University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 8th February 2023 at 9.30 am to 12.15 pm
Trust Boardroom, Third Floor, Springfield, Royal Stoke

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	**2.**	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 4th January 2023	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
10 mins	**6.**	Chief Executive's Report – January 2023	Information	Mrs T Bullock	Enclosure	
10:05		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (02-02-23)	Assurance	Prof A Hassell	Enclosure	1
15 mins	**8.**	Care Quality Commission Action Plan	Assurance	Mrs AM Riley	Enclosure	1, 2, 3, 5
10:25		**PEOPLE**				
5 mins	**9.**	Transformation and People Committee Assurance Report (01-02-23)	Assurance	Prof G Crowe	Enclosure	2, 3, 4, 6, 9
10 mins	**10.**	Q3 Raising Concerns Report	Assurance	Mrs C Cotton	Enclosure	2
10:40		**RESOURCES**				
5 mins	**11.**	Performance & Finance Committee Assurance Report (31-01-23)	Assurance	Dr L Griffin	Enclosure	5, 7, 8
10:45 – 11:00 COMFORT BREAK						
11:00		**RESPONSIVE**				
40 mins	**12.**	Integrated Performance Report – Month 9	Assurance	Mrs AM Riley Mr P Bytheway Mrs J Haire Mr M Oldham	Enclosure	1, 2, 3, 5, 8
11:40	**GOVERNANCE**					
5 mins	**13.**	Audit Committee Assurance Report (02-02-23)	Assurance	Prof G Crowe	Enclosure	
10 mins	**14.**	Q3 Board Assurance Framework	Approval	Mrs C Cotton	Enclosure	
5 mins	**15.**	SFI and Scheme of Delegation Policies	Approval	Mr M Oldham	Enclosure	8
12:00	**CLOSING MATTERS**					
10 mins	**16.**	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	17.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 6th February to** Nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:10	**DATE AND TIME OF NEXT MEETING**					
	18.	**Wednesday 8th March 2023, 9.30 am, via MS Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 4th January 2023 at 9.30 am to 12.10 pm via MS Teams

MINUTES OF MEETING

Attended | **Apologies / Deputy Sent** | **Apologies**

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman (Chair)												
Mr P Akid	PA	Non-Executive Director												
Ms S Belfield	SB	Non-Executive Director												
Mrs T Bowen	TBo	Non-Executive Director							Obs.					
Mr P Bytheway	PB	Chief Operating Officer							KT					
Mrs T Bullock	TB	Chief Executive												
Prof G Crowe	GC	Non-Executive Director												
Baroness S Gohir	SG	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Dr M Lewis	ML	Medical Director						GH						
Prof K Maddock	KM	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse	SM				SM							
Mrs R Vaughan	RV	Chief People Officer												

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

In Attendance:

Dr A Arora	AA	Consultant in Elderly Care (item 1)
Mr S Cunningham	SC	Consultant in Obstetrics and Gynaecology (item 10)
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mr J Hardy	JH	Patient Representative (item 1)
Mrs S Jamieson	SJ	Head of Midwifery (item 10)
Ms B Pilling	BP	Head of Patient Experience (item 1)

Members of Staff and Public: 6

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
001/2023	Mr Hardy referred to his father William's story, regarding when he had attended the Trust in December 2022. He explained that his father had been diagnosed with early onset dementia a number of years ago and after being cared for by his family, he moved into a nursing home in September 2022. Mr Hardy highlighted that his father had fallen three times in the home and following his last fall he was	

	advised to come into the Emergency Department for an assessment after which time he was sedated to enable a CT scan to be undertaken. The family were informed that the CT scan identified a previous bleed on the brain which required William to stay in for monitoring and the following day a bed was found for him whereby he was transferred to Ward 76a, during which time he felt his father had deteriorated and continued to be sedated. He explained that his family was told his father was at the end of his life due to his swallow reflex stopping and prepared for the worst, however once his sedation was lifted his swallow reflex returned and he was able to be subsequently discharged. Whilst Mr Hardy was very happy with the care and compassion his father received, he felt that he deconditioned whilst in hospital and felt some of this could have been avoided if the family had been listened to more. Mr Wakefield apologised for the experience and he asked if Mr Hardy had discussed his concerns with the Consultant regarding his father's sudden deterioration and unusual behaviour, which Mr Hardy confirmed. Dr Lewis thanked Mr Hardy for the story and stated that it was recognised that hospitals were not always the safest place to manage frail patients and when they did require hospital admission, it was better for them to return to their usual place of residence as quickly as possible due to the risk of deconditioning. Mrs Riley referred to the work being undertaken to recognise any deconditioning via a monthly audit cycle as well as undertaking regular patient assessments so that early intervention can be put in place. Mrs Haire thanked Mr Hardy for highlighting the good care received, in particular from the nurse in the Emergency Department as well as the positive comments made regarding the nursing staff on Ward 76a, whereby the care received reflected the Trust's values. Dr Arora referred to the national and local actions being taken with regards to the appropriate management of deconditioning and thanked Mr Hardy for the story which would inform future learning. Mr Wakefield summarised the story and highlighted the learning with regards to early intervention in recognising sudden deterioration/deconditioning. Mr Wakefield asked Dr Arora for an update on deconditioning to be provided at a future meeting. **The Trust Board noted the patient story.** Mr Hardy, Mrs Pilling and Dr Arora left the meeting.	**ML/AA**
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
002/2023	Mr Wakefield highlighted the apologies received and thanked the staff for the work undertaken in the past few weeks during such challenging pressures.	
3.	**Declarations of Interest**	
003/2023	There were no declarations of interest.	
4.	**Minutes of the Previous Meeting held 7th December 2022**	
004/2023	The minutes of the meeting held on 7th December were agreed as a true and	

	accurate record with the exception of an amendment to page 6 to read "… to take forward an external review associated with neonatal mortality,…." Not paediatric mortality.	
5.	**Matters Arising from the Post Meeting Action Log**	
005/2023	PTB/573 – The Board agreed with the recommendation from the Quality Governance Committee (QGC) to receive quarterly updates on the Infection Prevention Board Assurance Framework going forwards.	
6.	**Chief Executive's Report – December 2022**	
006/2023	Mrs Bullock referred to recent Trust pressures and despite best efforts, as the Trust went into the Christmas period, there were far fewer empty beds than anticipated. In addition there had been a significant increase in patients coming into hospital with flu as well as covid and other seasonal viruses which required them to be segregated. This resulted in a very congested Emergency Department (ED) and a number of patients waiting in ambulances to get into the ED which reflected the challenges being experienced nationally. Mrs Bullock added that coinciding with the increased infections, staff sickness absence levels had also increased which had made the position more difficult. Mrs Bullock referred to the introduction of care of patients on the ED corridor which had been taken to mitigate some of the risks associated with the ambulance holds and in particular the increased likely risks associated with the ambulance strike action. She highlighted that senior manager / Executive presence had been in place during the festive period to assist and provide support to staff during this time. Mr Wakefield queried how staff were feeling and Mrs Bullock stated that whilst they were under immense pressure, they remained resilient and professional however, she noted that morale was particularly impacted and there was an overarching concern about what was next, knowing that January is usually a busier month. Mrs Bullock referred to the Ambulance strike on 21st December which was well managed and very few ambulances were held. The same arrangements had been identified for 28th December although the strike was cancelled. It was noted that future strikes were planned on 11th January and similar arrangements would be put in place, including 24/7 senior manager / executive cover. **The Trust Board received and noted the report and approved the eREAF 10258.**	
HIGH QUALITY		
7.	**Quality Governance Committee Assurance Report (22-12-22)**	
007/2023	Professor Hassell highlighted the following: • The Clinical Effectiveness Group had considered a gap analysis which identified the need for further resources • End of life annual report highlighted gaps in completion of ReSPECT forms including the quality of these which was to be audited • Positive assurance was provided by the Medical Examiner's Office whereby community deaths had started to be reported to the office	

	Ms Bowen referred to the risk assessments which were to be brought to future QGC meetings and queried the timings whereby Mrs Riley aimed for this to be considered in the next two months. **The Trust Board received and noted the assurance report.**	
8.	**Care Quality Commission (CQC) Report**	
008/2023	Mrs Riley highlighted the following: • Focussed inspection took place on medical core services in October 2022 in response to the warning notice issued in 2021 • The Trust had met the requirement of the Section 29a notice for Royal Stoke although there were some areas for improvement • The improvements which had already been made at County Hospital were noted, however there was an inconsistency in completion of documentation and as such two domains were downgraded to inadequate resulting in the overall medical service being rated as inadequate although all areas were not visited • Updates on the actions being taken were to be provided to the CQC by 26th January 2023 Mr Wakefield queried the actions being taken with regards to the addressing the requirements for consistent documentation and Mrs Riley stated that although there were inconsistencies, other actions were in place to ensure patients were assessed. She stated that ongoing assessments and mitigation of risk was undertaken in respect of vacancies and Mrs Bullock added that during Covid the Trust had told staff that if staffing levels reduced to a certain level, it would be accepted that some things would need to cease in order to mitigate the challenges, which included documentation as this would ensure that the focus remained on the safe care of patients, ensuring they were provided with the right care and treatment. Therefore the challenges regarding documentation was known and to be expected and the CQC had recognised this. Mrs Bullock stated that based on the above and a number of other factors such as ongoing staff challenges; the CQC acknowledgment of improvements from the last inspection; that only two wards and the emergency department were reviewed; that Mental Health was only a small part of the two domains that were downgraded and that the CQC noted that the care and treatment of patients was appropriate, she was very disappointed with the overall rating. Professor Hassell referred to the education needs of staff at County and actions being taken, and the challenges in accessing the Midlands Partnership NHS Foundation Trust Electronic Patient Record (EPR). Mrs Riley stated that in terms of mandatory training, she expected the relevant staff to have undertaken their training by 26th January which would be confirmed at QGC. In addition, whilst direct access to the EPR system was not available, information was available elsewhere. Mrs Freeman referred to the one health and shared care record which was in place and stated that this had been reviewed to assess what data was missing to establish if this could be added. Mr Wakefield queried if it was planned to invite the CQC back to the Trust and Mrs Riley stated that the CQC would confirm any future inspections, once they had considered the actions being taken. Professor Crowe queried whether further work was required in terms of assessing the adequacy of compliance and whether the internal audit plan should consider adequacy of compliance controls and reporting arrangements, to ensure the Trust	

	was addressing the weaknesses identified by the CQC. Mrs Cotton referred to an ongoing piece of work in identifying an assurance map for quality which would highlight the sources of assurance relied upon as well as the adequacy of assurance which would highlight any gaps to be addressed. Mrs Bullock added that CQC compliance was already a part of the internal audit programme **The Trust Board received and noted the CQC inspection report and noted that the revised action plan would be reported in due course to QGC.**	
9.	**ED Corridor Risk Assessment**	
009/2023	Mrs Riley highlighted that at the end of October the Trust had implemented Your Next Patient which was a direct response to the continuing increase in ambulance holds. She stated that some improvement had been made although the Trust continued to have an unacceptable level of ambulances being held. Therefore in December conversations were initiated by the ED senior leadership with regards to corridor care and although there was some nervousness it was considered that to mitigate some of the risk with ambulance holds that 15 trolleys could be utilised in specific corridors, with associated staffing. Mrs Riley explained that corridor care nursing commenced on 20th December in readiness for the ambulance strikes and it was noted that lower acuity patients were being cared for on the corridor. Mrs Riley added that regular visits continued to be undertaken with ED. Mr Wakefield referred to the importance of managing the associated risk of ambulance holds, whilst accepting that this is something the Trust would prefer not to take forward. Professor Maddock referred to page 5 of the Standard Operating Procedure (SOP) and that additional clarity was required in terms of point 5. She queried how often the SOP was being implemented, how many patients were on the corridor presently and requested assurance in terms of the staffing. Mrs Riley stated that 15 patients had consistently been cared for on the corridors, although not all of the time and this was continuing to be regularly risk assessed. In terms of staffing, the Trust had moved from relying on paramedics to booking nurses which was more reliable and which also ensured a more accurate view of the number of ambulance being held as whilst the crews cohorted and cared for up to 5 patients which released four ambulances, the number of holds continued to count all five as holds. Mrs Bullock added that this had been raised with the NHSE Regional Director who would be discussion with the West Midlands Ambulance (WMAS) Chief Executive. Professor Hassell queried what patients should expect if they are nursed on the corridor. Mrs Riley stated that a nurse or paramedic would be responsible for their care and ensuring they were provided with nutrition and hydration, as well as regularly risk assessing patient's conditions to ensure they were cared for in the most appropriate area. In response to a further question from Mr Hassell, she added that some patients could be discharged from the corridor given they were lower acuity but this depended on the patient. In addition, the patients would continue to be assessed by nurses / doctors as per other areas of ED. Ms Bowen queried the feedback received to date from patients / families of those cared for on the corridor and queried if they understood why this was being taken forward. Mrs Riley stated that patients had a broad understanding of the pressures facing the NHS and had been supportive of the staff.	

	Professor Crowe referred to the SOP and whether the practice was expected to continue for some time. He queried if, given this was being introduced throughout the country, whether national consideration was being given to a standardised SOP. Mrs Riley stated that she was not aware of any plans to standardise the practice and noted the difficulty in doing so as each ED and the issues they have would be very different. Mrs Riley also noted that the most important aspect of this was that our own board was assured with the actions UHNM were taking and that as far as possible was assured that care was appropriate for the patients. The interface between patients on the corridor and ambulance holds was queried in terms of the actions taken to make this a seamless interaction and Mrs Riley explained that corridor care was provided by UHNM staff and if ambulances were waiting outside these were regularly highlighted to UHNM and risk assessed. Mr Bytheway stated that as part of winter plan the Trust had a WMAS hospital liaison officer 24/7 to manage interactions with the ambulance crews. Mr Wakefield stated that whilst the concept of corridor care was something the Trust would prefer not to take forward, it was accepted that this was in the best interest of the residents in Stoke and Staffordshire due to the associated pressures on the Ambulance Service. He thanked the teams for the work undertaken to complete the risk assessment and welcomed the comments on the SOP. He stated that it was concerning that no national approach had been provided given the widespread challenges and asked Mrs Riley to raise this nationally in terms of sharing learning with others. Mr Wakefield queried the monitoring and reporting of this going forwards and suggested that key metrics be identified and reported to QGC which was agreed. Mr Wakefield added that it would be helpful if a timescale could be identified in terms of the anticipated end of corridor care. **The Trust Board received and noted the risk assessment and Standard Operating Procedure.**	**AMR**
10.	**NHS Resolution Maternity Incentive Scheme**	
010/2023	Mrs Jamieson referred to the report which confirmed compliance with 10 maternity safety actions. It was noted that the incentive scheme was in the fourth year and that some of the safety actions were supported by additional external assurance. Mr Wakefield thanked Mrs Jamieson for the work undertaken to achieve the safety actions given the challenges with staffing. He queried the recruitment of additional midwives and the impact of these on training compliance. Mrs Jamieson referred to 22 newly qualified midwives who commenced in October 2022 in addition to continuing recruitment campaigns and international recruits. It was noted that the increase in uplift as part of the previous business case should create backfill to enable staff to undertake the training required. Mrs Bullock noted this was the most comprehensive report on the 10 maternity safety actions that she had seen and felt very assured as the responsible individual for signing this off. She thanked the team or their hard work. **The Trust Board confirmed that it was satisfied that the evidence provided demonstrated achievement of the ten maternity safety actions and provided permission to the Chief Executive to sign the Board declaration form prior to submission to NHS Resolution.**	

	Mrs Jamieson and Mr Cunningham left the meeting.	
PEOPLE		
11.	**Transformation and People Committee Assurance Report (21-12-22)**	
011/2023	Professor Crowe highlighted the following: • Positive assurance was provided in terms of the implementation of the ENABLE programme as well as taking forward civility and respect and Be Kind • The main area of concern related to progress with recruitment and the nursing vacancies • A deep dive was to be undertaken on required resourcing levels • More evidence based / data driven decision making was to be provided in the assurance reports provided to the Committee going forwards Ms Bowen referred to the focus on the 'too tired to drive' initiative and queried if this was more extreme due to current pressures and what actions were being taken to ensure the wellbeing of doctors. Mrs Haire referred to the support being provided to ensure on call rooms were available for staff who were too tired to drive, ensuring staff were not at risk and added that this had also been discussed with the Local Negotiating Committee. **The Trust Board received and noted the assurance report.**	
RESOURCES		
12.	**Performance & Finance Committee Assurance Report (20-12-22)**	
012/2023	Mr Akid highlighted the following: • Two meetings had been held which reflected the number of business cases which needed to be considered which had been agreed and taken forward • Some concerns were raised in terms of the delay of business case reviews • The Trust was behind on the capital programme which continued to be managed on a regular basis • Identification of cost improvement programmes for the year was behind plan • The Committee received positive assurance in terms of the ED business case review • The Committee highlighted that the Finance Team won HFMA Team of the Year which was a positive achievement **The Trust Board received and noted the assurance report.**	
RESPONSIVE		
13.	**Integrated Performance Report – Month 8**	
013/2023	Mrs Riley highlighted the following in terms of quality of care: • Despite current pressures, the friends and family test for inpatients had exceeded the target although work continued to be required with regards to ED friends and family results • No never events had been reported during the month • Falls were in the normal range • In terms of pressure ulcers the number of deep tissue injuries had reduced but this continued to be monitored • 1 maternal death had been reported as a serious incident as per the national guidance which would be discussed at maternity QGC	

Mr Wakefield referred to the pressure ulcers and queried if these were in relation to reduced staffing although Mrs Riley highlighted that these were not as a result of lack of staff and were usually identified at the beginning of the patient journey.

Ms Bowen referred to the themes of the patient feedback with regards to pain relief from the ED friends and family test, and given the current pressures and use of corridor care she queried whether access to pain relief would worsen. Mrs Riley stated that the nurse to patient ratio on the corridor was 1:6 which was deemed acceptable to manage the patient need for that cohort, therefore she did not anticipate that this would have an additional impact although this would continue to be considered more broadly in terms of timeliness of medications.

Mr Bytheway highlighted the following in terms of urgent care performance for December:

- The Trust entered a critical incident at the end of December due to the high number of admissions in ED and high medically fit for discharge (MFFD) numbers
- On Christmas Day there were a significant number of ambulances queuing and numbers of patients in the department which resulted in surgical beds being used for 70 medical patients and the stepping down of elective orthopaedics so that this could be used as a medical outlier ward
- A further critical incident was declared from 29th December which extended into New Years Eve
- Although there had recently been a reduction in pressures, ambulance holds and numbers of DTAs in ED, the critical incident structure remained in place
- Work had been commissioned in January regarding the focus on discharges both complex and simple
- Work had also commenced regarding assessing any deviation from the winter plan

Mr Wakefield referred to the increase in covid and flu patients and queried given the challenges in ED what measures were in place to cohort these. It was noted that patients' initial symptoms were assessed and if they were symptomatic masks were worn and these patients were cared for in cohort areas and not on the corridor.

Mr Wakefield referred to bed occupancy levels which were high and given the issues with discharges queried whether the wider system partnership was working appropriately. Mr Bytheway stated that the Chief Operating Officers within the system met twice a day to consider the challenges it was noted that MFFD numbers had reduced although there were issues regarding ensuring the clinical risk was shared across all partners, and as such a system de-brief was planned.

Ms Bowen referred to the delay of the new ward and whether this had had an impact on performance. Mr Bytheway referred to Ward 128 which was the new ward due to open on 24th January as opposed to 1st January. He stated that as such the Trust was 28 beds short which was a significant impact although given the number of outliers was over and above this, even if the ward was open, there would still be a challenge in terms of the number of outliers.

Mr Bytheway highlighted the following in terms of cancer performance:

- There had been a reduction in patients waiting over 104 days and the total patient tracking list
- Continued improvements had been made in the faster diagnosis standard
- The projected outturn was expected to be achieved as planned

Mr Bytheway highlighted the following in terms of planned care and RTT performance:

- In terms of the 104 weeks position the Trust was expecting a deterioration in the position due to the impact of non-urgent operating as a result of the pressures
- The focus remained on 52 weeks which continued to be monitored by the planned care group
- The issues associated with planned care were regularly highlighted to NHS England as part of the tier 2 arrangements

Mr Bytheway highlighted that in terms of diagnostics, the Trust had funded additional resource and scanners in particular for ultrasound but headway had not been made, although he was confident that it was likely to meet the trajectory by the end of March.

Mrs Haire highlighted the following in terms of workforce performance:

- Turnover had reduced for the second month in a row although there continued to be an increasing vacancy rate due to the introduction of new posts as a result of approved business cases and posts introduced as part of the winter plan
- There had been an increase in sickness absence which largely related to chest and respiratory illnesses, reflecting the covid and flu cases, as well as anxiety and stress
- The Trust was below the target for PDR compliance and the operational pressures was contributing to performance, although Divisions had been asked to ensure trajectories were in place to improve the position
- The national staff survey had closed with an overall response rate below that of the national average

Mrs Riley referred to vaccination rates and in terms of Covid 51.4% of staff had received the vaccination, and for flu 58.9% staff had received the vaccine. She stated that these rates reflected most organisations whereby a reduction in vaccination uptake was being seen.

Mr Wakefield referred to the completion rate for the staff survey which was lower than the national average and queried if an update could be provided in terms of comparisons of response rates with the Trust's peer group so that this could be considered going forwards. **JH**

Mr Wakefield referred to the nursing vacancy rate of 15% and whilst accepting that total establishment figures had increased he queried the progress being made in terms of international recruitment. Mrs Haire stated that an additional 18 nurses were due to join between January and March 2023 and 150 were due to start between April 2023 and March 2024.

Professor Crowe referred to staff wellbeing over the Christmas period and queried if they were being provided with basic care requirements given the pressures. Mrs Haire referred to the support being provided in terms of ensuring the basic wellbeing needs were addressed of staff as well as being provided with psychological support.

Ms Bowen referred to the persistent vacancies and vacancies in hard to fill roles and whether transformation work had been undertaken to fill these gaps. Mrs Haire stated that skill mix and use of the apprenticeship offer was being utilised to bring in new starters as well as campaigns to reach other parts of the market to fill the hard to fill roles. She added that different job plans were also being considered to help address gaps in the medical workforce.

	Mr Oldham highlighted the following in terms of financial performance: • Month 8 achieved a £2.7 m surplus which was behind the plan of £3.8 m resulting in a forecast deficit of £7 m, which was anticipated to be mitigated by non-recurrent measures • The system continued to report an expected break-even position • Covid costs had reduced significantly some of which was related to the reduced levels of testing • Cost improvements continued to see some movement as savings were being validated • Capital was behind plan but this was being managed regularly Mr Wakefield referred to the operational plan for 2023/24 and the productivity assumptions referred to which would require close scrutiny regarding the changes to payment mechanisms / incentives and forecasts. Mr Oldham stated that Trusts had not yet received detailed allocations but the guidance was being reviewed. He stated that the conversion factor, level of efficiency and cost of inflation would be the most challenging aspects. **The Trust Board received and noted the report.**	
CLOSING MATTERS		
14.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
014/2023	No further comments were made.	
15.	**Questions from the Public**	
015/2023	Mr Syme referred to the Transformation and People Committee report and the reference to the 180 nursing vacancies and the unabated pressures on UHNM staff including recruitment difficulties. He queried how many nurses the Trust anticipated may leave over the next year and how many the Trust anticipated would be employed in the same timescale for newly qualified nurses. Mrs Haire stated that the Trust anticipated 215 nurses would leave the Trust in the next two years although 60 nurses were expected to return as part of retire and return. In terms of how many nurses were expected to be employed from local universities, the Trust aimed to recruit 100 nurses and to increase this number a scheme was available for local students to provide them with their first choice of ward / department when they qualify. Mr Syme queried if the Trust would continue to be heavily reliant on the recruitment of international nurses in the coming year and given the persistent and increasing pressures on acute care capacity he queried how the Trust would support any newly qualified nurses to avoid them from becoming disillusioned about having a nursing career within an acute hospital. Mrs Riley stated that the number of international nurses was monitored in terms of their experience and added that packages were in place to provide the nurses with a good experience. She stated that newly qualified staff had Preceptorship packages in place which also supported their professional career and educational development and legacy mentor roles were being considered for those at the end of career who could use their skills and knowledge to support nurses in the first 5 years of their career. Mr Syme referred to the Performance and Finance Committee report and referred	

	to the system bed model whereby a worst case scenario of 240 was identified. He queried if this meant that the 'System' was short of 240 beds to match care demand and whether that was just a 'winter' estimation or an estimation applicable for the foreseeable future. He queried whether such capacity i.e. beds had been identified as to availability and where these beds would be situated. Mr Bytheway referred to the PWC 5 year forward look of bed availability which determined that in 5 years time if nothing was done, it was likely that the Trust would require 249 additional beds. Mr Bytheway noted that discussions were to take place within the system in relation to this Mr Syme referred to corridor care which had been introduced to address the inconceivable pressures on care. He queried the projected timescale for the continuing use of corridor care or whether given the situation with ambulance handover delays that this could be 'normalised'. Mr Wakefield referred to the earlier discussion regarding the end of the corridor care which was expected to continue until pressures abated or another solution was available. Mr Wakefield referred to his recent visit to the ED and reiterated that this was being undertaken to mitigate the risks in the community. Mrs Riley stated that whilst it was agreed that this was not best for patients, it reflected the greater risks in the community and the pressures across the whole of the system and she noted that the quality of care delivered would continue to be monitored. She stated that any updates on harm events as a result of Your Next Patient and corridor care would be reported to QGC and subsequently to the Board.	
DATE AND TIME OF NEXT MEETING		
16.	**Wednesday 8th February 2023, 9.30am** **Trust Boardroom, Third Floor, Springfield Building, Royal Stoke**	

Trust Board (Open)

Post meeting action log as at 02 February 2023

CURRENT PROGRESS RATING		
B	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
GA / GB	On Track	Improvement on trajectory either: A. On track – not yet completed *or* B. On track – not yet started
A	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement .
R	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/546	08/06/2022	Integrated Performance Report - Month 1	To take an update to a future QGC meeting regarding measuring the impact on patients who had not received appropriate sepsis screening within the Emergency Department	Ann-Marie Riley	02/03/2023		It was noted at December's meeting that this was to be discussed at the QGC meeting in February. Target date moved.	A
PTB/548	08/06/2022	Annual Evaluation of Committee Effectiveness & Rules of Procedure	To provide a summary of changes to the Code of Governance at a future Audit Committee	Claire Cotton	02/02/2023	02/02/2023	Complete. Provided to Audit Committee Feb 2023.	B
PTB/568	09/11/2022	Patient Story	To provide an update on the areas identified as part of the patient story, to a future Quality Governance Committee (QGC) meeting.	Ann Marie Riley Paul Bytheway Matthew Lewis	~~02/02/2023~~ 02/03/2023		To be taken to QGC in March 2023	GB
PTB/569	09/11/2022	CQC Action Plan	To discuss the assurance map with Professor Crowe in order to highlight the work being undertaken to assess the adequacy of assurance.	Claire Cotton	~~31/01/2023~~ 31/03/2023		Target date moved - to be completed by end of Q4.	GB
PTB/570	09/11/2022	Q2 Board Assurance Framework	To consider the risk and impact associated with the underlying system deficit within BAF 8	Mark Oldham Claire Cotton	08/02/2023	17/01/2023	Complete - meeting held and BAF updated.	B
PTB/571	07/12/2022	Well-Led Self-Assessment	To update the document to include additional narrative for the actions within Section 6, including target dates and to discuss at a future NED meeting.	Claire Cotton Nicola Hassall	~~31/01/2023~~ 28/02/2023		The document has been updated to include additional narrative for the actions within Section 6. Target dates in the process of being identified and a date to discuss at a future NED meeting to be confirmed. Target date moved to reflect the need to arrange a session with NEDS.	GA
PTB/572	07/12/2022	Q2 Maternity Serious Incident Report	To expand on the ethnicity chart within the report, to clarify reasons for increases and whether any themes reflected national themes. In addition to identify the associated denominators and the total number of deliveries per ethnic group.	Ann Marie Riley Donna Brayford	08/03/2023		Action not yet due. This has been added to Feb QSOG and MQGC for discussion.	GB
PTB/574	04/01/2023	Patient Story	To provide an update on the actions being taken to prevent deconditioning to a future meeting.	Matthew Lewis Amit Arora	05/04/2023		Action not yet due.	GB
PTB/575	04/01/2023	Corridor Care	To identify key metrics associated with corridor care and report on these to future QGC meetings.	Ann Marie Riley	30/03/2023		This will be included in the quarterly staffing paper to TAP/QGC	GB
PTB/576	04/01/2023	Integrated Performance Report - Month 8	To provide an update on the comparisons of response rates with the Trust's peer group so that this could be considered going forwards.	Jane Haire	31/03/2023		The current staff survey response rate as reported on by the survey supplier compares our response rate to the average of 65 Acute/Acute Community Trusts. The final published data from the National Survey Coordination Centre will benchmark UHNM response rate and scores against all national Acute/Acute Community Trusts (around 126 in total).	GB

NHS
University Hospitals of North Midlands
NHS Trust

Chief Executive's Report to the Trust Board

January 2023

Part 1: Trust Executive Committee (TEC)

The Trust Executive Committee met virtually on the 25th January 2023. **Executive Directors** gave the following key updates:

- Key focus was on 78 week targets and a number of very specific asks had been set nationally which involved the tracking of patients against 78 weeks for admitted and non-admitted patients.
- The financial position at the end of December was on track to achieve break even.
- Some challenges within the ICB in particular around continuing healthcare costs.
- Planning guidance had been issued and work was being progressed in the development of a plan in conjunction with clinical divisions; the most significant change is a shift back to payment by results ensuring that elective productivity is a key area focus.
- Lots of work to be undertaken to deliver the final schemes as part of the capital programme as the financial year comes to an end. A number of strategic developments will continue throughout the coming year.
- Patients Know Best portal is now live and a significant volume of patients have now registered; this is an opportunity for improved communications / test results.
- Out to procurement for network services so that the market can be tested from a value for money perspective.
- National funds had been confirmed for support to develop a business case for a UHNM / Staffordshire electronic patient record. A timetable of engagement events would be organised so that clinical staff have opportunity to contribute to development of the specification.
- Windows upgrade now available for staff and Office 365 was approaching rollout in collaboration with the Digital Advocates Network.
- Whilst the Staff Survey data remained under embargo, raw scores had been shared with divisions to begin triangulation with other sources and identification of improvement activity.
- The People Strategy had been launched through Divisional Boards and Deputy Directors; a Plan on a Page was under development and due to be issued over the coming weeks.
- Wellbeing offers were being well publicised although divisions were asked to further promote these; a video was due to be launched which related to the staff support and counselling service.
- An overview of proposed industrial action was provided and plans were being developed to mitigate risk and to provide oversight, via the Tactical Planning Group.
- A response to the Care Quality Commission Section 29 which related to mental health / mental capacity assessments at County Hospital had been completed and was due to be submitted.
- The regional Deputy Director of Infection Prevention and Control was planning a visit which would be focussing on cleanliness. A visit to Neonates and the West Building had been confirmed and some areas would be spot checked.
- The Care Excellence Framework (CEF) process had been refreshed which was an enhanced assurance process to that previously in place.
- A review of face mask wearing in clinical areas had been undertaken and it was anticipated that this would result in a number of clinical areas no longer being required to wear face masks.
- A new post was being developed for a Deputy Chief Nurse Information Officer and would soon be advertised.
- The Care Quality Commission Working Group was now in place and a new approach to self-assessment had been launched based on the new national standards.
- A system wide review was being undertaken which would focus on lessons learned around winter pressures; the scope of this review would be presented to colleagues within the Trust Executive Committee.

Divisions took the opportunity to highlight any key matters requiring escalation, the following points were noted:

Medical Division

- The last two months had been the most challenging to date in terms of pressures; although it was felt that the approach to Your Next Patient and Corridor Care had been well supported and controlled. There had been some easing of pressures mid to end of January although a further peak was anticipated.
- The biggest challenges looking ahead were recruitment and retention of the workforce with particular concerns regarding the medical workforce; a recruitment programme was due to be launched.
- The Care Quality Commission and ICB members were invited into the Emergency Department to review Corridor Care processes and positive feedback was received.
- Work continued with the Enhanced Primary Care Service through collaboration with the GP Confederation and this as proving to be a positive development with improved prospects for recruitment.

Network Division
- Ward 112 had returned to elective orthopaedics and spines which meant that services could be resumed following a brief pause; challenging targets set by our regulators around the elective recovery programme.
- Neurosurgery and Stroke were now co-located in line with the Divisions' vision.
- A review of Clinical Haematology at Mid Cheshire Hospitals NHS FT was underway, with a view to presenting an options paper once due diligence had been completed.
- A number of cultural reviews had been undertaken, including within Trauma and Orthopaedics and work remained ongoing in terms of improvements needed. A review had also been undertaken within the Therapies Team and the process of feedback was now underway.
- Key priorities for the Division were around staff engagement / experience and their research priorities.
- A number of changes to senior leadership were identified and a risk identified around the leadership team within Trauma and Orthopaedics.

Surgical Division
- Theatre activity had been sustained despite operational pressures.
- 2 week wait standard had been achieved and the focus would now be on sustaining this. There had been a significant reduction to the waiting list.
- Focussing on 'Getting it Right First Time (GIRFT)' and the productivity benefits associated with this.

Women, Children and Support Services
- Director of Midwifery had presented nationally and was congratulated by the national Chief Midwife for her work and leadership.
- Some key business cases were now being recruited to in particular maternity and imaging.
- CNST accreditation had been achieved.
- A number of bids had been approved by NHS England, in particular around radiology opportunities.
- A drive to increase the response rate to the Friends and Family Test within Imaging has yielded improved results and these would be taken through the governance route.
- Imaging strategy was currently being developed, including a focus on recruitment and retention.
- Radiology reporting backlog continued to be of concern; the Improving Together methodology had been adopted in terms of recovery.
- Ultrasound capacity continued to be challenged due to increased demand and workforce.
- A key focus for the division was around delivery of the People Strategy and cultural improvement.

Pathology Network
- Lots of work continued around the implementation of the new Laboratory Information Management System with a go live date planned in February for Microbiology with a further phased roll out to all areas.
- The NMCPS Board met on Monday, overseeing the strategic development of Pathology.

Part 2: Contract Awards and Approvals

2.1 Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 15th December to 13th January, 4 contract awards, which met these criteria, were made, as follows:
- **Purchase of CTS at County Hospital – Phase 2** supplied by Novus Property Solutions, at a total cost of £989,863.01, approved on 09/12/22
- **Purchase of Modular Building** supplied by Portakabin Ltd, at a total cost of £1,500,000, approved on 13/12/22
- **Extension of Contract - Insourcing of Neurology Services provided by Elective Services** supplied by Elective Services Ltd, for the period 30.11.22 – 31.03.23, at a total cost of £610,000, approved on 28/11/22

- **Respiratory Consumables** supplied by Philips Respironics, Fisher & Paykel Healthcare, Breas Medical, Resmed, for the period 01.12.22 – 31.03.23, at a total cost of £544,800, providing savings of negated inflation £4,903 and cost avoidance £4,800, approved on 28/11/22

In addition, the following eREAFs were approved at the Performance and Finance Committee on 31st January, and also require Trust Board approval due to the value:

Supply Chain Coordination Limited (SCCL) - Trust wide Annual Expenditure including High-Cost Tariff-Excluded Devices (HCTED) - Increase to value of eREAF 8801 (eREAF 10347)

Contract Value £15,000,000 incl. VAT (requested extension value only).
Duration 01/04/22 – 31/03/23
Supplier Supply Chain Coordination Limited (SCCL)

Supply Chain Coordination Limited (SCCL) - Trust wide Annual Expenditure including High Cost Tariff devices (HCTED) (eREAF 10296)

Contract Value - £44,613,182.53 incl. VAT
Duration – 01/04/23 – 31/03/24
Supplier – Supply Chain Coordination Limited (SCCL)

The Trust Board is asked to approve the above eREAFs.

2.2 Consultant Appointments – January 2023

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Plastic Surgeon	New	Yes	TBC
Specialist Doctor in Cardiothoracic Radiology	New	Yes	01/02/2023
Locum Consultant obstetrician and Gynaecologist	Maternity	Yes	01/02/2023
Specialist Doctor in Anaesthetics with Interest in Chronic Pain	New	Yes	TBC
Consultant Urologist	Vacancy	Yes	TBC
Consultant Urologist	Vacancy	Yes	TBC
Consultant Intensivist	Vacancy	Yes	TBC
Specialist Doctor in Clinical Oncology	Vacancy	Yes	TBC
Consultant Orthopaedic Hand Surgeon	Vacancy	Yes	26/04/2023

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

Post Title	Reason for advertising	Start Date
Locum Consultant Spinal Surgeon	Vacancy	01/01/2023
Locum Consultant Urologist	Extension	01/01/2023
Consultant Cardiac Surgeon	New	01/01/2023
Medical Examiner	Vacancy	01/01/2023
Consultant Imaging - Neuro Radiologist	Vacancy	03/01/2023
Consultant Histopathologist	Extension	03/01/2023
Consultant Histopathologist	Extension	03/01/2023
Locum Consultant Body Radiologist	Vacancy	04/01/2023
Locum Consultant Plastic Surgeon	Vacancy	06/01/2023
Locum Consultant, Colorectal & General Surgeon	Extension	10/01/2023
Consultant Gastroenterologist with a specialist interest in IBD	New	13/01/2023
Consultant Histopathologist	Vacancy	17/01/2023
Consultant Intensivist	Extension	23/01/2023

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

Post Title	Reason for advertising	Note

Post Title	Reason for advertising	Note
Clinical Lead - Respiratory Medicine	03/01/2023	No Applications
Consultant Histopathologist	15/01/2023	No Applications
Consultant Orthodontist	15/01/2023	No Applications
Respiratory Consultants with Specialist Interests	15/01/2023	No Applications
Consultant Neurologist	15/01/2023	No Suitable Applications
Locum Consultant General Anaesthetist	08/01/2023	Candidate Withdrew
Locum Consultant obstetrician and Gynaecologist	22/01/2023	No Suitable Applications

2.3 Internal Medical Management Appointments – January 2023

There were no medical management interviews during January 2023.

The following provides a summary of medical management who have joined the Trust during January 2023:

Post Title	Reason for advertising	Start Date
Foundation Programme Director	Vacancy	01/01/2023
Clinical Lead Oncology	Vacancy	02/01/2023

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

Post Title	Closing Date	Note
Clinical Lead - Respiratory Medicine	03/01/2023	No Applications

Part 3: Highlight Report

3.1 Trust Pressures

It has been an extremely challenging winter and thanks go to all staff who have gone above and beyond by working additional hours inside and outside their normal place of work to ensure we keep our patients as safe as possible. The numbers of Flu cases throughout the latter part of January significantly reduced. Covid19 cases also reduced but have slightly increased again more latterly and as at 1st February sits at 157 Covid positive patients in the Trust. Industrial action has placed additional pressure upon us and these have been more regular and amongst different staff groups and we have had to put in place plans to mitigate the additional risk. These challenges were managed whilst also undertaking a series of ward moves which have seen patients move into our new respiratory ward (ward 128) following the conversion of office space in the Trent Building. Myself and a number of Board colleagues have visited the ward and it is an excellent facility for our patients and sets a new standard for our ward environment.

Despite the ongoing industrial action, our hospitals have begun to feel calmer with flu admissions significantly reducing to single figures as well as less ambulances holding and fewer patients being cared for on the corridor. It has started to feel like a 'normal' winter rather than the extreme pressures we experienced during December and at the very beginning of the year.

3.2 Care Quality Commission / Integrated Care Board Visit – Corridor Care

We invited the Care Quality Commission and colleagues from the Integrated Care Board to visit our Emergency Department so that they could observe the arrangements we have put in place for managing patients in the corridor. Whilst Corridor Care was not a decision made lightly, it was a necessity to help the offloading of patients from ambulances more quickly to respond those in our community who were

coming to harm as a result of long waits. This was not a formal inspection and therefore we are not expecting a report but immediate verbal feedback was hugely positive. ICB colleagues particularly were impressed by the open and honest views from ED staff they spoke to about processes to manage patients as safely as possible. We are immensely grateful to our ED leadership and wider team for working with us so constructively over such a difficult issue.

3.3 Integrated Care Board (ICB)

The ICB met on 19th January 2023 and a recording of the meeting and full papers are available on their website. Key highlights of the meeting and points of discussion were as follows:

- A Staff Story provided by the Compassionate Communities Network which includes individuals from across the health, care and voluntary sectors aiming to promote a more positive approach to death, dying and loss by connecting people to support services.
- An update from the ICB Chair and Chief Executive which included system pressures, industrial action, 2023/2024 planning and lessons learned in relation to winter pressures.
- Approval of a pre-consultation business case, communication and involvement plan and consultation in relation to inpatient mental health services.
- An update on NHS England delegation and the decision to delegate some of NHSE's direct commissioning functions to ICB's; a workshop is being held to consider the governance proposals around this and a proposal to establish an 'Office of the West Midlands' to coordinate commissioning activity across the 6 ICB's.
- An update on how the ICS Development Group can be utilised and how this group was an important touch point for all system work streams to come together and assess their impact on each other.
- Approval and signing of a Memorandum of Understanding regarding an Alliance developed under the previous three 'Place' arrangements.
- Consideration of the ICB Board Assurance Framework which had been developed in collaboration with system partners through the Governance and Risk Network; this continues to be developed.
- The System Finance Report where a risk of £12m was flagged to delivery of the financial plan.
- The System Operating Report which highlighted the national planning guidance published in December 2022 and the plans to develop and submit the Operating Plan by the end of March and a Joint Forward Plan by June.
- An update on performance including an update on delivery of the winter plan.
- A Quality and Safety Exception Report which included work being done via the Provider Collaborative in relation to safeguarding.
- Assurance Reports from Committees of the Board including Finance and Performance Committee, Audit Committee, People, Culture and Inclusion Committee and Safety and Quality Committee.

3.4 NIHR Senior Research Leader Programme for Nursing and Midwifes

I was delighted to hear that Alison Cooke, Assistant Director of Nursing (NMAHP) Research & Academic Development, has been offered a place on the 2023 Senior Research Leader Programme with the National Institute for Health and Care Research. The process involved a large number of strong applicants and each candidate was assessed by three reviewers to assist the selection panel in their decision making. This programme will provide Alison with a platform to make a significant impact on the nursing and midwifery research landscape for us at UHNM and I wish her all the very best.

3.5 Covid Public Inquiry

We have established a Task Group focussing on our preparations for responding to the Covid Public Inquiry which is led by our Chief Operating Officer. Whilst the group is in its early stages, we are keeping a close eye on national developments to ensure our readiness and we are liaising with colleagues in partner organisations to identify any learning or best practice that we can adopt. Our initial focus has been to identify the records that we need to retain and ensuring that we have appropriate systems in place to ensure these are accessible.

3.6 Public Sector Decarbonisation Scheme

I am delighted that UHNM has been successful in securing a £5.4m grant through a Public Sector Decarbonisation Scheme. The grant was highly sought after across the public sector and massively oversubscribed. The securing of such significant investment represents a monumental step in our journey to decarbonise our estate as well as prepare us for the potential introduction of the Geothermal Heat Network in Stoke-on-Trent. It puts UHNM firmly on the map in respect of our commitment as an anchor institution in supporting the delivery of the NHS Net Zero Carbon targets. Well done and thank you to our Sustainability Team within our Estates, Facilities and PFI Division and all those who supported the production of such a high quality bid application and Business Case.

3.7 Operational Planning Guidance

We received the national Operational Planning Guidance over Christmas and we are now working through this with our clinical divisions to ensure we develop a plan which delivers on the expectations of us. This will be presented to the Board for approval.

Quality Governance Committee Chair's Highlight Report to Board

2nd February 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Quarter 3 infection prevention highlighted that the number of C-difficile cases were above the upper limit although no themes had been identified. Inpatient sepsis performance stood at 87.6% compared to the target of 90%. Emergency portal sepsis screening performance stood at 84.1% with 65% having treatment within an hour and this remained an area of focus with staff within the Emergency Department to identify actions for improvement • The Committee noted the response to the CQC following the Section 29a notice and considered the updated action plan which highlighted the 14 problematic/delayed actions. Further assurance was requested in future updates to include evidence of audit results • Work was ongoing with Divisions to improve the recording and evidencing of written duty of candour • The Committee noted the increase in reported patient safety incidents which were considered to be attributed to the operational pressures • The majority of the risk scores on the Board Assurance Framework had remained unchanged from the previous quarter, although BAF 1 and BAF 5 risks had increased to Extreme 20 reflecting winter pressures and the associated mitigating actions being taken such as Your Next Patient and Corridor Care	• Combined maternity action plan to be presented in due course to identify the actions associated with the various national maternity reports and recommendations • To provide justification of the PSIRF training proposal for level 2 training, given this was recommended for all staff at Band 6 and above
✓ Positive Assurances to Provide	**Decisions Made**
• An update in relation to the Maternity Reading the Signals report was provided which highlighted positive progress made in respect of the four recommendations • Quarter 3 infection prevention report highlighted no MRSA bacteraemias reported and no confirmed cases of norovirus. • The Committee welcomed the work to refresh the Care Excellence Framework approach whereby 16 visits had been undertaken in Quarter 3, 11 of which were awaiting their rating. Of the remainder, 2 were rated as platinum, 1 gold and 2 silver. • 10 / 19 of the initiatives associated with the nutrition and hydration ambition had been completed and progress was being made for the majority of the remainder • A deep dive into paediatric sepsis screening highlighted that 5 associated adverse incidents were reported in the last 2 years with no harm although further audits were to be undertaken on a 3 month cycle in order to provide assurance as to determining any potential harm in relation to sepsis screening • The Committee noted the sustained decrease in falls resulting in harm reported in month which stood at 1.38 per 1000 bed days • The 7 day services update highlighted that the Trust was fully compliant with 3 / 4 priority standards; standard 2 (time to first consultant review), 5 (access to diagnostic tests) and 6 (access to consultant-directed interventions) and was now considered BAU • A progress update in relation to implementation of the Patient Safety Incident Review Framework (PSIRF) was provided which demonstrated that a number of actions had been completed including identifying the PSIRF ambition; the PSIRF plan was to be brought to a future meeting	• The Committee noted the nutrition and hydration ambition • The Committee noted the proposal for PSIRF training which was to be further considered at the Statutory and Mandatory Training Group • The Committee supported the proposal that UHNM nominate 35 staff for PSIRF investigation training along with ICS colleagues

Comments on the Effectiveness of the Meeting
Committee members welcomed the papers provided which were easy to read and understandable and enabled good discussion

2. Summary Agenda

No.		Agenda Item	BAF Mapping			Purpose	No.		Agenda Item	BAF Mapping			Purpose
			BAF No.	Risk	Assurance					BAF No.	Risk	Assurance	
1.	⊕	Reading the Signals – Maternity and Neonatal Services in East Kent	BAF 1	Ext 20	✓	Assurance	7.	⊕	Quality & Safety Report – Month 9 22/23	BAF 1	Ext 20	!✓	Assurance
2.	⊕	Q3 Infection Prevention Report	BAF 1	Ext 20	! ✓	Assurance	8.	⊕	7 Day Services Update	BAF 5	Ext 20	✓	Assurance
3.	⊕	CQC Action Plan	BAF 1	Ext 20	!	Assurance	9.		Board Assurance Framework Q3	-		-	Approval
4.	⊕	Care Excellence Framework Summary Report Q3 / CEF Refresh 2022	BAF 1	Ext 20	✓	Assurance	10.	⊕	Quality & Safety Oversight Group Assurance Report (23-01-23)	BAF 1	Ext 20	-	Assurance
5.	⊕	Nutrition and Hydration Ambition	-		✓	Assurance	11.	⊕	Patient Safety Incident Review Framework Delivery Plan Update	BAF 1	Ext 20	-	Information
6.	⊕	Paediatric Sepsis Update	BAF 1	Ext 20	✓	Assurance	12.	⊕	Patient Safety Incident Review Framework Training Proposal	-			Information

3. 2022 / 23 Attendance Matrix

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

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	8th February 2023
Report Title:	CQC Action Plan	**Agenda Item:**	8
Author:	Debra Meehan, Lead Nurse Quality & Safety		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 1	Delivering Positive Patient Outcomes	Extreme 20

Executive Summary

The University Hospitals of North Midlands CQC report was published on 22 December 2021. The inspection took place 24 and 25 August 2021 and involved:

- Royal Stoke -urgent and emergency care; medicine
- County – medicine; surgery

A Well Led inspection took place 5 and 6 October 2021. Following the initial inspection, the Trust was served a warning notice under Section 29a of the Health and Social Care Act 2008. The warning notice served to notify the Trust that the CQC had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health need in medicine at County Hospital required significant improvement. The remedial actions were required to be completed by the end November 2021 and evidence to support the actions completed have been submitted to the CQC.

The CQC rated the following services:

- Medicine (County) - Requires Improvement
- Surgery (County) – Good
- Urgent and Emergency Care (RSUH) - Requires Improvement
- Medicine (RSUH) - Good

On Tuesday 4th October 2022, the CQC conducted an unannounced visit to UHNM to review immediate actions taken. The two attached reports provide an overview of their feedback. Any recommendations will be incorporated into the action plan. Although the CQC were satisfied that the Trust had made significant improvements in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital they still had serious concerns about the assessment, recording and mitigation of risks associated with acute mental health concerns in medicine at County Hospital and subsequently issued a Section 29A Warning Notice under the Health and Social Care Act 2008. The Trust was required to provide evidence of significant improvement in relation to the Section 29A warning notice by 26th January 2023. This response has been provided and highlight to the Quality Governance Committee. Future updates will incorporate the associated actions within the action plan.

Although the CQC rated the safe and effective domains for medical care at County Hospital Inadequate, the overall ratings for both County Hospital and the Trust overall remains as 'Requires Improvement'. Overall, the Trust also saw improvement in two domains:

- Caring improved to a rating of 'Outstanding'
- Well Led improved to a rating of 'Good'

The report noted the over-arching actions the Trust must take and should take to improve.

Following feedback from the previous Quality Governance Committee meeting, work has been undertaken to review all the actions and ensure that they address the concerns raised by the CQC. Therefore, some duplicate actions have been removed which has reduced the number of total actions. The number of completed actions has increased in both the Must Do and Should Do sections.

Must Do Actions

Must Do Actions	As at 27th October 2022	As at 27th January 2023
Total number of actions	35	**34**
Total number complete	24 (68.5%)	**25 (73%)**
Total number on track	3 (8.5%)	**2 (6%)**
Total number problematic	8 (23.0%)	**4 (12%)**
Total number delayed	0 (0.0%)	**3 (9%)**

3 actions (9%) are considered to be "delayed", which is an increase from the previous quarter. This is due to applying increased rigour to the target dates for completion and assigning progress Rating against Target Date for Completion rather than the revised target date. Mitigating actions are summarised in the action plan.

Should Do Actions

Should Do Actions	As at 27th October 2022	As at 27th January 2023
Total number of actions	31	**28**
Total number complete	17 (55%)	**17 (61%)**
Total number on track	3 (10%)	**4 (14%)**
Total number problematic	11 (35%)	**3 (11%)**
Total number delayed	0 (0%)	**4 (14%)**

4 Actions (14%) are considered to be "delayed", which is an increase from the previous quarter. This is due to applying increased rigour to the target dates for completion and assigning progress Rating against Target Date for Completion rather than the revised target date. Mitigating actions are summarised in the action plan.

Key Recommendations

The Trust Board is asked to note the contents of the CQC action plan.

