor is unable to contact the complainant by telephone or the complainant does not wish to discuss the complaint with the Patient Experience Advisor either over the telephone or in a face-to-face meeting, the Patient Experience Advisor will determine the response period. The Patient Experience Advisor should notify the Complaints Administrators who will send the Complaints Plan letter to the complainant as above.

Complaints received from a third party such as an MP, GP or solicitor still require the completion of a complaints plan.

Any communication by email must be with the consent of the complainant. Consent should not be implied if the complainant's first contact is by email, consent should be confirmed with the complainant. Caution must be exercised regarding the sensitivity around emailing of reports and confidential information.

The investigation should be managed discreetly and confidentially and in a timely manner to ensure effective resolution. Any meetings with staff should be in private, written notes of the discussion should be taken or audio recorded, agreed by all parties and a copy retained in the electronic complaint file.

Telephone conversations should not take place in public places, and records concerning complaints should be stored in such a way that only those with a need to know have access. Correspondence should be conveyed electronically, where possible. In cases where this is not possible correspondence should be in sealed envelopes marked "Private and Confidential".

The complaint will be sent to the nominated complaint leads within the Directorate Teams along with the statement form who will liaise with the staff members concerned to request their comments. The Patient Experience Advisor or Directorate Leads may consider it more appropriate to meet with the staff concerned to obtain a statement or to clarify events. It is also useful to make it clear to those members of staff being asked to make a statement, exactly which elements of the complaint they need to answer. Statements should either be typed or neatly handwritten, stating the individual's name, position and the date the statement was written.

The Patient Experience Advisor should ensure that staff understand the procedure to be followed and offer support and guidance, if necessary. Staff should also be made aware that they can request professional support from their line manager or staff side representative if necessary.

If the Patient Experience Advisor encounters difficulties in obtaining statements from members of staff, this will initiate the escalation process (Appendix F).

As part of the investigation the Patient Experience Advisor should review relevant Trust policies to ascertain whether the care/service complained about was in line with established standards.

The Patient Experience Advisor should telephone/write to relevant members of staff who have left the Trust, if contact details are available, and ask for their comments. The member of staff may not be legally obliged to respond (dependant on professional registration status) although they should be encouraged to do so under their duty of continuing care.

Staff who have provided statements are given the opportunity within a 5 working day period to agree any responses. This should be completed during the sign off process. If nil response is received during this time the complaint response will proceed to the next level of sign off.

The Patient Experience Advisor, in agreement with the Executive Team may seek advice, where appropriate, from independent experts (clinical and otherwise) from both within and outside the Trust.

The Patient Experience Advisor should keep the complainant informed of the progress of the investigation. The Patient Experience Administrator will work alongside the Patient Experience Advisor to ensure timescales are met. If it is clear that the deadline cannot be met the Patient Experience Advisor or nominated administrator should contact the complainant, apologise for/explain the reason for the delay and agree an extension which should be documented with the rationale for any delay. The Complaints Administrators will update DATIX.

When the investigation is complete this should be formulated into a response to be approved and signed by the Chief Executive (See sign off flowchart Appendix G). A response should be given to the complainant as agreed in the Complaints Plan. Verbal feedback (telephone or meeting) should be followed up in writing, unless the complainant indicates that they do not wish to receive a written record. The complainant should be given the opportunity to contact the Patient Experience Advisor should they remain dissatisfied with the response or require clarification.

A link and QR code to the Complaint Survey form (Appendix I) is included within the covering letter of each complaint response. The purpose of this contact is to ascertain whether the response has resolved the complaint to the complainant's satisfaction and to elicit suggestions for improvement.

3. Learning from Complaints

The Trust will use any comments, compliments, concerns and complaints received to:

- Identify what is working well through compliment trends – share good practice.

- Help identify potential service problems through trends in concerns raised – early warning system.
- Highlight potential system failure and or human error – identify need for improvement.
- Provide the information required to review services and procedures effectively – respond to requests for patient experience data for service reviews/evaluations.

The Trust records, within the complaint file front sign off sheet, whether or not the complaint has been upheld, partially upheld or not upheld so that learning can be focused on where there have been service failures of any kind. The rational for the decision should also be explained.

At the end of each investigation, if shortfalls have been highlighted recommendations will be developed and an individual action plan generated. The action plan should be updated as and when the actions are completed. Divisional Senior Management should share any issues that have Trust wide implications with the Quality, Safety and Compliance Team.

Where a complaints investigation has highlighted that a patient has been caused harm this should be recorded on DATIX retrospectively if not reported at the time of the incident and this will be escalated to the relevant Divisional Governance Quality Safety Manger.

A summary of lessons learnt arising from complaints investigations will be included in the Patient Experience and monthly complaint reports. These are reported at a corporate level to the Quality and Safety Oversight Group and locally within divisional Clinical Governance Groups to ensure that lessons are shared as widely as possible.

