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

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Patient 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 7th August 2024	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
15 mins	**6.**	Chief Executive's Report - September 2024	Information	Dr S Constable	Enclosure	
10:10		**SYSTEM AND PARTNERS**				
10 mins	**7.**	Joint Stoke-on-Trent Health & Wellbeing Strategy 2025-28	Information	Ms H Ashley	Enclosure	**3**
10:20		**PEOPLE**				
10 mins	**8.**	Appraisal and Revalidation Annual Report	Assurance	Dr M Lewis	Enclosure	
10 mins	**9.**	2024 Workforce Race and Workforce Disability Equality Standard Reports	Assurance	Mrs J Haire	Enclosure	**2**
10:40 – 10:55 COMFORT BREAK						
10:55		**RESPONSIVE**				
60 mins	**10.**	Integrated Performance Report – Month 5 and Committee Assurance Reports (October 2024)	Assurance	Mrs AM Riley Mrs K Thorpe Mrs J Haire Dr M Lewis Ms H Ashley Mrs A Freeman Mr M Oldham Non-Executive Directors	Enclosure	**ALL**
11:55	**CLOSING MATTERS**					
5 mins	**11.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
	12.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 7th October to** nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:00	**DATE AND TIME OF NEXT MEETING**					
	13.	**Wednesday 6th November 2024, 9.30 am, Trust Boardroom, Third Floor, Springfield**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 8th August 2024 at 9.30 am to 12.30 pm
Trust Boardroom, Third Floor, Springfield, Royal Stoke

MINUTES OF MEETING

			Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman (Chair)												
Ms H Ashley	HA	Director of Strategy												
Mrs T Bowen	TBo	Non-Executive Director												
Mrs T Bullock	TB	Chief Executive												
Mrs C Cotton	CC	Director of Governance					NH							
Prof G Crowe	GC	Non-Executive Director												
Mr S Evans	SE	Chief Operating Officer	KT											
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 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	NH	Deputy Director of Governance (minutes)
Mrs J Adeshina		Quality Nurse – FEAU
Mrs J Holmes	JHo	Deputy Chief Nurse (representing Mrs Riley)
Mrs J Reece		Ward Manager - FEAU

Members of Staff and Public: 1

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Staff Story**	
121/2024	Mrs Haire introduced Mrs Adeshina to Board members and highlighted that she had recently won an award at the HSJ Patient Safety Congress for her poster on "obstacles hindering the career progression of Black, Asian and ethnic minority nurses in leadership roles at the Trust". Mrs Adeshina explained that she had changed to a career in nursing following relocation and initially joined the Trust in the winter escalation ward before working in Frail Elderly Assessment Unit (FEAU) after a secondment in Short Stay. She explained that she had been approached by the Centre for Nursing, Midwifery and AHP Research and Education Excellence (CeNREE) team to undertake a project and she focussed	

	on looking at the career progression of staff from ethnic minorities at the Trust. She highlighted that a number of issues were identified, and she had since completed anti racism training with NHS England which had helped her to teach others to be aware of their unconscious bias. She referred to the importance of managers supporting their staff with their career progression and explained that her aim was to help make the Trust a place people want to come and work, by providing them with the support and encouragement required. Professor Maddock queried how the Trust could help colleagues from an ethnic minority background to progress and Mrs Adeshina stated that line managers needed training in equality, diversity and inclusion so that they are aware of the way in which they could help to support colleagues as well as being held to account in terms of having a diverse workforce. Professor Toor queried what other support could be provided and Mrs Adeshina stated that her focus was on helping to ensure everyone's potential was being met, regardless of their protected characteristics. In addition, she added that it was important to ensure everyone was on the same level playing field. Dr Griffin referred to the importance of mentorship and the value in this which should be promoted more widely. Professor Hassell queried how the Trust could help managers to understand the perspectives of colleagues and their different cultures and Mrs Adeshina referred to the need to be mindful and accepting of differences whilst providing international colleagues with support in helping them to settle into the UHNM way of life. Mr Wakefield thanked Mrs Adeshina for the story and reflected on the positive way she had turned her disappointment in not getting a band 7 position, into an opportunity for a project. He also reflected on the need for staff to empower colleagues to seek support and development whilst 'having their back' and Mr Wakefield thanked Mrs Holmes for the mentorship provided, Mrs Adeshina's colleague Ali, and the support provided by Mrs Reece. **The Trust Board noted the story.** Mrs Adeshina and Mrs Reece left the meeting. Professor Crowe referred to the importance of sharing Mrs Adeshina's story in other forums and Ms Ashley agreed, stating that part of the Trust's independent well-led review referred to the need to hear the voice of staff which included staff networks and understanding the role they play. Mr Oldham reiterated the importance of managers providing colleagues with support to progress and the importance of using Mrs Reece to share her story with other managers in terms of the benefit of supporting staff with their career development. Professor Hassell also queried if reverse mentorship at ward manager level could be undertaken to increase awareness.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
122/2024	Mr Wakefield welcomed members to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate. Mr Wakefield referred to the recent unrest in the local area and provided a personal statement on the Trusts collective position supporting a zero-tolerance approach to discrimination, violence and aggression.	

	Mr Wakefield added that it was Dr Griffin's last Board meeting and thanked him for his time and the experience he brought to the role. He particularly paid tribute to his patient focus, his engagement with staff and focus on system working. Mrs Thomson provided her thanks to Dr Griffin on behalf of UHNM Charity.	
3.	**Declarations of Interest**	
123/2024	There were no declarations of interest raised.	
4.	**Minutes of the Meeting held 10th July 2024**	
124/2024	It was noted that there was a typographical error on page 8, which should read "… alternative time intervals…" rather than 'interviews'. In addition, it was agreed that Mrs Riley would confirm the wording within the last paragraph of page 4. With the exception of these amendments, the minutes of the meeting held 10th July 2024 were approved as a true and accurate record.	
5.	**Matters Arising via the Post Meeting Action Log**	
125/2024	It was noted that the two outstanding actions had been completed.	
6.	**Chief Executive's Report - July 2024**	
126/2024	Ms Ashley highlighted a number of areas from her report. Dr Griffin referred to the positive progress made in reducing the number of mothers smoking at the time of pregnancy which should be particularly celebrated. Professor Maddock queried if any of the housing to be built following the Project STAR scheme would be affordable housing to which Mrs Whitehead stated that this would be part of the planning submission which had not yet been determined and was outside the control of the Trust. Mr Wakefield asked Ms Ashley to provide an update on the impact on the Trust following the recent riots. Ms Ashley highlighted that the most recent Monday Message acknowledged the events which had happened and a joint open letter from herself and Mr Orosun, Chair of the Ethnic Diversity Staff Network, had been issued to staff setting out the Trust's zero tolerance to such behaviour as well as signposting staff to support. Mrs Haire explained that the Trust had engaged with staff network and trade union colleagues on the actions to be taken, as well as sessions being held with staff so that the Trust could continue to listen and understand the impact on staff. In addition, she highlighted that a briefing session for managers was to be held and the Trust had also engaged with national trade unions and system partners. Ms Toor referred to the vulnerabilities of non-white colleagues and queried the way in which staff were able to access the support, whilst there was a need for line managers to be mindful that some staff may choose to call in sick rather than accessing support due to their vulnerabilities. She added that the Trust also needed to define what was meant by zero tolerance and that this should be considered by the People, Culture and Inclusion Committee (PCI). Dr Lewis referred to the need to recognise that whilst accepting that the Trust	

	needed to protect its staff from abuse, some people would present with conditions which may affect their judgement as well as some patients having critical illnesses which the Trust would be obliged to treat. Professor Crowe added that there was an opportunity for the system and anchor institutions to take joint collective action and Ms Ashley added that the Trust was being supported by broader NHS colleagues and services. **The Trust Board received and noted the update.**	
HIGH QUALITY		
7.	**Quality Governance Committee Assurance Report (01-08-24)**	
127/2024	Professor Hassell highlighted the following: • The nurse staffing and quality report highlighted zero band 5 vacancies, although partial assurance was provided in respect of the areas where there remained areas of concern • The numbers of c-difficile and MRSA cases continued to be above trajectory and therefore received a rating of partial assurance • The management of beds had been highlighted as an area of challenge given that executive responsibility fell between a number of teams • Good progress was noted in developing the self-assessment tool for the new Care Quality Commission (CQC) assessment framework • A further update on progress with the local implementation of Martha's rule was to be provided to the Committee in September • The CQC had lifted the Section 29 notice at County Hospital following their recent visit Dr Griffin queried the nature of support provided to the 7 wards highlighted within the nurse staffing and quality report and Mrs Holmes stated that the quality team had provided the wards with bespoke education, as well as shifts being undertaken by senior leaders and patient led meetings. **The Trust Board received and noted the assurance report.**	
8.	**Quality Strategy Update**	
128/2024	Mrs Holmes highlighted the following; • Significant work had been taken forward across the four priority areas • Work to comply with both Section 29 notices had continued and it was noted that no negative comments had been made following the recent CQC visit Mr Wakefield referred to the progress made and the areas which had been delayed and queried whether a trajectory for each area was in place. Mrs Holmes referred to the need for stretch targets although there was no definite timescales in place. Mr Wakefield queried the progress with the patient partnership initiative and Mrs Holmes stated that the model had been reviewed and Ms Ashley added that part of the challenge was finding the right way to use the patient voice. Professor Hassell added that the Quality Governance Committee (QGC) had received encouraging updates on the progress made and that the trajectory for increasing patient involvement was positive. Mrs Cotton referred to the recent well-led independent review and change to	

	quality statements which had a greater emphasis on the experience of others and as such the Trust needed to consider how the voice of others could be built into existing mechanisms. Dr Lewis also provided a number of examples of the way in which the Trust was utilising the patient voice, including holding focus groups with patients to understand their experience of the ward environment as well as asking patients to review patient transport. Dr Griffin welcomed the reduction in HSMR. **The Trust Board received and noted the update.**	
9.	**Care Quality Commission Action Plan Update**	
129/2024	Mrs Holmes highlighted that actions A4 and A5 had been agreed to be archived and monitored via business as usual at the recent QGC meeting. In addition, there had been improvement with two of the actions. **The Trust Board received and noted the action plan and progress made to date.**	
10.	**Infection Prevention Board Assurance Framework**	
130/2024	Mrs Holmes highlighted the following: • 10 areas had been rated as partial compliance • The main areas of concern had identified key actions for improvement which related to food safety training, the data gap for staff MMR status and blood culture delays from sending samples from County to Royal Stoke • The document was to be refreshed and would be presented in future via a dashboard Mrs Whitehead referred to criteria 2 and the six areas of partial compliance whereby progress was being made in terms of improved education for cleaning and work around the food standards. Ms Bowen referred to criteria 6 and the two areas of partial compliance and queried when it was expected for these to be compliant, and Mrs Holmes agreed to provide this information separately. **The Trust Board received and noted the update.**	**JH**
IMPROVING AND INNOVATING		
11.	**Strategy & Transformation Committee Assurance Report (31-07-24)**	
131/2024	Ms Bowen highlighted the following: • Partial assurance was provided on the strategy updates whilst noting the actions in place • The Internal Audit into IT systems managed by operational areas received a minimal assurance rating with actions underway and partial assurance for IT service management. In addition, the Committee noted that a new cyber assurance report was being developed for the Audit Committee • A new assurance report on anchor institution was to be provided to the Committee every 6 months • An update was provided on transformation clarifying UHNM improvement programmes versus programmes of major change although these needed to	

	highlight how they linked to the Trust's enabling strategies • Improving together was being built into the lifecycle of employees and a summary report was to be provided going forwards, focussing on key areas Mr Wakefield referred to the internal audit and actions taken and Mrs Freeman stated that a framework had been identified, with standards which Divisional teams would need to adhere to, for any systems not managed corporately. She added that a gap analysis was also being undertaken the outcome of which would inform any further actions. **The Trust Board received and noted the assurance report.**	
RESOURCES		
12.	**Performance and Finance Committee Assurance Report (30-07-24)**	
132/2024	Professor Crowe highlighted the following: • Performance was generally positive in terms of the initiatives to tackle and control waiting lists, although this was rated partial assurance due to some continued delays • The Committee noted positive signs of improvement in terms of cancer and Emergency Department performance despite swings in demand • Limited assurance was provided in respect of the financial outlook and ability to meet current financial targets although a process was in place to identify recovery actions including the appointment of a Recovery Director for the system • Enhanced reports on initiatives to improve productivity and staff costs were to be provided **The Trust Board received and noted the assurance report.**	
13.	**Digital Strategy Update**	
133/2024	Mrs Freeman highlighted the following: • As at the end of March 2024, 48 new projects had been delivered with 4 significant system upgrades. Of the projects undertaken, these included digital noting in the Emergency Department at Royal Stoke which was positively affecting the triage process and a 24/7 cyber security operations centre which was a system initiative • In terms of productivity automated workflows and robotic automation were being considered Mrs Rodwell referred to the list of desired projects and given the lack of funding queried how these were being prioritised whilst managing any associated risks. Mrs Freeman referred to the matrix in place which considered a projects strategic alignment, impact on quality and safety, return on investment and whether the project related to mitigating a particular risk. She stated that in terms of risk management, often the risk was held within Divisions and managed locally and these were reported to the Executive Digital and Data Security and Protection Group. Mrs Cotton stated that in terms of Board Assurance Framework (BAF) the strategic risk for IT was to be broadened so that the focus was not solely on cyber. Mrs Freeman added that an additional piece of work on cyber security was to be provided to the Audit Committee. Mr Wakefield queried how the vitals reporting within the Emergency Department	

	(ED) was expected to benefit and Mrs Freeman explained that the system would replace paper documentation of recording vitals for those patients who need it, using the same system in place for inpatients. Mr Evans added that it was expected to save staff time as well as acting as an additional prompt for action whilst also improving communication between teams. Mr Oldham referred to IT being an enabler for efficiency and the need for projects to link to the recovery programme, given that capital was to be prioritised on a system basis. **The Trust Board received and noted the update.**	
RESPONSIVE		
14.	**Integrated Performance Report – Month 3**	
134/2024	<u>High Quality</u> Mrs Holmes highlighted the following: • There had been improvements across a range of metrics including some improvement with falls • Performance for c-difficile, timely observations and cases of MRSA had slightly improved • In terms of VTE assessment performance a digital solution was being scoped Mr Wakefield referred to the number of c-difficile cases and the national increase in infections across the county and queried what was causing the increase. Mrs Holmes stated that whilst she was unsure of the contributing factor, she explained that actions were focussed on the areas with the highest cases, antimicrobial resistance and a winter bed clean, including the coding of beds so that they remained in the same area. She added that initial conversations had also been held about the use of penicillin. Dr Lewis referred to the never event which took place and highlighted that since January 2021 there had been 18 never events, 7 of which related to wrong site surgery 4 of which occurred in 2024. He stated that the 4 cases took place within the skin and plastics specialties and a review of Root Cause Analyses had been undertaken which identified initial challenges due to the cases falling between two specialties as well as an element of outsourcing. He referred to the importance of standardising processes and Mr Wakefield queried if the Trust had benchmarked the approach taken in other organisations to establish if things were being done differently at the Trust. Ms Ashley referred to the capacity constraints when introducing new solutions or using third parties which by doing so could introduce further complexity and breakdowns in communication which needed to be borne in mind for the future including any appropriate safeguards. Dr Griffin referred to the drop in VTE performance to 88% and queried the reason for this. Professor Hassell explained that this was due to a change in scrutiny whereby it was being assessed as to whether it had been completed within 12 hours. Dr Lewis agreed and added that the assessments were being carried out but the issue was whether these had been completed in the recommended 12 hour window. Professor Crowe referred to the quality dashboard and the need to ensure this appropriately reflected failing performance, so that this identified areas of focus for QGC to receive further assurance on.	

Responsive

Mr Evans highlighted the following in terms of non-elective performance:

- 4 hour performance was better than trajectory and whilst unvalidated, performance for July had continued on this trend which had been the best consistent position since 2020
- The new Acute Medical Receiving Area (AMRAU) had opened which was a key part of recovery and since opening the unit, this had helped to more than halve the number of patients waiting more than 12 hours, in addition to reducing the number of patients waiting more than 60 minutes for an ambulance handover

Mr Evans highlighted the following in terms of elective performance:

- The 78 week position was being validated although the Trust did not achieve zero as per the trajectory but this had reduced. In addition, the Trust was not anticipating that zero would be achieved for August due to the impact of patients who had been too unwell to have their operations therefore it was forecast that the Trust would have 4 breaches for August
- In terms of the 65 week position, this demonstrated an increase as at the end of June although this was unvalidated and had reduced by more than 400 patients for July. The Trust was back on the trajectory for September and forecasting approximately 50 patients by the end of September
- There were seven 104 week wait patients which was unvalidated and the Trust continued to offer mutual aid where possible. It was noted that there was one patient waiting over 104 weeks which was a patient transferred back to the Trust from the Independent Sector

Mr Wakefield referred to the number of long wait patients and queried whether the breaches were related to the comorbidities of the patient, which had prevented them from being operated on. Mr Evans stated that in some cases their comorbidities may need to be treated first but he added that the delays were due to infectious diseases which had made them unwell.

Mr Evans referred to diagnostics performance whereby DM01 performance had deteriorated more than the original trajectory. He explained that a modular unit was onsite and one was being mobilised for County Hospital which would increase capacity and focus on patients waiting for surveillance procedures. He added that by the end of the year he expected performance to be back on track.

Mr Wakefield queried if the Community Diagnostic Centre would help with DM01 performance and Mr Evans confirmed that this would help in part.

Mr Evans continued to highlight the following in terms of cancer performance:

- 28 day performance continued to be positive although there had been a dip in 62 day performance. However, as a result of improved 28 day performance it was expected to also positively impact on 62 day performance
- The Trust had continued to operate within its fair shares consistently
- The Trust had asked NHS England to review the tiering for cancer performance

Dr Griffin queried the size of the wait past 62 days and Mr Evans stated that the number of patients waiting over 104 days had reduced and because of the small number this had a big range due to cases which often had multiple tumour sites.

Professor Crowe thanked Mr Evans for the way in which he presented the data and the reference to the improvement trajectory.

People

Mrs Haire highlighted the following:

- The staff engagement score for July had increased to 6.56 but this required further improvement
- The national staff survey would commence in September and as such the staff voice would pause until January 2025
- Women's, Children's and Clinical Support Services had seen a positive response from their campaign 'spill the beans' which aimed to increase the response rate for the staff voice
- The actions required to improve sickness absence continued to be considered by the People Directorate. The rate had increased in June to 5.18% which had been driven by covid absences although these were starting to reduce. Dr Lewis added that the number of inpatients with Covid had reduced to 56 and as such mask wearing was only required in high risk areas.
- It was noted that in terms of sickness absence, the conversation with Divisions were focussing on what was driving the main areas of sickness absence rather than policy compliance
- The target for vacancies had changed from 10% to 8% and the slight increase was due to a change in budget establishment
- Agency costs continued on a downward trend and were below the national standard due to the work undertaken in Divisions to reduce agency expenditure

Dr Griffin queried the plans to protect staff from flu going forwards and it was agreed to provide this information outside of the meeting. **JHo**

Professor Hassell referred to agency usage and queried how the costs had reduced when the number had increased. Mrs Haire stated that this was calculated as a percentage of the overall pay bill and some agency continued to be used while recruitment to cases took place. Professor Crowe stated that the Performance and Finance Committee (PAF) needed to understand the gross agency figures as well as knowing which areas were able to be controlled.

Improving and Innovating

Dr Lewis highlighted the following:

- 2 out of the 3 metrics continued to be worked up
- Metric 1 in terms of recruitment was below trajectory but the Trust had improved from the same period in 2023
- The year to date financial position for April had improved for research activity

Mr Wakefield referred to the metric regarding the number of employees engaged in research and Dr Lewis stated that work was ongoing to improve the data for that area as it was utilising an estimate.

System and Partners

Ms Ashley highlighted the work undertaken to identify key metrics one of which would be the maturity of an anchor institution, and the other five would reflect the outcomes framework developed by Mr Matthew Missen. She added that she expected these metrics to be included within the next report although the majority were not expected to change month on month therefore the narrative would provide assurance of the work being undertaken in this area.

Resources

	• Mr Evans referred to activity, whereby non-elective activity remained high although this may start to change due to the impact of AMRAU • Elective and daycases were delivering above plan and it was expected for this to continue to improve with the increase in numbers of patients being treated • The number of outpatient follow up appointments continued to be managed Dr Griffin referred to the dip in elective activity and queried whether this was due to Junior Doctor industrial action. Mr Evans confirmed this was the case and whilst the number had reduced due to preparing for the action, the Trust still overperformed. Mr Oldham highlighted the following in respect of financial performance: • As at month 3 the Trust had a deficit of £5.8 m, which was £5 m behind plan. The drivers of this shortfall related to the level of cost improvement savings, impact of industrial action and some medical staff pay overspends • The main focus continued to be on the cost improvement programme and a deep dive was being undertaken into pay overspends • The system quarter 1 position was off track by approximately £5 m and the ICB position was expected to deteriorate further • In terms of cost improvements the Trust had transacted £10.2 m against a target of £12 m • A cost improvement summit had been held with Divisions and the Recovery Director was working with the Trust on identifying additional potential schemes • The Trust was on track to deliver its capital plan and the initial shortfall identified had been mitigated following receipt of the IFRS allocation • The Trust continued to have a strong cash position which was £11 m ahead of plan • Financial forecasting had identified the most likely outlook of £22 m deficit although there was a potential to reduce this to £10 m Professor Crowe drew attention to cost improvement performance and the gap in cost improvement schemes which was sobering based on the savings delivered. He stated that PAF needed to consider the trajectory for 2024/25 as well as the underlying ability to deliver the longer term trajectory. Mr Oldham referred to the plan to deliver long term savings and Mr Evans added that for 2025/26, if there was a delay in receipt of national guidance as per 2024/25, the Trust were to decide on what could be set in motion for the beginning of the year whilst accepting that this may be subject to change. **The Trust Board received and noted the report.**	
GOVERNANCE		
15.	**Audit Committee Assurance Report (01-08-24)**	
135/2024	Mrs Rodwell highlighted the following: • Partial assurance had been provided to the ambulance handover data internal audit, with actions agreed although these required joint working to implement them • Two further audits had commenced and were to be reported in due course • Partial assurance rating were provided on reports such as corporate governance and outstanding declaration of interests but actions were in place with the aim of moving these to an acceptable assurance at the next meeting • Positive assurance had been received for the annual counter fraud functional standard return	

	The Trust Board received and noted the assurance report.	
16.	**Board Assurance Framework – Quarter 1**	
136/2024	Mrs Cotton highlighted the following: • The document had been refreshed to build on the outcome of the deep dives, the outputs of which were also provided to the Audit Committee. She added that going forwards the frequency of deep dives would be considered • A risk radar had been included and the three lines of defence and assurance map had been simplified • Further developments were to focus on the actions being taken to address the matters of concern identified in Committee discussions • Going forwards the full BAF would continue to be considered at Committees with the summary version presented at Trust Board **The Trust Board is approved the BAF and accepted the risk scores and assurance assessments were an accurate reflection of the position.**	
17.	**Board Development Programme Update – Schedule of Board Seminars**	
137/2024	Professor Hassell queried if there was any scope to consider development in terms of health inequalities and population health. Mrs Cotton stated that whilst there was some limitation in terms of capacity a Committee deep dive could potentially be utilised. In addition, she explained that the frequency of board meetings was to be reviewed to consider building in additional capacity. Ms Ashley agreed that if time was available, a session could be provided to include external colleagues so that updates on the wider system actions being taken could be provided. Dr Griffin queried whether a further session on productivity could be considered. **The Trust Board received and noted the update.**	**CC/HA**
CLOSING MATTERS		
18.	**Review of Meeting Effectiveness and Review of Business Cycle**	
138/2024	No comments were made.	
19.	**Questions from the Public**	
139/2024	There were no questions received.	
DATE AND TIME OF NEXT MEETING		
20.	**Wednesday 9th October 2024, 9.30 am via MS Teams** **NB. The Annual General Meeting will take place on Wednesday 4th September at 12.30 pm, Wade Conference Centre**	

Trust Board (Open)

Post meeting action log as at **03 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		Action not yet due.	GB
PTB/604	08/08/2024	Integrated Performance Report	To highlight the plans to protect staff from flu going forwards	Ann-Marie Riley Jane Holmes	09/10/2024	03/10/2024	The annual staff flu vaccination campaign concluded with 6,417 staff having received flu vaccinations and 4,966 staff having received their COVID vaccinations. The vaccine campaign for 2024/25 commenced in October 2024	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		Action not yet due.	GB

NHS University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

September 2024

Part 1: Highlight Report

This is my first report to the Trust Board as chief executive. It provides the Trust Board with an overview of a range of strategic and other issues since the last meeting on 4th September 2024, some of which are not covered elsewhere on the agenda for this meeting.

I would welcome feedback from colleagues as to content that is considered helpful.

1. National and Regional Context

On 4th September 2024 I attended an NHS England Leadership event in London. The Chief Executive of NHS England, Amanda Pritchard, set the scene for the day, which uniquely also included a keynote address from the Secretary of State for Health and Social Care, Rt Hon Wes Streeting MP.

We also had break-out sessions on winter resilience (and the development of the 10-year plan for the NHS, including the publication of the subsequent Darzi Report which talked a lot about capital investment (including digital and estates), leadership and the need for a left-shift from hospital to community-based care alongside upstream demand-management and prevention.

Both the Chairman and I attended a regional NHS England Midlands leadership event on 25th September 2024 with provider and ICB colleagues. Items on the agenda included winter planning/resilience as well as elective recovery, with plenty of examples shared of what has worked well in other parts of the region

2. System Financial Position

As part of the role of UHNM in the wider Staffordshire and Stoke-on-Trent Integrated Care System, we have been collectively in close communication with NHS England regarding the system financial position. The appointment of a System Recovery Director has been welcomed; we have been asked to consider how we will work in order to ensure the system gets back on its financial plans as submitted.

Given the financial situation facing the NHS all 42 Integrated Care Systems (ICSs) in England are required to deliver on their submitted financial plans (expenditure limits). For those systems that planned a financial deficit we had already been advised of the likely additional governance, oversight and scrutiny that would be applied.

To help ensure success, systems deemed to have significant risk to meeting their financial plans are required to take immediate action. Using a similar methodology to the oversight framework each system has then been categorised into one of four levels, from 1 (high confidence in delivery) to 4 (greatest concerns about delivery). This assessment also includes regional insights and past performance data. Systems with a '4' rating are being directed to undergo a rapid intervention process to reduce their rate of spend.

After reviewing the relevant data for our system, the Staffordshire and Stoke-on-Trent ICS has been assessed to have a rating of 4.

3. Leadership Changes

There are no new leadership changes to report this month.

4. New Communication Channels

In addition to my daily email communication, Good Morning UHNM, the first of our new look Team Brief was held on Friday 27 September 2024. This was the first of a virtual-only monthly meeting, and I was delighted to be joined by nearly 200 colleagues online with a broad representation from every corner of the Trust.

I undertook a 15-minute presentation taking an overview of all the things happening across the Trust, followed by a 15-minute Q&A.

Team Brief is open to everyone and in the spirit of continuous improvement we will continually seek views on Team Brief to make sure that Team Brief, and indeed all our communications, are easily accessible and relevant to all colleagues working across the Trust. Team Brief is an opportunity for myself and my fellow executive directors to share key updates related to our strategic direction and objectives. It also provides a space to for staff to ask questions.

5. WHO World Patient Safety Day

This month has seen the World Health Organisation's Patient Safety Day.

The World Health Organisation (WHO) observes World Patient Safety Day annually on 17th September. Patient safety is a serious global public health concern.

World Patient Safety Day aims to bring together patients, families, caregivers, communities, health workers, health care leaders and policy-makers to show their commitment to patient safety.

This year the theme has been "Improving diagnosis for patient safety" with the slogan "Get it right, make it safe!", highlighting the critical importance of a correct and timely diagnosis in ensuring patient safety and improving health outcomes. Key also is empowering families and patients to actively engage with their clinicians to improve diagnostic processes.

A diagnosis identifies a patient's health problem and is key to accessing the care and treatment they need. A diagnostic error is the failure to establish a correct and timely explanation of a patient's health problem, which can include delayed, incorrect, or missed diagnoses, or a failure to communicate that explanation to the patient.

Diagnostic safety can be significantly improved by addressing the systems-based issues and human factors that can lead to diagnostic errors. Systemic factors are organisational vulnerabilities that predispose to diagnostic errors, including communication failures between healthcare workers or between healthcare workers and patients, heavy workloads, and ineffective teamwork. Human factors involve training and experience as well as predisposition to biases, fatigue, and stress.

Listening to our patients and their families when things don't go well is also vital for us to learn and improve. This engagement is also an important feature of the new approach to reporting incidents across the NHS.

We have also taken the opportunity to further raise awareness of the Patient Safety Incident Response Framework or PSIRF. This replaces the Serious Incident Framework and not only involves all those affected in patient safety incidents, including staff and patients, but is about understanding how and why incidents have happened, looking at the bigger picture and any system issues and, more importantly, avoiding blame.

6. Quality Improvement Week

September has also seen National Quality Improvement (QI) Week, and it was a fantastic opportunity for us all to learn more about quality improvement and share ideas that can make a real difference across the Trust. Our QI team hosted two interactive events across both hospitals.

QI is central to enhancing the care we provide to our patients. The best ideas often come from those with first-hand experience - staff, our experts with experience. By harnessing their insights, alongside data-driven decisions, we can standardise our processes, improve efficiency, and ultimately provide even better care for our patients.

At both events, there was a chance to engage in activities such as games to learn about the Plan-Do-Study-Act (PDSA) cycle, try out a huddle board, and submit improvement ideas or suggestions.

I have been pleased to see some examples of this over the last month, including some on our Critical Care Unit at the Royal Stoke, hosted by Dr Chris Thomspon, consultant in critical care.

7. A Night Full of Stars 2024

I was delighted to join 200 staff and volunteers who came together to celebrate our annual A Night Full of Stars 2024 on 6th September 2024 at the Hilton Doubletree Hotel in Stoke-on-Trent. It was an uplifting evening of inspiration, admiration and positivity, with 11 awards handed out during the ceremony.

It really was wonderful to see so many colleagues come together under one roof and I was truly heartened to see once again the camaraderie and support shown by all guests towards our finalists and winners.

I am sure most would agree that everything was on point. As was our host, Lisa Thomson, Director of Communications & Charity, who did a fantastic job of keeping the evening flowing.

Congratulations to all of this year's winners and finalists, and indeed everyone who was nominated.

Here's our full list of A Night Full of Stars 2024 winners:

- Clinical Team of The Year: Adults Diversional Therapists Pilot
- Non-Clinical Team of The Year: Medical Staffing
- Leadership Impact Award: Sarah Jamieson, Director of Midwifery
- Service Improvement Award: John Hopkins Implementation Team and IM&T Development and Integration Team
- Being Kind and Compassionate Award: Claire Wright, Dental Nurse
- Rising Star -Clinical: Cosmina Schiteanu, Endocrine Specialist Nurse
- Rising Star – Non-Clinical: Rebecca Morton-Hand, Security Officer
- Rising Star – Apprentice: Lauren Griffiths, Cardiorespiratory Apprentice
- Volunteer of The Year Award: Lachlan Matthews
- UHNM Charity Award: Stephanie Wilcock, Staff Nurse, Emergency Department and Angela Power, Bowel Cancer Screening Programme Manager
- UHNM Charity Lifetime Achievement Award: Steve Rushton, Head of Charity

I must also mention and thank those involved in making the event such a success. That includes everyone who took the time to send in a nomination, our stars who were shortlisted and became our finalists and winners, and all those who made the event possible.

8. NHS National Staff Survey

The NHS National Staff Survey was launched on 18th September 2024. At the time of writing, we have now been live with the National Staff Survey for two weeks and our response rate is 20.57%; while this early response rate is encouraging, we still need to hear from more of our colleagues to ensure all voices are represented.

We know that the engagement of all is crucial in shaping the future of UHNM; hearing a wide range of experiences and diverse perspectives helps us to identify areas of improvement and celebrate what we are doing well. The feedback from the survey is an essential tool for understanding how we can better support teams and create a more inclusive and positive workplace.

We have shared a divisional league table to highlight how each division is currently engaging with the National Staff Survey. This table, which will be shared regularly throughout the survey period, gives teams a chance to see their progress and compare participation rates across each division. A little friendly competition can go a long way in boosting engagement; we encourage everyone to rally their teams, aim for higher response rates and ensure their voices are heard.

9. Freedom to Speak Up (FTSU)

October is National FTSU month. The focus this year is on “Listen Up”.

Often things get raised to FTSU when individuals or teams are not living our Trust values. People speak up as they feel they are not being heard, not having fair or equal opportunities; they talk culture in their team, relationship issues, policies and processes not being followed.

Creating a safe speaking-up environment is the first step, a way of doing things where everyone feels safe and supported to raise concerns. Equally, we have to foster trust in our speaking-up policy and belief that speaking up won’t result in retaliation or detrimental treatment.

In order for “Speaking Up” to work it is essential that leaders at all levels “Listen up” and “Follow Up” too. Through “Listen Up” there is an emphasis on leaders being approachable and giving individuals confidence to seek them out with difficulties and issues. All voices should be heard regardless of seniority or status. All concerns should be valued equally.

The role of the FTSU Guardian, and their supporting team, is crucial. The role is a neutral and confidential resource for everyone, offering an independent set of eyes and ears to offer impartial advice and facilitate the speaking up process, to help escalate concerns and seek suitable resolution.

As part of FTSU month, there will many awareness-raising activities.

10. Black History Month

October is Black History Month.

This year’s Black History Month theme “Reclaiming Narratives,” focusses on recognising and correcting the stories of Black History and culture. There is a busy month of activities and I am sure that I will report back at least some of these in my next report.

11. Seasonal Vaccination Campaign

Seasonal influenza (flu) is an unpredictable but recurring pressure that the NHS faces every winter. Vaccination offers the best protection, and I was pleased to hear that at UHNM staff always strive to get their flu jab and do so in large numbers. Having the vaccine will help to protect staff, their family, and the people we care for from getting the flu. For people in at-risk groups, such as older people or those with an underlying health condition, flu can be a serious disease and can cause death, so it is our duty to protect ourselves and each other. For me, it’s an important patient and staff safety measure.

The UHNM Flu and COVID-19 vaccination programme has been launched with clinics available for all staff – including contractors, Sodexo and those who work in our outlets - at both Royal Stoke and County Hospital and the message is *Get Winter Strong*. Staff have the opportunity to book both vaccines. More clinic times will be made available at the beginning of each week. More vaccinators are being trained and then more clinics can be arranged with additional appointments will be made available.

12. Stroke Thrombectomy Service

In 2009, a team at the Royal Stoke helped pioneer the UK's first 24/7 Stroke Thrombectomy service. This year marks the 15th anniversary of the service, and our patient outcomes remain the best in the UK.

In September, we hosted the UHNM Thrombectomy Awareness Day, attended by Professor Sir Stephen Powis, the National Medical Director of NHS England. The event brought together senior officials from NHS England, the Royal Colleges, local businesses, Members of Parliament, councillors, healthcare professionals, and stroke experts. The agenda included a range of insightful discussions and presentations, with patient stories providing a deeply personal understanding of the transformative impact of thrombectomy. The aim was to raise public awareness, engage with patients, and underscore the need for equitable access to thrombectomy services across the UK.

Professor Powis described our stroke services, and especially the mechanical thrombectomy service, as the best (or, if not, among the best) in the country. The delivery of innovation, research and training over the years has helped to position the UHNM stroke service at the vanguard of national units. The level of support and appreciation was very significant. Congratulations to all for making this service happen and delivering the great outcomes that it does.

13. Clinical Technology and BSI Audit

Clinical Technology provides corporate services for the effective management and safe use of medical devices at UHNM, ensuring compliance with CQC standards and MHRA guidelines. With a strong focus on governance, the department delivers assurance that meets the expectations of external regulators and recently, the department successfully passed the BSI (British Standards Institution) 13485:2016 recertification audit without any non-conformities. This certification confirms the department's robust quality management system, demonstrating its ability to consistently deliver medical device-related services that meet both customer and regulatory requirements. Key areas of focus include risk management, process-driven approaches, and maintaining the quality and safety of medical devices.

This achievement was a true team effort, and we are all delighted with the result. The dedication and collaboration across all departments were instrumental in making this success possible. The team are proud of what they have accomplished and remain committed to striving for excellence in all that they do.

14. 'My Health, My Way'

UHNM has for a long time has had a great record for supporting its frail and elderly to *Sit Up, Get Dressed and Keep Moving* as part of our campaign to prevent deconditioning while in our hospitals. This message is so important for our population at home as well and why I was interested to hear about a new pilot initiative launched across our Integrated Care System (ICS) patch in Staffordshire and Stoke-on-Trent which is benefiting more than 4,000 people with mild frailty.

My Health, My Way is a digital initiative for people aged over 65 who are registered with a GP practice in Staffordshire and Stoke-on-Trent and encourages them to sign-up for an online collection of information about factors that contribute to a healthy old age. There is a mixture of online leaflets, videos and signposting to local support groups and services with home exercise guides being particularly popular, helping users stay active and connected. What's more, feedback from users has been overwhelmingly positive, with 74 per cent rating the health content they've accessed as either 'very useful' or 'useful'.

Prevention and self-care is key to keeping our population well and at home – reducing the need and demand on our services in the long-term - and this project has the potential to reach even further, with a take-up rate of 20 per cent we could reach at least 15,000 individuals with advice and signposting around healthy ageing if scaled across the full cohort of 75,000 people with mild frailty in the area. It is clear that My Health, My Way is already having an impact, and with our continued awareness and support, hopefully together we can make a real difference to even more lives.

15. 'Keep Warm, Keep Well'

The award-winning UHNM 'Keep Warm, Keep Well' Community Energy Scheme was featured on ITV News Central in September. The feature focused on the role that community energy projects play in giving rise to many benefits for the local community - with UHNM having one of the best examples in the Midlands. Louise Stockdale, Head of Transformation and Sustainability, talked about how the Trust is using solar power to help tackle climate change, reduce its energy bills and support its vulnerable patients at risk of fuel poverty.

16. Employee and Team Recognition

i) Chief Executive Awards - Dr Mohamed Haris, Respiratory Consultant, and Dr Viktoria Oakden, Pleural and Advanced Bronchoscopy Fellow

I have been very pleased to make my first Chief Executive Awards at UHNM. Two of our doctors from the North Midlands Pleural Interventional Unit have been recognised for helping to save the life of an infant who had inhaled a peanut. Dr Mohamed Haris, Respiratory Consultant, and Dr Viktoria Oakden, Pleural and Advanced Bronchoscopy Fellow, answered the call for help from colleagues at Staffordshire Children's Hospital at Royal Stoke to help retrieve the nut from the 18-month old's left lung. Dr Haris and Dr Oakden, who used a small camera and forceps to safely remove the peanut, which, if not removed, could have had serious consequences.

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

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

- Helen Ashley, Deputy Chief Executive & Director of Strategy & Transformation
- Suzanne Bailey, Executive Assistant Executives
- Scott Taylor, Deputy Unit Manager - Endoscopy Unit
- Donna Bailey, People and OD Consultant
- Chris Bird, Project Director - Strategy & Transformation
- Dr Daisy Evans, FY2 Doctor - Surgery
- Claire Cotton, Director of Governance
- Elaine Andrews, Deputy Director of Strategy
- Sarah O'Reilly, Fundraising Officer - UHNM Charity

Part 2: Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Geriatrician with an interest in Ortho Geriatrics	Vacancy	Yes	24/09/24
Consultant Histopathologist	Newly created	Yes	30/09/24
Consultant Oral & Max	Vacancy	Yes	TBC
Consultant ENT/Body Radiologist	Newly created	Yes	TBC
Consultant Cardiothoracic Anaesthetist	Newly created	TBC	TBC

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

Post Title	Reason for advertising	Start Date
Consultant in Emergency Medicine (3 new starters)	Newly created	01/09/24, 02/09/24, 23/09/24
Consultant in Obstetrics & Gynaecology	Newly created	02/09/24
Consultant in Acute Medicine	Vacancy	01/09/24
Consultant Ophthalmologist	Vacancy	30/09/24
Consultant Geriatrician	Vacancy	24/09/24
Consultant in Neonatal Medicine	Vacancy	30/09/24
Consultant in Trauma & Orthopaedics	Vacancy	30/09/24
Consultant in Neonatal Medicine	Vacancy	17/09/24
Consultant in General Medicine	Vacancy	23/09/24

No medical vacancies closed without applications / candidates during September 2024:

Medical Management Appointments – September 2024

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

Part 3: Academic Appointments

I am delighted that four UHNM colleagues have been awarded professorships in recognition of their career achievements.

- Dr Pensee Wu, Consultant Obstetrician, and Dr Mark Lambie, Consultant Nephrologist, have been appointed professors at Keele University.
- Dr Timothy Scott, Consultant Anaesthetist, and Alison Cooke, Assistant Director of Nursing for Research & Academic Development and lead for the Centre for NMAHP Research and Education Excellence Lead (CeNREE) have been appointed professors at the University of Staffordshire (formerly Staffordshire University).

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7.
Report Title:	Stoke on Trent Joint Health and Wellbeing Strategy	**Agenda Item:**	9th October 2024
Author:	Helen Ashley, Director of Strategy		
Executive Lead:	Helen Ashley, Director of Strategy		

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 risks currently identified	

Executive Summary

Situation

- The attached draft Health and Wellbeing Strategy for 2025-2028 is currently under consultation by the City of Stoke on Trent. It is being shared with Trust Board members in order to seek feedback and comments prior to the deadline of 18th October 2024.

Background

- The strategy has been updated to focus on preventing poor outcomes for people and mirrors the vision and ambition of the Staffordshire and Stoke on Trent Integrated Care System.

Assessment

- The ambitions of the strategy are to create healthier and happier lives for citizens, increasing preventative activity within communities, moving towards helping people to stay well, building resilience and wellbeing and investing in early support.
- The main focus of the strategy is to reduce health inequalities, support family lift, support people to live independently, support physical and mental wellbeing and reducing harms from addictions
- 10 key metrics have been identified and it is anticipated that the strategy will be finally ratified in March 2025.

Key Recommendations

The Trust Board is asked to provide any comments and feedback on the proposed strategy by 16th October 2024 so that these can subsequently be collated and shared with the City of Stoke on Trent Council by the deadline of 18th October 2024.

Stoke on Trent Joint Health and Wellbeing Strategy

2025-2028

1

Contents

2

Foreword

As Chair and Vice Chair of the Stoke-on-Trent Health & Wellbeing Board, we are pleased to introduce the Joint Health and Wellbeing Strategy 2025-2028.

Stoke-on-Trent is a unique and great place to live, work and visit and we are immensely proud to be able to celebrate 100 years of history and culture during our Centenary in 2025. Yet despite our pride in our rich history, we cannot ignore the fact that Stoke-on-Trent is currently the 13th most deprived local authority in England, where health and wellbeing is generally worse than the England average.

In order to address this challenge, our focus for this strategy is community wellbeing and inclusive growth. In delivering on our priorities, we will work closely with our partners and our residents in order to help the people of Stoke-on-Trent lead more fulfilling lives. Having healthy communities is crucial not only for our residents to live well but also so we have a healthy workforce to fulfil our economic ambitions.

This strategy focuses on access and outcomes for good quality care and support, with particular focus on children and young people and older adults, though clearly cross cutting themes associated with health inequalities are relevant to residents of all ages. The priorities have been developed following engagement with partners and communities, with reference to our Joint Strategic Needs and Assets Assessment (JSNAA)[i], an evidence base that builds a picture of the health, care and wellbeing needs of local people and communities based on a range of data and analysis. The JSNAA informs our plans and strategies, which allows us to plan and commission services to meet the needs of residents across the City.

We are ambitious for our residents and will encourage them to work with us to help shape the future care and support for our City whilst addressing the wider determinants of health. We will adapt our approach to their changing needs by listening to our residents and responding flexibly to their needs. We invite you to work with the Health and Wellbeing Board, using your voices, your energy and your influence to help us improve wellbeing for everyone who lives and works in Stoke-on-Trent.

Councillor Jane Ashworth OBE

Chair of Stoke-on-Trent Health & Wellbeing Board
Leader of Stoke-on-Trent City Council

Buki Adeyemo

Vice Chair of Stoke-on-Trent Health & Wellbeing Board
Chief Executive North Staffordshire Combined Healthcare NHS Trust

3

Our Ambition

This is our joint strategy to create healthier and happier lives for all of our citizens. We will do this by developing an environment in which people and organisations can work together to improve the health and wellbeing of all our residents. Our previous strategy followed the City's response from Covid-19 and the impacts it had on the City. Now in pursuit of greater wellbeing, we will have an unrelenting focus on increasing preventative activity deep in communities that prevents poor outcomes for people. We will make a deliberate and permanent shift towards investment in activity that helps people to stay well, as well as to develop themselves and to work collaboratively within their communities.

We will always start from the perspective of understanding the strengths of people and communities, rather than just seeing their needs. That means looking for the positive foundations on which we can build resilience and wellbeing. Working together we will invest in early support, getting alongside people in their communities and giving them the tools to deal with the challenges they face.

Mirroring the vision and ambition of the Staffordshire and Stoke-on-Trent Integrated Care System, we are striving to create healthier, happier communities in which residents live fulfilling lives (see figure 1 below). We aim to reduce persistent health inequalities through improving access, quality and outcomes from care and support. Additionally, we will ensure our investments go to the areas of greatest need and have added social value.

Figure 1 ICP Vision, Ambition, Values and Principles

4

Figure 2 5 P's/Improving health and wellbeing

Source Figures 1&2: Staffordshire and Stoke-on-Trent Integrated Care Partnership ICP Strategy /icb.nhs.uk

5

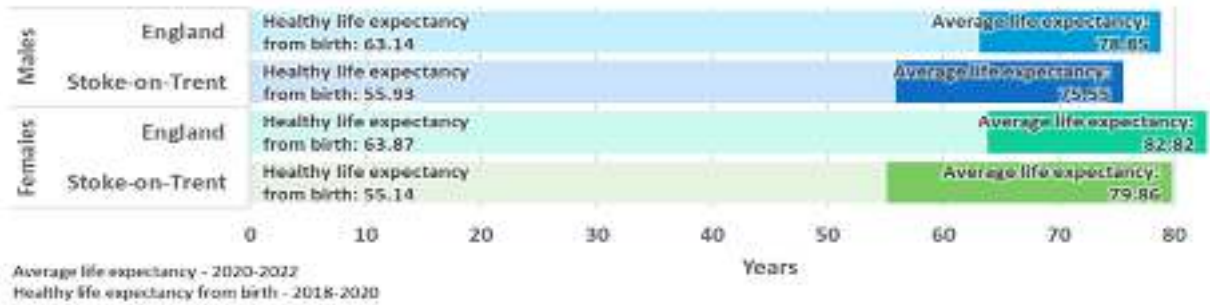
Our People of Stoke-on-Trent

Over many generations, a multitude of factors have conspired to hold back our city and harm the life chances of many residents and there is still much to do to improve the wellbeing of our residents. However, as we celebrate the city's centenary, we will work collaboratively with our strong and well networked voluntary and community sector to improve the wellbeing of our residents, building on the resilience and attitude of our residents, who take pride in the City and it's unique heritage. Significant gaps between outcomes for people in Stoke-on-Trent and those in other parts of the England have continued to exist, and in some cases have actually widened in recent years. Whilst there have been improvements across a number of key health outcomes i.e. teenage pregnancy, smoking rates, self-harm and cancer deaths, the health of local people is still generally worse than the England average. The most serious inequalities relate to gaps in outcomes for life expectancy, educational attainment, the development rates for young children and numbers of children in local authority care.

Over the 20-year period from 2001 to 2021 the population of Stoke-on-Trent increased by 7% to 258,037, with the population projected to rise further to 263,265 in 2028. The main driver of population change being the number of births exceeding the number of deaths. Stoke-on-Trent is becoming an increasingly ethnically diverse city with the people from non-white British backgrounds growing by 20.5% between 2001 and 2021 and an increasing number of languages spoken. The age profile remains largely unchanged with the exception of increasing numbers of children under 5 and adults over 65, which has clear implications for our health and care services. By 2030 the over-65 population of the city is projected to increase by almost 20%, with over-65s whose day-to-day activities are limited by long-term illness predicted to increase further by 2030.

There are more people with long term health conditions in Stoke-on-Trent compared with England. Figure 3 below demonstrates how l expectancy and healthy life expectancy from birth for men and women in Stoke-on-Trent is less than the England average.

Figure 3 Comparative data according to local and national averages



6

To summarise, the key challenges for the City according to our Joint Strategic Needs and Assets Assessment are:

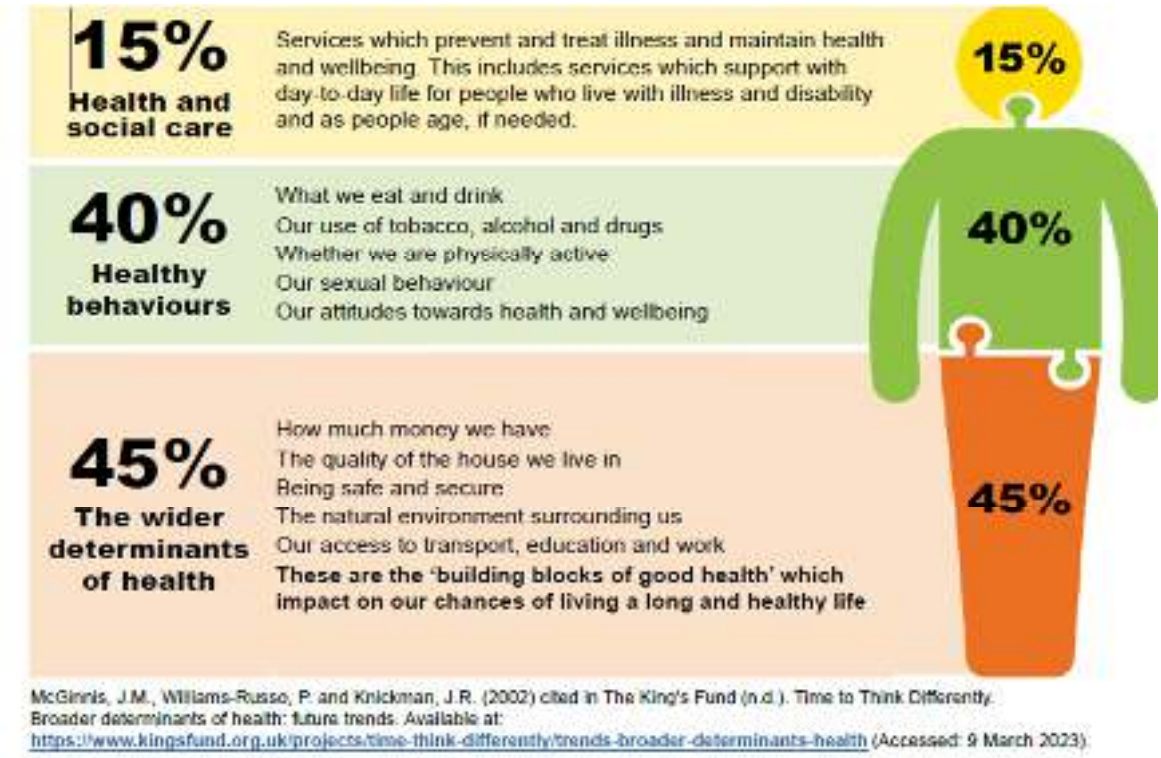
- Low rates of life expectancy and healthy life expectancy in the city;
- Higher rates of infant mortality, obesity and lower levels of physical activity;

- High numbers of adults and children with poor mental health and high rates of loneliness and isolation;
- Poor physical and/or mental health lead to high levels of economic inactivity;

What has the biggest influence on lives being cut short?

The health of our population is dependent on a complex relationship between our genes, the broader factors of health care, our behaviours and the socio-economic factors. Figure 4 estimates that the contribution of healthy behaviours and the socio-economic determinants of health have a far greater impact on health and wellbeing than contact with services which prevent and treat illness. Therefore it is important to link this strategy and actions with other strategies in the city, notably our economic, housing and community safety strategies.

Figure 4 Broader determinants of health



McGinnis, J.M., Williams-Russo, P. and Knickman, J.R. (2002) cited in The King's Fund (n.d.). Time to Think Differently. Broader determinants of health: future trends. Available at: https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health (Accessed: 9 March 2023)

7

Role of the Health and Wellbeing Board

Building on the improvements on key measures within the Joint Health and Wellbeing Strategy 2021-25 have led to Stoke-on-Trent closing the gap against a number of England average health and wellbeing indicators. The 2025-2028 strategy focuses in on areas where the City needs to make greater progress and will maintain a focus in our priority areas of:

- Supporting family life
- Supporting people to live independently
- Supporting physical and mental wellbeing
- Reducing harms from addictions
- Reducing health inequalities.