CQC Action Plan 2022/23

As at 02 February 2023

CURRENT PROGRESS RATING		
	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
	On Track	Improvement on trajectory either: On track – not yet completed *or* On track – not yet started
	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement - **target date moved once**
	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required - **target date moved twice or more**

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating (As against Target Date for Completion not revised target date)	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
A1	SAFE	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust MUST ensure that there are enough suitably qualified, competent, skilled and experienced medical staff on each shift to deliver safe and effective care and treatment. **Regulation 18 (1)**	The Directorate will develop a Standard Operating procedure to mitigate gaps in the ED Medical Staffing Rota.	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete			Staffing figures Number of incidents relating to staffing levels	•SOP in use •New Rota System commencing in June 2022 which will demonstrate skill mix and gaps •Agreed rates of pay for rota cover	Quality Safety Oversight Group Quality Governance Committee
						The Directorate will continually monitor gaps in the rota and associated mitigation by the ED Senior Leadership Team.	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete			Staffing figures Number of incidents relating to staffing levels	•SOP in use •New Rota System commencing in June 2022 which will demonstrate skill mix and gaps •ANP's to be included on new rota as per Royal College Guidance	Quality Safety Oversight Group Quality Governance Committee
						The Directorate will introduce Emergency Department Operational and Safety Huddles (8 times each day)	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete			Minutes / actions from Safety Huddles	•Actions from huddles documented by progress chaser (in hours)	Quality Safety Oversight Group Quality Governance Committee
						The agreed actions to mitigate the risk to patient safety from Medical Staff Shortages in ED will be included as points of consideration for the ED Safety Huddles	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete			Staffing figures Number of incidents relating to staffing levels	•Medical staffing gaps also discussed three times daily at the Junior Doctor Handovers in a structured WHO checklist style approach	Quality Safety Oversight Group Quality Governance Committee
						To recruit to the approved establishment in the ED business case	Richard Hall Clinical Director Debbie Lowe Associate Directorate Manager	Dec-22	Feb-23		Recruitment against plan monitored through CQC action plan oversight group	•Junior and Middle Grade Medical Staff recruitment ongoing •A focus upon Consultant and Paediatric ED Consultants ongoing •Training Programme in place for Tier 3 to Tier 4 development • As at 25th January 2023, the outstanding posts to be recruited were 7 SHO posts and 1 Clinical Fellow. Interviews for these have been held and appointments will be offered in due course.	Quality Safety Oversight Group Quality Governance Committee
A2	SAFE	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust MUST ensure they provide patients with a first assessment within 15 minutes of arrival to the ED in line with the conditions placed upon their registration. **Regulation 12 (1) (2) (a)**	Compliance with the 15 minute assessment times will be monitored following implementation of the new model that was developed following successful Emergency Department Test of Change.	Rebecca Viggars Deputy Associate Director	Dec-22	Mar-23		Clinical Audit of time to triage times	•Ongoing Development of Enhanced Primary care service to afford UHNM autonomy of triage and recruitment. Plans for integration of EhPC and Out of Hours service •Relocation of Ambulatory patients close to triage to facilitate senior decision make support to triage •Development of Fit to Sit area • SOP recirculate to reception to outline their responsibilities • Ongoing discussions with the team regarding the actions required to further improve up on current triage performance • As at 25th January 2023, current performance has been impacted by staff absences, increased footfall and acuity and stands at 70.1%	Quality Safety Oversight Group Quality Governance Committee
						Compliance with the 15 minute assessment time will be reported to the CQC on a monthly basis in line with the Section 31 conditions placed upon our registration.	Rebecca Viggars Deputy Associate Director	Complete			Monthly Section 31 Reports	•Monthly Section 31 Reports available •Overall current performance for September/October 2022 has ranged from 59.6% - 77.3%	Quality Safety Oversight Group Quality Governance Committee
A3	SAFE	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust MUST ensure that patients are risk assessed appropriately, in a timely way and provide mitigation for risks when identified. **Regulation 12 (1) (2) (b)**	The Trust will implement the new Triage Model that was developed following successful Emergency Department Test of Change	Joanne Allen Matron	Complete			Clinical audit of Documentation CEF	•New triage model in place •Successful recruitment to triage nurse posts- predicting 3% vacancy factor by October 2022	Quality Safety Oversight Group Quality Governance Committee
						The Directorate will conduct harm reviews for patients experiencing long ambulance and trolley waits in order to identify any potential harm and areas for improvement in the standard of care delivered	Joanne Allen Matron/ Debra Meehan lead Nurse - Quality & Safety	Complete			Review of incidents relating to harm in the ED Department	•Harm Review Process in place supported by the Corporate Nursing Team •Summary Reports presented to patient Safety Group •Plan to redesign process in relation to new National Standards	Quality Safety Oversight Group Quality Governance Committee
						To review the MH proforma and actions to include the risk assessment of MH patients behind the cubicle doors	Joanne Allen Matron	Complete - 25/01/2023			Review of incidents relating to harm in the ED Department	•SOP developed for assessment of MH patients and included within the MH proforma • Business case has been rewritten and is going through the governance process	Quality Safety Oversight Group Quality Governance Committee
						Directorate Governance Meetings will ensure that all incidents are discussed in a timely manner and mitigating actions are put in place	Joanne Allen Matron	Complete			Meeting agenda Meeting minutes Review of incidents	•Meeting notes available •Incident reviews undertaken	Quality Safety Oversight Group Quality Governance Committee
						The Directorate will continue the daily Matron CEF reviews supported by the corporate nursing team assurance process	Joanne Allen Matron	Complete			Clinical Audit of Documentation	•Daily CEF reports available •Toolkit incorporated into Tendable process	Quality Safety Oversight Group Quality Governance Committee

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating (As against Target Date for Completion not revised target date)	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
A4	SAFE	Royal Stoke	Medicine	Urgent and Emergency	The Trust MUST ensure patients are kept safe from infection and avoidable harm and staff receive appropriate guidance and support to enable them to do this. **Regulation 12 (1) (2) (h)**	Infection Prevention poster which describes correct PPE for red and green areas to be displayed through ED	Joanne Allen Matron	Complete			Review of incidents relating to harm in the ED Department	•PPE Posters in place	Quality Safety Oversight Group Quality Governance Committee
						The Directorate will ensure that all staff receive updates in PPE training/mask fit training, according to latest National Guidance	Joanne Allen Matron	Complete			Training figures	•Training programme in place	Quality Safety Oversight Group Quality Governance Committee
						Weekly CEF reviews to include equipment cleaning checks	Joanne Allen Matron	Complete			Environment Audit Results	•Audit results available	Quality Safety Oversight Group Quality Governance Committee
A5		Royal Stoke	Medicine	Urgent and Emergency	the Trust **MUST** ensure all risks are appropriately identified, assessed and mitigation put in place where possible. **Regulation 17 (1)**	The risk register will be updated to include all current risk relating to the ED Department	Richard Hall Clinical Director Joanne Allen Matron	Complete			Escalation paper to Divisional Governance Group	•Risk Register Review Process in place	Quality Safety Oversight Group Quality Governance Committee
						The Directorate will develop a harm review process	Richard Hall Clinical Director Joanne Allen Matron	Mar-23			Outcome of harm reviews	• Process in place to review harm for patients who have been subject to a long wait (i.e. 12 hour breaches, ambulance handover delay, Your Next Patient and Corridor Care) • CQC and ICB Chief Nurse invited to the Trust on 18th January 2023 to review safety measures in place for Corridor Care and Your Next Patient - positive feedback received.	Quality Safety Oversight Group Quality Governance Committee
A6	SAFE	County	Medicine	Medicine Care	The Trust must ensure associated with acute mental health needs are assessed, recorded and mitigated. **Regulation 12 (1) (2) (a) (b)**	The Trust will further develop the ED Mental Health Assessment Tool to accompany the patient on admission and facilitate ongoing mental health assessment in assessment and ward areas.	Kirsty Smith Matron Mental Health	Complete			Clinical Audit of the Mental Health Assessment Tool Review of incidents relating to the provision of mental health assessments	• ED mental health assessment tool has been reviewed and updated • Review of the ward risk assessment booklet undertaken and all of the checklists relating to Mental Health/Dementia/Learning Disability and Autism have now been simplified and amalgamated and sit under the Vulnerable patient banner, at the front of the booklet. This includes Vulnerable Patient trigger questions and a nursing risk assessment related to mental health. This assessment supports the Registrant to make a judgement regarding whether the patient will require close supervision due to harm to themselves or potential harm to others.	Quality Safety Oversight Group Quality Governance Committee
						The Trust will report and monitor the number of mental health referrals via the Mental Health Operational Group, which has representation from all clinical divisions, the mental health liaison team and psychiatric liaison team. The Group will oversee operational priorities such as referrals, access to Mental Health Act assessment, training and incidents. Areas of escalation and assurance will be reported into the Trust Mental Health and Learning Disability Group.	Kirsty Smith Matron	Complete			Mental Health Operational Group agenda and minutes Escalation report to the Trust Mental Health and Learning Disability Group	•Reporting process in place via Mental Health Operational Group	Quality Safety Oversight Group Quality Governance Committee
						The Trust will further develop the current audit tool of the ED Mental Health Assessment Tool (Report published June 2020) to reflect its use through to AMU and all Ward areas. The Revised audit will be prioritised on the Trust Clinical Audit Programme 2022 / 2023	Kirsty Smith Matron	Nov-22	Jun-23		Clinical Audit of the Mental Health Assessment Tool Review of incidents relating to the provision of mental health assessments	• Corporate Audit Process in place •Planned rollout to other emergency portals and ward areas through Tendable CEF audit • Following the Section 29 notice, we have recruited a senior nursing post: Head of Nursing - County Hospital to commence 1st March 2023, in order to continue to embed significant improvements in the assessment, recording and mitigation of risks associated with acute mental health concerns. The post holder will be responsible for conducting spot checks and initiating relevant actions to improve practice with regard caring for patients with acute mental health concerns, vulnerabilities and requirements for an interpreter • Audit results are to be presented to Quality and Safety Oversight Group (and escalated as necessary to QGC) in February/ March 2023. The results of the spot checks are expected to be available in June 2023.	Quality Safety Oversight Group Quality Governance Committee
						Development of a Trust-Wide Harm Free Care Alert	Kirsty Smith Matron	Complete			Review of incidents relating to the provision of mental health assessments	Complete	
A7					The Trust MUST ensure nutritional risk	The Trust will relaunch a training programme emphasising key learning around assessing, managing and monitoring patients nutrition	Ann Griffiths Chief Dietician	Complete			Training compliance CEF visits	•Nutrition and Hydration awareness training delivered within new NA programme. •Update training delivered at County by dietetics team. •Ward based training targeted to AMU and FEAU at Royal Stoke. •Ward staff have requested a video training to be available, this is currently being investigated. •Training programme delivered in Key admission areas, presentation to be added to Dietetics section of intranet	Quality Safety Oversight Group Quality Governance Committee
						A Focus Group will be convened to review the current Nutrition bundle (evidence of care planning). Representatives from Ward teams and Dietetics will explore the barriers to its use, how we can revitalise and consider its digitalisation journey.	Ann Griffiths Chief Dietician	Complete			CEF Visits Clinical Audit of Nutritional Management	•Audit of completion compliance undertaken. •Focus group identified. • Initial feedback, wards are happy with the document. •Nutrition Bundle updated, with Harlow for first proof	Quality Safety Oversight Group Quality Governance Committee

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating (As against Target Date for Completion not revised target date)	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
	SAFE	**County**	**Medicine**	**Medicine Care**	assessments and care plans are completed in line with their policy. **Regulation 12 (1) (2) (b)**	The Trust will develop a process of sharing Vital Pac reports detailing MUST compliance with Ward teams	Ann Griffiths Chief Dietician	Complete			CEF Visits Clinical Audit of Nutritional Management	•Dashboard developed by BI team, initial validation completed, •Changes made to include actual MUST scores, and risk category in addition to MUST completion within 24hrs and rescreening compliance. For final validation after Vitals upgrade June 2022 • Approval to be sought from deteriorating patient group •Nutrition Dashboard from Vital now approved and live in UHNM Report centre	Quality Safety Oversight Group Quality Governance Committee
						In order to promote on-going monitoring around the assessment and management of nutrition, a spot check audit will be developed using the Tendable Audit Programme	Ann Griffiths Chief Dietician	Jul-22	Apr-23		Tendable Audit Spot Check results	• Tendable has been rolled out to County. First audit submitted by 31st December 2022 and being further embedded. • Tendable being rolled out to Royal Stoke January / February 2023 • Further data and assurance to be obtained in terms of completion of nutritional risk assessments/care plans	Quality Safety Oversight Group Quality Governance Committee
A8	SAFE	**County**	**Medicine**	**Medicine Care**	The Trust MUST ensure patients receive timely swallow assessments. **Regulation 12 (1) (2) (a) (b)**	A position paper will be presented at the Acute Patient Flow group which will highlights the shortfalls in the service provision to inpatient medical wards, across both sites	Lois Dale Head of Speech and Language Therapy	Complete			Acute Patient Flow Group Minutes	•The position paper was presented to the Acute Patient Flow group in April 2022	Quality Safety Oversight Group Quality Governance Committee
						The Trust will develop an education programme to support ward teams regarding 'what makes a good referral' and how to escalate referrals	Lois Dale Head of Speech and Language Therapy	Complete			Review of incidents relating to insufficient referrals Review of the number of rejected referrals	•Guidance has been developed to advise wards how to escalate referrals •Circulated via Comms	
						MNP/ANP nurse swallow screening training will be implemented at RSUH to support service provision. Consider rollout at County Hospital	Lois Dale Head of Speech and Language Therapy	Sep-22	Sep-23		Review of incidents relating to SALT provision at Ward level	• MNP training at RSUH took place in Jan 2021 and was completed successfully. •ANP training was undertaken in September 2021 •Training has not been offered to County ANP's to date due to ongoing limited SLT resources over at County. There has been recent recruitment within SLT which will support this development. Target date amended to reflect the delay in providing the training at County.	Quality Safety Oversight Group Quality Governance Committee
						To explore the options available to obtain data from OrderComms, so that assurance can be provided that timely swallowing assessments are being undertaken.	Lois Dale Head of Speech and Language Therapy	Mar-23			Review of OrderComms Data	In progress	Quality Safety Oversight Group Quality Governance Committee
A9	SAFE	**County**	**Medicine**	**Medicine Care**	The Trust MUST ensure Mental Capacity Act Assessments are consistently completed in a timely and responsive manner. **Regulation 11 (1) (2) (3)**	The Clinical Audit Programme will be reviewed to ensure that all audits relating to the delivery of care include questions around whether mental capacity should have/was assessed	Victoria Lewis Quality Assurance Manager	Complete			Clinical Audit results	The additional question has been added to all data collection forms throughout 2022 / 23. A total of 51 audits have been completed to date, and metal health status is not routinely documented unless the patient is admitted with a mental health co-morbidity. There is currently no trigger question in the Nursing Assessment booklet to prompt staff to consider mental health concerns if patients are admitted with none mental health issues. An audit of the provision of a mental capacity assessment tool was published in June 2022 looking at the care of patients admitted with mental health concerns e.g. self harm. A Mental Capacity Assessment Tool commenced in 27.5% cases. The Audit has been considered by the ED Governance Meeting and the Vulnerable Adults Safeguarding Group with the following actions identified to improve compliance: 1) The Education Team will provide a communication campaign to ensure all staff are aware of: - the importance of documenting the initial level of mental health risk - the importance of completing the Mental Health Booklet 2) Grand Rounds focussing on MCA and MHA will be prioritised and advertised amongst all Junior Doctors	Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee
						The following audits will be prioritised on the Trust Clinical Audit programme to monitor compliance with Trust Policy: Audit of the Mental Capacity Act Audit of Deprivation of Liberty	Victoria Lewis Quality Assurance Manager	Complete			Clinical Audit results	At the request of the Matron for Mental Health, the 2 audits have been combined into one project to provide ease of data collection. The audit involves the provision of a clinical review and is currently in data collection. The audit is expected to be completed by March 2023. The audit will be considered by the Safeguarding Vulnerable Adults Steering Group and the Clinical Effectiveness Sub Group. and shared across all Divisions	Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating (As against Target Date for Completion not revised target date)	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
						The Trust will introduce a template to remind / guide staff through the MCA assessment process	Kirsty Smith Lead Nurse: Mental Health & Learning Disability	Complete			Clinical Audit results	•A MCA template and guide is available on the Safeguarding Intranet page- plan to relocate this information into its own resource area on the intranet for ease of location. •Monitor outcome through audit results	Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee
						The Trust will undertake a baseline review of current training compliance in relation consent training. A trajectory of improvement will be developed and monitored	Jamie Maxwell Quality, Safety & Compliance Manager Executive Lead: Dr Matthew Lewis Medical Director	Apr-22	Feb-23		Clinical Audit of the Consent Process	•A consent compliance clinical audit has been included in the audit programme and scheduled for December 2022 •Identify training needs and develop trajectory for improvement according to audit results	Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee
						A review of the current training packages will be undertaken to ensure that any training around the provision of care to vulnerable patients, includes MCA information	Grant Heatlie Deputy Medical Director	Apr-22	Feb-23		Clinical Audit of the Mental Capacity Act	•Ensure that training packages contain reference/signposting to the MCA template and Guide •Monitor outcome through audit results	Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee

CQC Action Plan 2022/23

As at 02 February 2023

CURRENT PROGRESS RATING		
	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
	On Track	Improvement on trajectory either: On track – not yet completed *or* On track – not yet started
	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement - **target date moved once**
	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required - **target date moved twice or more**

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating (As against Target Date for Completion not revised target date)	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
B1	Safe	**Trust wide**	**Corporate**	**Trust wide**	The Trust SHOULD ensure it reviews and investigates significant incidents in a timely manner and in line with Trust Policy	The Trust has developed a twice weekly Serious Incident review meeting to review new incidents and ensure that 72 hour reports and plans for investigation are confirmed	Jamie Maxwell Head of Quality, Safety and Compliance	Complete			Quality and Safety Report	•Action log available from twice-weekly meetings Correspondence with ICB available for submitting Serious Incidents New PSIRF approaches are being implemented in preparation for September 2023 timeframe	SI Review Group Risk management Panel Quality Safety Oversight Group Quality Governance Committee
						The Trust will work collaboratively with the local ICB to monitor timescales for submission on STEIS and to redefine the TOR of the SI Sub-Group	Jamie Maxwell Head of Quality, Safety and Compliance	Complete			SI Sub Group Presentation	•SI Sub-group presentations and SI Reports available • As at December 2022, Q2 performance demonstrates 48 RCAs awaited by the ICB	SI Review Group Risk management Panel Quality Safety Oversight Group Quality Governance Committee
B2	Responsive	**Trust wide**	**Corporate**	**Trust wide**	The Trust SHOULD ensure all complaints are reviewed, investigated and responses are managed in a timely manner and in line with Trust policy	The Trust are reviewing the current formal complaints process to improve the quality and timeliness of reports and to streamline the sign off process	Debra Meehan Lead Nurse: Quality and	Oct-22	Feb-23		Complaints Report	•Complaint triage process in place •Electronic sign off process under development •New Deputy Chief Nurse commenced 5th January 2023 • Meeting scheduled to take place week commencing 30th January 2023 to review the process	Patient Experience Group Quality Safety Oversight Group Quality Governance Committee
B3	Well Led	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD ensure that measures are in place to keep patients records secure.	To undertake a risk assessment and improvement plan associated with records storage in ED and subsequently progress digitalisation of ED records.	Joanne Allen Matron Diane Adamson Clinical Lead	Oct-23			Review of incidents around record management and storage	•Digitalisation of ED records under development •Any incidents and impact of mitigating actions continue to be monitored by Record Services Operational Group	Urgent and Emergency Medicine Directorate Governance Meeting
B4	Well Led	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD ensure there is a recovery process in place to ensure all staff complete mandatory training and essential role training	The Directorate Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Richard Hall Consultant Joanne Allen Matron	Oct-22	Mar-23		Training figures	•Protected time allocated for training •Trajectory for improved compliance with annual Stat/Mand training and 3 yearly Stat/Mand training in place •Currently achieving 90.74% compliance . Directorate concerns about ability to achieve the trajectory by March 2023, due to ongoing operational pressures in addition to the national mandate to undertake Learning Disability/Autism training	Urgent and Emergency Medicine Directorate Governance Meeting
						The Departmental rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Richard Hall Consultant Joanne Allen Matron	Complete			Training figures	•Protected time allocated for training	Urgent and Emergency Medicine Directorate Governance Meeting
B5	Safe	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD ensure all staff follow best practice when completing care records to ensure they are an accurate record of care and treatment provided	The Trust will introduce digitalised care records to ensure the provision of individualised, accurate care plans.	Richard Hall Consultant Joanne Allen Matron	Mar-23	Oct-23		CEF Clinical Audit of documentation	•Digitalisation of ED records under development	Urgent and Emergency Medicine Directorate Governance Meeting
						The Department will continue daily Matron CEF reviews supported by the Corporate Nursing Team	Joanne Allen Matron	Complete			CEF Clinical Audit of documentation	•CEF reports available	Urgent and Emergency Medicine Directorate Governance Meeting
B6	Responsive	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD consider how they can improve information management for certain patient groups	A review of current documentation will be undertaken to ensure the provision of standardised templates for electronic referrals and Medical/Nursing handovers	Richard Hall Consultant Joanne Allen Matron	Mar-23			Clinical Audit of documentation	•Digitalisation of ED records under development •Development of standardised handover forms/processes underway	Urgent and Emergency Medicine Directorate Governance Meeting

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating (As against Target Date for Completion not revised target date)	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
B7	Safe	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD consider how the current layout of the Department is impacting on the safe running of the Department	The Directorate will conduct a feasibility Study to explore options to mitigate risk of patients being nursed in majors cubicles with doors, from both an infection prevention and avoidable harm perspective	Richard Hall Consultant Joanne Allen Matron	Complete			Review of incidents relating to harm in the ED Department	•ED Department reconfigured and business case re-written for removal of cubicle doors in Majors	Quality Safety Oversight Group Quality Governance Committee
B8	Well Led	**Royal Stoke**	**Medicine**	**Medical Care**	The Trust SHOULD ensure that it continues to work toward meeting trust targets for all mandatory training	The Divisional Management Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Jill Ayres Divisional Nurse Director Tony Cadwgan Divisional Medical Director	Sep-22	Mar-23		Training figures	•Trajectory for improved compliance with annual Stat/Mand training and 3 yearly Stat/Mand training in place •Currently achieving 90% compliance . Divisional concerns about ability to achieve the trajectory by March 2023, due to ongoing operational pressures in addition to the national mandate to undertake Learning Disability/Autism training	Directorate and Divisional Governance Meetings
						The Divisional rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Jill Ayres Divisional Nurse Director	Complete			Training figures	•E-Roster enables training time to be displayed	Directorate and Divisional Governance Meetings
B9	Effective	**Royal Stoke**	**Medicine**	**Medical Care**	The Trust SHOULD ensure that all wards display up to date audit results such as results from hand hygiene audits	Up to date audit results to form part of Tendable Ward audit system	Jill Ayres Divisional Nurse Director	Jul-22	Apr-23		CEF Visits, Tendable Audits	• Tendable has been rolled out to County. First audit submitted by 31st December 2022 and being further embedded. • Tendable being rolled out to Royal Stoke January / February 2023 •The audits undertaken on Tendable include the opportunity to provide photographic evidence of wards displaying the hand hygiene audits	Directorate and Divisional Governance Meetings
B10	Safe	**Royal Stoke**	**Medicine**	**Medical Care**	The Trust SHOULD ensure medical wards are provided with adequate storage space	Ward teams will be encouraged to take part in "Dump the Junk" initiatives	Mike Brown Head of Soft Facilities Management	Mar-23			CEF Visits	•Under Development • Target date reset due to the action moving over to the responsibility of Mike Brown	Directorate and Divisional Governance Meetings
						Ward Teams will be encouraged to adopt Lean Methodologies with regard to equipment/storage as part of their Improving together/Shared Governance projects	Estates Team / Medical Division Matrons	Complete			CEF Visits	•Included as part of Improving Together methodologies	Directorate and Divisional Governance Meetings
B11	Safe	**Royal Stoke**	**Medicine**	**Medical Care**	The Trust SHOULD ensure patient records are kept in a structured and consistent format so that staff can easily access them	The Trust will conduct an options appraisal of available standardised formats for health records	Alison Legan Patient Records Manager	Complete			Record Keeping Clinical Audit	•Meeting has taken place to consider the options available and determined that digitalisation of patient records will be pursued rather than implementing new paper records / folders. Discussions on going with ward clerks to ensure awareness of responsblities for filing information	Quality Safety Oversight Group Quality Governance Committee
B13	Responsive	**Royal Stoke**	**Medicine**	**Medical Care**	The Trust SHOULD ensure that waiting times from referral to treatment and arrangement to admit, treat and discharge to be in line with national standards	Monitor waiting times and assign mitigating actions through Directorate, Divisional and Corporate meeting structures	Divisional Leadership Team	Complete			Divisional Performance Report	Marked as complete. However, UHNM are not consistently achieving the national standards in terms of waiting times and specific workstreams are in place, which include actions to address and improve performance for both urgent and planned care. These actions are reported separately via the updates to Performance and Finance Committee.	Quality Safety Oversight Group Quality Governance Committee
B15	Safe	**County**	**Medicine**	**Medical Care**	The Trust SHOULD ensure all serious incidents are investigated effectively	The Division will ensure that immediate mitigating actions are identified and shared, following all Serious Incidents	Jill Ayres Divisional Nurse Director Dr Tony Cadwgan Divisional Medical Director	Apr-23			Quality and Safety Report	• There has been an improvement in the completion of 72 hour reports for serious incidents. • Further data is to be obtained to provide assurance that this is being undertaken consistently	Directorate and Divisional Governance Meetings

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating (As against Target Date for Completion not revised target date)	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
B15	Safe	County	Medicine	Medical Care	and in a timely manner to reduce the risk of future harm	The Division will monitor timeliness of investigations and share learning through Divisional Governance Structures	Jill Ayres Divisional Nurse Director Dr Tony Cadwgan Divisional Medical Director	Complete			Quality and Safety Report	•Monitored through governance meetings and performance review packs	Directorate and Divisional Governance Meetings
B16	Safe	**County**	**Medicine**	**Medical Care**	The Trust SHOULD consider taking action to ensure key information about patients care in consistently recorded. For example, ensuring clear wound care plans are in place for all patients with a wound	A review of the proposed Clinical Audit programme will be undertaken to ensure that appropriate documentation audits are in place to review the standards of patient documentation and identify areas for improvement	Victoria Lewis Quality Assurance Manager	Complete			Clinical Audit Progress Report	Clinical Audit prioritised on the 2022 / 23 audit programme. The audit will review practice against Trust policy in relation to the timely completion of assessments and care plans. The audit results will be considered by the Tissue Viability Steering Group and the Clinical Effectiveness Sub Group. The report and actions will be shared across all Divisions. In addition to the annual audit, the timely completion of assessments is reviewed as part of the Care Excellence Framework. During Q3, a Team visited 21 clinical areas. Only 1 area had gaps in compliance in relation to wound care documentation. The development and completion of an action plan to address shortfalls is supported and monitored by the Corporate Nursing Team. During Quarter 3, a total of 1051 none hospital acquired pressure ulcer / damage were identified in the Emergency Portals, providing ongoing assurance that staff are carrying out effective assessment	Clinical Effectiveness Group
						The Trust has developed a Wound Care Document. The document is currently being ratified and a roll-out plan is being finalised	Katie Leek Lead Nurse: Tissue Viability	Complete			Review of Tissue Viability incidents	•Proof document received and roll out plan in place	Quality Safety Oversight Group Quality Governance Committee
B17	Safe	**County**	**Medicine**	**Medicine Care**	The Trust SHOULD consider making the speech and language therapy service provision equitable across County Hospital	A position paper will be presented at the Acute Patient Flow group which will highlight the shortfalls in the service provision to inpatient medical wards, across both sites	Lois Dale Head of Speech and Language Therapy	Complete			Meeting Minutes	•The position paper was presented to the Acute Patient Flow group in April 2022	Quality Safety Oversight Group Quality Governance Committee
						The Trust will develop an education programme to support ward teams regarding 'what makes a good referral' and how to escalate referrals	Lois Dale Head of Speech and Language Therapy	Complete			Review of incidents relating to insufficient referrals Review of the number of rejected referrals	•Guidance has been developed to advise wards how to escalate referrals •circulated via Comms	Quality Safety Oversight Group Quality Governance Committee
						MNP/ANP nurse swallow screening training will be implemented at RSUH to support service provision. Consider rollout at County Hospital	Lois Dale Head of Speech and Language Therapy	Sep-22	Apr-23		Review of incidents relating to SALT provision at Ward level	• ANP training for Respiratory ANP's was completed by SLT. A meeting is being arranged to discuss competency assessment process. •Training has not been offered to County ANP's to date due to ongoing limited SLT resources over at County. There has been recent recruitment within SLT which will support this development.	Quality Safety Oversight Group Quality Governance Committee
B18	Safe	County	Medicine	Medicine Care	The Trust SHOULD continue to work towards the provision of a full	The Division will initiate a number of promotional activities to ensure that Ward staff are aware of the services available at County Hospital across seven days	Claire Mackirdy Site Director of Operations	Complete			Divisional Performance Report	•A presentation of the services available at County for all the wards has been developed and shared.	Operational Groups

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating (As against Target Date for Completion not revised target date)	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
B18	Safe	County	Medicine	Medicine Care	multidisciplinary seven-day service at the County Hospital site	The Trust will include consideration of seven-day service provision in all service reviews at County Hospital	Claire Mackirdy Site Director of Operations	Complete			Divisional Performance Report	•Seven-Day service provision considered in all service reviews/developments •Any Datix incidents relating to lack of access to services at weekends are monitored and reviewed	Operational Groups
B19	Well Led	County	Surgery	Surgical Care	The Trust SHOULD ensure that medical staff are up to date with all mandatory training	The Divisional Management Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Dr Stephen Merron Clinical Director	Dec-22	Mar-23		Training Figures	•Trajectory developed •A letter has been circulated to Surgical Division seeking improved compliance. Divisional HR provide monthly update for S&M training. • Divisional concerns about ability to achieve the trajectory by March 2023, due to ongoing operational pressures in addition to the national mandate to undertake Learning Disability/Autism training	Directorate and Divisional Governance Meetings
						The Divisional rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Dr Stephen Merron Clinical Director	Complete			Training Figures	•All permanent staff have 1 SPA included in job plans for CEPD. This will include the completion of Statutory & Mandatory Training. Each Directorate also allocates time during Audit and Training afternoons to address some of the Stat & Mand maintenance. •Rotational trainees all undergo Stat & Mand Training as part of the induction process, and are required to maintain certain elements as a requirement for ARCP.	Directorate and Divisional Governance Meetings

Transformation and People Committee Chair's Highlight Report to Board

1st February 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The number of Keele graduates applying for UHNM posts is low with only 12 out of 83 commencing in post in August 2022. • Guardian of Safe Working Report demonstrated an increase in exception reports from Trauma and Orthopaedics and County Emergency Department which are being explored further. Challenges with engagement with junior doctor's forums also cited. • 98 exception reports to the Guardian of Safe Working during Q2 of which 5 were safety related and being investigated. • Increase in average disciplinary investigation duration in Q3 due to a number of complex cases being concluded. • ENABLE programme attendance levels had been flagged as a concern although countermeasures have been introduced to reduce DNA rates. There were also some concerns raised regarding the accuracy of the Electronic Staff Record in terms of identification of supervisory roles, both for attendee identification purposes and wider use of ESR. • All Divisions are reviewing the initial raw data from the national staff survey to identify areas of focus in line with people driver metrics using the Improving Together methodology to identify key areas of focus. • Recruitment challenges were flagged as a consistent theme across Divisions and a number of actions were underway including social media campaigns and process changes to improve this. • Concerns regarding clinical tutor time being pulled from teaching due to competing pressures • Divisions were unable to give assurance around their ability to reduce agency expenditure in line with target due to vacancy and unavailability gaps. • Concern raised regarding the thefts in the theatres as highlighted via the Executive Health & Safety Group • Concern was expressed around the ability to reduce the strategic risk for Research and Innovation within the target identified and a trajectory was requested • Careflow performance was being discussed with providers as there had been some challenges experienced	• National Education Training Survey (NETS) November 2022 survey results are expected at the end of January 2023 • Further consideration needed in terms of governance and oversight within divisions of medical trainees along with increased engagement in junior doctors forums • Work will be undertaken to adopt an 'Improving Together' approach to the running of TAP meetings, ensuring a focus on key driver metrics / watch metrics with reporting in A3 format • The Culture Heat Map is being used as part of discussions with Divisions in identifying their driver metrics • Divisions have been asked to ensure that clinical tutor time is protected • Whilst progress was being made against the Clinical Strategy, some areas are further advanced that others and it was recognised that a delivery plan with clear milestones needed to be developed • An Executive Steering Group to provide strategic leadership to the Improving Together Programme is currently being established
✓ Positive Assurances to Provide	**Decisions Made**
• National Education Training Survey (NETS) November 2021 results showed significantly improved performance across all domains and UHNM performed above the benchmark; 77% respondents would recommend their training placement. Where the GMC or NETS identified concerns, there has been additional investment in educational leadership • Undergraduate and Physician Associate programme students regularly achieve high level pass rates and engagement and commitment from consultants with teaching is excellent with very positive student feedback • The ENABLE programme is very well received by delegates • 54 contacts with the Speaking Up Guardian were made during Q3 and this was the highest number of contacts to date, correlating with Speaking Up Month taking place in October 2022 • Time to hire for general recruitment was now meeting the KPI identified • Confirmation had been received from the HSE that they were satisfied with the actions taken in response to the Brucella incident and RIDDORS are being reported in accordance with the statutory timeframe • Improving Together training remains on trajectory	• Approval of the Board Assurance Framework (BAF) for submission to the Trust Board

Comments on the Effectiveness of the Meeting

- No particular comments made

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Medical School Annual Report	BAF 3	Ext 15	! ✓	Assurance	8.	Executive Workforce Assurance Group Assurance Report (20-01-23)	BAF 2/3	12 16	-	Assurance
2.	Postgraduate Medical Education Report	BAF 3	Ext 15	! ✓	Assurance	9.	Executive Health & Safety Group Assurance Report (19-01-23)	-		! ✓	Assurance
3.	Guardian of Safe Working Q2	BAF 3	Ext 16	!	Assurance	10.	Board Assurance Framework Q3 2022/23	-		!	Approval
4.	Speaking Up Report Q3	BAF 2	High 12	✓	Assurance	11.	Update on Delivery of Clinical Strategy	-		-	Assurance
5.	Formal Disciplinary Activity Q3	BAF 2	High 12	-	Assurance	12.	Improving Together Countermeasure Summary	-		✓	Assurance
6.	Enable Programme - Interim (6 months) Evaluation	BAF 2	High 12	! ✓	Assurance	13.	Executive Digital and Data Security & Protection Group Assurance Report (18-01-23)	BAF 6		!	Assurance
7.	Workforce Report – M9 2022/23	BAF 2/3	12 16	!	Assurance						

3. 2022 / 23 Attendance Matrix

No.	Name	Job Title	A	M	J	J	A	S	O	N	D	J	F	M
1.	Prof G Crowe	Non-Executive Director (Chair)												
2.	Ms H Ashley	Director of Strategy and Transformation												
3.	Ms S Belfield	Non-Executive Director												
4.	Mrs T Bullock	Chief Executive												
5.	Mr P Bytheway	Chief Operating Officer						OW						
6.	Mrs C Cotton	Associate Director of Corporate Governance					NH			NH				
7.	Baroness S Gohir	Non-Executive Director												
8.	Mrs J Haire	Chief People Officer												
9.	Dr L Griffin	Non-Executive Director												
10.	Dr M Lewis	Medical Director				NC		ZD						
11.	Prof K Maddock	Non-Executive Director												
12.	Mrs A Riley	Chief Nurse												
13.	Prof S Toor	Associate Non-Executive Director												

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	8th February 2023
Report Title:	Quarter 3 Speaking Up Report	**Agenda Item:**	10.
Author:	Kerry Flint, FTSU Guardian and Claire Cotton, Associate Director of Corporate Governance		
Executive Lead:	Claire Cotton, Associate Director of Corporate Governance		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 2	*Leadership, Culture & Delivery of Values / Aspirations*	*12 (High)*

Executive Summary

Situation

This report provides a brief overview of Speaking Up activities for Quarter 3 2022/23. It provides a high level summary of the more detailed qualitative and quantitative information presented to the Executive Workforce Assurance Group and the Transformation and People Committee which covered national and local developments, numbers of concerns including national benchmarking, training data and further developments planned. It presented to the Board for information and assurance purposes.

Background

In line with the requirements of the National Guardians Office, we have local policies and procedures in place to ensure that staff are able to speak up about their concerns. As set out within the national People Promise and our own Strategic Priorities, our aim is to ensure that 'we each have a voice that counts' and that 'UHNM is a great place to work'. Our quarterly report has therefore been designed to provide assurance against those policies, procedures and strategic aims.

Assessment

We are continuing to use the new guidance and tools issued by NHS England and the National Guardian's Office to guide our activities and development plan. With the increase in Speaking Up resource, we have been able to deliver a more proactive approach to staff engagement and in addition to raising awareness, we hope that this will instil confidence in our staff that they can speak up when they are concerned. The early indications continue to be that the approach is having a positive effect as we are seeing an increase in the number of concerns being raised, with quarter 3 2022/23 seeing the highest number of concerns being raised to date at 54.

The following table sets out the key observations at Quarter 3:

	Areas of Concern / Items for Escalation	Solutions
!	Attitudes and behaviours remain the highest category of concern reported and benchmarking data demonstrates that this was higher than the average during Q1	We will be working with our People Directorate to triangulate information regarding attitudes and behaviours to further assist in the identification of hotpot areas for our Cultural Improvement Programme.
!	There has been a slight deterioration in staff who have raised concerns feeling that their issue / concern has been resolved.	We will be undertaking some further work to understand why staff do not feel that their issue has been resolved.
!	Further cases of detriment as a result of speaking up have been highlighted during this quarter (2 cases)	We will ensure that there is a focus on detriment within our policy and our new strategy, so that staff feel able to raise concerns without fear of detriment. We are also looking at developing a risk assessment.

!	5 ‘hot spots’ have been highlighted via our Heat Map – 1 of which was a hot spots during Q2.	These will continue to be monitored – there are existing cultural support and improvement programmes in place and we will ensure that there are targeted actions via divisions and corporately to address concerns.
!	Training levels are low	We have refreshed our training needs analysis and we are looking to streamline the training programmes available.

Aligned with the solutions outlined about, a summary of priorities for the coming quarter has been included. In order to support further feedback and awareness, we will also be developing a quarterly newsletter for staff with key messages around Speaking Up, including a focus on preventing detriment.

Key Recommendations

- The Trust Board is asked to **note** the findings within this report and **approve** the priorities set out above.

Freedom to Speak Up
Your voice matters at UHNM

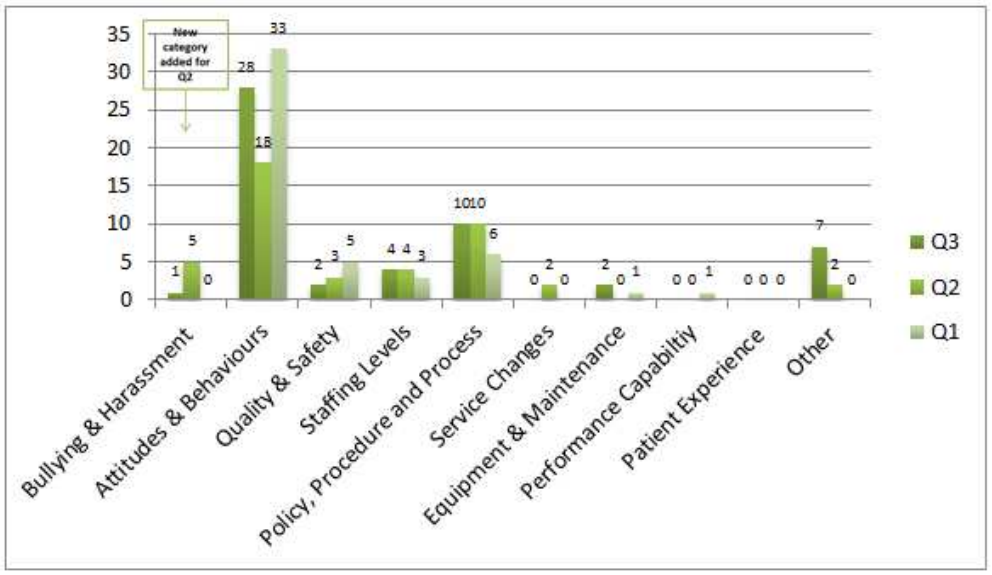
Speaking Up
Board Brief – Quarter 3 2022/23

1. Headlines

- 54 concerns raised through the Freedom to Speak Up (FTSU) Guardians Office during Quarter 3 2022/23, 21 of these were reported during October 2022, these are our highest numbers to date – this was Speaking up Month
- 52% of these concerns were in relation to 'Attidudes and Behaviours'
- 37% of concerns were raised by Registered Nurses / Midwives (20 concerns), 33% raised by Admin / Clerical / Maintenance / Anxiillary (18 concerns) and 22% by Allied Health Professionals (6 concerns)
- Top 3 'Hotspot' areas for the Quarter are Obstetrics (5 concerns), Therapies (5 concerns) and Corporate Nursing (5 concerns)

2. Summary of Concerns Raised During the Quarter

Types of Concerns Raised



*some concerns relate to more than category

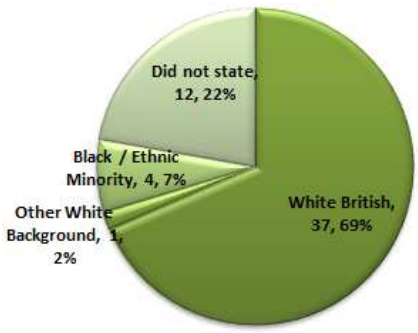
Cases of Detriment

- 2/54 cases in Q3 where individuals reported detriment as a result of raising their concern
- A reduction from the 10 cases reported during Q1 and 4 in Q2
- We will be taking action to tackle this.

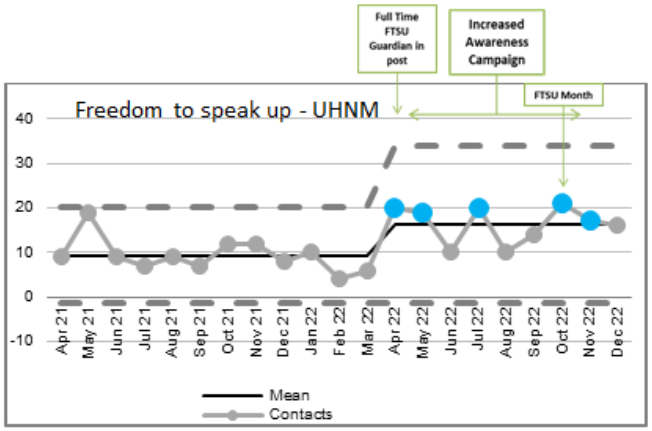
Outcomes

Ongoing case review process / investigation	18
Action taken – case closed	36
Anonymous report – no feedback	0

Ethnicity of Reporters



SPC – Concerns Raised



3. Key Developments During the Quarter

Local Developments

Continued work on the visual presence of Speaking Up within wards / departments and FTSU month during October with information stands and an opportunity to meet the FTSU Guardian

	accessible locations across both sites		
	Pledges made on how staff will support Speaking Up in the workplace		Drop in sessions in area where staff have raised concerns and attendance at several workshops

4. Priorities for the Next Quarter

No.	Source	Strategic Priorities	Action
1.	National Developments		Ensure that our Speaking Up Strategy as a strong focus on removing barriers and giving our staff the confidence to raise matters of concern without fear of detriment.
2.	Local Developments		Follow up on feedback received on the speaking up process to understand why staff have felt their issues / concerns have not been resolved.
3.	Spotlight on Concerns		Working alongside colleagues within the People Directorate we will be triangulating concerns with other sources of information to identify any further hotspots.
4.	Spotlight on Concerns		Divisional Leadership Teams to consider high level themes at local Culture / Workforce Groups and to ensure that local actions are identify to call out and tackle poor behaviours.
5.	Tackling Detriment		• Hold a discussion with Board colleagues around detriment and our strategy to prevent it. • Incorporate regional guidance regarding detriment into our revised Speaking Up Policy • Look at how a risk assessment for detriment can be incorporated into our process, in line with the national 'follow up' training • Develop a quarterly newsletter for staff with key messages around Speaking Up, including a focus on preventing detriment
6.	Training		• Replace information contained within mandatory training with the Speak Up module • Define roles regarded as Senior Managers to clarify those required to complete 'Follow Up' training and review the format of that training to ensure it is accessible and user friendly • Ensure that all Board members have completed Follow Up training • Promote the availability of training • Develop clear performance targets for completion of training

5. Key Conclusions

	Attitudes and behaviours remain the highest category of concern reported although benchmarking data demonstrates that this was lower than the average during Q2. Our Cultural Improvement Programme is designed to tackle attitudes and behaviours of staff and the issues contained within this report will be used to influence and inform further improvement activities.
	Further cases of detriment as a result of speaking up have been highlighted during this quarter. We will be raising awareness around this being unacceptable and we will be discussing these in more detail with the designated Non-Executive Lead for Speaking Up.
	4 'hot spots' have been highlighted via our Heat Map – 1 of which were hot spots during Q1 and Q2 (Maternity). These will continue to be monitored as part of our Cultural Improvement Programme.
	Training levels continue to be lower than expected and we are working with colleagues within the People Directorate to provide greater clarity on our expectations for training.

Performance and Finance Committee Chair's Highlight Report to Board

31st January 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Whilst the business case review associated with speech recognition demonstrated some progress there remained further work required to embed and adopt the new processes with clinicians so that all elements were utilised effectively • During December, due to the national coverage of paediatric Strep A, the Children's Emergency Department saw attendances doubling over a weekend for a two week period. In addition the Committee noted the continued focus on reviewing productivity within the Emergency Department • Loss of orthopaedic activity due to winter pressures impacted upon planned care performance and as such the position for 104 week waits had deteriorated. In addition the Trust was not on trajectory to eliminate 78 week waits by the end of March although plans were in place to minimise the number of breaches which included using the Independent Sector and seeking mutual aid • A recent Get It Right First Time (GIRFT) report highlighted that the Trust was in the bottom quartile associated with theatre productivity and an update on the reasons for this and actions being taken to improve productivity were highlighted with further information to be provided on the different comparators available • The Board Assurance Framework (BAF) demonstrated increased risk scores associated with delivering positive patient outcomes and delivering responsive patient care, as a result of the continued pressures and introduction of Your Next Patient and Corridor Care • Continued challenges associated with identification of cost improvement programme savings were highlighted, as £9.3 m of savings had been validated with a full year impact of £5.3 m against the recurrent target of £13.6 m.	• To provide an assurance report to the Quality Governance Committee on the safety of corridor care • To provide an update at the next Committee to review urgent care performance during December 2022 compared to the assumptions in the winter plan • Clinical assessment of long wait spinal patients being undertaken to assess their suitability to be treated at other hospitals • Weekly overview meetings taking place for diagnostics to review performance • Ongoing work taking place to identify realistic target risk scores for the risks on the BAF as well as trajectories for improvement which would be discussed with the Board in March 2023 • Update to be provided to the next meeting in relation to the National Delivery Plan for Urgent and Emergency Care
✓ Positive Assurances to Provide	Decisions Made
• An update was provided in terms of taking forward Corridor Care to mitigate the risks associated with ambulance waits, whereby this was only being used at times of escalation alongside other initiatives such as Your Next Patient and on a risk assessed basis and noting the strict criteria for introduction was being followed at all times. • Improvements for cancer performance were highlighted in particular the size of the waiting list continuing to reduce and the current backlog compared to the overall patient treatment list was 15.1% • The year to date financial position had improved and the forecast as such had improved by £2 m to £6.6 m deficit (unmitigated). • The annual audit into overseas visitors provided positive assurance in terms of ensuring correct investigations were made and actions had been identified in respect of the 2 discrepancies identified for non-chargeable patients. • The quarterly update for procurement highlighted bottom line savings of £6.15 m and highlighted the ongoing work associated with collaboration across the system and work on the national Future Operating Model and Central Commercial Function	• The Committee approved BC0513 ICB Network Security Operations Centre and Security Information Event Monitoring Business Case although confirmation was required of the reduction in associated risks • The Committee approved the continued funding for speech recognition until March 2025 but requested an annex to highlight the money spent and revised realistic KPIs and objectives • The Committee approved the following eREAFs 10272, 10296 and 10347
Comments on the Effectiveness of the Meeting	
• Welcomed the discussion on performance whilst noting the need to manage time accordingly given the requested deep dives	

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Business Case Review: BC-0449 Speech Recognition	-		!	Approval	7.	Board Assurance Framework Q3 2022/23	-		-	Approval
2.	BC-0513 ICB Network Security Operations Centre and Security Information Event Monitoring	BAF 6	9036 (15) 21784 (12)	-	Approval	8.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-		-	Approval
3.	Performance Report – Month 9 2022/23 • Update on Discharges / Ambulance Holds	BAF 5	Ext 20	! ✓	Assurance	9.	Finance Report – Month 9 2022/23	BAF 8	High 9	! ✓	Assurance
4.	Corridor Care and Your Next Patient Update	BAF 1/5	Ext 20	✓	Assurance	10.	Overseas Visitors Annual Policy Audit	BAF 8	High 9	✓	Assurance
5.	Theatre Improvement Programme Update	BAF 5	Ext 20	!	Assurance	11.	Quarterly Procurement Update Report	BAF 8	High 9	✓	Assurance
6.	Planned Care Improvement Group Highlight Report (19-01-23)	BAF 5	Ext 20	-	Information	12.					

3. 2022 / 23 Attendance Matrix

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

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

Executive Summary

Meeting:	Trust Board	**Date:**	8th February 2023
Report Title:	Integrated Performance Report, Month 9 2022/23	**Agenda Item:**	12.
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & Safety; Operational Performance: Warren Shaw, Strategic Director of Performance & Information; Matt Hadfield, Associate Director of Performance & Information. Workforce: Paul Williams, Assistant Director of Human Resources; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Paul Bytheway: Chief Operating Officer Jane Haire: Director of Workforce Mark Oldham: Director of Finance		

Purpose of Report

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

Alignment with our Strategic Priorities

High Quality		People		Systems & Partners	
Responsive		Improving & Innovating		Resources	

Risk Register Mapping

Executive Summary

Situation

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

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

Assessment

Quality & Safety

Key messages

The Trust achieved the following standards in December 2022:

- Friend & Family (Inpatients) 96.6% and exceeds 95% target.
- Harm Free achieved 96.5% against 95% target rate

- 0 Never Event
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.5% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- E. Coli Bacteraemia cases on trajectory with 16 in December compared to target of 16.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- Inpatients Sepsis Screening above 90% target rate at 91.45%.
- Inpatient Sepsis IVAB within 1 hour achieved improved to 91.7% and above 90% target rate
- Children's Sepsis Screening compliance improved to 90.9% and above the 90% target.
- Maternity IVAB compliance improved to 100% and above the 90% target for audited patients
- HSMR is lower than benchmark.

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E remains below 85% target at 63.5%
- Friend & Family (Maternity) improved to 66.7% but remains below 95% target.
- Falls rate was 6.0 per 1000 bed days for December 2022
- There were 37 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 80% verbal Duty of Candour compliance recorded in Datix
- 21% compliance with Duty of Candour 10 working day letter performance following formal verbal notification and under review for completion and upload of letter on Datix
- C Diff YTD figures above trajectory with 14 against a target of 8.
- Sepsis Screening compliance in Emergency Portals reduced to 78% below the target 90%.
- Emergency Portals Sepsis IVAB in 1 hour decreased to 59% and remains below the 90% target for audited patients
- Maternity Sepsis Screening compliance improved to 80% against 90% target

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

- The rate of complaints per 10,000 spells is 17.46 and is below the target of 35 and within normal variation. Majority of complaints in December 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents increased in month (1914) and the rate per 1000 bed days has also decreased at 47.07
- Total incidents with moderate harm or above and the rate of these incidents are above upper control limits and outside normal variation levels. These increase are following increased pressures within the Emergency Departments
- Rate of falls reported that have resulted in harm to patients currently at 1.38per 1000 bed days in December 2022. The rate of patient falls with harm continues to be within the control limits and normal variation.
- Medication related incidents rate per 1000 bed days is 5.4 and patient related 4.6 which are higher to previous month and mean rates. The monthly variation is within the normal expected variation and consistent with Trust mean rates.
- Pressure Ulcers per 1000 bed days developed under UHNM care has seen a increase during December 2022
- Hospital Associated Thrombosis is within outside variation.
- Increased numbers of Definite Hospital Onset / Nosocomial COVID-19 cases reported in December 2022 with 69 in total.
- 5 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 8 Serious Incidents reported during December 2022.
- SHMI has seen increases and under review for diagnosis groups but is within expected range (see funnel plot chart)

Recording of Duty of Candour completion within Datix continues to require improvement. Reporting of compliance with Duty of Candour is confirmed when Datix is updated and copies of the letters uploaded. The compliance with Duty of Candour has been escalated and discussed at QSOG with Deputy Medical Director and Divisions are working with clinicians and Q&S teams to raise further awareness and education on how and why Duty of Candour is to be completed. Dedicated sessions were provided in Emergency Medicine on 15th December 2022. New processes introduced within Emergency Medicine to include Division Quality & Safety Manager in all duty of candour correspondence to facilitate further recording and uploading of details to Datix.

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

All data used in this report is as recorded on 6th January 2023 and figures may change following further review/investigation/update

Operational Performance

Emergency Care

- December was an extremely challenging month from both an operational and clinical perspective with the majority of metrics deteriorating, with several falling to all time lows. This was primarily driven by increases in both attendances and acuity, coinciding with extreme IP restrictions. In order to quantify the impact of the significant acuity and IP measures we analysed the numbers of ambulance arrivals where patients were triaged with a 5+ NEWS (23% rise between the last two weeks of November and the last two in December), and the difference between expected average IP bed demand and actual peak experienced (excess demand of 29 flu and 38 COVID for a total of 67 beds).

- The national coverage of paediatric Strep A cases also precipitated an over doubling of CED attendances over a single weekend, which sustained for approximately a two week period. These attendances were very much of the so called 'worried well' cohort, demonstrated by only an 11% rise in admissions to CAU with less than half of this amount admitted to the paediatric bed base. Despite this lack of requirement for admission there was a significant demand on triage and WTBS times in order to ensure patients requiring attention were not at risk of deteriorating while waiting in long queues. In order to ensure this risk was managed appropriately a Business Continuity Incident was stood up and extraordinary actions taken (including bolstering triage capacity, Consultant oversight, and direct pathways to both EhPC/GPOOH and CAU).

- Numerous actions were taken in order to respond to operational pressures, ensure patient safety, and the appropriate management of system wide risk. These included the expansion of YNP into acute portals, the utilisation of additional inpatient areas, and most significantly the restarting of corridor in the ED. These actions and others were managed through establishing Tactical Command & Control structures as part of a Level 3 System Critical Incident which was supported by the standing down of all non-essential meetings.

- The refocussing on Your Next Patient (YNP) saw continued benefits with a return to previous highs of 50% of flow occurring pre 13:00 instead of post 13:00. The Division of Medicine also introduced further refinements to the SOP, Gantt chart, and risk assessments. Other Divisions are now well practiced at standing up YNP as required by imbalances of capacity and demand. In these instances specialties will in reach across the UEC footprint to find the most appropriate patients possible in order to minimise disruptions to the patient journey and the requirement for outlying reviews.

Cancer

- Most recent submitted Cancer Waiting Times position is November 22 which was 49.4% for 62 day performance. December is currently predicted to be 46.4% although this will improve post validation.
- In August the PTL was over 6000 – this has now reduced by 2529 patients to 3471 in total. The PTL has reduced consistently for the past 13 weeks
- The 62 day target is expected to continue an improvement trajectory as additional capacity is put into colorectal by insourcing. Skin have effective recovery plans to reduce their backlog.
- In December the backlog of patients has seen a significant reduction from 1041 at the end of August to 558 at the end of December. .
- The incremental decrease of the Skin and Colorectal backlogs have been modelled up to the end of March 2023 where the new trajectory meets the initial trajectory submitted in 22/23 operational plans. Both specialties have enacted recovery plans and are ahead of the new trajectories to reduce the number of patients waiting beyond 62 days on the pathway.
- Skin have implamented recovery plans which has seen implementation of telederm and builds both triage and excision capacity.
- The 28 Day Faster Diagnosis position is currently 67.4% for December, an increase on the performance from 58.8% in November. This standard will be a focus of an Improving together project covering all pathways.
- Two week wait performance is now boking within standard at 13 days.
- Cancer will form a workstream as part of the Planned Care governance structure – this will initially focus

on our challenged pathways of Skin and Colorectal, alongside 2WW and FDS more generally.
- The Trust remains in Tier 2 for cancer performance with weekly meetings with the Regional NHSE team.

Planned Care
- Day Case activity and Elective Activity have moved from delivering 96% and 88% respectively in November to 92% and 93% in December. This is still some way from the national ask of 110%/108%. This is against a backdrop of increase cancelations. There is a real focus on the reintroduction of 6-5-4 with support from the regional theatres team.
- Theatre transformation has been added as an additional workstream under Planned Care and begins with a focus on the 6-4-2 booking process with support from the regional theatres team. This is in discussion as a driver for the surgical Improving together programme.
- The focus has moved to 78 week waiters and the Trust Annual Plan submitted an initial position of 292 patients by March 2023, the National ask is to achieve 0 patients waiting over 78 weeks by the end of March. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge well before March so any treatment can be carried out to meet the 78 week standard. 78+ patients have been gradually reducing, but had reached a plateau in November at 725. This has increased in December to 863, due to winter pressures in combination with industrial action. The trust is no longer on trajectory to eliminate 78 weeks waits by end of March 2023. Plans are in place to minimise the number of breaches, so that only patients who choose not to be treated before end of March or who have a highly complex case are still waiting at 78+ weeks.