The Patient Experience Advisor should feedback the outcome of the investigation to the staff involved.

The Patient Experience Advisor should review the Risk Assessment (Appendix C) made on receipt of the complaint, based on the results of the investigation and re-categorise as necessary.

4. Complaints involving more than one organisation

A local agreement is in place across Health and Social Care for complaints involving more than one organisation. The Complaints Administrator will be responsible for co-ordinating this process.

5. Action to be taken when the complainant is not satisfied

In those situations when complainants are not satisfied with the response made by the Trust to their complaint, the Patient Experience Advisor or Complaints Administrator should contact the complainant to identify why they are dissatisfied, what issues remain outstanding and the expected outcomes. The Complaints Team will then review the outstanding issues and the action taken so far to resolve the complaint and identify an appropriate course of action. The Patient Experience Advisor or Patient Experience Administrator should then contact the complainant again to agree the proposed course of action, and timescale, if the Trust are able to investigate further.

The following actions may be explored in order to affect resolution:

- Further investigation by the Patient Experience Advisor

- Meeting with Trust representatives
  - Any meeting with complainants should be in line with Trust protocol.

- Mediation/Conciliation
  - Mediation/Conciliation is a method of facilitating a dialogue to resolve an issue. It is an intervention whereby a third party helps the parties to reach a common understanding. It gives space to resolve issues, preserve on-going relationships and time to defuse or calm heightened situations. The Chief Nurse may consider the use of mediation/conciliation in the resolution of a complaint.

- Consideration of an independent review by internal/external reviewer

The Patient Experience Advisor should make every effort to resolve the complaint locally.

On completion of the further work a written response should be sent to the Complainant, signed off by the Chief Executive, which should again invite the complainant to refer back to the Patient Experience Advisor, should they require further clarification or remain dissatisfied.

If the complainant does not wish the Trust to investigate the complaint further, or if the Division believe that all avenues for local resolution have been exhausted, the complainant should be reminded of their right to ask the Parliamentary and Health Service Ombudsman (PHSO) to review their case and information should be provided concerning this process. The final decision as to whether the Division have exhausted local resolution will be made by the Patient Experience Advisor/Complaints and PALS Manager, in liaison with the Directorate Manager.

6. Complaints referred to the Chief Nurse/Divisional Nurse Director/ Chief Executive

Complaints requiring referral to the Chief Nurse/Divisional Nurse Director/ Chief Executive

Complaints requiring referral include those which:

- involve allegations of serious misconduct;
- involve the police in the investigation of possible criminal activity;*
- could attract media attention;
- indicate a serious breakdown in clinical management;
- are detrimental to the image of the Trust;
- include serious criticism of the implementation of the Trust's policies and procedures, particularly those regarding suspected abuse of children or vulnerable adults;
- relate to a serious adverse incident.

* Where allegations of theft or misuse and abuse of assets are involved, the matter should also be reported to the Director of Finance in accordance with Standing Financial Instructions.

7. Stage Two – Parliamentary Health Service Ombudsman (PHSO)

If the complainant remains dissatisfied with the Trust’s attempt(s) at Local Resolution, they can ask the PHSO to review their case. The complainant should be advised in the Trust’s final response of their right to refer their case to the PHSO if they are not satisfied. Any correspondence received from the PHSO relating to such requests should be forwarded to the Patient Experience Administrator for action.

8. Habitual and Vexatious Complainants

We are committed to dealing with all complainants fairly and impartially. However, people who bring habitual and vexatious complaints can be difficult to deal with. If the complainant raises the same or similar issues repeatedly, despite receiving a full response, it is important to consider other factors that may be influencing this.

A habitual and vexatious complainant is someone who raises the same issue despite having been given a full response. They are likely to display certain types of behaviour such as:

- Complains about every part of the health system regardless of the issue.
- Seeks attention by contacting several agencies and individuals.
- Always repeats full complaint.
- Automatically responds to any letter from the Trust.
- Persistently insists that they have not received an adequate response.
- Focuses on trivial matters.

- Is abusive or aggressive.

Regardless of the manner in which the complaint is made and pursued, its substance should be considered carefully and on its objective merits.

Complaints about matters unrelated to previous complaints should be similarly approached objectively, and without any assumption that they are bound to be frivolous, unreasonable or unjustified.

If a complainant is abusive or threatening, it is reasonable to request that they communicate via one method i.e. in writing and not by telephone – or solely with one or more designated members of staff. It is not reasonable to refuse to accept or respond to communications about a complaint until it is clear that all practical possibilities for resolution have been exhausted. For further support please refer to Policy C74 – Habitual and Vexatious Complainants.

9. Identifying a habitual and vexatious complainant

Please refer to Policy C74 – Habitual and Vexatious Complainants.

10. Options for dealing with habitual and vexatious complainant

Please refer to Policy C74 – Habitual and Vexatious Complainants.

11. Withdrawing habitual and vexatious complainant status

Please refer to Policy C74 – Habitual and Vexatious Complainants.