The Joint Health and Wellbeing Board is a statutory partnership which brings together leaders from Stoke-on-Trent City Council, the NHS (including primary, acute and community services and the Staffordshire and Stoke-on-Trent Integrated Care Board), along with Healthwatch Stoke-on-Trent, and Voluntary, Community and Social Enterprise (VCSE) sector organisations, further education and emergency services who will work together to improve health outcomes for residents.

Recognising the interconnectedness and co-dependence of our partners and the shared accountability in achievement of our goals, we will strengthen relationships with our peer partnerships who will support the wider influences on health and wellbeing and working with the community, VCSE, statutory and private sectors to collectively improve wellbeing, we will:

- Work with people to help them source, understand, and use information and services to inform health-related decisions.
- Providing added value by holding others to account and supporting partners to align agendas, as well as gaining assurance on the social inequalities impact of proposals and decisions.
- Receiving regular updates and assurance from supporting delivery groups on action and progress on target outcomes who will provide evidence that our collective actions are having an impact on our priorities. Outcomes will be monitored via the Health & Wellbeing Board with ambitious aspirations provided by year on year improvements on agreed measures.

In addition to assurance relating to this Joint Health and Wellbeing Strategy, the Board will fulfil their role of governance around the following statutory duties:

- Pharmaceutical Needs Assessment
- Joint Strategic Needs and Assets Assessment
- Better Care Fund.

8

Our Priorities

The focus for our strategy is to ensure the foundations for good health and wellbeing are in place so that residents have access to care and support where needed. There will be a particular focus on the following priorities which have been developed following engagement with partners and communities, with reference to our Joint Strategic Needs and Assets Assessment.

Supporting family life - We will prioritise working together to ensure families are able to give their children and young people the best possible start in life. We will work together to provide support for communities to help avoid family breakdowns where possible and reduce the numbers of children and young people who are placed in the care of the local authority.

Supporting people to live independently - The Health and Well Being Board has oversight of the Better Care Fund, a pooled budget between the NHS and the City Council, aiming to reduce the barriers often created by separate funding streams and promote the integration of health and social care. The objectives of the Better Care Fund in Stoke-on-Trent are to enable people to stay well, safe and independent at home for longer and to provide the right care in the right place at the right time.

Supporting physical wellbeing – Keeping active is a central to keeping well.
Too often modern lifestyles make it difficult for our communities to be active enough to reap the physical and mental benefits of physical activity. This in turn contributes to many health issues, including excess weight, cardiovascular disease, and mental health challenges such as anxiety and depression. Sedentary habits, driven by work demands, increased screen time, and limited access to safe and inviting spaces for physical activity, can undermine our wellbeing and restrict opportunities for social mobility, skills development and community cohesion. Physical activity provides more than just health benefits, it offers a platform for learning new skills, building confidence, and connecting with others. By promoting active lifestyles, we help individuals improve their health and enhance their social and economic prospects.

Supporting mental wellbeing - Mental wellbeing is more than just the absence of mental illness; it involves a state of balance, resilience, and the ability to navigate life's challenges. We are steadfast in our commitment to fostering a culture where mental wellbeing is valued as much as physical health. By collaborating with our partners and the public, we aim to empower residents to take proactive steps on their mental health journeys, to create a community where mental wellbeing is at the forefront of our minds, reducing stigma and ensuring that every person living in Stoke-on-Trent has the opportunity to thrive.

Reducing harms from addictions – Addictions bring harm to individuals, their families, close associates and the wider society. Our ambition is to reduce addiction and the harms caused by it.

9

Actions will include reducing or stopping consumption and empowering communities, with professionals who are confident and well-equipped to challenge behaviour and support recovery making it visible across the city to bring about sustainable change to local communities.

Reducing health inequalities – In the delivery of our priorities, we will take a universal, proportionate approach to reducing health inequalities, ensuring that there is equitable access, outputs and outcomes through the actions we will take. This will mean putting greater resources and adapting our care and support to where there is greater/different need in our communities.

10

Principles of the Strategy

The focus of this strategy will be on what is uniquely the role of the Stoke-on-Trent Health and Wellbeing Board to improve health and wellbeing of our residents, whilst recognising the significant impact on wellbeing that other partnerships across the city have. Therefore on behalf of residents of the city, board members will strive to provide respectful challenge to each other and other partnerships in order that the aims and objectives of the strategy are met and residents are provided with the best possible outcomes.

We will work collaboratively to share what works and what doesn't to ensure that our efforts have real impact for our communities. We will have a preventative mind-set in everything we do to support individuals and communities to build their own health and care resilience, ensuring coordination with other partnerships to support the social and economic determinants of health and wellbeing. We will seek innovative approaches to improve the impact of our interventions, looking widely for best practice both across the system and with reference to and aligned to regional and national strategies.

We will seek opportunities to problem solve key health issues and inequalities in our City, engaging with communities and ensuring the voices of residents are heard to improve our understanding of the issues associated with the social determinants of health, whilst analysing our interventions to ensure our efforts have a meaningful impact.

To summarise we will:

- Take a population approach, working with communities and groups to improve wellbeing ensuring the most vulnerable are supported to reduce health inequalities ;
- Take a holistic approach to wellbeing focusing on mental, physical, and social wellbeing;
- Work with our local communities using lived experience and community voices to shape our work and develop longer term priorities;
- Coordinate our work with other key partnerships to align actions to make the largest gains as quickly as possible.[1]

[1] The strategy will align to other Council and NHS key strategies, for example, Our City Our Wellbeing: Stoke-on-Trent City Council Corporate Strategy 2024-2028, the Staffordshire and Stoke-on-Trent Integrated Care System (ICS) Children & Young People's Framework 2023/28, the ICB Joint Forward Plan and the ICB Health Inequalities Strategy.

11

Target Outcomes & Measures: Reducing Health Inequalities

Life expectancy and healthy life expectancy from birth for men and women in Stoke-on-Trent is less than the England average with life expectancy of men is 9.4 years lower and 8.8 years lower for those living in the most deprived areas, compared to the most affluent areas of the City.

In the delivery of our priorities, we will ensure health inequalities are reduced, ensuring that there is equitable access, outputs and outcomes in the actions in which we will take. We aim to reduce the gap in healthy life expectancy against the England average.

Target Outcome	Aspiration	Measure(s)
Improve healthy life expectancy of residents	Increase male healthy life expectancy from birth in line with the England average	55.9 in 2020/21 against England average of 63.1
	Increase female healthy life expectancy from birth in line with the England average	55.1 in 2020/21 against England average of 63.9

12

Target Outcomes & Measures: Supporting Family Life

Reduce Infant Mortality

During 2019-2021 70 infants died during their first year of life in Stoke-on-Trent, which equates to 7.5 per 1,000 live births, which was the highest in the country and significantly higher than the England rate of 3.9 per 1,000 live births.

There will be a continued focus on maternity safety, to include the wider determinants or maternal lifestyle factors, and service improvement as a system approach to maternity and neonatal care is developed. The Infant Mortality Steering Group will work collaboratively leading on a systematic and coordinated approach to reduce infant mortality.

Target Outcome	Aspiration	Measure(s)
Improved survival of babies and young children to reduce infant mortality rates	Infant mortality rate (per 1,000 live births) to reduce in line with England average	7.3 in 2021/22 (against England average of 3.9)
	Under 18's conception rate (Rate per 1,000) to reduce in line with England average	24.4 in 2021/2 (against England average of 13.1)
	Reduction in the number of mums smoking at time of delivery in line with the England average	13.9% locally (compared with 8.8% in England according to 2023-24 figures)
	Reduction in the number of pre-term births and babies with low birth rates in line with England average	8.1% of local babies had a low birthweight - below 2,500 grams compared with 6.8% in England.

Reduce the numbers of children in care

Other cities in the country with a similar economic profile to Stoke-on-Trent have got far less children in care, therefore there will be access to early help in communities as part of the enhanced Family Support offer.

Stoke-on-Trent City Council together with four partners will deliver Family Matters, a multi-agency programme to include the NHS, voluntary and community sector and businesses to provide families access to all the advice, tips and opportunities they need to give their children the best start in life.

Target Outcome	Aspiration	Measure(s)
A family support programme which can result in less children being at risk of or being taken into care	Reduce the number of children in care to close the gap to the statistical neighbour average	As at 31/03/24 there were 1156 children in care in Stoke-on-Trent - the statistical neighbour average was 561.

13

Target Outcomes & Measures: Supporting Family Life

Children achieve and sustain a healthy weight

The prevalence of obesity within Stoke-on-Trent is worse than the England average for both children, young people and adults. Unhealthy weight and obesity can have a significant impact on a child's quality of life, often leading to psychological problems and serious health conditions in later life.

Improvements in nutrition and access to physical activity are key factors and we will work closely with schools, sports clubs, cultural groups, and the voluntary and community sector.

Target Outcome	Aspiration	Measure(s)
Children and young people achieve and sustain a healthy weight	Reduce the number of children with prevalence of overweight (including obesity) in line with the England average *Note – prevalence of obesity in boys is higher than girls for both age groups and twice as high for children living in the most deprived areas.*	According to 2022/23 figures in Stoke-on-Trent 25.3% of 4-5 year olds were overweight (against the England figure of 21.3%) and for 10-11 year olds the prevalence was 42.8% in Stoke-on-Trent (against the England figure of 36.6%).

Effectively manage long term conditions of children

To improve care and outcomes for children and young people with asthma, epilepsy and diabetes and reduce variation in treatment and care to ensure the right support is provided to enable them to manage their condition close to home.

We will strive to increase competency and capability across all settings that have contact with a child or young person who has a long-term condition. This will help us to improve care and outcomes for children and young people to improve consistency in treatment and care.

Target Outcome	Aspiration	Measure(s)
Management of long term conditions to reduce avoidable admissions	Reduction in the number of u19's with common conditions that are admitted to hospital in line with England averages	Asthma – 152.7 against England average of 122.2 Diabetes – 56.2 against England average of 52.4 Epilepsy – 112.5 against England average of 74.1

14

Target Outcomes & Measures: Supporting people to live independently

Reduce long term adult social care

Specifically the over 65's, to include people with physical and learning disabilities, those with long term mental health conditions and older people suffering frailty.
We will work in partnership to connect people with communities, and communities with services to enable people to live independent lives. The partnership between health and social care will be strengthened to promote integration and choice to improve the experience of the city's residents. We will enable people to stay well, safe and independent at home for longer **and provide the right care in the right place at the right time.**

Target Outcome	Aspiration	Measure(s)
Support people to live independently and have greater control over their lives and futures	Reduce unplanned admission for ambulatory sensitive chronic conditions	NHS Outcome Framework indicator 2.3i
	Reduce emergency hospital admissions due to falls in people aged 65+	Emergency hospital admissions due to falls per 100,000 population. 2023-2024 rate TBC.
	Reduce admission to long term residential care for over 65's	Permanent admissions to residential care per 100,000 population. 2023-2024 rate of admissions was 521.
	Increase discharge from hospital to usual place of residence	According to 2023-2024 data, 95% returned to their normal place of residence.
	Increase the number of people aged 65+ discharged who are still at home after 91 days	2023-2024 planned performance target is 80.1%.

Reduce premature deaths amongst the under 75's

Avoidable deaths are those that are either preventable or treatable. A death is considered preventable if it can be avoided through effective public health and primary prevention interventions and a treatable death is a premature death which could be avoided through timely and effective health care interventions. **We will work with our partners to understand and effect improved health outcomes to close the gap between the under 75 mortality rate from preventable causes.**

Target Outcome	Aspiration	Measure(s)
Reduce premature deaths amongst the under 75's	Reduce the u75 mortality rate from causes considered preventable in line with England average	215 deaths in 2022 against the England average of 155

15

Target Outcomes & Measures: Supporting physical wellbeing

Despite an improving trend in the number of adults who are doing the recommended weekly physical activity levels, to close the gap on the national figure there needs to be further improvement in order for residents to benefit from preventative health measures of keeping active.

We will continue to promote good physical health by seeking to engage with communities, groups and individuals and who have previously had no, or limited participation, in the range of physical activities or active leisure opportunities the City has to offer. We will encourage more movement in the daily lives of our residents through initiatives and partnerships that improve access to and availability of a wide range of physical activities. By doing so, we not only contribute to healthier, more vibrant communities, but also create environments where residents can develop valuable skills, strengthen social ties, and improve their overall quality of life.

Target Outcome	Aspiration	Measure(s)
Physical activity levels increase to improve health outcomes and reduce the number of economically inactive adults	Increase the number of adults who walk or cycle for transport at least 3 times each week in line with the England average	35% in 2023/24 against England average of 45.8%
	Increase in the number of adults doing recommended physical activity levels (150 mins pw) in line with England average	56.8% in 2022/23 against England average of 63.1%
	Reduce the numbers of people of working age who are unable to work for health reasons (long term sick) in line with the regional average.	27.5% in 2023 against West Midlands average of 29.3%

16

Target Outcomes & Measures: Supporting mental wellbeing

It is widely reported that the covid pandemic had an adverse effect on the mental health of children and young people. According to a recent nationwide study 1 in 6 children aged 5 to 16 were identified as having a probable mental health problem in July 2021, a huge increase from 1 in 9 in 2017[ii].

Children and young people will be supported by the Mental Health Leads in Education Network which serves to engage with schools and education providers to support children and young people to achieve positive mental health and wellbeing outcomes. As the network grows we will strive to ensure young people need get the help they need as quickly as possible and a choice as to what support they receive.

Target Outcome	Aspiration	Measure(s)
Young people can achieve their potential and enjoy good emotional wellbeing and positive mental health	TBC	TBC
Improvement in adult mental health and reduction in suicide rates	Suicide rate (per 100,00 population) in line with England average	16 in 2020/22 against England number at 10.3
	Reduction in emergency hospital admissions as a result of self-harm (all ages) Standardised rate per 100,000	At 126.4 in 2022/23 the City is in line with the national average but planned reduction to 105
Improvement in personal well-being	Average ratings of life satisfaction - out of 10 - in line with the England average	Average of 7.16 against England average of 7.44

17

Target Outcomes & Measures:
Reducing harms from addictions

Addiction is most commonly associated with gambling, drugs, alcohol and smoking though it is possible for individuals to be addicted to just about anything, though in the case of drugs, alcohol and nicotine, these substances affect the way you feel, both physically and mentally. It is clear that addictions bring harm to individuals, their families, close associates and wider society therefore our ambition is to reduce the harms caused by addiction. There is a high prevalence of opiate, crack use in Stoke-on-Trent and challenges around the use of synthetic cathinone's (monkey dust). Addiction issues are exacerbated by unmet mental health needs and there is a high incidence of drug and alcohol deaths.

We will strengthen pathways between social care and Stoke-on-Trent Community Drug and Alcohol Service (CDAS) with co-located substance misuse and lived experience workers, and develop the partnership between housing providers and CDAS to provide tenants with drug and alcohol support. Plans will be developed to improve mental health support for people experiencing co-occurring drug and alcohol conditions and links with the Family Support Programme, the rough sleeper team and Housing Services will be strengthened.

Target Outcome	Aspiration	Measure(s)
Deliver an effective partnership approach to tackling drug and alcohol abuse and dependency	Reduce the number of alcohol-related hospital admissions (per 100,000 population) in line with England average	2562 locally in 2022/23 vs England average of 1705.
	Reduce alcohol-related mortality (per 100,000 population) in line in line with the England average	54.2 locally in 2022 vs England average of 39.7
	Reduce deaths from drug misuse (per 100,000 population) in line with the England average	10.8 locally in 2020-22 vs England average of 5.2

[i] Joint Strategic Needs Assessment (JSNA) | Joint Strategic Needs Assessment (JSNA) | Stoke-on-Trent

[ii] Mental Health Statistics UK | Young People | YoungMinds

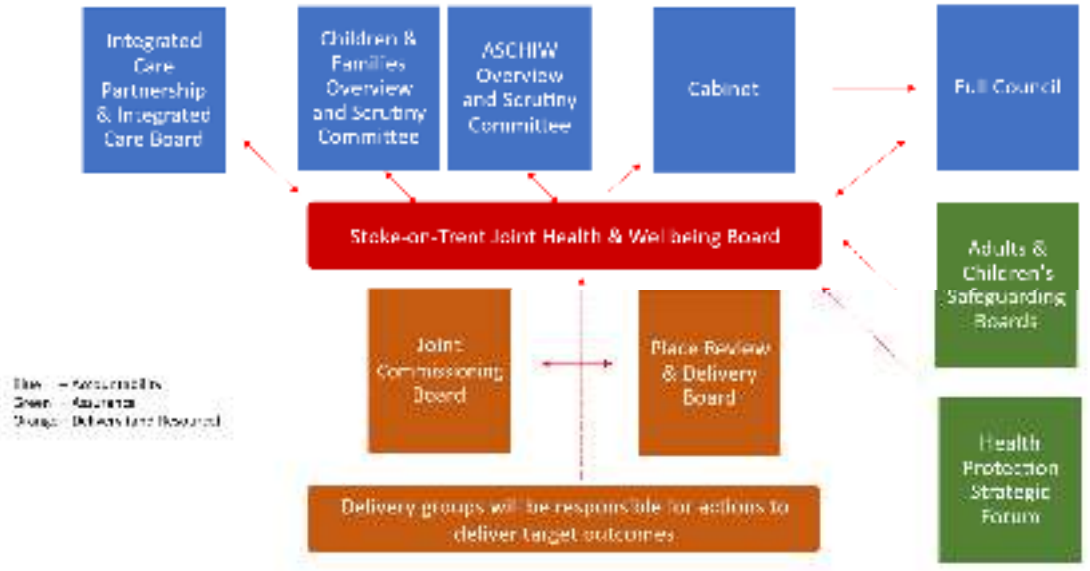
BOARD MEMBERS LOGOS TO GO HERE…..

Governance and Delivery Assurance

Implementation of the strategy will be overseen by the Health and Wellbeing Board, with specific delivery groups delivering actions to meet the outcomes of the strategy. Each partner agency will consider the strategy through their internal governance arrangements to support and enhance the accountability role of the Health and Wellbeing Board.

Assurance will take the form of quarterly reports detailing the outputs from the delivery groups or stakeholder/partner organisations. These will detail progress towards the strategy's outputs and outcomes. Additional reports may be requested by the Health and Wellbeing Board for specific measures as required.

Figure 4 An illustration of the Health and Wellbeing Board's governance/reporting structure.



The Health and Wellbeing Board is established as a committee of the Council in accordance with Section 194 of the Health and Social Care Act 2012. The Board carries out executive functions and it's terms of reference and membership are set out in the council's constitution.

The Adult Social Care Health Integration and Wellbeing Overview and Scrutiny Committee and the Children and Families Overview and Scrutiny Committee have a key relationship with the HWBB as they consist of democratically elected local councillors who are able to voice the views of constituents, and in the case of ASCHIW Overview and Scrutiny Committee, hold relevant NHS bodies and health service providers to account by reviewing and scrutinising health matters relating to the planning, provision and operation of the health service in Stoke-on-Trent. Both committees are able to make suggestions to the Stoke-on-Trent Health and Wellbeing Board.

The following boards/partnerships/forums have a strong relationship to the Health and Wellbeing Board, in terms of resource and delivery, however this list is not exhaustive as there will be a number of delivery groups responsible for actions to deliver target outcomes.

- Integrated Care Partnership and Integrated Care Board - to jointly determine the integrated approach that will best deliver holistic care and prevention activities including action on wider determinants in our communities;
- Cabinet - The Health and Wellbeing Board is established as a committee of the Council in accordance with Section 194 of the Health and Social Care Act 2012. The Board carries out Executive functions and it's terms of reference and membership are set out in the council's constitution.
- Joint Commissioning Board - oversees the commissioning of health and care services in Stoke on Trent and sets the outcomes and resources available to deliver those outcomes;
- Place Review and Delivery Board - oversees the delivery of health and care services in the City and ensures they are of a good quality and accessible for all residents and patients;
- Health Protection Strategic Forum - oversees action to protect residents and patients of Stoke on Trent covering infectious diseases, immunisations, screening and links with the Local Health Resilience Forum.

Healthwatch Stoke-on-Trent ensures the views and experiences of patients, carers and other service users are taken into account to help to inform where services are doing well or where they could be improved. Through evidence-based feedback Healthwatch can help to inform and shape the commissioning and delivery of local health and social care services and influence needs assessments and strategies.

The work of the Board is underpinned by population health management, which informs decision making and helps track the changing needs of our communities.

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th October 2024
Report Title:	Appraisal and Revalidation Annual Report	**Agenda Item:**	8.
Author:	Adrian Large, Deputy Chief Medical Officer (People)		
Executive Lead:	Dr Matthew Lewis, Chief Medical Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Executive Summary

The Responsible Officer (RO) is obliged, according to the RO regulations, to submit an annual board report and statement of compliance and then forward this to NHS England (NHSE). This contains details of revalidation information, appraisal compliance, and any issues relating to RO responsibilities within the organisation. The key messages in this year's report are summarised as follows:

- Arrangements for appraisal and revalidation are of high quality and in line with the Responsible Officer regulations.
- Appraisals are conducted in accordance with national standards and a detailed quality assurance exercise has demonstrated that appraisals are of high quality.
- The Trust needs to recruit additional appraisers to provide resilience to an increase in medical recruitment and losing appraisers to retirement - a recruitment drive will start shortly.
- A project is underway focussing on improving educational supervision and mentorship of locally employed doctors and international medical graduates.
- Effective systems are in place for monitoring the conduct and performance of all doctors and, where escalation is required, an appropriate consensus is reached to ensure that action is timely appropriate, and free from bias.
- A proposal for establishment of a Responsible Officer Advisory Group (ROAG) aligned with NHSE and General Medical Council (GMC) guidance to replace the current Professional Standards and Clinical Conduct Committee (PSCCC) is currently passing through the appropriate Trust Committees for ratification.
- The process for appointing a new Lead Appraiser is underway

Key Recommendations

To note the report and approve the findings.

Annex A
Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*
Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative
While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General
The board/executive management team of University Hospitals of North Midlands, can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Dr N Coleman stepped down from the role of Responsible Officer (RO) in March 2024.
Comments:	Dr Matthew Lewis, Chief Medical Officer (CMO) is the current Responsible Officer (RO).
Action for next year:	Dr Adrian Large, Deputy CMO (People) will take over the role of RO from 1 November.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year:	
Comments:	Sufficient resources are in place to carry out the responsibilities of the role.
Action for next year:	

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	
Comments:	The list of licensed medical practitioners is regularly reviewed on the GMC Connect application and updated to ensure it is accurate.
Action for next year:	

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	
Comments:	All relevant policies are updated as part of the Trust business cycle.
Action for next year:	

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	
Comments:	No recent peer review has been undertaken.
Action for next year:	Dr A Large, Deputy CMO (People) will organise an external peer review to be completed and reported on before September 30, 2025.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	
Comments:	All the Trust's doctors are supported with their appraisal and revalidation processes by the Deputy CMO (People), the Lead Appraiser, four Senior Appraiser and Medical Staffing colleagues. The Trust has recently appointed two Consultant Physicians as leads for Locally Employed Doctors (LED) and International Medical Graduates (IMG). Their remit includes developing a dedicated framework and systems for induction, continuing professional development, appraisal and revalidation for these groups of doctors.
Action for next year	To implement a dedicated framework and systems for induction, continuing professional development, appraisal and revalidation for LED and IMG doctors.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	
Comments:	Appraisers are allocated to all new appointments and rotated every 3 years for existing colleagues. The appraisal format is consistent with the current GMC guidance and is a streamlined process that puts focus on wellbeing. There has been a reduction in pre-appraisal paperwork requirements leading to a reduction in the burden on doctors. The RO expects the information presented to be limited to that which directly supports the doctor's clinical practice and should concentrate on clinical effectiveness, complaints and adverse events, and have a strong emphasis on personal development and the doctor's wellbeing.

Action for next year:	Appointment of a new Lead Appraiser to replace the current incumbent who intends to step down from the role in October.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	
Comments:	There are regular electronic reminders regarding appraisal and additional contact if deadlines are missed. All doctors non-compliant with the appraisal process are approached by the Lead Appraiser for him to understand the reason for non-compliance. The Lead Appraiser regularly updates the RO on cases of concern.
Action for next year:	

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	
Comments:	There is an agreed and approved medical appraisal policy in place.
Action for next year:	

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	
Comments:	There is currently a modest shortage of appraisers but this has not led to any appraisals being missed.
Action for next year:	The Deputy CMO (People) will work with the new Lead Appraiser on a recruitment drive aimed at correcting the shortage.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	
Comments:	The Lead Appraiser takes responsibility for ongoing training of the appraiser team, organises training events for them and supports review of their performance.
Action for next year:	

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	
Comments:	The Lead Appraiser regularly audits the appraisers' performance. Each of the appraisers has one, randomly selected appraisal scored by the Lead Appraiser using a quality assurance tool. The last audit showed 87 out of 114 appraisals scored 75% or more.
Action for next year:	The Deputy CMO (People) will work with the new Lead Appraiser on enhancing the quality assurance process to include an analysis of feedback from appraisees.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	
Comments:	The Trust is fully complaint with this standard. Recommendations are made promptly and in accordance with the GMC requirements. Each recommendation, including any information relevant to it, is recorded on the electronic appraisal system (Allocate eAppraisal) by the RO or his delegate.
Action for next year:	

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	
Comments:	Positive recommendations are not routinely communicated to the doctor in advance. Deferral recommendations (or very rarely declarations of non-engagement) are always preceded by written communication with the doctor in advance by the Deputy CMO (People). This communication contains a detailed explanation of the reasons for the proposed recommendation. It is supportive in tone and offers detailed advice, guidance and signposting to additional assistance.
Action for next year:	

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	
Comments:	UHNM has a strong framework for clinical governance with a tightly organised reporting infrastructure and effective implementation of agreed actions.
Action for next year:	

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	
Comments:	There are multiple sources of information used by the RO/CMO and Deputy CMO (People). These include participation in national and local audit, data from the Risk Management Panel, clinical governance forums, data from mortality reviews, structured judgement reviews and never events etc. Concerns about medical practitioners come from a variety of sources including local concerns, grievances, complaints, and the Freedom to Speak Up Guardian. These are systematically triaged, considered by a decision-making group and acted upon appropriately.
Action for next year:	Reform of current arrangements and establishment of a Responsible Officer Advisory Group (ROAG) aligned with NHSE and GMC guidance to replace the current Professional Standards and Clinical Conduct Committee (PSCCC).

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	
Comments:	All relevant information is provided for doctors in electronic document format which can be uploaded to the appraisal portfolio software provided by the Trust.
Action for next year:	

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	
Comments:	All concerns reaching the RO/CMO and Deputy CMOs are considered by a decision-making group (DMG) which uses a locally agreed decision-making algorithm to guide next steps. This algorithm was developed based on NHSE and GMC guidance on responding to concerns about medical practice. Using it, the DMG triages concerns according to seriousness, co-ordinates fact finding, considers evidence from fact finding and decides on appropriate responses including liaison with other agencies such as the GMC, PPA, Safeguarding Team, Police etc.
Action for next year:	

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	
Comments:	Currently all concerns regarding medical practice and practitioners are referred to the Professional Standards and Clinical Conduct Committee (PSCCC) where they are discussed

	in detail and appropriate actions agreed. This committee has wide representation to ensure that the RO can establish a broad consensus on action. A highlight report is prepared and escalated to the Trust's People, Culture and Inclusion Committee.
Action for next year:	The PSCCC will be replaced by a Responsible Officer Advisory Group (ROAG)

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	
Comments:	Requests for information from other organisations are reviewed by the revalidation admin team and information regarding complaints or concerns are sought from the clinical governance team and from the R.O. directly. These are processed quickly and efficiently.
Action for next year:	

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	
Comments:	Any concerns raised from a variety of sources are initially discussed by a decision-making group with the RO/CMO or Deputy CMO (People) always present. Where further action is taken this is managed according to our local disciplinary policy for Medical and Dental Staff which is consistent with the national MHPS process. We now have sufficient trained case investigators to ensure formal processes are not unnecessarily prolonged and all concerns are discussed in detail at meetings of the Trust's Professional Standards and Clinical Conduct Committee (PSCCC) where there is appropriate representation to ensure freedom from bias and discrimination. Referrals to the GMC are routine checked for impartiality, taking diversity into consideration. This is done in accordance with GMC R.O. referral guidance and guidance published by NHSE.
Action for next year:	The PSCCC will be replaced by a ROAG.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	
Comments:	These requirement and opportunities, when identified, are discussed in the meetings of the Professional Standards and Clinical Conduct Committee which co-ordinates the appropriate cascading of any learning / improvement opportunities.
Action for next year:	The PSCCC will be replaced by a ROAG.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	
Comments:	Professional standards arrangements are regularly reviewed in meetings of the Professional Standards and Clinical Conduct Committee. E.g. At the last meeting a proposal for establishment of a ROAG (as per NHS guidance) was considered and ratified by the group.
Action for next year:	

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	
Comments:	All doctors employed by UHNM are subject to the mandatory NHS pre-employment checks. In addition, a medical practitioner information template form (MPIT) is used for all doctors who have had prior NHS employment.
Action for next year:	

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	
Comments:	The PSCCC (soon to be ROAG) reports to the People, Culture and Inclusion Committee (PCIC). The latter functions as a barometer for the culture of our processes for responding to concerns about medical practitioners and act as a mirror for the PSCC. In this way openness and fairness are promoted as vehicles to protect patients, support professionalism and improve quality of care.
Action for next year:	

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	
Comments:	The Trust is committed to building an inclusive workforce which is valued and whose diversity reflects the community it serves, enabling us to deliver the best possible healthcare service to our patients, service users and communities. The Trust's Equality, Diversity and Inclusion Policy provides a framework from which strategy, policy and procedures are developed. It sets the standards to enable the Trust to meet its duties in line with the Equality Act (2010), Public Sector Equality Duty (PSED) and the Human Rights Act (1998), as both an employer and health service provider. Based on this policy there are numerous, successful initiatives which focus on promoting compassion, fairness, respect, diversity and inclusivity.
Action for next year:	

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	
Comments:	The Trust's Analysing and Learning Policy (RM09) promotes openness, transparency and a non-blaming learning culture. This is backed up by the Trust's Risk Management Strategy (RM01), Complaints Policy (RM02), Claims Policy (RM06) and Adverse Incident Reporting and Investigation Policy (RM07). The Trust's policy for encouraging and supporting speaking up is based on the national 'Freedom to Speak Up Policy for the NHS'. We welcome speaking up and we listen. The Trust's message to workforce members is that by speaking up at work they will be playing a vital role in the continuous improvement of our services in the interest of all patients and staff. We want to hear about any concerns our staff have, whichever part of the organisation they work in. We know some groups in our workforce can feel they are not heard or can be reluctant to speak up. They could be an agency worker, bank worker, locum or student. We also know that staff with disabilities or those from a Black, Asian or minority ethnic background or from the LGBTQ+ community can face barriers to speaking up. The policy is for all our staff, and we want to hear all their concerns. An appropriate structural framework is in place to facilitate the proper implementation of the above policies e.g. A Restorative Just & Learning Culture (RJLC) Model which is a 4-step process for managing and improving our people practices. This model applies to all Trust investigations and encourages learning from adverse events and incidents in a way which is supportive and compassionate towards the people we work with. Healthy attitudes and behaviours around patient safety are strongly incentivised and monitored whilst the Trust foster's strong leadership behaviour to this end e.g. Formal training for clinical leaders on the impact of organisational culture on quality of care, access to care and service sustainability.
Action for next year:	

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	
Comments:	Mechanisms to allow such feedback include a BMA Local Negotiating Committee, Staff Surveys, Medical Workforce Group, Freedom to Speak Up Guardian, twice weekly meetings between divisional media directors, RO/CMO and deputy CMO and a formal complaints procedure. In addition the CMO/RO, Deputy CMO (People) and Chief People Officer have an 'open door policy' and welcome direct feedback from any member of the workforce.
Action for next year:	

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	
Comments:	The PSCCC (soon to be ROAG) evidences to it's overnight committee that its processes are transparent and fair and that they do not discriminate against individuals with protected characteristics. This includes measuring the potential for unfair impact of this nature and mitigating against it if identified.
Action for next year:	

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	
Comments:	The CMO / RO, Deputy CMO attend RO network events. The RO/CMO regularly engages with the higher-level RO quality review processes.
Action for next year:	

Section 2 – metrics

Year covered by this report and statement: 2023/24 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 29 September 2024	1033

2B – Appraisal (01 Apr 2023 – 31 Mar 2024)

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	707
Total number of appraisals approved missed	0
Total number of unapproved missed	250

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	174
Total number of late recommendations	1
Total number of positive recommendations	126
Total number of deferrals made	47
Total number of non-engagement referrals	1
Total number of doctors who did not revalidate	48

2D – Governance

Total number of trained case investigators	**TBC**
Total number of trained case managers	**TBC**

Total number of new concerns registered	**5**
Total number of concerns processes completed	**3**
Longest duration of concerns process of those open on 31 March	**889 days**
Median duration of concerns processes closed	**743 days**
Total number of doctors excluded/suspended	**4**
Total number of doctors referred to GMC	**3**

2E – Employment checks
Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	TBC
Number of new employment checks completed before commencement of employment	TBC

2F Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary
This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Actions still outstanding
Current issues
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th October 2024
Report Title:	2024 Workforce Race and Workforce Disability Equality Standard Reports	**Agenda Item:**	9.
Author:	Charlotte Lees, OD, Culture & Inclusion Business Partner		
Executive Lead:	Jane Haire, Chief People Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 2	**Improving our Workforce Sustainability and Organisational Culture**		**Ext 16**
	Cause	**If** we are unable to achieve workforce (people) sustainability through an effective long term workforce strategy and plan which is underpinned by a positive, inclusive organisational culture …	
	Event	**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 …	
	Effect	**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.	

Executive Summary:

Situation

The annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are mandated through the NHS Contract. Each Standard measures a set of specific indicators that enable NHS organisations to compare the workplace and career experiences of Black, Asian and Minority Ethnic colleagues compared to white colleagues and Disabled staff compared to their non-disabled colleagues.

The WRES and WDES indicators incorporate data from the following primary sources: the NHS Staff Survey 2023, NHS Electronic Staff Record (ESR) and local HR and recruitment systems. The UHNM response rate for the 2023 staff survey was 45% with 18.7% of colleagues stating that they were from a Black, Asian or Minority Ethnic background, this compares to the peer average of 21.9%. 26.9% of all respondents stated that they had a physical or mental health condition or illness lasting or expected to last 12 months or more. This compares to the peer average of 24.3%.

Organisations should use the information to develop and publish an action plan to reduce the workforce disparities experienced by colleagues from these marginalised groups. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of race and disability equality.

Background

National evidence tells us that Black, Asian and Minority Ethnic and Disabled people and those with long term conditions are:

- less likely to be appointed from shortlisting
- more likely to experience harassment, bullying or abuse from all sources
- less likely to feel that they have equal opportunities for career progress or promotion
- underrepresented in senior pay bands

Assessment

WRES: This year's WRES indicators tell us that we are not making quick enough or sufficient enough progress in tackling racial inequalities and closing the gap between the experiences of colleagues from Black, Asian and Minority Ethnic backgrounds, which remain significantly less positive than white colleagues. Whilst there has been improvement in 6 of the 9 WRES indicators, our data is below that of peer comparator averages.

The indicators that have improved are:

- 3% increase in Black, Asian and Minority Ethnic representation
- .02 ratio reduction in the likelihood of Black, Asian and Minority Ethnic colleagues entering the formal disciplinary process
- .02 ratio improvement in the likelihood of white staff accessing non - mandatory training/CPD compared to Black, Asian and Minority Ethnic staff
- 7.2% reduction in the percentage of Black, Asian and Minority Ethnic colleagues reporting experience of bullying, harassment or abuse from patients, relatives and the public compared to last year
- 4.7% improvement in the percentage of Black, Asian and Minority Ethnic colleagues experiencing bullying, harassment or abuse from other staff
- Improved ethnically diverse board representation

Indicators that have deteriorated are:

- 0.5% of Black, Asian and Minority Ethnic colleagues that believe that the Trust offers equal opportunities for career progression or promotion
- Deterioration in the likelihood ratio of Black, Asian and Minority Ethnic applicants being appointed from shortlisting compared to white applicants
- Increase of 0.6% in Black, Asian and Minority colleagues reporting discrimination at work from a team leader/line manager

WDES: The 2024 data analysis demonstrates continued year on year improvement in the workforce experiences of colleagues with a disability or long term condition (9 of the 10 WDES indicators have improved) reflecting the deliberate focus we have placed on workplace adjustments and formalising these within policy and process. Improvements include:

- 3.11% reduction in the percentage of colleagues with a disability reporting experience of bullying, harassment or abuse from patients, relatives and the public compared to last year
- 1.2% of disabled colleagues experiencing bullying, harassment or abuse from other staff
- 0.8% increase in disability representation across the organisation as recorded on ESR
- 3.9% reduction in the percentage of colleagues with a disability reporting experience of bullying, harassment or abuse from managers in the last 12 months
- 5.8% improvement in colleagues with a disability reporting feeling pressured by their manager to come into work, despite not feeling well enough to perform their duties
- 1.4% increase in the percentage of colleagues with a disability who are satisfied with the extent to which the organisation values their work
- 2.7% increase in the percentage of disabled colleagues who reported that the organisation put reasonable adjustments in place to enable them to carry out their work

The indicator that has deteriorated is:

- 0.59% deterioration in the percentage of colleagues with a disability that believe that the Trust offers equal opportunities for career progression or promotion

Action Plan Our UHNM Staff Networks are integral to shaping the actions we identify to tackle the discrimination, bias and inequity experienced by people from marginalised groups and meet our obligations under the Public Sector Equality Duty, the aims of the NHS EDI Improvement Plan and our UHNM EDI Strategy. In partnership with our networks, we have identified the following priority actions for 2024-25:

- Establishment of a Race Equality Task & Finish Group, chaired by Chief Nurse and Ethnic Diversity Staff Network Sponsor Ann Marie Riley. The group will utilise the expertise of our new cohort of WRES Champions along with our Ethnic Diversity Network leads and key stakeholders from recruitment, employee relations and learning & development to take an Improving Together methodology approach to implement and monitor the priority actions of:
    - Debiasing recruitment & selection processes
    - Improving equity in career development and promotion
    - Tackling harassment, bullying and abuse from all sources

Our disability inclusion actions will focus on:

- Embedding the Reasonable Adjustments Policy and processes
- Empowering colleagues to have positive and confident conversations about long term conditions
- Increasing awareness and support for colleagues with neurodifferences

Furthermore the Trusts Equality, Diversity and Inclusion Group is being strengthened to become an EDI Steering Group to enhance the reporting and governance around our workforce EDI activities.

In summary, this report demonstrates some areas for celebration with notable improvements in colleague experiences, particularly in the WDES indicators, but acknowledges that there remains much to do to address inequity in all aspects of workplace experiences for colleagues. Achieving equality requires targeted listening and action to overcome specific inequalities, discrimination and marginalisation and this is the intention of our action plans this year.

Progress will be measured by improved performance in the 2024 National Staff Survey, 2025 WRES and WDES submissions, divisional EDI dashboards and the monitoring of other relevant metrics including the lived experiences of our diversity staff network membership.

Our proposed assurance assessment is:

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

Key Recommendations:

This report has been presented to Executive Workforce Assurance Group and People, Culture and Inclusion Committee for review and approval. This report is agreed to have partial assurance and Trust Board is asked to note the associated action plans, which identify the priorities we have identified to improve the workplace experiences of our ethnically diverse colleagues and those with a disability and long-term health condition.

University Hospitals of North Midlands NHS Trust

Workforce Equality Standards
2024 Reports

Introduction

The NHS was established on the principles of social justice and equity, but evidence tells us that the treatment of colleagues from Black, Asian and Minority Ethnic (BAME) backgrounds and people with disabilities and long term conditions can fall short. Inequalities in any form are at odds with the values of the NHS and we know that fair treatment, inclusion and feeling safe to raise concerns and make suggestions enhances the sense of belonging for our colleagues and is directly linked to better clinical outcomes and better experience of care for our patients.

The national evidence from each workforce race and workforce disability equality standard reports over the years has shown that ethnically diverse colleagues and colleagues with a disability or long term condition are less well represented at senior levels, have measurably worse day to day experiences of life in NHS organisations, and have more obstacles to progressing in their careers.

The workforce equality standards have been designed to deliver tangible and lasting improvements in race and disability inclusion. NHS providers are expected to show progress against a number of indicators of workforce equality. The WRES and WDES is intended to provide a platform and direction to encourage and help NHS organisations to:

- Reduce the differences in the treatment and experience evidenced by these marginalised groups
- Compare not only their progress in reducing the gaps in treatment and experience but to make comparisons with similar organisations about the overall level of such progress over time
- Identify and take necessary remedial action on the causes of disparities in the indicator outcomes
- The WRES and WDES are mandated annually as part of the NHS Standard Contract. NHS Organisations are required to publish their data and action plans on their public facing website.

Note on Terminology: The terms Black, Asian and Minority Ethnic (BAME) and ethnically diverse will be used throughout this report to describe colleagues from ethnically diverse backgrounds. We should recognise however that experiences can vary between different ethnic groups. The term Global Majority is becoming increasingly popular to refer to people who are not white British and an alternative to terms that are seen as racialised.

NHS EDI Improvement Plan

This NHS EDI Improvement Plan, launched in June 2023 builds on the People Plan and identifies six high impact actions organisations across the NHS can take to address the prejudice and discrimination – direct and indirect, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

UHNM EDI Strategy Workforce Priorities:

1. To listen to, understand and learn from the experience of all staff
2. To respect and value all colleagues and their contribution and have a strategic focus on dignity and respect
3. To develop a culture of inclusive and compassionate leadership
4. To ensure that people are recruited, trained and promoted according to their abilities and in the proportions one would expect for the populations represented

The actions we have taken to advance race and disability equality during 2022/23

During 2023-24, we have undertaken the following actions and activities in partnership with our equality staff networks to ensure we listen to and act upon the voices of ethnically diverse colleagues and colleagues with a disability/long term condition:

- Created our Anti Racist Statement
- Reviewed recruitment, disciplinary and speaking up processes based on learning from the Michelle Cox Employment Tribunal
- Ensuring EDI is embedded within our governance and decision making spaces via our Race Equality Code actions
- Supported five colleagues through the WRES Champions Programme who will now support the organisation as members of the Race Equality Task & Finish Group
- Increased the frequency of 'Our NHS People' inclusivity masterclass to monthly
- Introduced an Anti-Racist masterclass for our Gold and Platinum Connects Leadership Programme
- 1,351 colleagues including 58% of all colleagues identified as supervisors in ESR have completed the ENABLE programme designed to nurture inclusive, appreciative leadership within UHNM
- Introduced the See ME First initiative – a visible pledge and commitment of allyship

- Raised awareness through a range of events from our Inclusion Calendar including Race Equality Week, Black History Month, Show Racism the Red Card Events
- Introduced the Reasonable Adjustments Policy, with the aim of increasing knowledge and understanding of the importance of equity and meeting individual needs to enable colleagues with disabilities and long term conditions to reach their potential
- Reviewed the Capability Policy and the Sickness Absence Management Policy from a disability lens and updated the policies with the feedback from our Network members

- Revised our mandatory EDI training with increased focus on disability inclusion
- Began our work on Confident Conversations, a project to empower colleagues with disability/LTC to start the discussions about what support they need at work.
- Held our first Disability Inclusion Conference with a spotlight on neurodifference inclusion and adjustments based on individual need
- Established a Flexible Working Task & Finish Group which has identified and started implementing actions to make flexibility a reality for everyone
- Increased the number of Disability Champions across the organisation
- Implemented the refreshed Performance Development Review (PDR) process as a supportive wellbeing conversation and linking the review with the Tailored Adjustments Plan to ensure colleagues have the right support and adjustments in place to increase sense of belonging and engagement and to reach performance objectives and career aspirations
- Used national campaigns such as Disability History Month to raise understanding and awareness of disability inclusion and to place positive value in the employment of disabled people
- Continued the success of the Project Search internship programme, which since 2018 has helped 21 young people with disabilities and learning difficulties secure paid work
- Launched Mental Health First Aid training with 30 accredited practitioners
- Secured Disability Confident 'Employer' status, following a self-assessment review by our Disability & Long Term Conditions Network

Workforce Race Equality Standard (WRES) 2024

Key Findings from the 2024 WRES:

There has been an increase in the number of Black, Asian & Minority Ethnic colleagues with a headcount of **3,347** (an increase of 574) in the last year, with representation in the workforce increasing from **23.5%** to **26.6%**

White applicants are **1.72 times** more likely to be appointed from shortlisting than Black, Asian & Minority Ethnic applicants

29.9% of **Black, Asian & Minority Ethnic colleagues** reported experiencing harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public in the last 12 months (down by 7.2% from **37.2%** in 2022).

41.3% of Black, Asian Minority Ethnic colleagues believe our trust provides equal opportunities for career progression or promotion compared to **59.9%** of White colleagues

11% of Trust Board members are from a Black, Asian or Minority Ethnic background

A higher percentage of ethnically diverse staff **(21.9%)** than white staff **(7.5%)** report experiencing discrimination from other staff in the last 12 months

Black, Asian & Minority Ethnic colleagues are **less likely** to enter a formal disciplinary process compared to white staff, with a metric of **0.76**

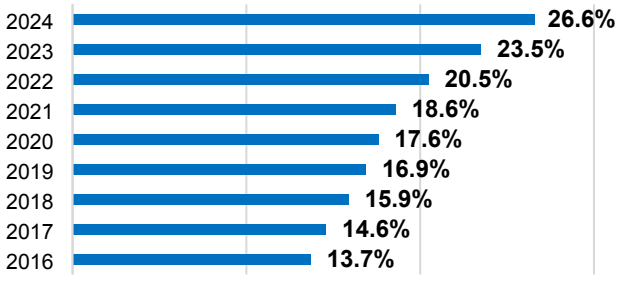
7.7% of colleagues in pay bands 8a and above are from Black, Asian & Minority Ethnic heritages. Significantly lower than the overall organisation

Black, Asian & Minority Ethnic colleagues represent **25.0%** of our **Clinical** Workforce **9.0%** of our **Non-Clinical** Workforce and **66.7%** of the **Medical & Dental** workforce

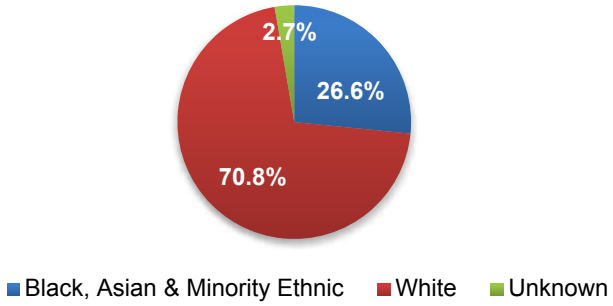
WRES Indicator 1

Percentage representation by ethnicity at each AfC pay band, amongst non-clinical staff, clinical staff and within the Medical & Dental professional group

Black, Asian & Minority Ethnic Representation at UHNM Trend



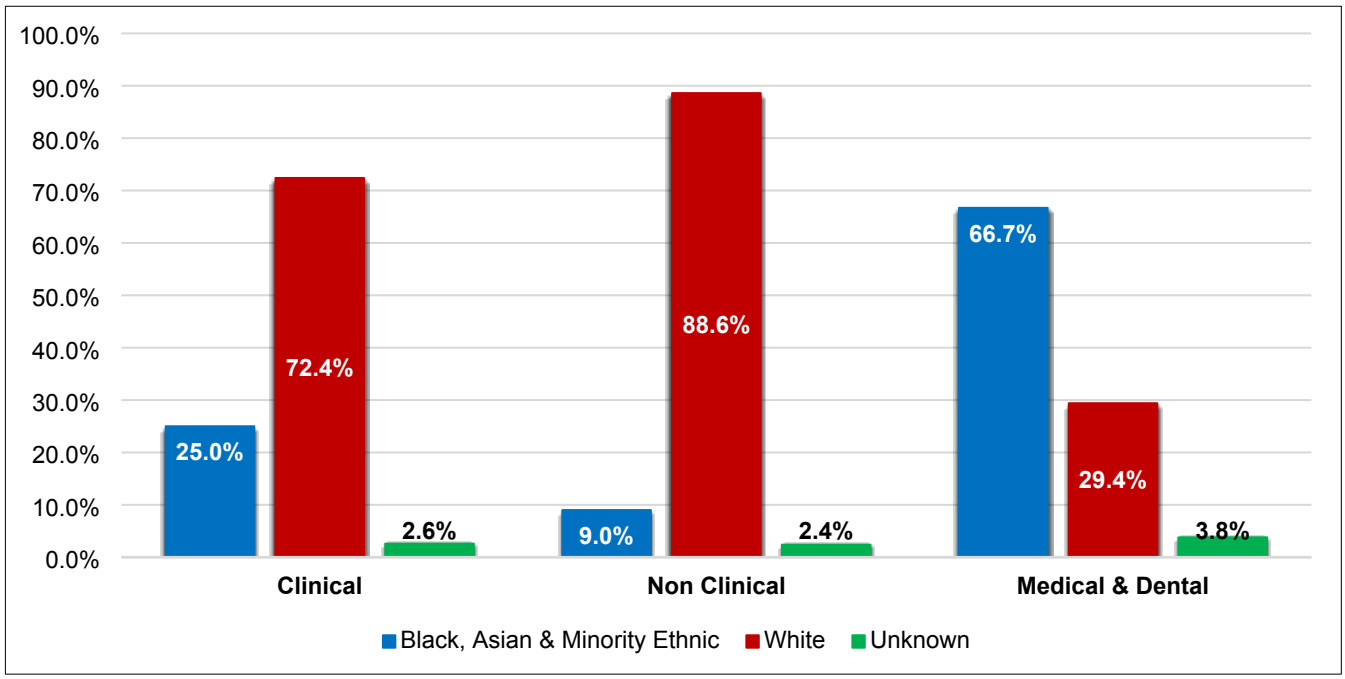
Ethnicity Representation at UHNM - 31st March 2024



At 31st March 2024, Black, Asian and Minority Ethnic colleagues represented 26.6% of our overall workforce (3,347 people). This is an increase of 574 compared to the previous year.

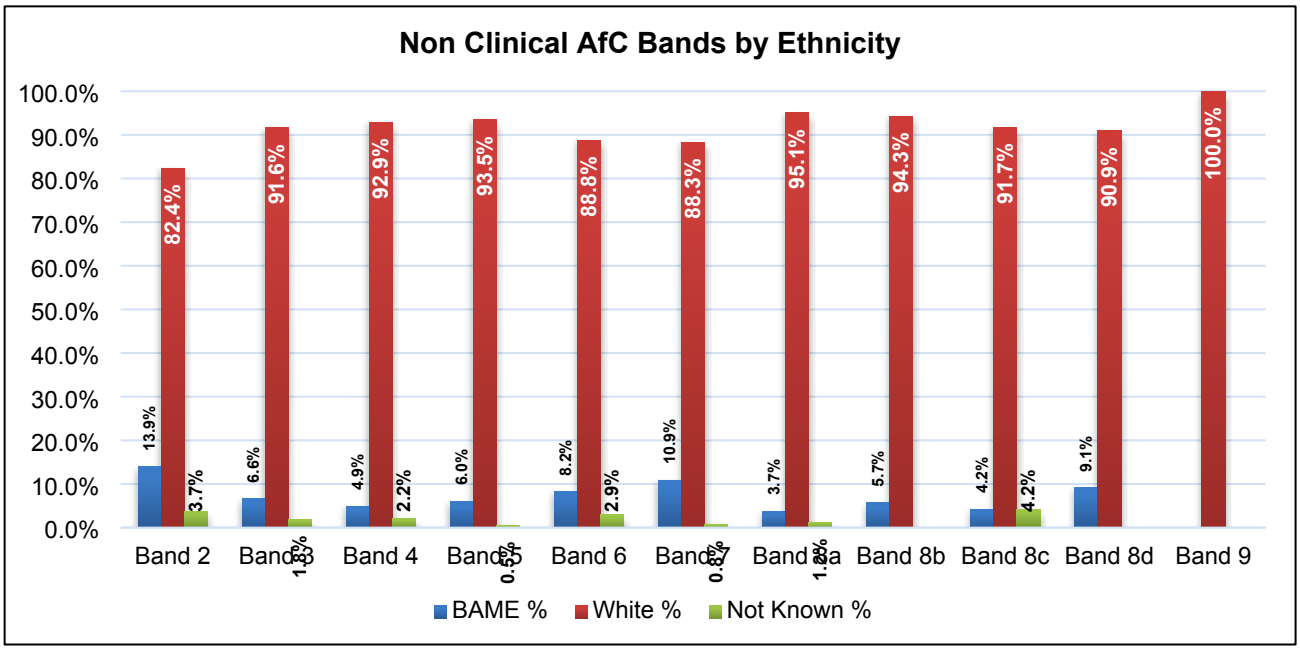
The most recent National WRES Data Report (2023) states that 26.4% of the workforce across all NHS trusts came from a Black, Asian and Minority Ethnic background (380,108 people). This is an increase of 43,070 (13%) from the previous year.