RTT
- The overall Referral To Treatment (RTT) Waiting has slightly increased from 77,727 in November to 77,750 in December (unvalidated).
- The number of patients > 52 weeks continues to increase – from 4377 in August, 4,569 in September, 4628 in October, 4927 in November and 5429 in December.
- At the end of December the numbers of > 104 weeks was 50. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment.
- The Trust remains in Tier 2 for 104> performance with weekly meetings with the Regional NHSE team.

Diagnostics
- Overall DM01 performance was 61%, an decrease in performance on last months 62%.
- Within DM01, the greatest proportions of > 6 week waits are within Non-obstetric ultrasound and endoscopy. Both ultrasound and endoscopies positions are related to an increase in demand alongside workforce shortfalls
- Full DM01 recovery plan agreed which sees the Trust achieving 6ww by end March 2023 in line with national requirement; this will be monitored through the planned care group.Key risk has been identified in endoscopy with weekly performance meetings instigated for the specialty and a risk to the March delivery target. There is now a challenge to the recovery of non obstetric ultrasound and we are now having weekly performance improvement meetings which Endoscopy and Imaging. This is the same process followed with LGI and Skin in the cancer pathways.
- Radiology backlog of reporting risk remains.
- Activity across key modalities up against previous month activity. Incentive schemes starting to improve activity (non-obs ultrasound notably)

Workforce

Key messages

- Our two main areas of focus continue to be on addressing staff availability in relation to high absence rates and turnover.
- The 12m Turnover rate in December 2022 reduced to 10.3% and this the 3rd month that this figure has sat below the trust target of 11%. However, the overall vacancy rate has increased to 14.1%

due to an increase in budgeted establishment.

- For December 2022, the in-month sickness rate increased by 1.4% to 6.71% (5.24% in November 2022). The 12-month cumulative rate marginally increased to 6.25% (6.24% in November 2022).
- Chest and respiratory (which includes Covid) remains top at 26.2%, closely followed by Anxiety and Stress at 22.0%.
- Focusing specifically on Covid related absence by 1 January 2023 covid-related absences stood at 101, which was 12.11% of the 834 open absences. This is 1.6.% increase on same time the previous month.
- The appraisal (PDR) rate has increased by 1% to 79.5%. For PDRs, divisions continue to report that due to increasing operational pressures, management time has been reduced and alongside reported high levels of sickness absence and vacancies. Divisions have been asked to review key issues and provide actions to work towards meeting target. The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance and making the process enhance employee experience.
- We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory
- The National Staff Survey 2022 closed November, and the final response rate was 33.24% putting the trust under average response for an acute setting of 45.55%. The Staff Voice trust survey for December received a total of 207 submissions providing an overall engagement score of 6.59.
- Internal measures to monitor reduction is agency expenditure continue. Divisional targets for agency ceilings have been calculated. As part of the monitoring divisions were asked to present an update on their action plan to reduce expenditure to Executive Workforce Assurance Group (EWAG).
- Chartered Society of Physiotherapists (CSP) Industrial action will take place on the 9 February, our EPRR team continue to plan for any action that takes place.

Finance

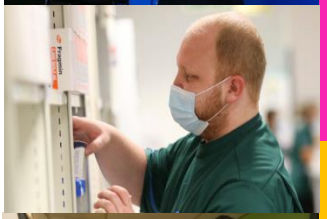
Key elements of the financial performance year to date are:

- For the year to date the Trust has delivered an actual surplus of £0.7m against a planned surplus of £3.3m; this is primarily driven by underperformance against the Trust's in year CIP target.
- The Trust incurred £0.5m of costs relating to COVID-19 in month; with £0.4m of this being chargeable for COVID-19 testing costs. The Trust has overspent by £2.9m against its original in envelope allocation due to the in envelope funding allocation ceasing after Month 2.
- To date the trust has validated £9.3m CIP savings in year; these schemes have a full year impact of £5.3m, which presents a considerable variance to the Trust's recurrent target of £13.6m which was identified as a key risk in the Trust's financial plan submission.
- Capital expenditure in Month 9 is £29.4m which is 5.8m behind the plan of £35.1m. Of the expenditure to date £10.7m is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 9 is £97.3m, which is £24.3m higher than plan. Cash received is above plan due to Capacity and Virtual Ward income received from the ICB.
- The Trust has carried out a forecast for the year based on the actual position at Month 8; this forecast is for a £6.6m deficit before mitigations and has improved by £2m from the forecast at Month 7. It is likely that the Trust can deliver a breakeven position for the year although this is likely to be dependent on further non-recurrent mitigations.
-

Key Recommendations

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

NHS
University Hospitals of North Midlands
NHS Trust



Integrated Performance Report

Month 9 2022/23

Delivering Exceptional Care with Exceptional People

Contents

Section		Page
1	Introduction to SPC and DQAI	3
2	Quality	5
3	Operational Performance	17
4	Workforce	52
5	Finance	58

A note on SPC

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

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

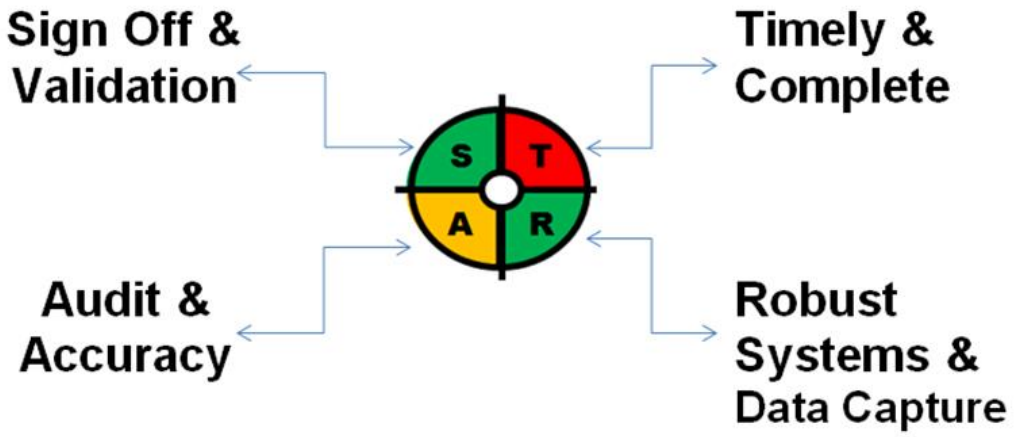
Assurance - how assured of consistently meeting the target can we be?

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

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

A note on Data Quality

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



Explaining each domain

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

RAG rating key

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

NHS
University Hospitals of North Midlands
NHS Trust

Quality

Caring and Safety

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

Quality Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

The Trust achieved the following standards in December 2022:

- Friend & Family (Inpatients) 96.6% and exceeds 95% target.
- Harm Free achieved 96.5% against 95% target rate
- 0 Never Event
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.5% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- E. Coli Bacteraemia cases on trajectory with 16 in December compared to target of 16.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- Inpatients Sepsis Screening above 90% target rate at 91.45%.
- Inpatient Sepsis IVAB within 1 hour achieved improved to 91.7% and above 90% target rate
- Children's Sepsis Screening compliance improved to 90.9% and above the 90% target.
- Maternity IVAB compliance improved to 100% and above the 90% target for audited patients
- HSMR is lower than benchmark.

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E remains below 85% target at 63.5%
- Friend & Family (Maternity) improved to 66.7% but remains below 95% target.
- Falls rate was 6.0 per 1000 bed days for December 2022
- There were 37 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 80% verbal Duty of Candour compliance recorded in Datix
- 21% compliance with Duty of Candour 10 working day letter performance following formal verbal notification and under review for completion and upload of letter on Datix
- C Diff YTD figures above trajectory with 14 against a target of 8.
- Sepsis Screening compliance in Emergency Portals reduced to 78% below the target 90%.
- Emergency Portals Sepsis IVAB in 1 hour decreased to 59% and remains below the 90% target for audited patients
- Maternity Sepsis Screening compliance improved to 80% against 90% target

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

- The rate of complaints per 10,000 spells is 17.46 and is below the target of 35 and within normal variation. Majority of complaints in December 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents increased in month (1914) and the rate per 1000 bed days has also decreased at 47.07
- Total incidents with moderate harm or above and the rate of these incidents are above upper control limits and outside normal variation levels. These increase are following increased pressures within the Emergency Departments
- Rate of falls reported that have resulted in harm to patients currently at 1.38per 1000 bed days in December 2022. The rate of patient falls with harm continues to be within the control limits and normal variation.
- Medication related incidents rate per 1000 bed days is 5.4 and patient related 4.6 which are higher to previous month and mean rates. The monthly variation is within the normal expected variation and consistent with Trust mean rates.
- Pressure Ulcers per 1000 bed days developed under UHNM care has seen a increase during December 2022
- Hospital Associated Thrombosis is within outside variation.
- Increased numbers of Definite Hospital Onset / Nosocomial COVID-19 cases reported in December 2022 with 69 in total.
- 5 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 8 Serious Incidents reported during December 2022.
- SHMI has seen increases and under review for diagnosis groups but is within expected range (see funnel plot chart)

Quality Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1947	1914	H	
Patient Safety Incidents per 1000 bed days	50.70	47.91	47.07		?
Patient Safety Incidents per 1000 bed days with no harm	N/A	20.74	25.73	L	
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.47	12.17		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.17	2.17		
Patient Safety Incidents with moderate harm +	N/A	32	52	H	
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.79	1.28	H	
Harm Free Care (New Harms)	95%	96.1%	96.2%		?
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		?
Patient Falls per 1000 bed days	5.6	6.2	6.0		
Patient Falls with harm per 1000 bed days	1.5	1.3	1.4		?
Medication Incidents per 1000 bed days	6	4.7	5.1		?
Medication Incidents % with moderate harm or above	0.50%	1.13%	1.02%		?
Patient Medication Incidents per 1000 bed days	6	3.9	3.9		F
Patient Medication Incidents % with moderate harm or above	0.50%	1.37%	1.32%		?

Metric	Target	Previous	Latest	Variation	Assurance
Serious Incidents reported per month	0	12	8		F
Serious Incidents Rate per 1000 bed days	0	0.30	0.20		F
Never Events reported per month	0	0	0		?
Duty of Candour - Verbal/Formal Notification	100%	91%	80%	L	?
Duty of Candour - Written	100%		21.0%	L	?
All Pressure ulcers developed under UHNM Care	TBC	51	49		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	2.58	1.65		
All Pressure ulcers developed under UHNM Care lapses in care	12	12	17		?
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.3	0.39		?
Category 2 Pressure Ulcers with lapses in Care	8	1	2		?
Category 3 Pressure Ulcers with lapse in care	4	0	0		?
Deep Tissue Injury with lapses in care	0	5	9		
Unstageable Pressure Ulcers with lapses in care	0	2	1		?

Delivering Exceptional Care with Exceptional People

Quality Dashboard

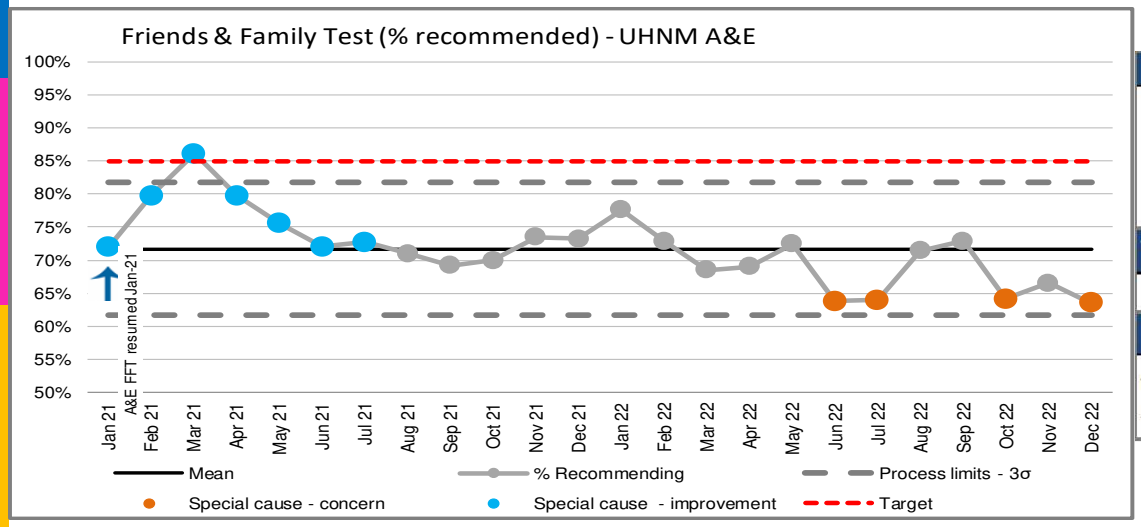
NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	66.5%	63.5%	L	F
Friends & Family Test - Inpatient	95%	99.0%	98.0%		P
Friends & Family Test - Maternity	95%	100%	100.0%		
Written Complaints per 10,000 spells	21.11	19.12	23.24		?
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	98.44	94.77		P
Rolling 12 Month SHMI (4 month time lag)	100	103.22	105.20	H	?
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	3	5		
VTE Risk Assessment Compliance	95%	99.6%	98.9%		
Reported C Diff Cases per month	8	11	14		?
Avoidable MRSA Bacteraemia Cases per month	0	0	0		?
HAI E. Coli Bacteraemia Cases per month	8	13	18		?
Nosocomial "Definite" HAI COVID Cases - UHNM	0	34	69		

Metric	Target	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	96.5%	91.4%		?
Inpatient IVAB within 1hr (Contracted)	90%	89%	91.7%	L	P
Children Sepsis Screening Compliance (All)	90%	96%	90.9%		?
Children IVAB within 1hr (All)	90%	N/A	N/A	H	P
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	84%	78.3%	L	?
Emergency Portals IVAB within 1 hr (Contracted)	90%	68%	59.3%	L	?
Maternity Sepsis Screening (All)	90%	75%	80.0%	H	F
Maternity IVAB within 1 hr (All)	90%	67%	100.0%	H	F

Delivering Exceptional Care with Exceptional People

Friends & Family Test (FFT) – A&E



Variation	Assurance
L	F

Target	Oct 22	Nov 22	Dec 22
85%	64.1%	66.5%	63.5%

Background

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

What do the results tell us?

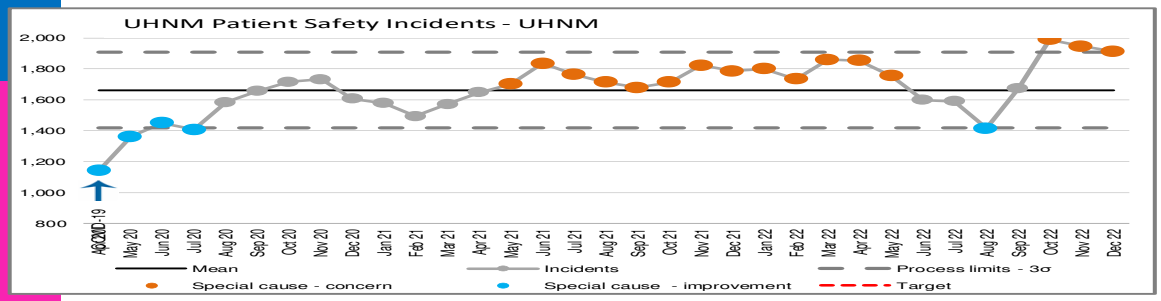
- The satisfaction rate for ED remains below our internal target at 63.5% for December 2022, and is a decrease on previous months. The Trust received 1126 responses which is a slight increase on the previous month with a 12% response rate for overall. The Trust's overall satisfaction rate is significantly lower than the national average of 75% (Nov 22 NHS England).
- Feedback from patient experience of using 111First and the kiosks is being monitored. 34% of respondents in December 2022 used 111First prior to attending ED, which is a 7% increase on November 2022. Satisfaction score of patients using 111First was 49% for December 2022 which is a decrease on the previous month and is lower than the overall satisfaction rate for ED attendees.

Actions :

- Themes from patient feedback remain the same and are around wait times, staff attitude and access to pain relief. Meeting with ED team and Division Senior Team week commencing 30.01.2023 to confirm actions further actions to try and improve response scores based on feedback and themes.
- Volunteer in ED supporting with refreshment rounds is also going hand out paper copies of the survey.
- Patient Experience Team are waiting for dates from ED management regarding their patient experience meetings and have also extended the invite to Trust Patient Experience Group meetings for an ED representative to attend.

Reported Patient Safety Incidents

University Hospitals of North Midlands NHS Trust

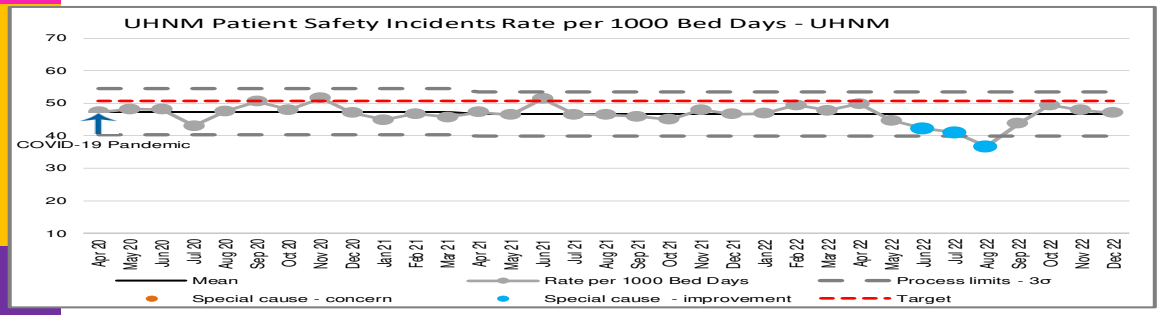


Variation	Assurance
H	

Target	Oct 22	Nov 22	Dec 22
N/A	1990	1947	1914

Background

Total Reported patient safety incidents



Variation	Assurance
	?

NRLS Mean	Oct 22	Nov 22	Dec 22
50.70	49.41	47.91	47.07

What is the data telling us:

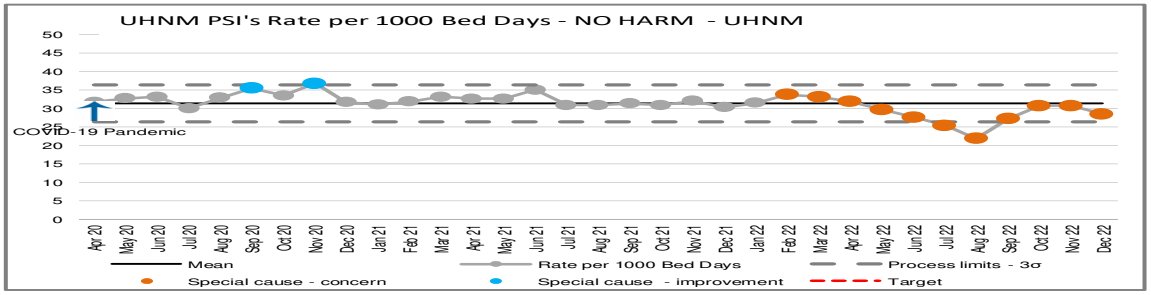
The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The December 2022 total is above the mean total since COVID-19 started. However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total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

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

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

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

NHS
University Hospitals of North Midlands
NHS Trust

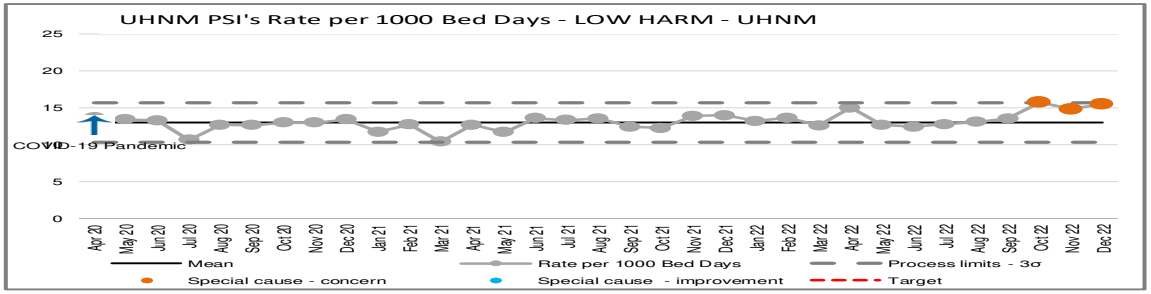


Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
N/A	30.66	30.71	28.45

Background

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

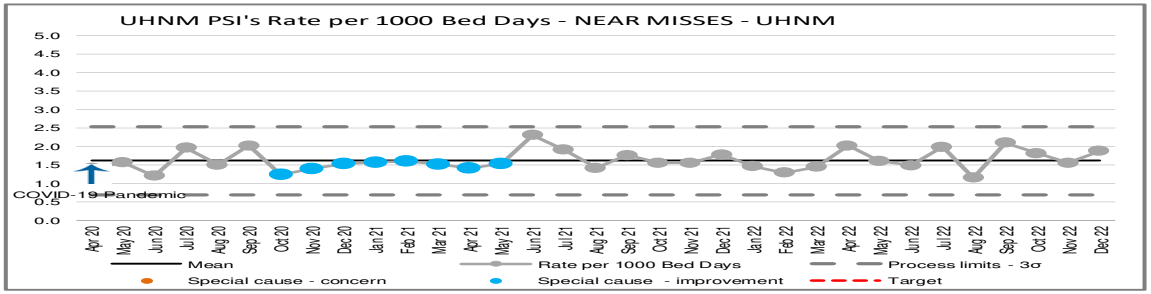


Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
N/A	15.74	14.84	15.47

Background

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



Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
N/A	1.81	1.55	1.87

Background

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

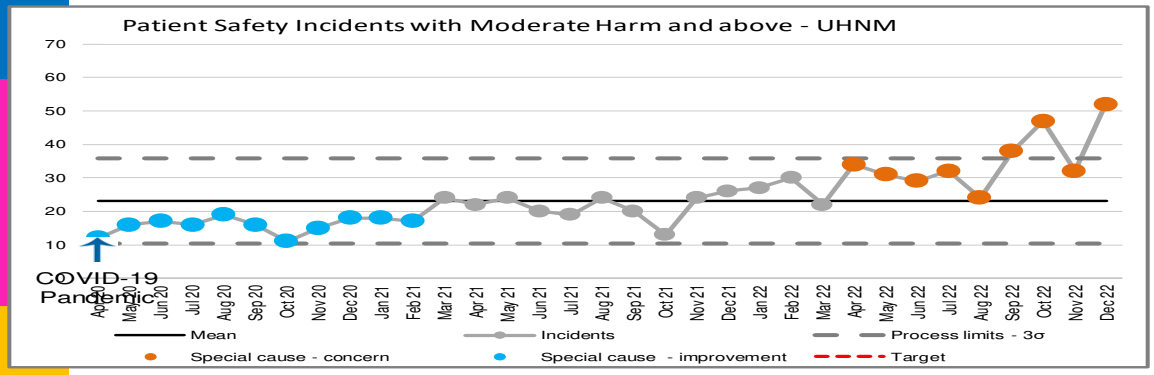
What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with low harm or near misses are showing more consistent trends. The low harm incidents are near the upper control limit hence the higher variation indicator. The no harm incidents have seen reductions in last 2 months. These are no clear reasons for change in no harm except for increase in rate of near misses.

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

Reported Patient Safety Incidents with Moderate Harm or above

NHS
University Hospitals of North Midlands
NHS Trust

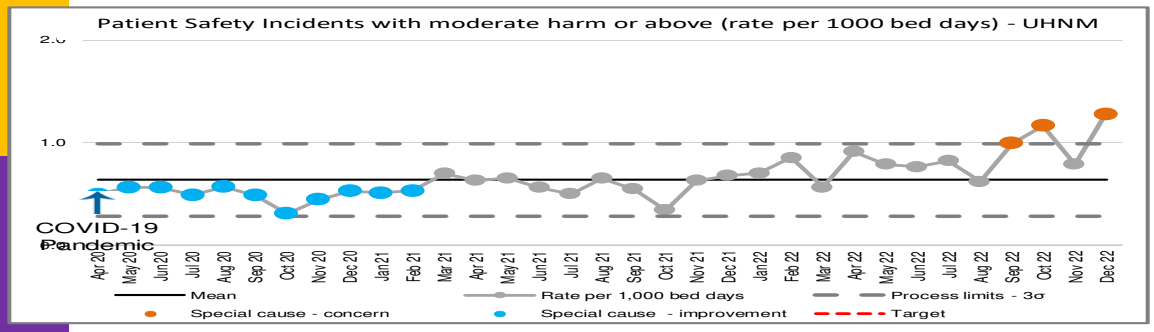


Variation	Assurance
H	

Target	Oct 22	Nov 22	Dec 22
N/A	47	32	52

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance
H	

Target	Oct 22	Nov 22	Dec 22
N/A	1.17	0.79	1.28

What is the data telling us:

The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is above the upper process control limit and has shown increasing total numbers during the last 4 months since August 2022. December 2022 total is above the November 2022 total. The rate of incidents with moderate harm has also increased.

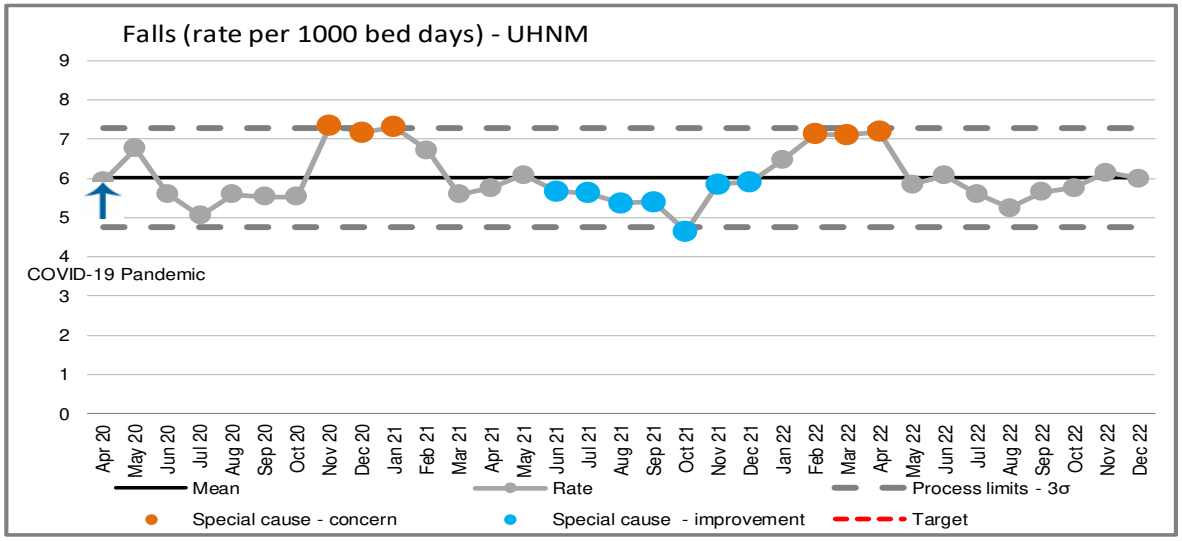
The reason for the increased totals are linked to increased numbers of moderate harm incident being reported during December 2022 in Emergency Department, Acute Medicine and General Medicine as the operational pressures have increased across the organisation and health system.

patient related falls and also Pressure Ulcer related incidents.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 13 Patient Flow (due to the exception operational pressures in ED), 9 Falls, 5 Medication,6 Clinical Assessment, Treatment/procedure, 5 Pressure Ulcer (hospital acquired), 4 treatment related

Patient Falls Rate per 1000 bed days

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
N/A	5.8	6.2	6.0

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

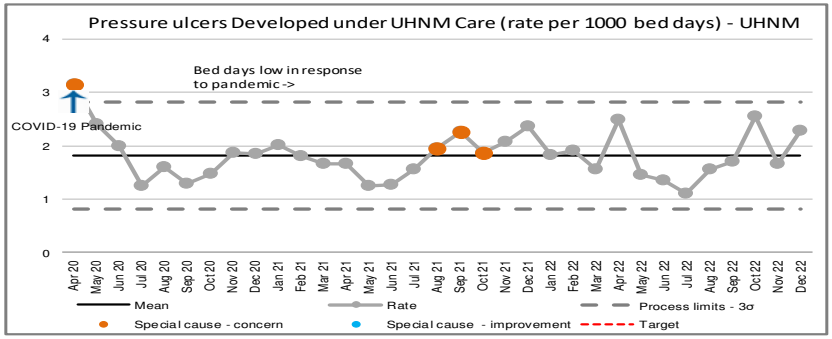
The Trust's rate of reported patient falls per 1000 bed days was within the normal range in December.

The areas reporting the highest numbers of falls in December 2022 were:
Royal Stoke AMU – 22 falls, Royal Stoke ED – 17 falls, County AMU – 10 falls, FEAU – 9 falls

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

- Audits continue to take place on the TOP 5 reporting areas and support with multiple fallers has been provided.
- A new falls champion day and a new nursing assistant session training has taken place.
- FEAU falls have increased since locating to ward 210. The layout of the ward and the increased side rooms makes observation of the patient and cohorting the patients more difficult (previously 25 beds including 3 side rooms, now 29 beds including 9 side rooms.
- Patients with falls risk factor that require a side room are placed nearest to the nursing station
- Patients requiring enhance observations have MCA and DoLS application completed and extra staff requests submitted to Matron
- Staffing establishment is under review
- There have been no multiple fallers on FEAU and falls audit on 04.01.2023 carried out and fedback to ward
- There has been 1 SI reported, unfortunately this lady was in the process of being discharged and lost her balance when placing on her shoes.
- Audits continue on ECC and AMU across both the Stoke and the County site.

Pressure Ulcers developed under care of UHNM per 1000 bed days

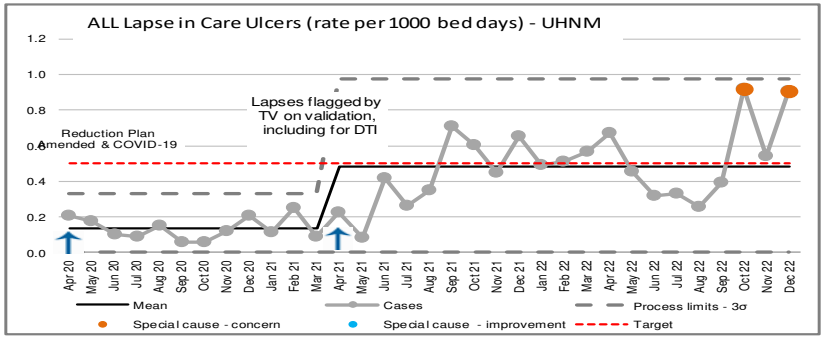


Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
N/A	2.56	1.67	2.29

Background

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



Variation	Assurance
H	?

Target	Oct 22	Nov 22	Dec 22
0.5	0.92	0.54	0.91

Background

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

What the data is telling us

The rate of pressures ulcers reported as developed under UHNM care remains within expected limits for December, but the rate of ulcers with lapses in care was significantly above average.

Acuity for ward areas is taken into account in line with lapses in care.

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

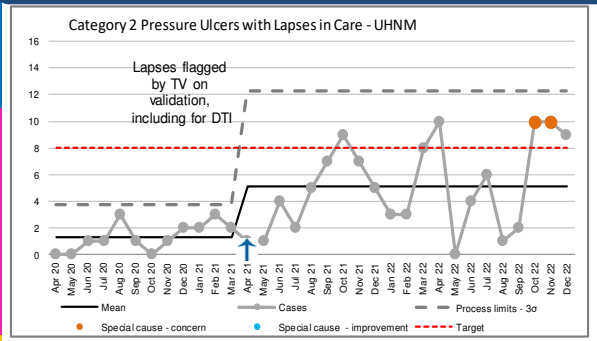
Pressure Ulcer prevention is an annual objective and a key driver metric as part of the Trust's Improving Together programme.

Actions

- Training continues for PUP champions, nursing assistants and on ED statutory and mandatory training days and bespoke on request.
- Categorisation training dates have now been confirmed for this year. Training has now been provided to registered nurses and nursing assistants through nurse bank.
- ESR training request made for prevention, awaiting confirmation
- Training video has been made for care of catheters after an increase in urethral damage, along with the catheter life chart being updated and plans to re-launch
- Tendable has now been launched at County, ED and AMU, and the west building for pressure ulcer prevention questions have been included.

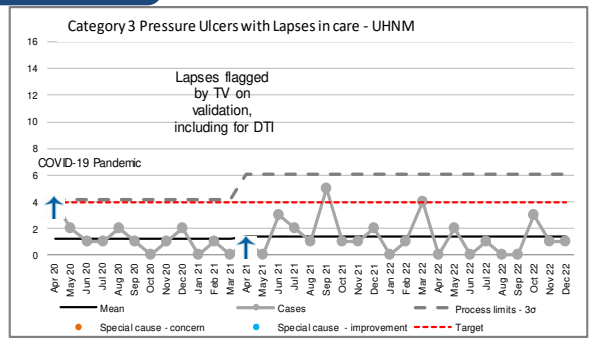
Pressure Ulcers with lapses in care

NHS University Hospitals of North Midlands NHS Trust



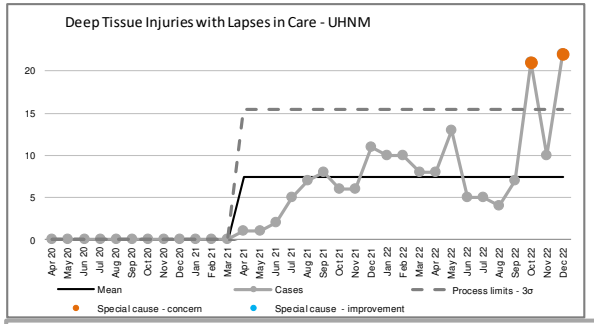
Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
8	10	10	9
Background			



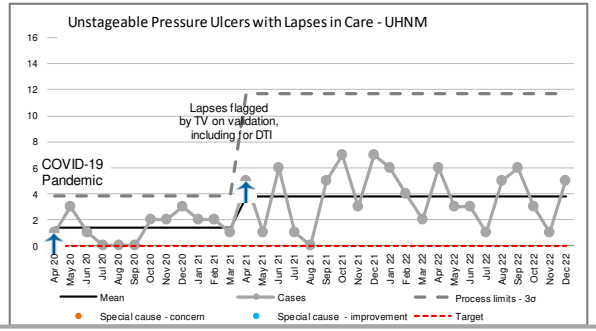
Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
4	3	1	1
Background			
Category 3 pressure ulcers which developed under the care of UHNM with lapses in care associated			



Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
N/A	21	10	22
Background			
Deep Tissue Injuries which developed under the care of UHNM with lapses of care associated			



Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
0	3	1	5
Background			
unstageable ulcers which developed under the care of UHNM with Lapses in care associated			

What is the data telling us:

The number of DTI's reported as developing under UHNM care with identified lapses in care was significantly above average in December. Numbers in other categories are showing only normal variation for December. As shown in the table below, the most common lapses identified were management of heel offloading & repositioning.

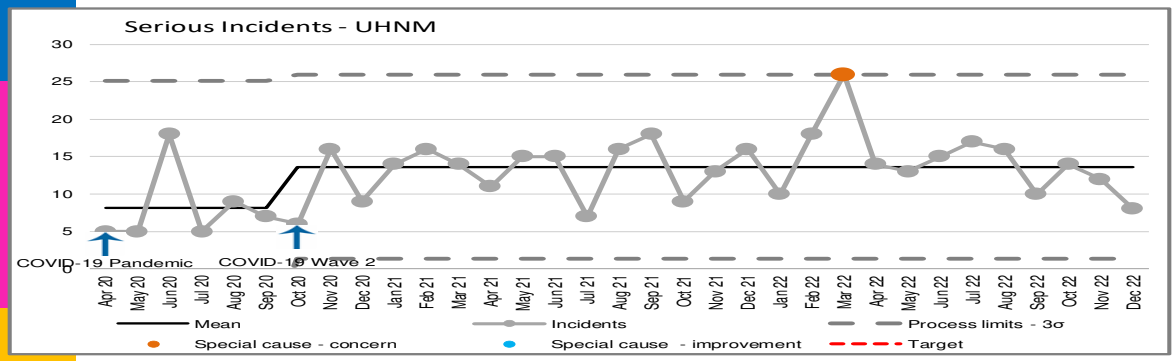
Root Cause(s) of damage - Lapses - Dec 2022	Total
Management of heel offloading	20
Management of repositioning	19
Management of device	2
Management of non-concordance	1
Clinical condition	1

Locations with more than 1 lapse in December 2022 were:
ED (Stoke) (7) , AMU (Stoke) (3) , FEAU(2) , Ward 14 (2) , Ward 106/7 (2) , Ward 123 (2)

Actions:

- Met with Supplies and procurement to ensure AMU have adequate stock of utility pads for heel offloading
- Ongoing AMU audits of documentation fed back to ward manager and AP mattresses supplied. Staff support being offered
- Support given to ED regarding use of Repose Companions
- Plans are now in place for the continuation of RCA panels as pressures continue. Plan are underway to alien investigation process with PSIRF
- High reporting wards will be sent notification, with audits and action plans to be implemented to support improvement
- Wards are invited to RCA panels to focus on improvements and learning, to focus on the lapse identified. Support is being offered to wards along with assurance visits following panels. Wards are being asked for feedback on the RCA process for adjustments and/or improvements to be made

Serious Incidents per month

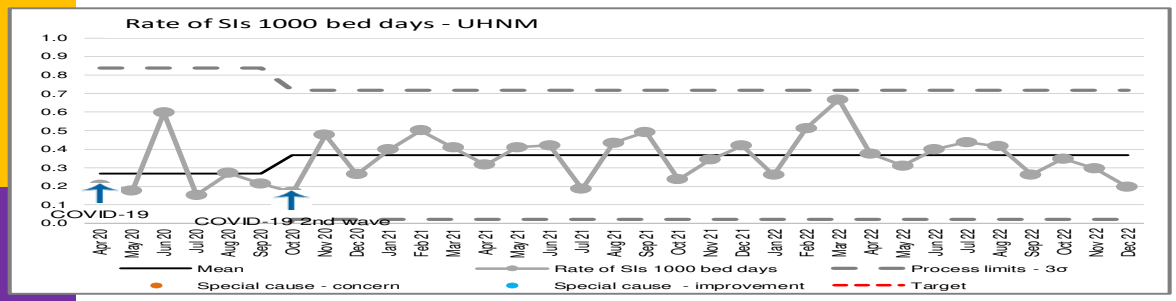


Variation	Assurance

Threshold	Oct 22	Nov 22	Dec 22
0	14	12	8

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
0	0.35	0.30	0.20

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

Monthly variation is within normal limits. Target has been set at 0 for serious incidents but this remains under review to develop trajectory for reducing serious incidents across UHNM. December 2022* saw 12 incidents reported:

5 Falls related incidents

1 Diagnostic related

1 Maternity/Obstetric incident (baby only)

1 Treatment delay related

The rate of SIs per 1000 bed days has varied consistently within confidence limits indicating normal variation and there has not been any significant trends. The current rate of SIs per 1000 bed days for December 2022 is 0.20 and is lower than the long term mean of 0.4 since COVID-19 started in December 2020.

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

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

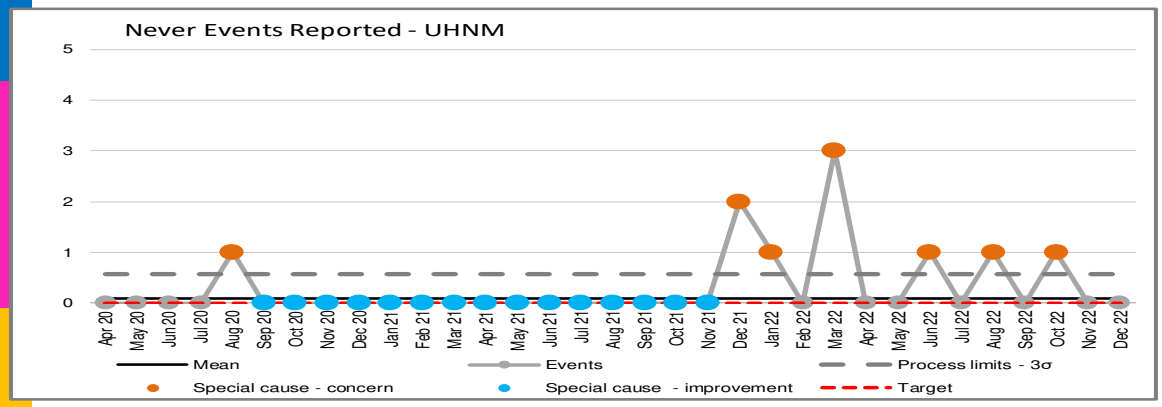
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during November 2022. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

There was 1 Maternity related Serious Incidents reported on STEIS during December 2022

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2022/26955	White British	Maternity/Obstetric incident (baby)	14/03/2023	Reporting SI following review and potential for learning due to unexpected and extraordinary nature of the outcome. Baby born in difficult circumstances (impacted fetal head at 34 weeks following Caesarean Section). Unfortunately baby later passed away

Never Events



Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
0	1	0	0

Background

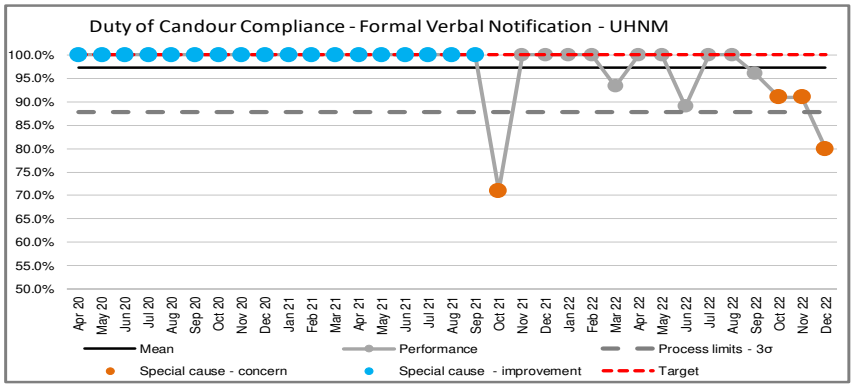
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

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

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

Duty of Candour Compliance

NHS University Hospitals of North Midlands NHS Trust

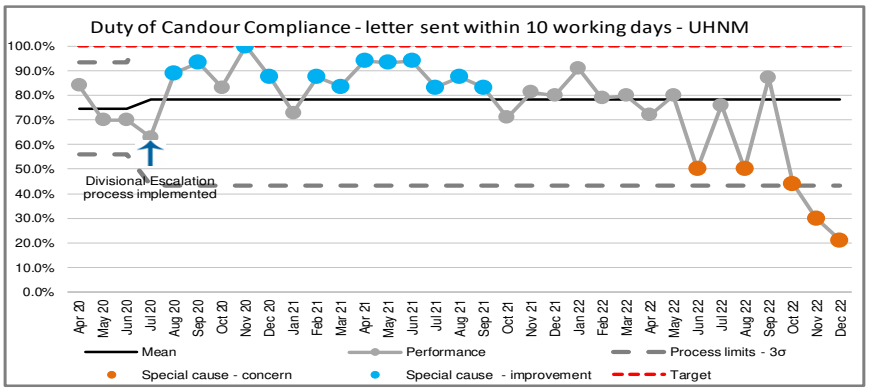


Variation	Assurance
L	?

Target	Oct 22	Nov 22	Dec 22
100%	91.0%	91.0%	80.0%

Background

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



Variation	Assurance
L	?

Target	Oct 22	Nov 22	Dec 22
100%	44.0%	30.0%	21.0%

Background

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

What is the data telling us:

During December there were 38 incidents reported and identified that have formally triggered the Duty of Candour. 80% have recorded that the patient/relatives been formally notified of the incident in Datix.

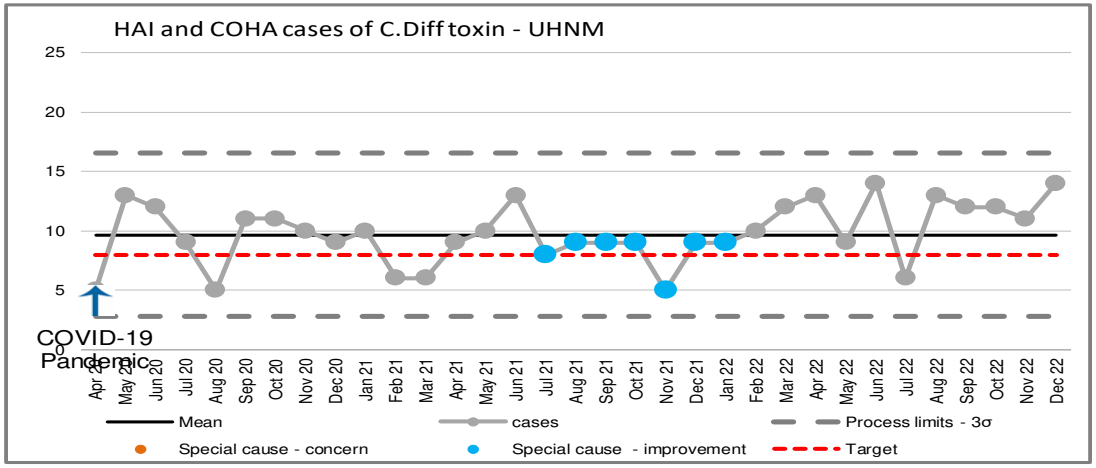
Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification **and recorded in Datix**) during December 2022 is 21% as 6th January 2023 including those letters that are still within timescale. Outstanding letters / information uploaded to Datix has been escalated with individual wards/departments and via Directorate/Divisional structures.

Actions taken:

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

Emergency Medicine have agreed all Duty of Candour correspondence is now copied to Divisional Quality & Safety Manager to support the clinicians with uploading and updating on Datix to evidence Duty of Candour completed especially during the continued increased extraordinary operational pressures. Compliance is included in Divisional reports for discussion and action.

Reported C Diff Cases per month



Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
8	12	11	14

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

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

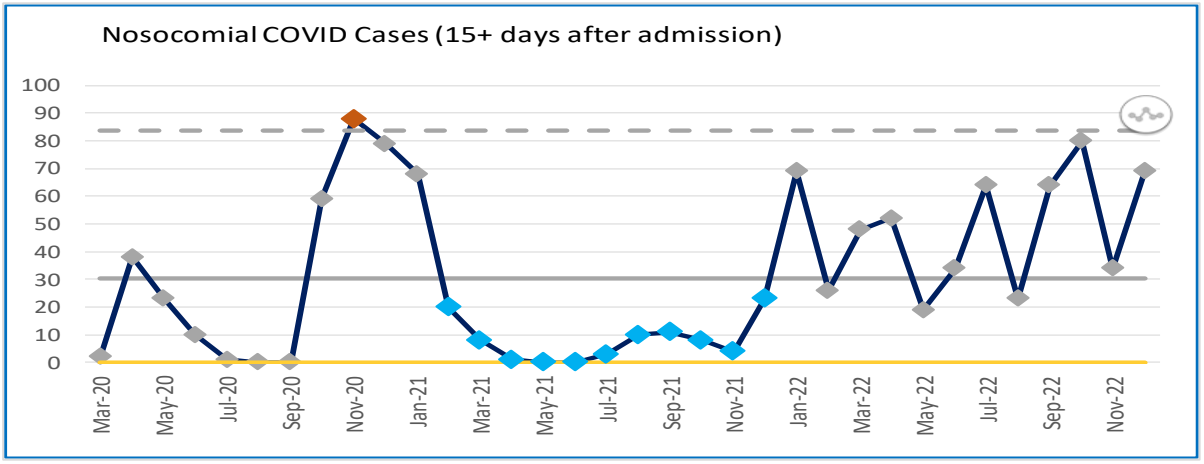
There have been 14 reported C diff cases in December with 11 being Hospital Associated Infection (HAI) cases and 3 COHA cases.

HAI: cases that are detected in the hospital three or more days after admission (day 1 is the day of admission)
COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
There have been two clinical area that have had more than one Clostridium *difficile* case in a 28 day period. Ribotyping results have only been reported on 4 of the 5 cases involved to date all of which are different to each other.

Actions:

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

HAI Nosocomial COVID Cases per Month



What do these results tell us?

- Increase in cases throughout December 2022 with 69 definite Healthcare Acquired COVID -19 cases.
- Monthly total is within normal variation
- Follows national profile for increasing cases within the community during December 2022
- COVID screening guidance changed 14/09/2022. Patients only swabbed on admission if being admitted to high risk area, immunocompromised or symptomatic for COVID. Otherwise patients are now not routinely screened.

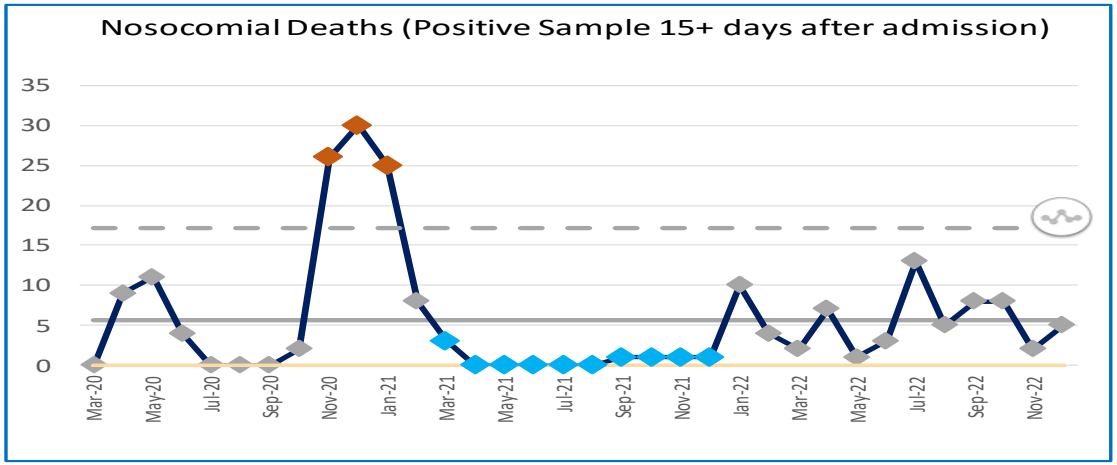
Actions :

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

	UHNM		
	Total Admissions	COVID cases	
		Prob	Def
Dec 20	14701	107	79
Jan 21	14255	128	68
Feb 21	14101	31	20
Mar 21	17105	12	8
Apr 21	16554	3	1
May-21	17273	0	0
Jun-21	18527	0	0
Jul-21	18168	4	3
Aug-21	17160	14	10
Sep-21	17327	11	10
Oct-21	17055	8	8
Nov-21	17700	4	4
Dec-21	16688	13	23
Jan-22	16109	67	69
Feb-22	16278	39	26
Mar-22	18518	71	48
Apr-22	16538	72	52
May-22	18484	14	19
Jun-22	18380	34	34
Jul-22	17983	45	64
Aug-22	18247	16	24
Sep-22	18279	58	64
Oct-22	18351	81	80
Nov-22	19607	29	34
Dec-22	18240	78	69

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

University Hospitals of North Midlands NHS Trust



What do these results tell us?

Increase in monthly total but within normal variation limits

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

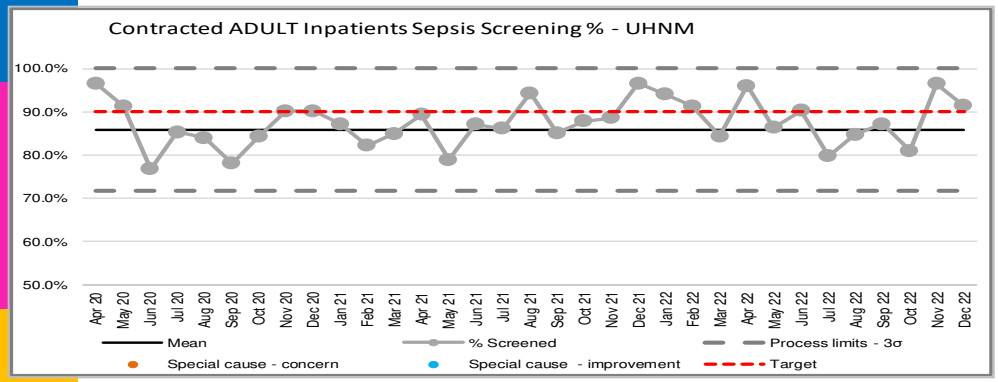
- 5 recorded definite hospital onset COVID-19 deaths in December 2022
- Total 188 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since 1st March 2020 up to 31st December 2022
- 53 Definite Hospital acquired COVID-19 deaths during 2022/23 YTD
- The mean number of deaths per month since March 2020 is 6.

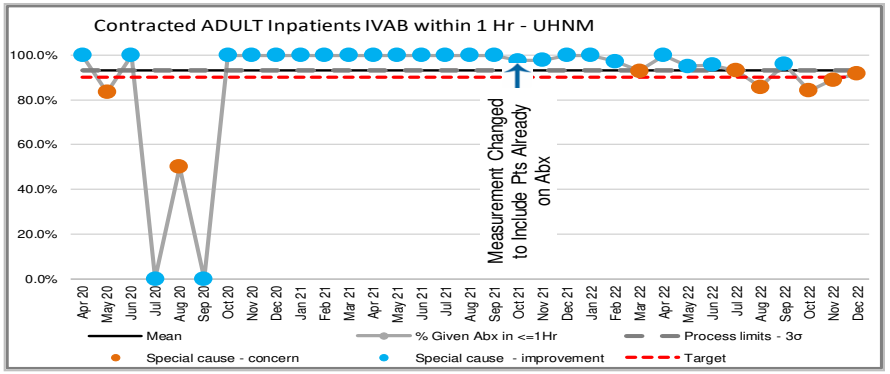
Actions :

Nosocomial COVID-19 deaths are continuing to be reviewed via the COVID Nosocomial Review Panel and updated report is due to be presented to Mortality Review Group identifying the outcome of the case reviews assessing the aspects of COVID-19 management of the patients in January 2023.

Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust





Variation	Assurance
	

Target	Oct 22	Nov 22	Dec 22
90%	81.0%	96.5%	91.4%

Background

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

Variation	Assurance
	

Target	Oct 22	Nov 22	Dec 22
90%	84.2%	88.9%	91.7%

Background

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

What is the data telling us:

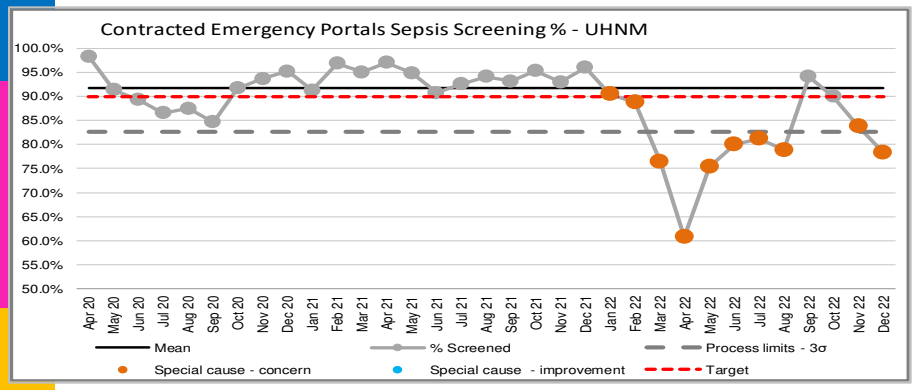
Inpatient areas achieve both the screening & IVAB within 1 hour target in December 2022. There were 93 cases audited with 8 missed screening from different ward areas or divisions. Out of 93 cases audited, 57 cases were identified as red flags sepsis with 33 cases have alternative diagnosis and 24 cases were true red flags. Out of 24 true red flags cases, 22 were already on IVAB treatment, 2 delayed treatment in which given above two hours (one each from Medicine and Network Division).