12. GMC/NMC Complaints

Complaints referred directly from the General Medical Council or Nursing & Midwifery Council should be forwarded to the Medical Director or Chief Nurse, as appropriate. If the Medical Director or Chief Nurse are aware of further issues that suggest that the GMC/NMC should undertake a full investigation into the doctor's/nurse's fitness to practice they should notify the GMC/NMC accordingly. If this is not the case, the complaint should be investigated as described above.

13. Confidentiality

Refer to Trust PolicyDSP10 Data Security, Protection and Confidentiality and the NHS Confidentiality Code of Practice (gateway reference 1656)

Patients entrust the UHNM with or allow the gathering of sensitive information relating to their health and other matters as part of their treatment. They do so in confidence, and they have the legitimate expectation that staff will respect their privacy and act appropriately. In some circumstances patients may lack competence or may be unconscious, but this does not diminish the duty of confidence. It is essential, if the legal requirements are to be met and the confidence of patients is to be retained, that this Trust provides a confidential service. For full guidance on the disclosure of patient identifiable information refer to the NHS Confidentiality Code of Practice or contact the Head of DSP.

14. Subject Access Requests

Complainants may request when making a complaint to receive copies of any correspondence that they were named in, Subject Access Request (SARS) If a request is made this request should be forwarded to the Data Security & Protection Team (DPS) for processing.

15. Third party complaints

If a third party submits a complaint on behalf of another, a thorough check must be undertaken to ensure that the complaint is being made with the knowledge and consent of the person concerned. Patient-identifiable information must not be used or disclosed, for purposes other than direct healthcare, without the individual's explicit consent, some other legal basis, or where there is a robust public interest or legal justification to do so" (NHS Confidentiality Code of Practice).

A complaint may be made by a representative acting on behalf of the patient who:

- has died
- is a child
- is unable to make the complaint themselves due to:
  (i) physical incapacity
  (ii) lack of capacity within the meaning of the Mental Capacity Act 2005(a)
- has requested the representative to act on their behalf

If there is any doubt that a person complaining on behalf of another may be making a complaint without the knowledge of the person concerned, the person on whose behalf the complaint is allegedly being made, should be contacted to ensure that they provide consent for personal information concerning themselves to be released to the complainant. The conversation should then form part of the electronic complaint file.

It may be appropriate, when a number of complaints raising similar issues are made on the same person's behalf, to contact the person concerned and agree that one composite response will be sent to them personally, rather than multiple responses being sent to each complainant.

16. Health records

Documentation relating to complaints and PALS issues must not be stored in health records and no reference to the complaint/PALS issue or that the person has raised an issue should be made in a health record.

17. Reports

Extreme caution must be exerted when writing letters or reports as part of the complaints procedures that third party confidence is not breached. Any people mentioned by name in a letter or report must be made aware of what is written and agree to its inclusion.

18. Freedom of Information Act

Many complaints contain requests for corporate information. The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway for the disclosure, to the public, of corporate information held by this Trust.

There is a legal requirement to provide any information requested under the FOIA (or site an exemption allowed for under the Act) within 20 days and for a record to be kept of all such requests. If corporate information is requested as part of a complaint **DSP and complaints teams will discuss and agree best way to correspond with the complainant regarding the FOI request.** In the case of the complainant stating in their original response that they do not wish their details to be passed to another department, the FOI response will be given to the complaints department who will then send it directly to the complainant.

If the Trust feels an exemption allowed for under the FOI Act applies to the requested information and therefore does not propose to disclose the requested information, complainants should be informed of this along with their right to appeal to the Trust and, if still unsatisfied, to complain directly to the Information

Commissioner's Office (ICO). Contact details for the ICO are given with each FOI response. If they wish to pursue their complaint through the Trust's Complaints Procedure this should be processed as described in Section 5. The DSP Manager (Records) will be responsible for the investigation of all FOIA complaints. Complainants who remain dissatisfied at the end of Local Resolution should be advised to progress their complaint via the Information Commissioner.

Appendix B

COMPLAINTS RISK SCORING MATRIX (PRE AND POST INVESTIGATION)

SECTION 1 – IMPACT	
1. Negligible	• Local to a specific location/service and organisation • Outcome for the patient is minor and temporary • Reduced quality of patient experience not directly related to the delivery of clinical care (logistics/transport/waiting)
2. Minor	• Local to one organisation • Involving <3 Specialties/Services/Directorates • Suboptimal treatment with minor implications for patient outcome or safety • Unsatisfactory patient experience directly related to clinical care/readily resolvable
3. Moderate	• More than one organisation involved • Involving <4 Specialties/Services/Directorates involved • Significant impact on timeliness or effectiveness of treatment/intervention • Mismanagement of patient care – short term effects less than one week
4. Major	• Multiple organisations involved • Impact across many services/specialities/directorates • Mismanagement of patient care which fails to meet national requirements for timeliness or intervention • Mismanagement of patient care, long term effects (more than a week)
5. Catastrophic	• Totally unacceptable level of treatment or quality of service • Gross failure of patient safety • Gross failure to meet national standards • Totally unsatisfactory patient outcome or experience • Irreversible consequence/outcome on patient care