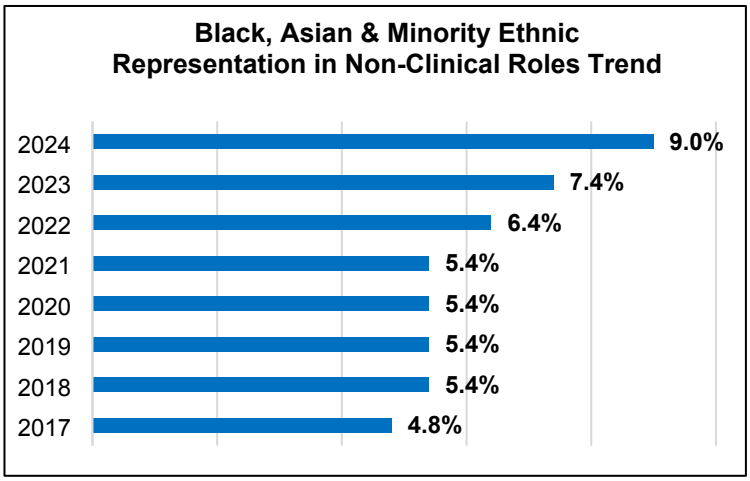
Percentage representation by ethnicity in professional groups at UHNM:



The most significant increase in representation is within Clinical AfC Bands, where ethnically diverse representation has increased by 414 people, most notably in Bands 2 (+ 142), Band 5 (+245), Band 6 (+37) and Band 7 (+ 20). This may be a reflection of the increase in international recruitment undertaken during 2023-24.

Percentage representation by ethnicity in AfC non-clinical pay bands:

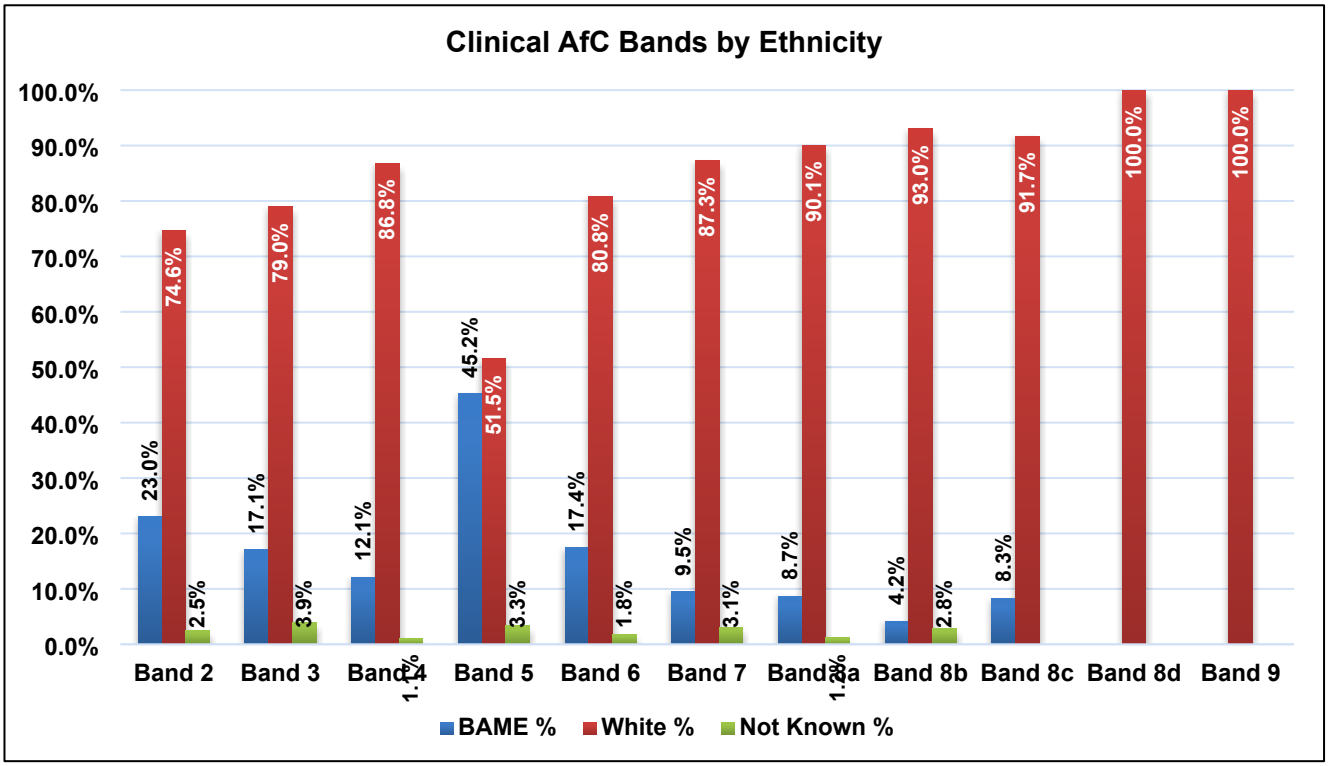


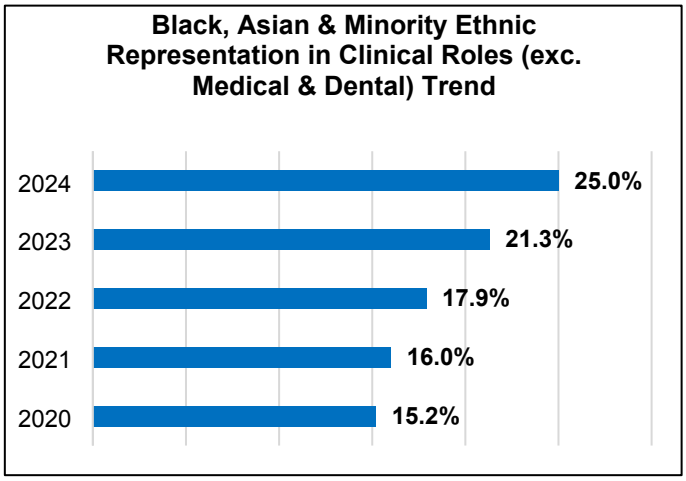


Black, Asian and Minority Ethnic representation in non-clinical roles has increased by 1.6% on the previous year, which is the largest increase we have seen since we began reporting the WRES. The current representation of 9% is below the ethnically diverse representation of 16.6% in Stoke on Trent but above that of Staffordshire (6.3%).

Nationally, the most recent data from 2023 shows that in non-clinical roles, BAME representation was at 17.3%.

Percentage representation by ethnicity in AfC clinical pay bands:

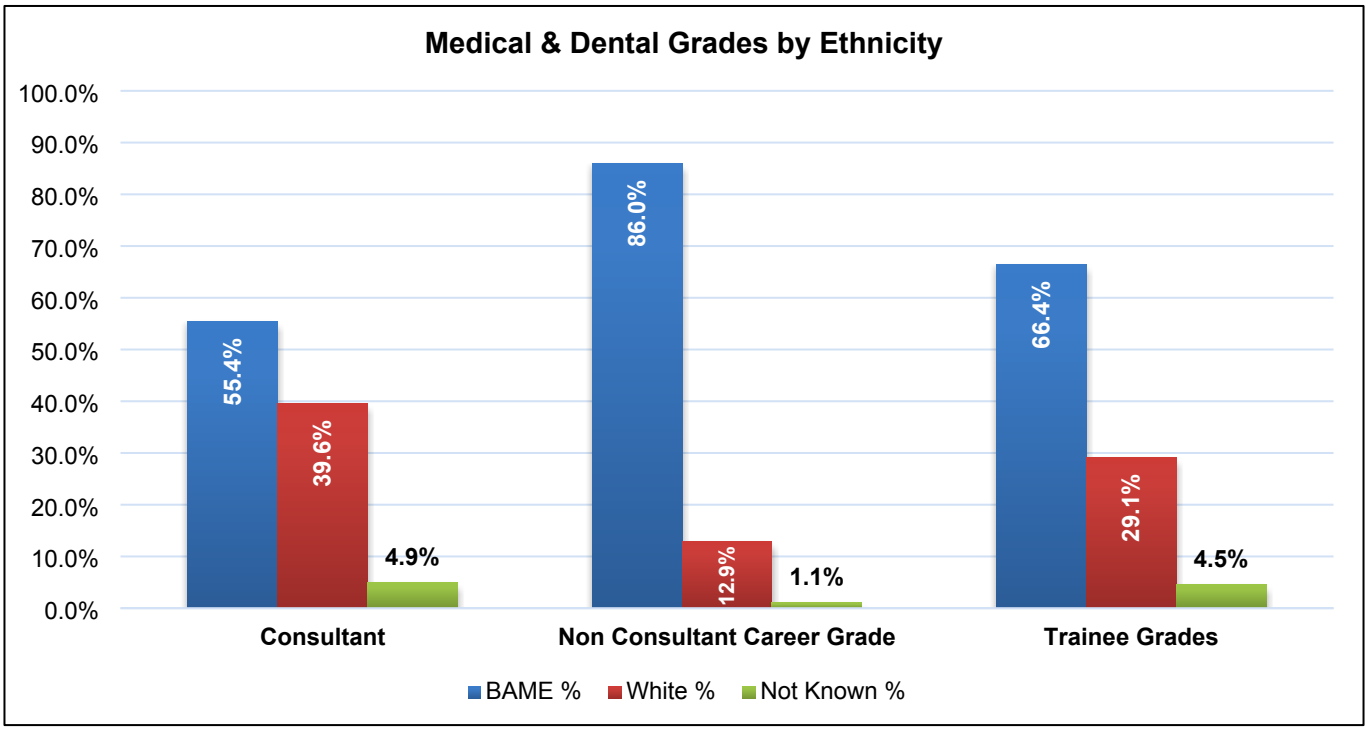


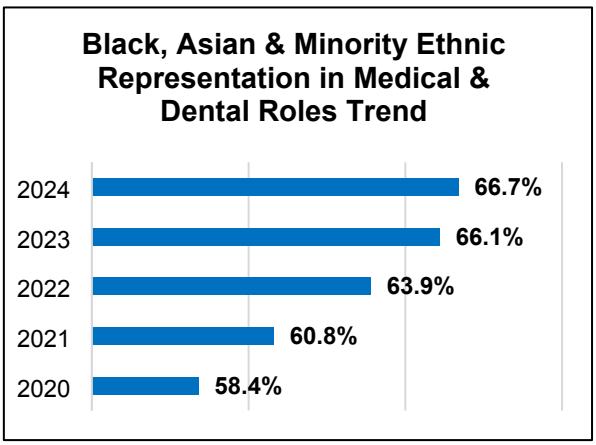


Ethnically diverse representation has increased year on year in clinical posts. The most significant change is seen in AfC Band 5, which has increased from 567 colleagues in 2021 to 1,047 in 2024, a percentage of 45.2%. This increase is directly linked to the international recruitment campaigns we have undertaken in recent years to tackle registered nursing vacancies.

Overall clinical representation is 25.0%, which is similar to the national representation of 26.9%. Nationally Band 5 is also the highest ethnically diverse pay band at 41.6%.

Percentage representation by Ethnicity in Medical & Dental Grades:



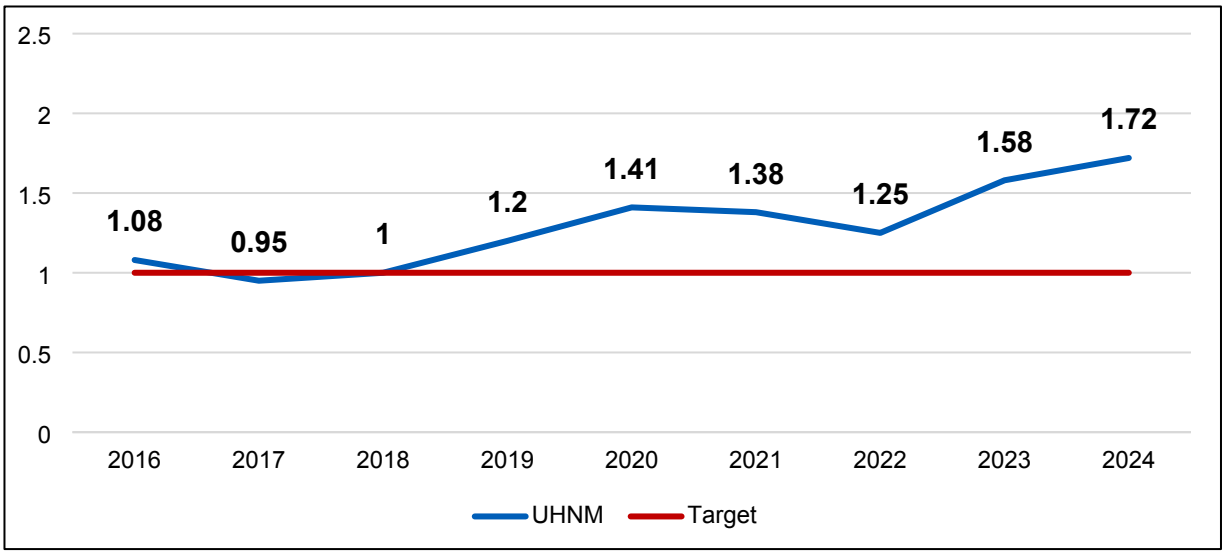


Black, Asian and Minority Ethnic representation has increased across all three pay groups, most significantly in non-consultant career grade doctors, which has increased from a headcount of 63 in 2016, when we first began reporting the WRES, to a current headcount of 326 in 2024. This also reflects our international recruitment of doctors campaign.

The 2021 Medical WRES National Report highlighted that ethnically diverse doctors are under-represented in senior roles and medical leadership positions. The report calls for internationally recruited medical graduates to have access to development opportunities.

WRES Indicator 2

Relative likelihood of white applicants being appointed from shortlisting across all posts compared to Black, Asian & Minority Ethnic applicants


2.5
2
1.5
1
0.5
0
1.08
0.95
1
1.2
1.41
1.38
1.25
1.58
1.72
2016
2017
2018
2019
2020
2021
2022
2023
2024
UHNM
Target

This metric has been on an upward (negative) trajectory since 2022. A metric of 1.72 means that white applicants are 1.7 times more likely to be appointed from shortlisting compared to Black, Asian and Minority Ethnic applicants. Nationally in 2023, 76% of NHS trusts white applicants were significantly more likely than BAME applicants to be appointed from shortlisting.

The race disparity ratio is a summary measure of the representation of Black, Asian and Minority Ethnic colleagues across the Agenda for Change pay bands compared to white colleagues. The workforce on AfC pay bands is considered at 3 levels. A ratio of 1.0 indicates parity of progression, and values higher than this reflect inequality, with a disadvantage for ethnically diverse staff. Locally, and nationally the gaps between Black, Asian & Minority Ethnic and white progression in clinical roles has been widening over the past 4 years, particularly in terms of the lower to middle and lower to upper levels.

Clinical Race Disparity Ratio	UHNM	National (2023)
Disparity ratio - lower to middle	2.64	1.83
Disparity ratio - middle to upper	2.14	1.39
Disparity ratio - lower to upper	5.66	2.55

Non Clinical Race Disparity Ratio	UHNM	National (2023)
Disparity ratio - lower to middle	0.99	0.9
Disparity ratio - middle to upper	2.28	1.36
Disparity ratio - lower to upper	2.26	1.23

The chart below shows ethnicity representation in Agenda for Change roles at UHNM and demonstrates the shifting ethnicity representation compared to the previous two years. Whilst ethnically diverse colleague representation in bands 1 – 5 has significantly increased, this increase is less visible in middle and upper pay bands. This may be explained by the recruitment campaign of internationally qualified clinical colleagues. We would wish to see parity in representation across all quartiles.

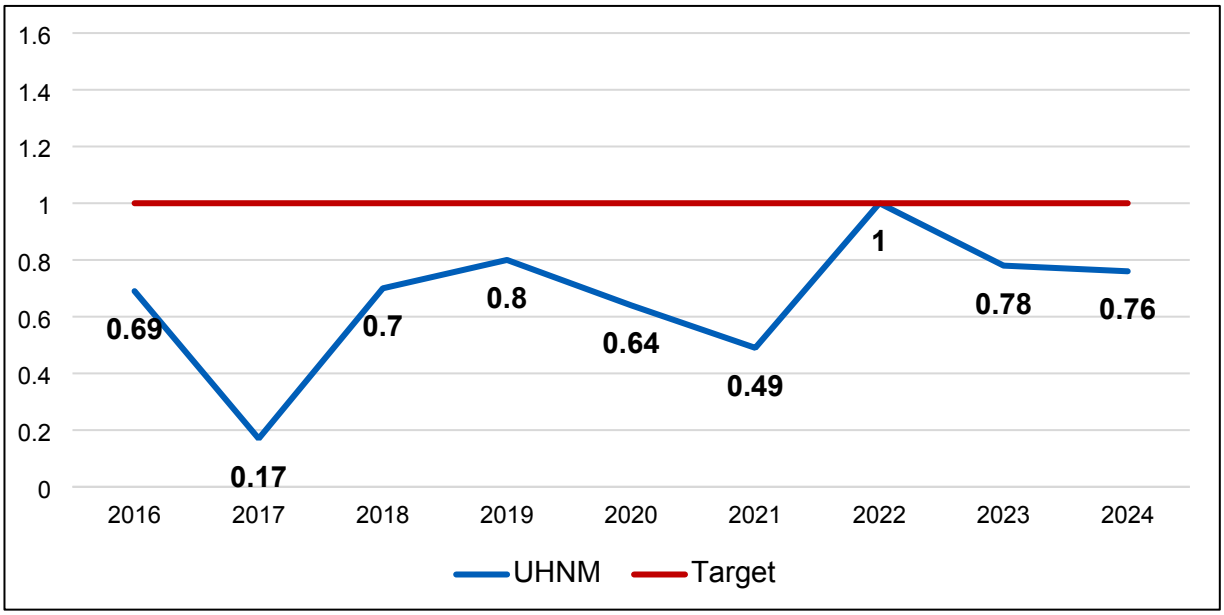
AfC Bandings	White %			Black, Asian & Minority Ethnic %			Unknown %		
	2024	2023	2022	2024	2023	2022	2024	2023	2022
1 to 5	72.6%	76.5	79.6	24.7%	20.6%	16.8%	2.8%	2.8%	3.6%
6 and 7	83.5%	84.9	86.3	14.3%	12.8%	11.3%	2.2%	2.3%	2.5%
Band 8a+	92.0%	91.7	92.6	6.7%	6.4%	5.8%	1.3%	1.6%	1.6%
Grand Total	**76.4%**	**79.6**	**82.0**	**21.0%**	**17.7%**	**14.8%**	**2.5%**	**2.6%**	**3.2%**

Progress against our Model Employer Aspirational Targets for Black, Asian and Minority Ethnic representation in senior leadership roles continues in a positive trajectory but below the aspirational target allocated by NHS England.

	Black, Asian and Minority Ethnic Headcount at 31.03.24	Model Employer Target for 2024
Band 8A	32	38
Band 8B	6	10
Band 8C	2	4
Band 8D	1	2
Band 9	0	1
VSM	1	1

WRES Indicator 3

Relative likelihood of Black, Asian & Minority Ethnic staff entering the formal disciplinary process compared to white staff:

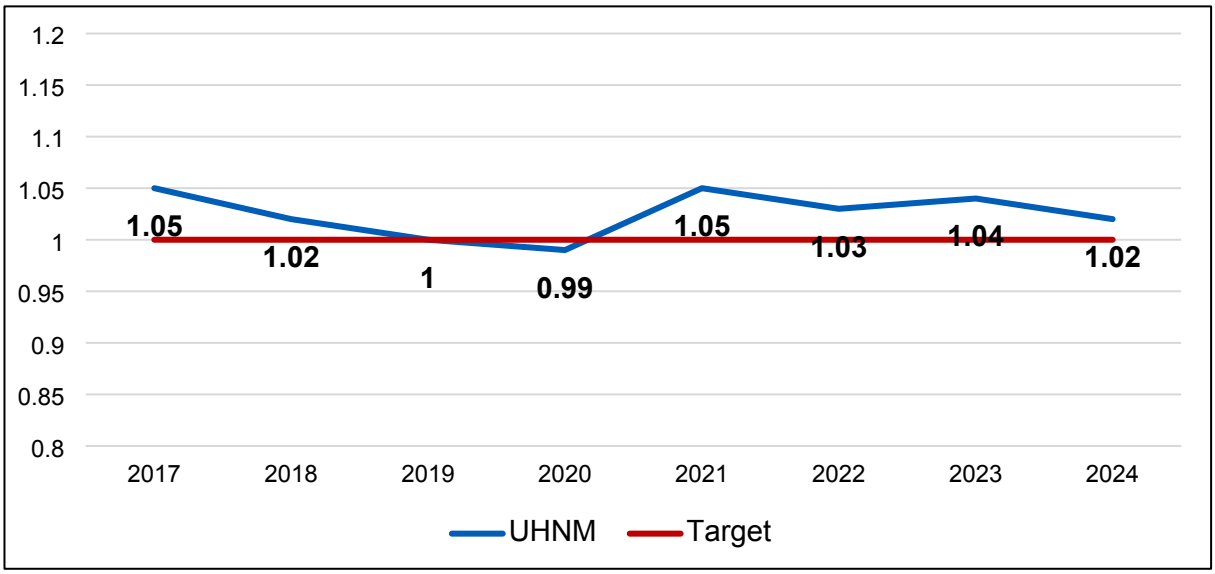


Since we began reporting the WRES our Black, Asian and Minority Ethnic colleagues have not been more likely than white colleagues to enter into a formal disciplinary process, going against the national position. UHNM is within the top quartile of organisations in relation to this indicator. The introduction of the Just and Learning approach, with a checklist to determine whether disciplinary action is appropriate has further enhanced the independent decision making process.

Nationally, the 2023 WRES Data Report showed that in 46% of NHS trusts, Black, Asian and Minority Ethnic staff were over 1.25 times more likely than white staff to enter the formal disciplinary process.

WRES Indicator 4

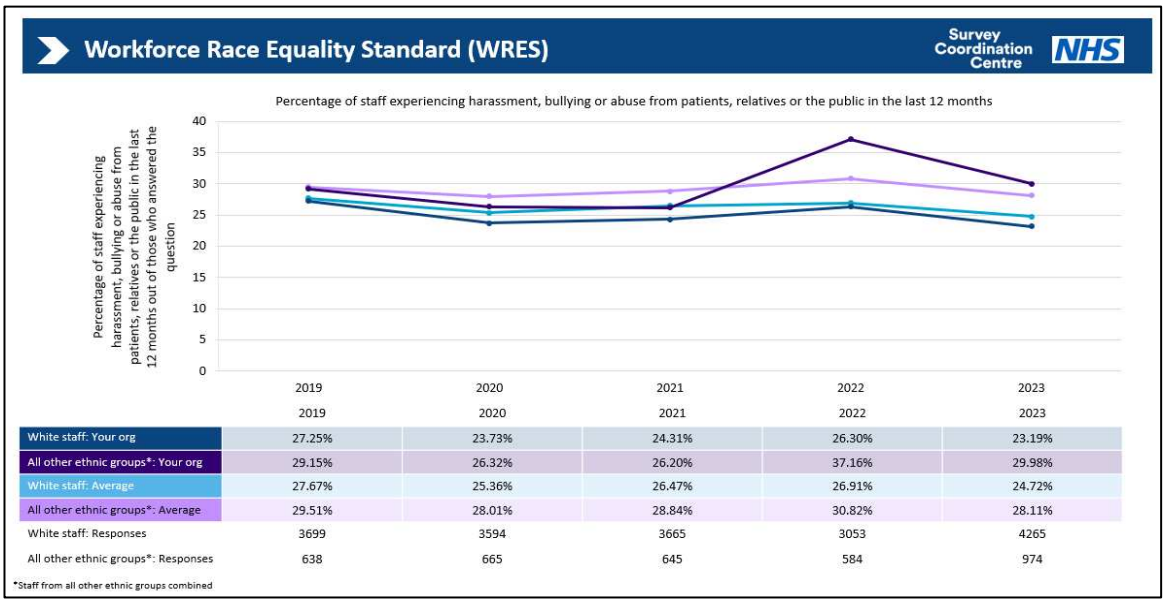
Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to Black, Asian & Minority Ethnic staff:



Our data shows no significant difference for colleagues accessing non-mandatory training as recorded on ESR. In 2023 this indicator fell within the non-adverse range of 0.80 to 1.25 across the country for all NHS Trusts in England.

WRES Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients / service users, their relatives, or the public in the last 12 months (national staff survey q14a):



	2019	2020	2021	2022	2023
White staff: Your org	27.25%	23.73%	24.31%	26.30%	23.19%
All other ethnic groups*: Your org	29.15%	26.32%	26.20%	37.16%	29.98%
White staff: Average	27.67%	25.36%	26.47%	26.91%	24.72%
All other ethnic groups*: Average	29.51%	28.01%	28.84%	30.82%	28.11%
White staff: Responses	3699	3594	3665	3053	4265
All other ethnic groups*: Responses	638	665	645	584	974

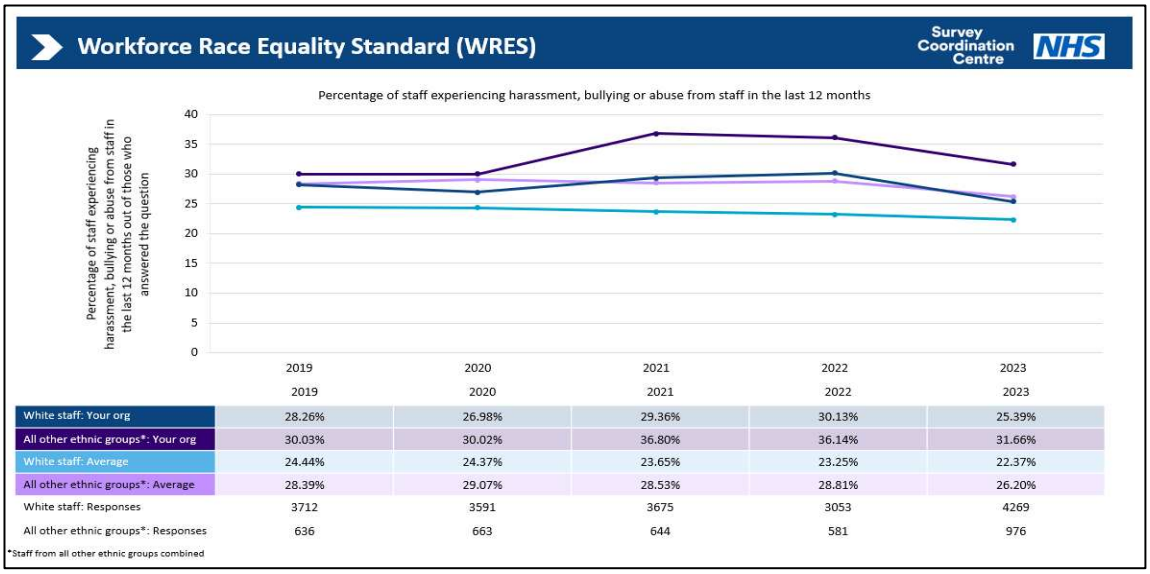
*Staff from all other ethnic groups combined

In 2023, a higher percentage of Black, Asian and Minority Ethnic colleagues (29.98%) than white staff (23.19%) reported being harassed, bullied, or abused by patients, their relatives, or the public in the last 12 months; a pattern that has been evident since the WRES began. There has been a significant reduction compared to our 2022 staff survey in reported experiences (37.2%) and has returned to levels more in comparison with our NSS peer comparator group.

Nationally, the majority of NHS trusts (81%) reported a higher proportion of Black, Asian and Minority Ethnic staff experiencing harassment, bullying or abuse from patients, relatives or the public compared to white colleagues.

WRES Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (national staff survey q14c)



	2019	2020	2021	2022	2023
White staff: Your org	28.26%	26.98%	29.36%	30.13%	25.39%
All other ethnic groups*: Your org	30.03%	30.02%	36.80%	36.14%	31.66%
White staff: Average	24.44%	24.37%	23.65%	23.25%	22.37%
All other ethnic groups*: Average	28.39%	29.07%	28.53%	28.81%	26.20%
White staff: Responses	3712	3591	3675	3053	4269
All other ethnic groups*: Responses	636	663	644	581	976

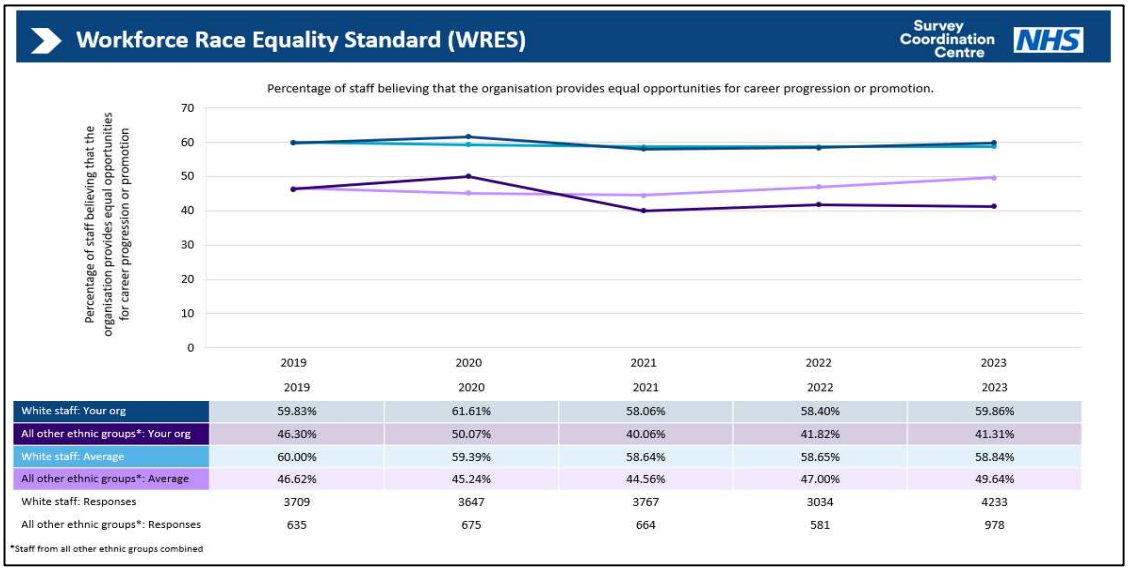
*Staff from all other ethnic groups combined

There has been a notable improvement compared to the previous year for both Black, Asian and Minority Ethnic colleagues (by 5%) and white colleagues experiences of harassment, bullying or abuse from other colleagues, however our data remains higher (worse) than the NSS peer comparator group average. In the summer of 2023 we launched our Being Kind Compact, with a trust wide awareness campaign in our Being Kind approach and new resolution policy. This training now forms part of our mandatory suite of employee training.

National data shows that in 2023 94% of trusts reported a higher proportion of Black, Asian and Minority Ethnic colleague experience of harassment, bullying or abuse from other staff compared to white colleagues.

WRES Indicator 7

Percentage of staff believing that their trust provides equal opportunities for career progression or promotion (staff survey q15)



	2019	2020	2021	2022	2023
White staff: Your org	59.83%	61.61%	58.06%	58.40%	59.86%
All other ethnic groups*: Your org	46.30%	50.07%	40.06%	41.82%	41.31%
White staff: Average	60.00%	59.39%	58.64%	58.65%	58.84%
All other ethnic groups*: Average	46.62%	45.24%	44.56%	47.00%	49.64%
White staff: Responses	3709	3647	3767	3034	4233
All other ethnic groups*: Responses	635	675	664	581	978

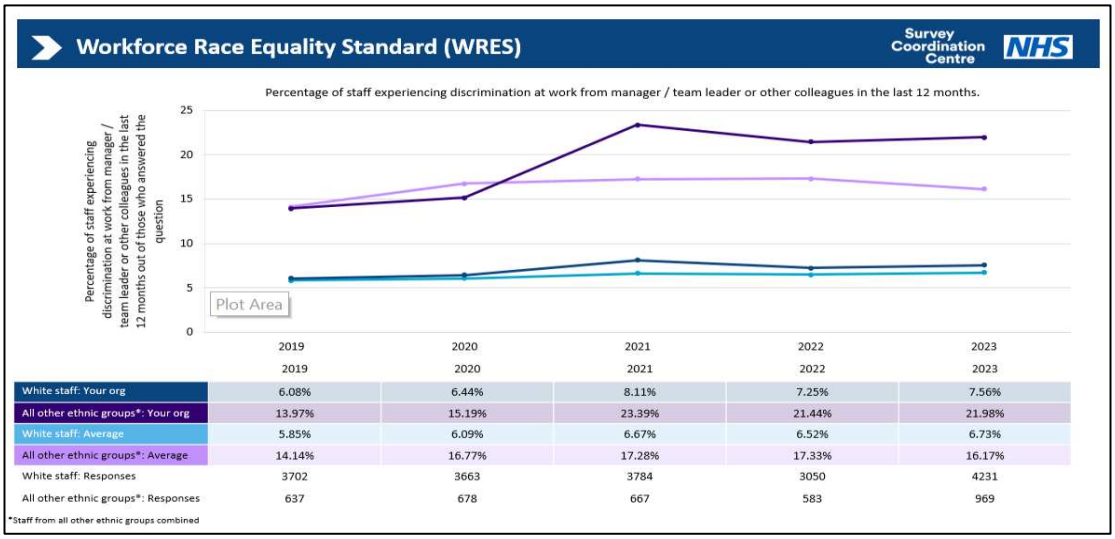
*Staff from all other ethnic groups combined

A lower percentage of Black, Asian and Minority Ethnic colleagues (41.31%) than white colleagues (59.86%) felt that the Trust provides equal opportunities for career progression or promotion. This represents a deterioration in this indicator of 0.51% and the gap between BAME and white colleagues has widened by 2% compared to the previous year. This is also 7.3% worse than our NSS peer comparator group average for Black, Asian and Minority Ethnic colleagues.

The 2023 national WRES report showed that a lower percentage of Black, Asian and Minority Ethnic staff in England (46.4%) felt that their trust provides equal opportunities for career progression or promotion compared to white colleagues (59.1%).

WRES Indicator 8

Percentage of staff experiencing discrimination at work from other staff in the last 12 months (staff survey q16b)



	2019	2020	2021	2022	2023
White staff: Your org	6.08%	6.44%	8.11%	7.25%	7.56%
All other ethnic groups*: Your org	13.97%	15.19%	23.39%	21.44%	21.98%
White staff: Average	5.85%	6.09%	6.67%	6.52%	6.73%
All other ethnic groups*: Average	14.14%	16.77%	17.28%	17.33%	16.17%
White staff: Responses	3702	3663	3784	3050	4231
All other ethnic groups*: Responses	637	678	667	583	969

*Staff from all other ethnic groups combined

Black, Asian & Minority Ethnic colleagues have reported significantly higher rates of discrimination from a line manager/supervisor (21.98%) than white colleagues (7.56%). This represents a 0.54% increase (deterioration) of Black, Asian and Minority Ethnic colleague experience of discrimination compared to the previous year and is 5.9% higher than our NSS peer comparator group average.

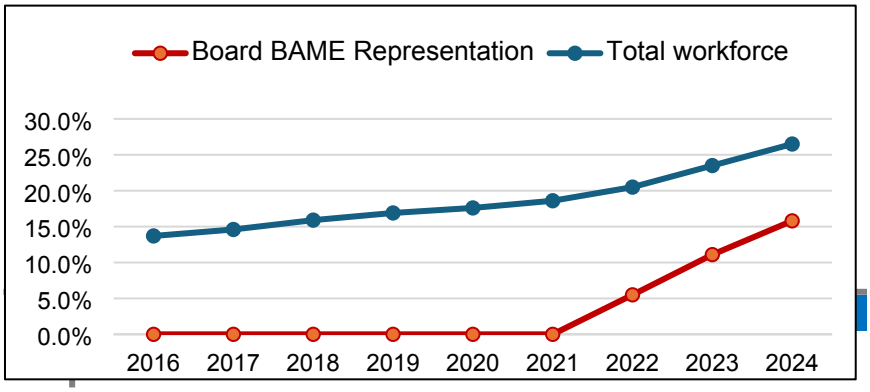
At all trusts across England in 2023, a higher percentage of Black, Asian and Minority Ethnic staff experienced discrimination from a manager/team leader or other colleagues compared to white colleagues.

WRES Indicator 9

Representation amongst board members by ethnicity compared to the workforce overall

This indicator measures the difference between the ethnicity composition of our Board membership compared to the overall organisation. Boards are expected to be broadly representative of their workforce. UHNM's Black, Asian and Minority Ethnic representation is 26.6% compared to the board representation being 15.7%.

Board Representation	2024
Difference Total Board: Overall Organisation	-11%
Difference Voting Board Membership: overall organisation	-2%
Difference Executive Board Membership: overall organisation	-17%



In 2023 across every region, there was a lower percentage of BAME board members compared to their overall workforce. The percentage of board members recording their ethnicity as Black, Asian and Minority Ethnic has increased year-on-year at a national level. However, this has not kept up with the rate of increase in the percentage of ethnically diverse staff in the NHS workforce overall. The national average representation was 15.6% overall board membership, and 10.8% executive board membership.

Summary and Action Plan

This year's WRES indicators tell us that we are not making sufficient progress in tackling racial inequalities and closing the gap between the experiences of colleagues from Black, Asian and Minority Ethnic backgrounds, which remain significantly less positive than white colleagues. Whilst there has been improvement in 6 of the 9 WRES indicators, our data is below that of peer comparator averages.

Intensive focus is required and we have established a Race Equality Task & Finish Group, chaired by Chief Nurse and Ethnic Diversity Staff Network Executive Sponsor Ann Marie Riley. The group will utilise the expertise of our new cohort of WRES Champions along with our Ethnic Diversity Network leads and key stakeholders from recruitment, employee relations, talent management and learning and development to take an Improving Together approach to identify, implement and monitor actions and the impact of interventions.

During 2024-25 we will focus on the following three WRES workstreams:

Work Stream			
Metric	**Debiasing recruitment & selection processes**	**Improving equity in career development/promotion**	**Tackling harassment, bullying and abuse**
	WRES Metrics 1,2,7	WRE Metrics 1,2,7	WRES Indicators 5,6,7
Actions for change	• Process map recruitment process, identifying systemic barriers or opportunities for bias • Deep dive recruitment data and likelihood ratios to identify priority areas for focus • Introduce an audit process for recruitment decisions • Provide local metrics on the likelihood of appointment from shortlisting • Monitor compliance and impact of the inclusive recruitment training • Widening participation strategy to be aligned to increasing marginalised groups in our communities accessing employment at UHNM • Bid for national monies to introduce a Cultural Ambassador programme	• Develop a long-term inclusive talent management approach - building capabilities for all leaders and managers with an explicit focus on addressing issues of inequity, diversity and inclusion • Ensure line managers are developed and supported to achieve their talent management responsibilities • Set representation targets for career development offerings that reflect the make-up of our organisation • Introduce clear career pathways • Provide ethnically diverse colleagues with access to professional support, such as job application skills, coaching, mentoring and senior sponsorship • Assess the impact of the revised Performance Review process	• Implement the zero-tolerance anti-abuse public campaign • Introduce yellow/red card warning system • Enhance training for colleagues and line managers • Continue to embed Being Kind approach • Enhance line manager skills in difficult conversations, facilitated resolution and policy application • Implement the learning from the August civil unrest ensuring our colleagues are supported effectively
Aim	To reduce the likelihood ratio year on year aspiring to reach target of 1.0	To increase belief amongst Black, Asian & Minority Ethnic colleagues that the trust provides equal opportunities for career progression/promotion to at least the national average of 47% by 2025 and close the gap with white colleague experience (national average for white colleagues is 59.4%)	To achieve long term reduction in experiences of all colleagues of abuse from all sources and specifically reduce the disparity of Black, Asian, and Minority Ethnic staff compared to White staff.

Progress will be measured by improved metric results in the 2024 Staff Survey, 2025 WRES submission, divisional EDI dashboards and the monitoring of other relevant metrics including the Employee Voice feedback, Speaking Up information and the lived experiences of our Ethnic Diversity Staff Network membership.

Workforce Disability Equality Standard (WDES) 2024

Key Findings from the 2024 WDES:

4.5% of UHNM colleagues have shared a disability or LTC on ESR compared to **27%** in our last Staff Survey

51% of colleagues with a disability/LTC compared to **58%** of colleagues without a disability/LTC believe our trust provides equal opportunities for career progression or promotion

Colleagues with a disability/LTC are **8%** more likely to feel pressure from their manager to come to work, despite not feeling well enough to perform their duties, compared to colleagues without a disability/LTC

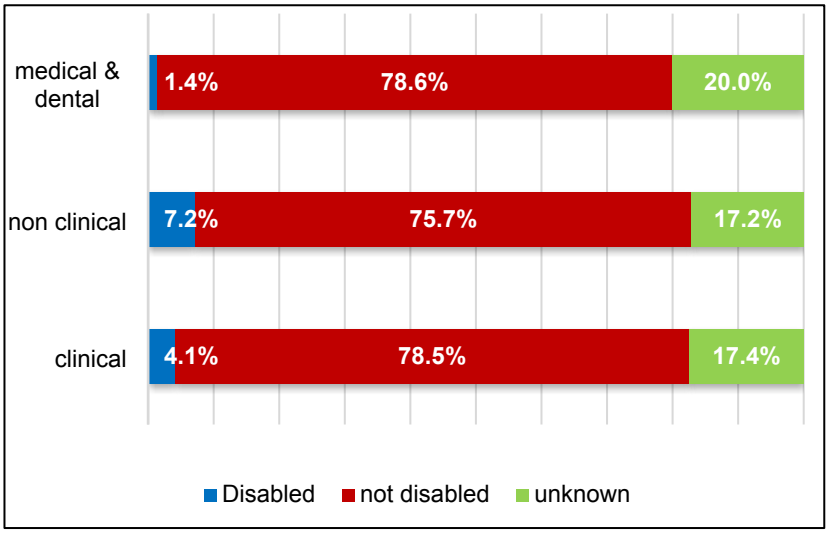
30% of colleagues with a disability/LTC don't feel they have had the adjustments they need to do their job

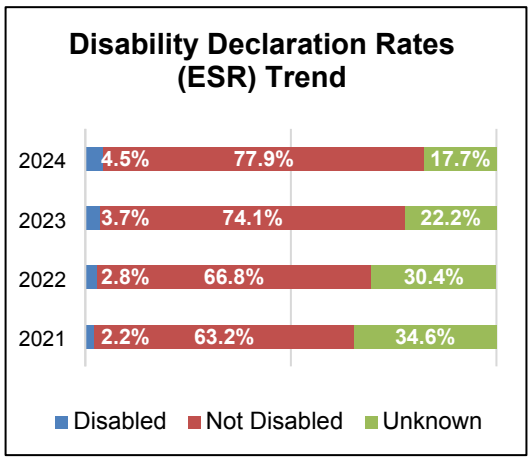
Non disabled applicants are **1.09 times** more likely to be appointed from shortlisting than applicants without a disability

29% of colleagues with a disability/LTC reported experiencing harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public in the last 12 months

The WDES comprises of 10 indicators. Six of the WDES indicators are drawn from the NHS Annual National Staff Survey. The UHNM response rate for the 2023 staff survey was 45% with 26.9% of respondents (1,411) stating that they had a physical or mental health condition or illness lasting or expected to last 12 months or more. This compares to the peer average of 24.3% and is our highest ever response rate.

WDES Indicator 1
Percentage Representation of Workforce Disability





Last year we set ourselves an organisation-wide target of disability declaration of 4.0%. At 31st March 2024 the declaration rate on ESR was 4.5%. This is a notable increase from 1.54% in 2019. In the long term we would wish to see a similar declaration rate on ESR to that shared by colleagues in the National Staff Survey. The trend analysis shows the progress made with increasing disability declaration rates, and the number of unknown status has improved significantly.

UHNM uses recruitment monitoring and the ESR system to capture and record employee disability status. We regularly encourages our workforce to update their ESR record and the number of records where colleagues have not disclosed their disability status has improved from 41% in 2020 to 17.7% at 31st March 2024. Nationally it is recognised that there is a significant under reporting across the country of the numbers of staff who disclose a disability on ESR, compared to those sharing this information when completing the anonymous NHS Staff Survey.

Positively, the percentage of UHNM colleagues that have declared their disability status on ESR has continued to improve year on year, with 82.4% of employees sharing their status compared to 59% in 2020. The percentage of staff working with a disability is currently 4.5%. Nationally, 4.9% of the NHS workforce is recorded as having a disability, 78.4% not disabled and 16.6% unknown status. (source: 2023 WDES Data Report)

UHNM Workforce Disability Status	Headcount (31.03.24)	%
Disabled	565 (+132)	4.5%
Not Disabled	9,835	77.9%
Unknown	2,230	17.7%
Total	**12,630**	**100%**

Disability Category (ESR)	%
Learning disability/difficulty	20.2%
Long-standing illness	33.1%
Mental Health Condition	9.8%
Yes (unspecified)	9.8%
Physical Impairment	7.2%
Sensory Impairment	7.4%
Other	12.4%

In the most recent national data available from the 2023 WDES Data report 4.9% of NHS colleagues have declared a disability on the ESR system.

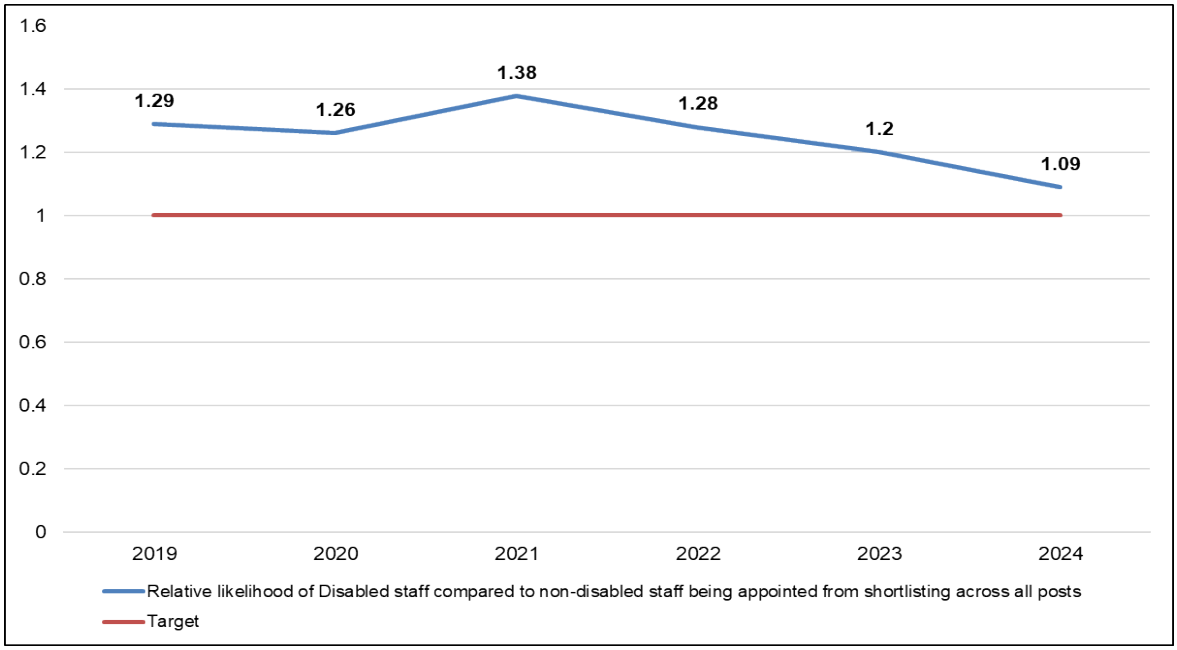
The WDES presents workforce data in 4 Agenda for Change clusters and a Medical & Dental professional group. The percentage of employees with a disability has increased in all clinical and non-clinical pay clusters compared to the previous year (2023 data in brackets to show the change) with a reduction in the number of disability unknown status:

AFC Pay Cluster	Disabled Headcount	Disabled %	Non-disabled Headcount	Non-disabled %	Unknown Headcount	Unknown %	Total
Bands 1 (& under) 2,3 & 4	300 (235)	5.9% (4.8%)	3,913 (3,560)	76.4% (72.8%)	909 (1,096)	17.7% (22.4%)	5,122 (4,891)
Bands 5,6 & 7	219 (159)	4.1% (3.2%)	4,239 (3,645)	79.3% (74.2%)	890 (1,106)	16.6% (22.5%)	5,348 (4,910)
Bands 8a & 8b	20 (22)	3.7% (4.2%)	417 (375)	77.2% (70.8%)	103 (132)	19.1% (25.0%)	540 (529)
Bands 8c, 8d, 9 & VSM	5 (3)	6.0% (3.8%)	59 (58)	70.2% (72.5%)	20 (19)	23.8% (23.7%)	84 (80)
Medical & Dental	21 (14)	1.4% (1%)	1,207 (1,110)	78.6% (79.6%)	308 (271)	20.1% (19.4%)	1,536 (1,395)

Totals	565 (433)	4.5% (3.7%)	9,835 (8,748)	77.9% (74.1%)	2,230 (2,624)	17.7% (22.2%)	12,630 (11,805)

WDES Indicator 2

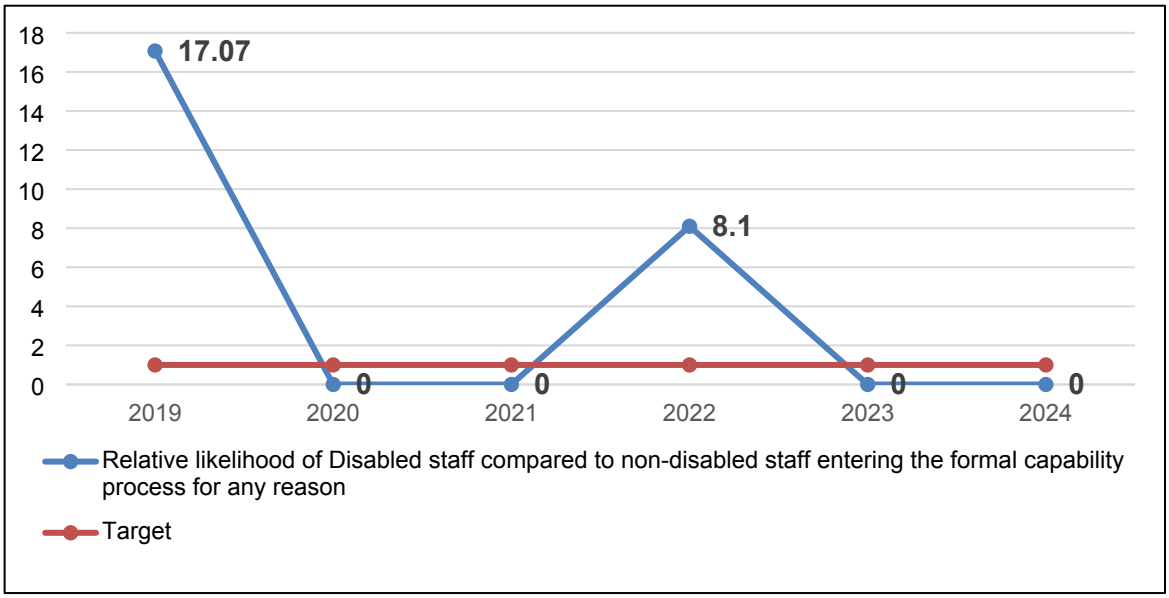
Relative likelihood of Disabled applicants being appointed from shortlisting across all posts compared to applicants without a disability.



Analysis of recruitment activity recorded on the TRAC recruitment system shows that non-disabled applicants are 1.09 times more likely to be appointed from shortlisting compared to Disabled applicants (a metric of 1.0 represents equal likelihood of disabled and non-disabled applicants being appointed from shortlisting). A continued downward (positive) trajectory in our recruitment data compares with the most recent national average metric from 2023, which was 0.99.

WDES Indicator 3

Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff



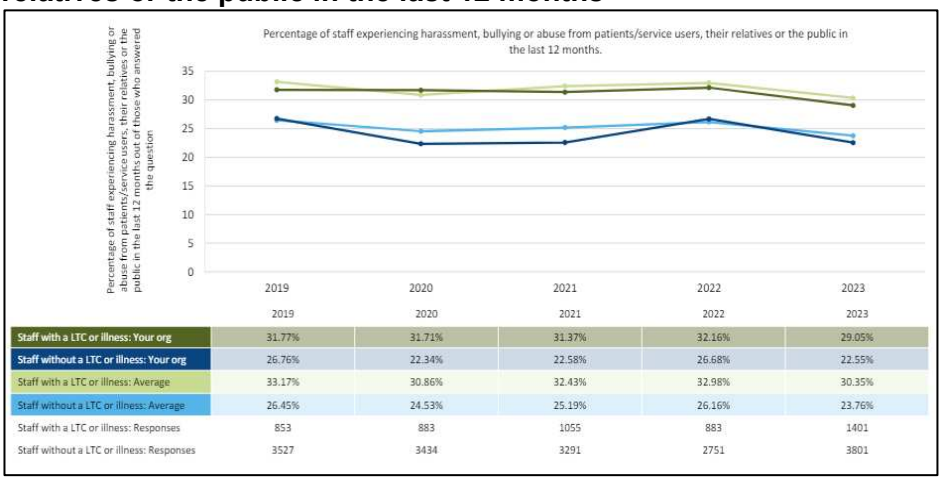
This indicator is based on data from a two-year rolling average of entry into a formal capability process as recorded on the Employee Relations Case Tracker. From 2022 this metric is related to entry into the formal capability process for all reasons (previously the metric measured entry into the capability process due to performance issues only).