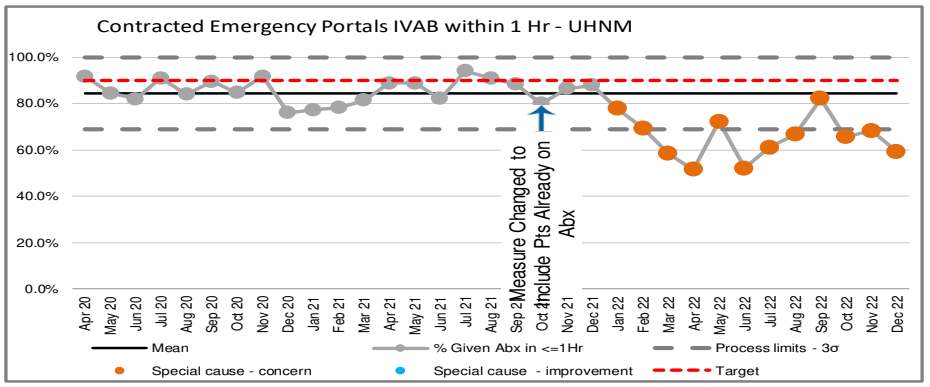
Actions:

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

Sepsis Screening Compliance (Emergency Portals Contract)

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
L	?

Target	Oct 22	Nov 22	Dec 22
90%	90%	84%	78%

Background

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

Variation	Assurance
L	?

Target	Oct 22	Nov 22	Dec 22
90%	66%	68%	59%

Background

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

What is the data telling us:

Adult Emergency Portals screening has not met the target for December 2022. There were 46 cases audited (to be updated on next report) with 10 missed screening in total from 6 of the emergency portals.

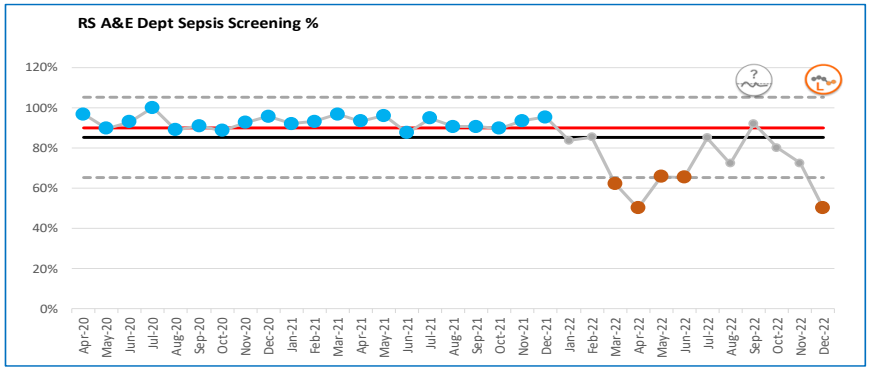
The performance for IVAB within 1hr below target rate in December 2022 is at 59%. Out of 46 cases, there were only 36 red flags sepsis in which the 9 cases already on IVAB, 27 cases were newly identified sepsis and 9 cases have alternative diagnosis. There were 11 delayed IVAB with 6 cases delayed within 2 hours and 5 cases above 2 hours. Delayed IVAB within 1 hour and screening, mainly contributed by both ED Royal Stoke and County fro this month.

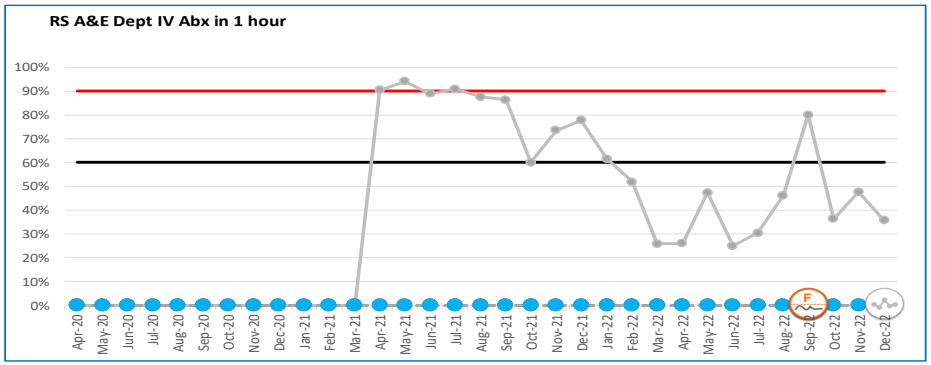
Actions:

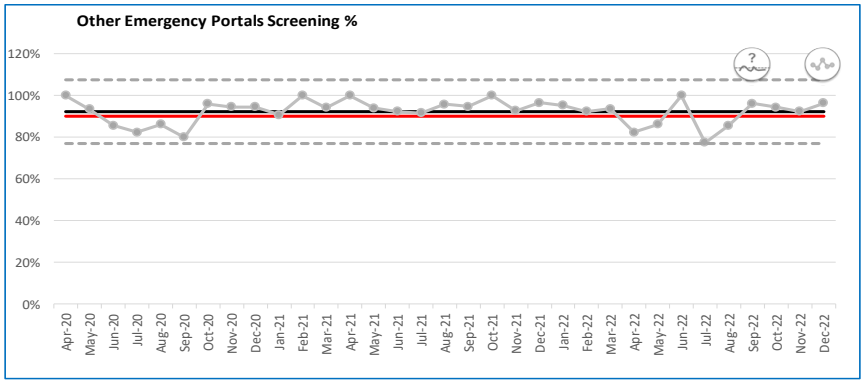
- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E regularly. Provide sepsis session when staffing and acuity allows
- The Sepsis team is working collaboratively with the A&E Quality nurses, sepsis champions, senior team and A&E sepsis clinical lead to provide support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

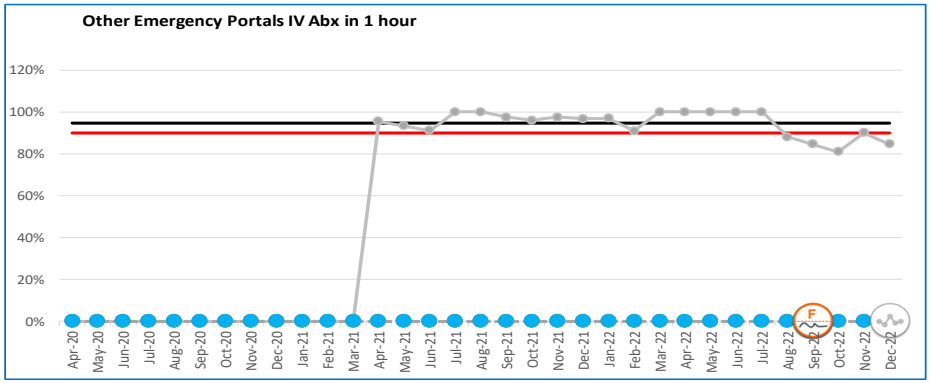
Sepsis Screening Compliance (Emergency Portals RSUH ED & Other Portals)

NHS University Hospitals of North Midlands NHS Trust









What is the data telling us:

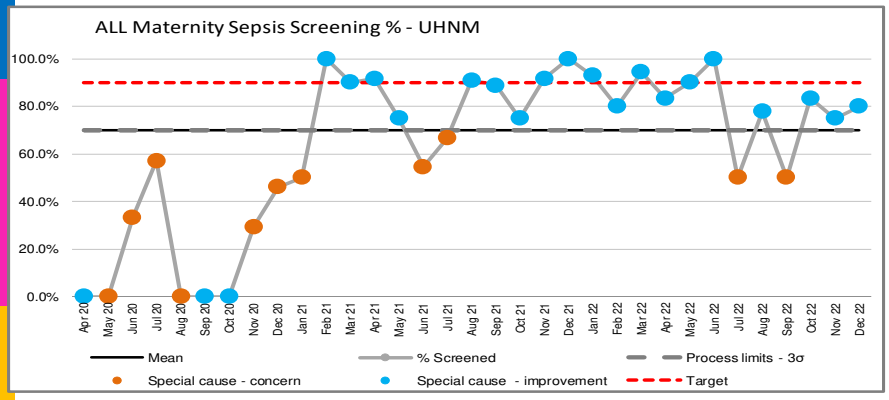
RSUH Emergency Department performance since February 2022 has been below target rate and compliance is significantly lower than control limits. The RSUH ED is driving the overall Emergency Portals performance as other emergency portals are achieving Screening compliance but slightly below target for IVAB in hour target.

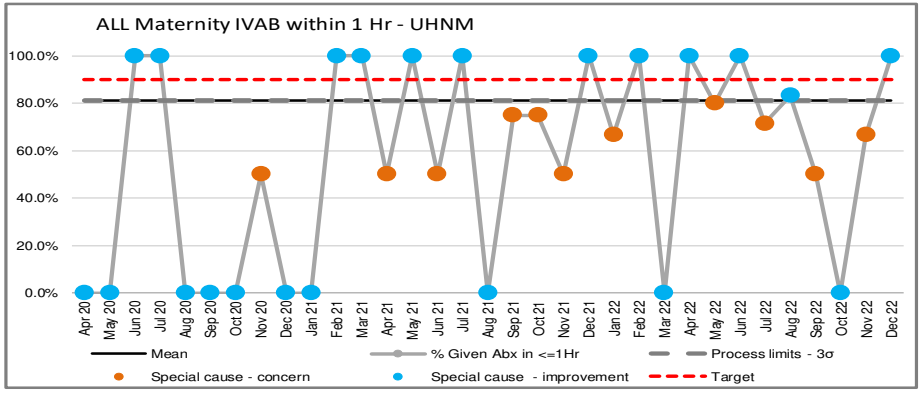
Actions:

Medicine Division Senior Team are meeting with Emergency Department to identify support and actions to improve performance

Sepsis Screening Compliance ALL Maternity

University Hospitals of North Midlands NHS Trust





Variation	Assurance
H	F

Target	Oct 22	Nov 22	Dec 22
90%	83.3%	75.0%	80.0%

Background

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

Variation	Assurance
H	F

Target	Oct 22	Nov 22	Dec 22
90%	N/A	67%	100%

Background

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

What is the data telling us:

Maternity audits in screening compliance is below the target at 80% but IVAB within 1 hour is reported at 100% during December 2022 randomise audits (audit report will be further updated). This compliance score is based on a very small number, however a regular spot checks audit is being conducted monthly.

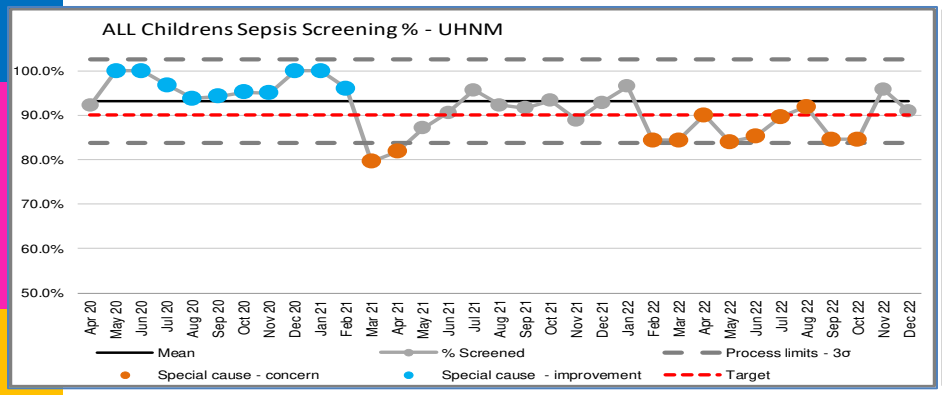
There were only a total of 5 cases audited from emergency portal (MAU) and inpatients with 1 missed screening. There were 2 true red flags identified from the randomise audits, 1 is already on IVAB treatment and 1 case received IVAB within 1 hour.

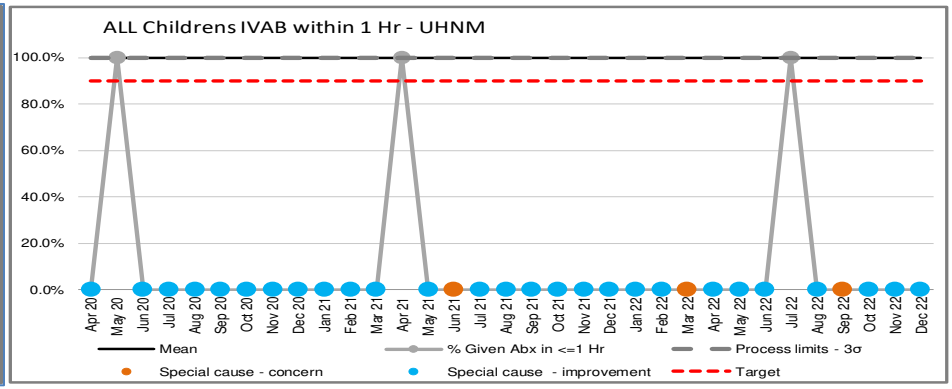
Actions:

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

Sepsis Screening Compliance ALL Children

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
90%	84.6%	95.8%	90.9%

Background

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

Variation	Assurance

Target	Oct 22	Nov 22	Dec 22
90%	N/A	N/A	N/A

Background

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

What is the data telling us:

Children's Services show normal variation and higher than target of 90%. Still seen small numbers of children trigger with PEWS > 5 & above in Inpatients areas. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks).

There were 33 cases audited for emergency portals and inpatients with 3 missed screening (1 from CAU and 2 from ED children). No red flag identified from the randomise audits. None was identified trigger with PEWS 5> in Inpatients areas during audits.

Actions:

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

NHS
University Hospitals of North Midlands
NHS Trust

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Emergency Care

- December was an extremely challenging month with a majority of metrics deteriorating including a number of all time lows. While this is disappointing and remedial actions are in place to recover it is important to note that these performance trends are mirrored both regionally and nationally. This is most clearly demonstrated by the maintenance of our position nationally and amongst peers for most KPI.
    - Four Hour performance reduced from 63% in November to 55% in December.
    - 12 Hour Trolley Waits in the ED increased from 990 to 1300.
    - ED WTBS increased from 120 minutes in November to 143 minutes in December.
    - Ambulance Handovers remained a significant challenge with those over 60 minutes increasing to 1379 from 1298.
- The final few days in December saw an improvement in performance as patients presenting with IP restriction, acuity, and activity levels fell rapidly. It is hypothesised that this change in circumstance is as a result of the steep and early nature of the flu curve, and a change in public behaviour following prolific nation news coverage of current and upcoming Industrial Actions. It is expected that these trends will continue and January will show improvements on December right across the non-elective pathway.

Cancer

- Trust overall 2WW Performance predicted to land at 97% in December – increasing from 91% in November, as a result of schemes such as the Lower GI Community Referral hub and Community Teledermatology pathways being successfully implemented. Breast symptomatic (where cancer is not suspected) is expected to 86% achieve in December.
- The 62 Day Standard is predicted to land at 46% in December. This is an un-validated and incomplete position that is expected to change as pathology confirms or excludes cancer for treated patients. Contributing factors include capacity, with robust plans in place to tackle the most challenged specialties (Skin & LGI) over the next quarter.
- The 31 Day Standard is predicted to land at 87% for December and the 31 day Subsequent Anti Cancer Drugs standard is expected to achieve 100% in December, in addition to Subsequent Radiotherapy achieving the standard at 95% in December.
- The 28 Day Faster Diagnosis Standard for 2WW referrals is predicted to land at around 57% in November. Breast Screening is predicted to achieve the FDS in November. The December FDS position is expected to report a further improvement to over 60%.
- Suspected Breast Cancer, Skin and Lower GI are now booking 2WW referrals within 7 days, for first appointments – an improvement since last month.
- The backlog has reduced since last month and total PTLs in Skin and LGI has significantly reduced.
- In August the PTL was over 6000 – this has now **reduced by around 2500** patients to 3471 in total.

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Planned Care

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

- Day Case activity and Elective Activity have moved from delivering 96% and 88% respectively in November to 92% and 93% in December. This is still some way from the national ask of 110%/108%. This is against a backdrop of increase cancelations. There is a real focus on the reintroduction of 6-5-4 with support from the regional theatres team.
- The focus has moved to 78 week waiters with an Annual Plan to reduce them to below 300 patients by March 2023. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge well before March so any treatment can be carried out to meet the 78 week standard.

RTT

- The overall Referral To Treatment (RTT) Waiting has increased from 76,902 in November to 77,727 in December.
- The number of patients > 52 weeks continues to increase – 5397 in December. 4377 in August, 4,569 in September, 4628 in October and 4979 in November.
- At the end of December the numbers of >104 patients was 50. An increase of 11 from the end of November (albeit largely different patients).
- The Trust has continued to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment.

Diagnostics Summary

- During December the Diagnostic activity dipped just below 100% when compared with 19/20 BAU at 96%.
- DM01 performance was 61% overall, with key areas of underperformance in non-obstetric ultrasound and Endoscopy

Histology position – this is a slightly improved position from last month:

- Urgent - 95% reported at Day 19, 80% of cases reported by Day 10
- Accelerated - 95% reported at Day 35, 80% of cases reported at Day 27
- Routine - 95% reported at Day 39, 80% reported at Day 31

Radiology reporting backlog:

- High risk relating to 'routine / non cancer reporting' due to reporting capacity and delays in diagnosis Risk 25512 remains at score - 20

Endoscopy:

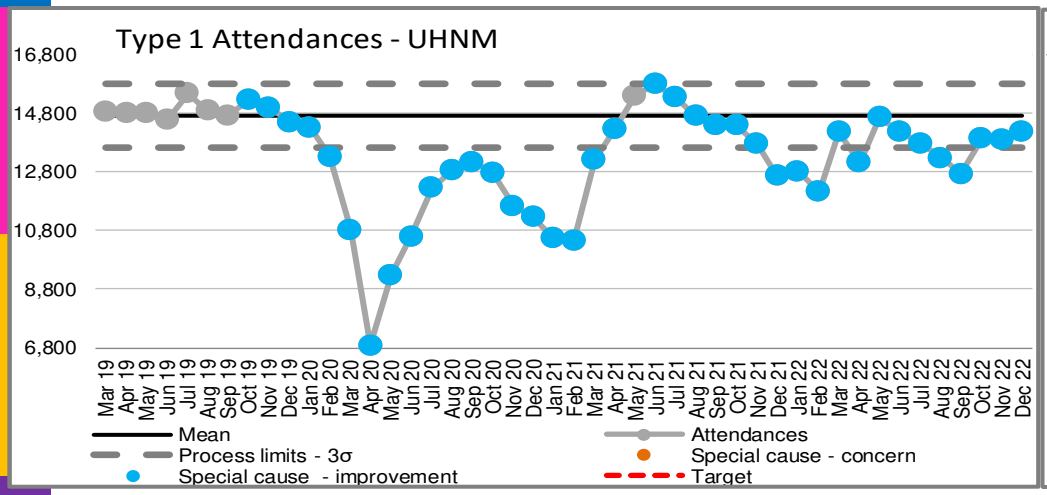
- Improvement plan being developed and there are now weekly performance meeting for this service

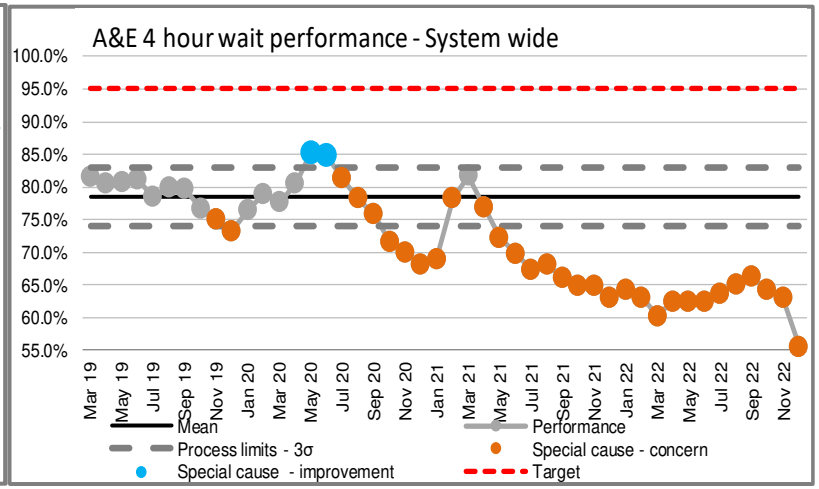
Section 1: Urgent Care

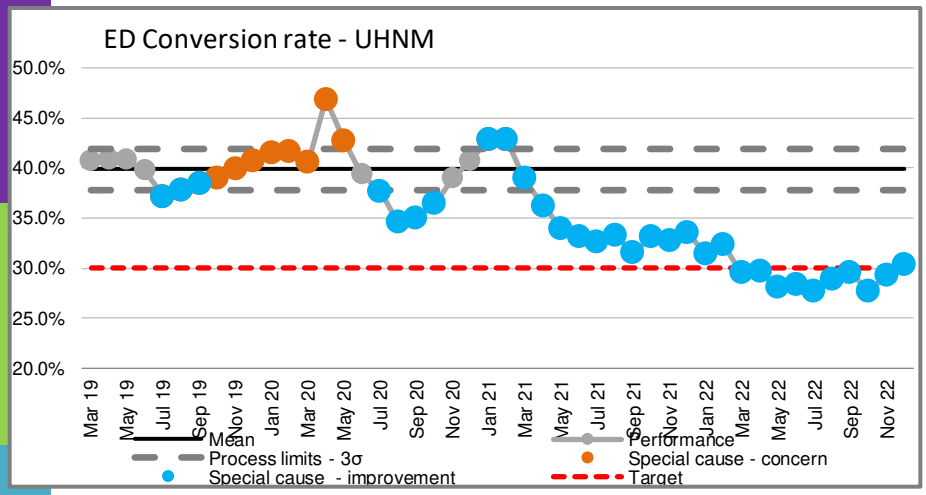
Headline Metrics

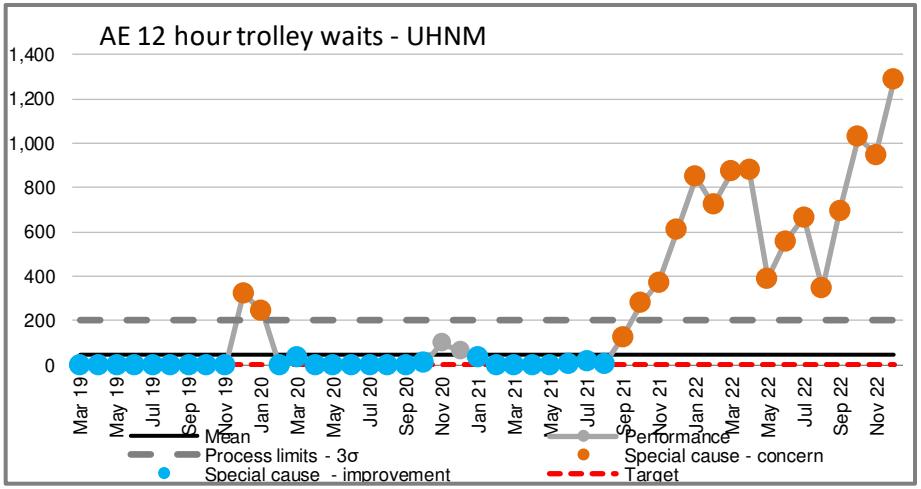
Urgent Care – monthly *(context)*

NHS
University Hospitals of North Midlands
NHS Trust



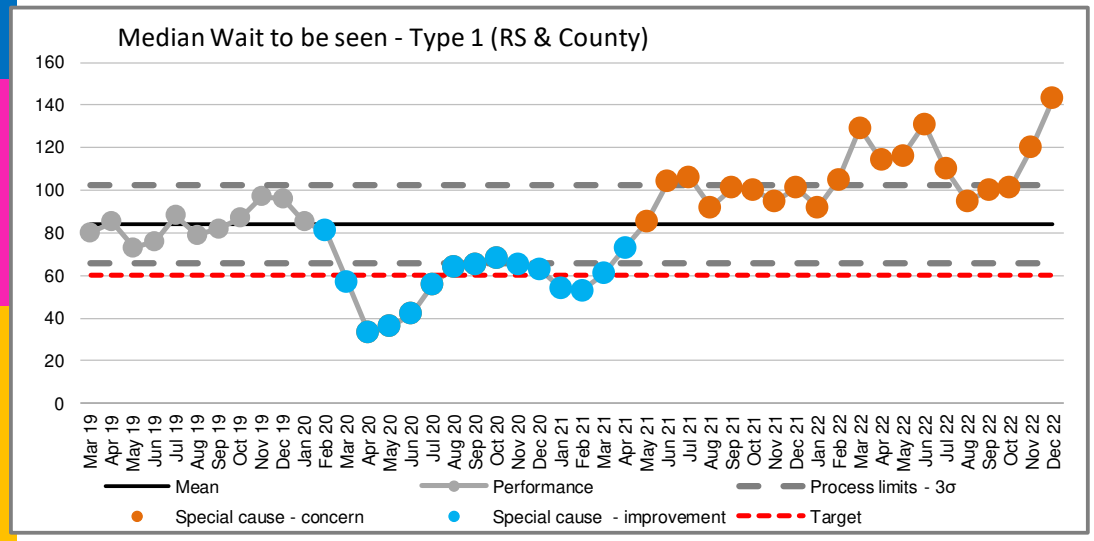






Delivering Exceptional Care with Exceptional People

WTBS & 12 Hour in department



Variation	Assurance
H	F

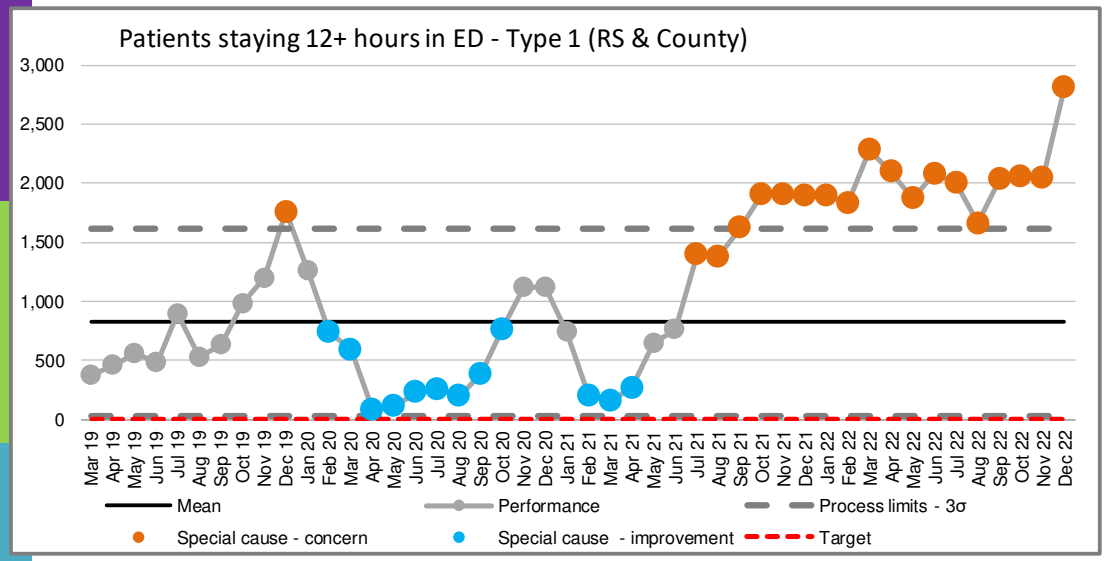
Target	Oct 22	Nov 22	Dec 22
60	101	120	143

Background

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

What is the data telling us?

Median wait to be seen remains higher than the upper control limit, with December reaching an all time high of 143 minutes.



Variation	Assurance
H	F

Target	Oct 22	Nov 22	Dec 22
0	2061	2043	2817

Background

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

What is the data telling us?

The number of patients waiting over 12 hours has increased significantly over the last 12 months. December reaching an all time high of 2817 patients.

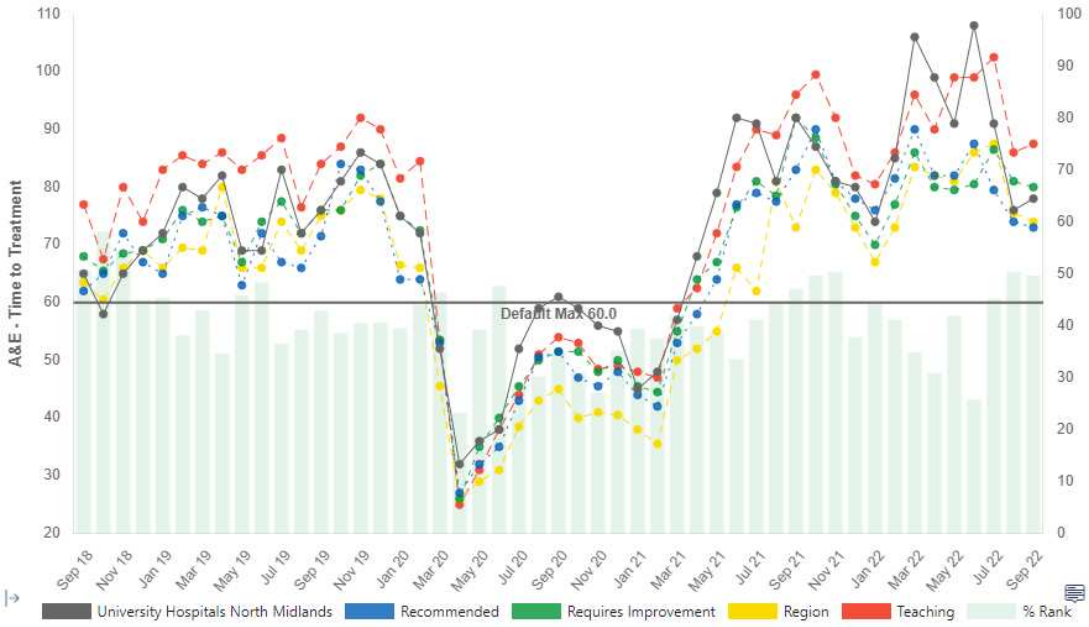
Urgent Care – Time to Treatment

NHS
University Hospitals of North Midlands
NHS Trust

Key Performance Indicator

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

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



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

(Metric not updated since previous report)

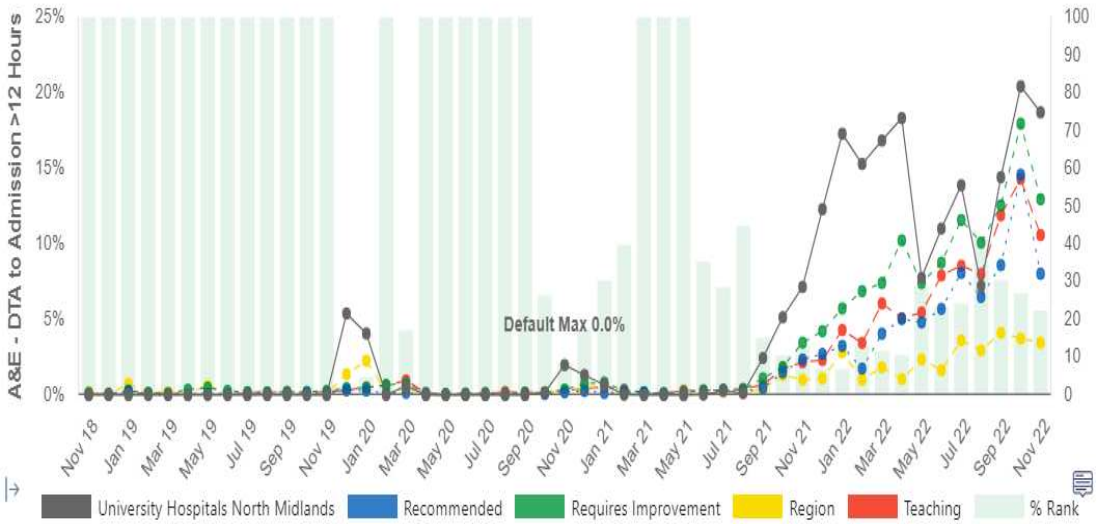
Urgent Care – DTA waits over 12 hours

University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Nov 22	95.00%	63.0%	L	33
A&E - 4 Hour Standard (Type 1)	Nov 22	95.0%	43.2%	L	11
A&E - 4 Hour Standard (Type 2 ...	Nov 22	95.0%	94.8%	L	31
A&E - Conversion Rate	Nov 22	25.0%	22.4%	L	31
A&E - DTA to Admission >12 H...	Nov 22	0.0%	18.7%	H	22
A&E - DTA to Admission >12 H...	Nov 22	0.0	947.0	H	5
A&E - DTA to Admission >4 Ho...	Nov 22	10.00%	34.4%	H	58
A&E - Left Without Being Seen	Oct 22	5.00%	0.0%	C	100
A&E - Reattendance Rate	Oct 22	5.0%	9.6%	C	12
A&E - Time to Initial Assessment	Oct 22	15.0	9.0	C	63
A&E - Time to Treatment	Oct 22	60.0	-	C	-
A&E - Total Time in A&E	Oct 22	160.0	187.0	H	62
A&E - Total Time in A&E (Admit...	Oct 22	180.0	-	C	-
A&E - Total Time in A&E (Non-...	Oct 22	140.0	168.0	C	63

A&E - DTA to Admission >12 Hours | Ranking | Trend | Delta | SPC | Commentary



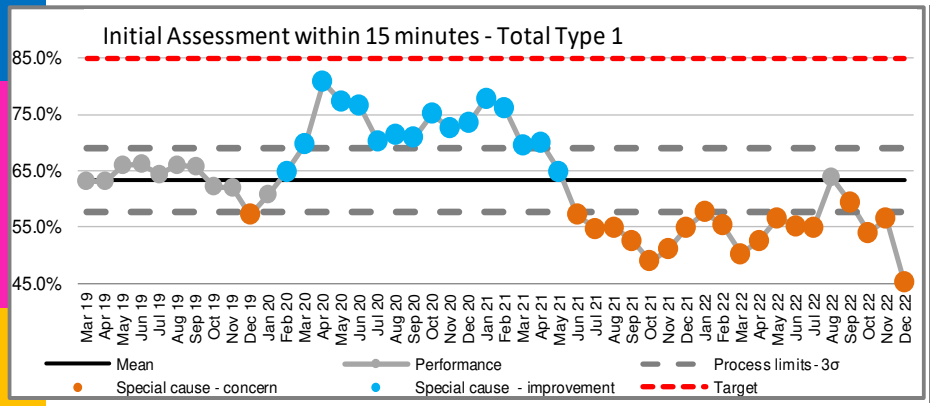
- The percentage of patients waiting over 12 hours from the point of DTA has been much higher than peers since September 21.
- During the middle of 2022 this improved, however since September 22 UHNM remain above all peers.

Section 1: Urgent Care

Workstream 1; Acute Front Door

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

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

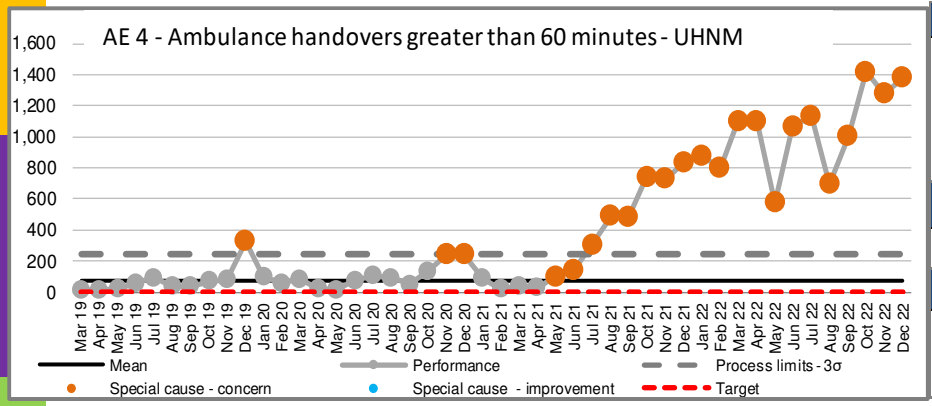
Target	Oct 22	Nov 22	Dec 22
85%	54.0%	56.4%	45.2%

Background

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

What is the Data telling us?

Performance remains below the 1920 lower control limit at 56%. December dropped significantly to 45%, the lowest seen for this metric.



Variation	Assurance
H	?

Target	Oct 22	Nov 22	Dec 22
0	1419	1279	1379

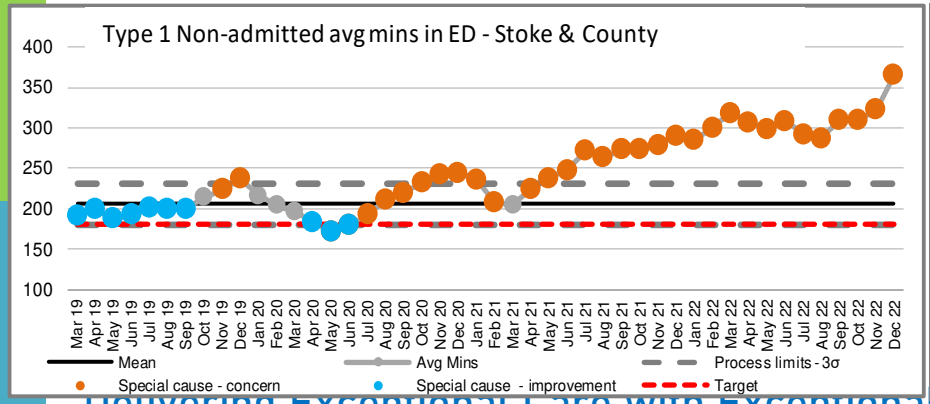
Background

The number of ambulance handovers greater than 60 mins

What is the Data telling us?

Handover delays over 1 hour have risen dramatically since June 21, with these data points sitting outside of the upper control limits of 201920.

Over the last three months, volumes have averaged 1379 each month.



Variation	Assurance
H	?

Target	Oct 22	Nov 22	Dec 22
180	309	323	365

Background

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

What is the Data telling us?

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

Time To Triage, Ambulance Handover, & Treatment

NHS
University Hospitals of North Midlands
NHS Trust

Summary

- Time to Initial Assessment decreased from 56.4% to 45.2%. This includes a surge of CED attendances following the nationally reported Strep A outbreak. News coverage of this event resulted in a more than doubling of 'worried well' parents attending over a weekend which sustained for an approximate two week period.
- Ambulance Handovers remain a challenge with 60 minute delay instances increasing from 1298 to 1379. Despite YNP being embedded, corridor care in the ED was enacted to try to alleviate further pressure in the system and reduce ambulance holds. This deterioration of performance follows regional and national trends.
- The Non-Admitted Average Time In ED rose slightly from 323 minutes in November to 365 minutes in December and follows trends of increasing congestion.

Actions

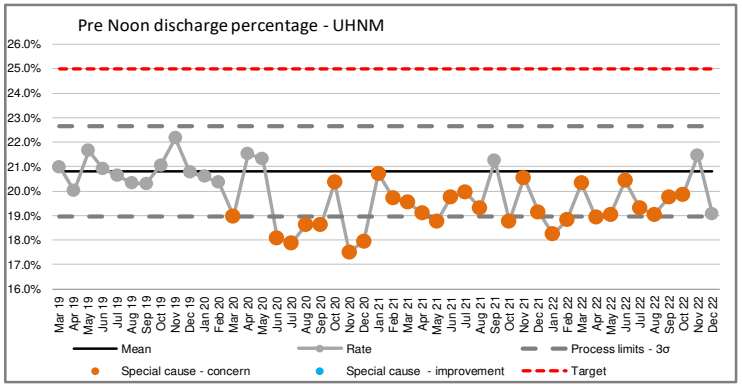
- Given the declaration of a Level 3 System Critical Incident, formal Workstream 1 meetings were stood down for the month of December. However, multiple actions were taken at the Acute Front Door to manage risks to patient safety. The most significant of these was the reopening of the Emergency Department corridor as additional capacity. This decision was taken by the Emergency Department leadership team and support by the Executive with appropriate risk assessments up to a maximum of 15 patients. These spaces will now be flexibly utilised to offload patients arriving by ambulance.
- Negotiations are underway with Totally (Vocare) to relocate the GPOOH service alongside EhPC from the CDC building commencing February 2023. This will include an extension of the GPOOH service to ensure greater overlap and evening coverage, increasing deflection of primary care attendances to UHNM and removing an average of 20 additional patients every evening. This now has ICB agreement.

Section 1: Urgent Care

Workstream 2; Acute Patient Flow

Pre-Noon, Simple & Timely, & Occupancy

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

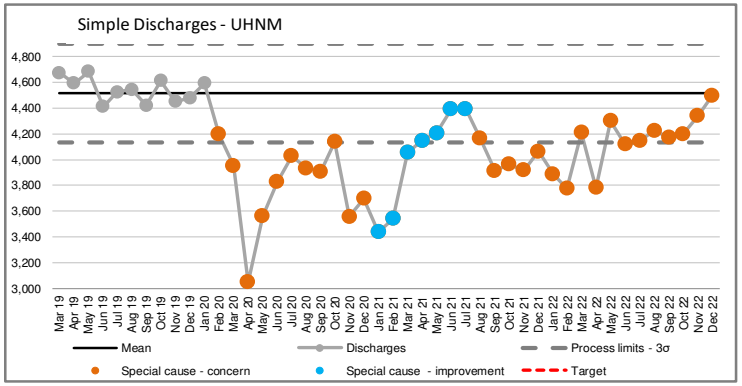
Target	Oct 22	Nov 22	Dec 22
25%	19.9%	21.5%	19.1%

Background

The percentage of discharges complete before 12 noon.

What is the data telling us?

Pre noon discharges have been below the 1920 mean since June 20, with December reaching the lower control limit of 19%.



Variation	Assurance
L	

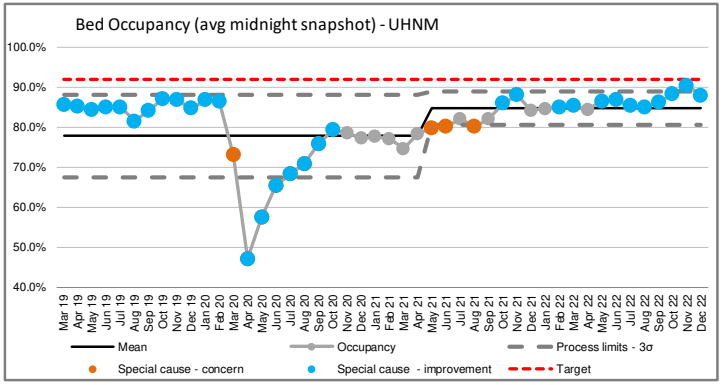
Target	Oct 22	Nov 22	Dec 22
N/A	4200	4341	4499

Background

Patients discharged without complex needs

What is the data telling us?

Simple & timely discharges is seeing an improving trend and reached the 1920 mean average of 4499.



Variation	Assurance
H	F

Target	Oct 22	Nov 22	Dec 22
92%	88.3%	90.4%	87.9%

Background

The percentage of general and acute beds occupied overnight at UHNM

What is the data telling us?

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

Pre-Noon, Simple & Timely, & Occupancy

NHS
University Hospitals of North Midlands
NHS Trust

Summary

- Pre-Noon Discharges dropped back below baseline to 19.1% from 21.5% in November. This is another consequence of extreme congestion across the Trust which ultimately resulting in the bedding of all areas which would be utilised to facilitate early discharges.
- The number of Simple & Timely discharges improved again from 4341 in November to 4499 in December. This improvement will both be as a result of adjusting of clinical risk thresholds following declaration of a Level 3 System Critical Incident and increased occupancy, resulting in more patients in the hospital, and therefore more to discharge.
- There was a slight improvement in the Bed Occupancy of the hospital to 87.9% in December from 90.4% in November. However, this figure may not paint a comprehensive picture given the volume of IP patients and subsequently restricted beds which would not flag as 'occupied'.

Actions

- Given the declaration of a Level 3 System Critical Incident, formal Workstream 2 meetings were stood down for the month of December. There was however a facilitated session to develop the A3 and structure for the workstream going forward which will ultimately decide how the LOS improvement projects are pulled together.
- The Regional Productivity Team have been engaged to support a benchmarking exercise against comparable Trusts. Initial summaries indicated that while the majority of KPI were well within expected limits, two outliers were number of total admissions and frailty metrics. Further work is required to validate data and so a deep dive has been requested.
- Following a decrease to approximately 30% of flow moving from post 13:00 to pre 13:00 a refocusing of YNP has improved performance back to the previous peak of approximately 50%. This has now been expanded to include AMU utilising out spaces to take three YNP of their own.

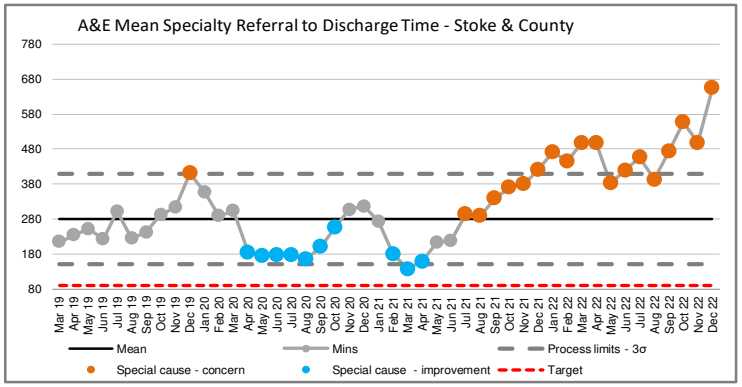
NHS
University Hospitals of North Midlands
NHS Trust

Section 1: Urgent Care

Workstream 3; Delivering UEC Standards

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

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Oct 22	Nov 22	Dec 22
90	557	498	655

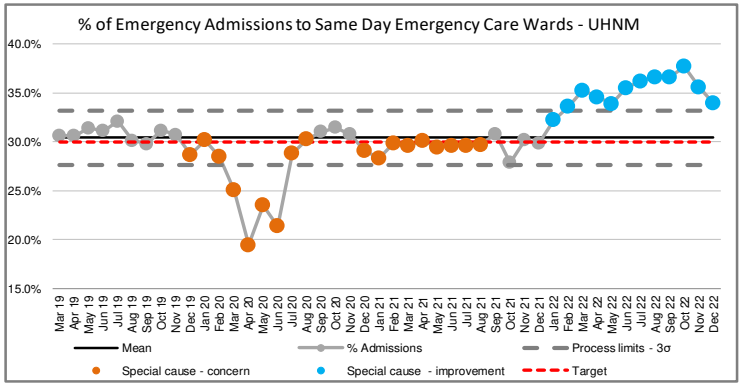
Background

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

What is the data telling us?

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

December significantly increased to an all time high of 655 minutes.



Variation	Assurance
H	?

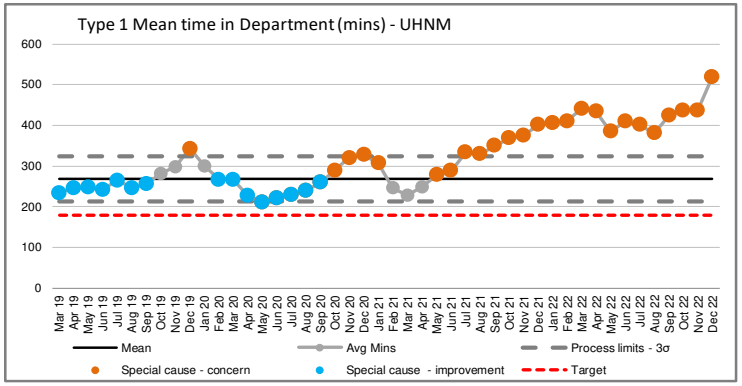
Target	Oct 22	Nov 22	Dec 22
30%	37.7%	35.6%	33.9%

Background

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

What is the data telling us?

The Trust has been consistently above the upper control limits for the last 11 months, with December performance dropping for the second month to 33.9%.



Variation	Assurance
H	F

Target	Oct 22	Nov 22	Dec 22
180	437	437	519

Background

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

What is the data telling us?

Total time in department has been increasing since March 2021 with December peaking at 519 minutes.

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

NHS
University Hospitals of North Midlands
NHS Trust

Summary

- The average time from Specialty Referral to Discharge increased greatly from 498 minutes in November to 655 minutes in December. This will partly be due to inefficiencies created during times of extreme congestion.
- SDEC Utilisation reduced slightly to 33.9% in December from 35.6% in November. While this is the second month in a row of deterioration this is still above previous levels and the stated target of 30%.
- The Mean Time in ED for all patients also increased from 437 minutes in November to 519 minutes in December. This further deterioration can be seen to be driven by increasing numbers of MFFD patients during the month of December, Trust wide congestion, and significant numbers of IP patients and subsequent restrictions on admitted pathways as well as the ED itself.

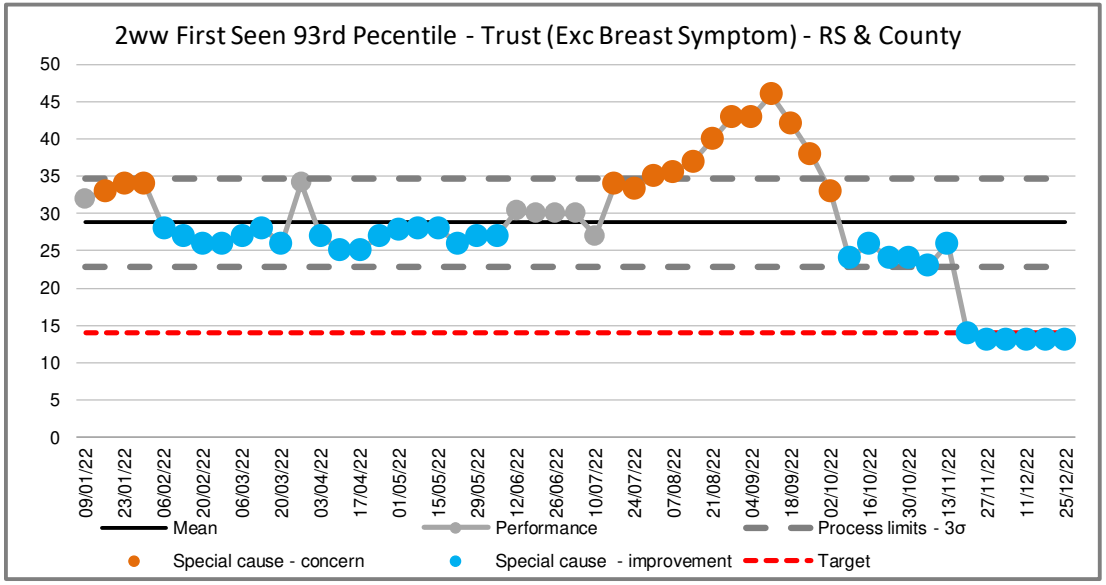
Actions

- There will need to be continued intensive education and engagement with the ED Consultant body in order to ensure the portal push model of patients and timely escalations is adhered to as there remain exceptions to the now well established Referral & Admission SOP.
- Further work is underway with NHS 111 looking at deflection opportunities with a focus on specific clinical pathways (for example low acuity palpitations). ED has also been given a stretch target to maximise kiosk usage at the front door to increase redirection to other services.
- The Front Door Reconfiguration is scheduled to complete on the 23rd of January. This will see SDU move to its new footprint and be co-located with stroke and neurology wards. Engagement with medical leadership as to how the potential of this space can be maximised has commenced and updates will be tracked through Workstream 3.

Section 2: ELECTIVE CARE

Cancer – Headline metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

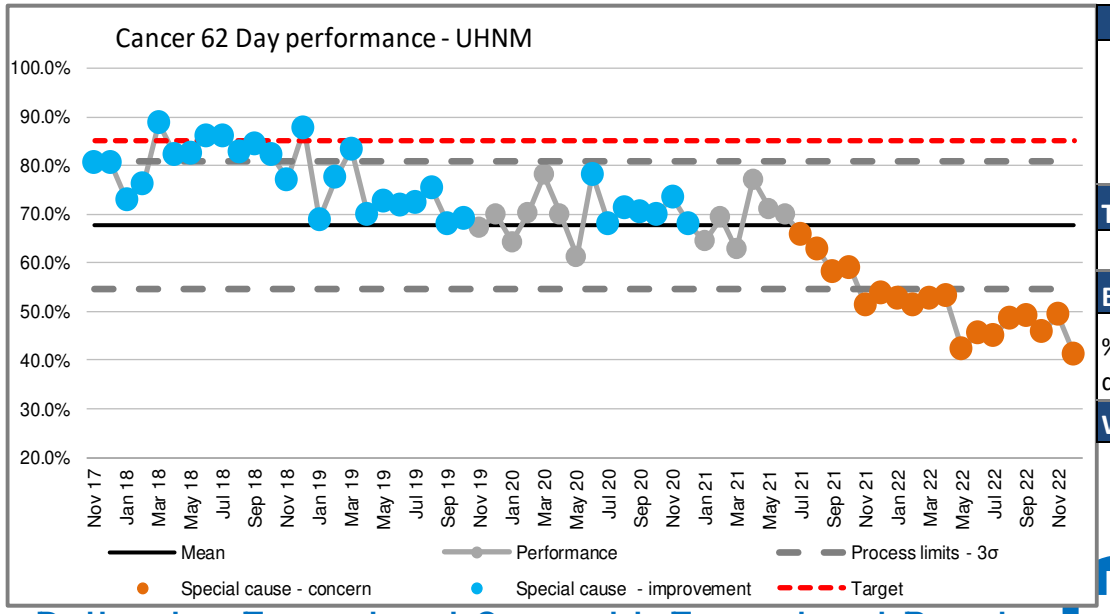
Target	11/12/2022	18/12/2022	25/12/2022
14	13	13	13

Background

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

What is the data telling us?

Trust wide – all suspected cancer 2WW referrals. Excluding Breast symptomatic referrals where cancer is not suspected.
93 % of patients first seen for the last week in December had a 14 day clock stop within day 13 of the pathway.
.