Likelihood Descriptions		Likelihood Score	✓
Rare	This will probably never happen / recur.	**1**	
Unlikely	Do not expect it to happen / recur but it is possible it may do so.	**2**	
Possible	Might happen or recur occasionally.	**3**	
Likely	Will probably happen / recur but it is not a persisting issue.	**4**	
Almost Certain	Will undoubtedly happen / recur, possibly frequently.	**5**	

To identify your risk score, you must take the result of your likelihood assessment and the result of your impact assessment and use the multiplication table below.
For example, if the likelihood score is '3' and the impact score is '4', when multiplied together, these you will give you a risk score of '12'.

		Impact Score				
		1	**2**	**3**	**4**	**5**
Likelihood Score	**1**	**1**	**2**	**3**	**4**	**5**
	2	**2**	**4**	**6**	**8**	**10**
	3	**3**	**6**	**9**	**12**	**15**
	4	**4**	**8**	**12**	**16**	**20**
	5	**5**	**10**	**15**	**20**	**25**

The numerical risk score will fall within a range as shown below, this will determine whether the risk is either, 'low, 'moderate', 'high' or 'extreme'.

Risk Score	
1 – 3	**Low**
4 – 6	**Moderate**
8 – 12	**High**
15 – 25	**Extreme**

Appendix C

Complaints Investigation Scoring Matrix

Name of complainant:	
Complaint number:	
Date matrix completed:	
Matrix completed by	

Scoring Indicators:					**Enter Scores**
Number of Organisations Involved (Excluding CCG)	**1**	**2**	**3**	**4**	
CCG				**4**	
Number of Divisions Involved	**1**	**2**	**3**	**4**	
Number of Specialities Involved *e.g. imaging, medicine, surgery*	**1**	**2**	**3**	**4**	
Size of Complaint *i.e. number of issues identified*	**(1-5) 2**	**(6-10) 4**	**(11-14) 6**	**(15+) 8**	
Number of staff involved	**0 (1-3 staff)**	**2 (4-5 staff)**	**4 (6-7 staff)**	**6 (8+ staff)**	
Risk category of complaint	**0 (low)**	**1 (moderate)**	**2 (major)**	**4 (catastrophic)**	
	5	13	21	34	

Total score: 34

Using the total score, use the table below as a **guide** to agreeing the number of days at which you will provide a response to the complainant. You should still apply your own knowledge/judgement depending upon the issues raised.

Score:	**Level 1 0 to 5**	**Level 2 – 6 to 21**	**Level 3 – 22 to 34**
Days:	**25**	**40**	**60**
Number of days allocated:			
Factors affecting Timescale:			
Reasons for extended timescale:			
Date response due:			

Appendix D

Investigation and completion timescales

For Written Responses

Days refer to working days

Day 1 – Receipt of complaint
Day 1-5 – Acknowledge and triage of complaint severity. Patient Experience Advisor to contact complainant and formulate and send plan to complainant/statement form to directorate.

Level 1 Complaint

Day 5 – 5 days to complete and return statements to the Patient Experience Team
Day 10 – 5 days for Patient Experience Advisor to review statements and compile draft response
Day 15 – 25 – Sign off process
Please note directorate sign off should take no more than 3 working days rather than 5 for Level 1 complaints*

Level 2 Complaint

Day 5 – 10 days to complete and return statement to the Patient Experience Team
Day 15 – 10 days for Patient Experience Advisor to review statements and compile draft response
Day 25 – 40 – Sign off process

Level 3 Complaint

Day 5 – 20 days to complete and return statement to the Patient Experience Team
Day 25 – 15 days for Patient Experience Advisor to review statements and compile draft response
Day 40 – 60 – Sign off process

****Extensions to the above timescales may be agreed by exception only and the Patient Experience Team should be notified at the earliest possible opportunity****

First Resolution Meetings

Days refer to working days

Day 1 – Receipt of complaint
Day 1-5 – Acknowledge and triage of complaint severity. Patient Experience Advisor to contact complainant and formulate and send plan to complainant/statement form to directorate requesting a meeting be arranged.