Our Capability Policy is designed to be supportive and encouraging to enable colleagues to reach the desired performance level through informal processes and hence very small numbers of staff enter the formal stage of the Policy. The policy was also reviewed as an action from last year's WDES Action Plan and has been updated reflecting feedback from the Disability & LTC Staff Network in 2023/24.

This result gives a relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff score of 0.0, compared to the most recent national result of 2.17.

WDES Indicator 4a

Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	31.77%	31.71%	31.37%	32.16%	29.05%
Staff without a LTC or illness: Your org	26.76%	22.34%	22.58%	26.68%	22.55%
Staff with a LTC or illness: Average	33.17%	30.86%	32.43%	32.98%	30.35%
Staff without a LTC or illness: Average	26.45%	24.53%	25.19%	26.16%	23.76%
Staff with a LTC or illness: Responses	853	883	1055	883	1401
Staff without a LTC or illness: Responses	3527	3434	3291	2751	3801

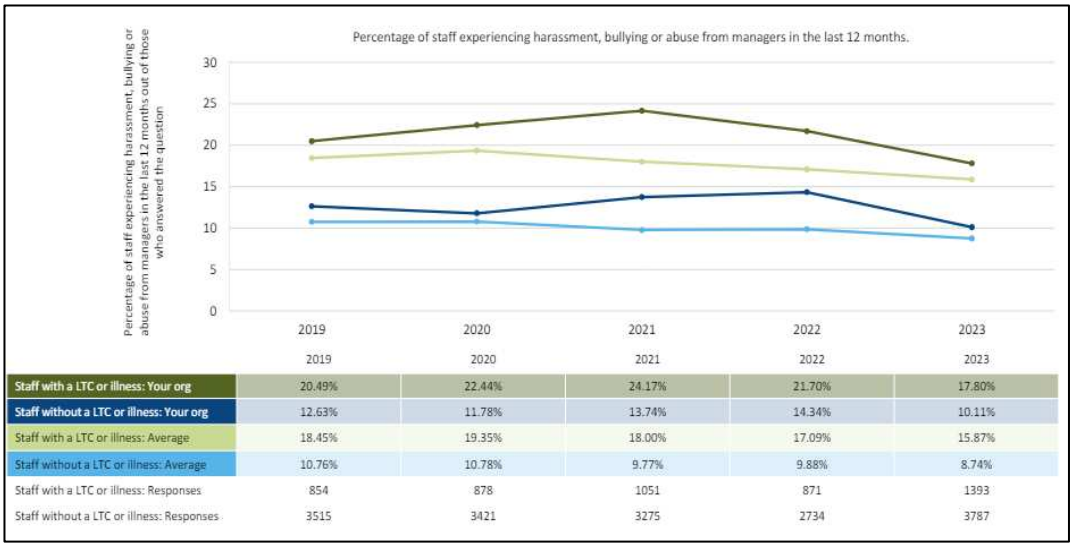
Whilst the levels of abuse experienced by colleagues is unacceptably high, this year's figure is our best performance for colleagues with a disability/LTC since we began reporting the WDES and is better than our peer comparator group. The difference with non-disabled colleagues has also reduced.

Nationally 33.2% of disabled colleagues and 26% of non-disabled colleagues (a difference of 7.2%) reported experience of harassment, bullying and abuse from patients/service users, their relatives or public in the previous 12 months.

A UHNM Zero Tolerance Task and Finish Group has been established to take forward the work commenced on addressing abuse levels from the public.

WDES Indicator 4a

Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months

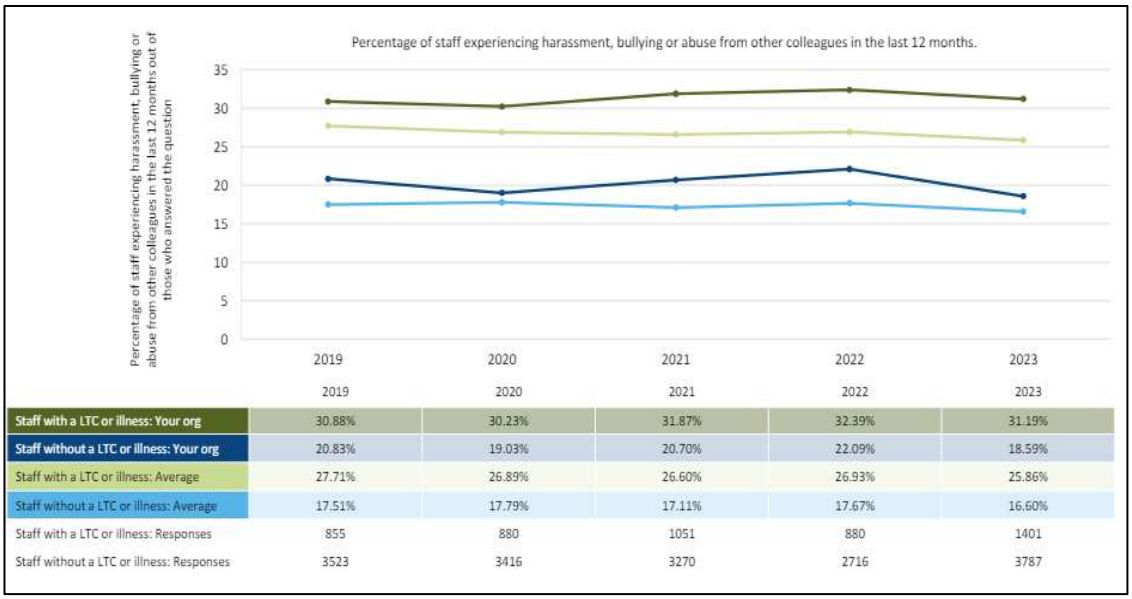


	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	20.49%	22.44%	24.17%	21.70%	17.80%
Staff without a LTC or illness: Your org	12.63%	11.78%	13.74%	14.34%	10.11%
Staff with a LTC or illness: Average	18.45%	19.35%	18.00%	17.09%	15.87%
Staff without a LTC or illness: Average	10.76%	10.78%	9.77%	9.88%	8.74%
Staff with a LTC or illness: Responses	854	878	1051	871	1393
Staff without a LTC or illness: Responses	3515	3421	3275	2734	3787

This year's performance is a notable improvement on previous years for both colleagues with a disability/LTC and those without and is our best percentage yet for disabled colleagues reporting experience of harassment, bullying or abuse from managers in the last 12 months, but it should be recognised that this is still worse than our national staff survey peer comparator group, and the 2023 WDES average of 16.1%

WDES Indicator 4a

Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months

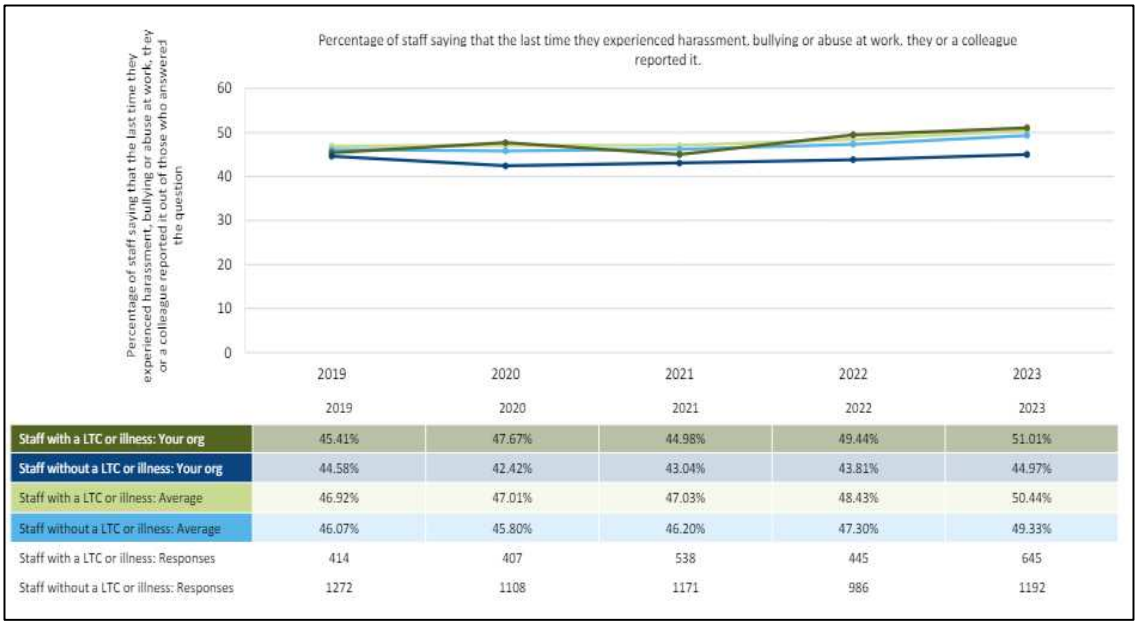


	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	30.88%	30.23%	31.87%	32.39%	31.19%
Staff without a LTC or illness: Your org	20.83%	19.03%	20.70%	22.09%	18.59%
Staff with a LTC or illness: Average	27.71%	26.89%	26.60%	26.93%	25.86%
Staff without a LTC or illness: Average	17.51%	17.79%	17.11%	17.67%	16.60%
Staff with a LTC or illness: Responses	855	880	1051	880	1401
Staff without a LTC or illness: Responses	3523	3416	3270	2716	3787

There has been a small improvement in this indicator, but the gap between the experiences of colleagues with a disability/LTC and staff without has widened. Our performance is worse than our National Staff Survey peer comparator group.

WDES Indicator 4b

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it



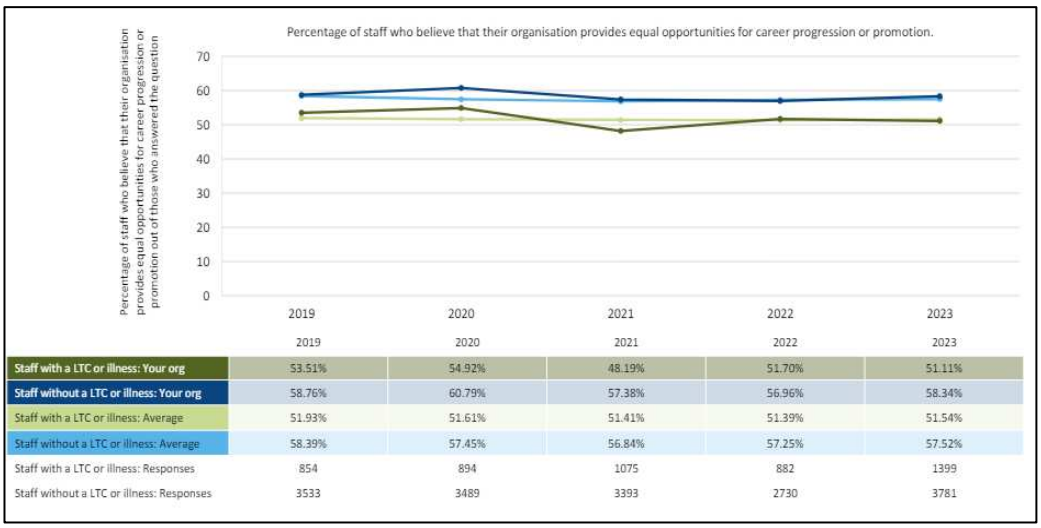
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	45.41%	47.67%	44.98%	49.44%	51.01%
Staff without a LTC or illness: Your org	44.58%	42.42%	43.04%	43.81%	44.97%
Staff with a LTC or illness: Average	46.92%	47.01%	47.03%	48.43%	50.44%
Staff without a LTC or illness: Average	46.07%	45.80%	46.20%	47.30%	49.33%
Staff with a LTC or illness: Responses	414	407	538	445	645
Staff without a LTC or illness: Responses	1272	1108	1171	986	1192

Positively this is our best performance since the WDES began in the percentage of colleagues with a long term condition (and those without) saying that they have reported experience of harassment, bullying or abuse at work. 51.01% is higher than our National Staff Survey peer comparator group average for colleagues with a long term condition and can be a reflection of the investment in our Speaking Up service, the introduction of Disability Champions and the support from the Staff Networks.

The 2023 national WDES figure was 31.3% (taken from the 2022 National Staff Survey)

WDES Indicator 5

Percentage of staff who believe that the organisation provides equal opportunities for career progression or promotion



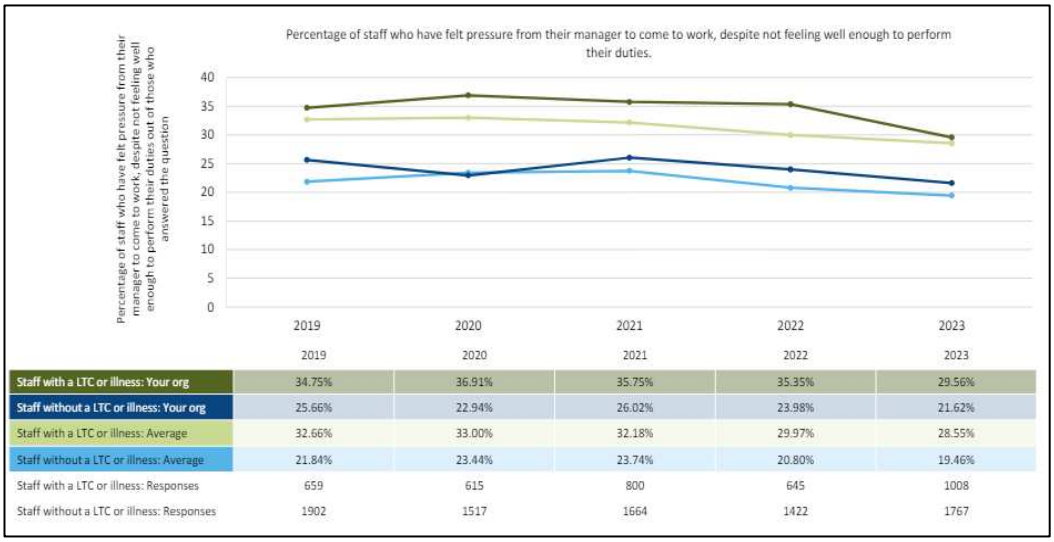
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	53.51%	54.92%	48.19%	51.70%	51.11%
Staff without a LTC or illness: Your org	58.76%	60.79%	57.38%	56.96%	58.34%
Staff with a LTC or illness: Average	51.93%	51.61%	51.41%	51.39%	51.54%
Staff without a LTC or illness: Average	58.39%	57.45%	56.84%	57.25%	57.52%
Staff with a LTC or illness: Responses	854	894	1075	882	1399
Staff without a LTC or illness: Responses	3533	3489	3393	2730	3781

This indicator has slightly deteriorated but is similar to our National Staff Survey peer comparator group. However the gap between colleagues with a disability/LTC and those colleagues who do not has widened. The 2023 WDES Data report average (from the 2022 NSS) was 52.1% for colleagues with a disability/LTC and 57.7% for colleagues without a disability/LTC.

This deterioration is also apparent in our Workforce Race Equality performance on the same indicator. The Trust's work on inclusive talent management during 2024-25 will be designed to address inequity in recruitment and talent processes for all marginalised groups.

WDES Indicator 6

Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



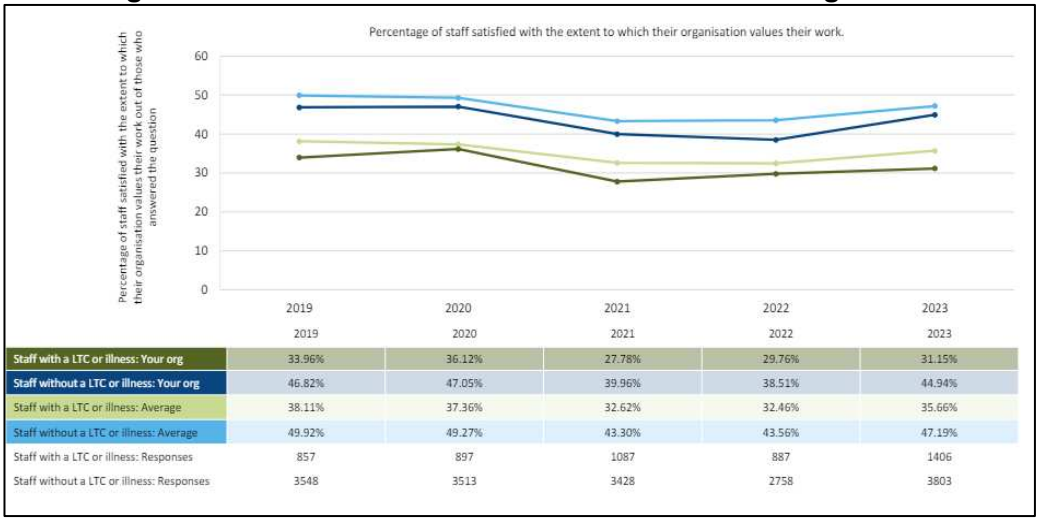
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	34.75%	36.91%	35.75%	35.35%	29.56%
Staff without a LTC or illness: Your org	25.66%	22.94%	26.02%	23.98%	21.62%
Staff with a LTC or illness: Average	32.66%	33.00%	32.18%	29.97%	28.55%
Staff without a LTC or illness: Average	21.84%	23.44%	23.74%	20.80%	19.46%
Staff with a LTC or illness: Responses	659	615	800	645	1008
Staff without a LTC or illness: Responses	1902	1517	1664	1422	1767

This year's data shows a significant improvement for disabled colleague experience of feeling pressure from their manager to come to work despite not feeling well enough to perform their duties (known as presenteeism), with an improvement of 5.8%. The difference between the experiences of colleagues with a long term condition compared to those who do not has also improved by 3.4%.

Our performance, which is our best ever for both colleagues with a disability/LTC and those without remains above the average for our NSS peer comparator group.

WDES Indicator 7

Percentage of staff satisfied with the extent to which the organisation values their work



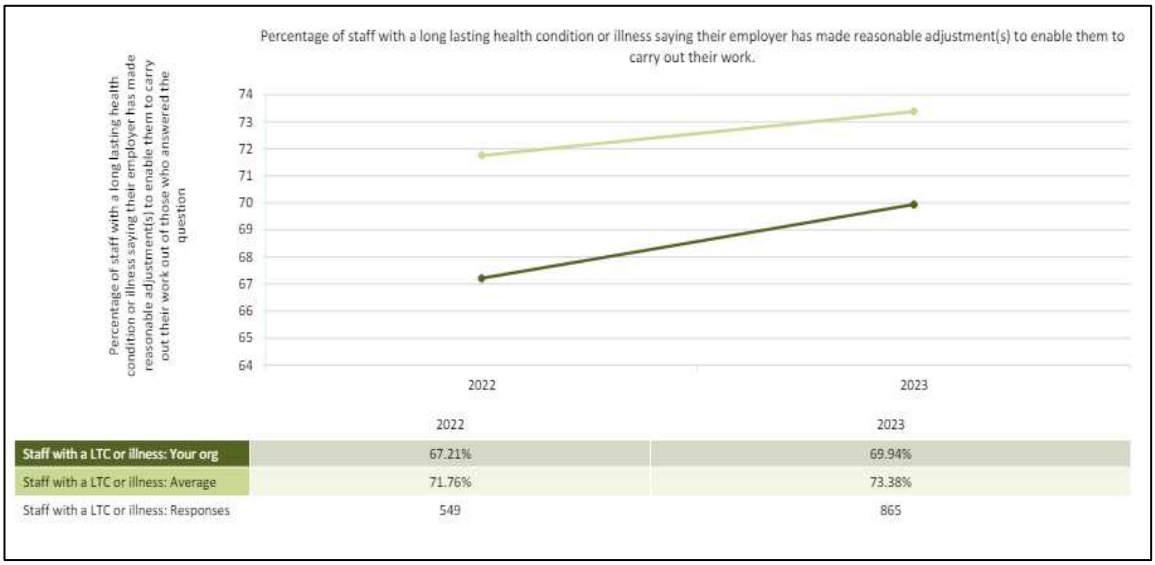
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	33.96%	36.12%	27.78%	29.76%	31.15%
Staff without a LTC or illness: Your org	46.82%	47.05%	39.96%	38.51%	44.94%
Staff with a LTC or illness: Average	38.11%	37.36%	32.62%	32.46%	35.66%
Staff without a LTC or illness: Average	49.92%	49.27%	43.30%	43.56%	47.19%
Staff with a LTC or illness: Responses	857	897	1087	887	1406
Staff without a LTC or illness: Responses	3548	3513	3428	2758	3803

This indicator has improved on the previous year, and the third year of improvement for colleagues with a disability or long term condition. During 2023 we launched the revised Personal Development Review with a focus on recognising trust values and inclusion and supporting colleagues to achieve their potential. The process also encourages colleagues to discuss any wellbeing support required and to review the effectiveness of workplace adjustments..

Our data is below the comparator peer group average and the WDES national average (from the 2022 staff survey) of 35.2%

WDES Indicator 8

Percentage of staff with a long lasting health condition or illness saying the organisation has made reasonable adjustments to enable them to carry out their work



	2022	2023
Staff with a LTC or illness: Your org	67.21%	69.94%
Staff with a LTC or illness: Average	71.76%	73.38%
Staff with a LTC or illness: Responses	549	865

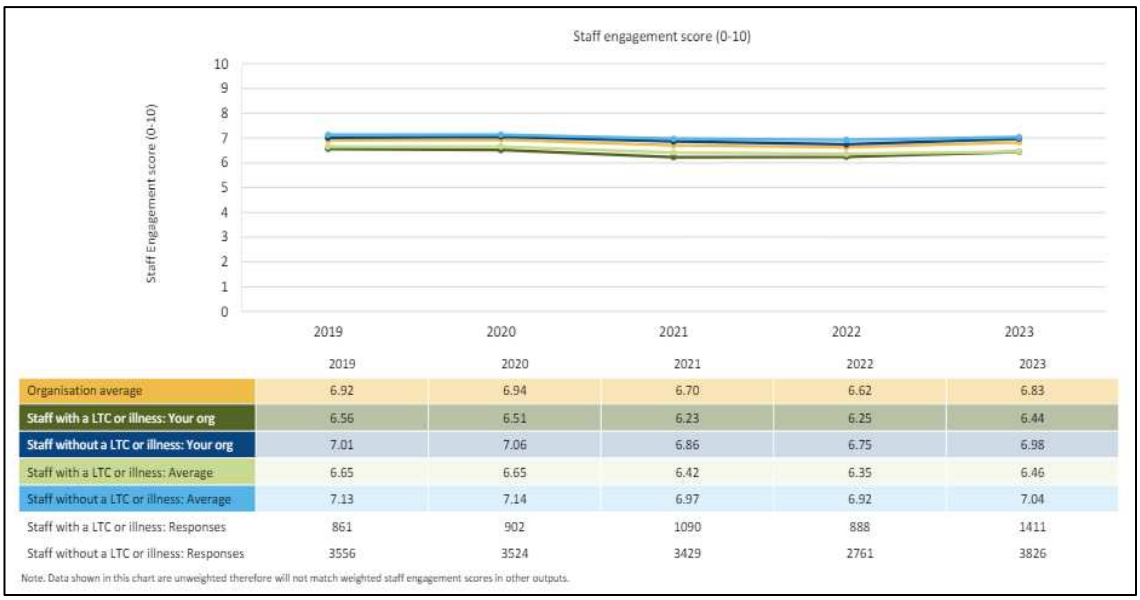
This metric has improved but is lower than our NSS peer comparator group and the national WDES average of 73.4%. It does demonstrate progress and the 2023 staff survey also had a larger number of respondents.

In November 2023 we introduced a new Reasonable Adjustments Policy, developed with our Disability and Long Term Conditions Staff Network. This was accompanied with two recorded webinars – one targeted at line managers and applying the policy and the second being a step by step guide to having a conversation to complete a Tailored Adjustments Plan.

This clear commitment from the organisation to the provision of reasonable adjustments will hopefully be reflected in an improved score for this indicator in the 2024 national staff survey.

WDES Indicator 9

Staff Engagement Score



	2019	2020	2021	2022	2023
Organisation average	6.92	6.94	6.70	6.62	6.83
Staff with a LTC or illness: Your org	6.56	6.51	6.23	6.25	6.44
Staff without a LTC or illness: Your org	7.01	7.06	6.86	6.75	6.98
Staff with a LTC or illness: Average	6.65	6.65	6.42	6.35	6.46
Staff without a LTC or illness: Average	7.13	7.14	6.97	6.92	7.04
Staff with a LTC or illness: Responses	861	902	1090	888	1411
Staff without a LTC or illness: Responses	3556	3524	3429	2761	3826

Note. Data shown in this chart are unweighted therefore will not match weighted staff engagement scores in other outputs.

Whist this indicator has seen improvements for all colleagues compared to the previous two years, it is below our NSS peer comparator group, but in line with the WDES national average from the 2023 Data Report of 6.4 for colleagues with a long term condition and 6.9 for colleagues without a long term condition.

WDES Indicator 10

Percentage difference between the organisations Board voting membership and its organisations overall workforce, disaggregated by the voting membership of the Board and executive membership of the Board

Disability Representation	2024
Difference Total Board: Overall Organisation	11.32%
Difference Voting Membership: Overall Organisation	12.2%
Difference Executive Membership: Overall Organisation	15.53%

Boards are expected to be broadly representative of their workforce. The percentage difference between the organisation's Board membership and its organisation's overall workforce is a positive 15.8% and an improvement on last year and better than the national average of 5.7%.

Summary and Action Plan

The 2024 WDES data analysis demonstrates continued year on year improvement in the workforce experiences of colleagues with a disability or long term condition (9 of the 10 WDES indicators have improved) reflecting the sustained focus we have placed on workplace adjustments and formalising these within policy and process.

With more than 1 in 4 of UHNM colleagues sharing through the national staff survey that they are working with a long term condition or illness it is essential that we close the gaps that exist in experience between colleagues and build upon the progress made in the last 12 months.

The actions we have identified below recognise the areas of continued concern from this year's WDES. The work we are also doing regarding colleague experience of bullying, harassment and abuse and discrimination as part of the Race Equality Task & Finish Group is also designed to address the behaviours experienced by colleagues with disabilities or long-term conditions as well as other marginalised groups and intersectionality represented amongst our workforce.

During 2024-25 we will:
1) Embedding the Reasonable Adjustments Policy and processes
2) Supporting colleagues to have positive and confident conversations about long term conditions
3) Increasing awareness and support for colleagues with neurodifference

	Embedding the Reasonable Adjustments Policy	Supporting Colleagues to have Confident Conversations	Supporting colleagues with neurodifferences
Indicator	1,2,3,4,5,6, 7,8,9	4,5,6,7,8,9	4,5,6,7,8,9
Actions for change	• Review the effectiveness of our Reasonable Adjustments Policy, one year on from its launch • Refresh the line manager people policy application training to increase capability on compassionate management of colleagues with long term conditions and the importance of adjustments in the recruitment process	• Introduce the purple space Confident Conversations approach at the 2024 Workforce Disability Inclusion Conference • Continue to increase the number of Disability Champions buddy programme	• Introduce guidance about the adjustments available in the recruitment process for neurodifferent applicants • Raise awareness of neurodifference through a range of resources and sessions (including a specialist session from Diverse Learners at the 2024 Workforce Disability Inclusion Conference) • Increase neurodifferent Disability Champion representation
Aim	Increase the percentage of staff with a long lasting health condition or illness saying the organisation has made reasonable adjustments to enable them to carry out their work to at least the national WDES average of 73.4%. Reduce the percentage of colleagues reporting experience of harassment, bullying and abuse from managers to WDES average of	Increase the percentage of staff with a long lasting health condition or illness saying the organisation has made reasonable adjustments to enable them to carry out their work to at least the national WDES average of 73.4% and the Staff Engagement Score to 6.4	Increase the staff engagement score to at least 6.4 and increase the percentage of staff with a long lasting condition who say that reasonable adjustments have been made to enable them to carry out their work to at least 73.4%

	16.1% and presenteeism indicator of 28.5%		

Progress will be measured by improved metric results in the 2024 Staff Survey, 2025 WDES submission, divisional EDI dashboards and the monitoring of other relevant metrics including the Employee Voice feedback and the lived experiences of our Disability and Long Term Conditions Staff Network membership.

Conclusions from the 2024 WRES and WDES

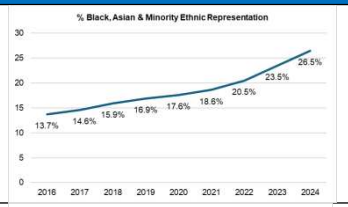
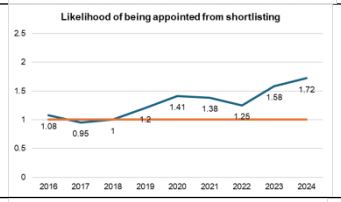
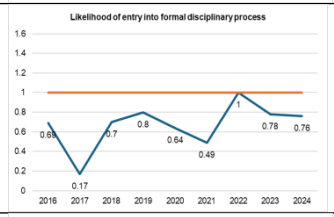
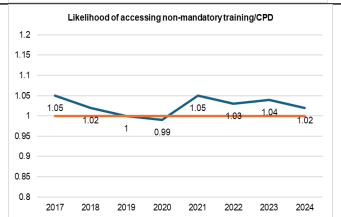
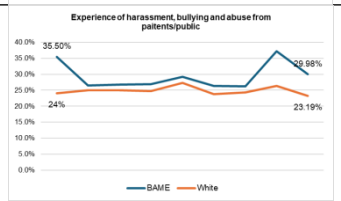
This report demonstrates some areas for celebration with notable improvements in colleague experiences, particularly in the WDES indicators, but acknowledges that there remains much to do to address inequity in all aspects of workplace experiences for colleagues.

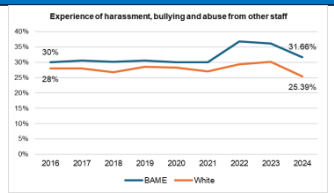
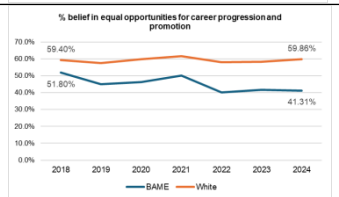
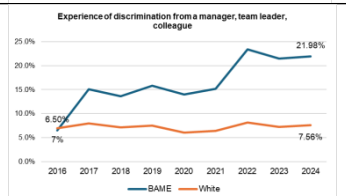
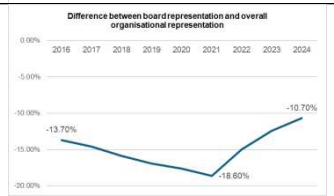
Achieving equality requires targeted listening and action to overcome specific inequalities, discrimination and marginalisation and this is the intention of our action plans this year.

Progress will be measured by improved performance in the 2024 National Staff Survey, 2025 WRES and WDES submissions, divisional EDI dashboards and the monitoring of other relevant metrics including the lived experiences of our diversity staff network membership.

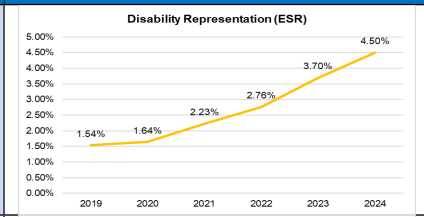
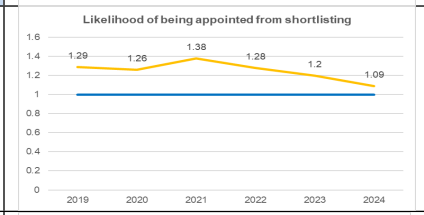
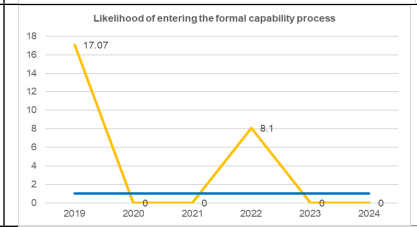
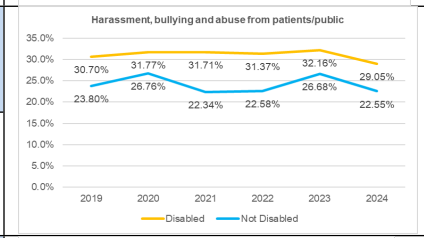
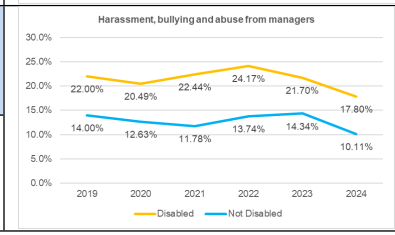
Our enhanced Trust EDI Steering Group will monitor the delivery and impact of the WRES and WDES actions on a quarterly basis.

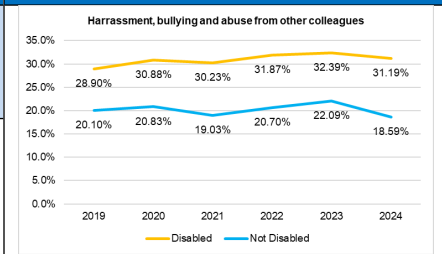
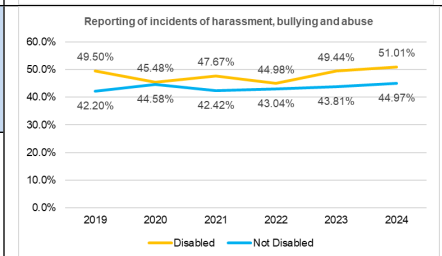
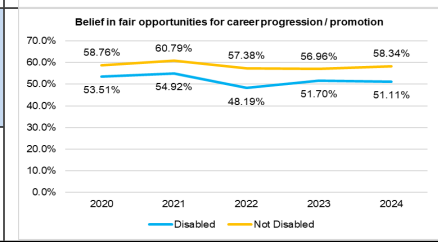
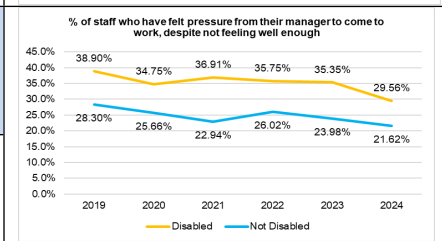
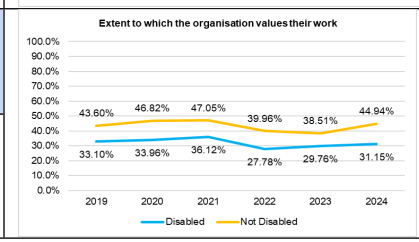
Appendix 1: Summary of WRES Indicator Trends

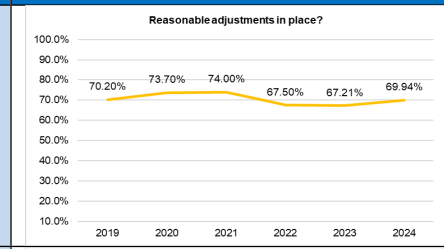
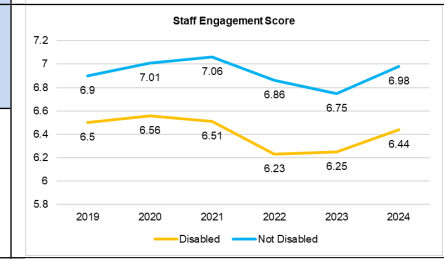
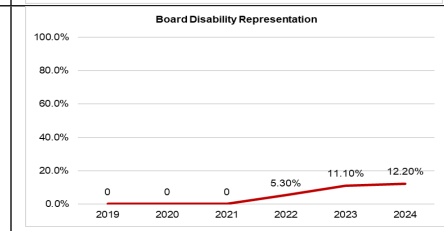
	WRES Indicator		2016	2017	2018	2019	2020	2021	2022	2023	2024	TREND
1	Percentage of Black, Asian & Minority Ethnic (BAME) colleagues within UHNM workforce		13.7%	14.6%	15.9%	16.9%	17.6%	18.6%	20.5%	23.5%	26.5%	
2	Relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants		1.08	0.95	1.0	1.20	1.41	1.38	1.25	1.58	1.72	
3	Relative likelihood of BAME staff entering formal disciplinary processes compared to white staff		0.69	0.17	0.70	0.80	0.64	0.49	1.0	0.78	0.76	
4	Relative likelihood of white staff accessing non - mandatory training/CPD compared to BAME staff		-	1.05	1.02	1.0	0.99	1.05	1.03	1.04	1.02	
5	% of staff experiencing harassment, bullying & abuse from patients, relatives and the public	BAME	35.5%	26.5%	26.7%	26.9%	29.15%	26.32%	26.20%	37.16%	29.98%	
		White	24%	25%	25.%	24.7%	27.25%	23.73%	24.31%	26.30%	23.19%	

WRES Indicator			2016	2017	2018	2019	2020	2021	2022	2023	2024	TREND
6	% of staff experiencing harassment, bullying & abuse from other staff	BAME	30%	30.6%	30.2%	30.5%	30.03%	30.02%	36.80%	36.14%	31.66%	
		White	28%	28%	26.7%	28.5%	28.26%	26.98%	29.36%	30.13%	25.39%	
7	% of staff believing the trust provides equal opportunity for career progression/promotion	BAME			51.8%	45.0%	46.30%	50.07%	40.06%	41.82%	41.31%	
		White			59.4%	57.5%	59.8%	61.6%	58.1%	58.4%	59.86%	
8	% of staff personally experiencing discrimination from a manager / team leader / colleague	BAME	6.5%	15.1%	13.6%	15.8%	13.97%	15.19%	23.39%	21.44%	21.98%	
		White	7%	8%	7.1%	7.5%	6.08%	6.44%	8.11%	7.25%	7.56%	
9	BAME Board representation		-13.7%	-14.6%	-15.9%	-16.9%	-17.6%	-18.6%	-15%	-12.4%	-10.7%	

Appendix 2: Summary of WDES Metric Trends

WDES Indicator			2019	2020	2021	2022	2023	2024	TREND
1	Disability representation in the organisation		1.54%	1.64%	2.23%	2.76%	3.7%	4.5%	
2	Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting		1.29	1.26	1.38	1.28	1.20	1.09	
3	Relative likelihood of Disabled staff compared to non-disabled staff entering into the formal capability process		17.07	0.0	0.0	8.1	0.0	0.0	
4a	% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months	Disabled	30.7%	31.77%	31.71%	31.37%	32.16%	29.05%	
		Not Disabled	23.8%	26.76%	22.34%	22.58%	26.68%	22.55%	
4b	% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	Disabled	22.0%	20.49%	22.44%	24.17%	21.70%	17.80%	
		Not Disabled	14.0%	12.63%	11.78%	13.74%	14.34%	10.11%	

WDES Indicator			2019	2020	2021	2022	2023	2024	TREND
4c	% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	Disabled	28.9%	30.88%	30.23%	31.87%	32.39%	31.19%	
		Not Disabled	20.1%	20.83%	19.03%	20.70%	22.09%	18.59%	
4d	% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Disabled	49.5%	45.48%	47.67%	44.98%	49.44%	51.01%	
		Not Disabled	42.2%	44.58%	42.42%	43.04%	43.81%	44.97%	
5	% of staff that believe the Trust provides equal opportunities for career progression and promotion	Disabled	-	53.51%	54.92%	48.19%	51.70%	51.11%	
		Not Disabled	-	58.76%	60.79%	57.38%	56.96%	58.34%	
6	% of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Disabled	38.9%	34.75%	36.91%	35.75%	35.35%	29.56%	
		Not Disabled	28.3%	25.66%	22.94%	26.02%	23.98%	21.62%	
7	% of staff satisfied with the extent to which the organisation values their work	Disabled	33.1%	33.96%	36.12%	27.78%	29.76%	31.15%	
		Not Disabled	43.6%	46.82%	47.05%	39.96%	38.51%	44.94%	

WDES Indicator			2019	2020	2021	2022	2023	2024	TREND
8	% of staff with a long lasting health condition or illness saying the organisation has made reasonable adjustments to enable them to carry out their work	Disabled	70.2%	73.7%	74.0%	67.5%	67.21%	69.94%	
9	Staff Engagement Score	Disabled	6.5	6.56	6.51	6.23	6.25	6.44	
		Not Disabled	6.9	7.01	7.06	6.86	6.75	6.98	
10	Board disability representation		0.0	0.0	0.0	5.3%	11.1%	12.2%	

University Hospitals of North Midlands NHS Trust

Integrated Performance Report (IPR)

Month 5 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 Sepsis - Adult Inpatient Screening Agency Utilisation Cancer 28 Day FDS Daycase / Elective Activity Outpatients' 1st	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
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 Pressure ulcers developed under UHNM per 1000 bed days 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 UEC Cat Handover Average Time Outpatients' Follow Up Subject Access Request Performance Data Security Breaches	Family & Friends Test - ED Employee Engagement Sickness Absence (In Month) Cancer 31 Day Combined Cancer 62 Day Combined UEC 12 Hour Trolley Wait Freedom of Information Performance	Increase Clinical Academic Posts/Honorary Contracts
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, MW triage, falls with harm, pressure ulcers developed under UHNM, pressure ulcer with lapses in care, DOC verbal, MRSA bacteraemia, FFT inpatients, hospital acquired thrombosis, sepsis inpatients and HSMR/SHMI.

Some metrics, whilst not at target, are seeing continual improvement including C-diff and timely observations. We failed to meet the required target for DOC written, e-coli , VTE assessments and sepsis in maternity and children. We are also reporting 2 never events 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 . Maternity Sepsis is now a Directorate Driver metric and progress will be monitored via MNQSOG/QSOG.

We had a CQC inspection in relation to the S29a at County on 4th July. We received confirmation from the CQC that we did meet the S29a requirements and we still await the draft report.

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

What is driving this?

Falls with harm reducing overall since peak in April 2022 however in month there were 5 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

Nationally infections continue above pre-pandemic levels whilst differential regional trends persist. The Midlands is the 3rd highest region for hospital onset C-Diff per 100,000 bed days.

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.

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.

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

UHNM are participating in regional work focusing on C-Diff to consider root causes of increased rates and any learning for organisations. If e-coli and C-diff rates remain as they are currently, or continue to improve, we would hope to meet the 24/25 objectives.

The never events are being reviewed thematically utilising PSIRF PSII

Intensive corporate support to Bronze CEF wards

What can we expect in future reports?

NHSE and UKHSA issued the 2024/25 HCAI objectives on 27th August 2024. In addition to the usual MRSA bacteraemia and C difficile toxin, thresholds have been issued for the Gram negative blood stream infections: e-coli, pseudomonas aeruginosa and klebsiella spp. Inline with other NHS Hospitals in England the UHNM objective for MRSA bacteraemia is zero. There is a NHSE ambition to reduce C-Diff outturn by 5% -UHNM objective 179; E-Coli objective 246; Pseudomonas objective 35 and Klebsiella spp objective 79.

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

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

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

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

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%	98.0%	97.7%						
Maternity Triage	85.0%	96.0%	92.3%						
Patient Safety Incidents rate per 1000 bed days	50.7	51.0	46.2						
Patient Safety Incidents with moderate harm and above per 1000 bed days	0.6	0.6	0.8						
Patient falls with harm per 1000 bed days	1.5	1.7	1.4						
Medication Incidents per 1000 bed days	6.0	5.8	5.4						
Medication Incidents % with moderate harm or above	0.5%	3.3%	1.3%						
Patient Safety Incident Investigation (PSII's) instigated	0.0	6.0	2.0						
Never Events per month	0.0	0.0	2.0						
Pressure ulcers developed under UHNM per 1000 bed days	1.6	1.7	1.5						
Family & Friends Test - Inpatient	95.0%	95.4%	95.7%						
Family & Friends Test - ED	85.0%	68.2%	77.1%						
Family & Friends Test - Maternity	95.0%	90.4%	86.7%						
Sepsis - Adult Inpatient Screening	90.0%	94.1%	94.2%						
Sepsis - Adult Inpatient IVAB	90.0%	100.0%	100.0%						
Sepsis - ED Portals Screening	90.0%	91.5%	84.7%						
Sepsis - ED Portals IVAB	90.0%	75.0%	82.1%						
Sepsis - Childrens Screening	90.0%	88.0%	85.7%						
Sepsis - Childrens IVAB	90.0%	n/a	n/a						
Sepsis - Maternity Screening	90.0%	72.2%	78.9%						
Sepsis - Maternity IVAB	90.0%	71.4%	0.0%						
Reported C Diff case per month	8.00	12.00	10.00						
HAI E Coli Bacteraemia cases per month	16.00	20.00	19.00						

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 outside the process limits.

The icon will change to orange when we consistently fall 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)

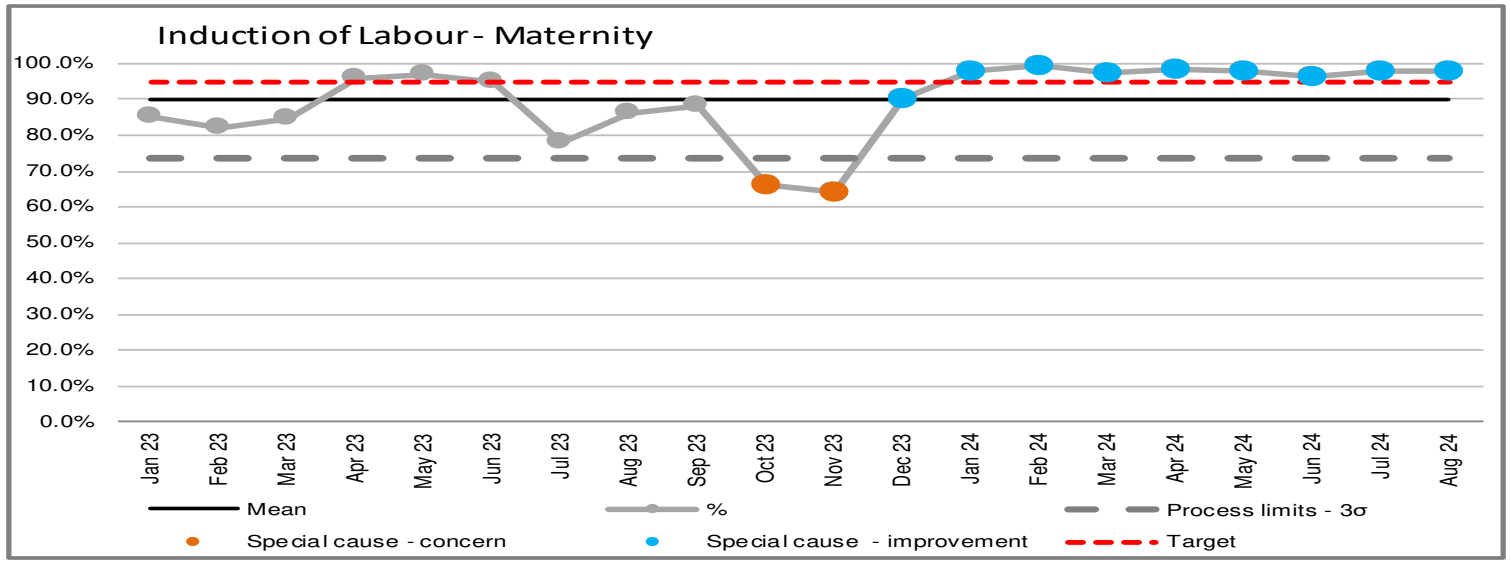
Quality Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 1: Delivering Positive Patient Outcomes	High 12	Partial					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	Jun 24	Jul 24	Aug 24
95%	96.3%	98.0%	97.7%

Background

Induction of Labour Compliance

What is the data telling us?

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

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

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

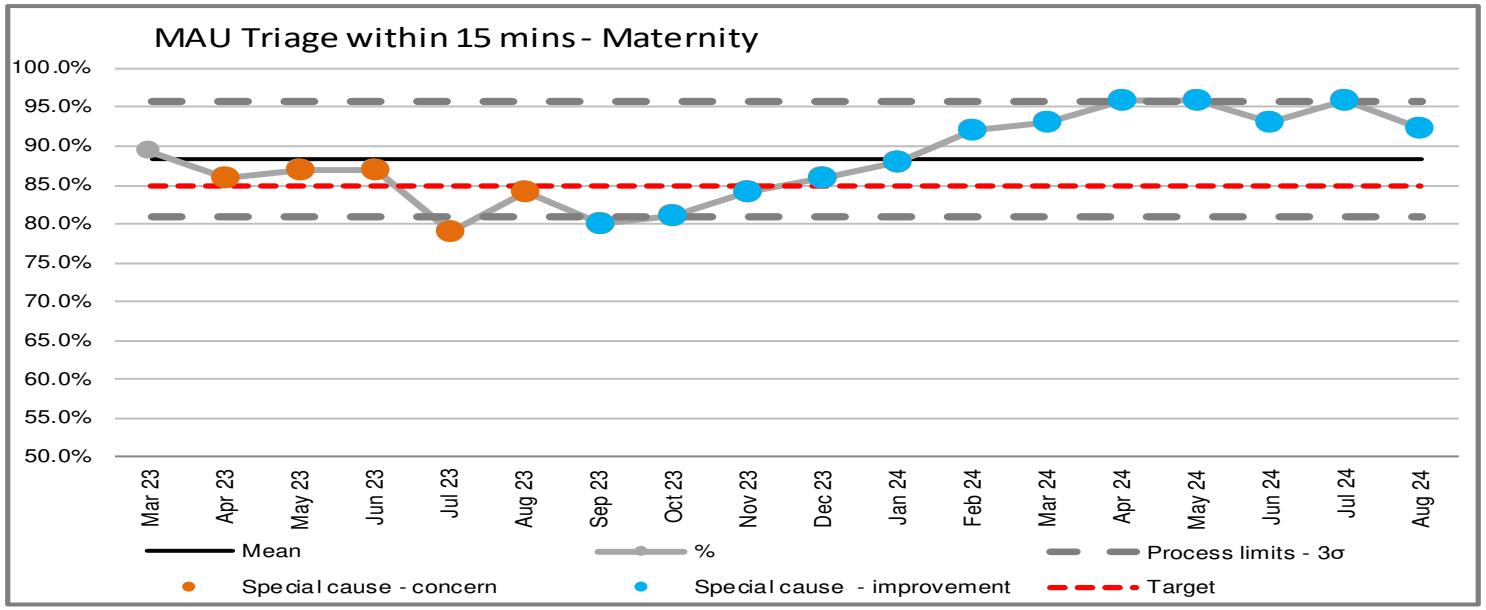
What are we doing about it?

Any IOL breaches are safety netted and incident reported for full review through the internal governance process.
IOL Datix are grouped into an IOL Improvement group tab, allowing a refined audit & review with focus on IOL themes.
Any IOL breaches are discussed daily at the patient safety huddle and escalated.
Any IOL breaches will have a well being 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
H	P

Target	Jun 24	Jul 24	Aug 24
85%	93.0%	96.0%	92.3%

Background

Maternity patients triaged within 15 minutes.

What is the data telling us?

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

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

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

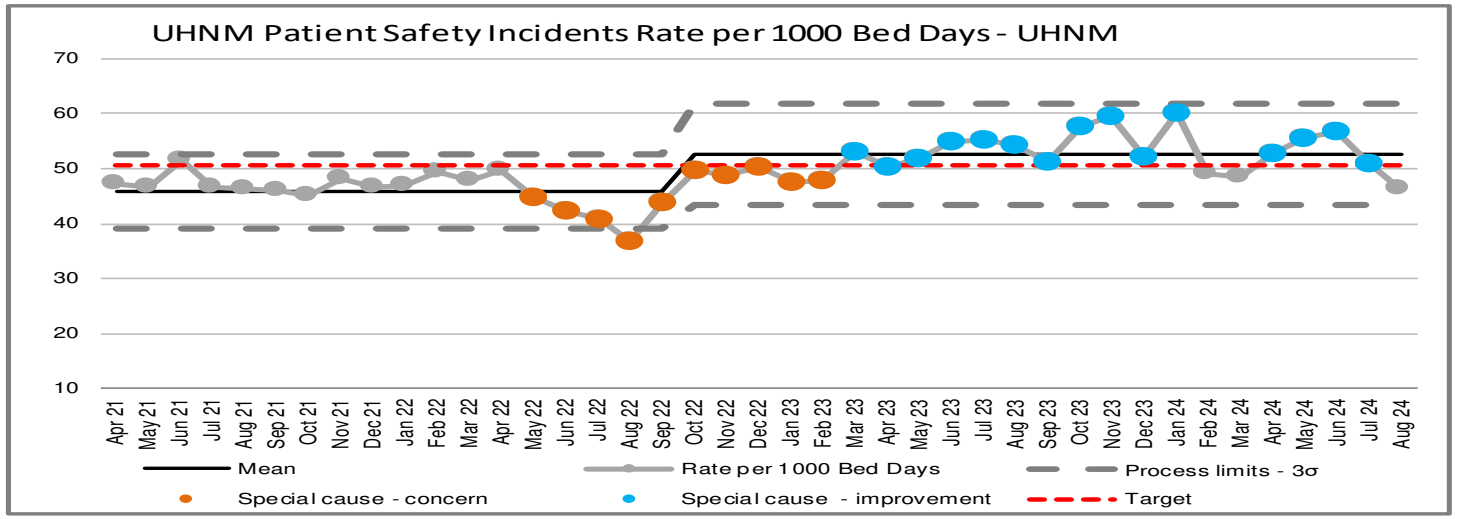
What are we doing about it?