Variation	Assurance
L	F

Target	Oct 22	Nov 22	Dec 22
85%	45.8%	49.4%	41.1%

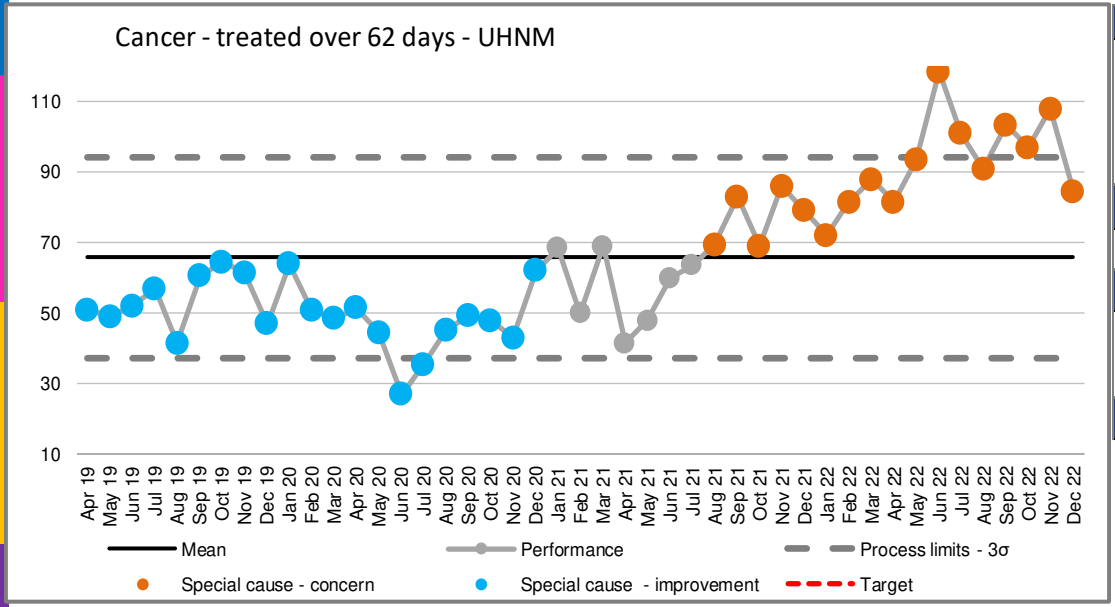
Background

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

What is the data telling us?

Performance significantly challenged and below standard for the past 12 months with a steep decline in May and predicted at for 41% for December – position still to be validated

Cancer - Headline metrics



Variation	Assurance
H	

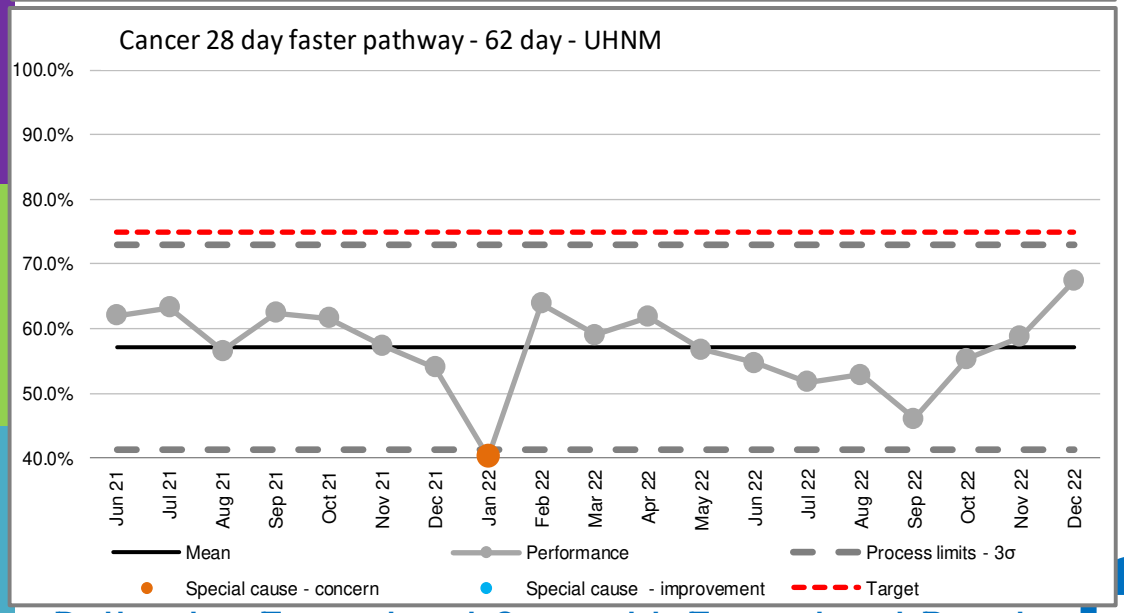
Target	Oct 22	Nov 22	Dec 22
N/A	97.0	108.0	84.5

Background

The number of patients treated over 62 days

What is the data telling us?

Demonstrates total volume of patients who have been treated beyond day 62 is a cause for concern and has been rising over the past 12 months. As the trust clears and treats the backlog of patients waiting, this metric is expected to further decline before improving.



Variation	Assurance
	F

Target	Oct 22	Nov 22	Dec 22
75%	55.3%	58.8%	67.4%

Background

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

What is the data telling us?

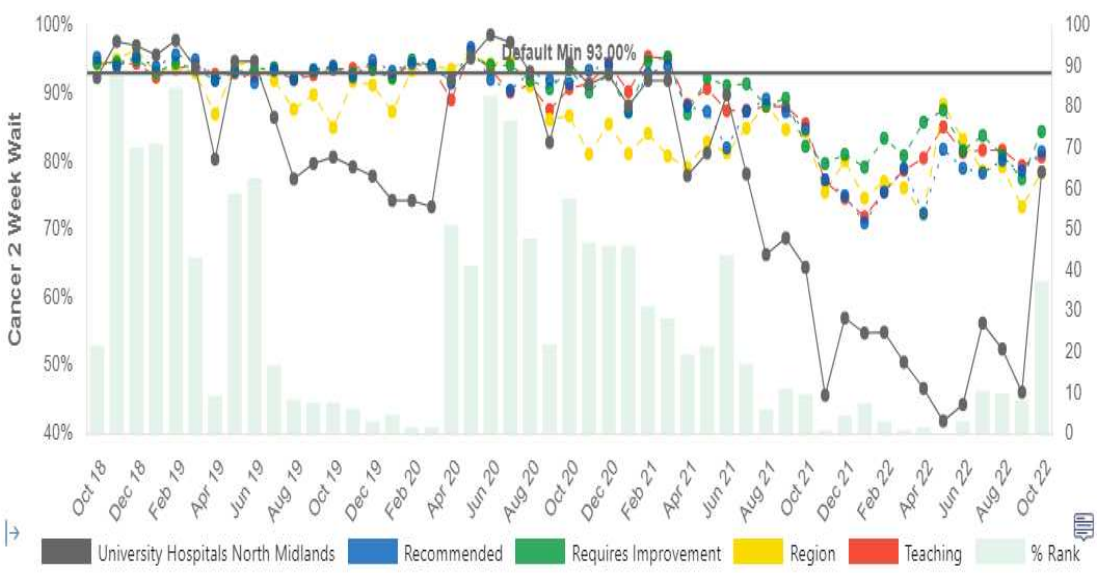
The FDS performance remains stable with pockets of good practice. E.g. Breast, Lung and Upper GI all achieve the standard in November22. The December position is yet to be finalised and is predicted to land above 60% however is still going through validation as pathology results are available.

Cancer – benchmarked

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Cancer 2 Week Wait	Oct 22	93.00%	78.4%	L	37
Cancer 2 Week Wait Breast Sym...	Oct 22	93.0%	97.1%	C	72
Cancer 31 Day First Treatment	Oct 22	96.00%	87.2%	L	14
Cancer 31 Day Subsequent Trea...	Oct 22	96.0%	86.6%	L	17
Cancer 62 Day All Sources	Oct 22	85.00%	58.1%	L	24
Cancer 62 Day Consultant Upgr...	Oct 22	85.0%	77.9%	H	56
Cancer 62 Day Screening	Oct 22	90.0%	72.4%	L	48
Cancer Sub Treat Drugs	Oct 22	96.0%	100%	C	100
Cancer Sub Treat Radiotherapy	Oct 22	96.0%	91.7%	C	32

Cancer 2 Week Wait | Ranking | Trend | Delta | SPC | Commentary



- UHNM have seen 14 day performance deteriorate at a greater scale than it's peers since July 2021.
- October saw a marked improvement back to peer levels.

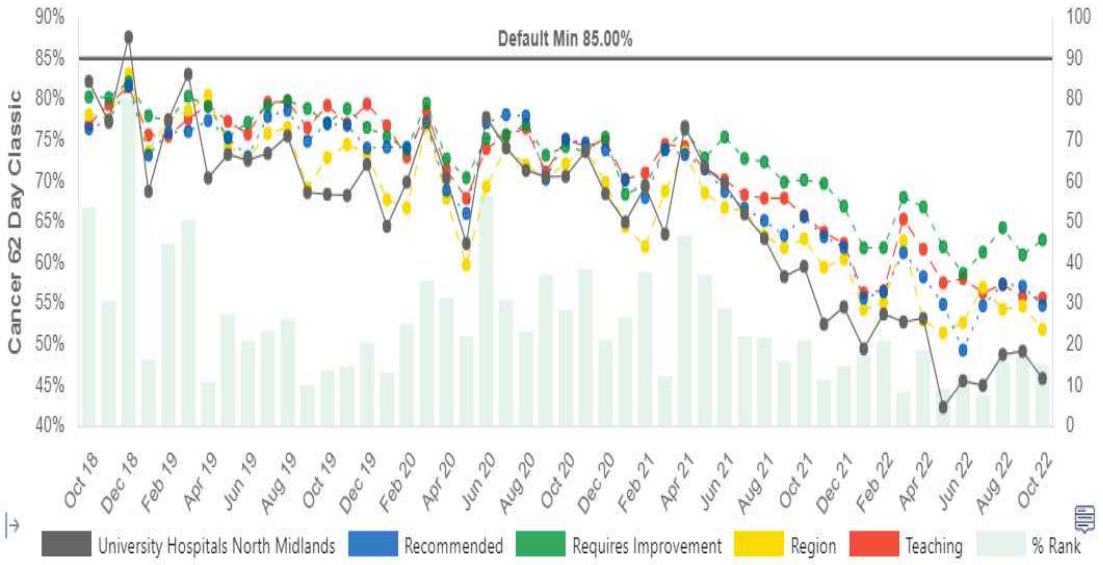
Cancer - Benchmarked

University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Breast Cancer	Oct 22	85.00%	60.9%	L	25
Cancer 62 Day Classic	Oct 22	85.00%	45.8%	L	15
Lower Gastrointestinal Cancer	Oct 22	85.00%	13.3%	L	13
Lung Cancer	Oct 22	85.00%	52.6%	L	59
Other Cancer	Oct 22	85.00%	46.3%	L	33
Skin Cancer	Oct 22	85.00%	39.5%	L	8
Urological Cancer	Oct 22	85.00%	52.6%	L	44

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



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

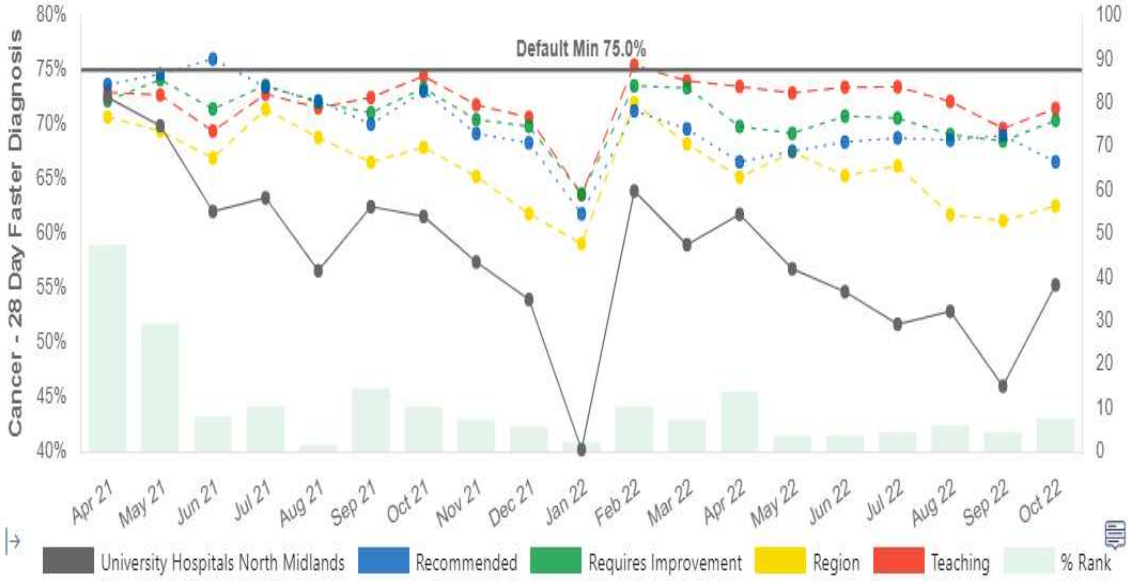
Cancer

NHS University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	55.3%	L	8
FDS Acute Leukaemia	Oct 22	75.0%	100%	C	100
FDS Brain Tumours	Oct 22	75.0%	-	C	-
FDS Breast Cancer	Oct 22	75.0%	91.9%	C	46
FDS Breast Symptoms	Oct 22	75.0%	96.8%	C	69
FDS Children's Cancer	Oct 22	75.0%	36.4%	L	4
FDS Gynaecological Cancer	Oct 22	75.0%	46.3%	L	19
FDS Haematological Malignanci...	Oct 22	75.0%	31.1%	L	19
FDS Head & Neck Cancer	Oct 22	75.0%	67.3%	C	24
FDS Lower Gastrointestinal Can...	Oct 22	75.0%	17.2%	L	4
FDS Lung Cancer	Oct 22	75.0%	56.4%	C	16
FDS Missing or Invalid	Oct 22	75.0%	-	C	-
FDS Other Cancer	Oct 22	75.0%	-	C	-
FDS Sarcoma	Oct 22	75.0%	80.0%	C	80
FDS Skin Cancer	Oct 22	75.0%	50.1%	L	12
FDS Testicular Cancer	Oct 22	75.0%	78.3%	C	38
FDS Upper Gastrointestinal Can...	Oct 22	75.0%	91.8%	H	98
FDS Urological Malignancies	Oct 22	75.0%	54.7%	L	39

Cancer - 28 Day Faster Diagnosis | Ranking | Trend | Delta | SPC | Commentary



- The 28 Day Faster Diagnosis position for all peers has seen a drop since earlier this year.
- UHNM affected more than peers and remains in the lowest quartile nationally
- November data predicted to report a further improvement to 67% - the highest performance this year.

Cancer Trajectories

NHS
University Hospitals of North Midlands
NHS Trust

Provider Level					April 2022	May 2022	June 2022	July 2022	August 2022	Septemb er 2022	October 2022	Novembe r 2022	Decembe r 2022	January 2023	February 2023	March 2023
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	E.B.32	Count	The number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site specific symptoms	462	440	420	400	380	360	340	320	300	280	250	191
				UHNM snap-shot PTL position	579	632	639	815	1041	894	887	730	558			

National planning guidance 22/ 23 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. The PTL Backlog trajectory for UHNM is set out above; the actuals shown above are a snap shot in time of the PTL position. This is for the week ending last full week of the month per PAF report.

For the month of December 2022, the backlog position was 558 - this includes patients with a decision to treat and a future treatment date scheduled. The majority of the backlog is attributable to Skin and Colorectal. High proportion of patients waiting over 62 days in both tumour sites have future scheduled treatment dates.

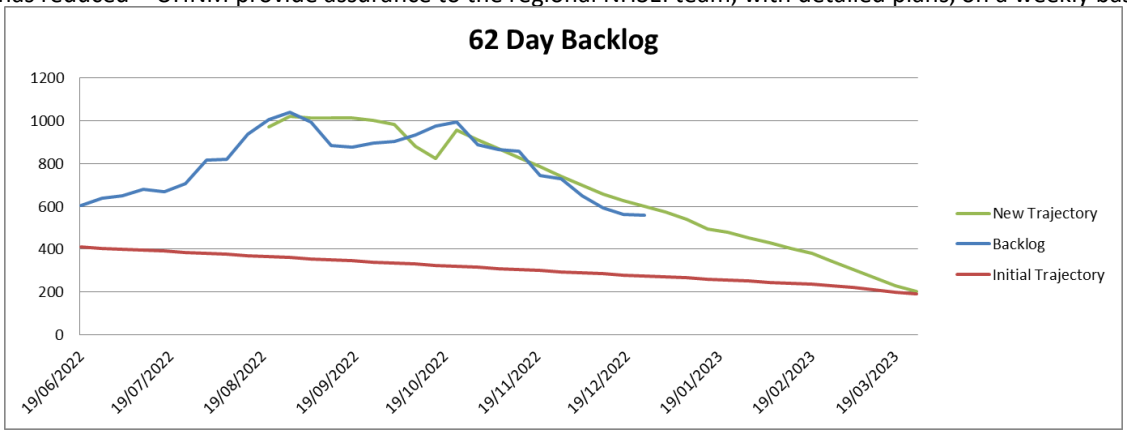
There are multiple contributing factors include delays to diagnostic reporting in pathology and imaging, urology robotic surgery capacity, oncology capacity, complex pathways, increasing element of patient choice and outstanding clinical reviews.

All Divisions are focusing on the backlog and discharge patients where appropriate. Pathway plans are detailed overleaf – there is a concentration on the first appointments and diagnostics and treatments including Surgical and Oncology. All diagnostic modalities have submitted plans for a reduction in waiting times which includes additional staffing, insourcing and outsourcing and building additional capacity through CDC's.
Intensive exec level support is being provided to Skin and Colorectal pathways, which are the main drivers for the backlog position.

Cancer

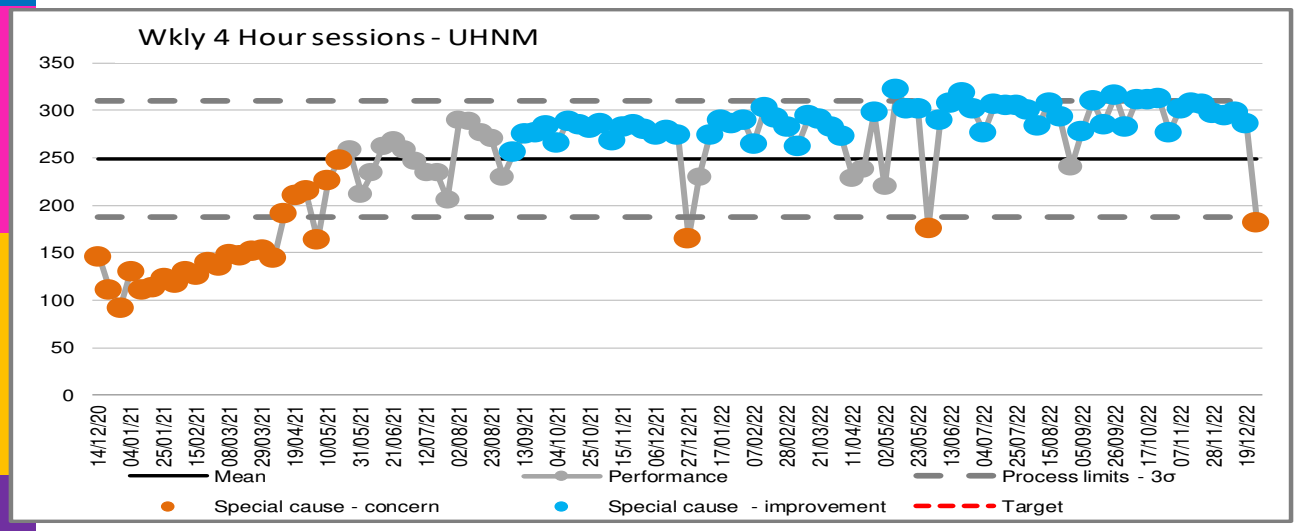
Actions

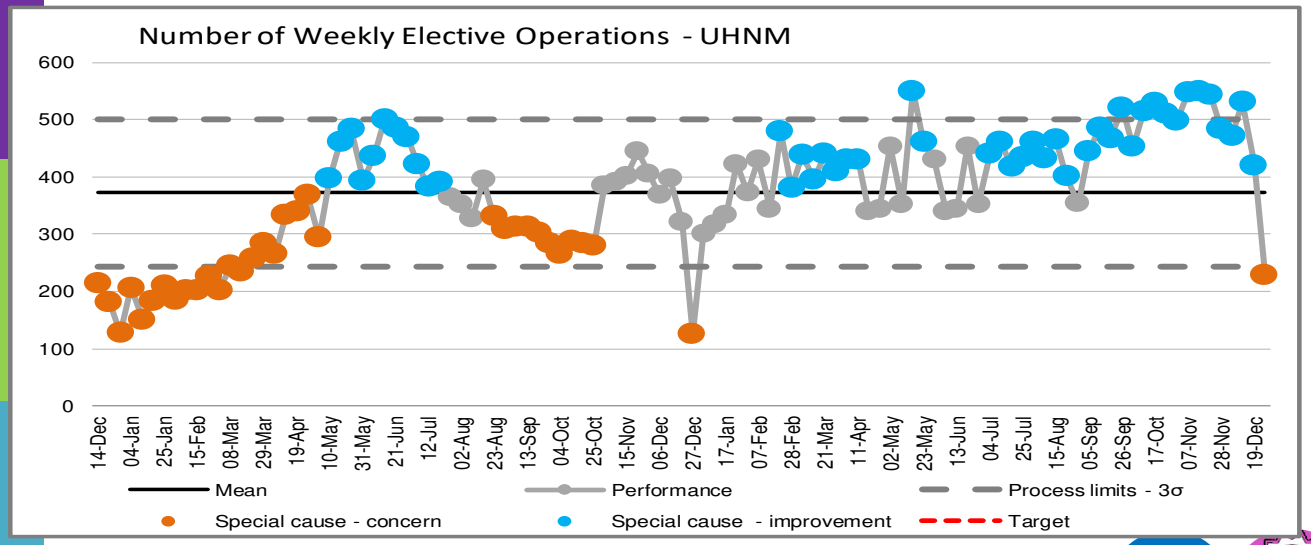
- The backlog has reduced – UHNM provide assurance to the regional NHSEI team, with detailed plans, on a weekly basis.



- The incremental decrease of the Skin and Colorectal backlogs have been modelled up to 05/02/23, where the new trajectory meets the initial trajectory submitted in 22/23 operational plans. Both specialties have enacted recovery plans and reducing the number of patients waiting beyond 62 days on the pathway.
- The 62 day backlog has reduced by 433 patients since August - from 1041 to a current position for WE 15.01.23 of 608. There was a slight increase over the Christmas period, which is being recovered to align to trajectory. The regional team remain assured and have called on UHNM to share recovery pathways with peer organisations in need of support.
- The West Midlands Cancer Alliance (WMCA) continue to support with investment of additional capacity schemes. Lower GI & Skin business cases are in development that will ensure sustainability beyond the pump prime.
- Over the past 4 weeks the block backlog in Pathology has reduced, supporting overall PTL recovery. There is a revised escalation report, matching Path data with Cancer PTL data which streamlines escalations and will provide a growing evidence base of turn around times of cancer pathway specimens.
- The 2WW FDS is predicted to achieve 57% in November with 100% data completeness against the standard – this in addition to Best Practice Timed Pathway (BPTP) data analysis will support targeted and evidence based improvements on challenged cancer pathways, using WMCA investment.
- UHNM is still recording a high number of first treatments, demonstrating increased activity which supports PTL reduction.
- In August the PTL was over 6000 – this has now **reduced by around 2500** patients to 3471 in total.
- Improvements have mainly been in the overall Skin PTL – which was at 2259 in Aug and has **reduced by 1538 patients to 721** currently.
- Recovery schemes continue to be successful – with the LGI hub optimising referrals, and the community Teldermatology service contributing to a huge reduction in wait times for patients on a skin cancer pathway. The system is working towards next steps for the optimal Lower GI pathway – by expediting alternative pathways for FIT negative patients.
- The day by which 93% of patient receive a 2WW 14 day Clock Stop on the LGI pathway has reduced by over 45 days since September – to a current position of within 13 days.

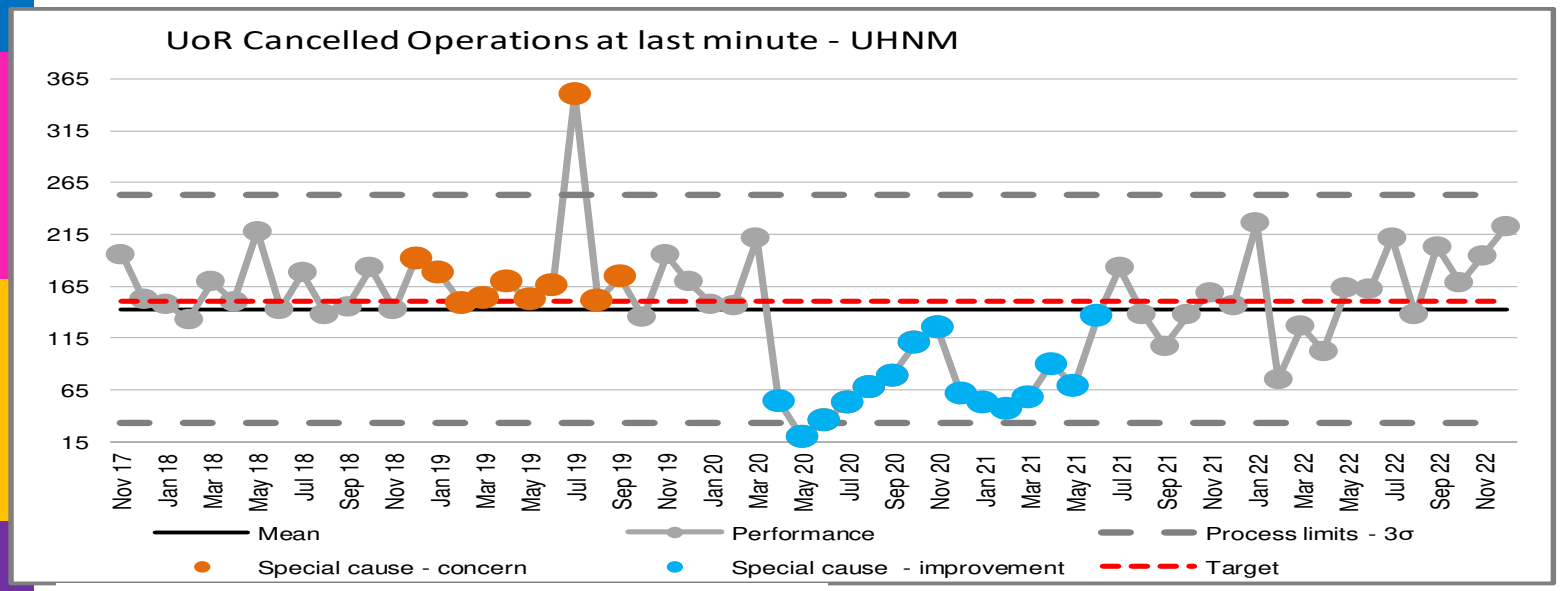
Planned care – *Inpatient Activity*





The number of 4 hour sessions taking place had remained fairly consistent, however the last recorded week in this months data was 19/12/22 where there has been a significant reduction. This was due to a stand down of activity aligned to the week prior to the critical incident which was called on 8th-13th December, there was then a second which ran 29thDec – 12th January.
As a result of this the number of weekly elective operations also declined in the same week as did the increase in cancelled operations. This was managed carefully as the reduced operation was planned and so patients were given notice of the changes to appointments.

Planned care – *Inpatient Activity*



Row Labels	Count of COMMENTS
Consultant - Cancelled for an Emergency	25
Consultant - Cancelled for more Urgent Case	31
Hospital Cancelled Admin Error	25
Hospital COVID-19	2
No Anaesthetist Available	7
No Consultant Available	30
No Equipment Available - Equipment Faulty/Failed	4
No Equipment Available - Equipment Not Booked	5
No ITU/HDU Beds Available	9
No Nursing Staff Available	19
No Suitable Beds Available	31
No Theatre Staff Available	3
No Theatre Time Available	16
No Theatre Time Available - List Overbooked	1
No Theatre Time Available - List Overrun	14
Grand Total	**222**

The patient cancelations has seen an increase, due to critical incident, this is highlighted by the high number of cancelations due to consultant cancelations for emergency/more urgent cases and bed availability.

Planned care - *Inpatients*

NHS University Hospitals of North Midlands NHS Trust

Elective inpatients Summary

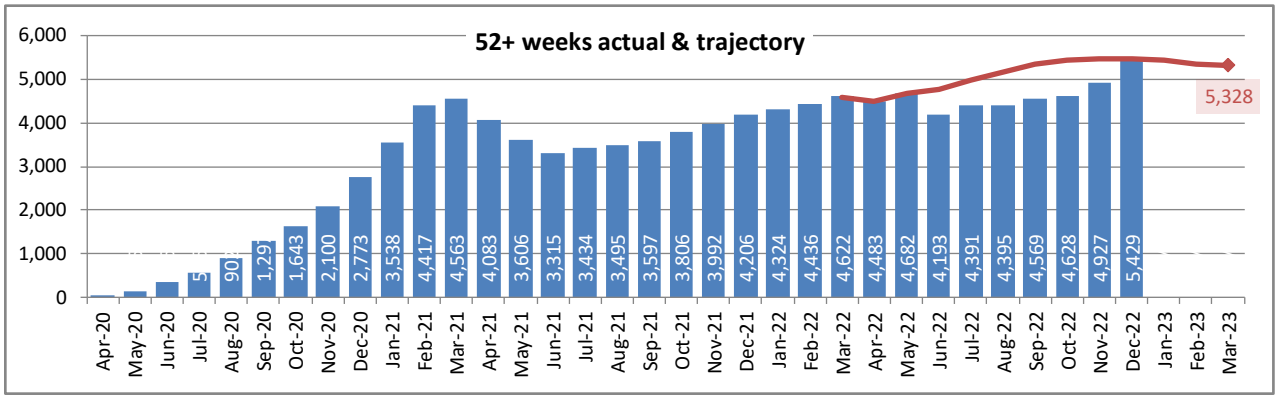
- Day Case and Elective Activity delivered 92% and 93% respectively for December 22 against the national ask of 110%/108%.
- There is a real focus on 104w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 78week+ patients.
- At the end of December the numbers of > 104 weeks was 50. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity. This has increased by 11 due to a National directive around the recording or corneal transplant patients.
- Insourcing arrangements at weekends continue and have been bolstered to provide more weekend capacity in T&O through County Hospital. This is planned to continue through to the end of the financial year.
- Nuffield have agreed to take all T&O patients at risk of breaching 78 weeks by end of March who are clinically suitable.
- County and Royal Stoke Theatres have re-implemented a "6-5-4" weekly operational meeting to ensure a higher proportion of available lists are fully used and to move capacity to the specialties most needing it. This also tracks and ensures bookings so that patients and staff are given more notice so cancellations and non-attendances can be driven down

Actions

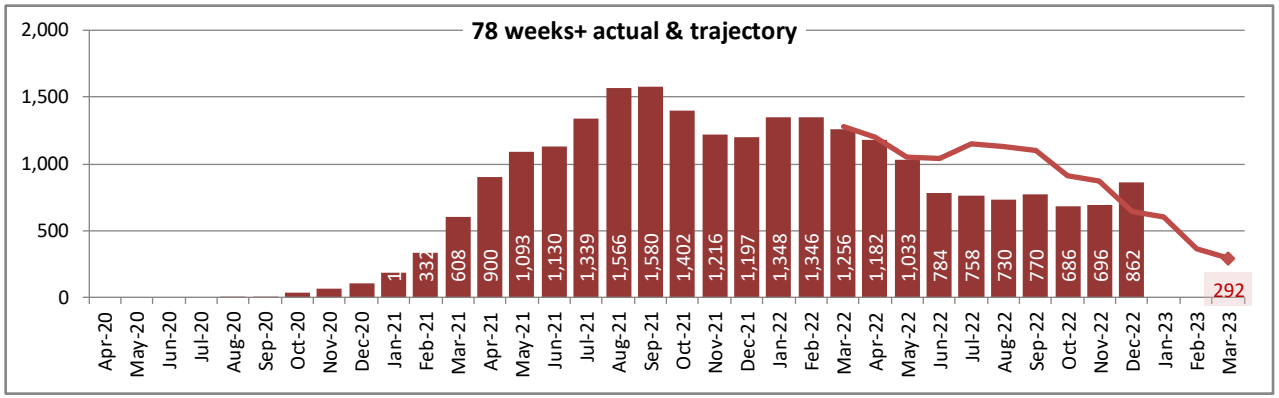
- External validation support completed end of October. 3 validators have been approved and are currently in the recruitment process to support effective patient pathways
- Trust wide revamp of validation & training underway, focusing on tracking long waiters, exposing and addressing bottlenecks in pathways. Phase 1 to deep dive training needs analysis complete. Phase 2 underway – RTT Bitesize training now available to divisions., focused on key areas requiring improvement.
- Active reporting focus on ensuring the right patients (urgent and longest waiters) are the patients booked into all available capacity so that the limited resource available continues to be used for the right patients by clinical need
- Patient by patient monitoring by each specialty and by the corporate team on the small number of patients at risk of the breaching 104 weeks by end of month, combined with forecasting for January and onwards. This monitoring has now been extended to 78 weeks also.
- Key enablers to the continued focus on long waiting patients are ring fencing of beds for Orthopaedics as RSUH, modular theatre at County and improvement in theatre utilisation and booking.
- The progress that had been seen in reducing these patient numbers has been impeded do to the critical incident – the impact of which can be seen on slide 27
- Increased focus on non-admitted patients and increasing outpatient & diagnostic capacity, improving utilisation and business processes to move patients to a decision to admit. This will be supported by the IST RTT training programme which takes place in February and March.
- Roll-out of Palantir's Foundry platform underway, with working group to be up and running with plans for initial rollout end Jan subject to technical testing.

Planned care – *RTT Trajectories*

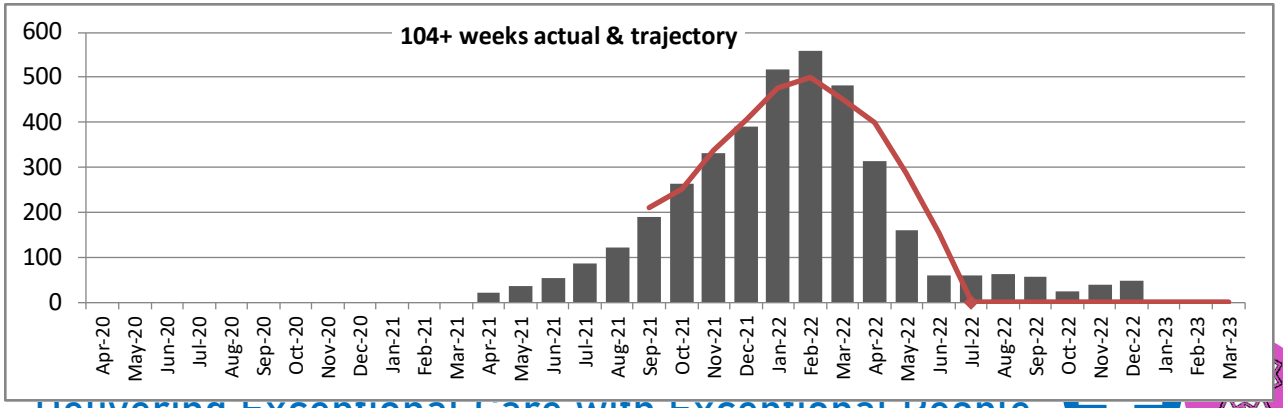
NHS
University Hospitals of North Midlands
NHS Trust



52 Week Waits have been gradually growing since June 21. December data is unvalidated.



78 Week Waits have been reducing for the last 9 months. December data is unvalidated.



104 Week Waits have been continually decreasing since early March, however the last three months have seen a slight increase each month (December data is unvalidated). This is made up of patient choice, patients presenting unwell or complex pathways.

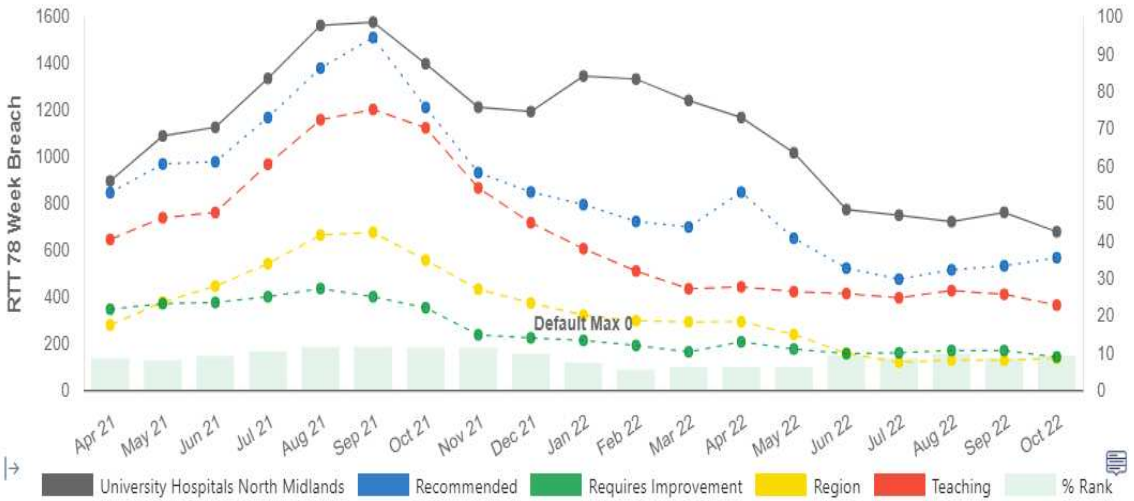
RTT - Benchmarked

University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
RTT 104 Week Breach	Oct 22	0	24	L	8
RTT 52 Week Breach	Oct 22	0	4,612	H	10
RTT 78 Week Breach	Oct 22	0	683	L	10
RTT 95th Percentile Admitted W...	Oct 22	18.0	82.2	H	9
RTT 95th Percentile Non-Admitt...	Oct 22	18.0	54.1	H	24
RTT Admitted Treatment Within...	Oct 22	90.0%	55.0%	L	35
RTT Average (Median) Admitte...	Oct 22	9.0	15.4	H	34
RTT Average (Median) Non-Ad...	Oct 22	5.0	8.2	H	60
RTT Average Wait for Incomplete	Oct 22	7.00	16.4	H	16
RTT Incomplete 92nd Percentile	Oct 22	-	48.1	H	25
RTT Incomplete Pathways With ...	Oct 22	25.0%	14.6%	H	46
RTT Non-Admitted Treatment ...	Oct 22	95.0%	71.7%	L	50
RTT Total Clock Starts	Oct 22	-	14,999	C	81
RTT Total Clock Stops	Oct 22	-	13,111	C	85
RTT Total Incompletes	Oct 22	-	77,721	H	11

RTT 78 Week Breach | Ranking | Trend | Delta | SPC | Commentary



- 78 Week waits are seeing a slight reduction compared to last month across all peer groups except “Recommended”, where this has increased.
- UHNM have seen the same slight reduction.
- UHNM remain in the lowest quartile

Planned care

NHS
University Hospitals of North Midlands
NHS Trust

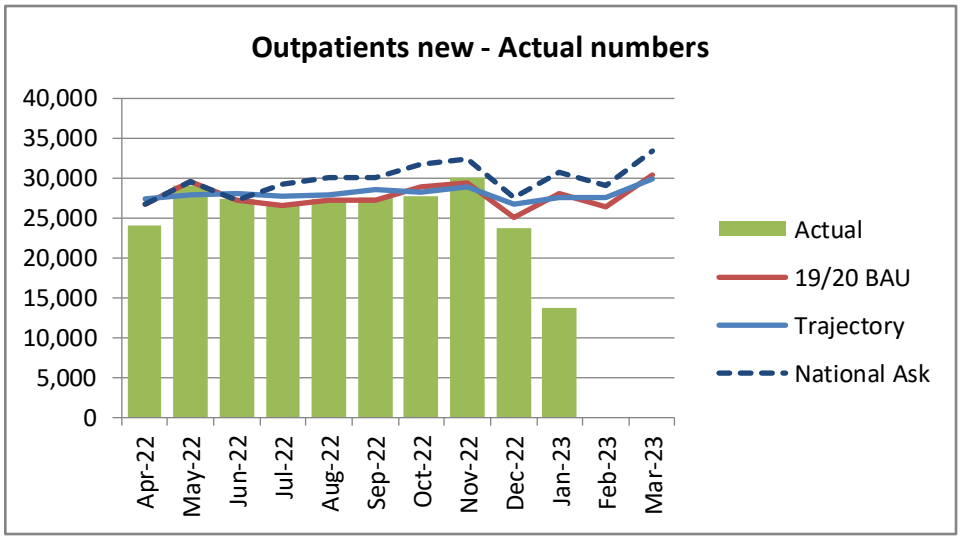
Summary

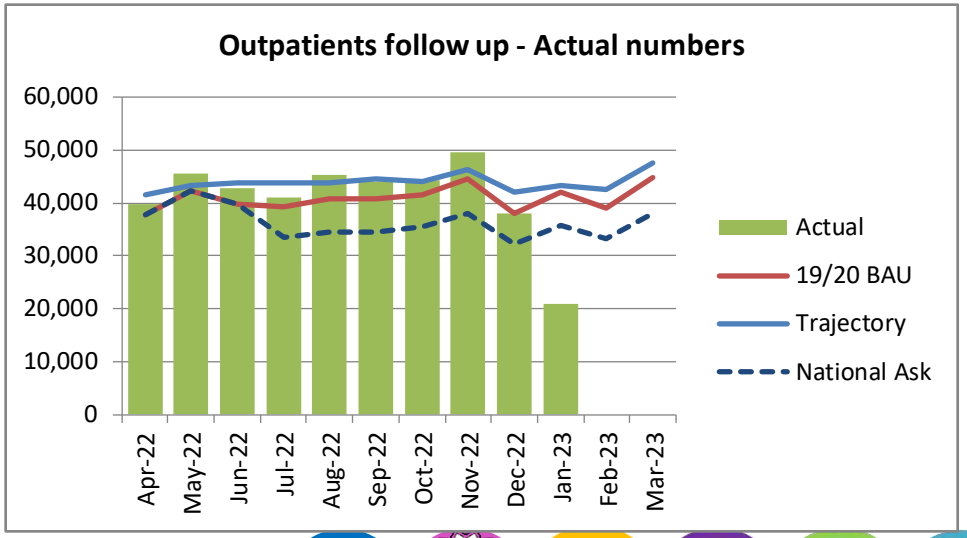
- 52+ week patients increased in December to 5,356
- 78+ patients have been gradually reducing, but had reached a plateau in November at 725. This has increased in December to 863, due to winter pressures in combination with industrial action. The trust is no longer on trajectory to eliminate 78 weeks waits by end of March 2023. Plans are in place to minimise the number of breaches, so that only patients who choose not to be treated before end of March or who have a highly complex case are still waiting at 78+ weeks.
- At the end of December the numbers of > 104 weeks was 50. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity. This has increased by 11 due to a National directive around the recording or corneal transplant patients.
- The overall Referral To Treatment (RTT) Waiting list has started to show signs of stabilisation. April was 76,023, May 75,858, June 75,538 , July 77,242 and August 76,838, September 77,985, October 77,546, November 77,727. Whilst this did decrease over the festive period, the (un-validated) list now sits at 77,750 (as at 13/01/23)

RTT

- Validation has increased with extra resource. This will provide an accurate picture of the resource required in the medium term to reduce the list.
- At the end of December the numbers of > 104 weeks was 50 - a increase from 39 in November. All patients in this cohort are either there due to patient choice, or complexity of pathway. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance has decreased at 50.5%. (53.7% October)
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

Planned care – *Outpatient activity & RTT*





Planned care – *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Actions

- OP Cell Programme Structure & TOR updated for 22/23 to reflect Elective Recovery Planning Guidance. Linking with Business Planning re 23/24 plans.
- **Work stream 1 Outpatient Service Delivery & Performance**
    - Partial Booking Rollout, Netcall Rollout, CAF Issues Action Plan, and OP Clinic Process vs. Maturity model. Utilisation focus; bookings, DNAs & cancellations, OP Cell Dashboard revised with utilisation at Trust / Division / Specialty / session code level; Divisional Targets proposed in December with improvement trajectory. Additional focus on Unoutcomed activity position, with recent reduction.
- **Work stream 2 Outpatient Transformation**
    - **OP GIRFT:** issued November, aimed at clinicians & operational teams. Common Themes & Specialty-Specific Guidance for 12 specialties (+3 issued December) including waiting list validation, specialist advice/triage & specific pathway guidance including remote consultations & PIFU. UHNM detailed template devised for gap analysis. Current position statements received for specialty areas of focus; maturity model created to assess baseline & monitor on-going progress. Midlands acknowledgement return submitted Dec 14th.
    - **Enhanced Advice & Guidance** ICS Referral Optimisation Steering Group set up (now termed Demand Management Steering Group).
    - **PIFU**; divisional % PIFU Targets, on track for trajectory to meet 5% in March 2023. PIFU captured for >25 specialties (Dec 3.8% vs 3.7% plan). Benchmarking vs national median Nov 2022- UHNM: 16th out of 142 providers (4.5% vs 1.8%). Scoping Robotic Process Automation with UHNM BI for PIFU Discharge letters, piloting with Neurology & Urology Feb. Exploring post-proc PIFU opportunities with T&O. Clarifying reporting methods/requirements for new CDS April 2023 onwards. Identifying additional PIFU pathway opportunities from OP GIRFT guidance
    - **Virtual Care >25%;** SUS submission 'fix' implemented from Nov 2021 (with BI); longer term, alignment of clinic booking and media type outcomes. NHS Remote Monitoring Toolkit issued early December, baseline assessment submitted 19th December.
    - **Patient Portal**; support provided to identify potential OP benefits; PKB config working groups - reps invited to OP Cell for updates / discussion. Director of Digital Transformation attended OP Cell in October to share Digital Vision. Patient Portal live in January, and patients will be contacted from February 2023 by letter or SMS to register for PKB via the NHS App. Patients will be able to view appointments and test results initially.
    - **SMS via Netcall to Waiting List**. From successful trial in derm & plastics to backlog pts, Partial Booking module used to contact New Waiting List pts (>38wks) during Super September. Rolling out vs plan Nov to Feb for follow ups in top 14 backlog specs. Gastro & Urology complete (3000pts, 38-40% response rate, 3.5%-5% of pts contacted no longer require appt). Gynaecology completed, to be analysed. Next neuro, cardiology, paeds.
    - **Virtual Clinic reviews** enabled 432 clock stops from 1693 pathways validated. NHSE identified UHNM as a potential national case study for this approach during feedback at regional network.

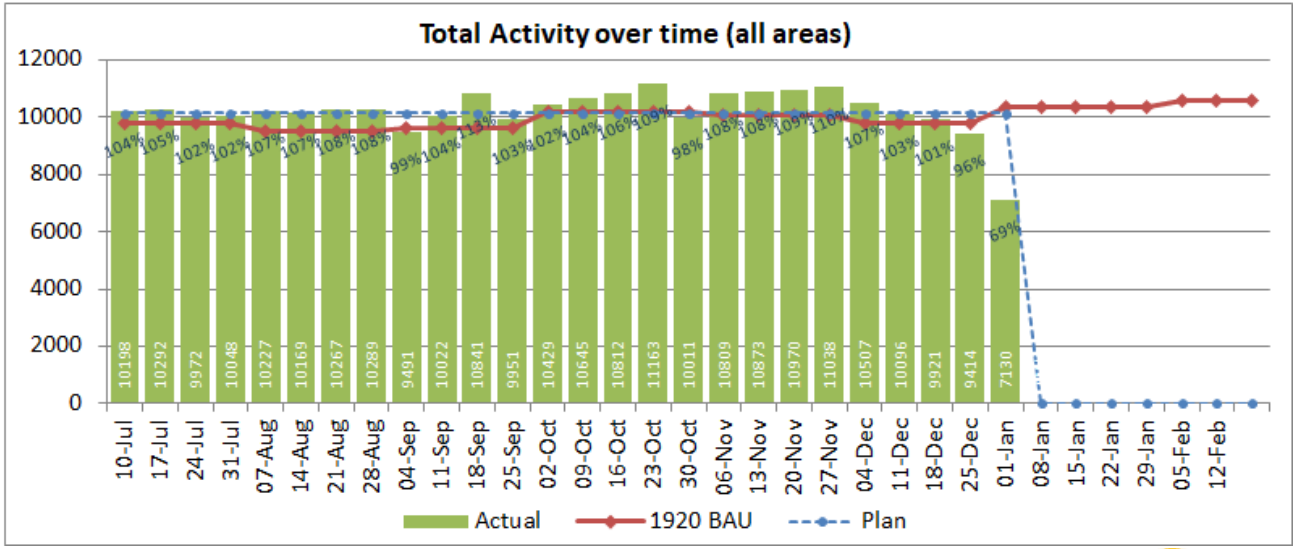
Risks

- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, on Divisional Risk Registers.
- Clinical Validation requirement; risk of achieving vs resources available.
- Lack of pace on schemes linked to System Partners, escalated at Planned Care Improvement Board.

Diagnostic Activity

NHS
University Hospitals of North Midlands
NHS Trust

		Oct-22				Nov-22				Unvalidated Dec-22			
Area	DM01 Test	Total WL	6+	%	Activity	Total WL	6+	%	Activity	Total WL	6+	%	Activity
Imaging	Magnetic Resonance Imaging	4,634	774	83.3%	3,666	4,722	1,052	77.7%	3,726	4,267	959	77.5%	3,348
	Computed Tomography	4,141	12	99.7%	8,292	3,731	26	99.3%	8,641	3,633	86	97.6%	8,072
	Non-obstetric ultrasound	11,224	6,171	45.0%	5,343	10,841	6,205	42.8%	5,325	9,667	5,597	42.1%	5,087
	Barium Enema								0				
	DEXA Scan												
Physiological Measurement	Audiology - Audiology Assessments	283	1	99.6%	285	264	0	100.0%	328	311	40	87.1%	281
	Cardiology - echocardiography	2,283	651	71.5%	1,330	2,374	730	69.3%	1,399	2,548	907	64.4%	990
	Cardiology - electrophysiology	0	0		3	0	0		4	1	0	100.0%	1
	Neurophysiology - peripheral neurophys	307	0	100.0%	267	311	0	100.0%	277	292	0	100.0%	233
	Respiratory physiology - sleep studies	556	124	77.7%	293	444	84	81.1%	334	505	97	80.8%	208
	Urodynamics - pressures & flows	0	0		0	0	0		0	0	0		
Endoscopy	Colonoscopy	933	417	55.3%	364	911	493	45.9%	369	919	571	37.9%	133
	Flexi sigmoidoscopy	553	236	57.3%	88	559	274	51.0%	69	554	351	36.6%	32
	Cystoscopy	135	6	95.6%	226	143	17	88.1%	226	274	115	58.0%	167
	Gastroscopy	810	429	47.0%	727	828	450	45.7%	674	680	403	40.7%	321
	Totals	25,859	8,821	66%	20,884	25,128	9,331	63%	21,372	23,651	9,126	61%	18,873

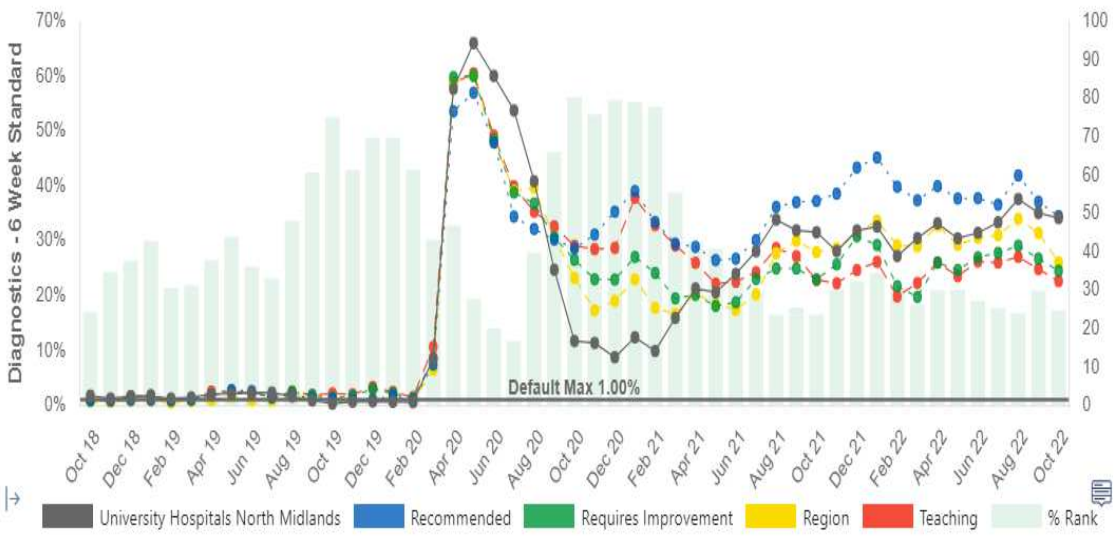


Diagnostics - benchmarked

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Audiology	Oct 22	1.00%	0.4%	L	79
Colonoscopy	Oct 22	1.00%	44.7%	H	30
Computed Tomography	Oct 22	1.00%	0.3%	L	75
Cystoscopy	Oct 22	1.00%	4.4%	L	75
DM01 Waiting <13 Weeks	Oct 22	100.00%	90.1%	L	38
Diagnostics - 6 Week Standard	Oct 22	1.00%	34.1%	H	25
Diagnostics - 6 Week Standard ...	Oct 22	99.00%	65.9%	L	25
Echocardiography	Oct 22	1.00%	28.5%	H	45
Electrophysiology	Oct 22	1.00%	-	C	-
Flexi Sigmoidoscopy	Oct 22	1.00%	42.7%	H	29
Gastroscopy	Oct 22	1.00%	53.0%	H	12
Magnetic Resonance Imaging	Oct 22	1.00%	16.7%	H	32
Neurophysiology	Oct 22	1.00%	0.0%	L	100
Non-obstetric Ultrasound	Oct 22	1.00%	55.0%	H	4
Sleep Studies	Oct 22	1.00%	22.3%	C	46
Urodynamics	Oct 22	1.00%	-	C	-

Diagnostics - 6 Week Standard | Ranking | Trend | Delta | SPC | Commentary



- Performance at UHNM is showing the same trend as all other peers and in line with the "Recommended" group.
- UHNM remains in the bottom quartile.

Planned care - *Diagnostics*

NHS University Hospitals of North Midlands NHS Trust

Diagnostics Summary

- During December the Diagnostic activity dipped just below 100% when compared with 19/20 BAU at 96%.
- DM01 performance was 61% overall, with key areas of underperformance in non-obstetric ultrasound and Endoscopy

Histology position – this is a slightly improved position from last month:

- Urgent - 95% reported at Day 19, 80% of cases reported by Day 10
- Accelerated - 95% reported at Day 35, 80% of cases reported at Day 27
- Routine - 95% reported at Day 39, 80% reported at Day 31

Actions

Top 6 contributors for DM01 performance have developed recovery plans, and have been requested to refresh these plans in line with National timescales for recovery (March 23). To be monitored once complete by Planned Care Group.