Level 1 Complaint

Day 5 – 25 days – Meeting arranged, takes place, meeting notes drafted, approved and sent to complainant

Level 2 Complaint

Day 5 – 40 - Meeting arranged, takes place, meeting notes drafted, approved and sent to complainant

Level 3 Complaint

Day 5 – 60 - Meeting arranged, takes place, meeting notes drafted, approved and sent to complainant

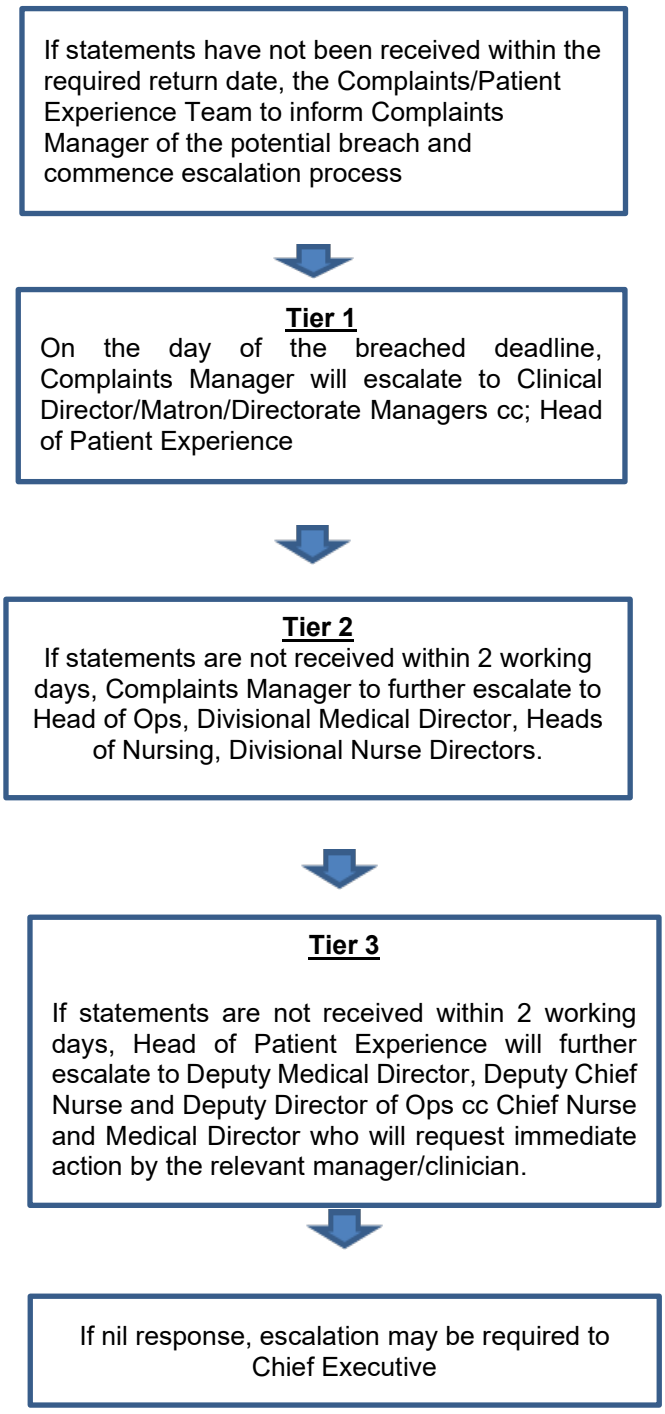
Extensions to the above timescales may be agreed by exception only and the Patient Experience Team should be notified at the earliest possible opportunity

Appendix E

1. The Escalation Process

To effectively manage open complaints to ensure they meet the agreed deadline, there needs to be a clear and robust escalation process. Exceptions to this will be agreed on an individual basis in conjunction with the Investigating Officer and Complaints Manager in order to support timely responses.

This will be as follows:

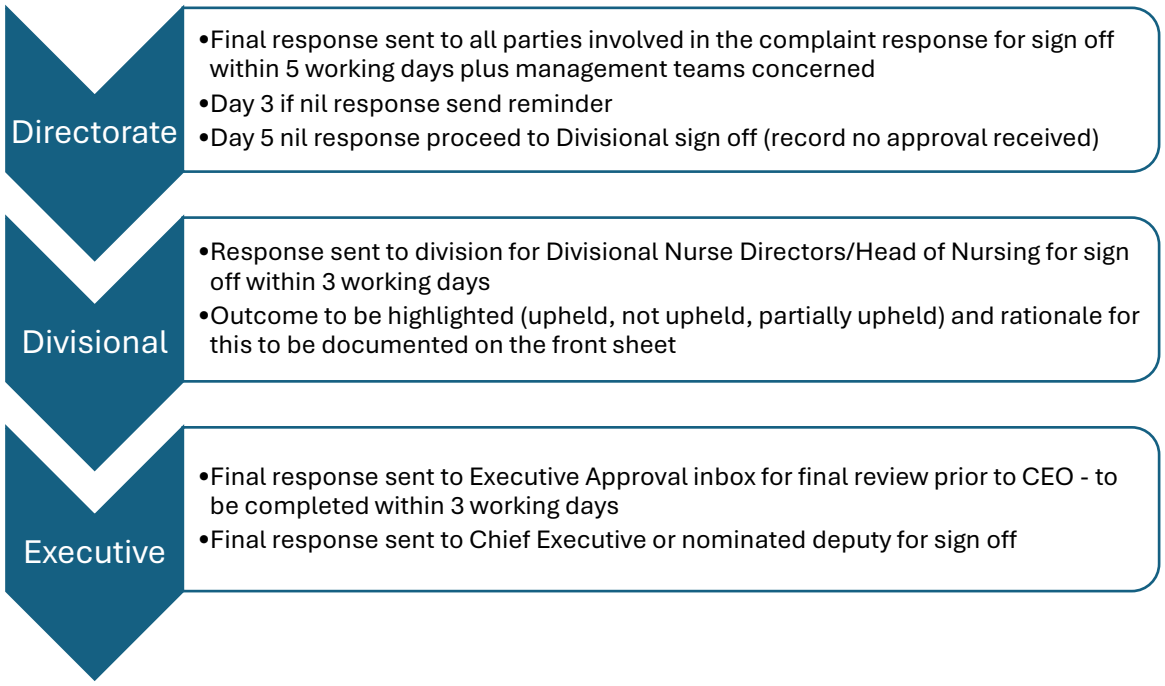


If at any point of the escalation process the complaints team are asked for an extension to deadline, if the extension date is not met, the escalation process restarts on the day and moves to the next level.

Appendix F

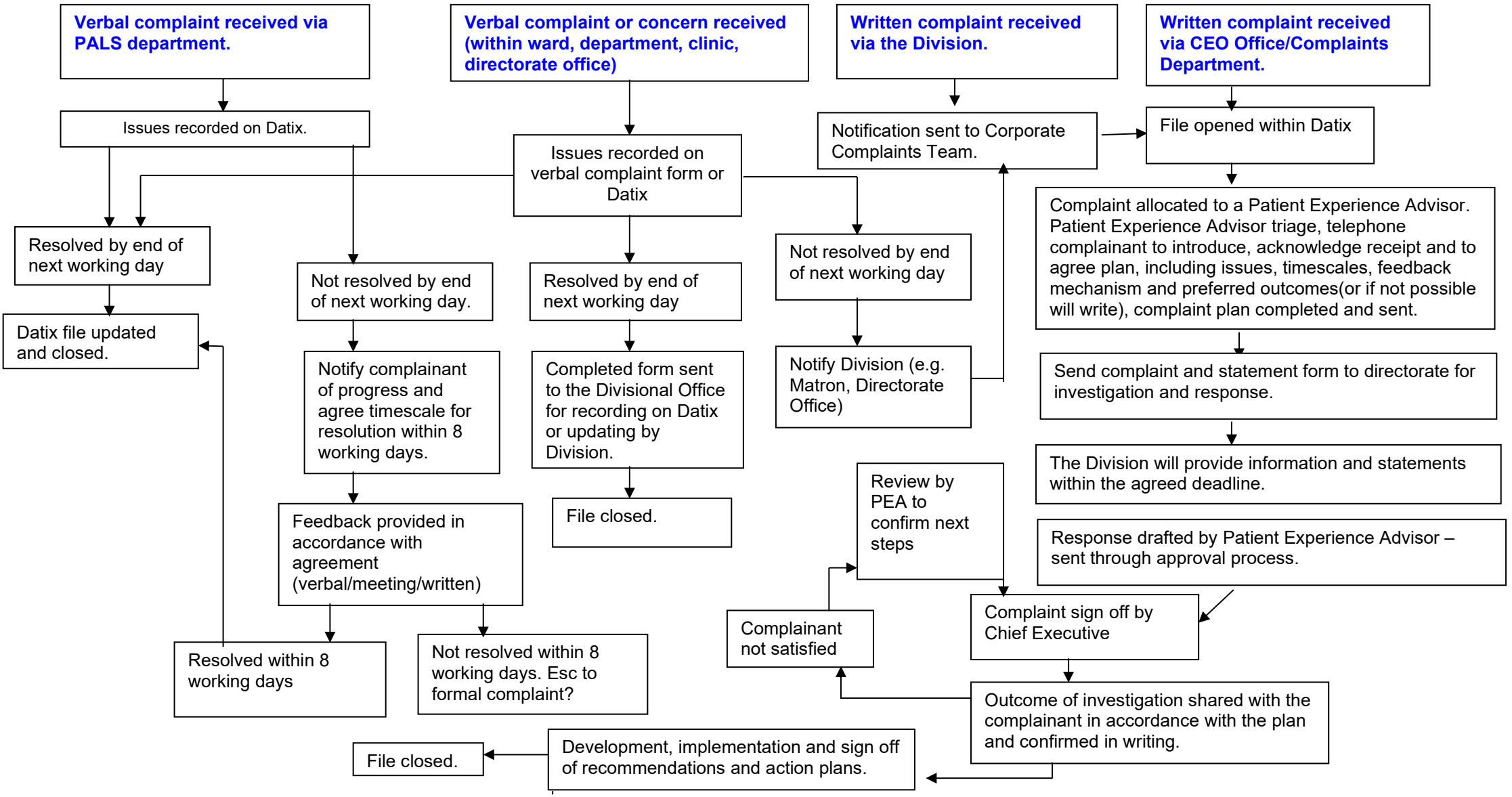
Complaint sign off Process

To ensure that the correct sign off is achieved at all levels throughout the process, which finalises the response and validates the quality and content, all parties must take responsibility for reading and authorising their part in the response.