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

High Quality | [PSIs per 1000bed days]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

NRLS Mean	Jun 24	Jul 24	Aug 24
50.70	56.65	51.01	46.18

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.

However, August 2024 is lower that 2023 with 46.18 compared to 54.2. Until this current month, the additional questions had not adversely affected the reporting of incidents when comparing rates with 2023.

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

What are we doing about it?

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

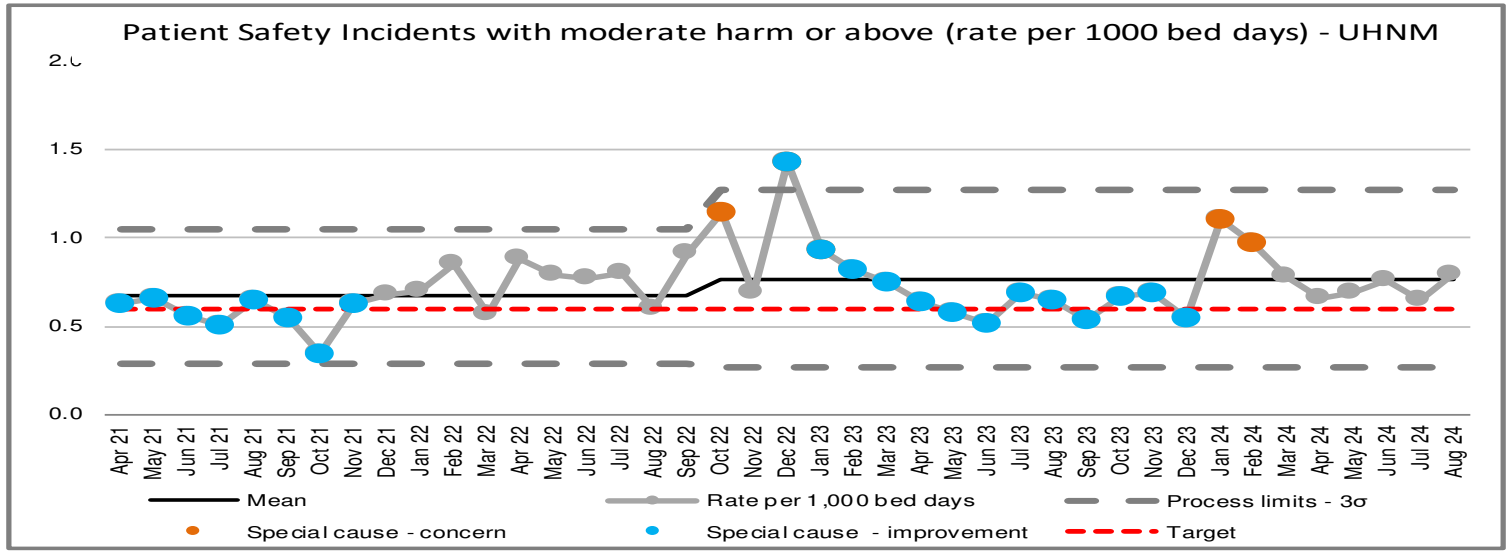
Will continue to monitor the internal reporting rates and identify if there are any specific reasons for reduced rate per 1000 bed days.

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

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jun 24	Jul 24	Aug 24
0.60	0.76	0.65	0.80

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 is returning to previous lower levels noted in 2023.

The rate in July 2024 was initially noted as increasing but following review of the reported incidents, when the data has been refreshed for August 2024, the July rate reduced to 0.65 from initial 0.86.has increased but is within normal variation.

What are we doing about it?

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

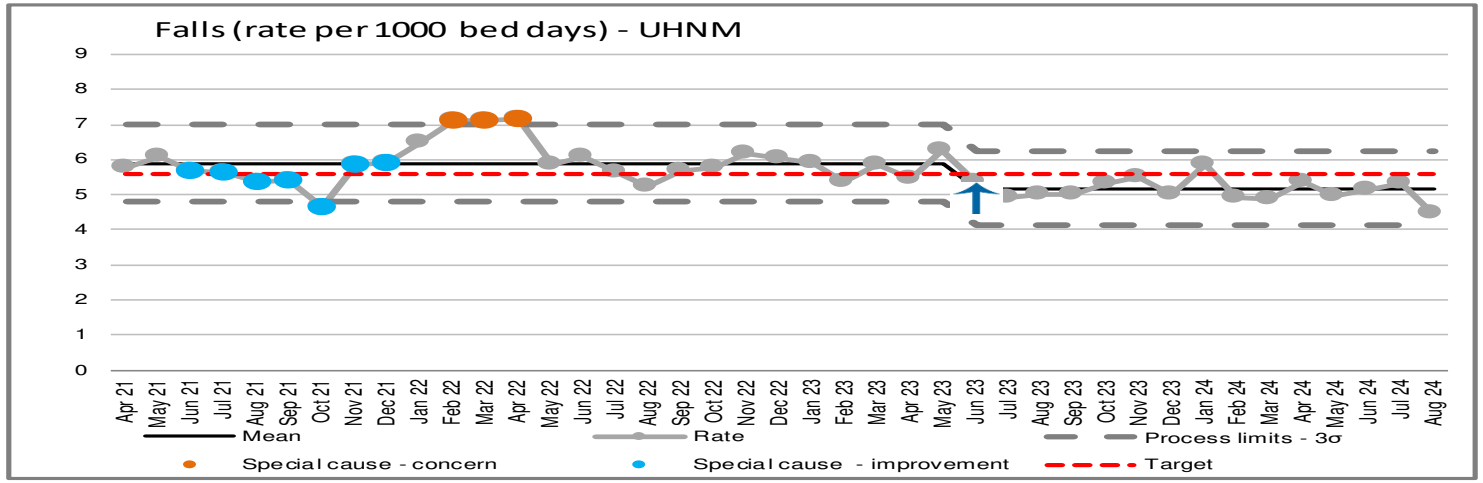
To support PSIRF principles we are reviewing learning and proportionate responses to incident reviews with formal review scheduled in October 2024.

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 per 1000 bed days]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
5.6	5.1	5.3	4.5

Background

The number of falls per 1000 occupied bed days

What is the data telling us?

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

The areas reporting the highest numbers of falls in August 2024 were:
Royal Stoke ECC – 13 falls, Ward 126 – 10 falls

What are we doing about it?

ECC have introduced yellow wristbands for those patients that have falls risk factors and data of this is being collected. ECC continue to document the risk assessments and falls bundles electronically. Further discussions have taken place regarding the electronic documentation to ensure conciseness and clarity.

Audits and discussions have been undertaken in both areas to improve compliance.

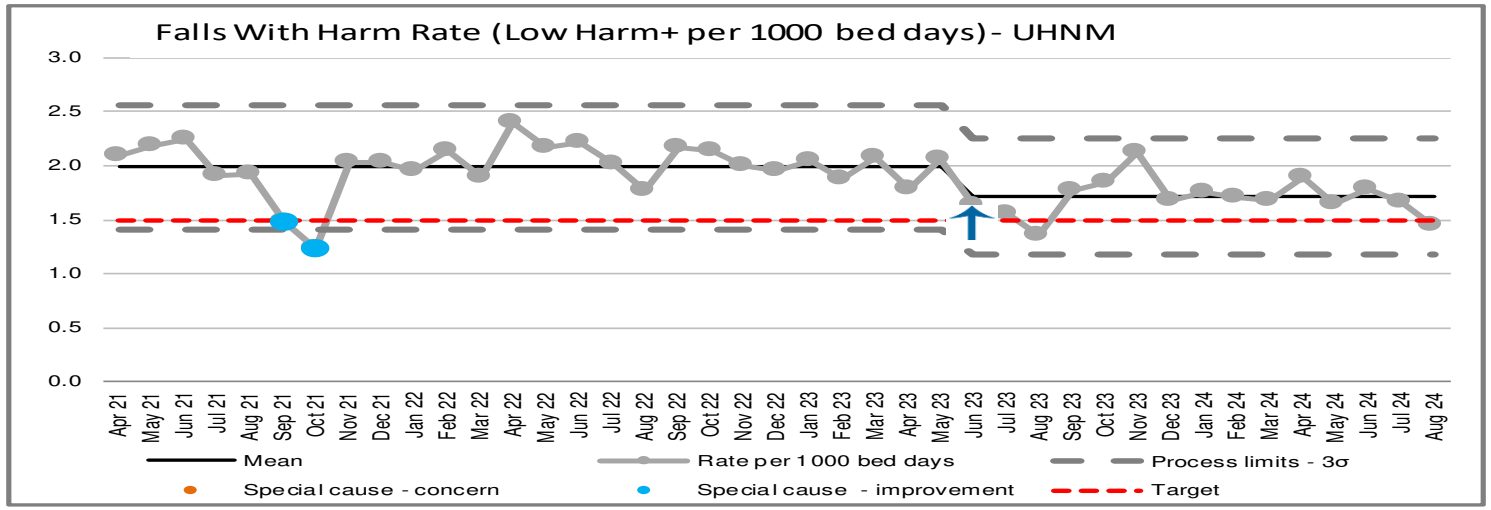
There have been 2 weeks where no multiple fallers have occurred.

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

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
1.5	1.8	1.7	1.4

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 August 2024.

Wards with falls reported as resulting in serious injuries in August (5 incidents):
Stoke ED, SSU, Ward 12, Ward 78, Ward 113

What are we doing about it?

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

Investigations to the 5 injuries showed:

2 patients had not pressed the call bell to ask for assistance

1 patient had not used their mobility frame to walk

1 patient had requested to sleep in the chair and had slipped to the floor while asleep

1 patient had lost strength when standing and had been lowered to the floor

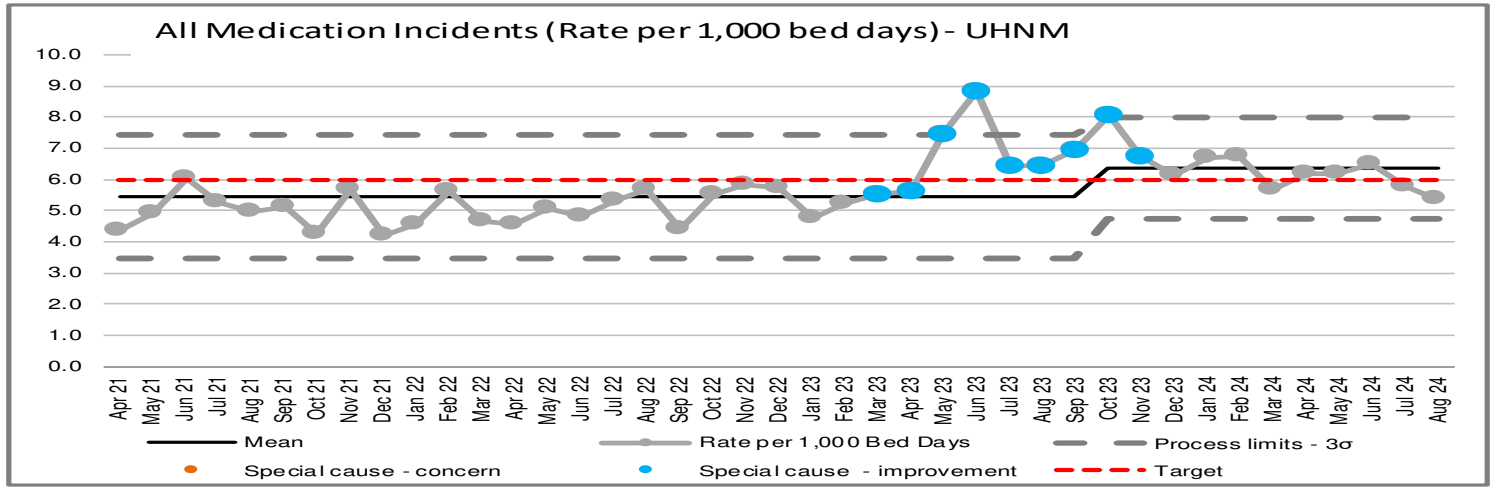
New call don't fall posters have been produced, they advise that the staff are there to support and assist patients.

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

High Quality | [Medication Incidents per 1000 bed days]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

NRLS Mean	Jun 24	Jul 24	Aug 24
6.0	6.5	5.8	5.4

Background

Reported Medication incidents rate per 1,000 bed days

What is the data telling us?

In, ondansetron, suspicious losses of Codeine 30mg tabrecent months the rate of medication related incidents had reduced following increases during 2023 with promotion of reporting medication errors as PSIs. However, the longer-term trend is still showing improvement/increased reporting compared 2021 and 2022.

Recent themes includes insulin, anticoagulantslets.

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

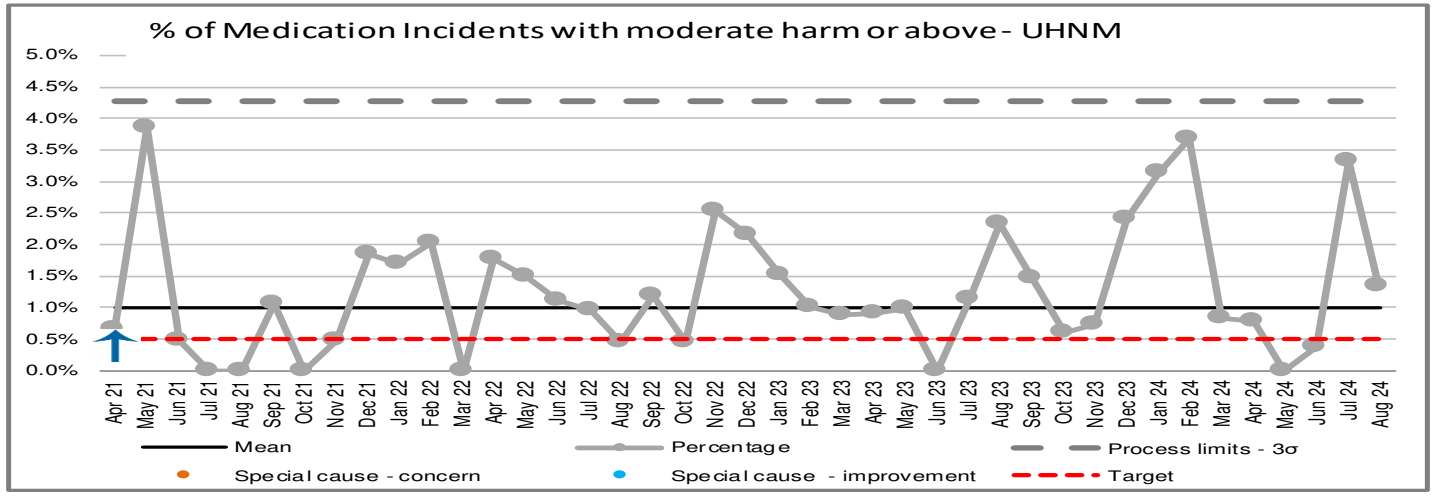
What are we doing about it?

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

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
0.5%	0.38%	3.33%	1.35%

Background

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

What is the data telling us?

The August 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?

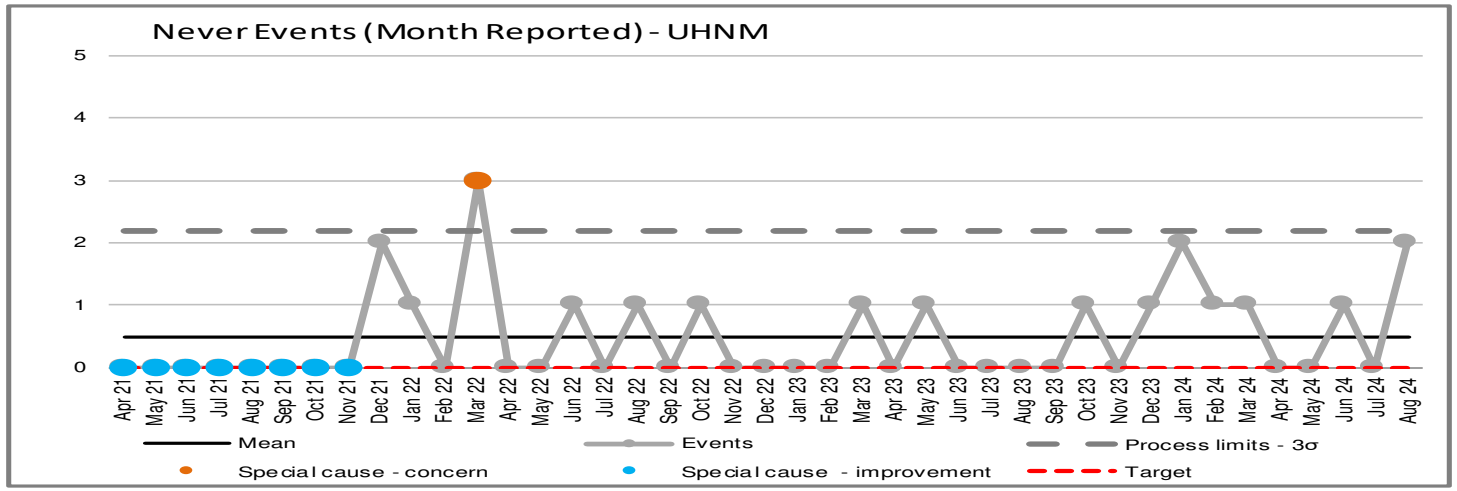
The reported incidents are reviewed and assessed via the Pharmacy Safe Medications Team along with input from the relevant clinical areas to share learning and actions

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



Variation	Assurance

Target	Jun 24	Jul 24	Aug 24
0	1	0	2

Background

NHSE defined as Incidents that are wholly preventable, as strong systemic protective barriers should be in place.

What is the data telling us?

There has been 2 reported Never Events during August 2024.

Both incidents related to wrong site surgery which occurred at end of July 2024 but were reported as Never Events in August 2024.

- Incorrect varicose veins procedure undertaken
- Incorrect skin lesion removed for biopsy

What are we doing about it?

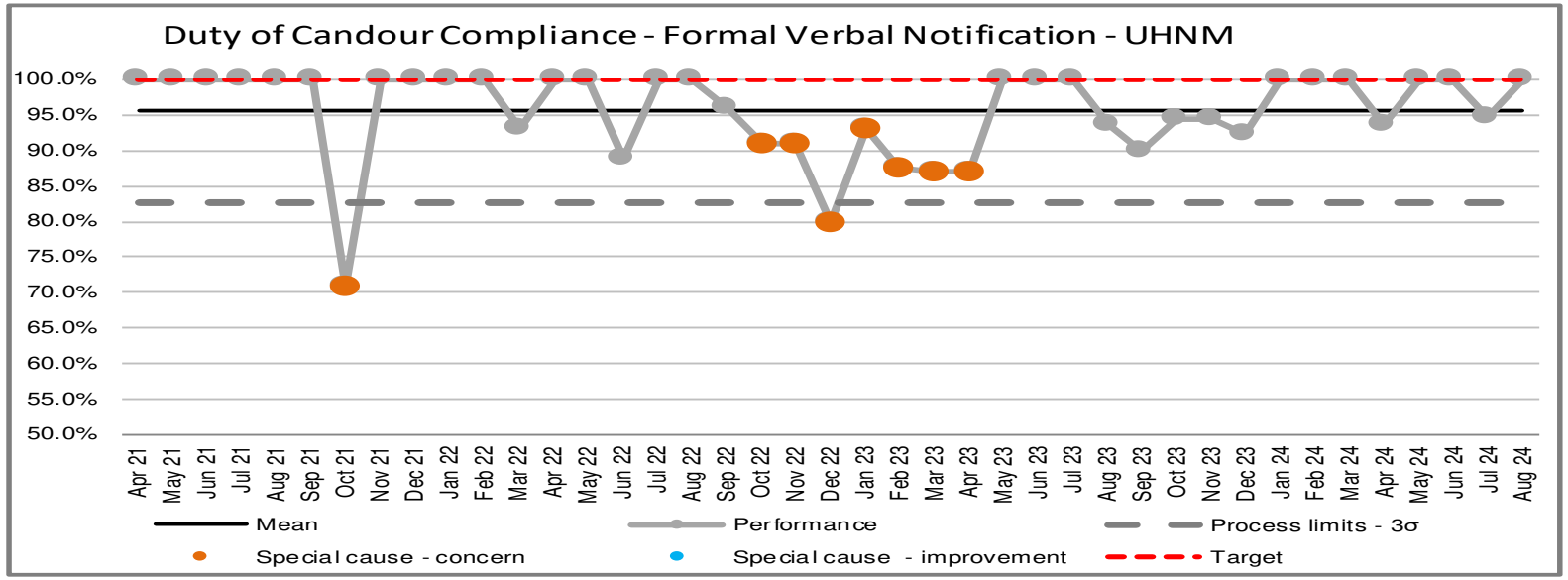
The Never Events reported during 2024 which relate to Wrong site surgery (incorrect lesions removed or biopsy) are under review within Specialised Surgery services utilising PSIRF Patient Safety Incident Investigation along with thematic review of these new incidents and previously reported wrong site 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 | [Duty of Candour – verbal/formal notification]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
100%	100.0%	94.7%	100.0%

Background

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

What is the data telling us?

The achievement of verbal duty of Candour has been inconsistent with the recording of the completion of this in Datix. During August 2024 we have noted all cases had verbal Duty of Candour completed.

What are we doing about it?

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

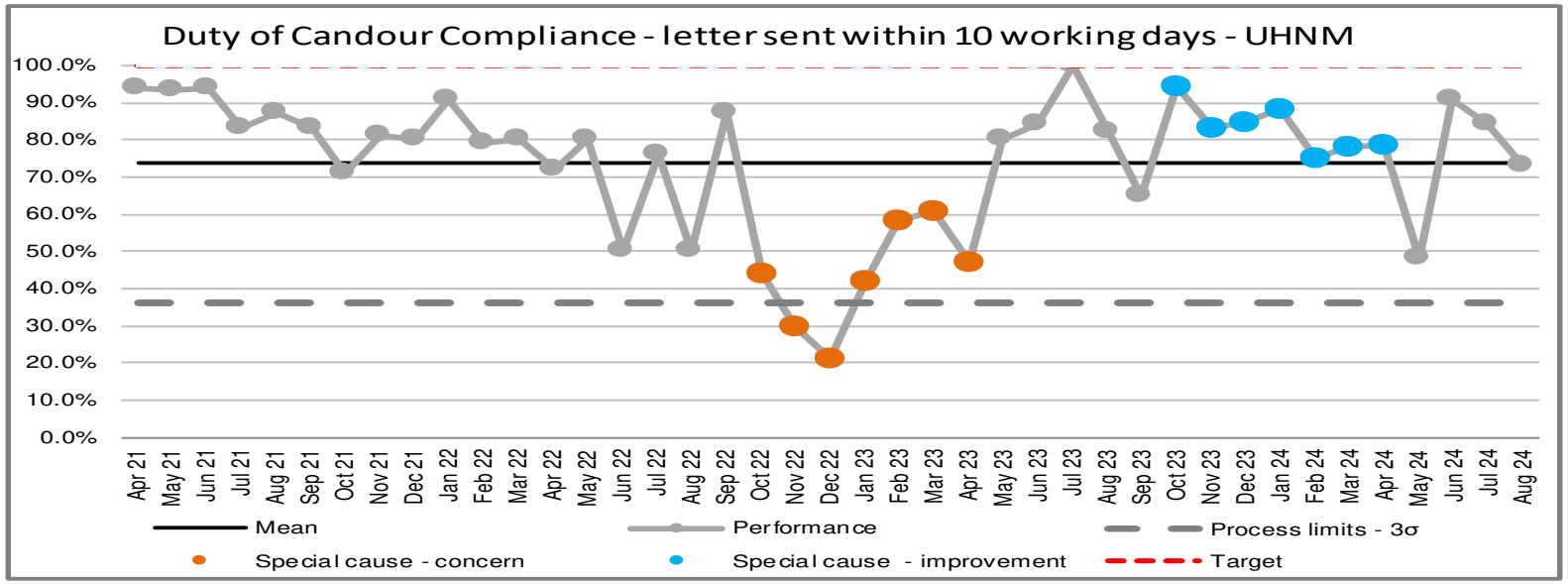
Teams are reminded that evidence of verbal Duty of Candour must be recorded in Datix and notes to demonstrate that conversations have been completed. When reviewing and discussing with staff the discussions are being held but these are not always being appropriately recorded in Datix.

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

High Quality | [Duty of Candour – written notification]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jun 24	Jul 24	Aug 24
100%	91.0%	84.2%	73.1%

Background

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

What is the data telling us?

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

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

There were 7 out of 26 cases that were not completed with 10 working day target within Medicine and WCCSS Divisions

What are we doing about it?

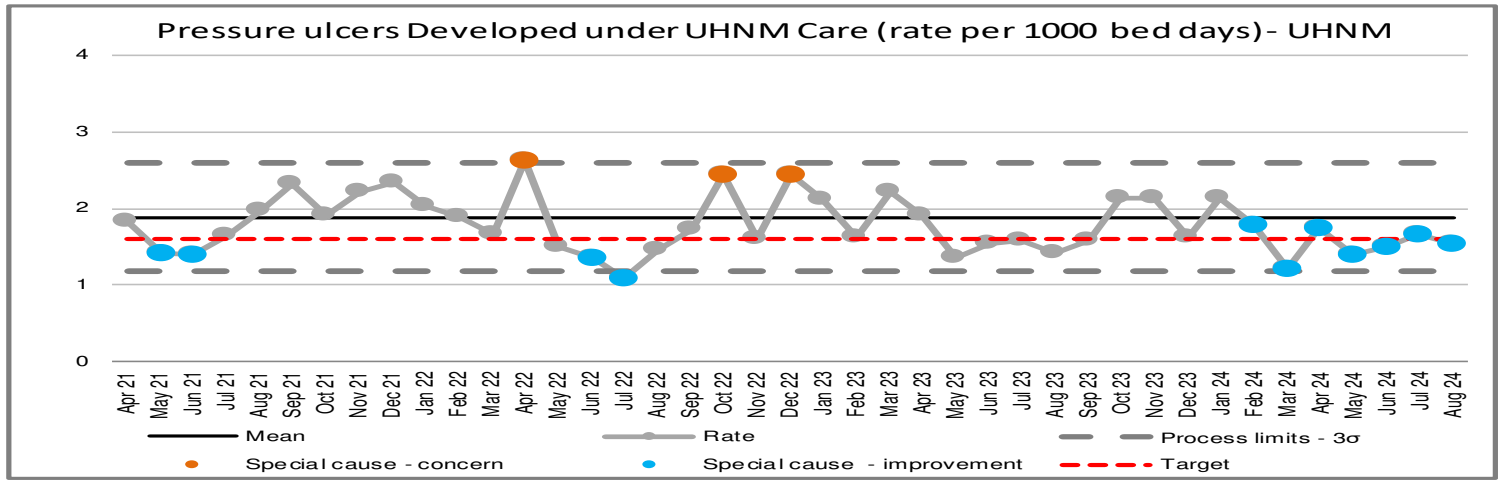
Divisions are reviewing the cases of non compliance and following up with respective areas to work on improving the timely completion and evidencing that letters have been sent out.

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

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
1.6	1.49	1.66	1.54

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 7 months which may indicate significant change.

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

As well as pressure ulcers, 4 urethral splits were reported in July, 2 with lapses identified (1 TBC). This is fewer than have been reported any time in the past 2 years.

What are we doing about it?

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

The implementation of Purpose T in the new risk assessment booklet is now in circulation. Education has been shared with departments.

Focus of the month has been shared which will focus on assessments.

Surface upgraded reminder included on the electronic documentation.

Prompt cards being developed to include QR codes for prevention, categorisation, and appropriate pathways. .

Consultant connects to be trailed in AMU.

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

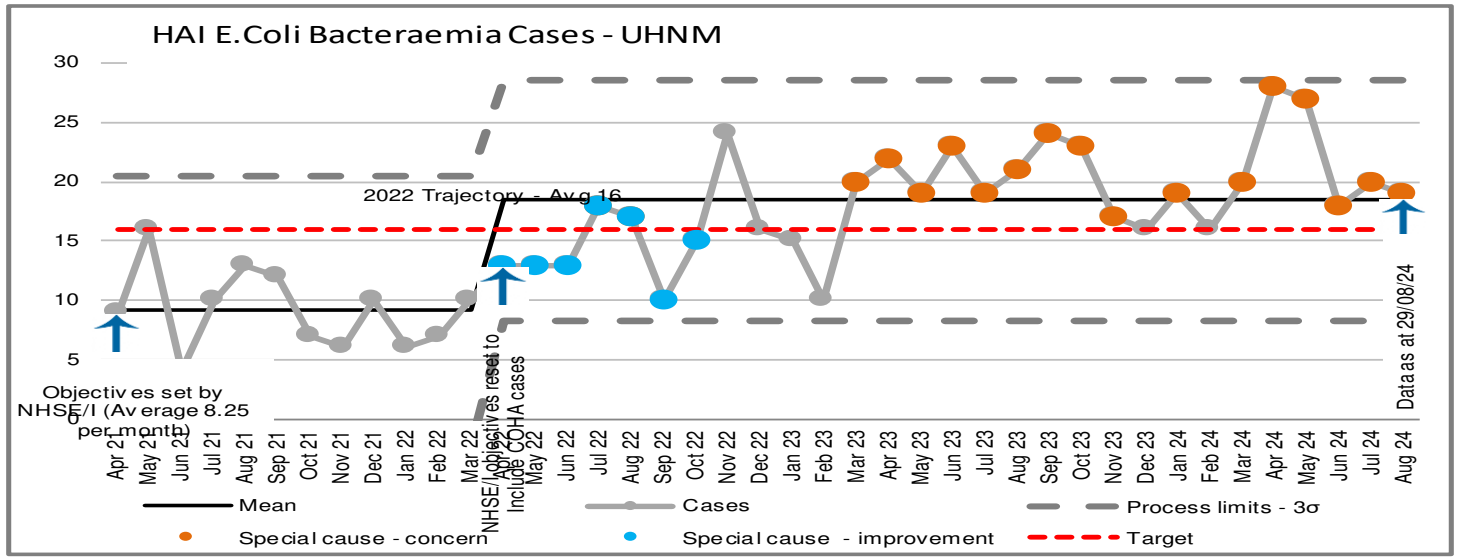
Harm free care educators in post to support improvements.

External company supporting with education for catheter trays, fixation, and Purewick.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
16	18	20	19

Background

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

What is the data telling us?

E.coli rates remain above trajectory.

The 2022/23 target trajectory changed to include both Hospital (HAI) and Community onset healthcare associated (COHA) infections which explains the increase in monthly cases reported since April 2022 compared to fiscal year 2021/22. We are awaiting the new thresholds from NHSE for 24/25

What are we doing about it?

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

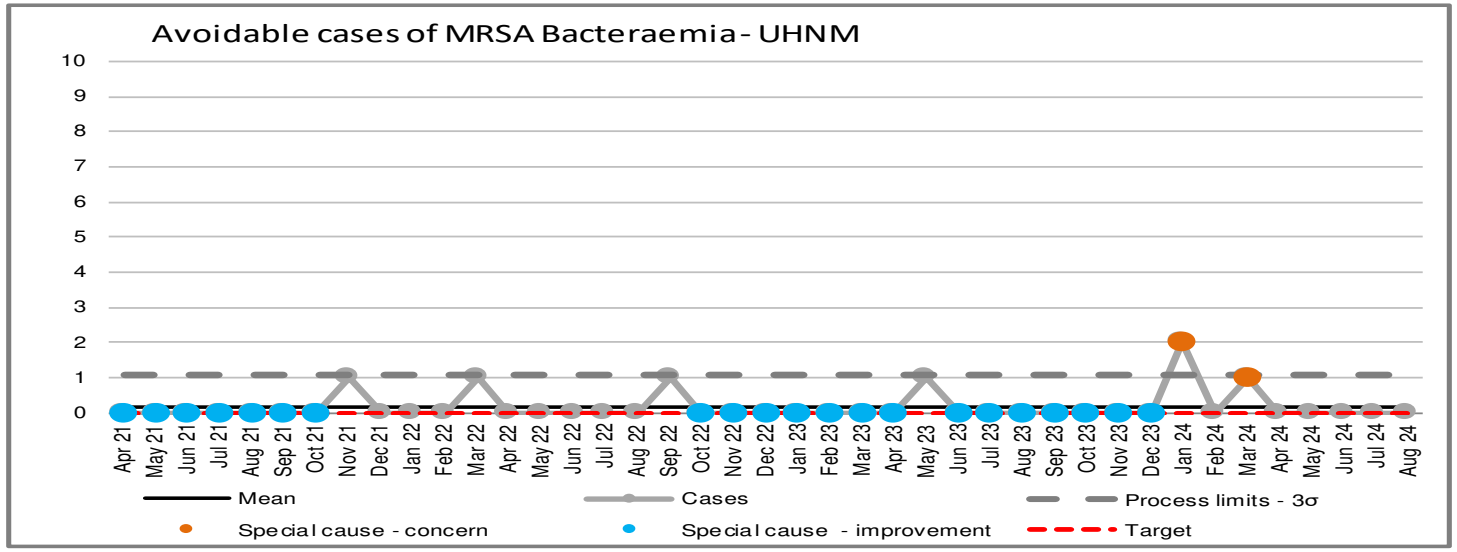
Additionally the ICB have established a T&F group to look at urinary tract infections.

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

High Quality | [Avoidable MRSA Bacteraemia cases per month]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
0	0	0	0

Background

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

What is the data telling us?

Zero avoidable cases during August 2024

What are we doing about it?

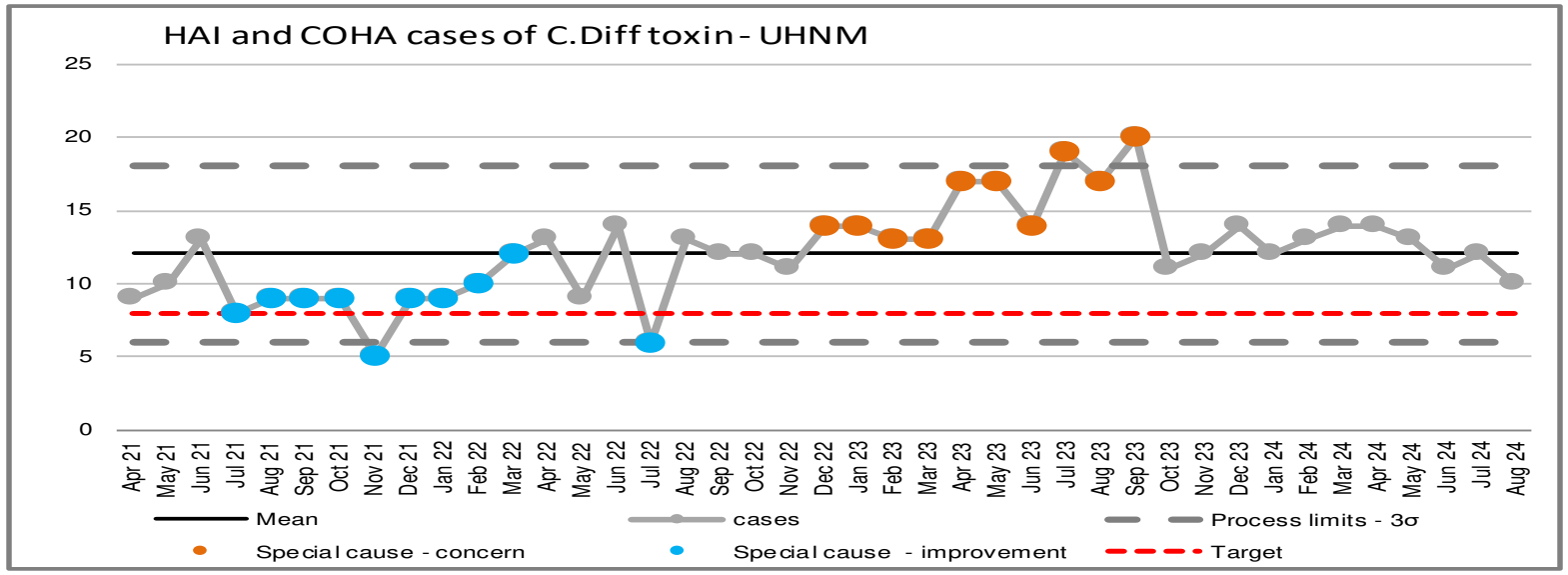
MRSA screening education continues.

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

High Quality | [Reported C Diff cases per month]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



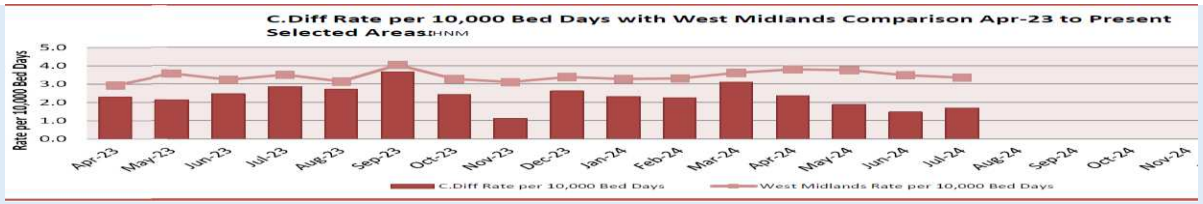
Variation	Assurance

Target	Jun 24	Jul 24	Aug 24
8	11	12	10

Background

Number of HAI + COHA cases reported by month

What is the data telling us?



Number of Cdiff cases still above trajectory although reduced from the peak in September. There have been 10 reported C diff cases in August 2024. 6 x HAI and 5 x COHA

The new thresholds from NHSE/UKHSA for 24/25 have now been received and the 24/25 objective for C-Diff is 179 cases or less. the AMR Core Contract metrics have been provided for Q1 24/25.

We are one of only 17% of Trust regionally (22% nationally) achieving a reduction in line with the target reduction in Watch and Reserve Antimicrobials

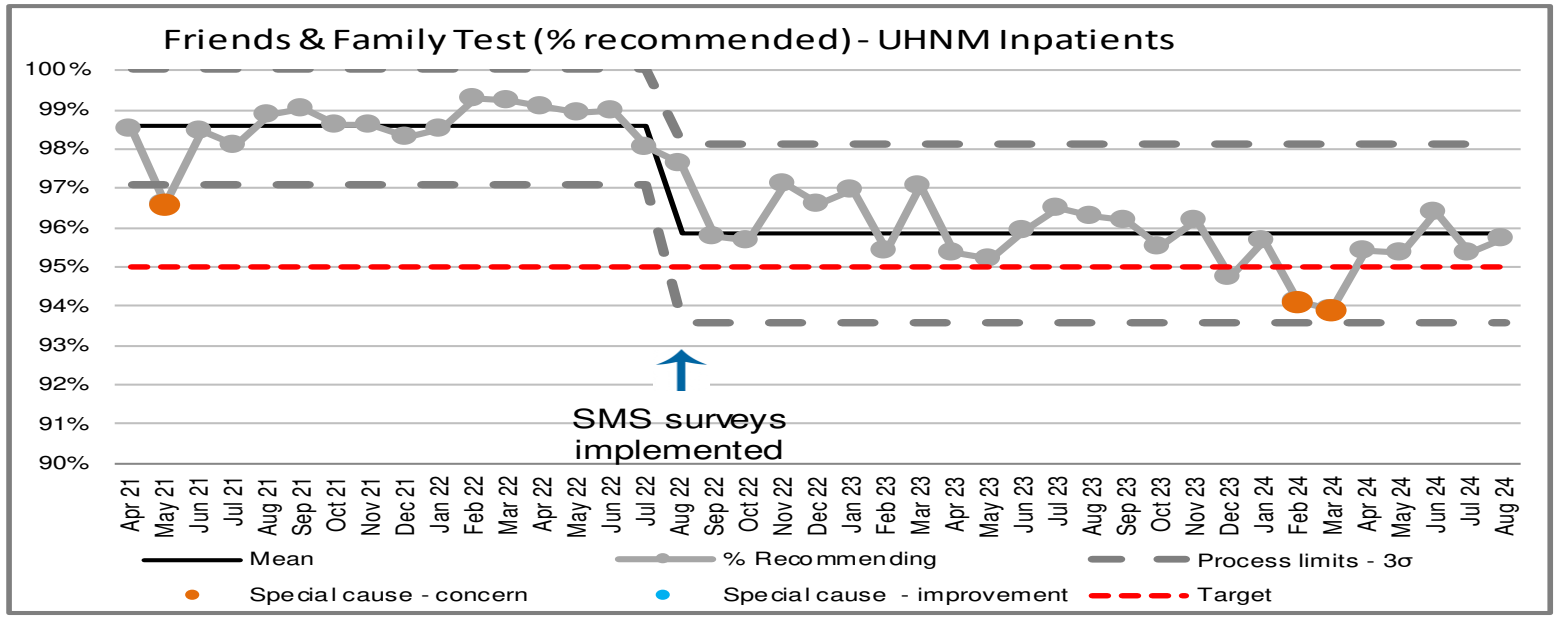
What are we doing about it?

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

High Quality | [Friends & Family Test - Inpatients]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jun 24	Jul 24	Aug 24
95%	96.4%	95.4%	95.7%

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 August 2024. The average rate remains above the national average of 94% (April 2024 NHS England).

In August 2024, a total of 3192 responses were collected from 67 inpatient and day case areas (11842 discharges) equating to a 27% return rate which, although lower than the internal target, is the highest volume response rate in at least 2 years. NHS England data has not been updated since April 2024 therefore UHNM remain the 16th highest response rate for all reporting Trusts in the country (152) and are 81st for percentage positive responses (NHS England April 24 latest data).

- Scores split by Division:
- Network- 29% response rate 97% satisfaction score
- Surgery- 28% response rate 93% satisfaction score
- Medicine- 26% response rate 95% satisfaction score

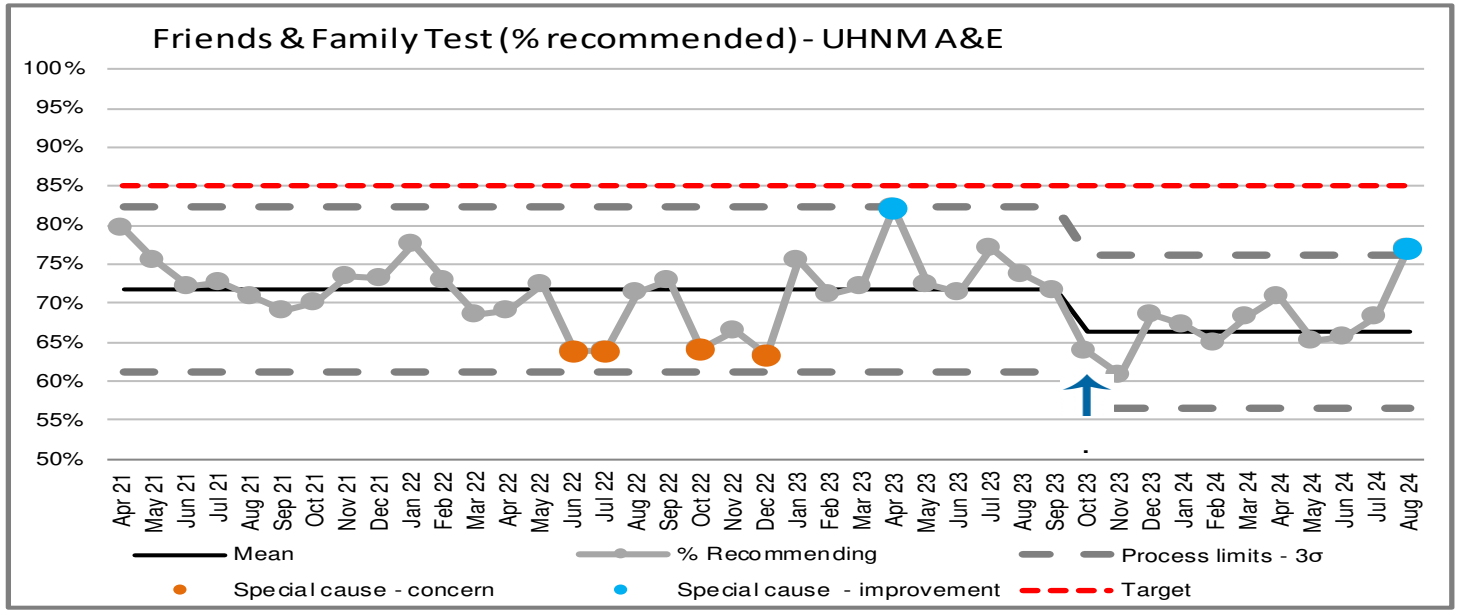
What are we doing about it?

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
H	F

Target	Jun 24	Jul 24	Aug 24
85%	65.6%	68.2%	77.1%

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 significantly higher in August 2024 than the average since October 2023.
The Trust received 1199 responses which was 8% and remains the same as the previous few months. The Trust's overall satisfaction rate is 77% while the national average is 79% UHNM is 39th out of 124 Trusts for the number of responses in ED (NHS England April 24), and 87th out of 124 Trusts for the percentage positive results (NHS England April 24- latest figures)

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

What are we doing about it?

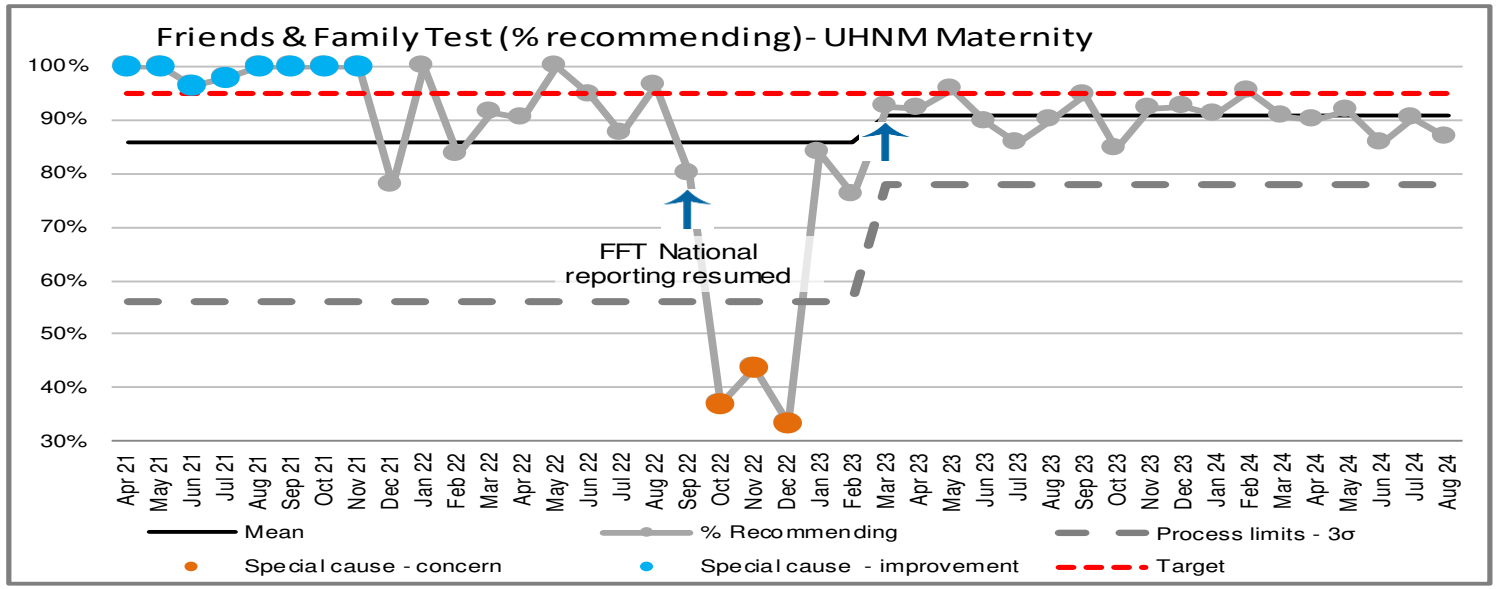
QR code made visible throughout the department.
Consideration to alternative methods of sharing QR code such as "business cards" available on reception and throughout the department.
Discuss with Dept Leads regarding ensuring mobile phone numbers are recorded in the "mobile" phone part of Iportal (not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

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

High Quality | [Friends & Family Test - Maternity]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
95%	85.5%	90.4%	86.7%

Background

FFT Maternity % patients Recommending Service

What is the data telling us?

The average % recommending has been stable since 2023.
There were a total of 158 surveys were received in August 2024 across all 4 touch-points (ante-natal, birth, post-natal ward; post-natal community) with 86 of these being collected for the "Birth" touch-point, providing a 17% response rate (based on number of live births- significant increase on previous month) and a 90% satisfaction score which is a 1% decrease on the previous month.
The Antenatal touch point scored 79% recommendation (29 surveys) which is an increase. The post-natal ward touch point scored 87% satisfaction rate (39 surveys).

Compared to the latest national data available (April 24) out of 112 reporting Trusts, UHNM were 64th for number of responses for antenatal & 79th for percentage positive; 54th for number of responses for birth & 83rd for percentage positive, 50th for post-natal ward & 48th for percentage positive; and 36th for post-natal community & 33rd for percentage positive.

What are we doing about it?

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

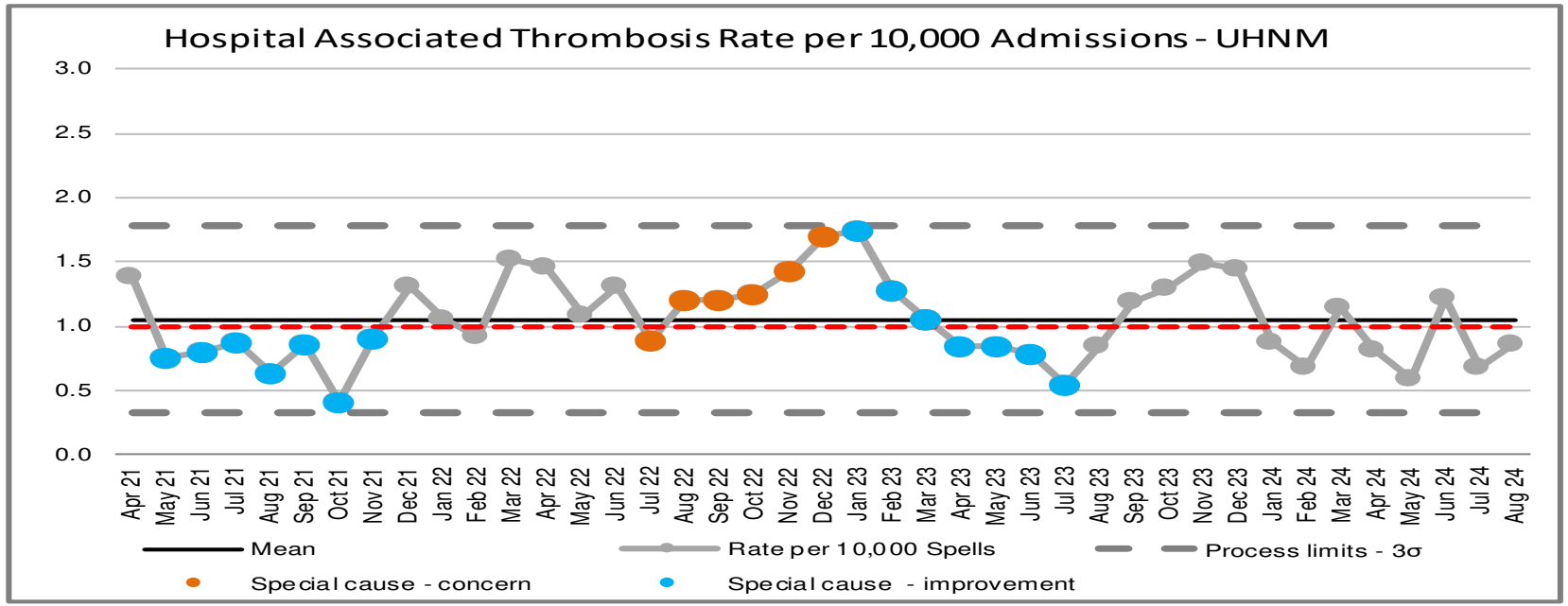
Look at incorporating the questions from the National Maternity Survey which requires the most improvement into the FFT survey.

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

High Quality | [Hospital Associated Thrombosis rate]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
1	1.23	0.68	0.87

Background

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

What is the data telling us?

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

What are we doing about it?