DM01 performance 61%: 9,126 patients waiting 6 weeks+; while the DM01 % has deteriorated from last month the total number of patients waiting over 6 weeks has come down from 9,776

Top Contributors – in order of highest breach %

1.	Flexi Sigmoidoscopy (36.6%)	351 breaches of 554 patients
2.	Colonoscopy (37.9%)	571 breaches of 919 patients
3.	Gastroscopy (40.7%)	403 breaches of 680 patients
4.	Non-Obstetric Ultrasound (42.1%)	5597 breaches of 9667 patients (total waiting list size reduced by 1174 patients in month)
5.	Cystoscopy (58%)	115 breaches of 274 patients

Radiology reporting backlogs;

- Radiology workforce business case part approved – approval to recruit to 10wte radiology consultants; 2 Locum radiologists have been recruited and started in post.
- Weekly Radiology backlog risk management meetings are now in place with the speciality clinical leads, divisional and directorate management representatives with specialty specific action plans and individual risk register entries
- Price per scan TI payment model approved until Dec 2023 to support an increase in reporting and outsourcing remains in place
- Risk 25512 remains at score - 20
- Current no of radiology reports in the backlog is: c16,500
- **Non – obs Ultrasound capacity for routine patients** New outsourced provider procured & reflected in boost in activity. Trajectory to meet DM01 by March ’23
- **Endoscopy;** Fluctuating cancer referral demand against lack of scopist availability. Full recovery plan in negotiation, this remains of concern

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Planned Care

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

- Day Case activity and Elective Activity have moved from delivering 96% and 88% respectively in November to 92% and 93% in December. This is still some way from the national ask of 110%/108%. This is against a backdrop of increase cancelations. There is a real focus on the reintroduction of 6-5-4 with support from the regional theatres team.
- The focus has moved to 78 week waiters with an Annual Plan to reduce them to below 300 patients by March 2023. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge well before March so any treatment can be carried out to meet the 78 week standard.

RTT

- The overall Referral To Treatment (RTT) Waiting has increased from 76,902 in November to 77,727 in December.
- The number of patients > 52 weeks continues to increase – 5397 in December. 4377 in August, 4,569 in September, 4628 in October and 4979 in November.
- At the end of December the numbers of >104 patients was 50. An increase of 11 from the end of November (albeit largely different patients).
- The Trust has continued to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment.

Diagnostics Summary

- During December the Diagnostic activity dipped just below 100% when compared with 19/20 BAU at 96%.
- DM01 performance was 61% overall, with key areas of underperformance in non-obstetric ultrasound and Endoscopy

Histology position – this is a slightly improved position from last month:

- Urgent - 95% reported at Day 19, 80% of cases reported by Day 10
- Accelerated - 95% reported at Day 35, 80% of cases reported at Day 27
- Routine - 95% reported at Day 39, 80% reported at Day 31

Radiology reporting backlog:

- High risk relating to 'routine / non cancer reporting' due to reporting capacity and delays in diagnosis Risk 25512 remains at score - 20

Endoscopy:

- Improvement plan being developed and there are now weekly performance meeting for this service

Inpatient and Outpatient Decile & Ethnicity

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

Inpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	10.53%	9.18%	9.00%	7.46%	7.54%	11.70%	12.32%	10.18%	14.05%	7.56%	0.49%
Weeks Waited- 78-104	15.80%	12.21%	9.69%	7.33%	6.68%	9.85%	10.42%	8.31%	13.03%	4.97%	1.71%
Weeks Waited- 52-77	13.33%	12.27%	9.68%	9.09%	6.29%	11.18%	10.80%	9.53%	11.99%	4.95%	0.90%
Weeks Waited- Under 52	13.84%	11.65%	10.19%	9.16%	7.49%	10.91%	10.19%	8.88%	11.11%	5.40%	1.19%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.03%	10.19%	9.23%	9.13%	7.77%	11.26%	11.39%	9.94%	12.46%	6.61%	0.99%
Weeks Waited- 78-104	13.36%	11.04%	9.78%	8.77%	7.65%	10.54%	10.82%	9.55%	11.55%	5.99%	0.96%
Weeks Waited- 52-77	12.55%	11.42%	9.77%	9.08%	7.99%	10.76%	10.47%	8.85%	11.60%	6.36%	1.15%
Weeks Waited- Under 52	13.41%	11.40%	10.08%	8.96%	7.55%	10.60%	10.55%	9.02%	11.27%	5.97%	1.20%

Inpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.22%	0.41%	0.08%	0.38%	0.38%	0.62%	0.05%	0.05%	0.19%	0.38%	0.43%	0.22%	0.05%	0.03%	93.22%	0.35%	0.76%	1.89%	0.30%
Weeks Waited- 78-104	0.49%	0.73%	0.08%	0.49%	0.24%	1.22%	#N/A	0.33%	0.33%	0.08%	1.06%	0.08%	#N/A	0.08%	89.90%	0.24%	1.47%	1.79%	1.38%
Weeks Waited- 52-77	0.44%	0.59%	0.25%	0.62%	0.47%	1.06%	0.09%	0.16%	0.12%	0.65%	1.56%	0.09%	0.19%	0.09%	86.99%	0.34%	2.46%	1.74%	#N/A
Weeks Waited- Under 52	0.41%	0.64%	0.24%	0.61%	0.60%	1.20%	0.13%	0.16%	0.14%	0.50%	1.61%	0.28%	0.14%	0.24%	84.41%	0.27%	2.81%	2.52%	3.09%

Outpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.27%	0.48%	0.22%	0.48%	0.43%	0.84%	0.09%	0.17%	0.11%	0.40%	1.46%	0.17%	0.13%	0.09%	88.35%	0.35%	2.64%	2.06%	1.27%
Weeks Waited- 78-104	0.37%	0.61%	0.17%	0.51%	0.56%	1.03%	0.07%	0.17%	0.10%	0.51%	1.87%	0.32%	0.17%	0.19%	86.90%	0.26%	2.31%	2.09%	1.80%
Weeks Waited- 52-77	0.39%	0.62%	0.18%	0.67%	0.54%	1.30%	0.16%	0.21%	0.18%	0.62%	1.69%	0.28%	0.12%	0.21%	84.74%	0.32%	2.91%	2.34%	2.53%
Weeks Waited- Under 52	0.45%	0.65%	0.20%	0.63%	0.58%	1.25%	0.14%	0.17%	0.15%	0.57%	1.78%	0.33%	0.17%	0.24%	82.81%	0.29%	3.26%	2.77%	#N/A

APPENDIX 1

Operational Performance

NHS
University Hospitals of North Midlands
NHS Trust

Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	Percentage of Ambulance Handovers within 15 minutes	0%	42.95%			
	Ambulance handovers greater than 60 minutes	0	1379	H	?	
	Time to Initial Assessment - percentage within 15 minutes	85%	45.22%	L	F	
	Average (mean) time in Department - non-admitted patients	180	365	H	?	
	Average (mean) time in Department - admitted patients	180	519	H	F	
	Clinically Ready to Proceed	90	655	H	F	
	12 Hour Trolley Waits	0	1289	H	?	
	Patients spending more than 12 hours in A&E	0	2817	H	F	
	Median Wait to be seen - Type 1	60	143	H	F	
	Bed Occupancy	92%	87.91%			
Cancer Care	Cancer 28 day faster pathway	75%	67.35%		F	
	Cancer 62 GP ref	85%	41.11%	L	F	
	Cancer 62 day Screening	90%	85.00%		?	
	31 day First Treatment	96%	89.88%	L	?	
	2WW First Seen (exc Breast Symptom)	93%	97.33%	H	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.8%		?	
	Cancelled Ops	150	222		?	
	Theatre Utilisation	85%	75.1%			
Inpatient / Discharge	Same Day Emergency Care	30%	34%	H	?	
	Super Stranded	183	192	H	?	
	MFFD	100	104	L	F	
	Discharges before Midday	25%	19.1%		F	
	Emergency Readmission rate	8%	9.4%	L	F	
Elective waits	RTT incomplete performance	92%	50.60%	L	F	
	RTT 52+ week waits	0	5429	H	F	
	Diagnostics	99%	60.70%	L	F	

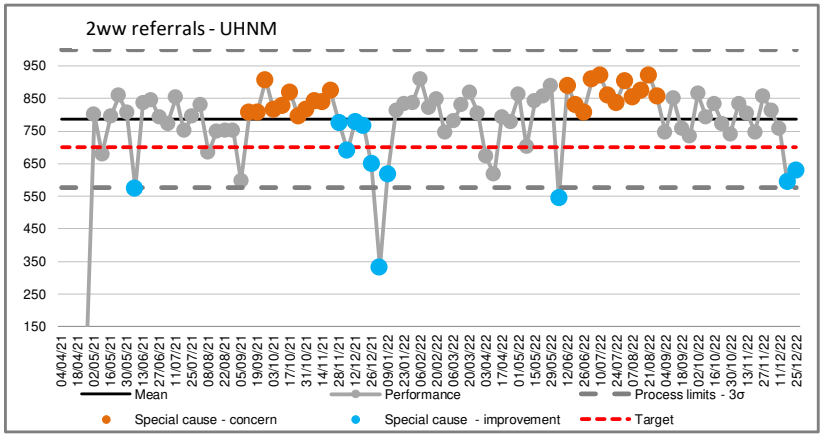
Delivering Exceptional Care with Exceptional People

Cancer – 62 Day

Target	Oct 22	Nov 22	Dec 22
700	756	593	629

Background

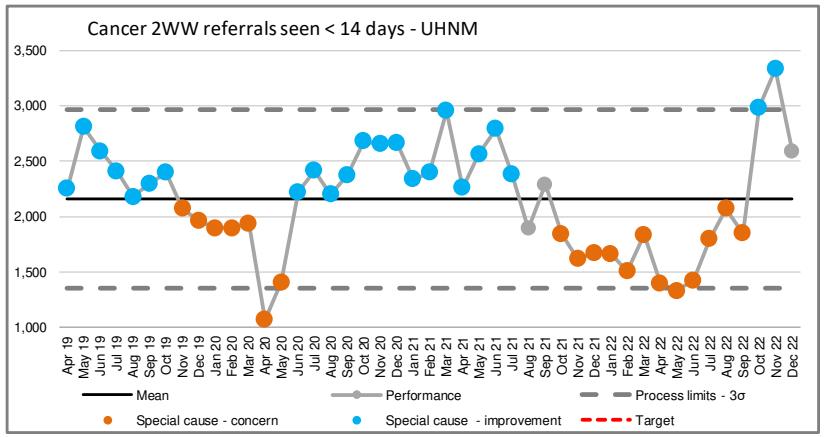
The number of patients referred on a cancer 2ww pathway.



Target	Oct 22	Nov 22	Dec 22
N/A	2984.0	3332.0	2587.0

Background

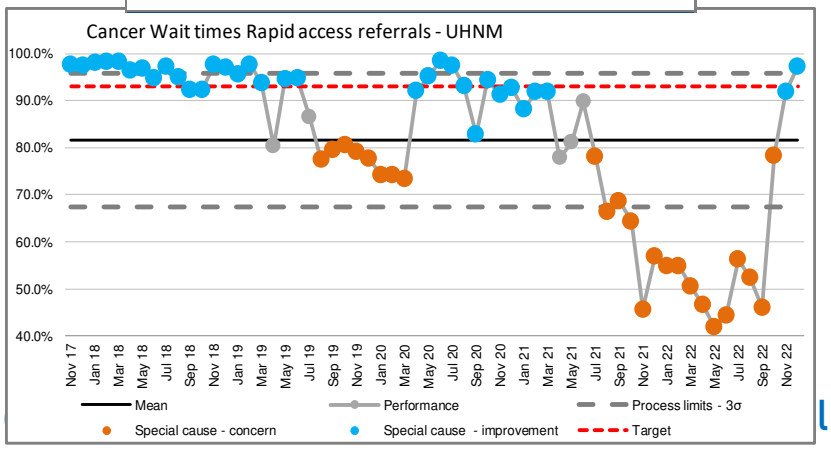
The percentage of patients waiting over 18 weeks for treatment since their referral.



Target	Oct 22	Nov 22	Dec 22
93%	78.4%	91.8%	97.3%

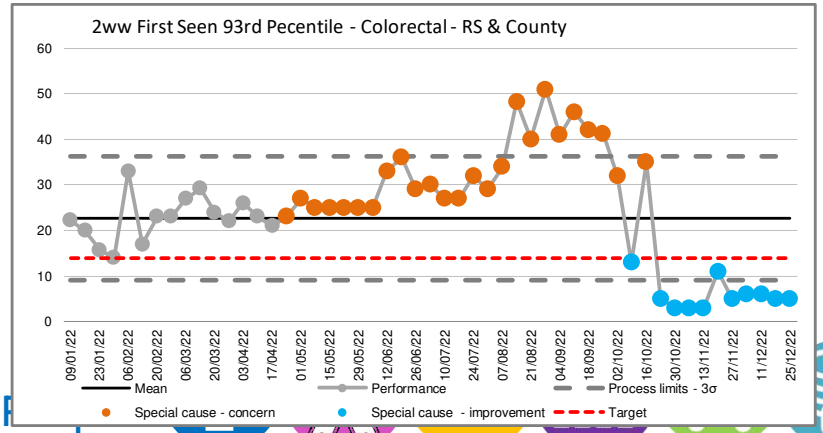
Background

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

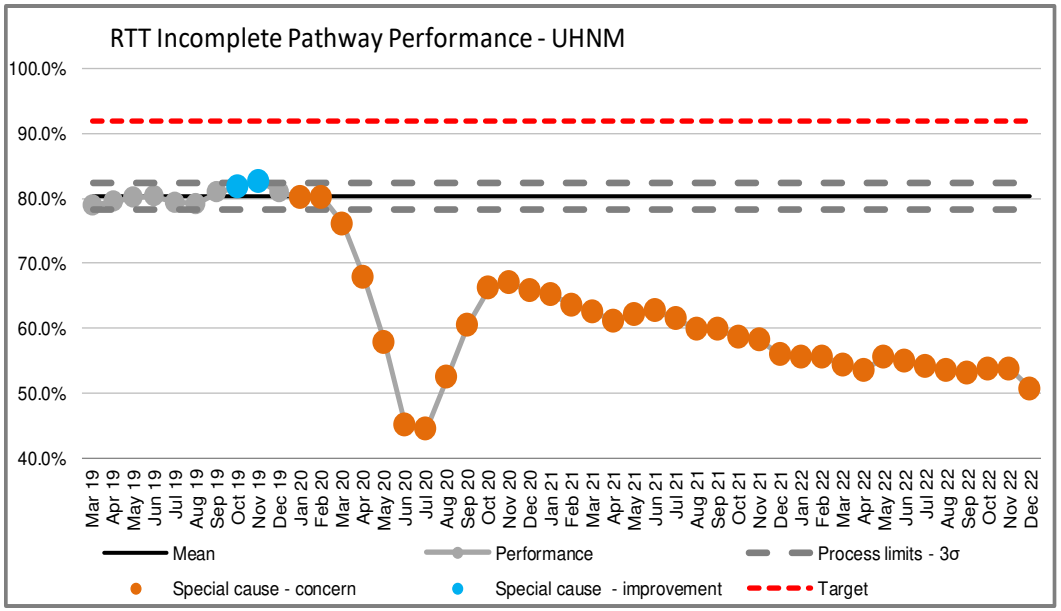


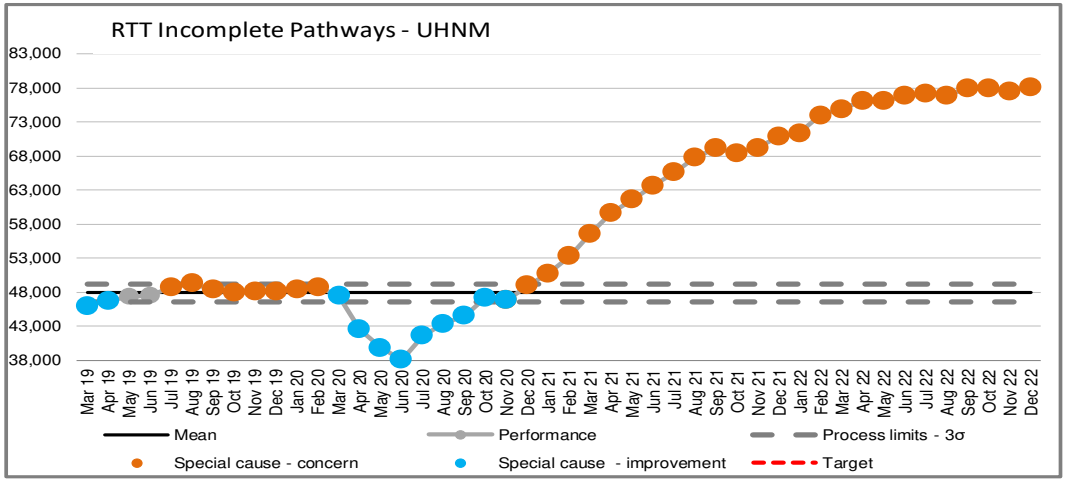
Variation	Assurance
	

Target	Dec 22	Dec 22	Dec 22
14	6	5	5



Referral To Treatment





Variation	Assurance
	

Target	Oct 22	Nov 22	Dec 22
92%	53.6%	53.7%	50.6%

Background

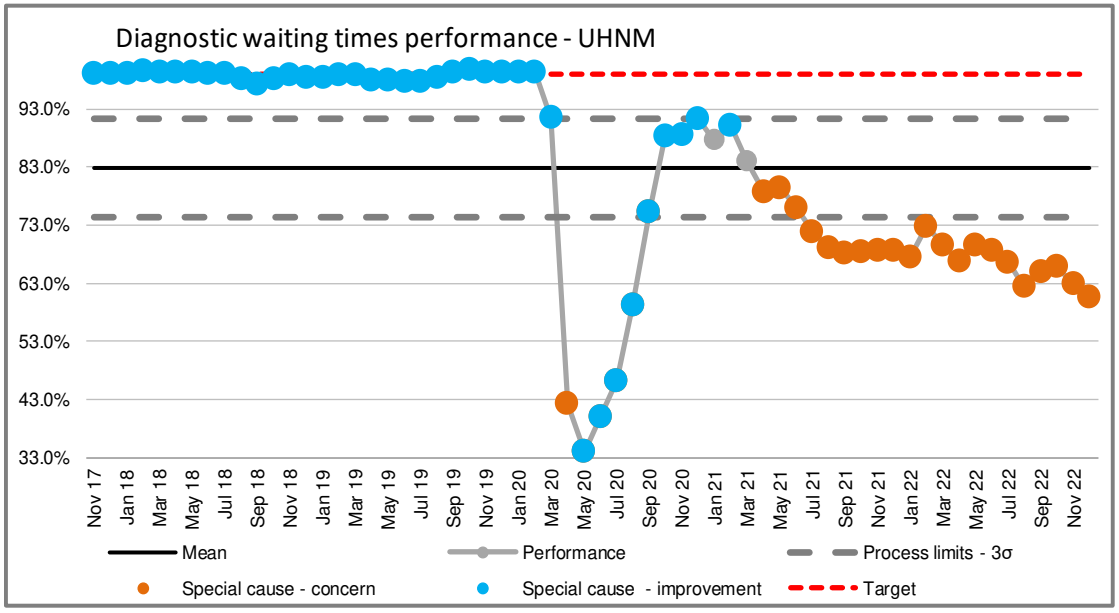
The percentage of patients waiting less than 18 weeks for treatment.

What is the data telling us?

Steady decline in performance since the pandemic began.

Diagnostic Standards

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
	

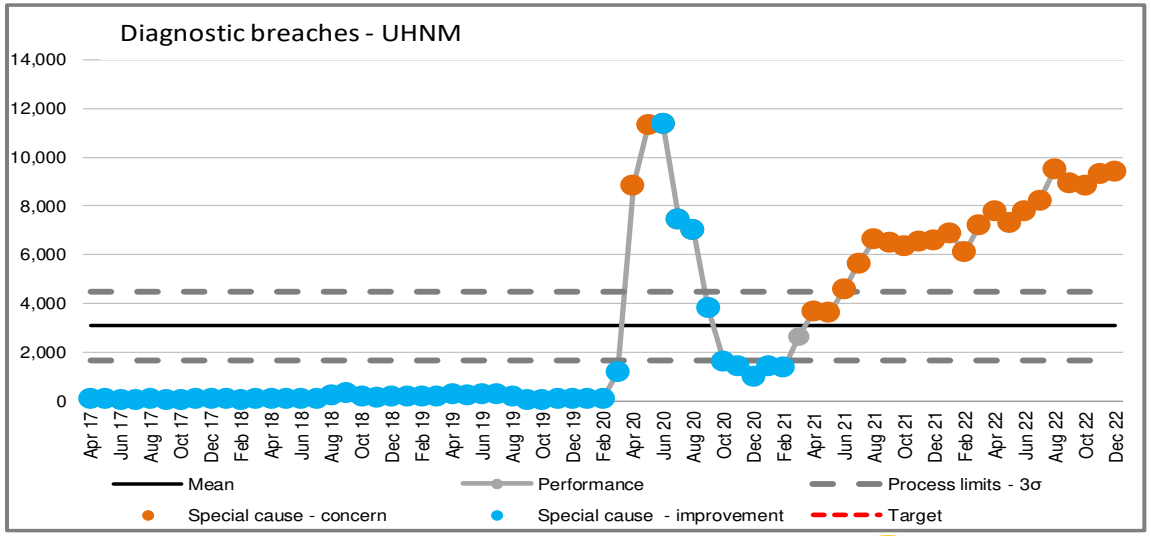
Target	Oct 22	Nov 22	Dec 22
99%	65.9%	62.9%	60.7%

Background

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

What is the data telling us?

The diagnostic performance has shown normal variation up until March 2020. Waiting times performance continues to reduce, with the number of patients waiting longer than 6 weeks for their test continues to increase.



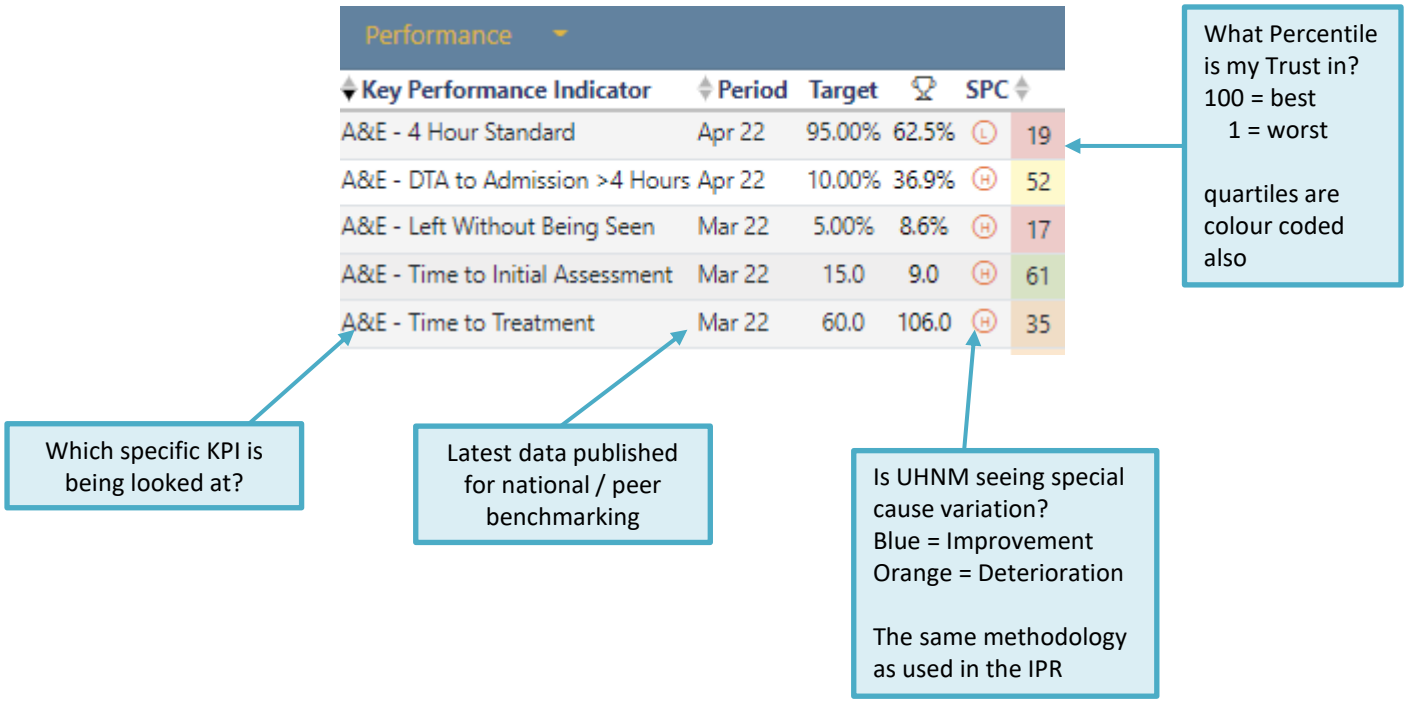
NHS
University Hospitals of North Midlands
NHS Trust

UHNM Benchmarked Performance

Contents

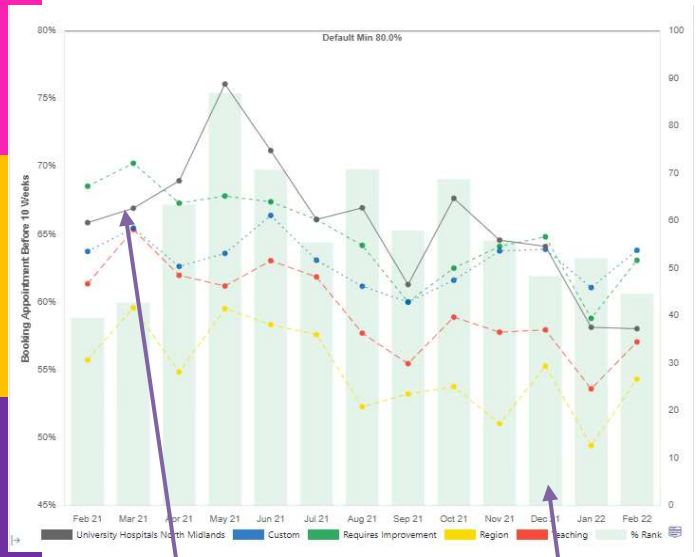
Section		Page
1.	Quick guide ➢ Understanding the Tables ➢ Understanding the charts	2
2.	Urgent Care	4
3.	Cancer	11
4.	Referral To Treatment	14
5.	Diagnostics	17

UHNM Benchmarked Performance – understanding the Tables



UHNM Benchmarked Performance – understanding the Charts

University Hospitals of North Midlands NHS Trust



Each different colour line represents a different group of Peers. These relate to the left hand axis.

The bars are UHNM's National ranking over time and correspond to the right hand axis number.

UHNM and 4 differing peer groups for comparison

The chart allows us to compare UHNM performance (black line) with four different peer groups. These groups are listed below;

University Hospitals North Midlands	➢	My Trust
Recommended	➢	A recommended group of Trusts based on combination of size, finance and activity (used in Model hospital/HED)
Requires Improvement	➢	All Trusts with a CQC rating of Requires improvement
Region	➢	All Local Trusts within the region (Midlands and East)
Teaching	➢	All Teaching hospitals

The selected Trusts for "recommended";

Recommended

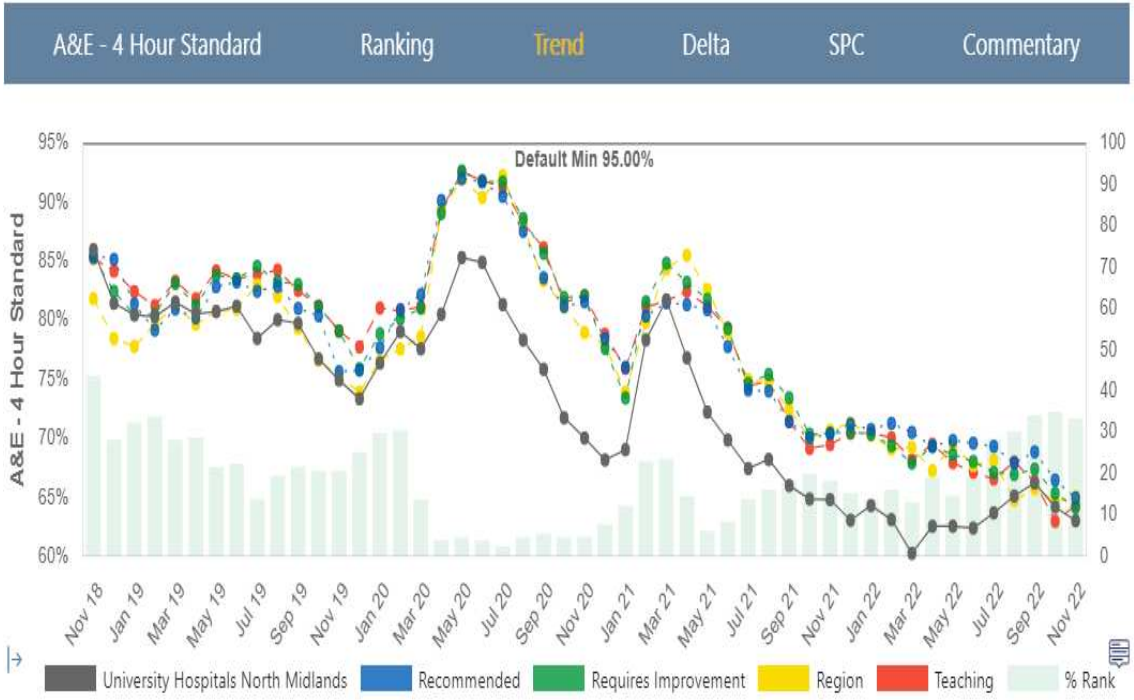
- University Hospitals Coventry and Warwickshire NHS Trust
- University Hospitals of Derby and Burton NHS Foundation Trust
- Nottingham University Hospitals NHS Trust
- University Hospitals Birmingham NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- East Kent Hospitals University NHS Foundation Trust
- York & Scarborough Teaching Hospitals NHS Foundation Trust
- East Suffolk and North Essex NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust

Urgent Care - 4 hour standard

NHS
University Hospitals of North Midlands
NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Nov 22	95.00%	63.0%	L	33
A&E - 4 Hour Standard (Type 1)	Nov 22	95.0%	43.2%	L	11
A&E - 4 Hour Standard (Type 2 ...	Nov 22	95.0%	94.8%	L	31
A&E - Conversion Rate	Nov 22	25.0%	22.4%	L	31
A&E - DTA to Admission >12 H...	Nov 22	0.0%	18.7%	H	22
A&E - DTA to Admission >12 H...	Nov 22	0.0	947.0	H	5
A&E - DTA to Admission >4 Ho...	Nov 22	10.00%	34.4%	H	58
A&E - Left Without Being Seen	Oct 22	5.00%	0.0%	C	100
A&E - Reattendance Rate	Oct 22	5.0%	9.6%	C	12
A&E - Time to Initial Assessment	Oct 22	15.0	9.0	C	63
A&E - Time to Treatment	Oct 22	60.0	-	C	-
A&E - Total Time in A&E	Oct 22	160.0	187.0	H	62
A&E - Total Time in A&E (Admit...	Oct 22	180.0	-	C	-
A&E - Total Time in A&E (Non-...	Oct 22	140.0	168.0	C	63



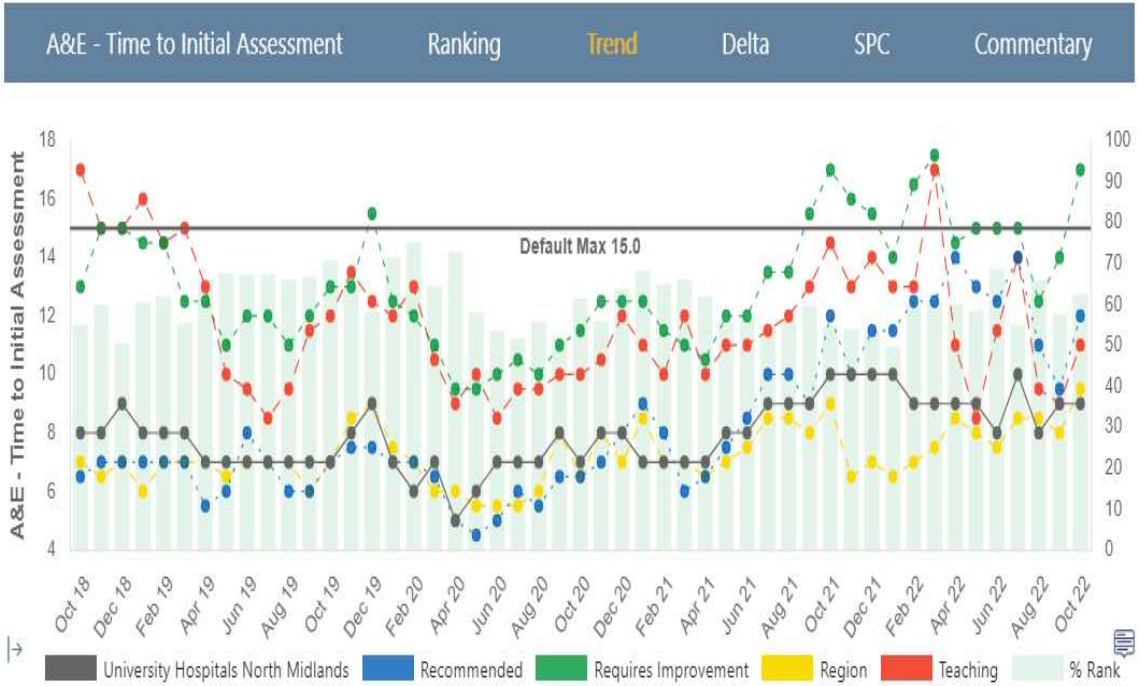
- UHNM 4 hour performance is below the three peer groups selected.
- The divergence from peer happened around May 2019 (pre pandemic) with the impact of Covid then widening the gap from peers.
- Since March 2022 UHNM have seen improvement in the 4 hour performance whilst pees remain on a downward trend, however since September UHNM are also seeing the same deterioration as all other peers.

Urgent Care – Initial Assessment

NHS University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Nov 22	95.00%	63.0%	L	33
A&E - 4 Hour Standard (Type 1)	Nov 22	95.0%	43.2%	L	11
A&E - 4 Hour Standard (Type 2 ...	Nov 22	95.0%	94.8%	L	31
A&E - Conversion Rate	Nov 22	25.0%	22.4%	L	31
A&E - DTA to Admission >12 H...	Nov 22	0.0%	18.7%	H	22
A&E - DTA to Admission >12 H...	Nov 22	0.0	947.0	H	5
A&E - DTA to Admission >4 Ho...	Nov 22	10.00%	34.4%	H	58
A&E - Left Without Being Seen	Oct 22	5.00%	0.0%	C	100
A&E - Reattendance Rate	Oct 22	5.0%	9.6%	C	12
A&E - Time to Initial Assessment	Oct 22	15.0	9.0	C	63
A&E - Time to Treatment	Oct 22	60.0	-	C	-
A&E - Total Time in A&E	Oct 22	160.0	187.0	H	62
A&E - Total Time in A&E (Admit...	Oct 22	180.0	-	C	-
A&E - Total Time in A&E (Non-...	Oct 22	140.0	168.0	C	63



- UHNM have maintained the time to initial assessment under 10 minutes
- In October UHNM performed better than all other peer groups

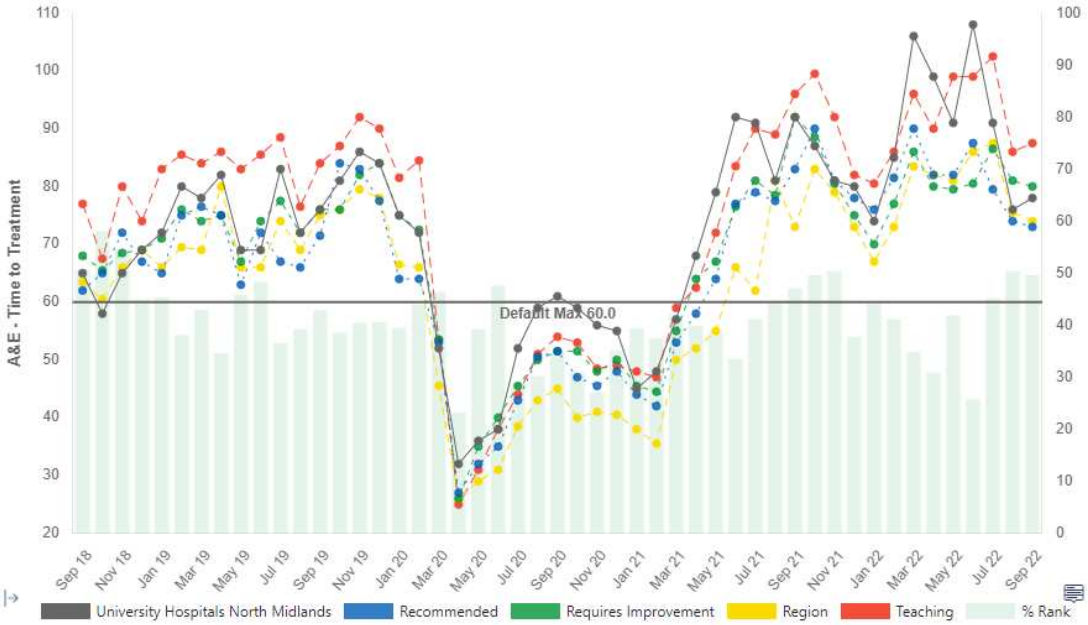
Urgent Care – Time to Treatment

NHS
University Hospitals of North Midlands
NHS Trust

Key Performance Indicator

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

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



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

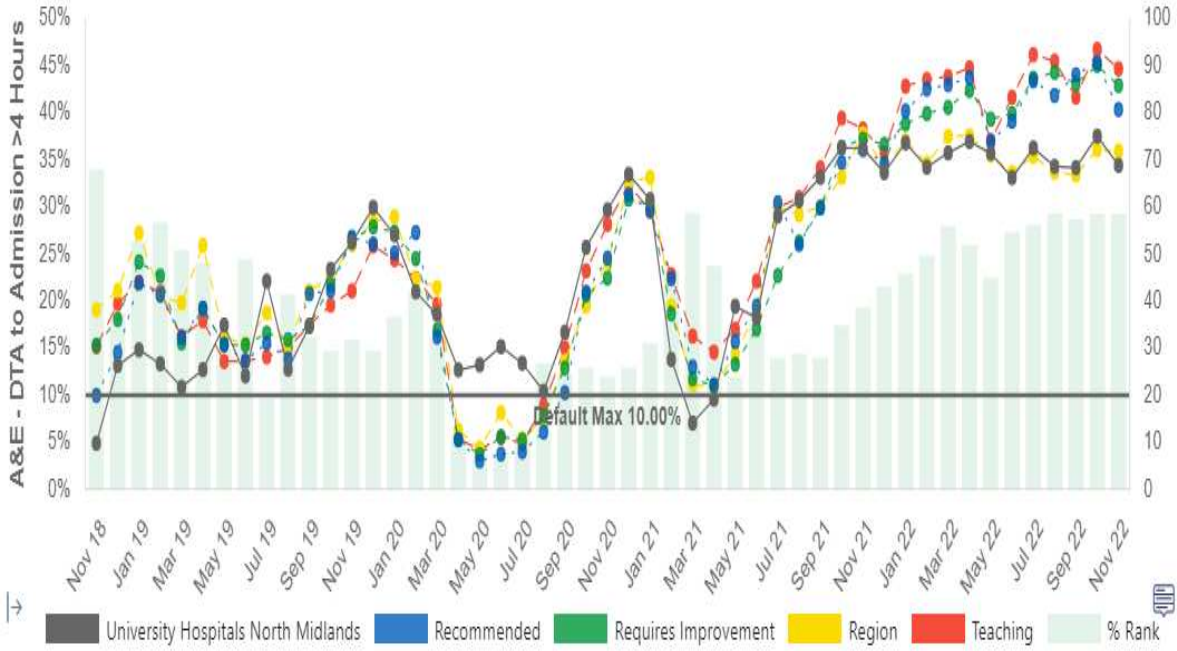
Urgent Care – DTA waits over 4 hours

University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Nov 22	95.00%	63.0%	L	33
A&E - 4 Hour Standard (Type 1)	Nov 22	95.0%	43.2%	L	11
A&E - 4 Hour Standard (Type 2 ...	Nov 22	95.0%	94.8%	L	31
A&E - Conversion Rate	Nov 22	25.0%	22.4%	L	31
A&E - DTA to Admission >12 H...	Nov 22	0.0%	18.7%	H	22
A&E - DTA to Admission >12 H...	Nov 22	0.0	947.0	H	5
A&E - DTA to Admission >4 Ho...	Nov 22	10.00%	34.4%	H	58
A&E - Left Without Being Seen	Oct 22	5.00%	0.0%	C	100
A&E - Reattendance Rate	Oct 22	5.0%	9.6%	C	12
A&E - Time to Initial Assessment	Oct 22	15.0	9.0	C	63
A&E - Time to Treatment	Oct 22	60.0	-	C	-
A&E - Total Time in A&E	Oct 22	160.0	187.0	H	62
A&E - Total Time in A&E (Admit...	Oct 22	180.0	-	C	-
A&E - Total Time in A&E (Non-...	Oct 22	140.0	168.0	C	63

A&E - DTA to Admission >4 Hours | Ranking | Trend | Delta | SPC | Commentary



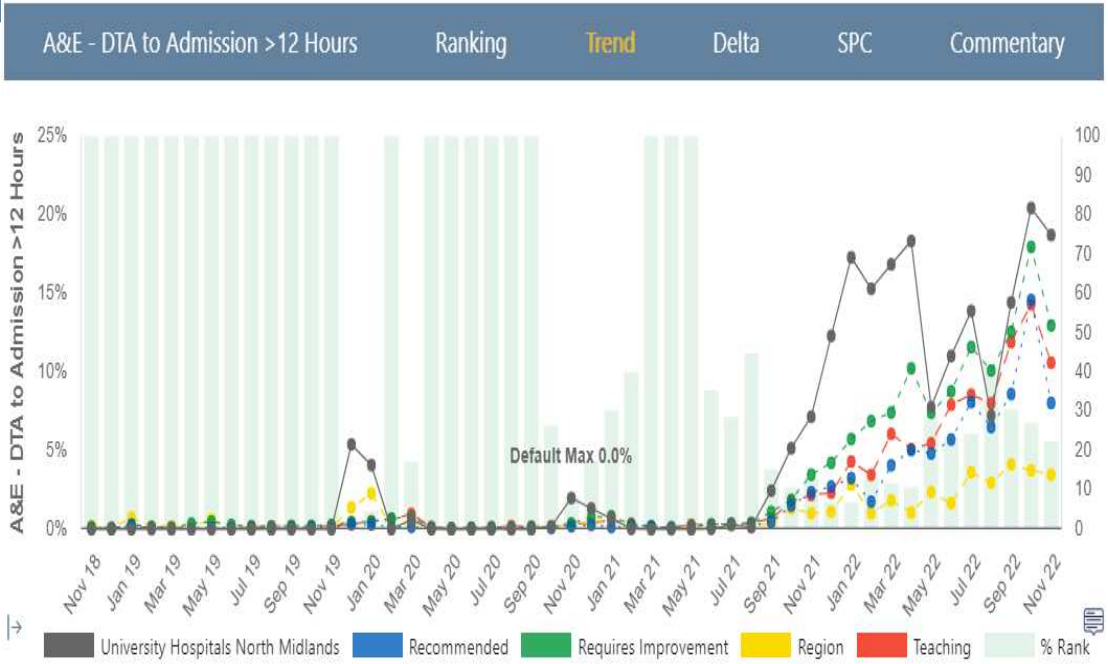
- The percentage of patients waiting over 4 hours from the point of decision to admit is in line with the Region peer, but below all other pee groups.
- Whilst Peers have seen a rise in patients waiting over 4 hours for a bed, UHNM and the Region have remained static since November 2021 around 33%.

Urgent Care – DTA waits over 12 hours

NHS University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Nov 22	95.00%	63.0%	L	33
A&E - 4 Hour Standard (Type 1)	Nov 22	95.0%	43.2%	L	11
A&E - 4 Hour Standard (Type 2 ...	Nov 22	95.0%	94.8%	L	31
A&E - Conversion Rate	Nov 22	25.0%	22.4%	L	31
A&E - DTA to Admission >12 H...	Nov 22	0.0%	18.7%	H	22
A&E - DTA to Admission >12 H...	Nov 22	0.0	947.0	H	5
A&E - DTA to Admission >4 Ho...	Nov 22	10.00%	34.4%	H	58
A&E - Left Without Being Seen	Oct 22	5.00%	0.0%	C	100
A&E - Reattendance Rate	Oct 22	5.0%	9.6%	C	12
A&E - Time to Initial Assessment	Oct 22	15.0	9.0	C	63
A&E - Time to Treatment	Oct 22	60.0	-	C	-
A&E - Total Time in A&E	Oct 22	160.0	187.0	H	62
A&E - Total Time in A&E (Admit...	Oct 22	180.0	-	C	-
A&E - Total Time in A&E (Non-...	Oct 22	140.0	168.0	C	63



- Following the peak in the percentage of patients waiting over 12 hours from the point of DTA early 2022, performance during the middle of the year dropped to the same levels as peer groups.
- Over the last two months this has increased again and UHNM is now higher than all peers.

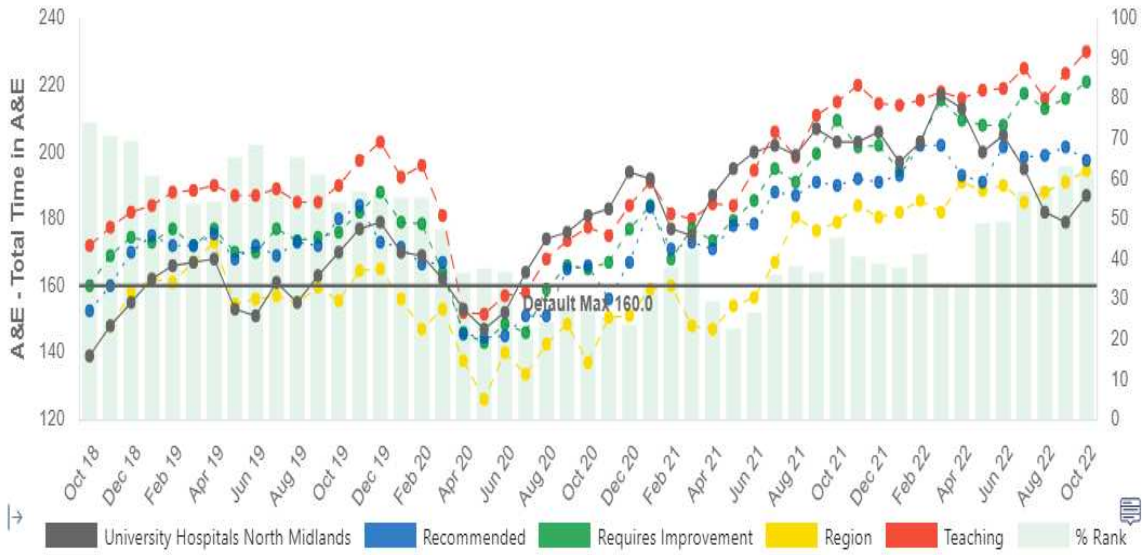
Urgent Care – total time in ED

NHS University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Nov 22	95.00%	63.0%	L	33
A&E - 4 Hour Standard (Type 1)	Nov 22	95.0%	43.2%	L	11
A&E - 4 Hour Standard (Type 2 ...	Nov 22	95.0%	94.8%	L	31
A&E - Conversion Rate	Nov 22	25.0%	22.4%	L	31
A&E - DTA to Admission >12 H...	Nov 22	0.0%	18.7%	H	22
A&E - DTA to Admission >12 H...	Nov 22	0.0	947.0	H	5
A&E - DTA to Admission >4 Ho...	Nov 22	10.00%	34.4%	H	58
A&E - Left Without Being Seen	Oct 22	5.00%	0.0%	C	100
A&E - Reattendance Rate	Oct 22	5.0%	9.6%	C	12
A&E - Time to Initial Assessment	Oct 22	15.0	9.0	C	63
A&E - Time to Treatment	Oct 22	60.0	-	C	-
A&E - Total Time in A&E	Oct 22	160.0	187.0	H	62
A&E - Total Time in A&E (Admit...	Oct 22	180.0	-	C	-
A&E - Total Time in A&E (Non-...	Oct 22	140.0	168.0	C	63

A&E - Total Time in A&E | Ranking | Trend | Delta | SPC | Commentary



- Total time in the department pre pandemic was consistently below peer, however since May 2020 UHNM have been above Peer
- During 2022 UHNM have improved to below peer levels which was seen pre pandemic.

Urgent Care - conclusion

University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Nov 22	95.00%	63.0%	L	33
A&E - 4 Hour Standard (Type 1)	Nov 22	95.0%	43.2%	L	11
A&E - 4 Hour Standard (Type 2 ...	Nov 22	95.0%	94.8%	L	31
A&E - Conversion Rate	Nov 22	25.0%	22.4%	L	31
A&E - DTA to Admission >12 H...	Nov 22	0.0%	18.7%	H	22
A&E - DTA to Admission >12 H...	Nov 22	0.0	947.0	H	5
A&E - DTA to Admission >4 Ho...	Nov 22	10.00%	34.4%	H	58
A&E - Left Without Being Seen	Oct 22	5.00%	0.0%	C	100
A&E - Reattendance Rate	Oct 22	5.0%	9.6%	C	12
A&E - Time to Initial Assessment	Oct 22	15.0	9.0	C	63
A&E - Time to Treatment	Oct 22	60.0	-	C	-
A&E - Total Time in A&E	Oct 22	160.0	187.0	H	62
A&E - Total Time in A&E (Admit...	Oct 22	180.0	-	C	-
A&E - Total Time in A&E (Non-...	Oct 22	140.0	168.0	C	63

Since the last benchmarking pack UHNM have improved in most ED pathway metrics, whilst there are some that require further improvement.

Metrics with the greatest improvement:

- Time to initial assessment – ranking has improved from 56 in July to 63 in October. UHNM have consistently been better than most peers.
- Total time in A&E – ranking has improved from 56 in July to 62 in October. Since June all peers have deteriorated whilst UHNM have improved. Predominantly seen for non admitted patients as this ranking has improved from 36 in July to 63 in October and is better than all peers.

Area that requires the greatest improvement:

- 12 hour waits for admitted patients – ranking has dropped from 41 in August to 22 in November. All peers are following the same trend, however UHNM is higher than peers.

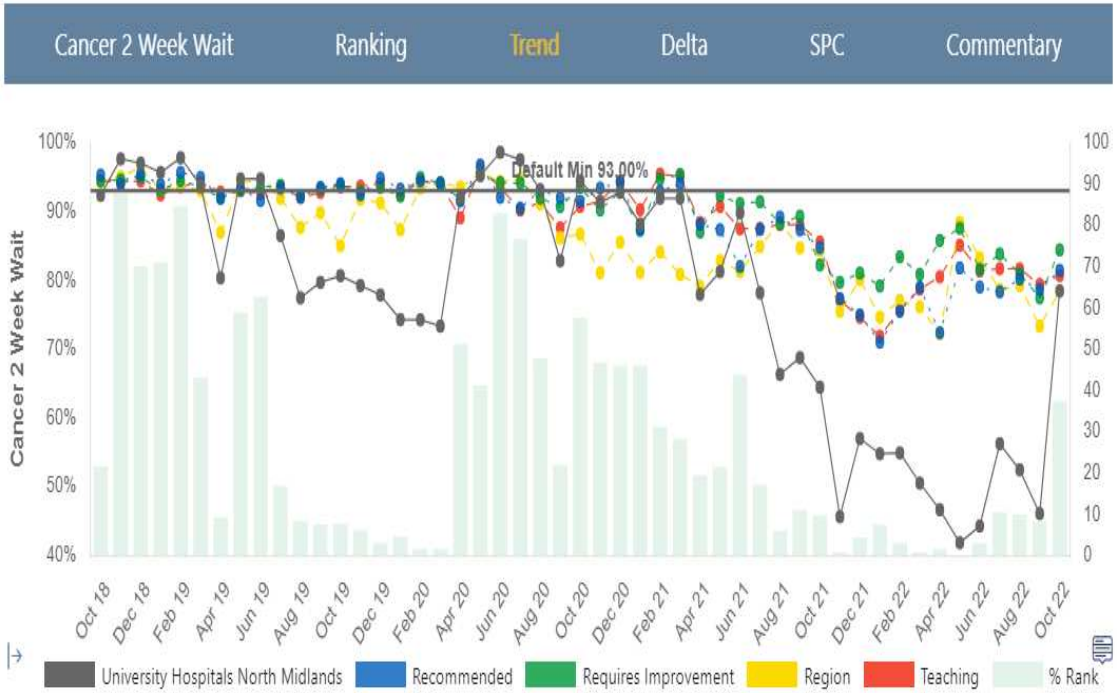
Additional suggested focus areas:

- 4 hour performance (Type 1) – performance remains similar to August 2022, however UHNM are ranked in the bottom quartile, at 11th. All other peers are better than UHNM.
- Re-attendance Rate – although this metric has remained unchanged since July, UHNM are in the bottom quartile, at 12th. All other peers are significantly better than UHNM.