Appendix G

LOCAL RESOLUTION



Appendix H

STANDARD OPERATING PROCEDURE (SOP)		
Title	**Complaints and PALS Consent Process**	
Purpose	The purpose of this document is to provide guidance and support to the complaints and PALS teams when requesting consent to release information to respond to a complaint or concern.	
Scope	This SOP highlights the process for requesting consent to provide information to a complaint from patients, relatives or other external requesters.	
	Instruction	**Photograph /Diagram**
1.	**The Patient Experience Team will refer to National guidance when requesting consent and will take a pragmatic approach towards verifying identity based on the risk of data breach and the information available.** **Consent will be sought however, if this is not received, the complaint should be shared with the relevant areas for their review.** For patients who are deceased, and in the instances of consent being required, the evidence required from the complainant would be: ▪ Copy of patients Will, will identify the complainant as executor or a person who is named in the Will. If it is a named person in the Will it is best practice to advise the Executor to keep them in the loop. The first page naming the complainant as executor and last page complete with signature is required Also ▪ Identification that complainant is who they say they are and confirm where they live (passport/birth certificate/ marriage certificate or utility bill/bank statement top section to confirm address) **Copies of this evidence may be received by email if it is not appropriate for the complainant to bring the original copies in directly. However, the provider must be made aware that unless the information is password protected, they will be sending it via an unsecure process** Most recent admission notes can be looked at if you are unable to identify next of kin/nearest relative, and or speaking with the Ward Manager to see if the complainant spent time on the ward with the patient. ***If no evidence can be provided, unfortunately the complaint response may not be provided***	
2.	For complainants who are the patient, it is assumed consent has been provided by them writing or speaking to us, name and address has usually been provided within the letter of complaint, (PALS will need to gain this for verbal complaints) also either date of birth or hospital patient number is also required.	

3.	For complainants who are the relative of a patient ▪ For a formal complaint, consent is required in writing from the patient; a consent form will be posted directly to the patient. ▪ For PALS if the complaint is received verbally consent must be sought from the patient either by telephone/ward visit etc. and ID of patient required such as hospital unit number, date of birth, address. How and what information was gained must be logged within progress notes on DATIX. ▪ Relatives (complainant) must also provide evidence of who they say they are (birth certificate/passport/driving licence) or utility bill bank statement top section. If consent is not received the complaint response may not be released (process for this in section 9)	
4.	For complaints where the patient lacks capacity ▪ A power of attorney (for health) Also ▪ Identification that the complainant is who they say they are (passport/birth certificate/ marriage certificate or utility bill bank statement top section to evidence where they live) **Copies of this evidence may be received by email or in person. However, the provider must be made aware that when sending via email, unless the information is password protected, they will be sending it via an unsecure process** Most recent admission notes can be accessed if you are unable to identify next of kin/nearest relative, and or speaking with the Ward Manager to see if the complainant spent time on the ward with the patient. ***If no evidence can be provided, unfortunately the complaint response may not be provided***	
5.	For complaints where the patient is a child. If the child is under 16 years of age consent is not required, however the mother / father or in some circumstances other relative or carer, must provide evidence of who they say they are, child's birth certificate and their own ID showing the capacity in which they care for the child. **Over 16 consent must be gained from the child as above processes** (point 3)	
6.	For complaints where the patient resides in a nursing/care home and the care home are making a complaint: ▪ Consent must be gained from the patient if they have capacity to do so. ▪ Consent must be gained from nearest relative and ID check ▪ If there is no next of kin/nearest relative the nursing/care home can raise the complaint on the basis of direct healthcare and in the best interest of the patient	