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

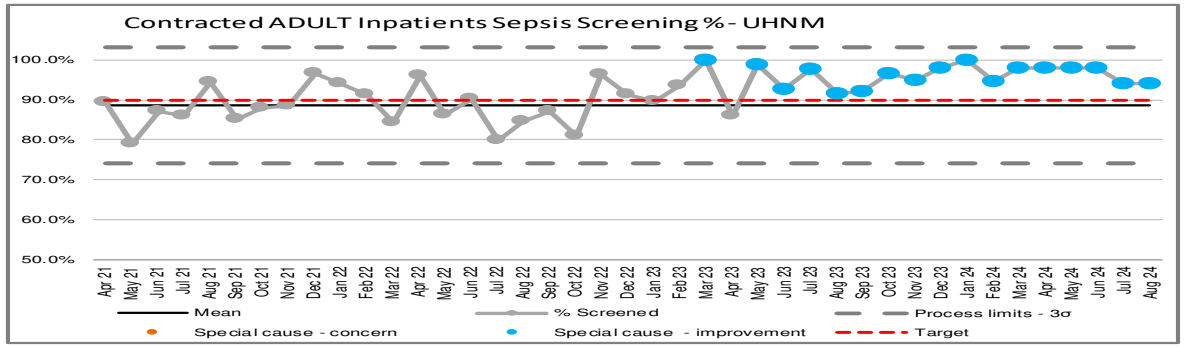
Key Themes identified from HAT Investigations; Missed doses of Prophylactic Dalteparin with no clear rationale recorded and inconsistent daily recording of mechanical thromboprophylaxis.

SSR Q&S undertaking 'Go Look Learn' in Theatres to understand the current practise for use of mechanical thromboprophylaxis intraoperatively.

High Quality | [Sepsis – Adult Inpatient]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

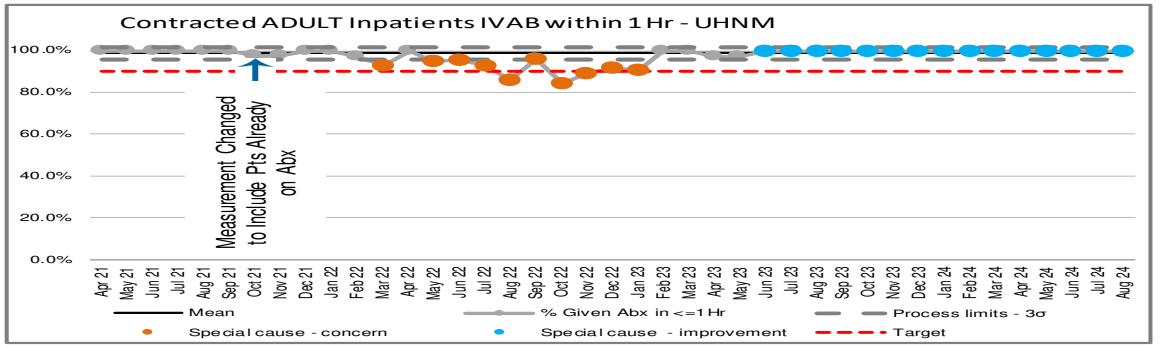


Variation	Assurance
H	?

Target	Jun 24	Jul 24	Aug 24
90%	97.9%	94.1%	94.2%

Background

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



Variation	Assurance
H	P

Target	Jun 24	Jul 24	Aug 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 August 2024.

There were 86 cases audited with 5 missed screening. Out of 86 cases audited 61 were identified as red flag sepsis with 41 having alternative diagnosis. 19 patients were already on IVAB treatment.

All true red flag sepsis patients received IVAB within 1 hour

What are we doing about it?

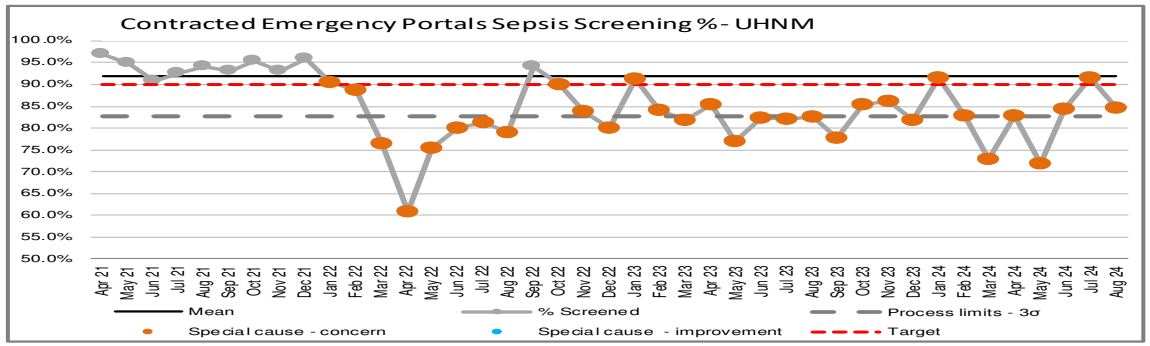
Sepsis sessions / kiosks continue to all levels of staff in the clinical areas that require immediate support.

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

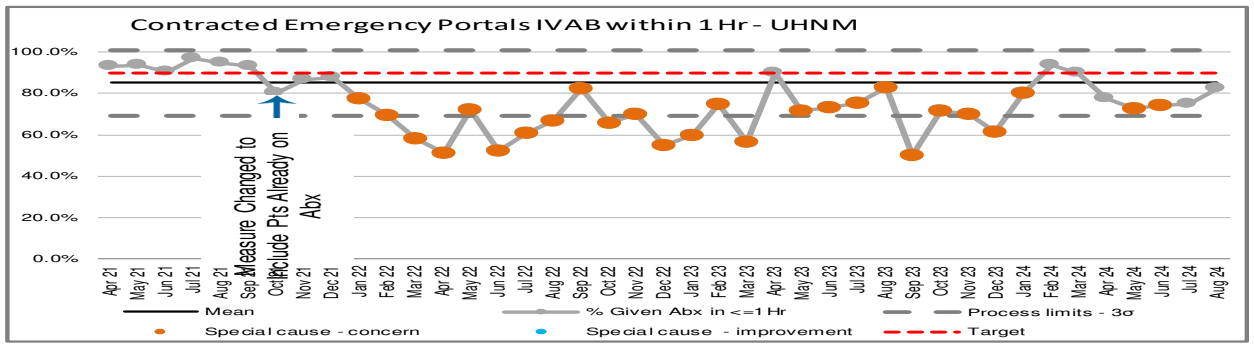


Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
90%	84%	91%	85%

Background

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



Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
90%	74%	75%	82%

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 August 2024 with 85%. Contributed to ED at Royal Stoke, FEAU and AMU at both sites . There were 59 cases audited with 9 missed screening in total from the emergency portals. The performance for IVAB within 1 hour improved to 82%

Out of 59 cases there were 48 red flag sepsis in which 12 patients were already on IVAB. 20 patients had an alternative diagnosis leaving 16 newly identified sepsis 4 patients received IVAB outside the target 1 hour window with 4 patients greater than a 2 hours delay.

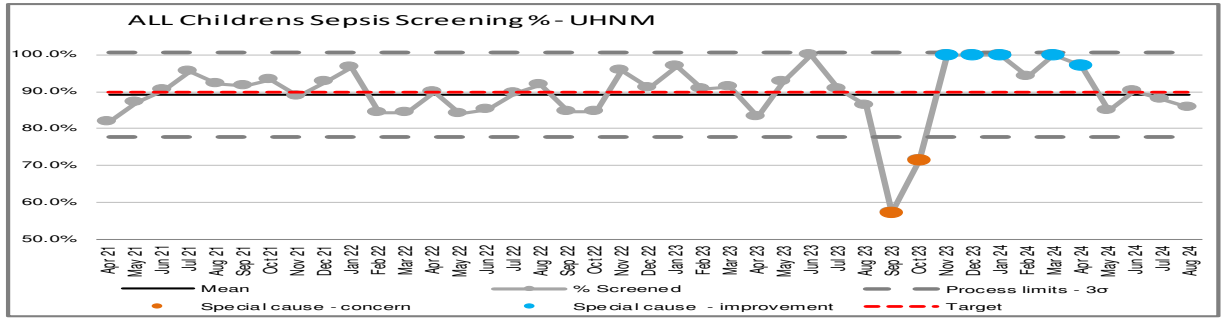
What are we doing about it?

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

High Quality | [Sepsis – Children]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

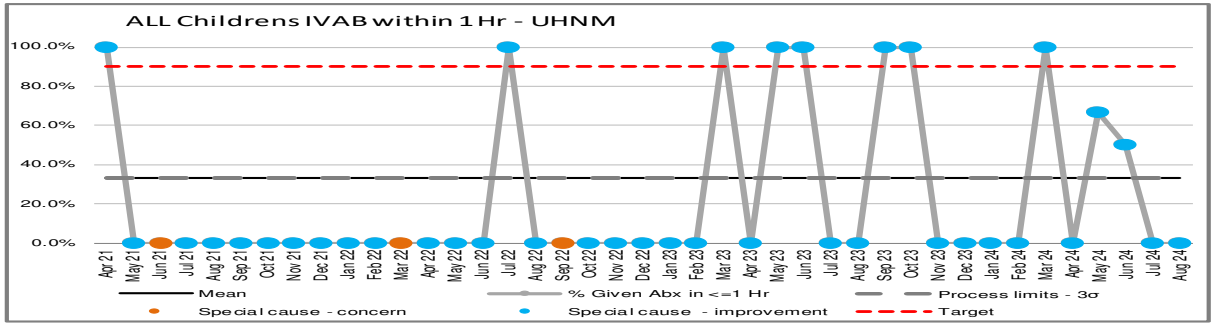


Variation	Assurance

Target	Jun 24	Jul 24	Aug 24
90%	90.2%	88.0%	85.7%

Background

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



Variation	Assurance

Target	Jun 24	Jul 24	Aug 24
90%	50.0%	n/a	n/a

Background

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

What is the data telling us?

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 22 cases audited for emergency portals with no missed screening.
No true red flag sepsis was identified from the randomised audits in the emergency portals or inpatients.

What are we doing about it?

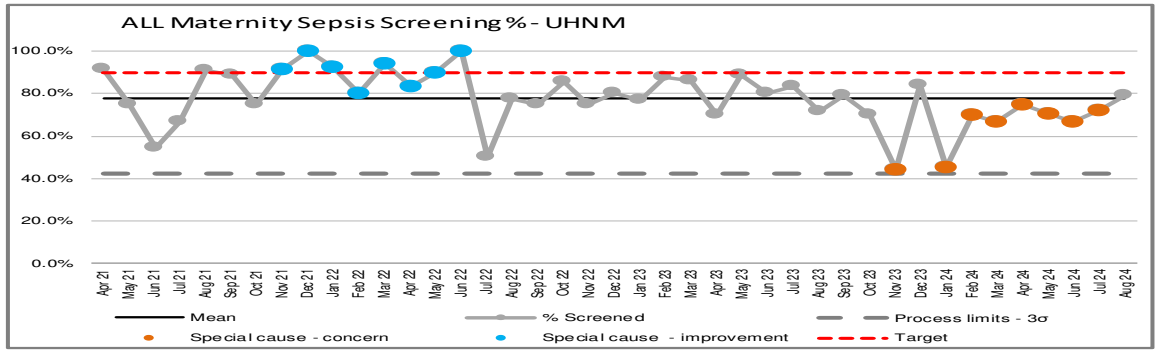
The sepsis team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective.

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

High Quality | [Sepsis – Maternity]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

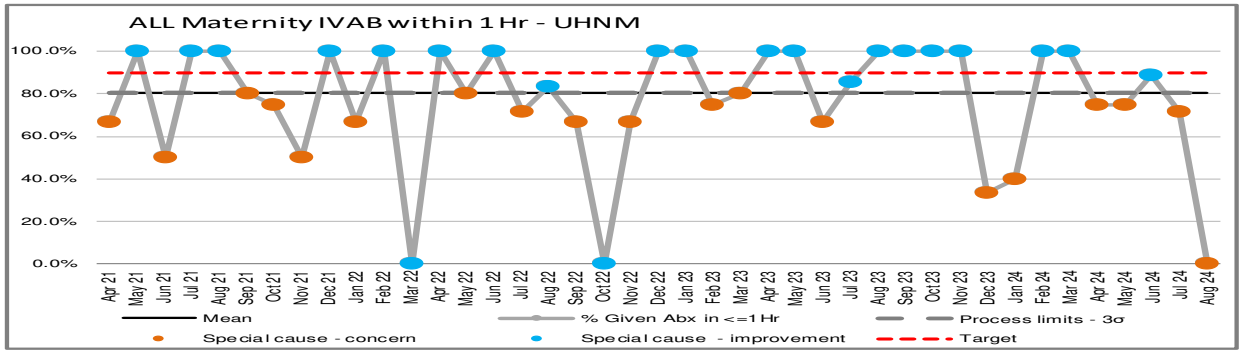


Variation	Assurance

Target	Jun 24	Jul 24	Aug 24
90%	66.7%	72.2%	78.9%

Background

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



Variation	Assurance

Target	Jun 24	Jul 24	Aug 24
90%	89%	71%	0%

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 8 cases audited from emergency portal MAU with 1 missed screenings. Inpatient had 11 cases audited with 3 missed screenings.

What are we doing about it?

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

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

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

Responsive | Overview

Provide efficient and responsive services

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. August validated position is 73% which is 1.8% above the July outturn and is 3% better than our improvement trajectory. This is the sixth consecutive month in a row where we have achieved over 70% and this consistency has not been achieved since 2020. Our relative performance is now in the 2nd quartile of Trusts regionally and nationally. For 12-hour wait performance we remain ranked in the second quartile for waits regionally.

August has seen a decrease in our number of patients spending more than 12 hrs from arrival in ED. This has moved from 1,992 to 1,224 a 38.56% reduction.

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 is July where the mean time was 22.59 minutes

Elective

We overachieved against the Cancer 28-day diagnostic performance trajectory in May, June, July and are predicting to report a further improved position in August achieving 77.5% against the 75.26% trajectory. Performance against the 62-day standard deteriorated slightly in July, achieving 62.6% against the 64.24% trajectory. The increase in endoscopy capacity and the associated reduction in referral to test time will continue to impact positively on patient pathways. A focus on other causes for delays including consultant review and histopathology reporting are continuing and will ensure sustainable improvements to performance are achieved.

Overall diagnostic / DM01 performance has deteriorated month on month since April 2024 achieving 56.6% against the 6w 95% standard. Endoscopy DM01 performance reduced by 9% in August compared to July, due to the increase in surveillance and planned pathways, as predicted. Non-Obstetric Ultrasound Scan (NOUS) performance reduced for the 5th consecutive month achieving in August achieving 40.01% against the agreed 59% DM01 current trajectory. Due to a 44% vacancy factor in this modality, there is the potential for performance to continue to deteriorate over coming weeks with achievement of a maximum 13ww at the end of September being at risk.

The number of patients waiting over 65 weeks for their treatment reduced from 899 in July to 609 in August. We are expecting c112 breaches of the 65 week standard in September against the national zero target, due in the main to ENT and Respiratory. The number of patients waiting 78 weeks or more for their treatment ended at 12 for August which was 1 more than July. There were 3 reportable 104 week breaches in August, all related to data quality errors. 2 of the 3 patients were treated in September. 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 3319 in August, supported by continued validation of all patient pathways over 52 weeks. Plans to achieve a maximum 52 weeks waiting time by March 2025 are being developed. A temporary increase in validation capacity commenced in August and it is expected that 12k patient pathways across RTT and Endoscopy will be validated over a period of 8 weeks. We achieved 55.87% performance against the 92% incomplete trajectory in August, an improvement for the 5th consecutive month.

Responsive | Overview

Provide efficient and responsive services

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 - August activity out turned 23,661 attendances verses 23,896 in June which equates to a 0.99% decrease. Flow for our patients in our Emergency Departments requiring inpatient treatment has improved but is still below the daily requirement to hit the end of year standard. Both admitted and non-admitted pathway, during July, has been strong in core hours but deteriorates out of hours and overnight.

The number of patients waiting an aggregated time of arrival decreased from July. August demonstrated a reduction of 768 patients. An overall reduction of 38.56% compared with July. The availability of medical inpatient beds and timeliness of accessing has continued to be the primary issue however the new AMRAU opened during this period. 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%. August achieved 57.25% of our patients accessed their onward pathway.

Both the capacity of Emergency Departments (overcrowding) and the profile of ambulance arrivals (variation can be 0 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 opened in mid August and is routinely seeing 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 an IS partner is identified. The reduction in performance is driven by a 44% vacancy factor and has been further exacerbated by AL in July and August.

Our 3 patients that breached the 104-week standards were identified through patient pathway validation x 2 and by 1 patient contacting the Trust as they were concerned that they had not been contacted. Our validation of patients >52 weeks on WL led to a high removal rate of 24% reflecting the opportunities to further improve data quality through training.

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. Resource for Workstream 2 (ward standard work – process improvement) is of risk and is being reviewed as part of winter planning including the support from the Emergency Intensive Support Teams at NHSE.

The Trust have agreed to go live in the first wave of Trusts for the Midlands with early handover of ambulances. This starts with a 45-minute standard and we will pilot this starting on the 30th September.

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. Following a procurement process, a supplier for the mobile unit was agreed in July and the unit became operational from mid-August 2024. 727 patients will have their tests through the unit each month - this will reduce our surveillance/planned backlog and support diagnostic recovery in line with trajectory. In addition to this we will continue to insource additional capacity this has been supported by cancer alliance and ERF funding throughout Q1-4. The 3rd element of the business cases for endoscopy recurrent staffing is currently in progress and expected to be presented to the Executive Team in October

Whilst there has been some delay in mobilising approved ERF bids particularly in ENT, it is expected that this will improve from September with the greater availability of consultant surgeons. Despite many efforts to identify regional NHS capacity to support, capacity for the casemix of patients that needed to be treated has not been identified. There is currently little appetite amongst consultants to undertake additional sessions due to the current rate of pay offered. We have increased capacity in Respiratory for sleep studies to support the pathway.

There is a 44% vacancy factor in Non Obstetric Ultra Sound (NOUS) which will be used to offset achievement of a 13ww, however there is likely to be a funding gap to achieve a 6ww. Identification of an insourcing partner has been challenging and options continue to be explored in August. It will not be possible to achieve the maximum 13ww for the service and Trust as a whole, at the end of September without additional capacity. Diagnostic capacity is becoming an increasing concern. The Diagnostic Cell was re-established in August through which performance will be monitored. This group will provide a focus regarding work force planning and demand management.

In July and August the central Patient Access Team validated all patients that breached the 52w standard and removed 23% of them from the RTT pathway. The validation exercise identified specialties that required additional training of RTT rules and additional RTT training capacity has been published for the coming 6 months with specific staff groups being targeted. We agreed an 8-week validation program in July that commenced in August to validate 12k patient pathways. This capacity is being provided by a tried and trusted external validation company. It is likely that a high % of patient pathways will be updated as a result of this exercise which will lead to both an increase in patients that can be legitimately removed from the waiting list, but also an increased risk of amended clock start dates and potentially an identification of long waiting patients. The Data Quality Task Force Group continues to meet every 2 weeks to oversee the learning from validation as well as follow through on previous internal audit recommendations.

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 expect 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 expect September to build on the step change in performance in response of the new SDEC modular build and process changes in regard to ambulance handover delays.

Alongside improvements in 4-hour performance we expect 12 hour and ambulance handover delays to continue to improve at 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 report.

Elective

For RTT/Planned Care we should expect to see a reduction in the number of patients >65 weeks in September with a forecast of c112 patients from predominantly ENT and Respiratory breaching at month end. ERF bids to support a further reduction in waiting times to 52 weeks by the end of March are currently being developed for review and approval, assuming that they make a positive contribution.

NOUS performance will potentially deteriorate, and this will impact upon the Trust DM01 position overall. It is unlikely that an improvement will be seen until at least September and possibly October, however once in place this will support delivery of the 13w DM01 performance. Achievement of the 6ww performance of NOUS is reliant on identification of funding – a business case is currently being developed and will be presented to the Executive Team in September. As a result of the mobile endoscopy unit that came into place in August, it is expected that there will be no patients waiting a diagnostic, surveillance or planned endoscopy >65 weeks by the end of September with zero surveillance, planned patients or diagnostic patients waiting >6w by January 2025 in line with the agreed business case and trajectory.

Cancer performance for 62 days is becoming an emerging concern due to backlog of patents >62 days increasing, driven particularly in Colorectal. A series of meetings with clinicians is planned to identify improvements in the patient pathway from September.

Validation of 12k pathways from mid-August over an 8-week period is likely to identify an increase in patients who have waited >65/78/104 weeks. In early September NHSE published the “Waiting List Data Quality Improvement Guide” that provides guidance to safely and transparently manage this patient cohort

Responsive | Dashboard

Provide efficient and responsive services

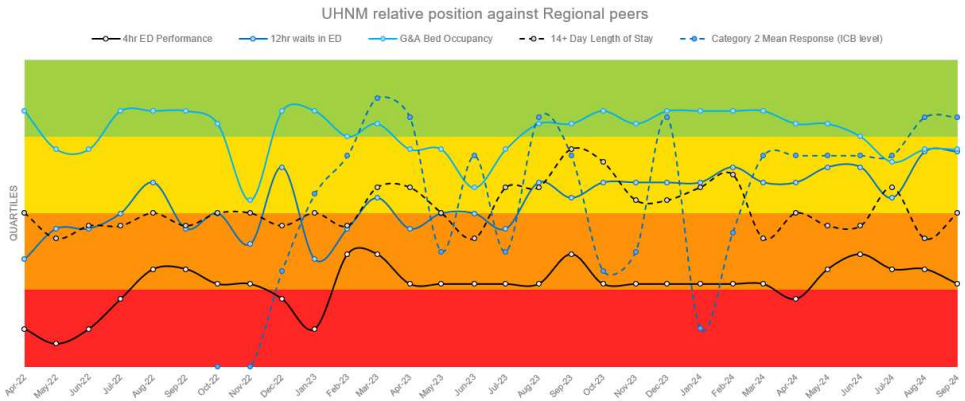
University Hospitals of North Midlands NHS Trust

Responsive

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
UEC 4 Hour Target	76%	71.2%	73.0%						
Over 12 hours in ED	0	1,992	1,224						
UEC Cat 2 Handover Average Time	00:18:00	00:28:30	00:22:59						
Cancer 28 Day FDS	75%	75.4%	77.5%						
Cancer 31 Day Combined	96%	89.3%	90.2%						
Cancer 62 Day Combined	85%	62.6%	58.5%						
Diagnostics DM01 Performance	99%	62.8%	56.6%						
RTT No. of Patients Waiting >52 Weeks	0	3,856	3,319						
RTT No. of Patients Waiting >65 Weeks	0	899	609						
RTT No. of Patients Waiting >78 Weeks	0	11	12						
RTT No. of Patients Waiting >104 Weeks	0	1	1						
Treating patients in a timely manner (Hospital Combined Performance Score)	7,000	3,997	3,997						

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)

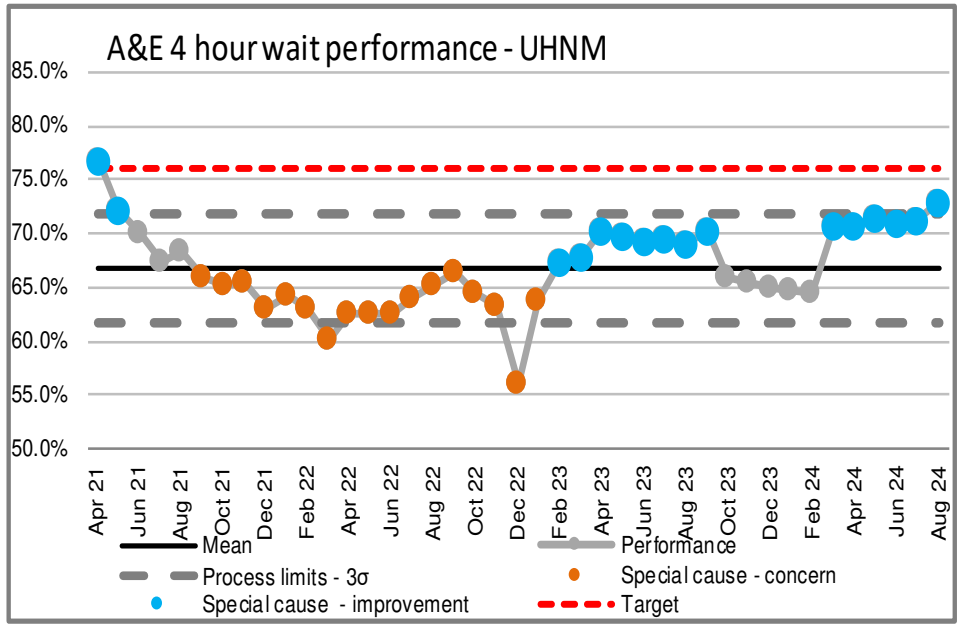
Quality Strategy

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

Responsive | UEC 4 hour Target

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

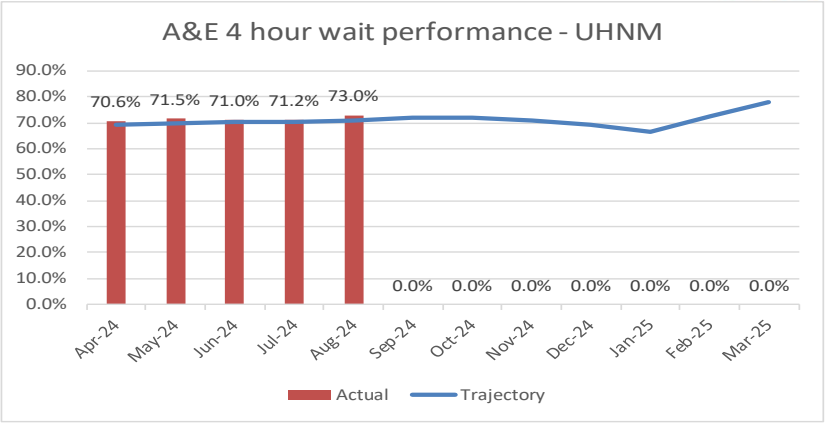


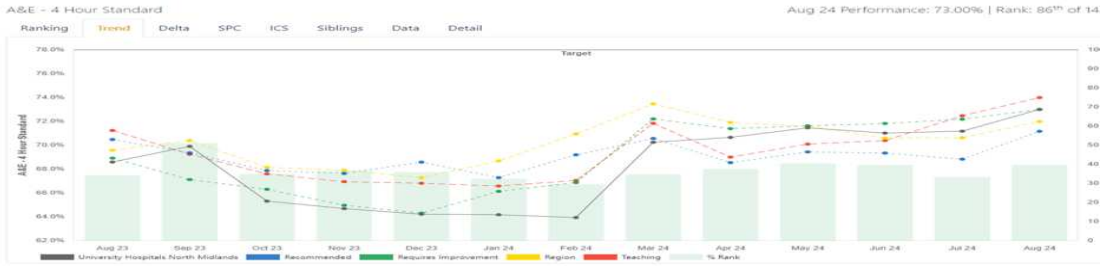
Variation	Assurance
H	F

Target	Jun 24	Jul 24	Aug 24
76%	71.0%	71.2%	73.0%

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 73% August which has improved since last month with a 1.8% increase and noting the average over the last 3 months has improved to 71.7%.
The submitted improvement trajectory against the 4hr standard set for August has been met (73% vs 70.7%) but is 3% 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.
Type 1 4hr performance for Royal Stoke was 46.7% which is 2.2% higher than last month at 44.5%, however of note performance since March there has been an average of 46.06% compared to the preceding 6 months at 39.68% which demonstrates a marked improvement of 6.38% during this 6-month period.
Type 1 4hr performance for County was 79.5% which is a significant improvement at 7.2% higher than last month's performance of 72.2%, and notably an increasing trend in performance since January.
There were 18 days throughout August where performance reached over 80% at the County site with the highest being 98.1% on 3rd August and 97.6% on 7th August.
As a trust, there were 2 days in August where we achieved greater than 78% - 81.4% (Aug 21st) and 79.4% (Aug 26th)
We are ranked 86the out of 142 Acute Trusts for August which is positive shift of 9 ranking positions.

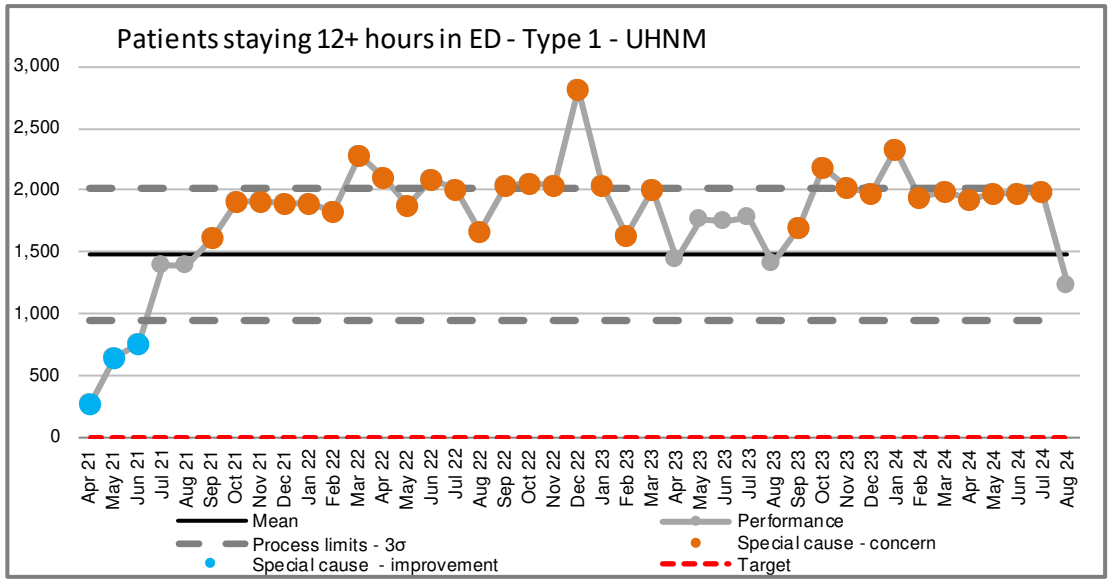
What are we doing about it?

- Ambulatory standard work continues across Royal Stoke and County sites, reviewing processes and identifying efficiencies.
- Operational huddles implemented in Ambulatory area reviewing safety including patient prioritisation, staffing and flow.
- CDU utilisation work continues Royal Stoke – ensuring consistency across all shifts.
- EhPC chest pain pathway agreed, and trial commenced during August.
- Revised process for management of cubicles in Ambulatory area, trial commenced.
- Management of surges to support triage at County site including Clinical Director review of processes and potential to identify further room to support triage during surges in demand.
- SDEC: AEC task and finish in place to work through potential opportunities. and new AMRA unit opened on 2nd August which has provided an increase in capacity which has positively supported management of flow through the Emergency Department.

Responsive | Over 12 hours in ED From Arrival

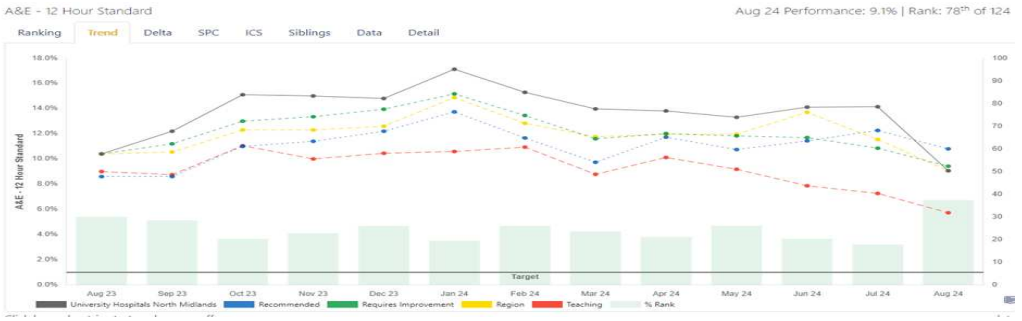
Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jun 24	Jul 24	Aug 24
0	1978	1992	1224



What is the data telling us?

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

August experienced 1224 patients with a greater than 12-hour length of stay compared with 1992 patients in July. This represents a 38.56% reduction (768 patients).

Our overall ranking improved from 105th out of 124 Acute Trusts in July compared to 78th out of 124 Acute Trust in August.

Mean time in the emergency department varies in and out of hours. Overall mean time in the Emergency Department for August was 5.78% type 1 only verse 7.00% in July. There remains an in hours and out of hours issue in terms of responsiveness.

What the chart does not tell us is percentage compliance against the Clinically Ready to Proceed (CRTP) target of no greater than 60 minutes. August demonstrated 54.96% compliance verses 55.67% in July which a slight deterioration. It is noteworthy that acute medicine decreased but other portals increased.

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 have identified actions following the root cause analysis to address the issues identified including TTO's, Transport, Diagnostic Delays and Discharge processes to support earlier in the day discharges.
- Frailty >75, single document for CGA & admissions agreed and planned for trial in October.
- Test of change completed for IDH in-reach to ED and support to FEAU, a review of the impact is being undertaken.
- 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 now operationally live, as such additional capacity has been created in AMRAU & SSU and is already demonstrating a positive impact on flow out of the Emergency Department.

Responsive | UEC Cat 2 Handover Average

Provide efficient and responsive services

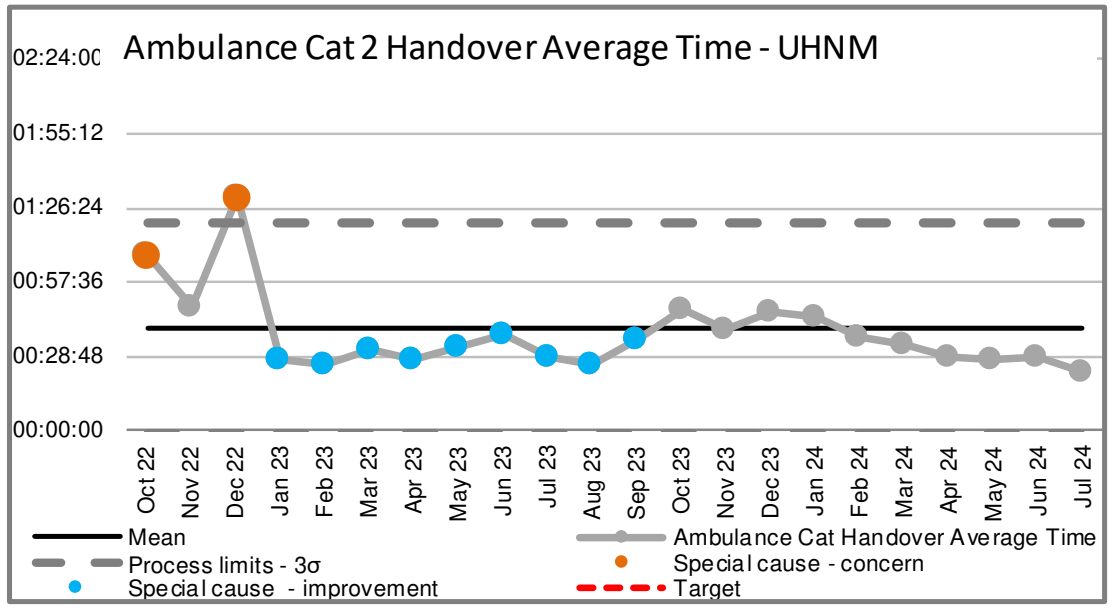
University Hospitals of North Midlands NHS Trust

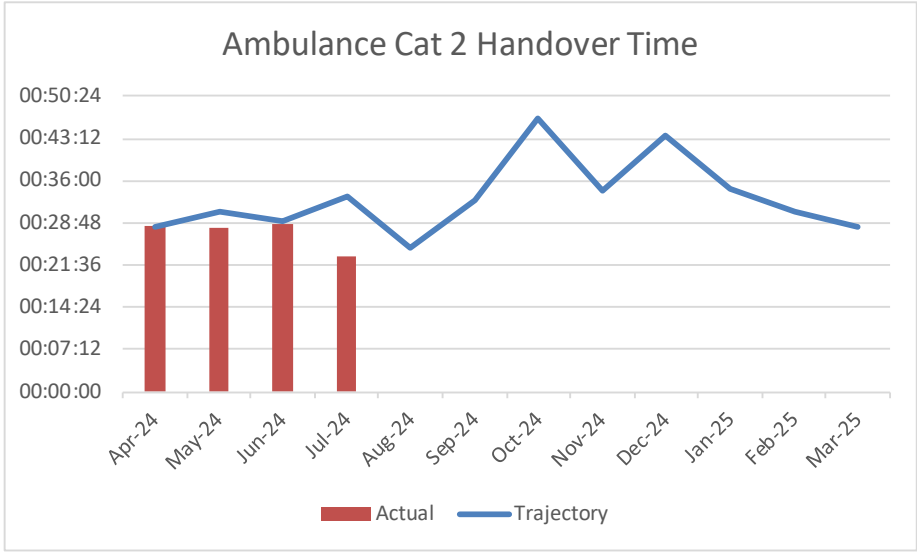
Variation	Assurance

Target	May 24	Jun 24	Jul 24
00:00:00	00:27:56	00:28:30	00:22:59

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 July at 22.59 minutes.

Handover within 15 minutes of arrivals in August demonstrated a 32.35% compliance compared to 21.98% compliance in July. An improvement of 10.37%.

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

What are we doing about it?

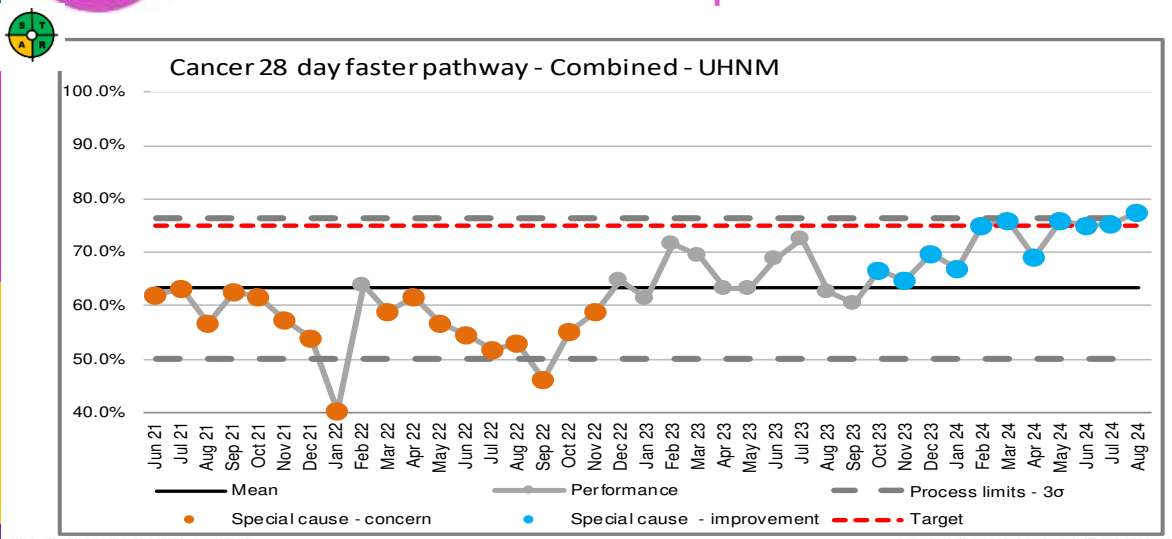
We have instigated an internal rapid handover process, which when triggered and enacted, drives the off load of 2 ambulances every 30 minutes until the pressure is reduced and the risk removed.
The 'corridor' in the emergency department is utilised to support the risk of reducing the waiting ambulances.
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 in now in train.
'Your Next Patient' protocol is enacted to decompress the emergency department to further support flow and off load capability.
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.

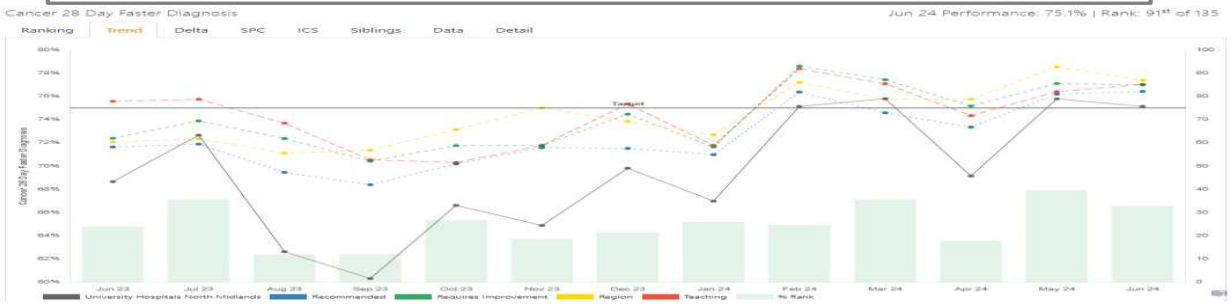
Responsive | Cancer 28 Day FDS

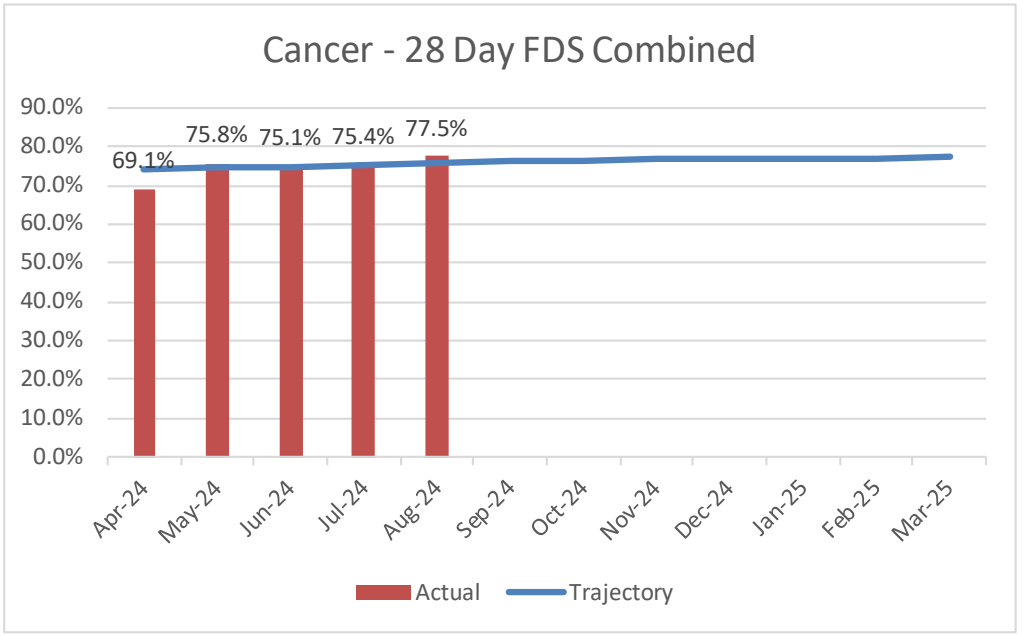
Provide efficient and responsive services

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 in May, June and July, and is predicted to report a further improved position in August.
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.

What are we doing about it?

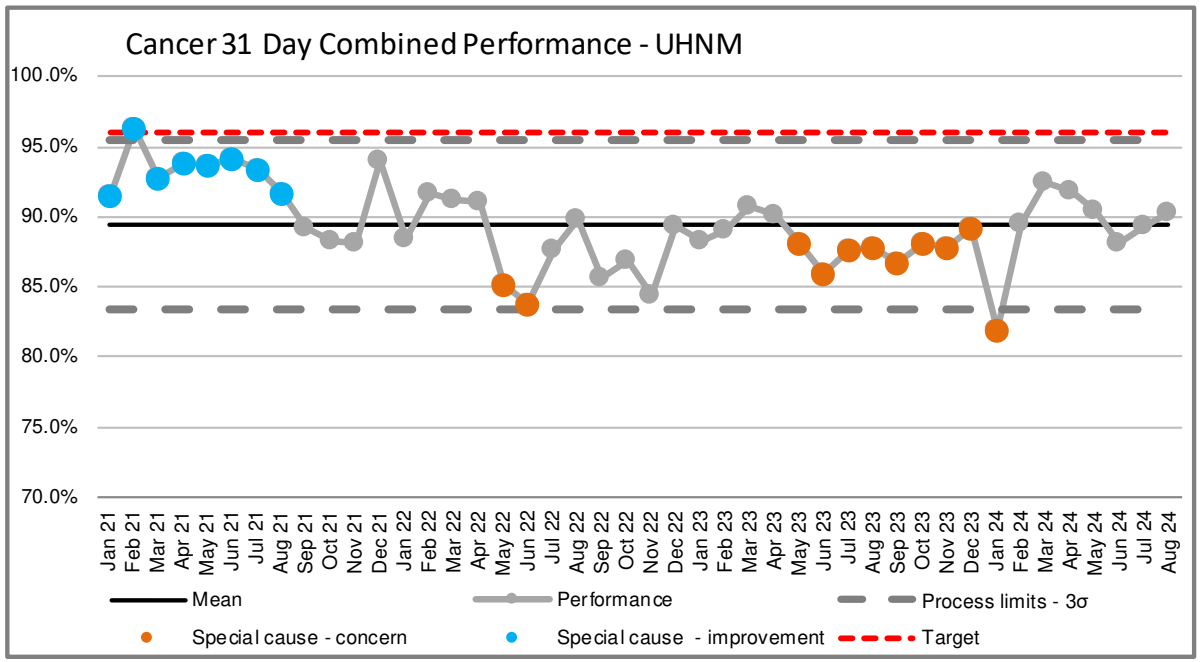
Improvement plans for lower performing pathways are in place; Gynae and Urology. Best practice from better performing providers is being implemented, such as referral vetting and speedy booking of 1st OPAs. Teams have implemented national priorities such as Cancer Navigators who expedite patient pathways. 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 90% in May, 88% in June and 89% in July, it is predicted to land slightly higher in August. 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?

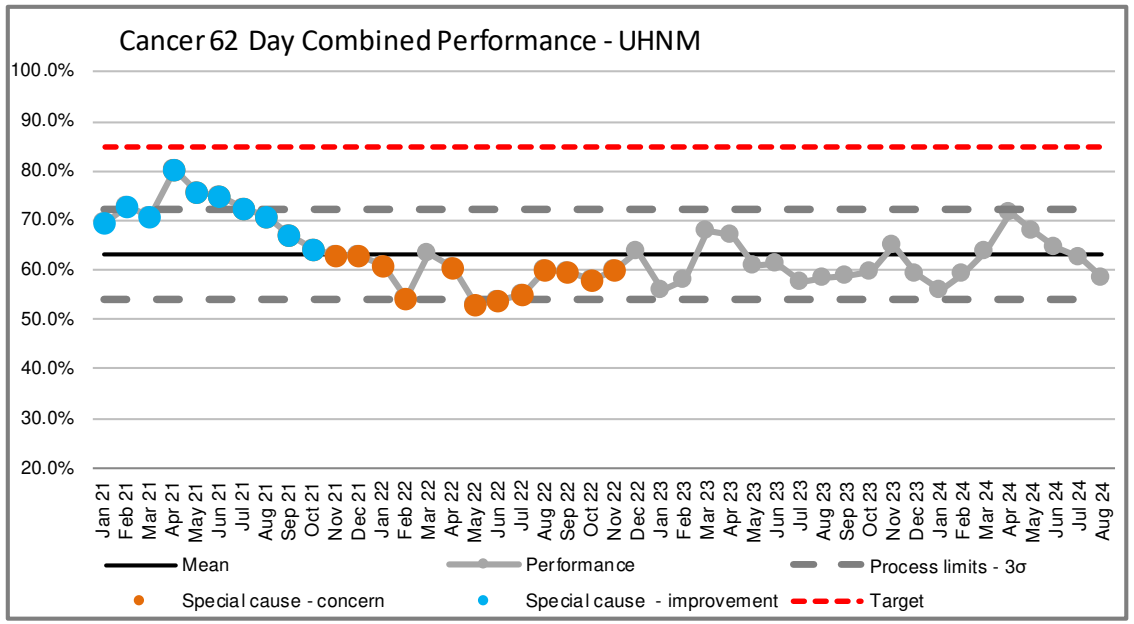
Access to robotic procedures are prioritised through the oversight group.
Partial Nephrectomy capacity has been escalated through the Tier 1 route with a request for mutual aid.
The endoscopy improvement plan is being enacted that will clear backlog and create sufficient capacity to meet therapeutic 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.

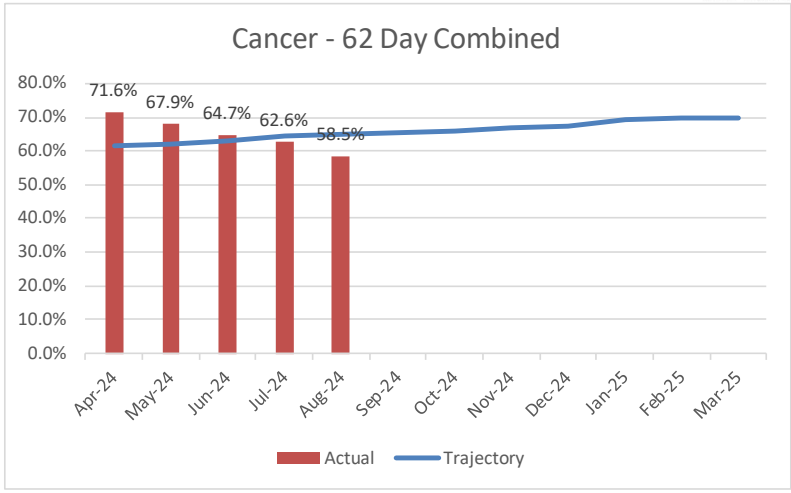
Responsive | Cancer 62 Day Combined

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive





What is the data telling us?

The combined 62-day performance was reported at 67.9% in May, 64.7% in June and 62.6% in July. UHNM have met the trajectory for the first 3 months of the year. August is still a provisional position as it is collected and validated for upload; currently at 60.18% which 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 including Hysteroscopy and 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

Responsive | Diagnostics DM01 Performance

Provide efficient and responsive services

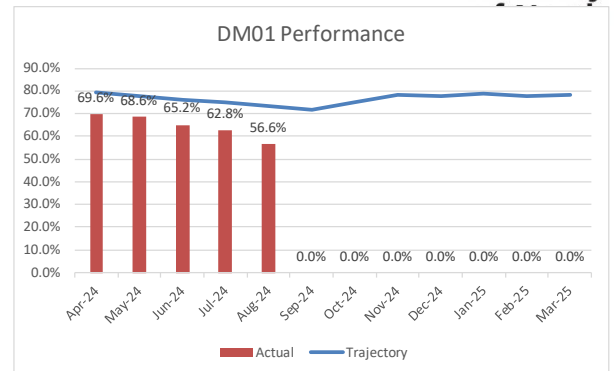
University Hospitals Midlands NHS Trust

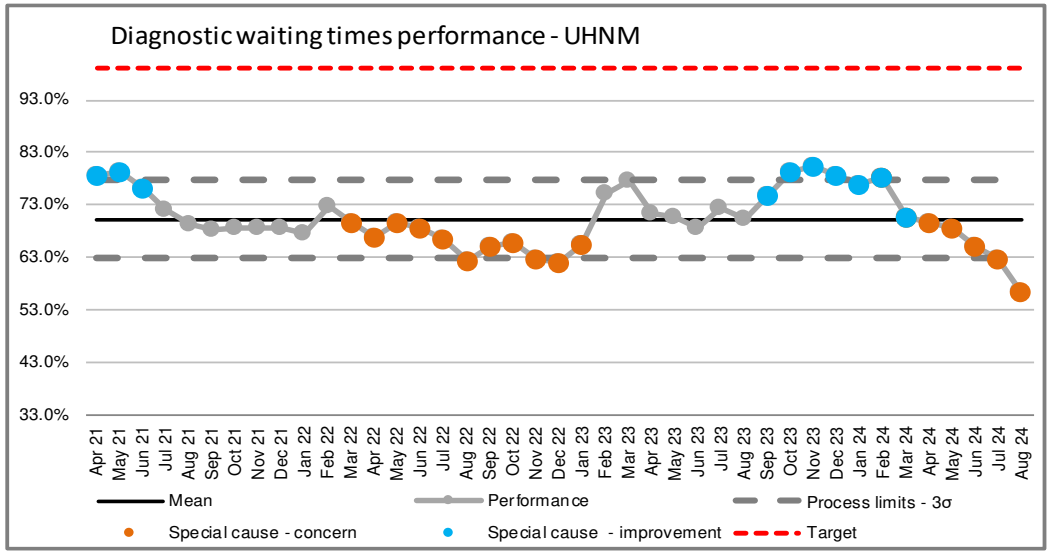
Variation	Assurance
L	F

Target	Jun 24	Jul 24	Aug 24
99%	65.2%	62.8%	56.6%

Background

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





What is the data telling us?

August DM01 data is unvalidated at time of writing this report however current performance was at 56.6% against the 95% six week standard. This is a continuation of the monthly deterioration over the last 5 months (July 62.8%).