Cancer

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Cancer 2 Week Wait	Oct 22	93.00%	78.4%	L	37
Cancer 2 Week Wait Breast Sym...	Oct 22	93.0%	97.1%	C	72
Cancer 31 Day First Treatment	Oct 22	96.00%	87.2%	L	14
Cancer 31 Day Subsequent Trea...	Oct 22	96.0%	86.6%	L	17
Cancer 62 Day All Sources	Oct 22	85.00%	58.1%	L	24
Cancer 62 Day Consultant Upgr...	Oct 22	85.0%	77.9%	H	56
Cancer 62 Day Screening	Oct 22	90.0%	72.4%	L	48
Cancer Sub Treat Drugs	Oct 22	96.0%	100%	C	100
Cancer Sub Treat Radiotherapy	Oct 22	96.0%	91.7%	C	32



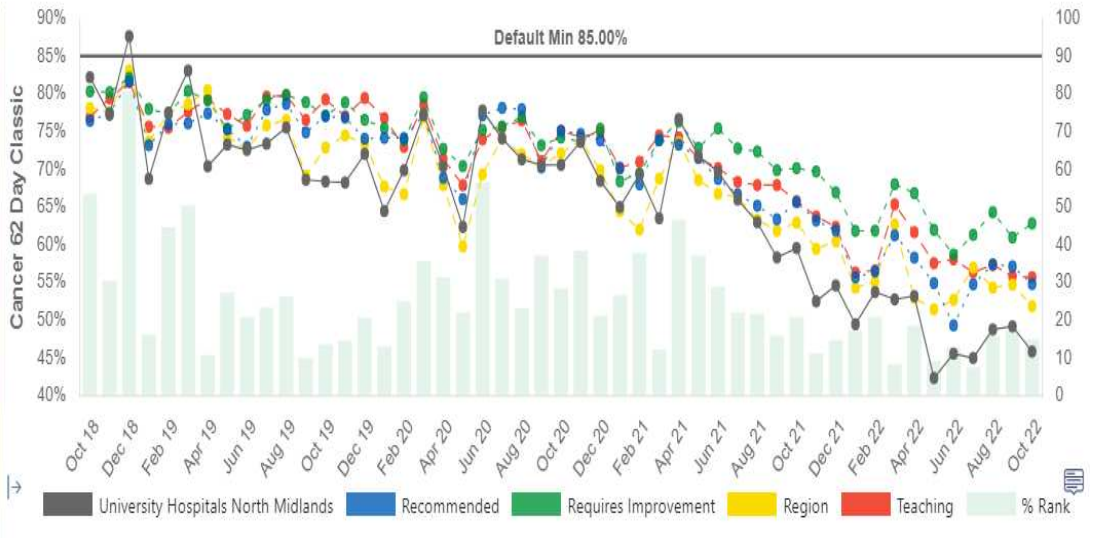
- UHNM have seen 14 day performance deteriorate at a greater scale than it's peers since July 2021.
- October 2022 has seen a much improved 14 day position at 78.4%. As a result UHNM have moved out of the lowest quartile to position 37.

Cancer

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Breast Cancer	Oct 22	85.00%	60.9%	L	25
Cancer 62 Day Classic	Oct 22	85.00%	45.8%	L	15
Lower Gastrointestinal Cancer	Oct 22	85.00%	13.3%	L	13
Lung Cancer	Oct 22	85.00%	52.6%	L	59
Other Cancer	Oct 22	85.00%	46.3%	L	33
Skin Cancer	Oct 22	85.00%	39.5%	L	8
Urological Cancer	Oct 22	85.00%	52.6%	L	44

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



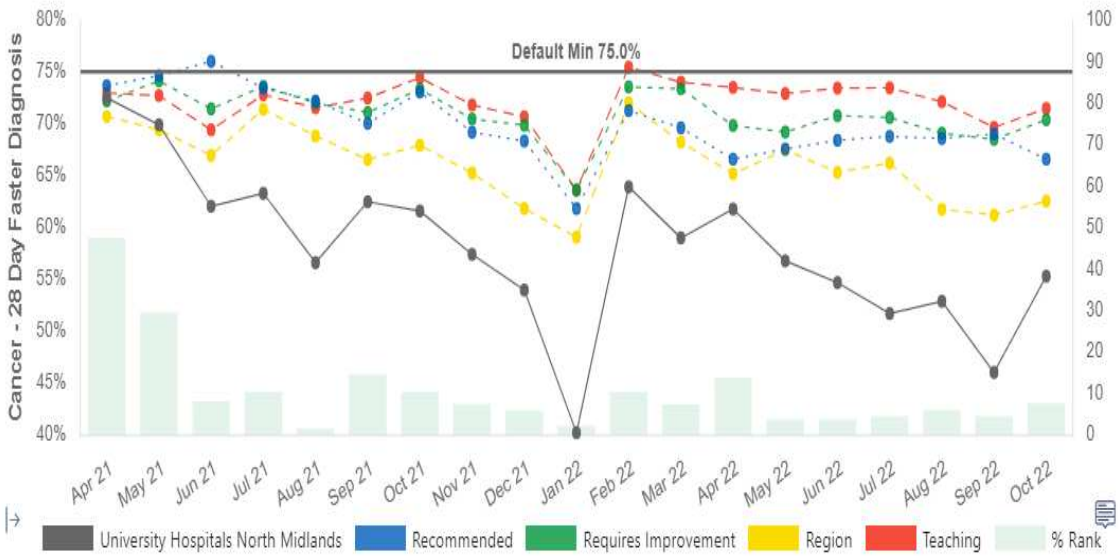
- Deterioration has been seen across all peer groups since April 2021 with UHNM seeing this more dramatically from August 2021
- UHNM remain in the lowest quartile for the 62 day performance.

Cancer

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	55.3%	L	8
FDS Acute Leukaemia	Oct 22	75.0%	100%	C	100
FDS Brain Tumours	Oct 22	75.0%	-	C	-
FDS Breast Cancer	Oct 22	75.0%	91.9%	C	46
FDS Breast Symptoms	Oct 22	75.0%	96.8%	C	69
FDS Children's Cancer	Oct 22	75.0%	36.4%	L	4
FDS Gynaecological Cancer	Oct 22	75.0%	46.3%	L	19
FDS Haematological Malignanci...	Oct 22	75.0%	31.1%	L	19
FDS Head & Neck Cancer	Oct 22	75.0%	67.3%	C	24
FDS Lower Gastrointestinal Can...	Oct 22	75.0%	17.2%	L	4
FDS Lung Cancer	Oct 22	75.0%	56.4%	C	16
FDS Missing or Invalid	Oct 22	75.0%	-	C	-
FDS Other Cancer	Oct 22	75.0%	-	C	-
FDS Sarcoma	Oct 22	75.0%	80.0%	C	80
FDS Skin Cancer	Oct 22	75.0%	50.1%	L	12
FDS Testicular Cancer	Oct 22	75.0%	78.3%	C	38
FDS Upper Gastrointestinal Can...	Oct 22	75.0%	91.8%	H	98
FDS Urological Malignancies	Oct 22	75.0%	54.7%	L	39

Cancer - 28 Day Faster Diagnosis | Ranking | Trend | Delta | SPC | Commentary



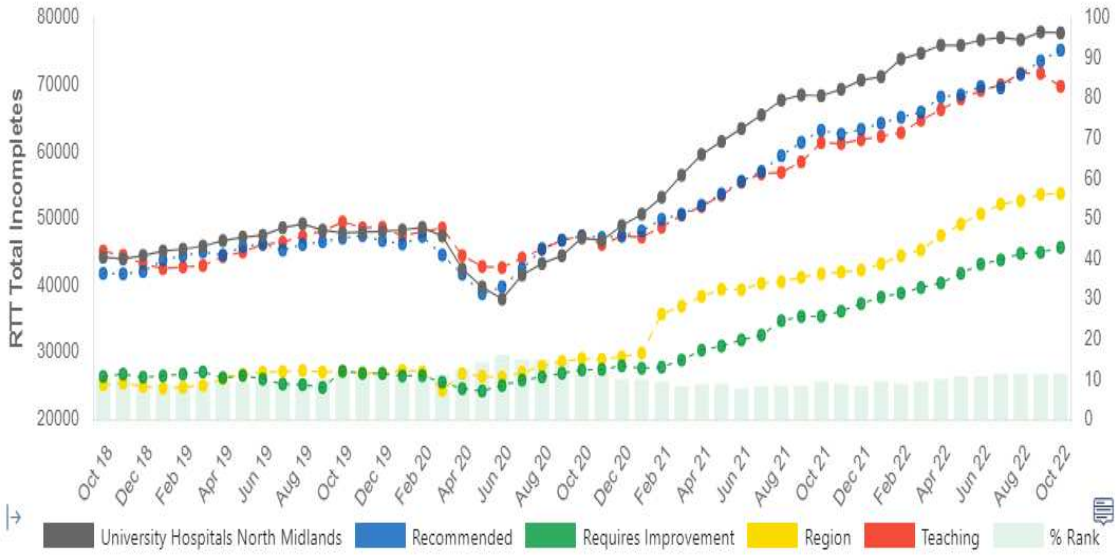
- The 28 Day Faster Diagnosis position has seen a deterioration since February 2022 and is much lower than peers.
- UHNM have seen a much greater improvement than peers in October
- UHNM remains in the lowest quartile nationally

RTT

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
RTT 104 Week Breach	Oct 22	0	24	L	8
RTT 52 Week Breach	Oct 22	0	4,612	H	10
RTT 78 Week Breach	Oct 22	0	683	L	10
RTT 95th Percentile Admitted W...	Oct 22	18.0	82.2	H	9
RTT 95th Percentile Non-Admitt...	Oct 22	18.0	54.1	H	24
RTT Admitted Treatment Within...	Oct 22	90.0%	55.0%	L	35
RTT Average (Median) Admitte...	Oct 22	9.0	15.4	H	34
RTT Average (Median) Non-Ad...	Oct 22	5.0	8.2	H	60
RTT Average Wait for Incomplete	Oct 22	7.00	16.4	H	16
RTT Incomplete 92nd Percentile	Oct 22	-	48.1	H	25
RTT Incomplete Pathways With ...	Oct 22	25.0%	14.6%	H	46
RTT Non-Admitted Treatment ...	Oct 22	95.0%	71.7%	L	50
RTT Total Clock Starts	Oct 22	-	14,999	C	81
RTT Total Clock Stops	Oct 22	-	13,111	C	85
RTT Total Incompletes	Oct 22	-	77,721	H	11

RTT Total Incompletes | Ranking | Trend | Delta | SPC | Commentary



- Total incomplete pathways have seen significant growth across all peer groups.
- Although UHNM incomplete pathways continue to grow, these are at a lesser rate than other peers and over recent months have levelled out more.
- UHNM remain in the bottom quartile.

RTT

NHS University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
RTT 104 Week Breach	Oct 22	0	24	L	8
RTT 52 Week Breach	Oct 22	0	4,612	H	10
RTT 78 Week Breach	Oct 22	0	683	L	10
RTT 95th Percentile Admitted W...	Oct 22	18.0	82.2	H	9
RTT 95th Percentile Non-Admitt...	Oct 22	18.0	54.1	H	24
RTT Admitted Treatment Within...	Oct 22	90.0%	55.0%	L	35
RTT Average (Median) Admitte...	Oct 22	9.0	15.4	H	34
RTT Average (Median) Non-Ad...	Oct 22	5.0	8.2	H	60
RTT Average Wait for Incomplete	Oct 22	7.00	16.4	H	16
RTT Incomplete 92nd Percentile	Oct 22	-	48.1	H	25
RTT Incomplete Pathways With ...	Oct 22	25.0%	14.6%	H	46
RTT Non-Admitted Treatment ...	Oct 22	95.0%	71.7%	L	50
RTT Total Clock Starts	Oct 22	-	14,999	C	81
RTT Total Clock Stops	Oct 22	-	13,111	C	85
RTT Total Incompletes	Oct 22	-	77,721	H	11

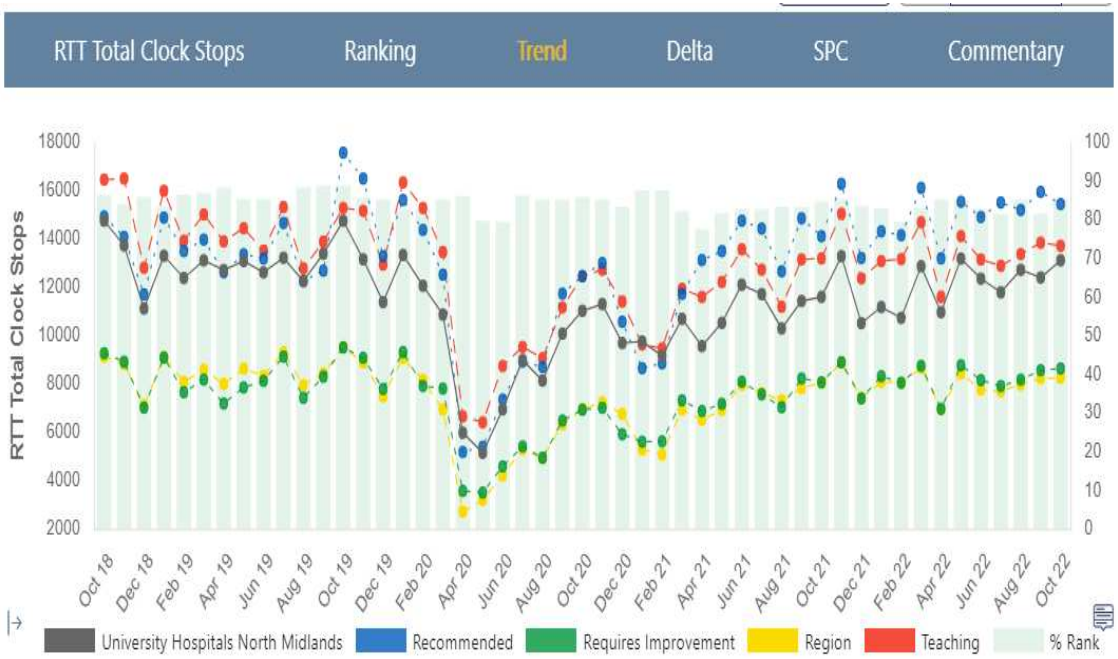
- 78 Week waits are reducing across all peer groups with the exception to “Recommended”
- The reduction at UHNM has been at a greater rate since January 2022 than other peers
- UHNM remain in the bottom quartile

RTT

University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
RTT 104 Week Breach	Oct 22	0	24	L	8
RTT 52 Week Breach	Oct 22	0	4,612	H	10
RTT 78 Week Breach	Oct 22	0	683	L	10
RTT 95th Percentile Admitted W...	Oct 22	18.0	82.2	H	9
RTT 95th Percentile Non-Admitt...	Oct 22	18.0	54.1	H	24
RTT Admitted Treatment Within...	Oct 22	90.0%	55.0%	L	35
RTT Average (Median) Admitte...	Oct 22	9.0	15.4	H	34
RTT Average (Median) Non-Ad...	Oct 22	5.0	8.2	H	60
RTT Average Wait for Incomplete	Oct 22	7.00	16.4	H	16
RTT Incomplete 92nd Percentile	Oct 22	-	48.1	H	25
RTT Incomplete Pathways With ...	Oct 22	25.0%	14.6%	H	46
RTT Non-Admitted Treatment ...	Oct 22	95.0%	71.7%	L	50
RTT Total Clock Starts	Oct 22	-	14,999	C	81
RTT Total Clock Stops	Oct 22	-	13,111	C	85
RTT Total Incompletes	Oct 22	-	77,721	H	11



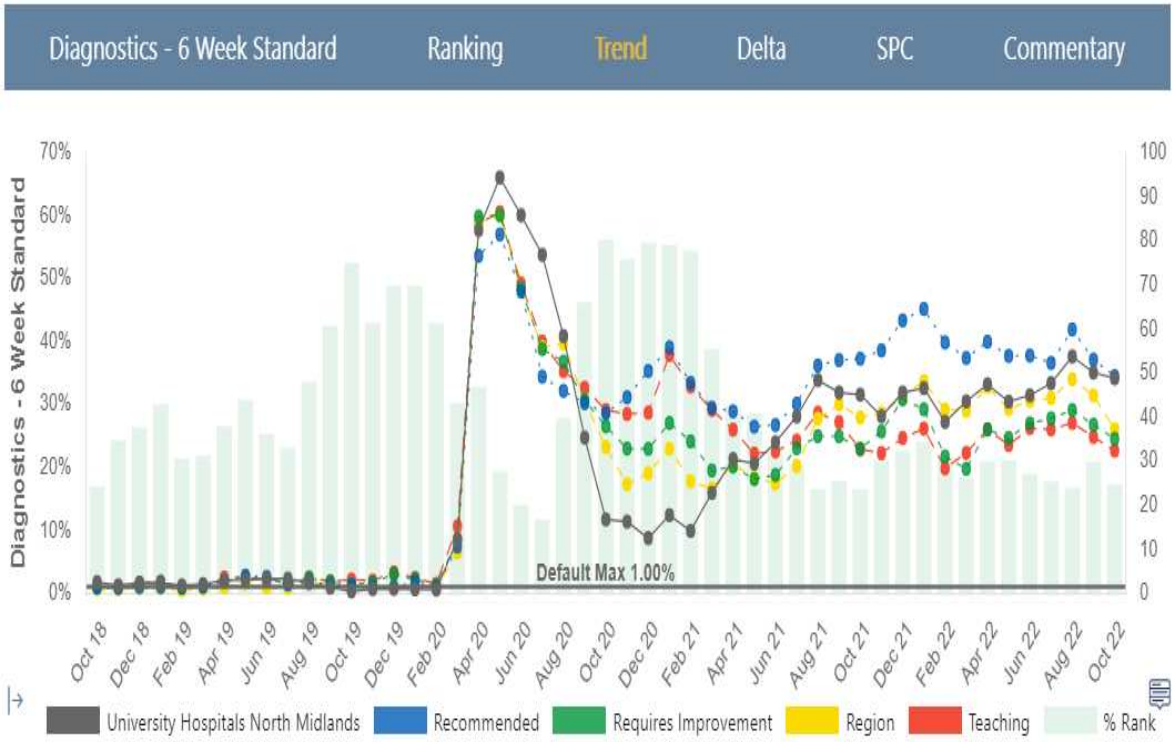
- RTT total clock starts and stops are in the upper quartile showing the volume of demand and throughput at UHNM is high
- UHNM are seeing a gradual increase in the number of clock stops
- UHNM continue to remain in the middle of all peers.

Diagnostics

NHS
University Hospitals of North Midlands
NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Audiology	Oct 22	1.00%	0.4%	L	79
Colonoscopy	Oct 22	1.00%	44.7%	H	30
Computed Tomography	Oct 22	1.00%	0.3%	L	75
Cystoscopy	Oct 22	1.00%	4.4%	L	75
DM01 Waiting <13 Weeks	Oct 22	100.00%	90.1%	L	38
Diagnostics - 6 Week Standard	Oct 22	1.00%	34.1%	H	25
Diagnostics - 6 Week Standard ...	Oct 22	99.00%	65.9%	L	25
Echocardiography	Oct 22	1.00%	28.5%	H	45
Electrophysiology	Oct 22	1.00%	-	C	-
Flexi Sigmoidoscopy	Oct 22	1.00%	42.7%	H	29
Gastroscopy	Oct 22	1.00%	53.0%	H	12
Magnetic Resonance Imaging	Oct 22	1.00%	16.7%	H	32
Neurophysiology	Oct 22	1.00%	0.0%	L	100
Non-obstetric Ultrasound	Oct 22	1.00%	55.0%	H	4
Sleep Studies	Oct 22	1.00%	22.3%	C	46
Urodynamics	Oct 22	1.00%	-	C	-



- Performance at UHNM has been better than "Recommended" peers
- UHNM have seen a slight improvement over the last three months, however not as great as all other peers.
- UHNM remain in the bottom quartile

Workforce

University Hospitals of North Midlands NHS Trust

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

Delivering Exceptional Care with Exceptional People

Workforce Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key messages

The Trust's People Strategy 2022-2025 sets identifies the workforce priorities required to support delivery of the Trust's strategic ambitions, vision and objectives whilst demonstrating our values in all that we do. To deliver this four key domains of focus have been identified within the strategy.

- We will look after our people
- We will create a sense of belonging
- We will grow and develop our workforce for the future
- We will develop our people practices and systems

Overall, the level of workforce risk remains at ext16 due to the cultural issues highlighted by the brap report, high sickness levels and the impact on workforce availability. There are measures in place to mitigate risks including a recruitment pipeline

The Cultural Improvement Plan has been updated following a monthly review of progress.

- A paper was presented to Execs in November and approved mandating as core for all staff of their Being Kind e-learning. This was taken to the Stat/Mand group on 14th December where it was approved and will be going to Quality and Safety Oversight Group (QSOG) for sign off.

Chest and respiratory (which includes Covid) remains top of reasons for sickness absence at 26.2%, closely followed by Anxiety and Stress at 22.0%. Focusing specifically on Covid related absence by 1 January 2023 covid-related absences stood at 101, which was 12.11% of the 834 open absences. This is 1.6.% increase on same time the previous month.

The National Staff Survey 2022 closed November, and the final response rate was 33.24% putting the trust under average response for an acute setting of 45.55%. The Staff Voice trust survey for December received a total of 207 submissions providing an overall engagement score of 6.59.

For Performance Development Reviews (PDR's), divisions continue to report that due to increasing operational pressures, management time has been reduced and alongside reported high levels of sickness absence and vacancies. Divisions have been asked to review key issues and actions to work towards meeting target. The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance and making the process enhance employee experience.

As part of the monitoring of the reduction to agency spend, divisions were asked to present an update on their action plan to reduce expenditure to Executive Workforce Assurance Group (EWAG).

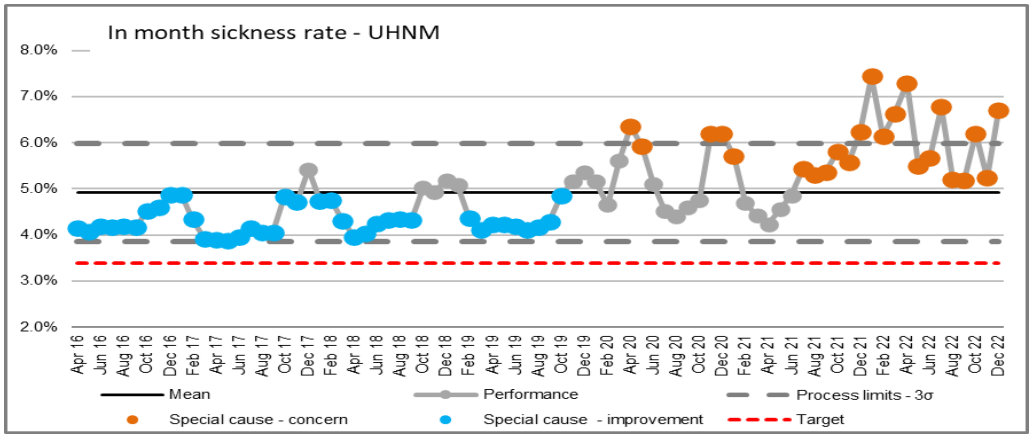
Chartered Society of Physiotherapists (CSP) Industrial action will take place on the 9 February , our EPRR team continue to plan for any action that takes place.

Workforce Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	6.71%		
Staff Turnover	11%	10.34%		
Statutory and Mandatory Training rate	95%	93.02%		
Appraisal rate	95%	79.54%		
Agency Cost	N/A	4.65%		

Sickness Absence



Variation	Assurance
H	F

Target	Oct 22	Nov 22	Dec 22
3.4%	6.2%	5.2%	6.7%

Background

Percentage of days lost to staff sickness

What is the data telling us?

Sickness rate is consistently above the target of 3.4%.

Summary

(12m cumulative Absence FTE %)

Org L2	Divisional Trajectory - March 2023	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trajectory
205 Central Functions	3.39%	3.80%	3.83%	3.89%	4.13%	4.13%	4.11%	4.19%	4.21%	4.20%	3.74%	3.71%	3.85%	↑
205 Women's, Children's & Clinical Support Services	5.25%	5.20%	5.29%	5.53%	5.88%	5.94%	5.97%	6.03%	6.07%	6.25%	6.35%	6.29%	6.32%	↑
205 Estates, Facilities and PFI Division	5.25%	5.13%	5.26%	5.56%	5.81%	5.75%	5.76%	5.85%	5.98%	6.04%	6.20%	6.22%	6.15%	↓
205 Medicine and Urgent Care	5.25%	6.01%	6.14%	6.33%	6.56%	6.64%	6.67%	6.76%	6.82%	6.85%	6.94%	6.86%	6.90%	↑
205 Division of Network Services	5.25%	4.64%	4.78%	4.96%	5.32%	5.47%	5.69%	5.89%	5.81%	5.78%	5.73%	5.75%	5.80%	↑
205 Division of Surgery, Theatres and Critical Care	4.50%	6.46%	6.57%	6.75%	7.02%	7.18%	7.30%	7.45%	7.39%	7.31%	7.30%	7.20%	7.12%	↓
205 North Midlands & Cheshire Pathology Service (NMCPS)	5.25%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	5.57%	5.61%	5.64%	↑

For M9, the in-month sickness rate increase by 1.4% to 6.71% (5.24% in November 2022).

Chest and respiratory (which includes Covid) remains top at 26.2%, closely followed by Anxiety and Stress at 22.0%.

Divisional trajectories for achieving a reduction in Sickness Absence can be seen in the table above. Many of the Divisions have seen a increase in sickness against the previous month.

1 January 2023 covid-related absences stood at 101, which was 12.11% of the 834 open absences. This is 1.6.% increase on same time the previous month.

Actions

The focus remains on managing areas of high sickness, and continued daily monitoring of sickness absence rates:

For the Medicine division Sickness absence continues to be monitored at monthly directorate performance reviews. Sickness assurance meetings took place in December

Surgery Division saw an increase in sickness and real time data showed a spike in short term sickness due to Cold/Flu and Cough and continue to implement a series of countermeasures.

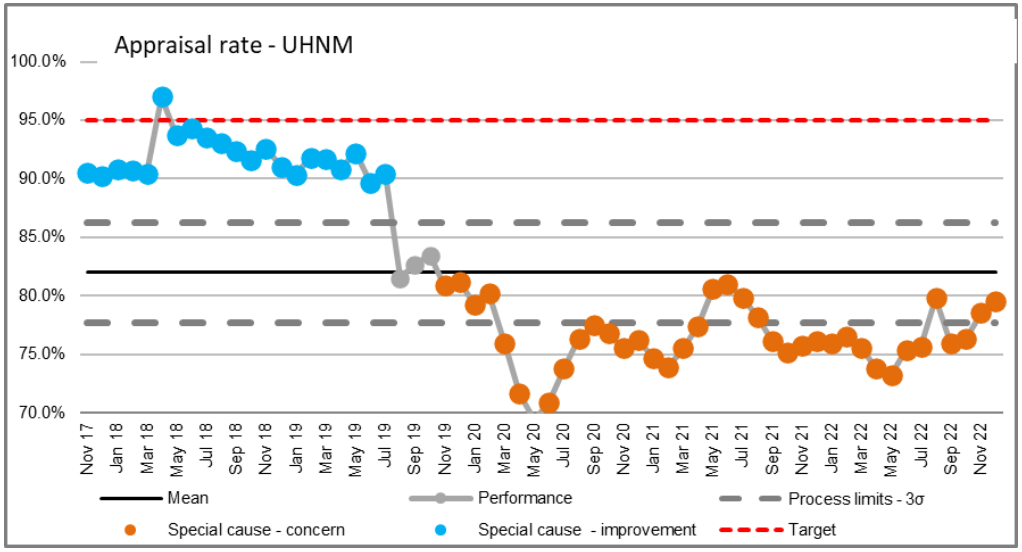
Network Division have commenced sickness assurance meetings.

Women's Children's and Clinical Division have had successful been implemented across all areas with higher levels of attendance. However, there are a High number of staff on sickness Stage 2.

NMCPS will be undertaking a deep dive into the short term absence increase with the help of their People Advisor.

Appraisal (PDR)

University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

Target	Oct 22	Nov 22	Dec 22
95.0%	76.4%	78.5%	79.5%

Background

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

What is the data telling us?

The appraisal rate is consistently below the target of 95%.

Note: Completion of PDRs was suspended during covid-19 unless there was capacity to complete them.

Summary

At 31 December 2022, the PDR Rate increased marginally to 79.5.% (78.5% at 30 November 2022).

This is the 2nd month that has shown a small upward trend; however, this figure still sits below the overall target and divisions have been asked to review key issues and actions to work towards meeting target. Indicative trajectories have been provided.

The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance and also making the process enhance employee experience.

Actions

The focus on ensuring completion of PDRs is continuing with:

Medicine Division are having weekly updates reports on compliance and details are being circulated to all directorates.

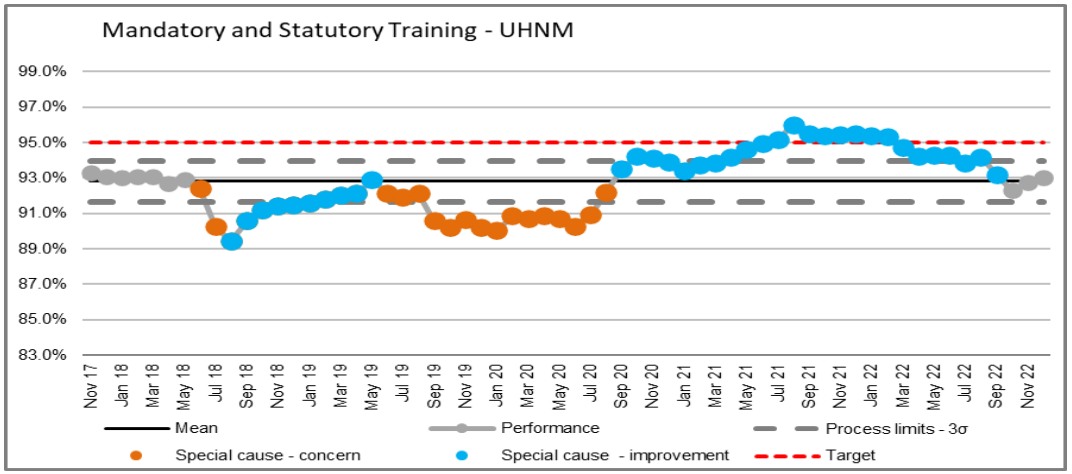
Surgery Division are undertaking a management time required project.

In Network Division a dedicated weekly PDR compliance hotspot and assurance meeting is being held. Continuing go, look, learn approach to support on ESR upload.

Women's Children's and Clinical Division are having Staff engagement plans being brought to DWAG to be reviewed. All Divisions are arranging for proxy access to be setup as a support mechanism for uploading completed PDRs on ESR.

Statutory and Mandatory Training

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
	F

Target	Oct 22	Nov 22	Dec 22
95.0%	92.3%	92.8%	93.0%

Background

Training compliance

What is the data telling us?

At 93%, the Statutory and Mandatory Training rate is just below the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate at 31 December 2022 was 93.0% (92.8% at 30 November 2022).This compliance rate is for the 6 'Core for All' subjects only.

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	11016	11016	10239	92.95%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	11016	11016	10231	92.87%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	11016	11016	10279	93.31%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	11016	11016	10257	93.11%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	11016	11016	10297	93.47%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	11016	11016	10131	91.97%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	11016	11016	9588	87.04%
NHS|CSTF|Information Governance and Data Security - 1 Year|	11016	11016	9609	87.23%

Actions

We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

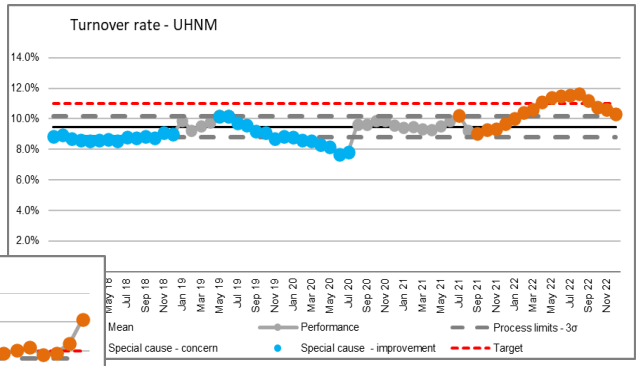
Compliance is monitored and raised via the Divisional performance review process.

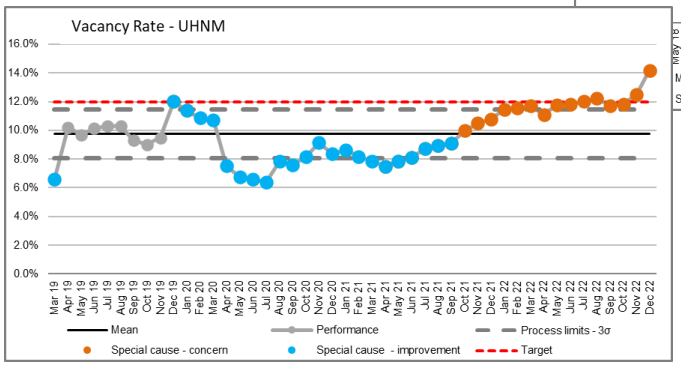
The Oliver McGowan Mandatory Training on Learning Disability & Autism is now live and will be reported separately for 12 months.

Workforce Turnover

University Hospitals of North Midlands NHS Trust

The SPC chart shows the rolling 12m cumulative turnover rate.





Variation	Assurance
H	P

Target	Oct 22	Nov 22	Dec 22
11.0%	10.8%	10.6%	10.3%

Background

Turnover rate

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

What is the data telling us?

The turnover rate for December 2022 remains below the trust target of 11%.

Vacancy rate has increased from 12.5% last month to 14.17% due to increases in budgeted establishment.

Summary

The 12m Turnover rate in December 2022 reduced to 10.3% and this the 3rd month that this figure has sat below the trust target of 11%.

The summary of vacancies by staff groupings highlight a small increase in the vacancy rate over the previous month.

Vacancies at 31-12-22	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,562.87	1,322.96	239.91	15.35%	13.82%
Registered Nursing	3,616.15	2,976.41	639.74	17.69%	15.53%
All other Staff Groups	6,745.96	5,936.12	809.84	12.00%	10.60%
Total	11,924.98	10,235.48	1,689.50	14.17%	12.51%

The M9 figure of 14.17% highlights an increase in the overall vacancy rate over the previous month. Although staff in post increased in December 2022 by 7.82 FTE, budgeted establishment also increased by 234.95 FTE, which increased the vacancy FTE by 227.13 FTE overall [*Note: the Staff in Post FTE is a snapshot at a point in time, so may not be the final figure for 31/12/22]

Actions

Divisional targets for agency ceilings have been set out and put forward. Divisional progress reports were presented at the December and January Executive Workforce Assurance Group.

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key elements of the financial performance year to date are:

- For the year to date the Trust has delivered an actual surplus of £0.7m against a planned surplus of £3.3m; this is primarily driven by underperformance against the Trust's in year CIP target.
- The Trust incurred £0.5m of costs relating to COVID-19 in month; with £0.4m of this being chargeable for COVID-19 testing costs. The Trust has overspent by £2.9m against its original in envelope allocation due to the in envelope funding allocation ceasing after Month 2.
- To date the trust has validated £9.3m CIP savings in year; these schemes have a full year impact of £5.3m, which presents a considerable variance to the Trust's recurrent target of £13.6m which was identified as a key risk in the Trust's financial plan submission.
- Capital expenditure in Month 9 is £29.4m which is 5.8m behind the plan of £35.1m. Of the expenditure to date £10.7m is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 9 is £97.3m, which is £24.3m higher than plan. Cash received is above plan due to Capacity and Virtual Ward income received from the ICB.
- The Trust has carried out a forecast for the year based on the actual position at Month 8; this forecast is for a £6.6m deficit before mitigations and has improved by £2m from the forecast at Month 7. It is likely that the Trust can deliver a breakeven position for the year although this is likely to be dependent on further non-recurrent mitigations.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	80.1		
	Expenditure - Pay	variable	49.6		
	Expenditure - Non Pay	variable	30.4		
Activity	Daycase/Elective Activity	variable	8,348		
	Non Elective Activity	variable	9,680		
	Outpatients 1st	variable	26,655		
	Outpatients Follow Up	variable	41,830		

Income & Expenditure

NHS University Hospitals of North Midlands NHS Trust

Income & Expenditure Summary Month 09 2022/23	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	915.4	76.8	76.8	0.0	684.6	686.1	1.5
Other Operating Income	86.9	7.6	7.5	(0.1)	65.2	67.3	2.1
Total Income	1,002.3	84.4	84.3	(0.1)	749.8	753.4	3.6
Pay Expenditure	(607.0)	(51.6)	(50.2)	1.4	(450.1)	(437.5)	12.6
Non Pay Expenditure	(335.0)	(28.3)	(31.4)	(3.1)	(251.0)	(271.2)	(20.2)
Total Operational Costs	(941.9)	(79.9)	(81.5)	(1.7)	(701.2)	(708.8)	(7.6)
EBITDA	60.3	4.5	2.8	(1.7)	48.6	44.6	(3.9)
Depreciation & Amortisation	(33.6)	(2.8)	(2.8)	0.0	(25.2)	(25.3)	(0.1)
Interest Receivable	0.3	0.0	0.3	0.3	0.2	1.1	0.9
PDC	(8.9)	(0.7)	(0.7)	(0.0)	(6.7)	(6.7)	(0.0)
Finance Cost	(18.1)	(1.5)	(1.5)	(0.0)	(13.6)	(13.4)	0.1
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Surplus / (Deficit)	0.0	(0.5)	(2.0)	(1.5)	3.3	0.4	(2.9)
DHSC PPE adjustment	0.0	0.0	0.0	0.0	0.0	0.3	0.3
Total	0.0	(0.5)	(2.0)	(1.5)	3.3	0.7	(2.6)

The main variances for the year to date are:

- Income from patient activities is £1.5m above plan due to additional income in respect of pass through devices and drugs for which corresponding additional costs have been noted with non-pay.
- Other operating income has over performed year to date and this is primarily driven by additional educational and training income and additional income from the North Midlands and Cheshire Pathology Alliance. Car parking and research income continue to under delivery against plan.
- Pay is underspent year to date by £12.6m which is significantly impacted by the £3.1m release of the premium element of the annual leave accrual in Month 3. The remaining variance is driven by underspends across registered nursing and NHS Infrastructure. Within the year to date budget is £2.8m non-recurrent CIP of which the nursing and NHS Infrastructure elements have delivered.
- Non-pay is overspent for the year to date by £20.2m with the non-delivery of recurrent CIP impacting the position by £5.3m. On a recurrent basis there is £5.3m of funding for excess non-pay inflation received in 2022/23 which was used to improve the bottom line rather than fund additional costs; this funding is available on a recurrent basis to support expenditure budgets.

Capital Spend

NHS University Hospitals of North Midlands NHS Trust

Capital Expenditure as at Month 9 2022/23 £m	2022/23 Plan June PAF	2022/23 Forecast Revised/ plan M09	In Month			Year to Date		
	Plan	Actual	Plan	Actual	Variance	Plan	Actual	Variance
PFI lease liability repayment	(10.5)	(10.5)	(0.9)	(0.9)	-	(7.9)	(7.9)	-
Repayment of IFRS16 leases	(3.7)	(3.7)	(0.3)	(0.3)	-	(2.8)	(2.8)	-
Pre-committed items	(14.3)	(14.3)	(1.2)	(1.2)	-	(10.7)	(10.7)	-
PFI lifecycle and equipment replacement (MES/PAC	(3.5)	(3.5)	(0.2)	(0.2)	(0.0)	(2.2)	(1.6)	0.6
PFI enabling cost	(0.3)	(0.0)	-	-	-	-	(0.0)	(0.0)
PFI related costs	(3.8)	(3.5)	(0.2)	(0.2)	(0.0)	(2.2)	(1.6)	0.6
Wave 4b Funding - Lower Trent Wards	(5.2)	(5.1)	(1.1)	(1.1)	0.0	(4.8)	(4.4)	0.4
Project STAR multi-storey car park	(6.8)	(6.8)	(0.7)	(1.2)	(0.5)	(2.4)	(2.9)	(0.5)
TIF 2 PDC (CTS Phase 1)	(3.9)	(4.6)	(1.0)	(0.5)	0.5	(1.7)	(1.1)	0.5
TIF 2 PDC (Day case unit)	(0.4)	(0.4)	(0.1)	(0.0)	0.0	(0.1)	(0.0)	0.1
TIF 2 PDC (Women's Hospital)	(0.6)	(0.3)	-	-	-	-	-	-
TIF 2 PDC (CTS Phase 2)	(0.1)	-	-	-	-	-	-	-
Emergency Department (restatement costs)	-	-	-	-	-	-	-	-
Home reporting breast care - PDC	-	(0.2)	-	(0.1)	(0.1)	(0.2)	(0.2)	0.0
MRI acceleration upgrades	-	(0.2)	-	-	-	-	-	-
Endoscopy equipment and works - PDC ICB allocatic	-	(0.4)	-	-	-	-	-	-
CT9 enabling and equipment - PDC	-	(1.2)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Frontline digitalisation equipment/ EPR - PDC	-	(1.2)	-	-	-	-	-	-
Diagnostic funding - CT8 and ultrasound	(1.4)	(1.5)	(0.0)	(0.0)	-	(0.0)	(0.0)	0.0
PDC - iRefer CDS	-	(0.2)	-	-	-	-	-	-
Schemes funded by PDC and Trust funding	(18.4)	(22.0)	(2.8)	(2.9)	(0.1)	(9.2)	(8.6)	0.5
LIMS (Laboratory Information Management System	(0.3)	(0.6)	(0.0)	(0.0)	(0.0)	(0.3)	(0.3)	0.0
EPMA (Electronic Prescribing)	(0.6)	(0.6)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0
CT7 enabling works (BC 415)	(1.1)	(1.1)	-	(0.1)	(0.1)	(1.1)	(0.4)	0.7
Patient Portal roll out costs (BC 462)	(0.5)	(0.4)	(0.1)	(0.0)	0.0	(0.3)	(0.1)	0.2
Pharmacy Dispensary	(0.3)	(0.3)	-	-	-	(0.3)	(0.3)	0.0
Anaesthetic medical records (Nasstar) (BC 444)	(0.1)	(0.2)	-	(0.0)	(0.0)	(0.1)	(0.1)	0.1
Home reporting implementation costs (BC 453)	(0.1)	(0.1)	-	-	-	(0.1)	(0.1)	0.0
Market testing refresh - CRIS/PACS/MRI	(0.5)	-	-	-	-	-	-	-
ED ambulance offload - enabling ward moves	-	(0.7)	-	(0.0)	(0.0)	(0.4)	(0.4)	(0.0)
Schemes with costs in more than 1 financial year	(3.6)	(4.1)	(0.1)	(0.3)	(0.2)	(2.9)	(1.9)	1.0
2022/23 schemes	(11.9)	(14.9)	(1.0)	(1.2)	(0.1)	(6.9)	(5.4)	1.5
IFRS 16 New Vehicles lease	(0.1)	(0.1)	-	-	-	-	-	-
IFRS 16 County Theatres TIF1 (IFRS16)	(2.1)	(2.1)	-	-	-	(2.1)	-	2.1
IFRS16 lease additions (incremental impact of IFRS1	-	(0.7)	-	-	-	-	-	-
Lease liability re-measurement	(0.1)	(0.1)	-	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
IFRS16 funded schemes	(2.3)	(3.0)	-	(0.1)	(0.1)	(2.2)	(0.1)	2.1
Donated/Charitable funds expenditure	(4.7)	(4.6)	(0.6)	(0.6)	-	(1.0)	(1.0)	-
Charity funded expenditure	(4.7)	(4.6)	(0.6)	(0.6)	-	(1.0)	(1.0)	-
Overall capital expenditure	(59.0)	(66.4)	(5.9)	(6.5)	(0.5)	(35.1)	(29.4)	5.8

Key variances at Month 9 are:

- PFI lifecycle and equipment replacement is £0.6m behind plan due to no refreshes of MES or PACS equipment having taken place in the year to date.
- The Lower Trent ward scheme is £0.4m behind plan due to contractor delays, and the opening of the new ward is expected to slip by four weeks in to January 2023. Project Star is £0.5m ahead of plan as work has been brought forward, but spend will be in line with plan at the year end. The TIF County CTS scheme is £0.5m behind schedule with slippage to the scheme in to April 2023.
- The enabling works for CT7 are behind plan and the completion of the scheme and installation of the equipment has slipped to March 2023 due to delays, it is anticipated that this will be complete by the year end.
- The IM&T infrastructure sub-group has a £0.7m underspend with slippage on a number of schemes, including the server and SQL upgrade; data centre utility refresh; firewall deployment; and the diamond linac. A majority of the underspend is due to the unavailability of staff resource.
- Within 22/23 schemes the estates sub-group has a £0.7m underspend due to slippage on a number of individual schemes, including AHU replacement; County RO plant; window frame replacements; West Building wet services replacement; and fire dampeners replacement., Medical Equipment is £0.5m ahead of plan due to the delivery of the monitor fleet replacement programme ahead of schedule and the bi-plane equipment and enabling scheme is £0.4m behind plan due to delays on agreement on the scope and costing of the enabling work, this work will now be undertaken in 2023/24.
- The County Theatres TIF1 (IFRS16) scheme is £2.1m behind plan due to delays in the process and enabling for the modular theatre. The modular building and lease are expected to be in place and recognised in February 2023.
- The purchase of the Children's Outpatient modular for £1.5m is expected to be completed in January 2023 and should be recognised in Month 10.

Balance sheet

Balance sheet as at Month 9	31/03/2022	31/12/2022			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	576.4	578.9	572.3	(6.7)	Note 1
Right of Use Assets	-	17.3	16.8	(0.5)	
Intangible Assets	20.7	16.9	16.9	(0.0)	
Trade and other Receivables	1.4	1.4	1.4	0.0	
Total Non Current Assets	598.6	614.6	607.4	(7.2)	
Inventories	16.3	15.8	17.2	1.4	Note 2
Trade and other Receivables	41.6	39.8	37.6	(2.1)	Note 3
Cash and Cash Equivalents	87.6	73.0	97.3	24.3	Note 4
Total Current Assets	145.5	128.5	152.1	23.6	
Trade and other payables	(116.6)	(107.4)	(125.3)	(17.9)	Note 5
Borrowings	(10.7)	(13.9)	(13.5)	0.4	
Provisions	(2.5)	(2.5)	(3.2)	(0.7)	Note 6
Total Current Liabilities	(129.8)	(123.8)	(142.0)	(18.2)	
Borrowings	(257.8)	(259.0)	(259.0)	(0.0)	
Provisions	(3.9)	(3.9)	(3.8)	0.1	
Total Non Current Liabilities	(261.6)	(262.9)	(262.8)	0.1	
Total Assets Employed	352.6	356.4	354.7	(1.7)	
Financed By:				-	
Public Dividend Capital	648.2	648.2	648.2	-	
Retained Earnings	(437.0)	(433.2)	(434.8)	(1.6)	Note 7
Revaluation Reserve	141.4	141.4	141.3	(0.1)	
Total Taxpayers Equity	352.6	356.4	354.7	(1.7)	

Note 1. This variance reflects slippage of £5.9m in capital expenditure in the revised year to date capital plan. The remaining variance is due to the timing of PFI equipment replacement as part of the managed equipment scheme which is funded through the PFI unitary payment in 2021/22.

Note 2. this variance reflects higher stock balances at Month 9 compared to the 31 March 2022 balances for pharmacy (£0.5m) and interventional radiology (£0.6m). The increase is partly due to higher stock balances at Month 9 due to the Christmas period and the replacement of high cost devices in interventional radiology that were previously held at nil cost due to the funding arrangements.

Note 3. Trade and other receivables are £2.1m lower than plan at Month 9. This is partly due to a reduction in the level of outstanding invoices on the sales ledger and reflects cash received relating to the recharge for the pathology alliance.

Note 4. This is mainly due to cash received from ICBs which is £6.4m ahead of plan in the year to date and reflects funding received relating to capacity and virtual wards from local commissioners in prior months. Cash received from Health Education England is also higher than plan and relates to year to date training income and full year funding relating to Nursing CPD and staff placements. Payments are £9.7m behind plan at Month 9 and reflect lower than expected levels of payments for general payables, capital expenditure and payments to NHS Supply Chain.

Note 5. Payables are £17.9m higher than plan due to a number of reasons:
Deferred income is higher than plan partly as a result of £3.7m cash received from Staffordshire and Stoke on Trent ICB for a number of schemes. The deferred income balance also includes significant balances relating to Health Education England training (£5.4m); digital pathology (£2.2m); and high cost devices (£3.9m). General payables are £9.7m higher than plan in the year to date which reflects the level of invoices outstanding on efinancials for general payments.

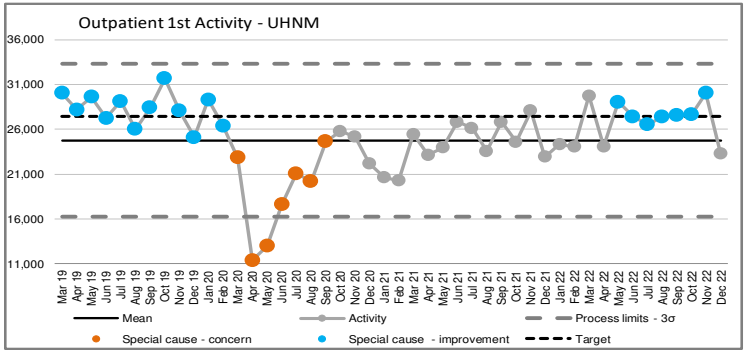
Note 6. Provisions are £0.7m higher than plan due to unforeseen new provisions arising in 2022/23. A case has arisen which relates to a staffing issue and which has a total potential cost to the Trust of £0.2m. A £0.6m provision is also required for a potential fine from the Care Quality Commission (CQC) relating to an on-going investigation.

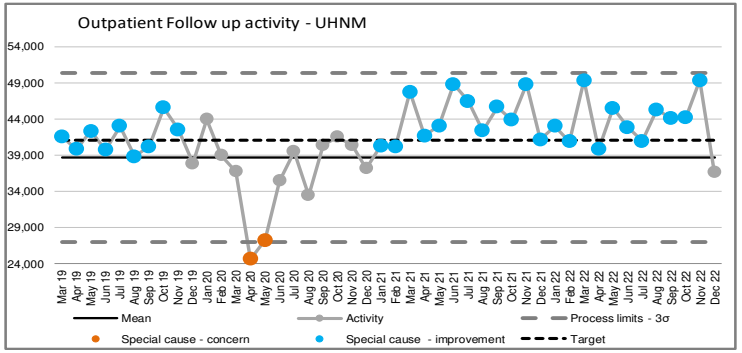
Note 7. Retained earnings show a £1.6m variance from plan and reflect the income and expenditure position at Month 9. This variance reflects the surplus/deficit position as would be reported in the Statement of Comprehensive Income within the Trust's annual accounts. Financial performance shows a variance of £2.6m from plan. This excludes the impact of donated income, depreciation and DHSC consumables which show a variance of £0.9m to plan at Month 9.