7.	For third party complaints such as MP/Advocacy Consent must be provided in writing by the enquirer/representative of the patient	
8.	Relatives/visitors who drop in at PALS to locate a patient ▪ Consent where appropriate must be gained from the patient (in a private area). PALS can check demographics on Careflow/iPortal to locate patient, a call must be made to the ward to advise of the enquiry to see if the patient wishes the person to be told of their whereabouts. ▪ Alerts must also be checked.	
9.	For complaints that fail at PALS ▪ Providing relevant consent has been obtained at the point of contacting the PALS Team, further consent will not be requested at the point of escalation. However, if consent has not been obtained then PALS Officers will advise the complainant that as their complaint has progressed to the formal process, this stage will require a signed consent form and relevant Identification, and that this request will be sent out to them from the complaints department in due course before the investigation commences. PALS must document this conversation on progress notes within DATIX	
10.	When requesting consent, a consent form is to be posted to the patient directly (If appropriate) ▪ Consent not received within 2 weeks send a second letter and consent form (c.c. complainant) ▪ If no consent after a further 2 weeks, write to the patient advising that without consent we cannot continue with complaint (c.c. complainant)	
11.	If consent is not received: ▪ Original complaint letter and consent chaser letters must be retained as evidence of trying to gain consent. ▪ This documentation must be kept in secure file separate from the active complaints, to be retained in line with the retention of complaints records for 10 years. ▪ Share complaint with the relevant area for review and consideration of learning.	
12.	PALS Logbooks used within the quiet room/ward visits. ▪ Logbooks should not be retained, the information per complainant should be scanned into a secure location on the computer either DATIX or a secure drive and the page within the logbook destroyed ▪ Separate pages should be used per complainant and not multiple complainants on one page to prevent data breaches	
13.	Escalation process: If at any point a problem arises that none of the above covers, advice should be sought, and a decision provided by either: ▪ Complaints and PALS Manager ▪ Head of Patient Experience ▪ Data Security and Protection Team	

Appendix I

Complaints Survey

We are continually looking at ways to improve our complaints service and would be very grateful if you would take the time to complete our survey by either visiting https://forms.office.com/r/kHvAaPcQBp or using the QR Code below.

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	Jan	Mar	Notes
		3	8	5	10	7	4	9	6	8	12	
HIGH QUALITY												
Chief Executives Report	Chief Executive											
Patient / Staff Story	Chief Nurse		Staff			Staff			Staff	Pt	Staff	
Quality Governance Committee Assurance Report	Director of Governance			NA								
Quality Strategy Update	Chief Nurse / Medical Director											
Care Quality Commission Action Plan	Chief Nurse											
Bi Annual Nurse Staffing Assurance Report	Chief Nurse											
Quality Account	Chief Nurse											
NHS Resolution Maternity Incentive Scheme	Chief Nurse											
Maternity Serious Incident Report	Chief Nurse											
Winter Plan	Chief Operating Officer											
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI											
Infection Prevention Board Assurance Framework	Chief Nurse											Update for February moved to March
RESPONSIVE												
Integrated Performance Report	Various											
Clinical Strategy Update	Director of Strategy											Deferred from May due to purdah and General Election period. November update to be considered at Trust Board Time Out
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer											
PEOPLE												
Transformation and People Committee Assurance Report	Director of Governance			PCI	PCI	S&T	N/A	PCI	S&T			
People Strategy Update												
Gender Pay Gap Report	Chief People Officer											
Revalidation	Medical Director											
Workforce Disability Equality Report	Chief People Officer											
Workforce Race Equality Standards Report	Chief People Officer											
Staff Survey Report	Chief People Officer											
Raising Concerns Report	Director of Governance											Report provided to EWAG and to be considered by the Board once it has been received at PCI Committee
Bi-Annual Establishment Review (Other Professions)	Chief People Officer											
IMPROVING AND INNOVATING												
Research Strategy Update	Medical Director / Chief Nurse / Director of Strategy											Interim update to be provided at Trust Board Time Out in November, as revised version not expecting to be ready until end of March / April 2025.
SYSTEM AND PARTNERS												
System Working Update	Chief Executive / Director of Strategy											
Population Health and Wellbeing Strategy	Director of Strategy											
RESOURCES												
Performance and Finance Committee Assurance Report	Director of Governance			N/A			N/A					
Estates Strategy Update	Director of Estates, Facilities & PFI											Exec decision to defer the strategy to November's Trust Board Time Out, to be presented with other enabling strategies
Digital Strategy Update	Chief Digital Information Officer											
Going Concern	Chief Finance Officer											
Annual Plan	Director of Strategy											
Board Approval of Financial Plan	Chief Finance Officer											
Final Plan Sign Off - Narrative/Workforce/Activity/Finance	Chief Finance Officer											
Activity and Narrative Plans	Director of Strategy											

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Jan	Mar	Notes
		3	8	5	10	7	4	9	6	8	12	
Capital Programme 2022/23	Chief Finance Officer											
Standing Financial Instructions	Chief Finance Officer											Next due for review February 2026
Scheme of Reservation and Delegation of Powers	Chief Finance Officer											Next due for review February 2026
GOVERNANCE												
Fit and Proper Persons Annual Assurance Report	Director of Governance											
Audit Committee Assurance Report	Director of Governance											
Trust Strategy	Director of Strategy											TBC
Board Assurance Framework	Director of Governance											
Annual Evaluation of the Board and its Committees	Director of Governance											
Annual Review of the Rules of Procedure	Director of Governance											
Board Development Programme	Director of Governance											Update for February moved to March
Calendar of Business	Director of Governance											
Well-Led Self Assessment	Director of Governance											Considered at July's Trust Board Seminar
Risk Management Policy	Director of Governance											Next due for review February 2027
Complaints Policy	Chief Nurse											