The main contributing modalities are:

- Endoscopy: Performance for Endoscopy at is 36.89%. This performance has dipped by around 9% from July, however total WL size has reduced by 435 patients.
- Non obstetric ultrasound performance has deteriorated from 59% in April to 45.5% in July and expected to reduce further to c40% in August.
- Echocardiogram performance has deteriorated from 55.6% in June to 50.28% in July.

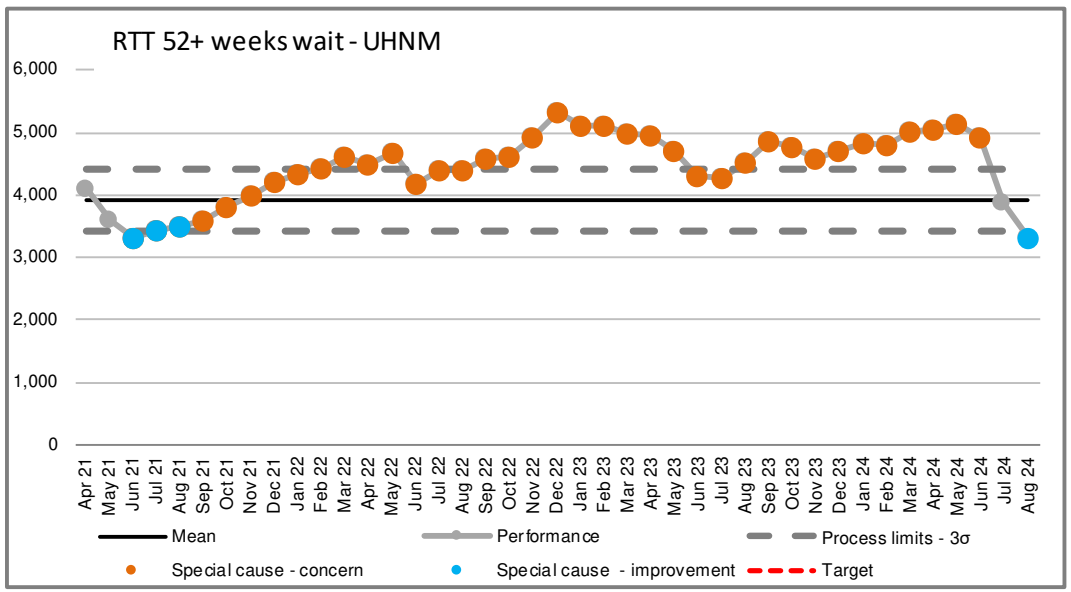
What are we doing about it?

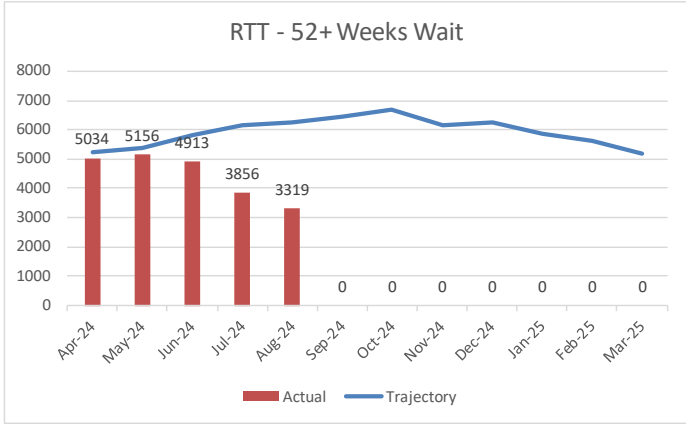
- Endoscopy: Q2-4 ERF funding has been approved ; this will enable the service to continue to insource to increase capacity. All vacant in week sessions are being covered by insourcing service, Trust TI session or locum consultants / Dr's.
- A mobile unit is now operational and scoping an average of 29 patients per day, 7 days per week. This will clear surveillance backlog and support diagnostic recovery in line with trajectory.
- The 3rd element of the business cases for endoscopy recurrent staffing is currently in progress through governance structures.
- Endoscopy are also validating both through administration and Clinical pathways all patients waiting beyond 52wks. This is alongside a focused piece to improve DNA and cancelation rates.
- Non obstetric Ultrasound: There is a 44% vac fac in the service. Discussions are ongoing to identify an IS partner to provide insourcing capacity
- Echo capacity continues to be supported by an external agency whilst we await recruitment to posts expected to commence in December 24. We are also exploring the option of short-term additional agency staff 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



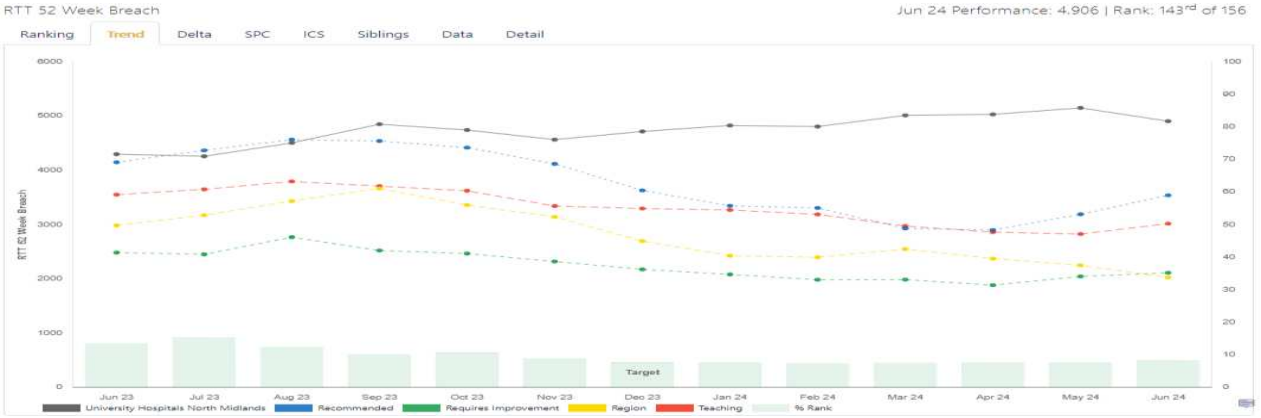


Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
0	4913	3856	3319

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. 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?

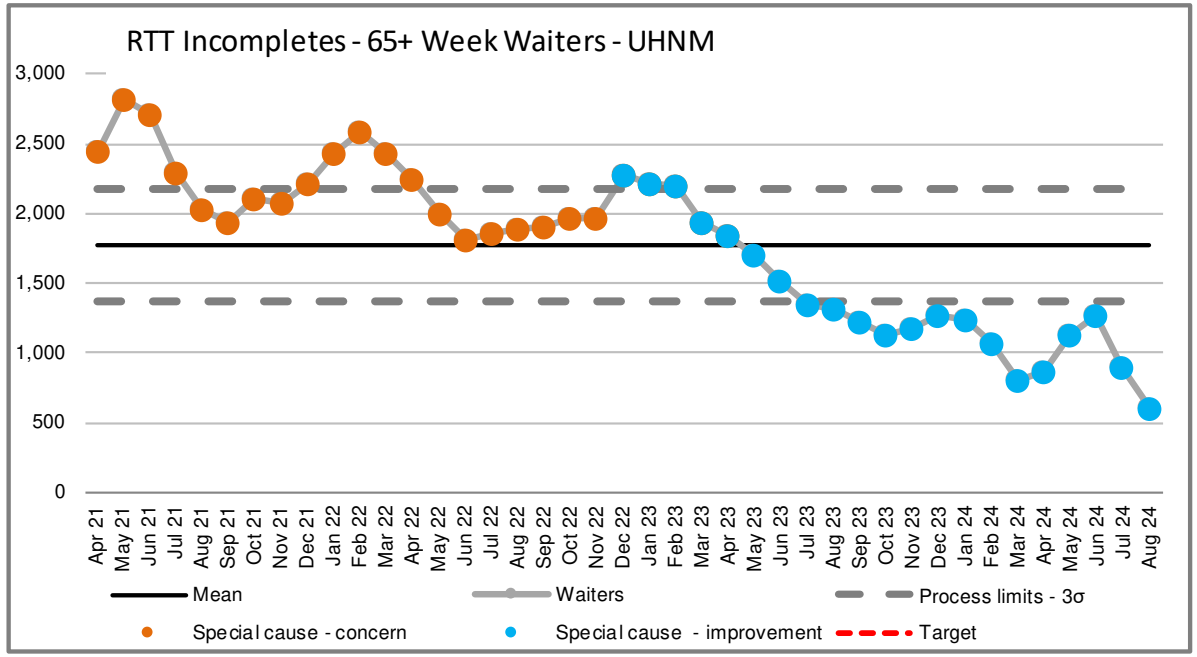
- Deep dive validation of all patients >52weeks who had not been validated in the past 12 weeks undertaken throughout August, with findings shared with Divisions and EOMG.
- Revamped RTT & Planned Care training offering now available, including Intermediate Training. RTT training performance will be monitored through Planned Care Board from August
- Clinician training now available combined with Clinic Outcome Form training. Available as eLearning from mid September.
- 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 7,148 patients wishing to be removed from the waiting list.
- Divisions supported with tracking and admin process improvements where resource allows.

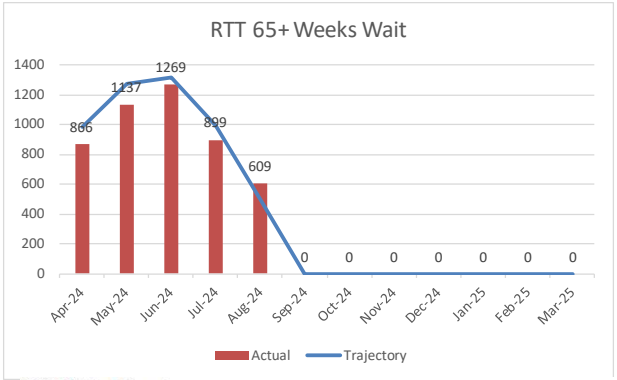
Responsive | RTT No. of Patients Waiting Over 65 Weeks

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive



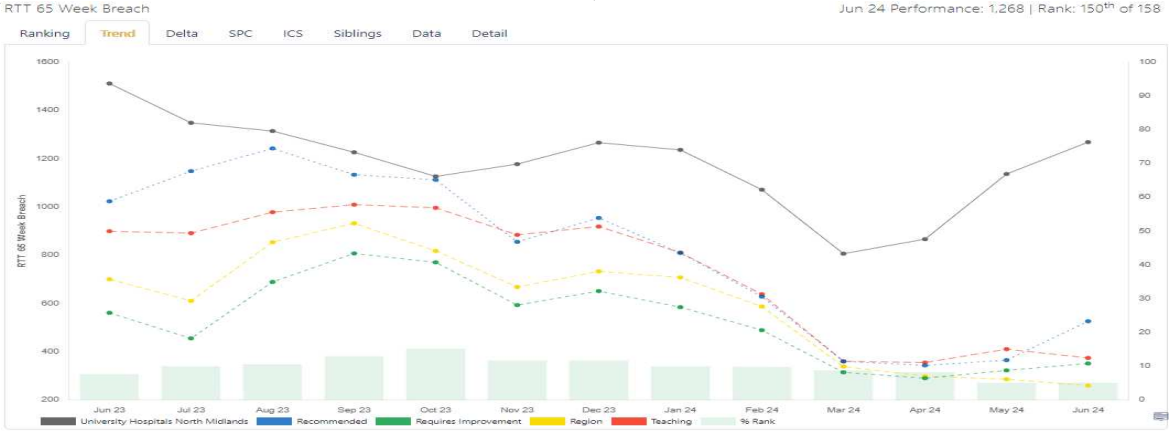


Variation	Assurance
L	F

Target	Jun 24	Jul 24	Aug 24
0	1,269	899	609

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 by 290 in August compared to July. 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?

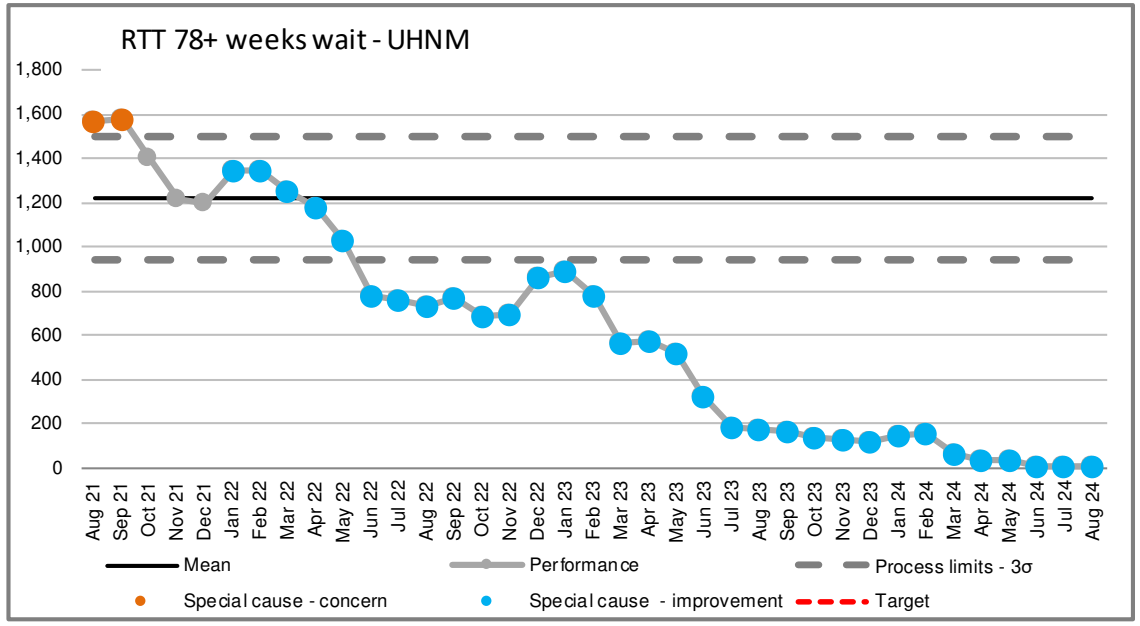
- ERF business cases for extra capacity through insourcing & WLIs now approved, so capacity secured and booking commenced.
- Focus on utilisation and productivity in theatres and outpatients
- Targeted validation on Respiratory, Gastro & ENT pathways
- Detailed plans and trajectories to illustrate the route to 65weeks have been developed and are formally monitored weekly through Elective Oversight Group

Responsive | RTT No. of Patients Waiting Over 78 Weeks

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust

Responsive



Variation	Assurance
L	F

Target	Jun 24	Jul 24	Aug 24
0	12	11	12

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 seen a slight increase in August (15, from 11 in July). This is due to identification of patients through the month end validation process that had a previous clock stop inappropriately applied

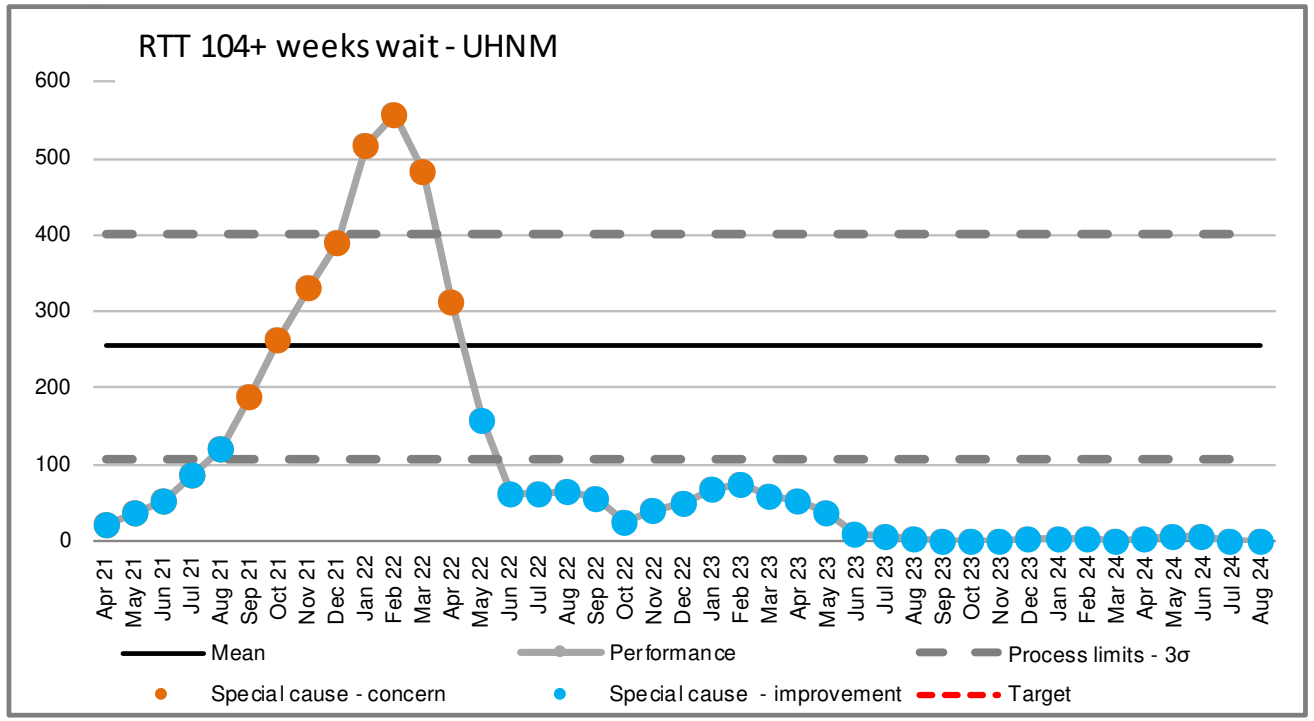
What are we doing about it?

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 address in month.

Responsive | RTT No. of Patients Waiting Over 104 Weeks

University Hospitals of North Midlands NHS Trust

Provide efficient and responsive services



Variation	Assurance
L	F

Target	Jun 24	Jul 24	Aug 24
0	5	1	1

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 three 104-week breaches for August, all due to administrative errors. 2 of these patients have been treated in September, with the third booked in for 23rd September.

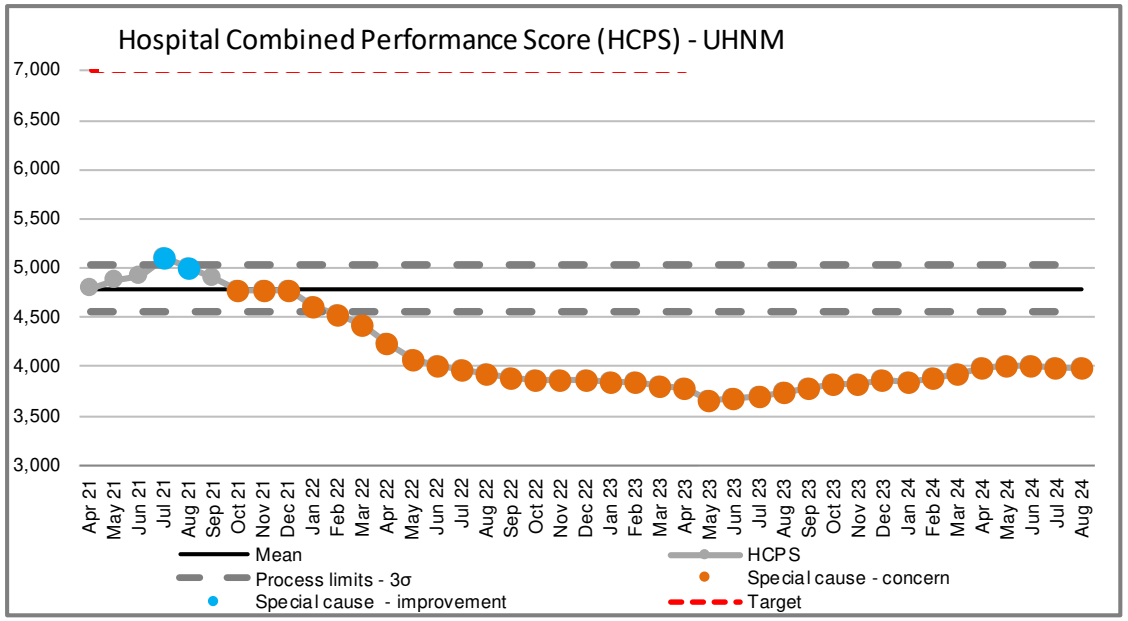
What are we doing about it?

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. All patients >52 weeks have been validated in July and August, providing valuable learning and identifying 3 specialties (Gastro, Resp and Gynae) providing an initial focus for training, which has been initiated in September, There are 2 areas of focus i) Medical staff understanding re completion of clinic outcome forms ii) medical secretary updating Careflow at point of tying clinic letter. A training plan is being taken to Planned Care Group in September for discussion and agreement

Responsive | Treating Patients in a Timely Manner (HCPS)

Provide efficient and responsive services

University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

Target	Jun 24	Jul 24	Aug 24
7000	4002	3997	3997

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 – August.
Top achievements and most improved include: patient safety culture, A and E 4 hour standard, elective IP activity, outpatient new activity, staff recommended care, sickness absence rate,
Top concerns and most deteriorated include: RTT 65 weeks, Diagnostics 65w, E Coli, Cancer 62 day, SHMI, Thrombosed within 1 hour

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 450 bank staff have signed up for the Wagestream solution, (404 in July-24) with a further 14 enrolling. There has been a total of 1,729 streams, totalling £259,000 of advances, since Wagestream's launch.

Sickness absence remains above our expected standard of 3.39%. In month we have seen a 0.58% decrease to 4.92%, while the 12-month cumulative rate remains at 5.3% for the fourth 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. The in-month sickness absence decrease was mainly driven by significant reductions in the reporting of chest & respiratory problems.

Turnover and *vacancy* metrics continue to perform well against our expected standards. The turnover rate in August 2024 increased slightly to 8.0% which remains consistently below our 11% target, for the last 23 months. Vacancies remained static at 8.7% for the second consecutive month. The main drivers of this were a 47.55 fte increased in colleagues in post, which was counter-balanced by a 50.19 fte increase in the total budgeted establishment.

Agency costs decreased to 2.97%, in August 2024, down from 3.38% in July 2024, which is below the threshold set by NHS England. In real-terms, overall agency usage decreased to 206.53 WTE in August 2024 from 241.33 WTE in July 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 previous three months of gradual sickness absence increases have seen a 0.58% reduction in overall in-month sickness, during August, which is most likely affected by the summer holiday season.

Agency expenditure is being driven by the continued need for escalation capacity, additional work related to the elective recovery programme and an increased demand in theatres and endoscopy services.

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

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%	5.50%	4.92%						
Vacancy Rate	8.00%	8.67%	8.66%						
Turnover Rate	11.00%	7.84%	7.96%						
Appraisal Rate	95.00%	87.48%	88.28%						
Agency Utilisation	3.20%	3.38%	2.97%						

Related Strategy and Board Assurance Framework (BAF)

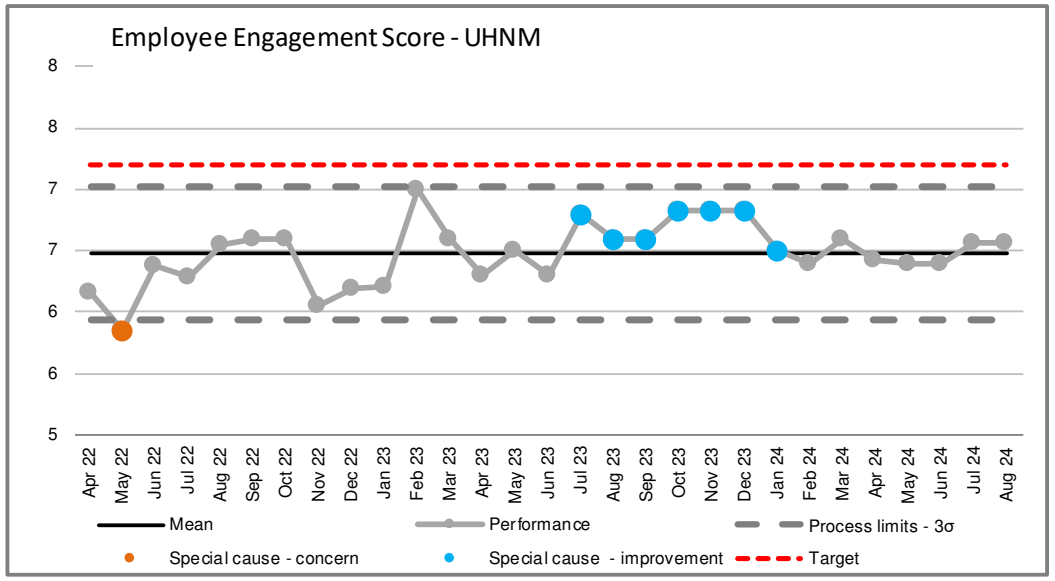
People Strategy

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

People | Employee Engagement

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Jun 24	Jul 24	Aug 24
7.2	6.4	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 8.7% effective 19th September, totalling 1,096 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.

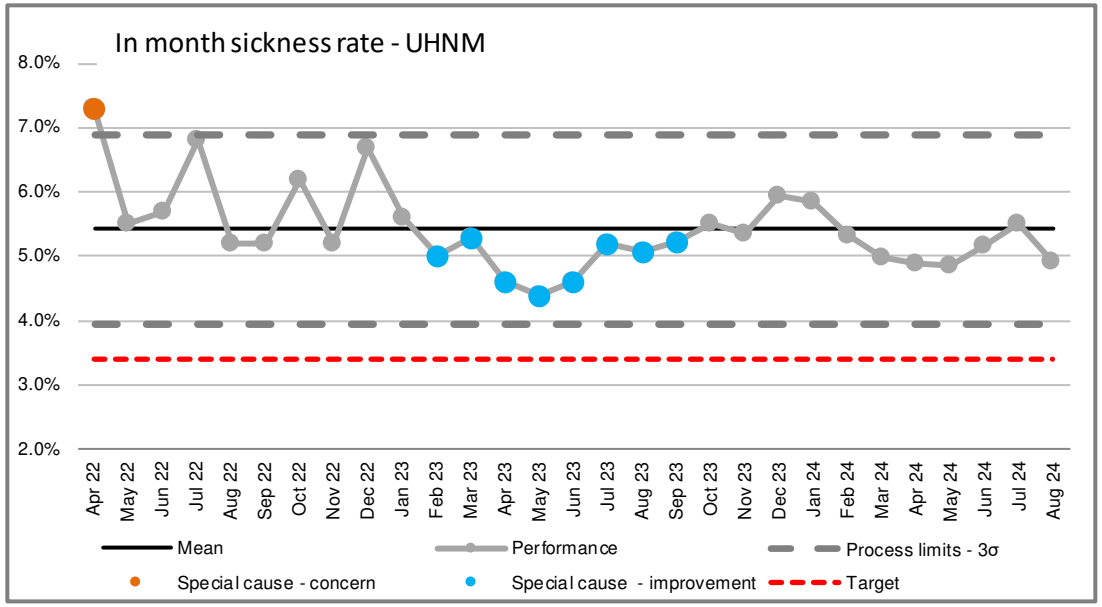
All Divisions are developing staff survey response plans and have a driver metric for staff engagement.

People | Sickness Absence in Month

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust

People



Variation	Assurance
	F

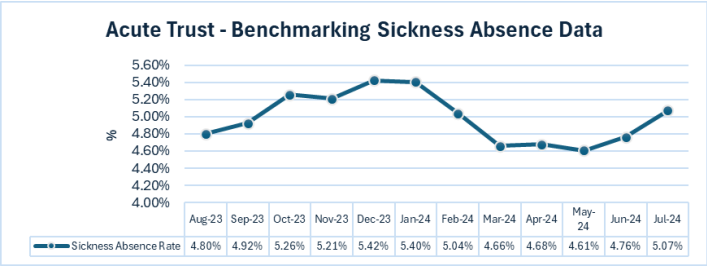
Target	Jun 24	Jul 24	Aug 24
3.4%	5.2%	5.5%	4.9%

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 5.30% (5.32% in July 2024) against the target of 3.4%.

The in-month sickness absence reduced to 4.92% in August (5.50% in July-24) with Anxiety/stress/depression/other psychiatric illnesses seeing the biggest increase, while Chest & Respiratory Problems saw a 5.5% reduction to 7.1% in August (12.6% in July-24)

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.

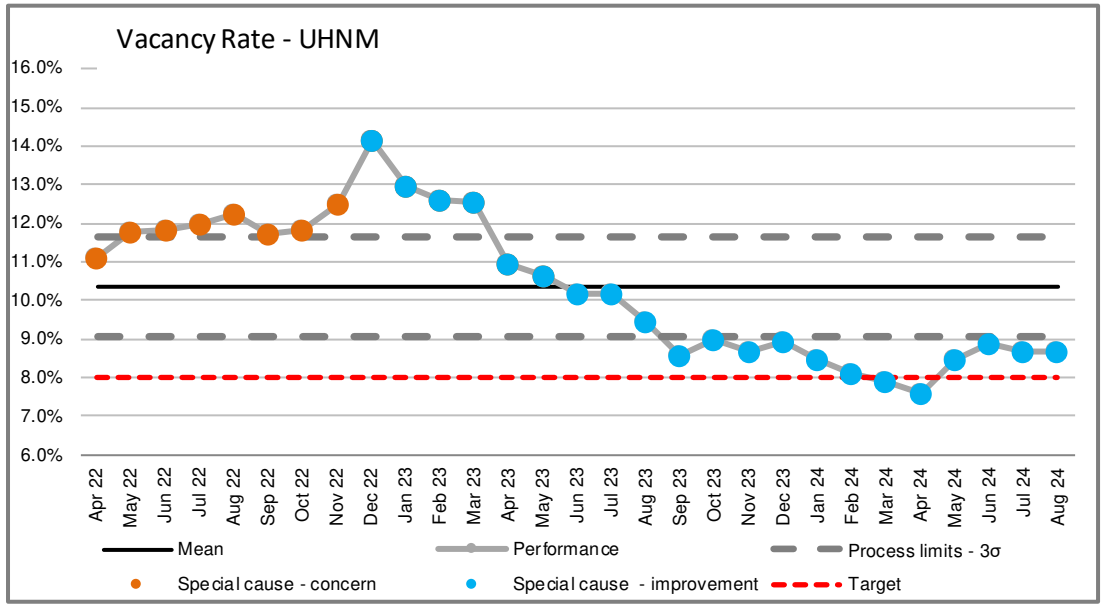
Network Division - commenced sickness assurance meetings.

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	Jun 24	Jul 24	Aug 24
8%	8.9%	8.7%	8.7%

Background

Based on Full Establishment (Substantive, Bank & Agency)

Vacancies at 31-08-24	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,712.06	1,556.98	155.08	9.06%	10.72%
Registered Nursing	3730.55	3406.13	324.42	8.70%	8.90%
All other Staff Groups	6876.25	6289.53	586.72	8.53%	8.05%
Total	12,318.86	11,252.64	1,066.22	8.66%	8.67%

What is the data telling us?

The summary of vacancies, by staff groupings, highlights a minor 0.01% 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 August 2024 by 47.55 fte, budgeted establishment increased by 50.19 fte, which increased the vacancy fte by 2.64 FTE overall.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 31/08/24]

What are we doing about it?

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

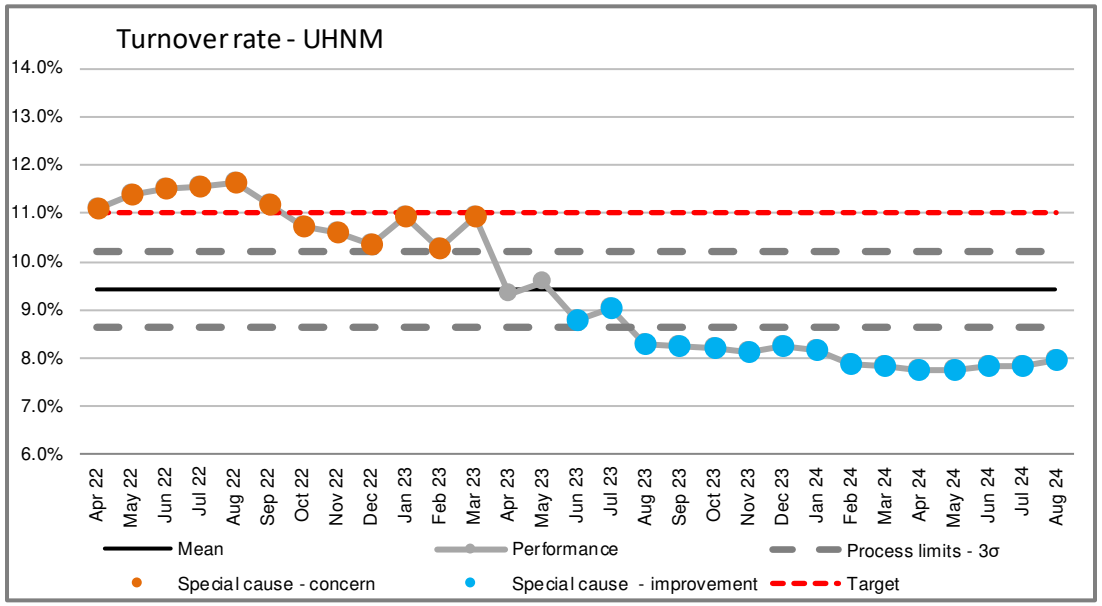
Targeted social media campaigns continue, advertising that our organisation is a great place to work.

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



Variation	Assurance
	

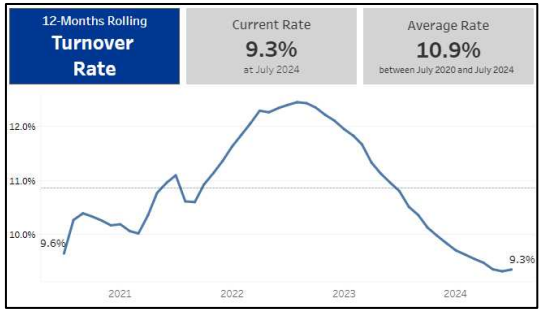
Target	Jun 24	Jul 24	Aug 24
11.0%	7.9%	7.8%	8.0%

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 August 2024 remains low, at 8.0% (7.8% in July 2024), which is consistently below the Trust's 11% target, for the last 23 months.

What are we doing about it?

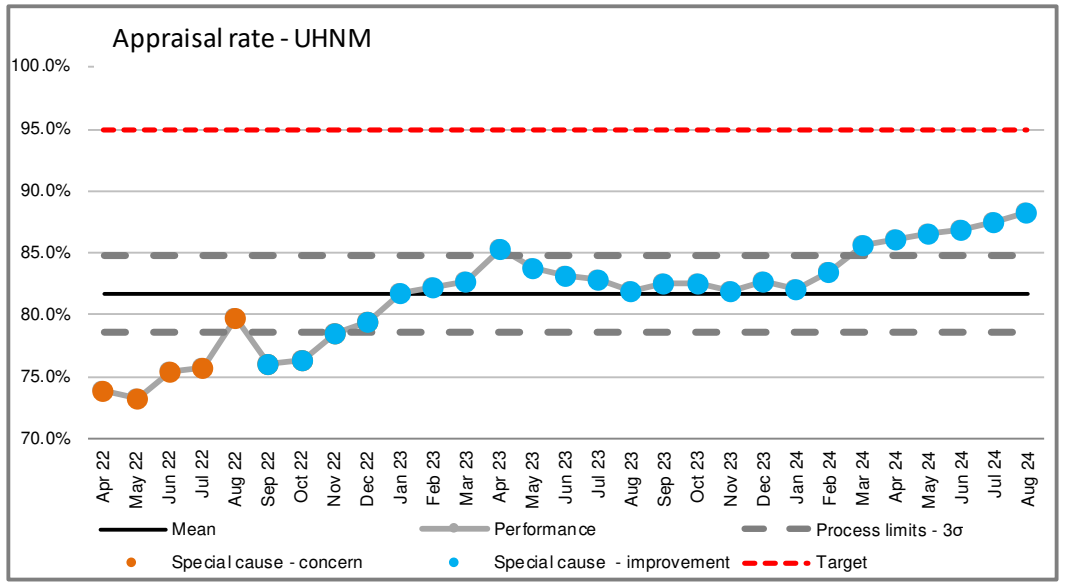
Turnover continues to perform well against our expected standards, reflecting our programmes of work which make this a great place to work. Some recent examples include :

- 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	Jun 24	Jul 24	Aug 24
95%	86.8%	87.5%	88.3%

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.

Over the last seven months we have seen consecutive improvements in our appraisal rates, which have gradually increased from 83.5% in February 2024 to 88.3% in August 2024, which is the highest rate seen, since July 2019.

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.

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-Aug = 565
24/25 Apr-Aug = 741
Increase on 23/24, when using benchmarkable data we are behind regional comparator Trusts, and are behind expected standards of a University Trust.

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. This has not changed from last report.

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-Aug 24/25 is over 30% higher than recruitment numbers during Apr-Aug 23/24. When benchmarked against regional Trusts our portfolio recruitments puts us behind comparator Trust, in 8th place.

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 383 to 389 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 will be allocating resource to this once new school term begins. 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 useful by stakeholders in the Research and Innovation Strategy Oversight Group (meeting date 18th September 2024) and this will now be added to the agenda for the next Executive Research and Innovation Group, and 2) we will conduct 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 will now be added to the agenda for the next Executive Research and innovation Group, and 2) we will conduct 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	145.0	170.0						
Increase Clinical Academic Posts/Honorary Contracts	-	8.0	8.0						
Increase Research Active Employees	-	383.0	389.0						

Improving & Innovating

Related Strategy and Board Assurance Framework (BAF)

Quality Strategy

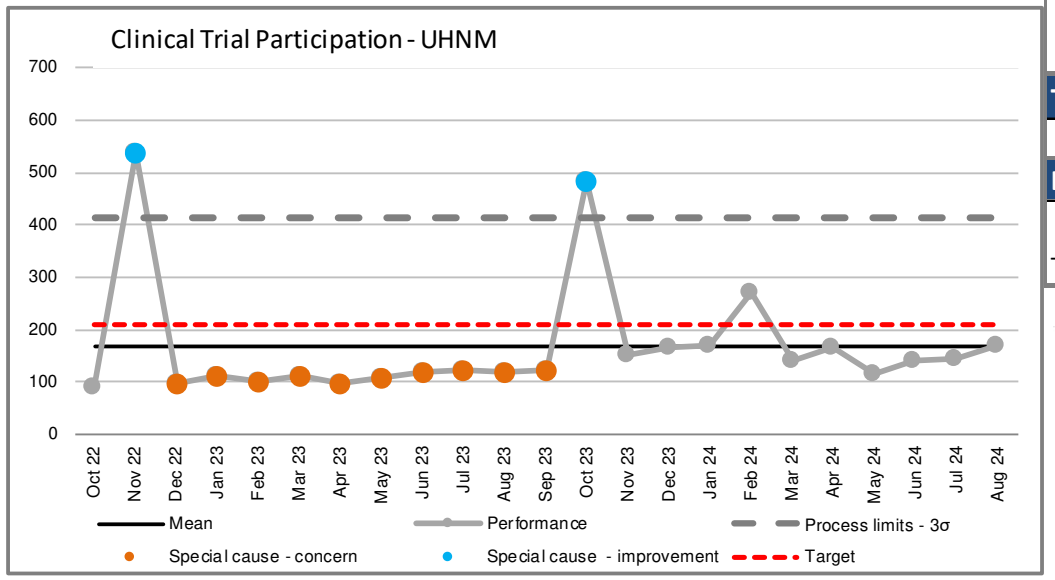
Research Strategy

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

Improving & Innovating | Clinical Trial Participation

Excellence in development and research

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jun 24	Jul 24	Aug 24
208	140	145	170

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?

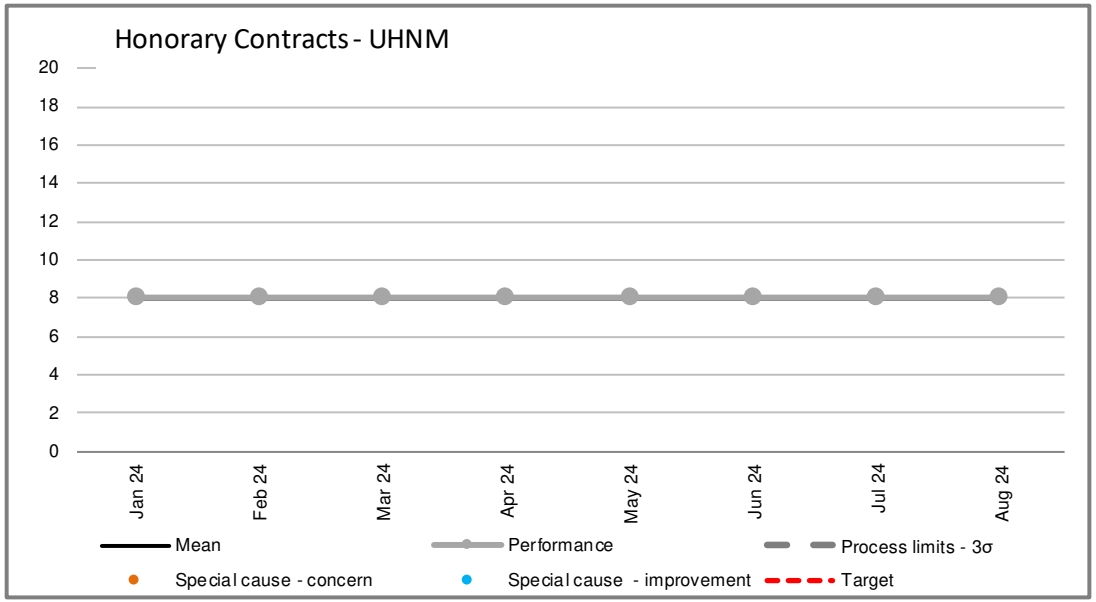
The directorate are mindful that a balanced portfolio is required, from research participation of questionnaire studies, through to full clinical trial. This portfolio is being developed over time. We have 2 studies in pipeline to improve it.
We also see our position within the region and are looking 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	Jun 24	Jul 24	Aug 24
N/A	8	8	8

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.

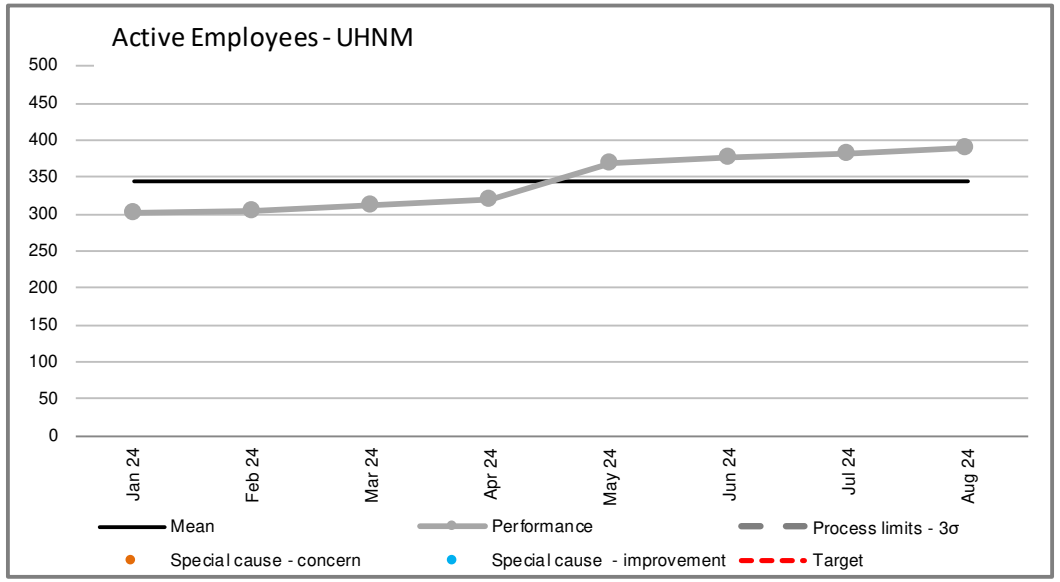
What are we doing about it?

We agreed a suggested definition of type of contract with stakeholders at a meeting on 18th September and this will be tabled for approval at the next Executive R&I Group meeting. We will then conduct 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	Jun 24	Jul 24	Aug 24
N/A	378	383	389

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 in reality this means that we are finding out about research activity, but 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 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.

Improving & Innovating

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?

What can we expect in future reports?

The next board update proposes to report
- Inpatient tobacco dependency treatment referrals
- Maternity tobacco dependency treatment referrals
- Anchor maturity assessment score.

System & Partners

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
Increased Partnership Working	-	0.0	0.0						
Improve the health of our population	-	0.0	0.0						

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 4: Improving the Health of our Population	15		15					

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 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. These were patients who otherwise would wait for excessive periods of time in ED. The opening of the new AMRAU on 2nd August has positively impacted on flow and Emergency Department overcrowding.

Elective
August activity over delivered against plan for DC and FU PODs and is overdelivering YTD against all PODs with the exception of Elective which delivered 90% in August and is at 94.1% YTD.
Day case 107%
Elective 93%
First OP Proc 99%
First Outpatient 100%
Follow up 102%

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 will be demonstrated through our Winter Planning document currently in train.
An important note on admissions is the use of the Clinical Decisions Unit which was, for a period, closed. This resulted in a number of 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 need 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 elective patient pathways is largely related to T and O (167 cases under plan YTD). NHSE Theatre Program Team are working with us to support an increase in theatre utilisation that will drive an increase in utilisation and number of cases per list.

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 in October 2024.
The Trust, System Partners and the ICB are currently reviewing all services, schemes and initiatives that will influence this and preparing for our winter planning and resilience.

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.

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
Further detail will be made available regarding the schemes being targeted to reduced non-elective admissions. August had a specific focus regarding the impact of the opening of the new AMRAU and short stay medical unit and whilst a obvious benefit has been seen, further work is required to ensure a continued positive benefits and impact.
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
We will continue to focus on delivering activity to the plan with workstreams through the Planned Care Group that support improving utilisation.
As the Executive Finance, Activity and Performance Groups with the divisions embed there will be specific feedback where escalation is required.
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)

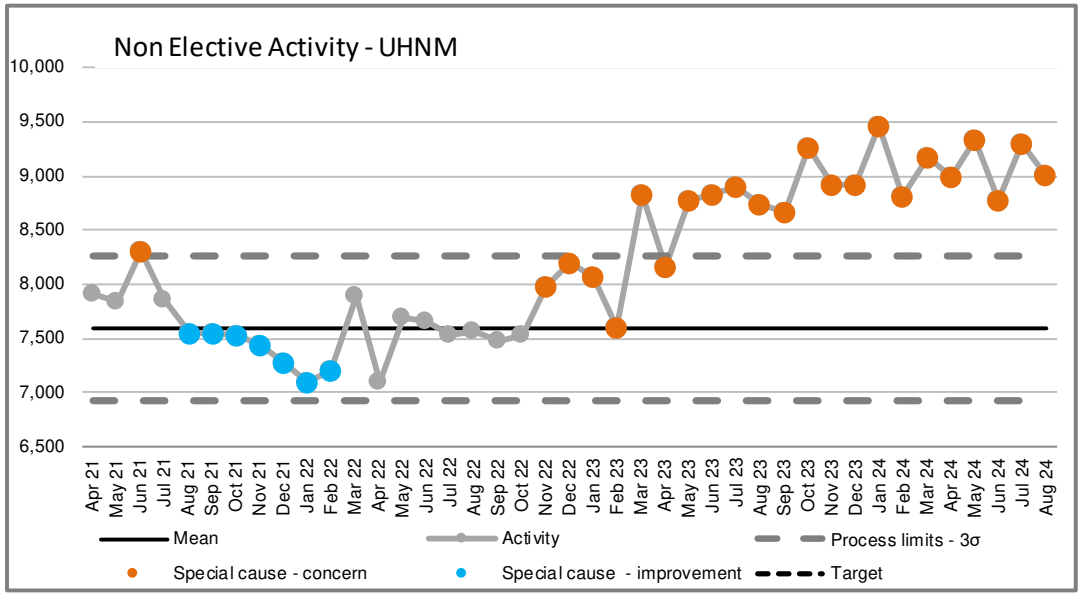
Digital Strategy

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

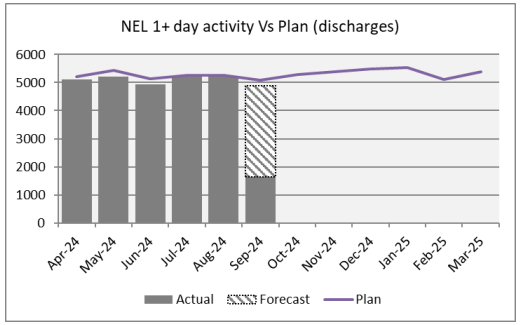


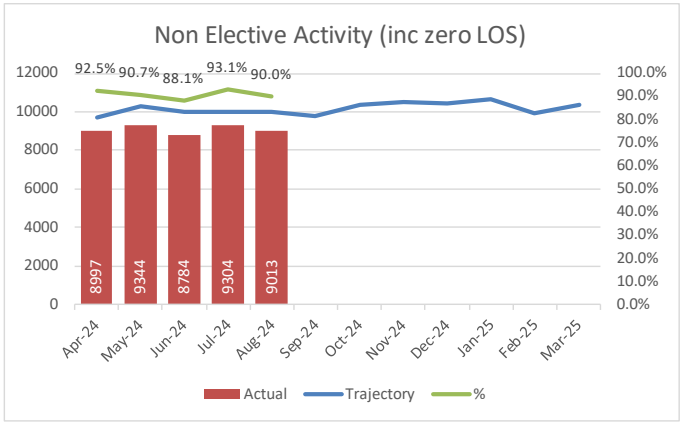
Variation	Assurance
H	P

Target	Jun 24	Jul 24	Aug 24
variable	8,784	9,304	9,013

Background

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





What is the data telling us?

In August we experienced a slightly lower demand in respect of our non-elective activity. August 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 23,691 patients but actual was 19,759 (a reduction of 16.6%). NEL+1 activity verse plan, Year To Date – the plan was 26,314 verses actual outturn was 25,681. A slight reduction of 2.41%.

The associated discharge profile for non-elective NEL zero-day achieved 90% against plan for August. NEL +1-day LoS achieved 98.7% against plan. Total expected discharges were 10,009 verses and actual of 9,013. Representing 996 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.

What are we doing about it?

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

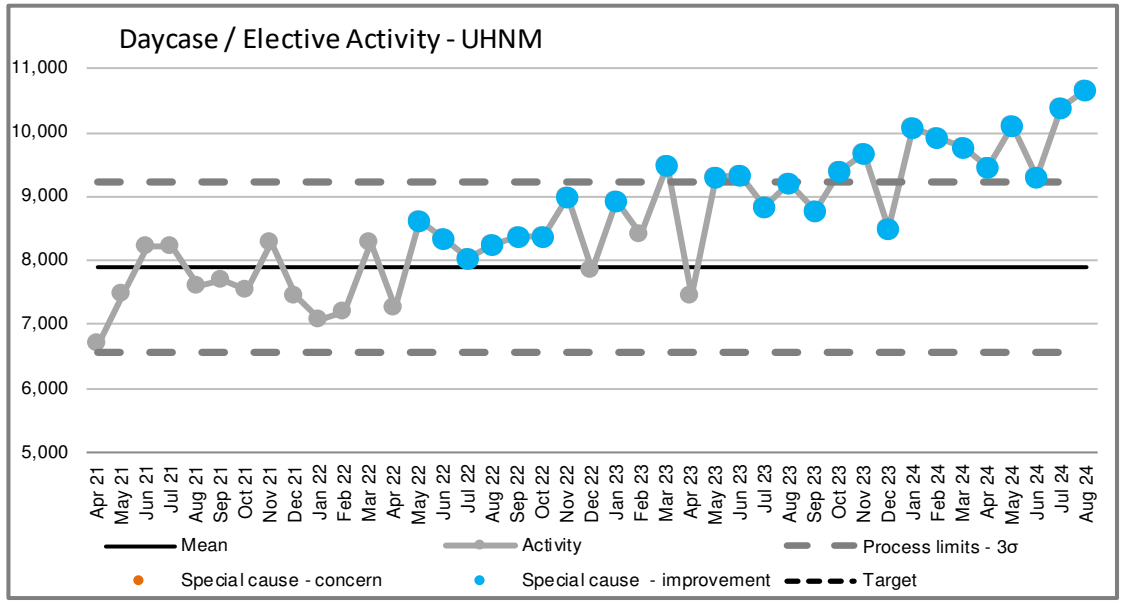
Renewed focus through Acute Care at Home (ACaH), has positively impacted on the utilisation of 'virtual ward' capacity. 2 in reach practitioners are in post to support a 'pull' model. This is now becoming 'Business As Usual' (BAU).

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

Resources | Daycase/Elective Activity

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

University Hospitals of North Midlands NHS Trust

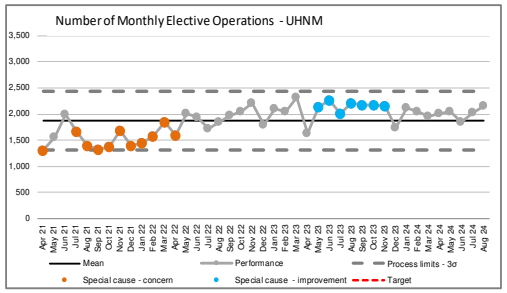


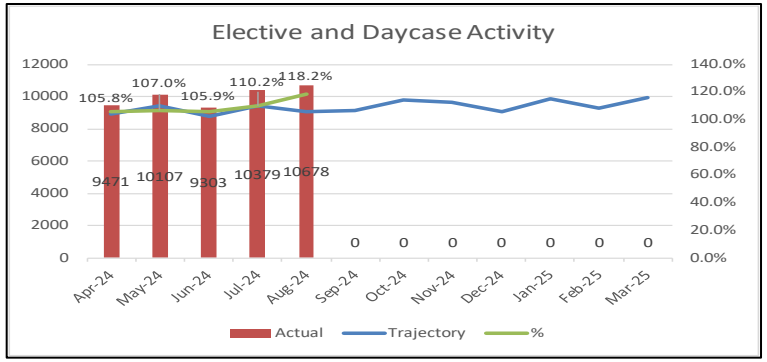
Variation	Assurance
H	F

Target	Jun 24	Jul 24	Aug 24
variable	9,303	10,379	10,678

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 July to 10,678. Data above relates to Trust wide Daycase & Elective activity, and shows 118.2% above plan.

Theatres:
Capped utilisation for theatres has improved slightly to 76.88%, increased focus on booking and scheduling processes along with tighter scrutiny at TPG expected to be key drivers for short term improvements whilst longer term perioperative pathway transformation will focus on improved efficiency and driving down cancellations and delays.

Theatres as a subset of overall trust DC/EL activity saw an increase in cases to 2147 in August 24. Cancelled ops remains below 24mnth mean, at 9% in August 24 although above plan target of 5%.

What are we doing about it?

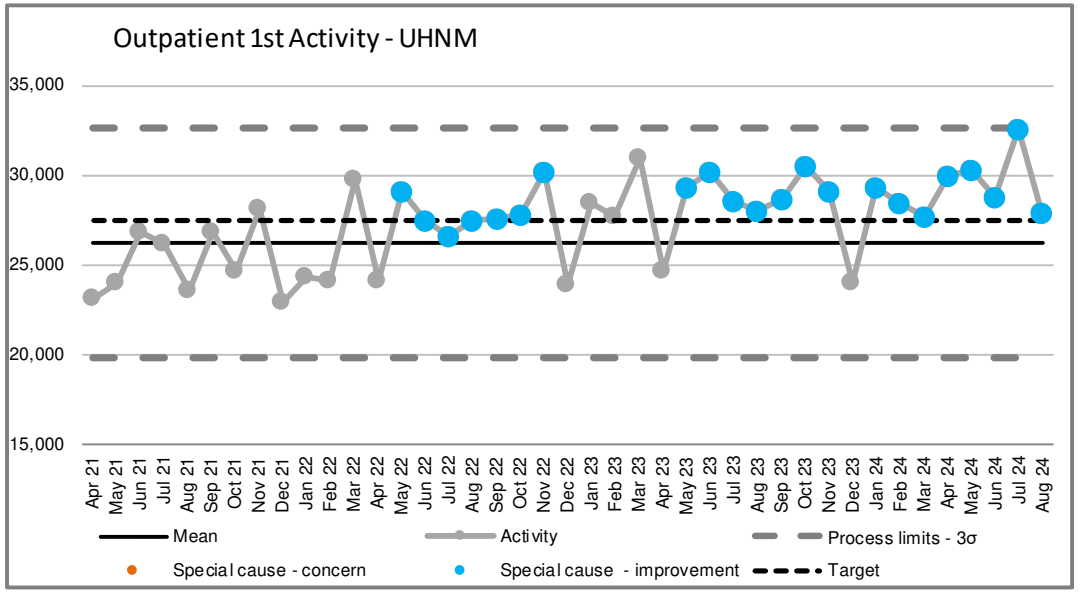
- SoP for Golden Patient developed and trial commencing with T&O this week
- Perfect week planning commenced for 4 x specialities at County w/c 7th October.
- List allocation meeting process approved with NHSE and commencing 15th September as proof of concept ahead of perfect week
- Perioperative Medicine 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 – 15 x successful cases used to backfill OTD cancellations – GA patients now lined up for perfect week.

Resources

Resources | Outpatient First Appt

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

University Hospitals of North Midlands NHS Trust

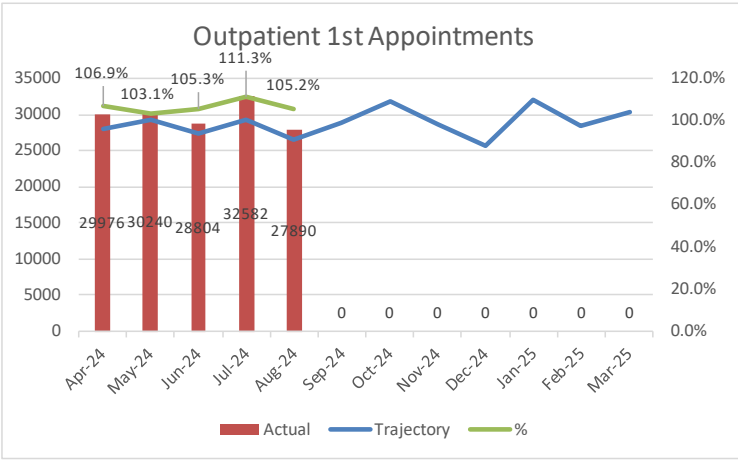


Variation	Assurance
	

Target	Jun 24	Jul 24	Aug 24
variable	28,804	32,582	27,890

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?

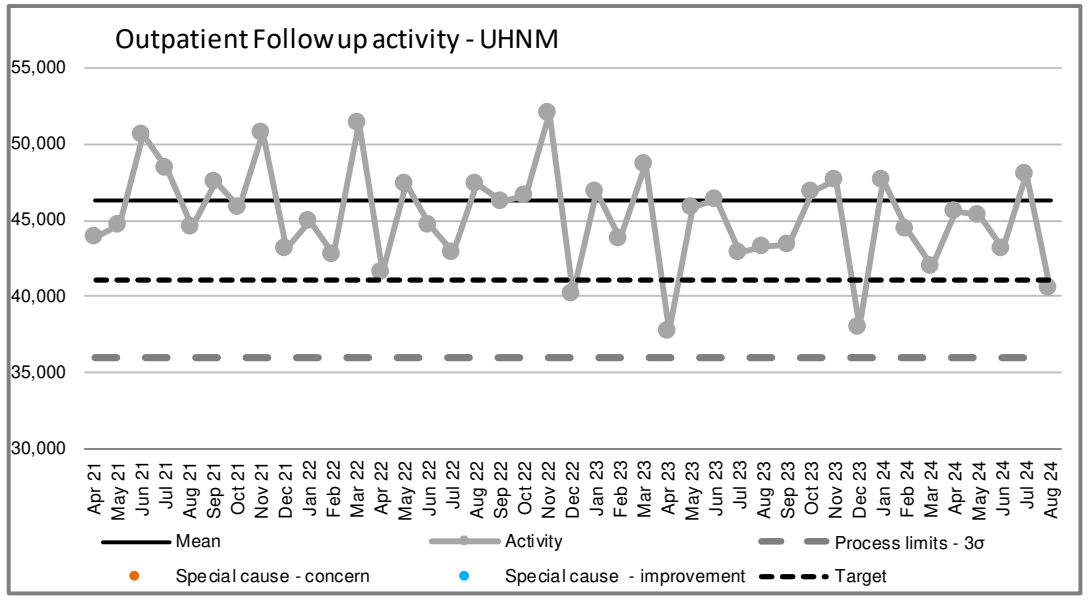
Countermeasure	Update / Next Steps
Advice & Guidance (A&G)	Advice & refer (triage by default) –scoping external support at System A&G Group –Birmingham & Solihull to present at Group. Final draft of proposed A&G standards circulated widely for comments. **Potential impact of GP Collective Action unclear.**
Patient initiated Follow Ups (PIFU)	>10 specialties live with RPA for PIFU Discharge letters. Gynae & Lymphoedema latest to go live with RPA. • ENT Clinical Lead & Deputy Chief Medical Officer meeting held based on benchmarking. Specialty to review vs stated PIFU pathways incl discharge rates. • UHNM volunteered to support PIFU Discovery Wayfinder Programme led by NHSE re PIFU & NHS App
Missed Appointments: - 2 Way messaging - Health Inequalities Audits	• **2 Way Messaging;** IM&T & supplier technical testing for implementation. Planned go live Sep/Oct • **Health Inequalities Audits** – benchmarking & initial analysis complete, dashboard developed, aligning with wider health inequalities approach, closely linking with public health consultant. Positive engagement, resource identified, pilot started July, now complete. Review underway to identify key actions and learning points, trying to identify resource for pilot contacting patient cohorts prospectively. • **Missed Appointment NHSE Community of Practice** – UHNM reps identified for first meeting 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.
Outcomes process review	Scoping approach; targeting those outstanding from previous months initially, outliers in limited number of medical specialties. Improving Together approach to follow RWL focus, in interim clinic outcome training actions identified.

Resources

Resources | Outpatient Follow Up Appts

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

University Hospitals of North Midlands NHS Trust

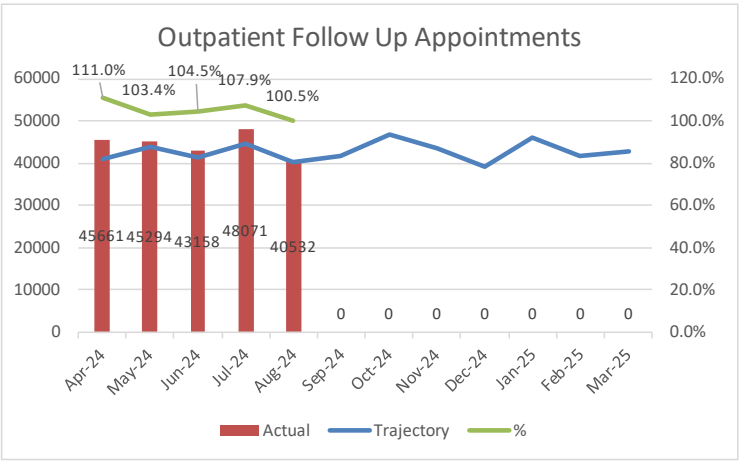


Variation	Assurance

Target	Jun 24	Jul 24	Aug 24
variable	43,158	48,071	40,532

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 6 points of 8 below mean.

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

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

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

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

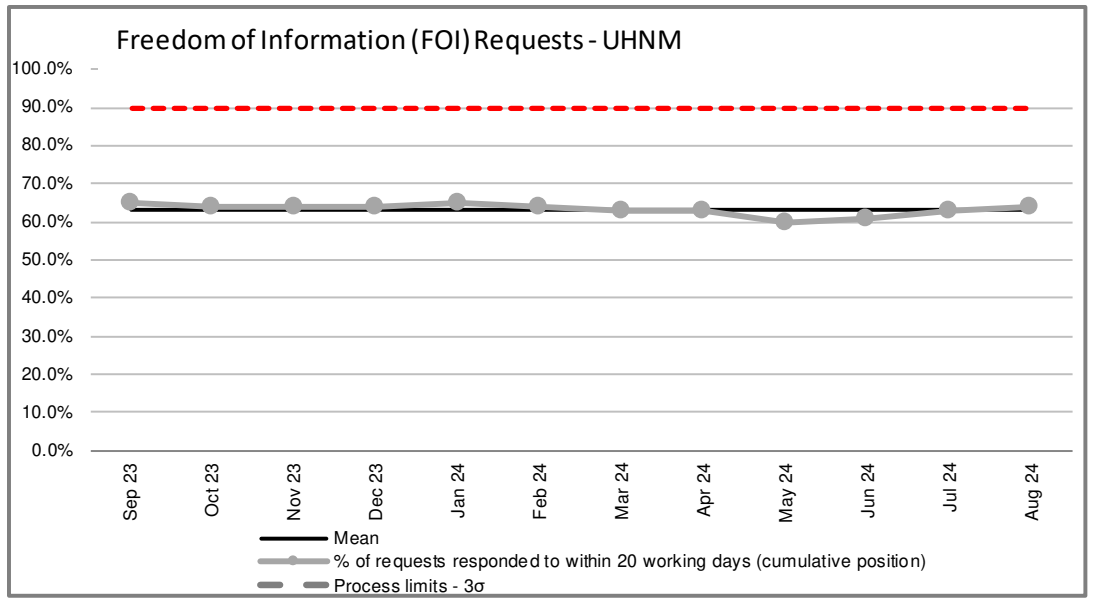
What are we doing about it?

Countermeasure	Update / Next Steps
Advice & Guidance (A&G)	Advice & refer (triage by default) –scoping external support at System A&G Group –Birmingham & Solihull to present at Group. Final draft of 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. • ENT Clinical Lead & Deputy Chief Medical Officer meeting held based on benchmarking. Specialty to review vs stated PIFU pathways incl discharge rates. • UHNM volunteered to support PIFU Discovery Wayfinder Programme led by NHSE re PIFU & NHS App
Missed Appointments: - 2 Way messaging - Health Inequalities Audits	• **2 Way Messaging;** IM&T & supplier technical testing for implementation. Planned go live Sep/Oct • **Health Inequalities Audits** – benchmarking & initial analysis complete, dashboard developed, aligning with wider health inequalities approach, closely linking with public health consultant. Positive engagement, resource identified, pilot started July, now complete. Review underway to identify key actions and learning points, trying to identify resource for pilot contacting patient cohorts prospectively. • **Missed Appointment NHSE Community of Practice** – UHNM reps identified for first meeting 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.
Outcomes process review	Scoping approach; targeting those outstanding from previous months initially, outliers in limited number of medical specialties. Improving Together approach to follow RWL focus, in interim clinic outcome training actions identified.

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

Target	Jun 24	Jul 24	Aug 24
90%	61%	63%	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 three months but is still below the target.

What are we doing about it?

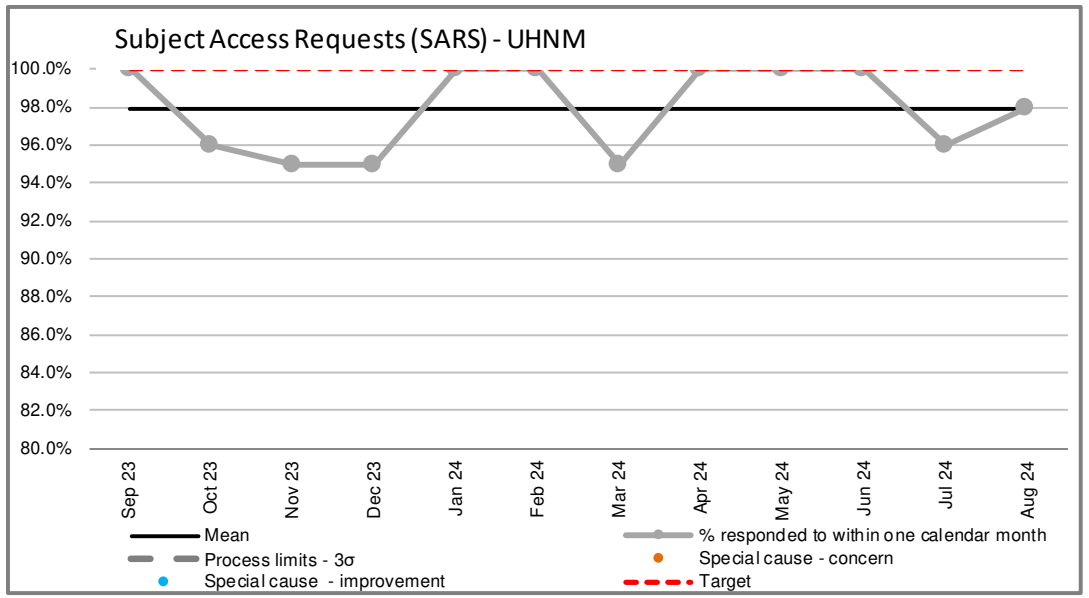
A task and finish group has been established to review the process and identify areas for improvement:

- A digital system has been procured following consultation with key stakeholders.
- The disclosure log work stream is underway. The proposed approach 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.

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	Jun 24	Jul 24	Aug 24
100.0%	100.0%	96.0%	98.0%

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).

August saw an improvement in the response times. The People Directorate, who co-ordinate staff subject access requests continue to receive complex cases, which is impacting on resources.

What are we doing about it?

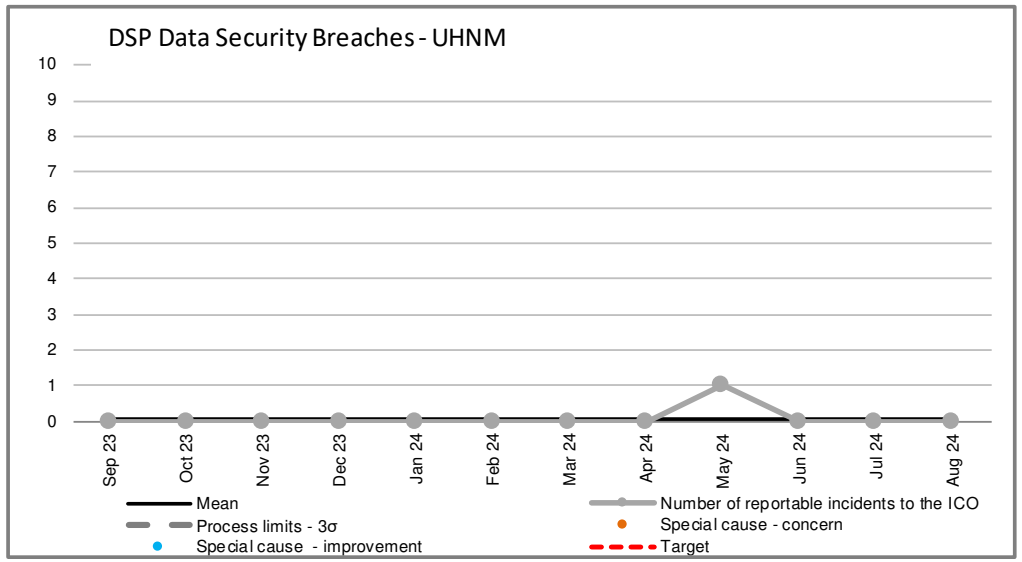
The Data, Security & Protection team are implementing a digital system for Freedom of Information Requests. This will also support the management of SARs. The People Directorate have agreed to move to the digital solution. This will facilitate a review of practice across DSP/Health Records and People 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.

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	Jun 24	Jul 24	Aug 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 in the period.

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. Further evidence has been submitted to support the ICO's investigation.

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	Grand Total
Essential	1	20	1	4	1	27
Essential – Proof of Concept (PoC)			1	3		4
Mandated		20	1	20	11	51
Other - High Priority	1	4		10		15
Other - Medium Priority		4		6		10
Other - Low Priority		3	1	12		16
Parked				1		1
PoC				1		1
TBC						
Grand Total	2	51	4	57	11	125

Variation	Assurance		
Target	Jun 24	Jul 24	Aug 24
N/A	120	121	119

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 51 IM&T projects that are in progress (no change in number from last month). 2 projects have been completed during August 2024. 68 projects have either not started or are currently on hold (a decrease of 2 from last month). As noted in the last report, there continues to be a large volume of IM&T projects slated for delivery during 2024_25.

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 have also started an exercise 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 August 2024 (Month 5).

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

- For Month 5 the Trust has delivered a year-to-date deficit of £9.4 against a planned deficit of £2.1m; this adverse variance of £7.3m is primarily driven by underperformance against the Trust's in year CIP target, the impact of industrial action and medical staffing pay.
- 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 £16.1m of CIP savings to Month 5 against a plan of £20.9m. Of the £16.1m saving delivered, £13.2m are non-recurrent against a plan of £12.6m.
- The full year forecast at Month 5 indicates that the most likely position remains a £22m deficit (excluding the Band 2-3 rebanding); a series of agreed actions which are incorporated into a draft system wide recovery plan moves this position to a realistic forecast of a £23.1m deficit which includes the impact of the band 2-3 rebanding.
- There has been £24.3m of Capital expenditure to Month 3. This is £0.5m below planned expenditure to Month 5.
- The cash balance at Month 5 is £84.6m which is £11.6m 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 a £9.4m deficit at Month 5 which is a £7.3m adverse variance from the planned deficit of £2.1m. The table below summarises the I&E position at Month 5.

Income & Expenditure Summary Month 05 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	1,082.1	93.0	89.4	(3.6)	447.9	450.9	3.0
Other Operating Income	90.4	9.2	8.0	(1.2)	37.9	37.7	(0.2)
Total Income	1,172.4	102.2	97.4	(4.8)	485.8	488.6	2.8
Pay Expenditure	(701.2)	(58.8)	(58.2)	0.6	(289.6)	(292.6)	(3.0)
Non Pay Expenditure	(438.1)	(41.3)	(37.6)	3.7	(184.5)	(192.0)	(7.5)
Total Operational Costs	(1,139.3)	(100.1)	(95.8)	4.3	(474.1)	(484.6)	(10.5)
EBITDA	33.2	2.1	1.6	(0.5)	11.8	4.0	(7.8)
Interest Receivable	4.0	0.4	0.6	0.2	1.7	2.8	1.1
PDC	(2.0)	(0.2)	(0.8)	(0.6)	(0.8)	(1.5)	(0.7)
Finance Cost	(35.2)	(2.9)	(2.9)	(0.0)	(14.7)	(14.7)	(0.0)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	0.0	(1)	(1.5)	(0.9)	(2.1)	(9.4)	(7.3)
Plan phasing adjustment	0.0	1.2	0.0	(1.2)	4.1	0.0	(4.1)
Surplus / (Deficit) reported to NHSE	0.0	0.6	(1.5)	(2.1)	2.1	(9.4)	(11.4)

Key issues to note within the Month 5 position include the following.

The year-to-date adverse variance of £7.3m is mainly driven by an under achievement of CIP £4.8m, the impact of industrial action £1.7m and medical staffing pay £1.4m. Income is over recovered by £2.8m mainly due to additional excluded drugs and devices income; this is off-set by non-pay overspends.

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 5, the Trust is reporting £16.1m savings in year, of which £13.2m relates to non-recurrent schemes. The in-month under-delivery of £0.7m is driven by the under-achievement of recurrent CIP delivery in the clinical divisions below the planned level.

The table below summarises the Month 5 position:

CIP Savings Month 5 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	(0.3)	1.6	0.2	(1.4)
Surgery, Theatres & Critical Care	3.6	0.3	0.0	(0.3)	1.5	0.1	(1.4)
Network services	2.8	0.2	0.0	(0.2)	1.2	0.1	(1.0)
Womens, Childrens & Clinical Support Services	2.6	0.2	0.2	(0.1)	1.1	0.4	(0.7)
Central functions	1.6	0.1	0.0	(0.1)	0.6	0.2	(0.4)
Estates, Facilities & PFI	1.0	0.1	0.4	0.3	0.4	0.4	0.0
North Midlands & Cheshire Pathology Services	1.2	0.1	0.0	(0.1)	0.5	0.1	(0.4)
Divisional CIP	16.7	1.4	0.7	(0.7)	6.9	1.6	(5.3)
Pay Underspend	6.0	0.5	0.5	-	2.5	2.5	-
Bank interest	2.0	0.2	0.4	0.3	0.8	2.0	1.1
Energy savings	3.2	0.3	0.3	-	1.3	1.3	-
Investment slippage	5.0	0.6	0.6	-	3.6	3.6	-
Other non recurrent	7.3	0.6	0.3	(0.3)	3.0	2.4	(0.6)
Additional CIP to 4% of cost base	6.3	0.5	0.5	-	2.6	2.6	-
Additional CIP to achieve breakeven	10.2		-	-			-
Total CIP	56.6	4.0	3.3	(0.7)	20.9	16.1	(4.8)

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	1.0	(0.7)	8.3	2.9	(5.3)
Non Recurrent	31.7	2.4	2.3	(0.0)	12.6	13.2	0.5
Total CIP target	56.6	4.0	3.3	(0.7)	20.9	16.1	(4.8)

Resources | Capital

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

University Hospitals of North Midlands NHS Trust

UHNM Capital Plan (£M)	Plan	Forecast	YTD Plan	YTD Actual	YTD Variance
Capital funding					
PFI & Loan Commitments	31.5	31.5	11.8	11.8	-
Base STP allocation	22.1	22.1	9.2	9.2	-
ICB fair share reduction	(0.5)	(0.5)	(0.2)	(0.2)	-
ICB brokerage	(3.1)	(3.1)	(1.3)	(1.3)	-
ICB IFRS16 CDC lease funding	5.0	5.0	-	-	-
ICB IFRS16 incremental increase allocation	4.4	4.4	-	-	-
Public Dividend Capital funding	40.9	41.8	6.9	6.9	-
Donated, granted other capital funding	7.0	7.0	1.8	1.8	-
Internal funding source (including capital receipts)	1.8	1.6	-	-	-
Total Capital funding	109.2	109.9	28.2	28.2	-
Capital expenditure					
PFI & Loan Commitments	(31.5)	(31.5)	(11.8)	(11.8)	-
Pre-committed investment items (ICB allocation)					
PFI enabling costs	(0.2)	(0.2)	(0.1)	(0.1)	(0.0)
Network & Comms BC525	(1.3)	(1.3)	(1.3)	(1.2)	0.1
IM&T computer hardware refresh programme	(5.2)	(2.2)	-	-	-
LED lighting BC546	(0.2)	(0.2)	-	-	-
Pharmacy Robot BC487 -	(0.0)	(0.0)	-	-	-
Investment funding	(0.5)	(0.3)	-	-	-
Central Contingency & risk	(0.3)	(0.3)	-	-	-
Project Star - car park completion/RI remedial work	(0.7)	(0.7)	(0.2)	(0.2)	(0.0)
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)	(0.0)
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)	(0.3)	-	-	-
Car park barriers BC550	(0.8)	(0.8)	-	-	-
Electronic Patients records BC/specification	(0.1)	(0.1)	(0.1)	(0.1)	0.0
Approved minor investments	(0.2)	(0.5)	(0.2)	(0.2)	-
Purchase of County Medical Records building	-	(1.4)	-	-	-
Funding to be allocated	(2.5)	(1.4)	-	-	-
Total Pre committed Investment items	(14.6)	(11.5)	(2.0)	(2.0)	0.0
IMT Sub Group Funding	(3.5)	(2.1)	(0.5)	(0.4)	0.1
IM&T lap top replacement top-slice	1.3	-	-	-	-
Medical Devices Sub Group Total Funding	(3.6)	(3.6)	(1.2)	(1.1)	0.1
Medical Devices Sub Group brought forward	-	(1.0)	-	-	
Estates Sub Group Total Funding	(4.3)	(4.3)	(0.7)	(0.4)	0.2
Health & Safety compliance	(0.2)	(0.2)	-	-	-
Net zero carbon (sustainability) initiatives	(0.1)	(0.1)	-	-	-
Total Sub Groups	(10.3)	(11.3)	(2.4)	(1.9)	0.5
Lease liability re-measurement	(0.4)	-	-	-	-
IFRS16 - lap top extension	(0.1)	(0.4)	-	-	-
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)	(0.3)	-	-	-
IFRS16 efficiency requirement	0.9	-	-	-	-
Total IFRS16 leases	(5.1)	(8.6)	-	-	-
Total Internal Capital Expenditure programme	(61.5)	(62.9)	(16.2)	(15.7)	0.5
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)	(9.4)	(0.8)	(0.8)	-
ICB brokerage allocated to CDC slippage	3.1	-	-	-	-
TIF 2 PDC (Breast care unit)	(7.5)	(7.5)	(0.6)	(0.6)	-
TIF 2 PDC (Day Case Unit) -	(8.7)	(8.7)	(2.6)	(2.6)	-
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)	(0.3)	(0.3)	-
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)	(3.5)	(1.7)	(1.7)	-
Total Additional CRL / PDC Funded expenditure	(47.8)	(47.0)	(8.7)	(8.7)	-
Total Capital Expenditure	(109.2)	(109.9)	(24.8)	(24.3)	0.5
Planned under/(over) spend	(0.0)	(0.0)	3.4	3.9	0.5

The table above sets out the capital plan for 2024/25 and the forecast at Month 5. As previously reported to the committee, there is an over commitment against the ICB capital funding allocation by MPFT and NSCFT due to additional costs in relation to the RAAC and Mental Health dormitory schemes respectively. As a result of this it has been agreed that UHNM will slip £3.057m of capital expenditure from 2024/25 to future years in order for these schemes to be completed in year. The slippage will be allocated against the CDC estates enabling scheme.

In Month 4 the Trust received confirmation from the ICB of £9.4m IFRS16 funding for 2024/25. £5m of this was previously included in our capital plan as it related to the pre-approved allocation for the CDC building lease. As a result of the overall IFRS16 allocation the plan now includes £2.5m of funding to be allocated."

At Month 5 the forecast identifies a number of variances from plan relating to

- a reduction in internal funding of £0.2m to smooth the phasing of future years capital plan.
- update of the IM&T computer hardware refresh programme to reflect the current proposal allocated between purchased and leased (to reflect the available funding).
- potential additional IFRS16 leases in respect of the cancer digital pathology and pathology MSC extension.
- additional forecast slippage of £1.7m on CDC. Overall forecast slippage of £4.7m partly offset by allocation of £3m ICB brokerage.
- medical devices brought forward expenditure of £1m approved in order to partly offset slippage.
- slippage on the 7th endoscopy room & ED ambulance handover enabling schemes due to building regulation issues.
- potential purchase of the County medical records building at end of the current lease (business case approval required).
- additional PDC awarded to the Trust relating to the purchase of a mobile breast screening unit (£0.5m) and workstations for pathology cancer reporting (£0.383m).

As a result the balance of funds to allocate in 2024/25 is forecast to be £1.4m, this will be discussed at CIG on 2 October. There are limited opportunities to bring forward expenditure from future years due to uncertainties on the timing of the capital commitments within the Pathology MSC contract, the timing and cost of the PET scanner replacement and uncertainty of the overall funding envelope for the next 3 years."
At Month 5 capital funding is in line with plan and capital expenditure is £0.5m lower than plan. Of the £24.3m expenditure, £11.8m 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 £0.5m behind plan. The estates sub-group is £0.24m behind plan mainly due to minor slippage in the schemes to replace operating theatre lighting and fire compliance work, it is expected that all schemes will be completed by the year end.

The planned underspend of £3.4m at Month 5 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 5	31/03/2024	31/08/2024			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	686.3	687.7	687.4	(0.2)	
Right of Use Assets	18.1	16.5	16.4	(0.2)	
Intangible Assets	16.3	14.2	14.2	0.0	
Trade and other Receivables	1.1	1.1	1.1	0.0	
Total Non Current Assets	721.7	719.5	719.1	(0.4)	
Inventories	17.7	17.7	18.4	0.7	Note 1
Trade and other Receivables	44.4	47.4	54.9	7.6	Note 2
Cash and Cash Equivalents	82.0	73.0	84.6	11.6	Note 3
Total Current Assets	144.1	138.1	157.9	19.8	
Trade and other payables	(125.6)	(114.7)	(146.3)	(31.6)	Note 4
Borrowings	(25.7)	(24.7)	(24.7)	(0.0)	
Provisions	(5.7)	(5.7)	(5.5)	0.2	
Total Current Liabilities	(156.9)	(145.0)	(176.5)	(31.5)	
Borrowings	(477.1)	(476.5)	(476.2)	0.3	
Provisions	(2.3)	(2.3)	(2.3)	0.0	
Total Non Current Liabilities	(479.4)	(478.8)	(478.5)	0.3	
Total Assets Employed	229.5	233.8	222.1	(11.7)	
Financed By:				-	
Public Dividend Capital	693.9	693.9	693.9	-	
Retained Earnings	(669.1)	(664.8)	(676.5)	(11.7)	Note 5
Revaluation Reserve	204.7	204.7	204.7	-	
Total Taxpayers Equity	229.5	233.8	222.1	(11.7)	

The balance sheet plan reflects the forecast included within the 2024/25 Financial Plan submitted to NHSE. Variances to the plan at Month 5 are explained below:

Note 1. The inventory balance is £0.7m higher than plan at Month 5. This is mainly due to an increase of £0.7m in pharmacy and £0.2m in hub theatres at month 5 compared to year end. The increase is partly offset by £0.1m reductions in the angioplasty and pacemaker inventory balances over the same time period.

Note 2. Trade and other receivables are £7.6m higher than plan. This is mainly due to prepayments of £12.9m being higher than expected, which relate to managed service contracts and annual licences paid for a full 12-month period in advance. NHS accrued income is also higher than plan due to income accrued with the ICB of £4.3m and NHS England of £2.3m relating to variable funding growth in a number of areas.

Note 3. At Month 5 our cash balance was £84.6m, which is £11.6m higher than the plan of £73m. Cash received is £21.9m higher than plan overall, of which £20.5m relates to the Staffordshire and Stoke ICB block mandate, which includes the upfront payment of ERF funding £12.4m (relating to months 6 to 12). Payments are £10.3m ahead of plan at the year end of which £7.7m relates to general payments. This overspend reflects the revenue overspend to Month 5 and the higher than planned level of prepayments in 2024/25.

Note 4. Trade and other payables are £31.6m higher than plan. This is mainly due to deferred income of £50m at Month 5 being significantly higher than plan. Of this balance £26.7m relates to Staffordshire and Stoke ICB due to the upfront payments of ERF funding £12.4m, 2024/25 block contract £9.9m and West Midlands Cancer Alliance funding £1.3m. At Month 5 the deferred income balance also included £2.9m in relation to Education Contract income from NHS England, £5.9m from NHSE relating to high-cost devices and £1.2m 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 £11.7m variance from plan which reflects the Month 5 financial performance deficit of £9.4m and adjustments relating to.

- donated income and donated depreciation £1m.
- adjust PFI revenue costs to a UK GAAP basis £1m.

Resources | Forecast revenue outturn

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

University Hospitals of North Midlands NHS Trust

The table below shows a summary of the best, realistic and worst case for the Trust with a range of a £14.3m-£29.9m deficit for the year before the impact of the Band 2-3 rebanding.

I&E 2024/25 year end forecast at Month 5	Best	Realistic	Worse
	£m	£m	£m
Divisional base surplus/(deficit) forecast	(32.1)	(32.1)	(32.1)
Divisional CIP schemes above forecast	4.0	3.0	-
Additional CIP stretch target to breakeven £10.2m			
ERF income	1.3		(1.3)
Divisional risk bias	4.0	2.1	-
Total Risks & Opportunities	9.3	5.1	(1.3)
2024/25 I&E surplus/(deficit) forecast range	(22.9)	(27.0)	(33.4)
Non recurrent mitigations	8.6	5.0	3.5
Total I&E forecast Surplus/(deficit)	(14.3)	(22.0)	(29.9)

As previously reported the system has appointed a turnaround director who is already working with us to develop a recovery plan. A first draft of a recovery plan has been produced that has as a series of actions that have been categorised as "likely", "possible" and "high risk" with the first two of these having been agreed by Chairs and CEOs. The impact of these is to reduce the forecast system deficit of £193m by £26.5m and £20.3m respectively to £146m. The impact of this for UHNM is summarised in the table to the right.

I&E 2024/25 year end forecast at Month 5	Best	Realistic	Worse
	£m	£m	£m
2024/25 I&E surplus/(deficit) forecast range	(22.9)	(27.0)	(33.4)
Non recurrent mitigations	8.6	5.0	3.5
Total I&E forecast Surplus/(deficit)	(14.3)	(22.0)	(29.9)
Band 2 to 3 risk	(15.0)	(15.0)	(15.0)
Forecast start point for System recovery plan	(29.3)	(37.0)	(44.9)
System Recovery Plan			
Additional balance sheet flexibility		3.6	
Further CIP/Mitigations		3.3	
Band 2 to Band 3 mitigation	7.0	7.0	
2024/25 I&E surplus/(deficit) forecast range	(22.3)	(23.1)	(44.9)

As can be seen the impact is to move the Trust's realistic scenario towards its best-case scenario with the additional balance sheet flexibility explicitly assumed in the best case and the impact of the further CIP/mitigations included as the improvements to the "Divisional CIP schemes above forecast" and "Divisional risk bias".

The initial assessment of the potential impact of the band 2-3 rebanding has been included in the start point deficit at £15m. The Trust has reviewed this and now assesses the likely risk at £8m resulting in a £7m improvement to the position.

There remains a potential upside if the Trust is able to deliver additional ERF related activity at below National tariff.

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 £9.4m at Month 5 against a planned deficit of £2.1m, resulting in an adverse variance year to date of £7.3m. This is primarily driven by the non-delivery of CIP, the impact of industrial action and medical pay. 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 | 3rd October 2024

Matters of Concern / Key Risks to Escalate

For information:

- Response to **NHS England Urgent & Emergency Care (UEC) assurance** request demonstrated partial compliance in 2/6 areas which reflect the risks and challenges to the UEC pathway and the ability of non-executives to speak to patients during walkabouts, requires further consideration.
- **Partial Assurance** for the **Infection, Prevention and Control Annual Report** due to being above trajectory for key indicators (noting the period is 2023/24 and improvements have been seen during 2024/25).
- **Partial Assurance** for the **Readmissions Analysis** as further review has identified coding improvements to be made and overseen via more regular audits through the Data Quality Group.
- **Partial Assurance** for the Patient Waiting List Backlog Clinical Harm Review process as whilst a small number of cases are being reviewed retrospectively, an electronic solution needs to be developed and embedded for prospective review although this is taking some time, and resources are constrained.
- **Partial Assurance** for the Q1 **Patient Experience Report** due to increasing volumes and complexity of complaints, combined with response timescales and further improvements needed with Family & Friends.
- Work is ongoing in response to wrong site surgical **Never Events**; systems and processes are being reviewed and this will be reported back at the next meeting. Work is also being undertaken around the follow-up letter for **Duty of Candour** (in relation to the 10-day timescale); this involves a desktop review of the incident response framework and how the duty to follow up verbal discussions is communicated.
- **Medication shortage** concerns were highlighted through the Quality & Safety Oversight Group although mitigation plans are in place.

Major Actions Commissioned / Work Underway

- Feedback from non-executive Maternity Champion Visits to be captured as part of the revised **Maternity Dashboard Report**.
- Consideration of the non-mandatory **CQUINs** will form part of the development to the refreshed Quality Plan (previously strategy).
- Recognition of areas achieving Platinum through the **CEF** process as well as reviewing the overall criteria against the updated Single Assessment Framework.
- Work is underway to strengthen mechanisms for sharing **learning arising from mortality** reviews.
- Agreement to be reached around the frequency / format of reporting on **readmissions**.
- Consideration to be given as to how **readmissions** data can be used to inform the management of patients / clinical decision making around discharge.
- Consideration to be given as to how the **Patient Experience Report,** plus other quality reports can be enhanced, ensuring that the patient voice is very prominent.
- Ongoing work with GPs around delays in referral of deaths to the **Medical Examiners Service**.
- An explanation around the 'assurance' points used in Statistical Process Control (SPC) will be included within the Board report.
- A report on the recent **Major Trauma Peer Review** will be shared at the next meeting

Positive Assurances to Provide

- 4/6 areas in the **NHSE UEC assurance** request were assessed as compliant which reflects the significant work undertaken in assessing plans against the year 2 recovery plan with many elements underway.
- **Acceptable Assurance** agreed for the monthly **Maternity Dashboard** with the number of mothers smoking at the time of delivery and 100% compliance with the Maternity Incentive Scheme being particular successes. The CEF report also demonstrated improvements in the Delivery Suite (Bronze to Gold).
- **Acceptable Assurance** for the **Mortality Assurance Report** due to review processes being in place, outcomes for HSMR being 'better than expected' and SHMI in line with expected, with further work ongoing to improve on learning processes. Highest Quartile for mortality within NHS Oversight Framework.
- **Significant Assurance** for the **Medical Examiners Service,** which is now a statutory 7-day service; processes working well and will be audited to provide further assurance. The service has been recognised at a national level.
- Continued improvements across a range of **quality metrics** and progress made to stabilise the Nursing, Midwifery & Allied Health Progressional workforce.

Decisions Made

- There were no items requiring decision.

Comments on the Effectiveness of the Meeting

- Excellent chairing, in depth discussions, agenda content felt right
- Quality of papers allows for much for more strategic / thematic review

Cross Committee Considerations

- There were no specific points identified.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	UHNM Response to NHSE UEC letter			Not Assessed	Assurance	7.	Readmissions Analysis Update	1	High 12	Partial	Assurance
2.	Maternity Dashboard: August 2024	1	High 12	Acceptable	Assurance	8.	Patient Waiting List Backlog	1	High 12	Partial	Assurance
3.	CQUIN Report			Not applicable	Assurance	9.	Patient Experience Report Q1 24/25	1	High 12	Partial	Assurance
4.	Care Excellence Framework Summary Report Q1 24/25	1	High 12	Partial	Assurance	10.	Medical Examiner Service Update	1	High 12	Significant	Assurance
5.	Infection Prevention Annual Report 23/24	1	High 12	Partial	Assurance	11.	Quality Performance Report - Month 5 24/25	1	High 12	Not Assessed	Assurance
6.	Mortality Assurance Report Q1 24/25	1	High 12	Acceptable	Assurance	12.	Executive Quality & Safety Oversight Group Highlight Report	1	High 12	Not Assessed	Assurance

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								
Matthew Lewis	Chief Medical Officer		AM									
Katie Maddock	Non-Executive Director											
Jamie Maxwell	Head of Quality, Safety & Compliance											
Ann-Marie Riley	Chief Nurse											
Sunita Toor	Non-Executive Director											

Highlight Report

People, Culture & Inclusion Committee | 2nd October 2024

Matters of Concern / Key Risks to Escalate

- Partial Assurance agreed in relation to the **Guardian of Safe Working Report** as whilst a positive impact from programmes of work was being seen, improvement is required around review of exception reports and the fines levied.
- The volume of cases being handled through the **Employee Relations** team is presenting challenges due to capacity constraints; and a rating of partial assurance was identified due to the timeframes to resolve cases and the volume of conclusions of 'no case to answer'.
- Partial Assurance for the 2024 Workforce Race and Workforce Equality Standard Report, as a deterioration in 4 indicators was noted although actions are in place.
- Partial Assurance was given for 'growing and developing our workforce' due to matters of concern regarding apprenticeship levy uptake and expenditure.

Major Actions Commissioned / Work Underway

- A plan is in place covering a range of actions associated with **Healthcare Scientists** which broadly cover awareness and recognition, funding, recruitment, retention and training, accreditation / regulation.
- Further review / follow up of actions associated with the **Guardian of Safe Working Report** via the Executive Team / Executive Workforce Assurance Group.
- A toolkit has been developed and **talent conversations** are requested to be completed by mid-October.
- Work is being undertaken to ensure that there is increased equity, equality and diversity in **career development and promotion** as well as conversations around how leadership development will be developed over the coming years.
- Priorities for 2024/25 for **Learning & Education** are around development / retention, apprenticeships, future workforce programmes in partnership with local education providers / communities and resource / infrastructure.
- Discussions are being held through the Executive Team in relation to resource within People Operations and Speaking Up, given the challenges around timeliness of responding to cases.
- Actions are in progress to improve workplace experience of ethnically diverse colleagues as well as those with a disability / long term condition, development of outcome metrics will be developed as part of the revised People Plan which is underway and will be discussed in November with the Board
- Campaign underway to support **National Speaking Up Month**, in particular around listening / following up

Positive Assurances to Provide

- Acceptable Assurance was agreed for the Chief Healthcare Scientists Report given the progress made and understanding of the position / additional actions required.
- **Appraisal and Revalidation Annual Report** demonstrated that appraisals were of high quality and in accordance with Responsible Officer Regulations.
- Acceptable Assurance was agreed for **Talent Management and Succession Planning**, in particular for most senior leaders, with a plan needed for wider workstreams.
- Acceptable Assurance was agreed for the **Learning & Education Annual Report,** given the significant achievements during the year.
- 6 Workforce Race indicators and 7 Workforce Disability indicators demonstrate an improvement when compared to the previous year, in particular around reasonable adjustments.
- Acceptable Assurance agreed for the **Equality, Diversity & Inclusion Annual Report** as it demonstrated the progress made against the 7 Objectives set for 2022 – 2025 in the strategy and the Public Sector Equality Duty.
- A review of 6 areas identified through the cultural review has been undertaken with agreement reached by the Executive Team around oversight and support from this point forward which will align with the national oversight framework
- Acceptable Assurance given for the **Chief People Officer's Report** generally as good progress has been seen across all four of the People Strategy domains.
- Significant Assurance agreed for **Security Management** as the report demonstrated that the service continues to be responsive and well-functioning.

Decisions Made

- Approval of Appraisal and Revalidation Annual Report

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Real improvements noted in the papers	• **Performance & Finance Committee:** oversight of bank and agency usage and the appropriate monitoring and oversight

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Chief Healthcare Scientist 6 Month Report	2	ID25120 ID28945 ID20616 ID31429 ID20626	Acceptable	Assurance	8.	Equality, Diversity and Inclusion Annual Report 23-24	2	Ext 16	Acceptable	Assurance
2.	Appraisal and Revalidation Annual Report			Not Assessed	Assurance	9.	Hotspot Areas Review	2	Ext 16	Acceptable	Assurance
3.	Guardian of Safe Working Report – Q1 24/25	2	Ext 16	Partial	Assurance	10.	Chief People Officer Report	2	Ext 16	Acceptable	Assurance
4.	Talent and Succession Planning Update	2	Ext 16	Acceptable	Assurance	11.	Executive Workforce Assurance Group Highlight Report (18-07-24 & 19-09-24)	2	Ext 16	Not Assessed	Assurance
5.	Learning and Education Annual Report 2023/24	2	Ext 16	Acceptable	Assurance	12.	Security Management Annual Report 2023/24	6	High 12	Significant	Assurance
6.	Employee Relations Casework Trends	2	Ext 16	Partial	Assurance	13.	Executive Health & Safety Group Highlight Report (19-07-24 & 27-09-24)			Not assessed	Assurance
7.	2024 Workforce Race and Workforce Disability Equality Standard Reports	2	Ext 16	Partial	Assurance	14.	Internal Audit Report: Data Quality - Annual Leave Indicators Follow Up			Some Progress	Assurance

2024/25 Attendance Matrix

No.	Name	Job Title	M	J	S	N	J	M
1.	Prof G Crowe	Non-Executive Director (Chair)						
2.	Mrs C Cotton	Director of Governance						
3.	Ms A Gohil	Non-Executive Director						
4.	Mrs J Haire	Chief People Officer						
5.	Prof K Maddock	Non-Executive Director						
6.	Mrs A Riley	Chief Nurse						
7.	Mrs L Thomson	Director of Communications			JD			
8.	Prof S Toor	Non-Executive Director						

Attended | Apologies & Deputy Sent | Apologies

Highlight Report

Performance and Finance Committee | 30 September 2024

Matters of Concern / Key Risks to Escalate

For information:

- Partial assurance given for the update on **business case reviews**. The Committee requested a forward plan for receipt of outstanding updates as well as including the value of the business cases and return on investment, to help prioritisation of outstanding cases
- Partial assurance given for the **productivity** update. The Committee welcomed the inclusion of the waterfall diagram which identified a residual productivity opportunity of 11.8%. However, the lack of benchmarking information was identified as a potential barrier, and it was noted that additional productivity opportunities for cost improvements had not been included for 2024/25
- Partial assurance given for the Month 5 **finance** report. The forecast for the year end had been updated to reflect the recovery plan submission and further assurance was to be provided in future monthly updates in terms of performance against the revised deficit
- Partial assurance given for the **Cost Improvement Programme** (CIP) report. The Committee noted the introduction of fortnightly meetings with each Division, to speed up the identification of CIPs which had provided additional assurance that Surgery and Network Services had made improvements in the identification of savings. It was noted that the Turnaround Director had also been involved with the confirm and challenge meetings with Divisions and it was noted that further discussions would continue to be held in the Executive finance and activity meetings
- A verbal update was provided in respect of the **Winter Plan** which identified ongoing challenges in respect of winter plan funding
- Partial assurance given for the **Performance** report whereby performance in relation to ambulance handovers within 45 minutes was presently at 65.96%, therefore further actions were to be taken to improve this metric within the workstream.
- **Diagnostics** performance highlighted that there remained outstanding challenges in non-obstetric ultrasound
- **Cancer** 62 day performance continued to be challenged, although histopathology was getting back on track and patients continued to be prioritised in treating those with the longest waits first
- **65 week wait** performance had deteriorated and 182 patients were expected to be outstanding for the end of September; the main issues being attributed to respiratory. In addition, the ear, nose and throat (ENT) specialty was challenged, and the Trust was continuing to work with a partner to provide additional lists. It was noted that 66 of these patients were at risk of not being treated by October

Major Actions Commissioned / Work Underway

- Mitigating actions were to be identified and confirmed to the Committee in respect of addressing the **capital** slippage from the Community Diagnostic Centre programme
- A further session was to be scheduled with the Committee on **productivity**, in particular the formula utilised
- Future **finance** reports to include month by month reforecast in addition to the recovery actions being taken. Additional assurance was also to be provided in terms of the controls in place to monitor agency and bank spend as well as separating the costs associated with utilisation of bank and agency to support elective recovery.
- To consider the governance associated with the **Finance and Activity Group** and reporting into the Committee
- The **winter plan** was to be considered by the Trust Board in October
- To discuss the improvement actions being taken to improve **urgent and emergency care performance** at the meeting in November

Positive Assurances to Provide

- Significant assurance given for the **Procurement** report where it was noted that a business case had been approved to develop a dedicated contract management resource for the North Midlands and Black Country procurement group
- **Cancer** faster diagnostic standard (FDS) had continued to track positively against the improvement trajectory and was presently ahead of trajectory.

Decisions Made

- The Committee approved the business case for the **IM&T Computer Hardware Refresh Maintenance Programme** and supported the recommendations to implement a structured programme.
- The Committee approved the following **Electronic Request for Executive Approvals** (e-REAF); Barriers for Car Parks (e-REAF 14856), Steam Supply for Central Sterile Service Department (e-REAF 14911) and Replacement X-Ray Rooms at County Hospital plus Turnkey costs (e-REAF 14914)

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Committee members reflected on the discussion held and the way in which the items on the agenda were covered, given the size of the agenda. It was queried if going forwards presenters should provide 2 to 3 points for each paper to avoid the discussion feeling rushed	• **People, Culture and Inclusion Committee** to consider the risk associated with sonographer workforce and the actions being taken in terms of retention given the ongoing diagnostic challenges

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	IM&T Computer Hardware Refresh Maintenance Programme	5	High 12	Not Assessed	Approval	6.	Trust Approach to Productivity	7 / 8	Ext 16	Partial	Assurance
2.	Business Case Review Update	-	-	Partial	Assurance	7.	Finance Report – Month 5 2024/25 & CIP Report	7 / 8	Ext 16	Partial	Assurance
3.	Executive Infrastructure Group Highlight Report	6	High 12	Not Assessed	Assurance	8.	Winter Plan – Verbal Update	4	Ext 20	Not Assessed	Information
4.	Quarterly Procurement Update Report	7 / 8	Ext 16	Significant	Assurance	9.	Performance Report – Month 5 2024/25	4	Ext 20	Partial	Assurance
5.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	Not assessed	Approval	10.	Internal Audit Report: Ambulance Handover Data	4	Ext 20	Partial	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						
6.	Mrs K Thorpe	Acting Chief Operating Officer	SE	SE	SE	SE	SE							
7.	Dr L Griffin	Non-Executive Director	Chair	Chair										
8.	Ms A Gohil	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 August to 14th September 2024, 3 contract awards over £1.5 m were made, as follows:

- **CDC - 2 MRI, 2 X-Ray, 2 CT and associated Turnkey and Storage Costs,** supplied by Siemens, at a total cost of £5,749,323.60, approved on 5th September 2024
- **Community Diagnostic Centre - Lease rental,** supplied by Fisher German, at a total cost of £9,859,315.00, for the period 03/05/2024 to 02/05/2039, approved on 5th September 2024
- **Clinical Waste Management Services Contract**, supplied by Sharpsmart Ltd, at a total cost of £1,768,426.00, for the period 01/10/2024 to 30/09/2026, providing savings of £29,474.00, approved on 5th September 2024

Trust Board

2024/25 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		3	8	5	10	7	4	9	6	4	8	5	12	
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse		Staff			Staff			Staff			Staff		
Quality Governance Committee Assurance Report	Director of Governance			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													
RESPONSIVE														
Integrated Performance Report	Various													
Clinical Strategy Update	Director of Strategy													Deferred due to purdah and General Election period
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						
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							
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above	Director of Strategy	NA				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	Dec	Jan	Feb	Mar	Notes
		3	8	5	10	7	4	9	6	4	8	5	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														
Nomination and Remuneration Committee Assurance Report	Director of 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													
Well-Led Self Assessment	Director of Governance													To be considered at July's Trust Board Seminar
Risk Management Policy	Director of Governance													Next due for review February 2027
Complaints Policy	Chief Nurse													
Closed Only:														
Anzu	Medical Director													
MHPS	Chief People Officer													