Activity

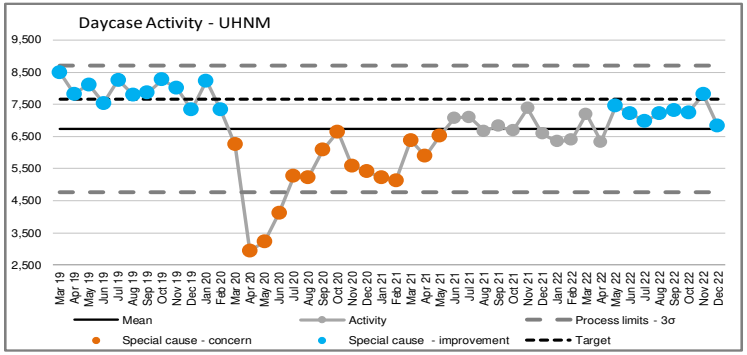
NHS University Hospitals of North Midlands NHS Trust

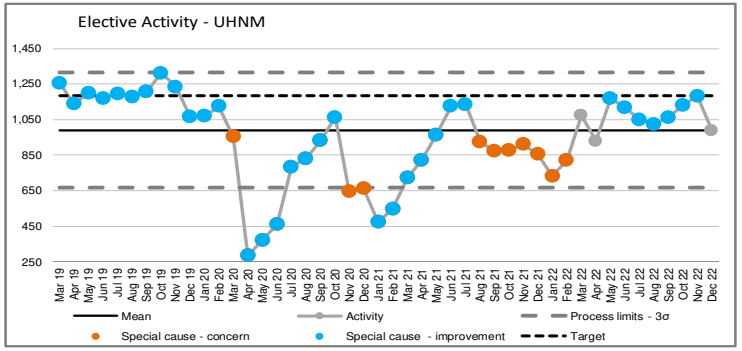
Planned care Outpatient



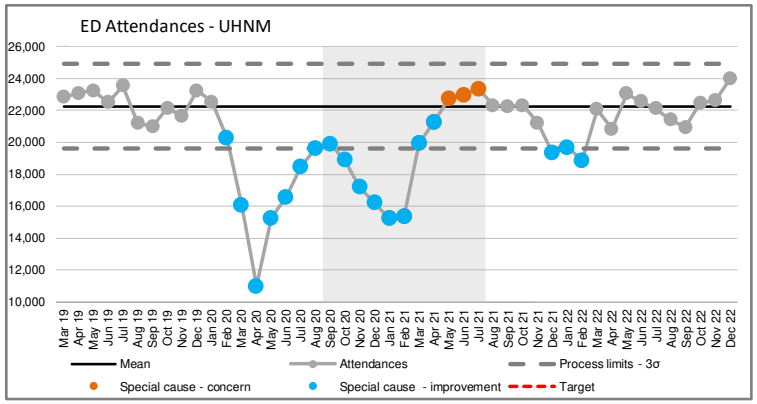


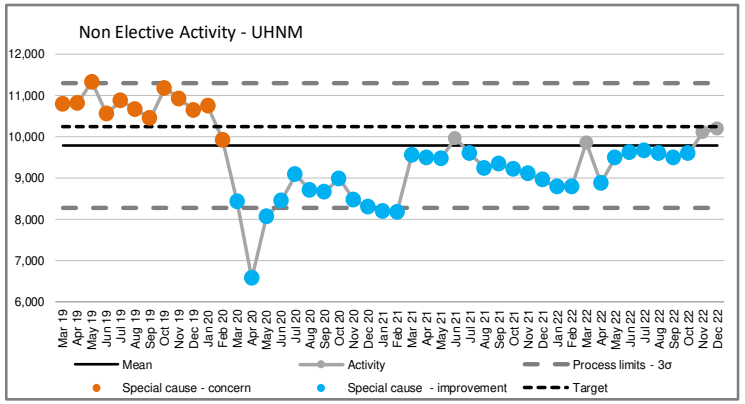
Planned care Inpatient





Urgent Care





Delivering Exceptional Care with Exceptional People

Audit Committee Chair's Highlight Report to Trust Board

2nd February 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The internal audits into Workforce Planning Framework and Framework for Clinical Audit concluded with partial assurance with a number of recommendations identified for improvement • The Board Assurance Framework highlighted that 2 / 9 risks had increased in risk score reflecting Trust pressures and mitigating actions to reduce ambulance delays. • An escalation from the Quality Governance Committee highlighted further improvements required in describing the assurances related to the Care Quality Commission (CQC) actions to ensure these addressed the root cause of the issue identified • Losses and special payments stood at £472,085 year to date but no themes or trends were identified • 4 Single Tender Waivers and 28 Standing Financial Instruction breaches were reported in the quarter which reflected levels reported previously. The Committee considered the actions being taken to reduce salary overpayments and a further update was requested to be provided to a future meeting	• To ensure good Executive ownership and agreement of actions arising from internal audit reviews in order to take forward improvements • The Board Assurance Framework would continue to be developed for Quarter 4, to include mapping and linkages to the ICB BAF risks in addition to identifying trajectories for risk reduction and clarification of expectations in terms of describing controls and assurances in line with the three lines of defence • Completion of a quality assurance map had commenced which would identify key sources of assurance relied upon for key regulatory / national obligations • Self-assessment of the new CQC standards was underway
✓ Positive Assurances to Provide	**Decisions Made**
• The internal audit review into Cost Improvement Programme Framework concluded with reasonable assurance. A further 2 draft internal audits were discussed which were due to be finalised. • The internal audit recommendation tracker highlighted that the majority of actions were on track with achieving their target date and updates were provided in respect of the 3 remaining recommendations whereby the target date had been revised • 71% of declaration of interest forms had been returned for 2022/23 and the remaining declarations were to be escalated as required in order to improve compliance by the year end. Positive assurance was also provided in relation to the timely review of out of date policies, the majority of which were due to be ratified before the next meeting • The Committee commented on the improved understanding of the Trusts strategic risks as reported in the BAF and welcomed the work being undertaken to identify mitigation to reduce the risk score towards the target. • The Committee noted the draft accounting policies, judgements and estimations expected to be utilised when preparing the 2022/23 accounts as well as the estimates and assumptions used to underpin the valuation of land and buildings in relation to the Modern Equivalent Asset • External audit progress report highlighted progress against the 21/22 deliverables in addition to the timescales associated with 2022/23 deliverables. The work already comments in respect of preparing the annual accounts was welcomed • The Local Counter Fraud Specialist progress report highlighted completion of the conflict of interest follow up review and the follow up review of mandate/invoice fraud and procurement fraud compliance checklists	• The Committee approved the self-assessment associated with the Code of Governance and noted the four provisions which had been assessed as requiring explanation. It was agreed for two of the associated actions to be further considered by the Nominations and Remuneration Committee • The Committee recommenced policies F01 Standing Financial Instructions and F02 Scheme of Reservation and Delegation of Powers for approval by the Trust Board • The Committee approved the recommendation to prepare the 2022/23 annual accounts on a going concern basis • The Committee approved the proposed Local Counter Fraud Specialist work plan for 2023/24

Comments on the Effectiveness of the Meeting
• The Committee agreed to consider the schedule of meetings for 2023/24 and to determine which meetings would be held face to face

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Internal Audit Progress Report • Workforce Planning Framework • Bank and Agency (Draft) • Digital Strategy Development (Draft) • Framework for Clinical Audit • Cost Improvement Programme (CIP) Framework	1, 2, 4, 5, 8	Ext 20 High 12 High 12 Ext 20 High 9	! ✓	Assurance	9.	SFI Breaches and Single Tender Waivers Q3 2022/23	BAF 8	High 9	!	Assurance
2.	Internal Audit Action Tracker	-		✓	Assurance	10.	Going Concern Assessment 2022/23	BAF 8	High 9	-	Approval
3.	Corporate Governance Report	-	10836 – Low 2	✓	Assurance	11.	Update on Accounting Policies, Critical Judgements and Estimation Uncertainty 2022/23	BAF 8	High 9	✓	Assurance
4.	Comply or Explain – Code of Governance	-		-	Assurance	12.	Valuation of Land and Buildings 2022/23	BAF 8	High 9	✓	Assurance
5.	Board Assurance Framework Q3 2022/23	-		! ✓	Approval	13.	Annual Accounts Timetable	BAF 8	High 9	-	Information
6.	Issues for Escalation from Committees	-		!	Assurance	14.	External Audit Progress Report	BAF 8	High 9	✓	Assurance
7.	Policies for Approval: F01 Standing Financial Instructions F02 Scheme of Reservation and Delegation of Powers	BAF 8	High 9	-	Approval	15.	LCFS Draft Work Plan 2023/24	BAF 8	10836 – Low 2	-	Approval
8.	Losses and Special Payments Q3 2022/23	BAF 8	High 9	!	Assurance	16.	LCFS Progress Report	BAF 8	10836 – Low 2	✓	Assurance

3. 2022 / 23 Attendance Matrix

No.	Name	Job Title	Apr	Jun	Jul	Oct	Feb
1.	Prof G Crowe	Non-Executive Director (Chair)					
2.	Dr L Griffin	Non-Executive Director	PA				
3.	Prof A Hassell	Associate Non-Executive Director	SB	SB			
4.	Mrs T Bowen	Non-Executive Director					
	Other Attendees:						
5.	Ms N Coombe	External Audit – Grant Thornton					
6.	Mr G Patterson	External Audit – Grant Thornton					
7.	Mr M Gennard	Internal Audit - RSM					AH
8.	Mr A Hussain	Internal Audit - RSM					KA
9.	Ms E Sims	LCFS - RSM			AD		EW
10.	Mrs N Hassall	Deputy Associate Director of Corporate Governance					
11.	Mr M Oldham	Chief Finance Officer					
12.	Mrs S Preston	Strategic Director of Finance					
13.	Mrs C Cotton	Associate Director of Corporate Governance					

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	8th February 2023
Report Title:	Quarter 3 Board Assurance Framework	**Agenda Item:**	14.
Author:	Claire Cotton, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

n/a	*Please refer to Appendix2 for full list of mapped risks to the Board Assurance Framework*	*n/a*

Executive Summary

Situation

This report sets out the Board Assurance Framework (BAF) for Quarter 3, 2022/23. The BAF is being presented to Committees of the Board in accordance with our Risk Management Policy and Annual Business Cycles for approval and assurance.

Background

The Strategic Risks contained within the enclosed BAF are mapped to our Strategic Priorities; these risks were identified by the Executive Team and approved by the Board in March 2022. Each Strategic Risk Assessment has been reviewed and updated by their Executive Lead and the BAF will be presented to each Committee of the Board ahead of being presented to the Trust Board.

Assessment

The BAF continues to be developed and improved, in order to increase its usability and effectiveness. When the Quarter 2 BAF was presented to Committees, it was agreed that a review of target dates and scores would be undertaken to ensure that this remain realistic; this work has been undertaken during Quarter 3 and is reflected within the enclosed document. Further work will be undertaken during Quarter 4 to review the strategic risks ahead of the 2023/2024 BAF being developed and also the identification of risk reduction trajectories.

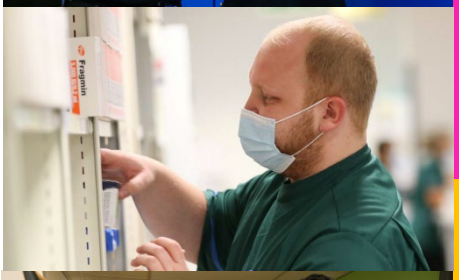
There are a number of key observations to draw out from the updated BAF:

- 7/9 strategic risk scores have remained unchanged (→) when compared to the previous quarter.
- 2/9 strategic risk scores (**BAF 1 – Delivering Positive Patient Outcomes and BAF 5 Delivering Responsive Patient Care)** have increased (↑) when compared to the previous quarter. This is largely due to winter pressures including capacity and actions taken in response to the national focus on minimising ambulance delays.
- 7/9 strategic risks have seen a revision to their target date or target risk score, following the work undertaken this quarter.
- There has been an increase in the overall number of linked risks on the risk register, with 4/5 seeing an increase in the number of linked risks scoring extreme; as expected this includes linked risks associated with BAF 1 and BAF 2.

Key Recommendations

- The Board is asked to note the observations identified above and the further work planned to continue to develop the BAF as we move into 2023/24.
- The Board is asked to approve the revised target scores / dates where identified and the revised risk description for BAF 1.
- The Board is asked to scrutinise the risk scores and determine whether these are an accurate reflection of risk.

NHS
University Hospitals of North Midlands
NHS Trust


Board Assurance Framework (BAF)

Quarter 3 2022/23

Delivering Exceptional Care with Exceptional People

1. Introduction

Situation

The Board Assurance Framework (BAF) is a structure and process that provides a focus for the Board on the key risks which might compromise the achievement of our Strategic Priorities. The BAF sets out the 'three lines of defence' or key controls which are in place to support delivery of those Priorities and to mitigate risk and it provides an assurance map, aligned with the work of our Executive Groups and Committees, which the Board can draw upon when considering the effectiveness of those controls. Where gaps in controls or assurance are identified, action plans are in place, which are designed to either provide additional assurance or reduce the likelihood or consequence of the risk identified towards the target, which is based upon our Risk Appetite (Appendix 1).

Background

The strategic risks contained within the 2022/23 BAF were identified by the Executive Team and agreed by the Board in March 2022; this is an annual process. The BAF continues to be improved in terms of format and function and during quarter 3, Executive leads have focussed on their target risk scores and due dates to ensure that they remain realistic; this has resulted in a number of revisions being made and these are summarised below.

During Quarter 4, a broader review of the Board Assurance Framework will be undertaken to identify the strategic risks as we move into 2023/24. This will include the development of risk trajectories, which was referred to in the Quarter 2 BAF.

Assessment

There are a number of observations to draw out from the updated BAF for quarter 3; these are summarised as follows:

	7/9 strategic risk scores have remained **unchanged** (➔) when compared to the previous quarter. Of these, 3 strategic risks have a revised target date for reduction of risk (see above BAF 3, 8 and 9).
	2/9 strategic risk scores have **increased** (🡅) when compared to the previous quarter. • **BAF 1** 'Delivering Positive Patient Outcomes' has increased from Extreme 16 to Extreme 20 as a result of significant winter pressures and the actions taken in response to the national focus on minimising ambulance delays including **Corridor Care and Your Next Patient**. The risk description has also been strengthened for this risk. • **BAF 5** 'Delivering Responsive Patient Care' has also increased from Extreme 16 to Extreme 20 as a result of insufficient capacity due to winter pressures and infection prevention restrictions along with changes in national guidance meaning an inability to step down elective activity to accommodate non-elective patients.
	As agreed during Quarter 3, Executive Leads have **reviewed target risk scores and dates** to ensure they remain realistic; this has resulted in the following changes: • **BAF 1:** Delivering Positive Patient Outcomes – target risk date has been revised from 3/12/22 to 31/3/25 • **BAF 2:** Leadership, Culture and Delivery of Trust Values – target risk score has been reduced to Mod 4 • **BAF 3:** Sustainable Workforce – target risk score has been revised from 30/4/23 to 31/3/24 • **BAF 5:** Delivering Responsive Patient Care – target risk score has been increased to High 12 • **BAF 6:** Delivery of IM&T Infrastructure – target score has increased to High 8 • **BAF 8:** Financial Performance – target risk date has been revised from 30/09/22 to 31/3/23 • **BAF 9:** Research and Innovation – target risk date has been revised from 31/3/23 to 31/9/23
	5/9 risks have seen an overall increase in the number of **linked risks** on the risk register: • 4/5 of these have seen an increase in the number of linked risks scoring Extreme • As expected, this includes the number of linked risks associated with **BAF 1** and **BAF 5** which have increased in risk score overall (as outlined above).

Recommendations

- Committees are asked to note the observations identified above and the further work planned to continue to develop the BAF as we move into 2023/24.
- Committees are asked to approve the revised target scores / dates where identified and the revised risk description for BAF 1.
- Committees are asked to scrutinise the risk scores and determine whether these are an accurate reflection of risk.

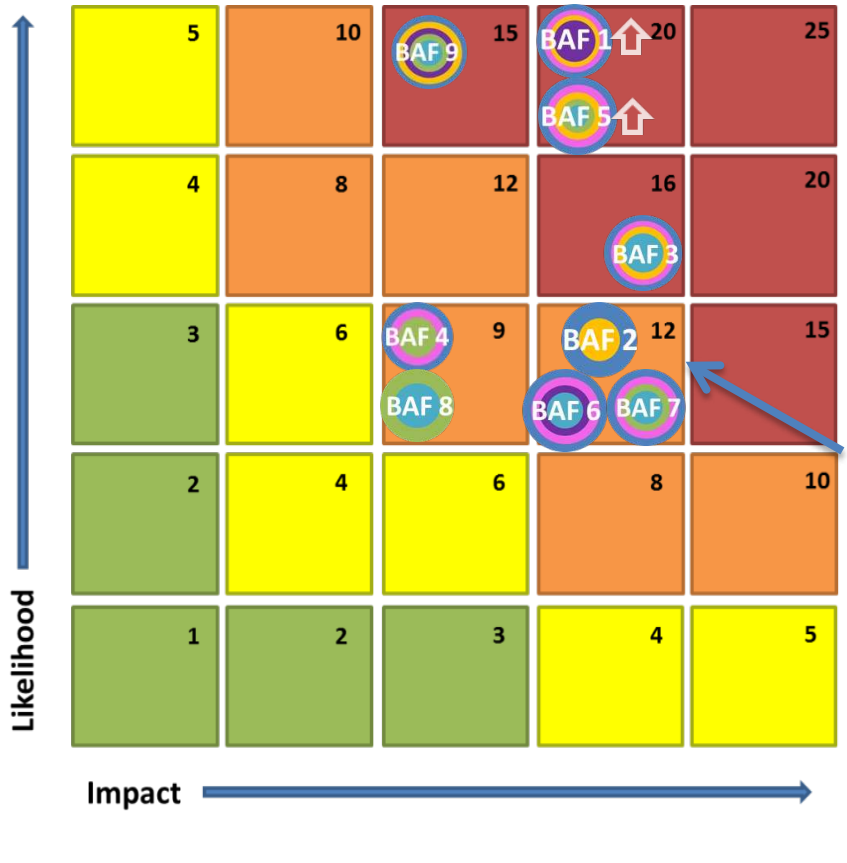
Key to 'BRAG' Ratings

BAF Action Plans – Key to Progress Ratings		
	On Track	Improvement on trajectory, either: GA – 'On track – not yet completed' or GB 'On track – not yet started'
	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement
	Delayed	Off track / trajectory / milestone breached. Recovery plan required.
	BAU	Business as Usual

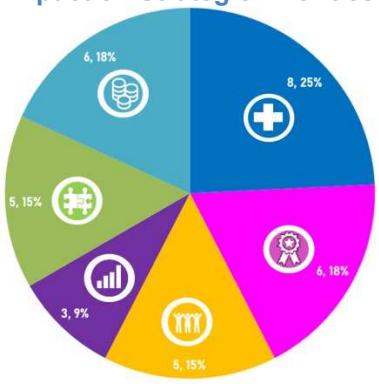
2. Summary Board Assurance Framework

BAF	Risk Title & Strategic Priority	Trajectory (T) / Actual (A)	Risk Likelihood (L), Consequence (C), Score (S)												Q2 Change	Target Risk and Date			Action Summary - BAF (B), On Track (OT), Delayed (D), Problematic (P)					No. Linked Risks (➔🡅🡇 Change from Previous Quarter)					Assurance Map Summary		
			Quarter 1			Quarter 2			Quarter 3			Quarter 4																			
			L	C	S	L	C	S	L	C	S	L	C	S		L	C	S	No.	B	OT	D	P	No.	Low	Mod	High	Ext	✓	!	✓/!
BAF 1	Delivering Positive Patient Outcomes	A	4	4	Ext 16	4	4	Ext 16	5	4	Ext 20				🡅	3	2	Mod 6 03/12/2022 31/03/2025	6 (2 new @ Q3)	0	3	0	3	68🡅	0	16🡅	39🡇	13🡅	31	21	13
		T	To be reviewed / completed during Q4 for 2023/24 BAF																												
BAF 2	Leadership, Culture, Delivery of Values	A	3	4	High 12	3	4	High 12	3	4	High 12				➔	2	2	Mod 4 31/03/2024	3	0	3	0	0	5🡅	0	1➔	2🡇	2🡅	11	3	11
		T	To be reviewed / completed during Q4 for 2023/24 BAF																												
BAF 3	Sustainable Workforce	A	4	4	Ext 16	4	4	Ext 16	4	4	Ext 16				➔	3	3	High 9 30/04/2023 31/03/2024	1	1	0	0	0	105🡇	1➔	26🡅	62🡇	16🡇	18	4	5
		T	To be reviewed / completed during Q4 for 2023/24 BAF																												
BAF 4	System Working	A	3	3	High 9	3	3	High 9	3	3	High 9				➔	2	3	Mod 6 31/03/2023	4	1	1	2	0	1➔	1➔	0➔	0➔	0➔	12	1	2
		T	To be reviewed / completed during Q4 for 2023/24 BAF																												
BAF 5	Delivering Responsive Patient Care	A	4	4	Ext 16	4	4	Ext 16	5	4	Ext 20				🡅	3	4	High 12 31/08/2023	7	2	3	1	0	40🡅	1🡅	6🡅	20🡇	13🡅	19	7	10
		T	To be reviewed / completed during Q4 for 2023/24 BAF																												
BAF 6	Delivery of IM&T Infrastructure	A	3	4	High 12	3	4	High 12	3	4	High 12				➔	2	4	High 8 31/03/2024	7	0	2	5	0	28🡅	2🡅	10🡅	13➔	3🡅	10	6	3
		T	To be reviewed / completed during Q4 for 2023/24 BAF																												
BAF 7	Compliant Estate Services	A	3	4	High 12	3	4	High 12	3	4	High 12				➔	3	3	High 9 31/03/2023	10	0	7	3	0	31🡅	0🡇	15🡅	15🡅	1➔	12	3	3
		T	To be reviewed / completed during Q4 for 2023/24 BAF																												
BAF 8	Financial Performance	A	3	3	High 9	3	3	High 9	3	3	High 9				➔	2	2	Mod 4 30/09/2022 31/03/2023	3	0	1	1	1	9🡇	0➔	1🡇	8➔	0➔	7	9	2
		T	To be reviewed / completed during Q4 for 2023/24 BAF																												
BAF 9	Research & Innovation	A	4	3	High 12	5	3	Ext 15	5	3	Ext 15				➔	2	2	Mod 4 31/03/2023 31/09/2023	9 (6 new @ Q3)	2	5	1	1	3➔	0➔	1➔	2➔	0➔	7	1	0
		T	To be reviewed / completed during Q4 for 2023/24 BAF																												

3. Strategic Risk Heat Map

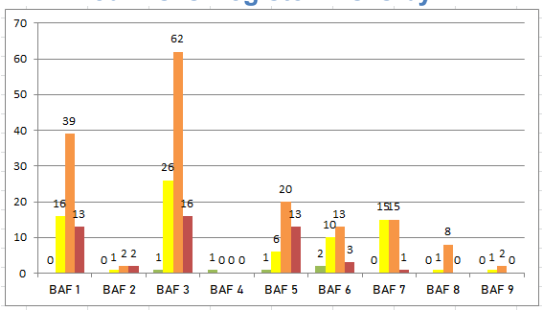


Impact on Strategic Priorities



The circles displayed on the heat map here represent (by colour) each BAF risk and the Strategic Priorities that they pose a threat to.

Linked Risks Register Risks by BAF



	• **High Quality** is the 'most threatened' Strategic Priority, in terms of the number of strategic risks posing a threat to it, 8/9 strategic risks (25%). 4 of these 8 strategic risks are scored as **Extreme**. • In addition, **BAF 1 'Positive Patient Outcomes'** has the second highest number of linked operational risks on the risk register (68 total) and joint second highest number of linked **Extreme** risks (13).
	• **People,** whilst threatened by fewer strategic risks – 5/9 (15%), 4 of these 5 strategic risks are scored as **Extreme**. • In addition, **BAF 3 'Sustainable Workforce'** has the highest number of linked operational risks (105 total) and the highest number of linked **Extreme** risks (16).

4. Board Assurance Framework 2022 / 23

	BAF 1:	Delivering Positive Patient Outcomes	Internally Driven	✓
			Externally Driven	

Risk Description (STRENGTHENED FOR Q3 2022/23)

Cause	Event	Effect
If systemic pressures across our system continue to exceed available capacity and resource	**Then** our patients will be unable to access high quality care in a timely manner, by the right	**Resulting in** poor patient outcomes, including higher than expected mortality, avoidable patient harm, poor patient experience and poor staff experience. This could affect statutory and regulatory compliance across a range of quality metrics, increase complaints and litigation and negatively impact staff availability.

Lead Director / s:	Chief Nurse and Medical Director	**Supported by:**	Chief Operating Officer
Lead Committee/s:	Quality Governance Committee / Transformation & People Committee	**Executive Group:**	Quality and Safety Oversight Group

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	5		**Likelihood:**	3	~~31/12/2022~~ 31/03/2025
Consequence:	4	4	4		**Consequence:**	2	
Risk Level:	**Ext 16**	**Ext 16**	**Ext 20**		**Risk Level:**	**Mod 6**	
Rationale for Risk Level:	During Quarter 3, services have continued to face considerable pressure as a result of increases in Covid, Flu, RSV, combined with increased staff absence. The national focus on minimising ambulance delays and the associated evidence of harm to patients has resulted in the extension of Your Next Patient across divisions and the introduction of patients being cared for in the corridor of the Emergency Department.						

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	0	16 ↑	39 ↓	13 ↑	68 ↑

Position Statement

What progress has been made during the last quarter?

During the last quarter, risk assessments have been undertaken across all areas for the suitability of them taking additional patients, SOPs have been developed and implemented for Corridor Care in ED and Your Next Patient. Risk based decisions are being taken to release beds from and Infection, Prevention and Control perspective.

A review of the integrated discharge function has been arranged; chaired by the Chief Operating Officer. A new dashboard has been developed which supports a review of all patients with a lower NEWS score. A deep dive of all patients with a NEWS score of 2 or below has been undertaken by the Chief Nurse and Chief Operating Officer. The system has escalated to critical incident level allowing for additional steps to be taken to manage risk across the ICS. A business case has been approved which enables maternity to be funded to meet Birth Rate Plus requirements. Further international nurse recruitment has been approved. A review of medically fit for discharge guidance is underway and acute patient flow A3 is in development with a key focus on occupancy, length of stay and simple / timely discharge.

Key Controls Framework – 3 Lines of Defence

1st Line	• Daily nurse staffing meetings to identify requirements and appropriate escalation of gaps and required support • Safer Staffing Tool completion twice daily by Ward staff • Local processes in place for medical and AHP staff to assess requirements and establishments • International Recruitment continues to be a source of registered nursing and midwifery recruitment • Site Safety Dashboard • Quality Impact Assessments undertaken for change in services regarding additional capacity areas and changes in establishments • Senior leadership team in place for each ward and department, with overarching accountability for delivering quality and minimising hospital acquired harm • Falls Champion role in each Ward/Department. • Tissue Viability Link Nurses in each Ward/Department • Corporate Quality & Safety Team co-ordinate Improvement Programmes for Pressure Ulcers, Falls and VTE • Specific governance arrangements in place for Maternity Services, including compliance with CNST requirements. • Infection Prevention Team co-ordinate Improvement Programmes for infections, including Sepsis and Nosocomial COVID-19 infections • Training Programmes in place for all key harms • Patient Experience team in place • Crude Mortality rates - monitoring and notification from Medical Examiner • Monthly Directorate Mortality and Morbidity meetings (M&M) are held to review deaths and discuss cases. • Risk assessments undertaken at ward level for Your Next Patient and Corridor Care in ED (which have been shared with the Care Quality Commission) • Business case agreed for Maternity; service funded to meet Birthrate Plus clinical requirements. LMNS funding supporting a number of specialist roles.
2nd Line	• 6 monthly nurse staffing establishment reviews to ensure established nursing numbers match acuity • Birth rate plus staffing assessment for midwifery services • Validation of pressure ulcers undertaken by Corporate Tissue Viability Team • Validation of infections undertaken by Infection Prevention/Microbiology Teams • Datix and Root Cause Analysis (RCA) training available to ensure accurate reporting and investigation of patient harm. Bespoke sessions arranged within Divisions. • Root Cause Analysis (RCA) Scrutiny Panels in place for Serious Incidents, Pressure Ulcers, Patient Falls, Venous Thromboembolism (VTE) and Infections • Agreed reduction trajectories in place for each patient harm • Collaborative working in place with CCG representatives regarding harm reduction • Care Excellence Framework refreshed and review meeting introduced with CN/DCN for any area rated Bronze overall or with any Bronze domain • COVID-19 deaths included in the Trust's SJR process to allow for review of care provided to patients and identify any potential areas for improvement/learning • Mortality Review Panel for Definite Nosocomial COVID-19 deaths established by Deputy Medical Director to identify learning and good practice. Review commenced to identify ward status for inclusion in mortality reviews. • Nosocomial COVID-19 Infections subject to RCA and reported to the Infection Prevention Committee • A strengthened clinical governance framework including revised Terms of Reference for the Quality and Safety Oversight Group (QSOG) and Quality Governance Committee (QGC) remains in place. Separate Quality and Safety Oversight Groups and Quality Governance Committee for Maternity and Neonates. • 'High Quality' identified as a Key Priority Domain for the UHNM Improving Together Programme • 52 week / 104 day Harm Review Panel process in place with CCG representation. Process currently under review to ensure robustness. • Agreed policies and procedures for the management of patients with mental health conditions and / or Mental Health Act including Standard Operating Procedure for Use of Ligature Knives and Trust Wide Corporate Ligature Risk Assessment • Policies and Procedures for the Management and care of patients with mental health conditions reviewed and actions completed and responded to in relation to the CQC Section 29a notice • Patient Safety Incident Reporting and Learning Plan (PSIRP) Steering Group • Tendable Steering Group established and reporting to Quality & Safety Oversight Group • SOPS approved and implemented for Corridor Care and Your Next Patient. • Refresh of work stream 2 Acute Patient Flow to focus on reducing length of stay and increasing capacity • Designated role within corporate nursing team focussing on excellence in discharge
3rd Line	• Registered and regulated by CQC • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM) • 6 nominated Patient Safety Specialists participating with development programme by NHSI as part of national NHS Patient Safety Strategy. Induction / Training • NHSEI scrutiny of COVID-19 cases/Nosocomial infections/Trust implementation of Social distancing, Patient/Staff screening and PPE Guidance • CQC briefed on risk assessment process for Your Next Patient and Corridor Care • System partners supported the review of patients during December to support discharge • LMNS scrutiny and sign off of CNST performance indicators

Assurance Map

Assurances Received by Committees (C) / Executive Groups (G) during this quarter

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
Saving Babies Lives Care Bundle	! ✓	Q2 Infection Prevention Report (C)	!	National Inpatient Survey	-

(C & G)				Results 2021 (G)	
Q2 Maternity Serious Incident Report (C & G)	!	Q2 Mortality Assurance Report (C & G)	! ✓	Care Quality Commission Action Plan & Section 29 A Notice (C)	!
Q2 Maternity Dashboard (C & G)	✓	M6, M7, M8 Quality & Safety Report (C & G)	!	Letter from NHS E, Reading the Signals East Kent Report (C)	-
Midwifery Workforce Report (C & G)	✓	M6, M7, M8 Performance Report (C)	! ✓		
Q2 Perinatal Mortality Report (C & G)	✓	M6, M7, M8 Workforce Performance Report (C & G)	!✓		
Neonatal Mortality Action Plan (C)	✓	Q2 Nursing and Midwifery Staffing and Quality Report (C & G)	! ✓		
Antenatal and Newborn Screening Programmes Annual Report 2021/22 (C)	✓	Q2 Patient Experience Report (C & G)	!		
BC-0502 Maternity Safe Staffing in line with Birthrate Plus® Business Case (C)	✓	Executive Workforce Assurance Group Report (C)	! ✓		
Maternity Incentive Scheme Year 4 (C)	✓	Executive Quality and Safety Oversight Assurance Report (C)	!		
Cardiothoracic Theatre Staffing Business Case (C)	✓	Q2 Serious Incident Report (C & G)	!		
Maternity Family Experience Report (C & G)	-	Your Next Patient Update & SOP (C & G)	! ✓		
Divisional Quality Updates (G)	! ✓	Resuscitation Annual Report (C & G)	!		
Divisional Clinical Effectiveness Delivery Plans (G)	! ✓	Executive Clinical Effectiveness Group Assurance Report (C)	!		
		Patient Safety Incident Review Framework (PSIRF) Update & Delivery Plan (C & G)	✓		
		Quality Strategy Update (C & G)	✓		
		Infection Prevention BAF (C)	✓		
		Care Excellence Framework (CEF) Summary and Refresh (C & G)	✓		
		Safer Mobility Ambition (C)	✓		
		Long Wait Harm Reviews - Option Appraisal (C & G)	-		
		Infection Prevention & Control Group Highlight Report (G)	!		
		Mental Health and Learning Disabilities Highlight Report (G)	!		
		Staffing Related Incidents Update (G)	!		
		Clinical Effectiveness Gap Analysis (G)	!		
		Medical Workforce Group Report (G)	✓		
		Clinical Audit Progress Report (G)	✓		
		Risk Management Panel Highlight Report (G)	-		
		Mortality Review Group Highlight Report (G)	-		
		Patient Experience Group Highlight Report (G)	-		
		Patient Safety Group Highlight Report (G)	-		
		Quality Impact Assessment Report (G)	-		
		MCA and DoLS Audit (G)	-		
Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)					
Pressure Ulcer Review (C)	!	Nurse and Midwifery Staffing Establishment Review (C)	! ✓		
Nursing Vacancies (C)	!	Maternity Quality & Safety Oversight Group Assurance Report (C)	! ✓		
Emergency Department Medical Workforce Update (C)	!	Infection Prevention, Vaccination & Sepsis Team Annual Report (C & G)	! ✓		
Neonatal Intensive Care Unit Mortality Report (C)	!	Never Events Review (C)	✓		
Midwifery Continuity of Care Update and Action Plan (C & G)	! ✓	Annual Plan 2022/23 (C)	✓		
Q1 Obstetrics & Gynaecology	!	Quality Strategy (C)	✓		

Quality Performance Report (G)					
Sepsis Deep Dive (C)	!				
Readmissions Analysis (C)	!				
Overview of Pressure Ulcer Serious Incident Cases (C & G)	!				
Ockenden Final Report (C)	✓				
52 Week Breach Assurance Report (C)	✓				
BC-0436 Specialised Decisions Unit Business Case (C)	✓				
BC-0477 NICU Nurse Staffing Establishment RSUH (C)	✓				
Expansion in Foundation Posts Business Case (C)	✓				
Maternity Services Assurance Map (C)	✓				
Q1 Ockenden Insight Visit Report and Action Plan (G)	✓				
Obstetric Consultant Ward Round Audit (G)	✓				
Q1 ATAIN (G)	✓				
Maternity Patient Story (C)	✓				
My Pregnancy Notes (C)	✓				
BC-0451 Oncology Clinical Workforce Business Case (C)	✓				
Falls Deep Dive (C)	✓				

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Recruitment to business cases identified following the establishment review and winter plan
- Conclude the review of the complaints process
- Conclude the review of the integrated discharge team and function
- Identify countermeasures to positively impact on occupancy. LOS and simple and timely discharges
- Completion of CQC report must and should do actions

Further Actions (to provide 'Additional Assurance' or 'Control to Reduce Likelihood / Consequence)

No.	Action Required	Intended Outcome of Action	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	To implement Tendable audit system and app across the Trust.	Additional Assurance	Chief Nurse	31/12/2023	**Original due dates 30/09/22 & 30/11/22.** Rollout of Tendable completed at County (Nov 22) – rollout plan in progress for RSUH.	
2.	To develop Trust Patient Safety Incident Review Plan (PSIRP) and engagement of Patient Safety Partners to support review and patient involvement in Trust quality meetings.	Control to reduce Likelihood	Chief Nurse & Medical Director	30/09/2023	National PSIRF guidance has been updated following Covid-19 with amended dates and learning from early adopters. This is under review and inclusion in UHNM PSIRP. UHNM steering group up and running, National timescale is to implement in 2023.	
3.	Recruitment of midwives in line with Business Case and Birth Rate Plus.	Control to Reduce Likelihood	Chief Nurse	31/03/2023	**Original due date 30/09/22 & 31/03/22.** Business case approved December 2022 – recruitment underway.	
4.	Recruitment against Emergency Department Business Case to be completed.	Control to Reduce Likelihood	Chief Nurse	31/12/2023	**Original due date 30/07/22:** Recruitment remains ongoing.	
5.	Conclude the integrated discharge function with system partners.	Control to Reduce Likelihood	Chief Operating Officer	30/06/2023	Inaugural meeting took place January 2023. System partner participation and shared vision.	
6.	Delivery of Workstream 2 actions focussing on length of stay, occupancy and simple and timely discharge.	Control to Reduce Likelihood	Chief Nurse	31/09/2023	A2 in development and performance metrics being gathered. Divisional performance reports and actions will be monitored at the WS2 meeting and reported to non-elective performance meeting.	

BAF 2: Leadership, Culture and Delivery of Values / Aspirations

Internally Driven	✓
Externally Driven	

Risk Description

Cause	Event	Effect
If we are unable to live our values and improve the culture of the organisation to make UHNM a place where all staff are treated with respect and have the opportunity to build a fulfilling career	**Then** staff may experience unacceptable behaviours and a climate of bullying, harassment and inequality	**Resulting** in an adverse impact on staff wellbeing, recruitment, retention and performance, ultimately reducing the quality of care experienced by patients.

Lead Director / s:	Chief People Officer	**Supported by:**	Chief Nurse, Medical Director and Chief Operating Officer
Lead Committee:	Transformation and People Committee	**Executive Group:**	Executive Workforce Assurance Group

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3		Likelihood:	2	31/03/2024
Consequence:	4	4	4		Consequence:	2	
Risk Level:	High 12	High 12	High 12		Risk Level:	Mod 4	

Rationale for Risk Level:

- Review of target likelihood risk score from 3 to 2 to match our active approach to delivery of activities to improve organisational culture.
- The National Staff Survey closed and the final response rate was 33.24% putting the Trust under average response for an acute setting of 45.44%
- The Staff Voice Survey reopened in November with 118 total submissions providing an overall engagement score of 6.05, December saw 207 entries with the score increase to 6.59. However submission numbers are down 738 compared to the last return in August pre the National Staff Survey.
- The Cultural Heat Map has been developed using key indicators of culture. The indicators have been cross referenced with the cultural improvement plan to ensure that most aspects of improvement are being measured. An electronic form of the cultural heat map is being amended following feedback from EWAG and TAP.
- The Resolution Policy is now live. Webinar based training sessions on the policy have begun.
- Sickness levels remain high and above target. Covid related absences continue to fluctuate, alongside the onset of flu and winter sickness bugs.
- A training plan for the roll out of Being Kind training across UHNM has been developed and this will include a roll out of an e-learning package (procured from A Kinder Life) which brings together the Resolution Policy and Being Kind elements. A paper was presented to Exec Team in November and approved mandating this training as part of the 'core for all' package.
- The key risk and challenge likely to prevent successful delivery of activities, aimed at improving organisational culture and behaviours and maximising the potential of our people to improve patient outcomes, is that operational pressures, the impact of Covid and other winter pressures, prevent staff from being released to undertake the necessary training and development.

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	0	1 →	2 ↓	2 ↑	5 ↑

Position Statement

What progress has been made during the last quarter?

Staff Engagement and Wellbeing

- The Winter Wellbeing 2022 offering is a 3 tiered approach to provide physical, psychological, emotional and financial wellbeing support
- The 2022 Staff Awards Ceremony took place on 11th November at our 'Night Full of Stars'

Staff Experience

- Equality, Diversity and Inclusion Strategy approved by the Board following consultation with staff engagement networks and Brap
- Pilot implementation of customer care training
- Culture Heat Map has continued to be developed
- Leadership Behavioural Compact (Being Kind) was launched in November 2022

Key Controls Framework – 3 Lines of Defence

1st Line	• Divisional Staff Engagement Plans set out the tailored actions to improve staff experience • Improving Together programme – Staff engagement A3 is developed • Roll out of Medical Leadership programme • Cultural Improvement Programme in place
2nd Line	• Staff Voice pulse check survey implemented from June 2021 • People Strategy and supporting HR Delivery Plan, with performance reported to Transformation and People Committee. The HR Delivery Plan is aligned to the NHS People Plan and updated for 2022/23 actions and objectives • Partnership working with the STP is in place to introduce a range of Recruitment and Retention initiatives • The Trust has set targets for staff engagement rates; sickness and turnover. Actual performance is monitored against target • 'Enable' our Middle Management programme to support leaders in maintaining positive, compassionate and inclusive behaviours • Meeting Etiquette and email guidance documentation is now available on the intranet pages via the Being Kind section therein • Resolution Policy which sets out the new approach to resolving disputes at work and replaces the Grievance Policy and Dignity at Work Policy, with associated training package now being rolled out • Resolution Policy Awareness events and webinars to take place during September/October. • Courageous Conversations Masterclass has been updated to include practical application of BUILD feedback model. • Being Kind Behavioural Framework and toolkit launched in November 2022 • Being Kind eLearning approved as Core for All within mandatory training in December 2022 • Training Plan for rollout of Civility and Respect intervention across UHNM approved by Executive Team in November 2022
3rd Line	• National Quarterly Pulse Survey was implemented from July 2021 • The 2021 National Staff is now live and results will be analysed and corporate improvement activities will be set out and reported to Board. • The Trust wellbeing plan and wellbeing offer is refreshed and updated periodically. • The Culture Review has been completed and the Cultural Improvement Programme has been finalised. A draft cultural heat map has been developed using key indicators of culture. The indicators have been cross referenced with the Culture Improvement Programme to ensure that most aspects of improvement are being measured. • Our Gender Pay Gap report shows the difference in the average earnings between all men and women employed at UHNM and the actions we are taking to further reduce the gender pay gap. • Leadership Development offerings are in place

Assurance Map

Assurances Received by the Committee (C) / Executive Group (G) during this quarter

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
Divisional Workforce Highlight Reports (G)	!✓	Q2 Employment Cases (C & G)	!✓		
		M6, M7, M8 Workforce Performance Report (C & G)	!✓		
		Workforce Race Equality Standard (WRES) Report (C & G)	!		
		Learning and Education Annual Report (C & G)	! ✓		
		Culture Improvement Plan & Monthly Update (C & G)	!✓		
		Wellbeing Update (G)	! ✓		
		Q2 Speaking Up Report (C & G)	! ✓		
		Executive Workforce Assurance Group Report (C)	!✓		
		Essential to Role Training (C)	-		
		Evaluation of the Enable Programme (G)	!✓		
		Improving Together Update (G)	!		
		Update and Refresh of the People Strategy (G)	✓		
		Statutory and Mandatory Training Group Highlight Report (G)	✓		
		Professional Standards Highlight Report (G)	-		
Other Assurances (assurances received by the Committee / Executive Group annually / bi-annually / ad hoc)					
		Creating a Great Place to Work: Improving our Organisational Culture (C)	! ✓	Retaining our Nursing and Midwifery Colleagues (G)	✓
		Workforce Disability Equality Standard (WDES) (C & G)	!✓		
		Culture Review Group Assurance Report (C)	!		
		People Plan 2022/23 (C)	✓		

		BRAP Report & National Staff Survey – Corporate Actions (C)	✓		
		Annual Plan 2022/23 (C)	✓		
		People Plan Annual Report 2021/22 (C)	✓		
		Health & Wellbeing Plan Progress Report (C)	✓		
		Update on Reflective Discussions / Progress with Hotspot Areas (G)	✓		
		Feedback from Culture Review Committee on Presentation of Improvement Plan (G)	✓		
		Equality, Diversity and Inclusion Strategy and EDI Progress Report (C & G)	✓		

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Up-skill managers to adopt a motivational and inspiring leadership style (Enable Programme)
- Improve and evidence the positive action taken on health and wellbeing (Staff Survey)
- Improve equality and diversity, staff morale and a culture of safety (Staff Survey)
- Improve Leadership and Management Development and Visibility (Staff Survey)
- Improve Staff Engagement (Staff Survey)
- Implement the Culture Review Improvement Plan and ensure there are processes in place to monitor and report progress
- Staff to undertake mandatory Being Kind training as part of Core for All compliance
- Teams to undertake focussed interventions in relation to the Being Kind face to face / virtual with OD and Culture Team

Further Actions (to provide 'Additional Assurance' or 'Control to Reduce Likelihood / Consequence)

No.	Action Required	Intended Outcome of Action	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Take forward the findings from the Trust Culture and Leadership Diagnostic Programme, and the Culture Review by formulating and embedding plans which reflects the themes identified including: a) Putting structures in place to help staff challenge and report inappropriate and bullying behaviours in the workplace b) Launch a programme of staff development underpinned by NHSI/E's "Kindness into Action" programme	Control to reduce Likelihood and Consequence	Chief People Officer	Separate Improvement Plan with timescales over 3 year period in place	Cultural Improvement Programme has been updated following a monthly review of progress and good progress is being made across the majority of actions. Meeting etiquette and email guidance documentation is now available on Intranet pages via the Being Kind section therein. A draft Cultural Heat Map has been developed using key indicators of culture. The indicators have been cross referenced with the Culture Improvement Programme to ensure that most aspects are being measured. An electronic form of the cultural heat map is being amended following feedback from EWAG and TAP.	
2.	Develop and promote the Trust's leadership and behaviour compact as outlined in the national People Plan	Control to reduce Likelihood and Consequence	Chief People Officer	Separate Improvement Plan with timescales over 3 year period in place	The leadership behavioural compact (Being Kind) has been co-created with our staff and being shared as part of the Middle Management Programme. We are supporting the Improving Together Programme and Quality Academy with those aspects linked to leadership behaviours and cultural change.	
3.	Promote the Civility and Respect agenda and a) Introduce a Resolution Policy. b) Deliver the National Civility and Respect Toolkit and c) implement a Civility and	Control to reduce Likelihood and Consequence	Chief People Officer	Separate Improvement Plan with timescales over 3 year period in place	Detailed actions and target dates are to be agreed by Trust Executives as part of the Culture Review implementation programme: • The Resolution Policy is now live. Webinar based training sessions on the policy have	

Further Actions (to provide 'Additional Assurance' or 'Control to Reduce Likelihood / Consequence)						
No.	**Action Required**	**Intended Outcome of Action**	**Executive Lead**	**Due Date**	**Quarterly Progress Report**	**BRAG**
	Respect training programme with a focus on race				ran during October and feedback has been extremely positive. • A training plan for roll out of Being Kind training has been developed and this will include rollout of an e-learning package which brings together the Resolution Policy and Being Kind elements. • A paper was presented to Executive Team in November which approved Being Kind training as mandatory.	

BAF 3: Sustainable Workforce

Internally Driven	✓
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to achieve a sustainable workforce	**Then** we may not have staff with the right skills in the right place at the right time	**Resulting** an adverse impact on staff wellbeing, recruitment and retention, increasing premium costs and potentially compromising the quality of care for our patients

Lead Director / s:	Chief People Officer	**Supported by:**	Chief Nurse, Medical Director and Chief Operating Officer
Lead Committee:	Transformation and People Committee	**Executive Group:**	Executive Workforce Assurance Group

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	4		Likelihood:	3	~~30/04/2023~~ 31/03/2024
Consequence:	4	4	4		Consequence:	3	
Risk Level:	Ext 16	Ext 16	Ext 16		Risk Level:	High 9	

Rationale for Risk Level:

- We have experienced increasing pressures on workforce supply. This is because of additional recruitment to fill vacant posts, increasing workforce turnover and demand for posts due to service developments and plans for more staff over the winter period. This situation is being experienced across the NHS and in industry partly because of a static workforce during the preceding years of the Covid pandemic.
- Unfilled vacancies increase pressure on staff, leading to high levels of stress and absenteeism, and high staff turnover.
- This makes workforce planning more urgent, particularly considering ongoing cost of living pressures and in terms of patient safety and satisfaction.
- Recent industrial action across the NHS and a six month mandate for industrial action has been received from the CSP, with an indication that action will take place early in the New Year.
- Unprecedented winter pressures on operations and staffing.
- Given this position, the target date has been reviewed and extended to 31/03/2024

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	1 →	26 ↑	62 ↓	16 ↓	105 ↓

Position Statement

What progress has been made during the last quarter?

- Approval of new People Strategy 2023 – 2025 focussing on 4 key strategic themes; 'We will look after our People', 'We will grow and develop our workforce for the future', 'We will create a sense of belonging where we are kind and respectful to each other', 'We will develop our people practices and systems'
- 2023/24 Priorities and Operational Planning Guidance and Joint Forward Plan Guidance was released 23rd December 2022 for review.
- Agency cost reduction – Divisions have been asked to provide reduction plans for discussion in the December / January EWAG meetings. Monthly expenditure p
- A PDR Recovery plan was raised after monthly figures continued to be in a negative position. Divisions were asked to provide key issues and actions for review December's EWAG. The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance alongside making the process enhance employee experience.
- Learning & Education Annual Report was presented in November EWAG to highlight 21/22 successes and learning points.
- For 2022/23 the report highlighted the need to focus on supply and demand of education and support, ensuing we have the right numbers of supervisor to support our demand for placements i.e. increased student numbers, introduction of T Level placements, work experience programmes.
- Recruitment update:
    - Fully recruited recruitment team as of 1st December 2022, we are now in a training process for half of the team which will have a significant impact on processing times and KPI's by the first quarter of 2023.
    - Processing backlog of contracts, ESR and Downloads - Initial 2000+ records reduced to 1387.
    - Recruitment event on 09th December 2022 to capture redundant employees from Wade Factory's that has gone into Administration – good candidate source for A and C and Estates roles.
    - UKVI have notified the Trust there is also a backlog in issuing VISA has increased from 8 weeks to a minimum of

12 weeks which is having a significant impact on start dates.
    - Pool of applicants for winter posts remains extremely low and as enter the end of the year it is unlikely this will increase.
- The cultural heat map has been developed using key indicators of culture and standard metrics such as turnover. The indicators have been cross referenced with the cultural improvement plan to ensure that most aspects of improvement are being measured. An electronic form of the cultural heat map is being amended following feedback from EWAG and TAP.
- The NHS Digital Staff Passport will be used to transfer staff data between organisations when staff move regularly. Workshops continue to take place to discuss beta (pilot) testing, specifics around the TRAC system interface; Occupational health, equality and diversity data have been discussed. A set of employer consultation meetings will be taking place to demonstrate the system and how the interfaces will work. (This has now been delayed to November due to national team developments).

Key Controls Framework – 3 Lines of Defence

1st Line	• Development of new workforce strategy for 2023-2025 highlights key strategic areas of workforce activity. • Workforce Plan reported to Transformation & People Committee • Workforce planning process ensures alignment with activity and financial plans. The Trust workforce plan for 2022/23 has been triangulated with Finance and Activity Plans and submitted to the System as part of the annual Operational Planning round • Workforce development is being supported by the Apprenticeship Levy and funding we have secured from Health Education England. Examples – Radiotherapy, Cardiology and Sleep, Anaesthetics, Pharmacy, Imaging and Pathology. • Actions to improve staff experience are detailed in Divisional Staff Engagement Plans • Ongoing review of recruitment processes • Work on initiatives focussing on the retention of our workforce • Rotas and rota coordinators management of roster processes • Medical rotas are reviewed, vacant shifts covered where possible from doctor bank and agency, adverts out for Trust grades where applicable. Locums are used / recruited to fill gaps where necessary • Directorate and divisional management teams monitor staffing levels • Chief Nurse staffing reviews • The UHNM Staff Voice is a monthly staff survey designed to help understand key issues important to staff about wellbeing, making improvements to where they work and the way they provide patient care. This survey also provides a local measure of staff engagement. • Divisional People Plans aligned to the corporate agenda • **Digital Agenda:** The draft People Digital Strategy for the NHS was released in September 2021 and sets out draft commitments for the next 3 years. The Digital Agenda is a system-led work programme initially covering the roll out of a Digital Staff Passport to hold staff 'verified employment and training credentials'.
2nd Line	• The Trust's People Strategy is supported by a HR Delivery Plan, with improvement activities cascaded via Divisional People Plans. The HR Delivery Plan has been updated for 2022/23 priorities and actions. • The system led workforce demand and supply process remains in place and will continue to manage redeployment of staff where required, as well as system wide recruitment initiatives. The Trust continues to progress its own recruitment plans as well. • Processes are in place to request mutual aid from across the system if required • The Workforce Bureau is now operating as a virtual bureau. • Established Banks are in place – including Nursing, Medics and other staff groups • Business cases have been approved to address staffing in ED, Anaesthetics and Critical Care and other hotspots and are being recruited to • Weekly meetings take place with Medical Staffing to review rotas, gaps and progress against recruitment • General recruitment drives are on-going and there is an element of head hunting via informal networks • Golden Handshakes and handcuffs can be used for new starters • Working with Divisional teams on high and long term agency workers to focus on exit plans • Targets allocated to Divisions for 10% agency reduction by 31st March 2023 • Continuing work with education teams and providers across the system to enhance opportunities for learning and the education experience for our trainees • **Digital Agenda:** The Trust has volunteered to participate in a trial of the digital staff passport.

3rd Line	• The Trust workforce plan for 2022/23 has been triangulated with Finance and Activity Plans and submitted to the System as part of the annual Operational Planning round
	• Plans remain in place to ensure the workforce issues associated with any surge in Covid-related absences remain in place, including:
	  ○ The *COVID-19 Staff Shortage Contingency Arrangements*, supplemented by the *Disruptive Incident Staffing Plan and Operational Workforce Plan*.
	  ○ Internal redeployment and volunteer process established to offer support to areas of need
	  ○ Partnership working with the STP, with system-wide processes for mutual aid and redeployment of staff where possible.
	• The 2022 National Staff Survey is now live and results will be analysed and corporate improvement activities will be set out and reported to Board
	• Workforce risks are reported via Datix and are monitored to ensure Divisional action and review.
	• Divisions report increased staffing challenges due to operational pressures and the opening of additional capacity, combined with high sickness rates and vacancy levels
	• Quarterly vacancy benchmarking data is available via NHS Digital

Assurance Map

Assurances Received by the Committee (C) / Executive Group (G) during this quarter

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
Divisional Workforce Highlight Reports (G)	✓!	Q2 Nursing and Midwifery Staffing and Quality Report (C & G)	! ✓		
Q2 Guardian of Safe Working (C & G)	✓	M6, M7, M8 Workforce Performance Report (C & G)	! ✓		
BC-0498 Expansion of Cardiac Physiology Workforce (C)	✓	Executive Workforce Assurance Group Report (C)	✓		
Midwifery Workforce Report (C & G)	✓	Recruitment Highlight Report (G)	! ✓		
BC0494 Imaging Services – Radiology Workforce Business Case (C)	✓	Medical Workforce Report (G)	✓		
BC-0502 Maternity Safe Staffing in line with Birthrate Plus® Business Case (C)	✓	Update and Refresh of the People Strategy (G)	✓		
Cardiothoracic Theatre Staffing Business Case (C)	✓	Agency Cost Reduction Plans (G)	-		
Business Case Review: BC-0426 ED Medical Workforce (C)	✓				

Other Assurances (assurances received by the Committee / Executive Group annually / bi-annually / ad hoc)

Nursing Vacancies (C)	!	Closing the Workforce Gap Report (C & G)	!		
Emergency Department Medical Workforce Update (C)	!	Agency Expenditure 2022-23 (G)	!		
BC-0436 Specialised Decisions Unit Business Case (C)	✓	Nurse Staffing Establishment Review (C)	✓!		
BC-0477 NICU Nurse Staffing Establishment RSUH (C)	✓	Annual Plan 2022/23 (C)	✓		
Expansion in Foundation Posts Business Case (C)	✓	People Plan Annual Report 2021/22 (C)	✓		
BC-0451 Oncology Clinical Workforce Business Case (C)	✓	Revalidation Annual Report (C)	✓		
		People Plan 2022/23 (C)	✓		

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Finalisation of Divisional People Plans and Workforce Plans for 2022/23, aligned to the corporate agenda
- Review of processes to assess workforce availability, covering sickness absence, vacancies and retention (Improving Together programme)
- On-going development of workforce supply and recruitment processes to address future workforce supply issues

Further Actions (to provide 'Additional Assurance' or 'Control to Reduce Likelihood / Consequence)

No.	Action Required	Intended Outcome of Action	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Align the Trust's workforce plan with capacity plans developing a local toolkit for use by management teams	Control to reduce Likelihood and Consequence	Chief People Officer	31/12/22	Trust workforce plan for 2022/23 has been triangulated with Finance and Activity Plans and submitted to the System	

BAF 4: System Working

Internally Driven	
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to effectively collaborate, engage and influence key stakeholders as part of the Integrated Care system	**Then** we may not be able to provide health services which meet the wider needs of the system population	**Resulting in** fragmented, poor quality, inefficient and ineffective services

Lead Director / s:	Chief Executive	**Supported by:**	Director of Strategy and Transformation
Lead Committee:	Transformation and People Committee	**Executive Group:**	Strategy and Transformation Group

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3		Likelihood:	2	31/03/2023
Consequence:	3	3	3		Consequence:	3	
Risk Level:	High 9	High 9	High 9		Risk Level:	Mod 6	
Rationale for Risk Level:	• The ICS Chair has resigned due to retirement at the end of December. Interim arrangements are in place via the Vice Chair. • System work was undertaken to produce a system owned and developed winter plan. However during extremis it was apparent that the risks and actions remained with the acute.						

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	1 →	0 →	0 →	0 →	1 →

Position Statement

What progress has been made during the last quarter?

- The ICB have now produced a draft strategy which has been shared for information and contribution and will be presented to UHNM Board in February
- System priorities / portfolios are agreed and all are assigned a Chief Executive Sponsor and SRO and most have an ICB Programme Director recruited to them
- Daily system calls take place to discuss operational pressures

Key Controls Framework – 3 Lines of Defence

1st Line

- Regular updates from the Executive Strategy and Transformation Group

2nd Line

- Regular discussions at Executive Team meeting each week
- Regular update on ICS transformation programme to Transformation and People Committee
- Regular updates in closed session of Trust Board and through Chief Executive's update to Public Board
- Board Seminars with a specific focus on partnership working and collaboration
- Adoption of a number of UHNM approaches to risk management and governance at system level through governance and risk system network
- Full conclusions from quarterly system review meeting to all Board members

3rd Line

- Representation in the formal governance structure of the ICB
- Members of the Executive Team play a key role in relevant system led forums / priority work streams.
- Medical Director has established a new Deputy Medical Director role with a specific focus on system working.

Assurance Map

Assurances Received by the Committee (C) / Executive Group (G) during this quarter

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		Children's Hospital Board – Highlight Report (G)	!✓	System Working / Provider Collaborative Update (G)	✓
		County Hospital Strategic Programme Board – Highlight Report (G)	!	ICS Transformation Update (G)	-
		Transformation Programme Update (C &	✓	Trust Population Health &	✓

		G)		Wellbeing Strategy (G)	
		Executive Strategy & Transformation Group Assurance Report (C)	✓	Integrated Care Partnership Briefing – September 2022 (C)	-
		Transformation and Service Change Programmes (C)	✓		
		Development of Corporate Strategy / Objectives (G)	-		
		Clinical Strategy Delivery Plans (G)	-		
		Review of Integrated Annual Planning Cycle (G)	-		
Other Assurances Received by the Committee / Executive Group (G) bi-annually / ad hoc					
		Annual Plan 2022/23 (C) Stakeholder Strategy Roadmap (G)	✓ ✓	Integrated Care System Board Partner Briefing – April 2022 (C) Quarterly System Performance Review Meetings (C)	✓ ✓!
		Annual Business Planning Cycle (G)	✓	Staffordshire and Stoke on Trent ICS Development Plan / Newsletter (C)	✓
		Enabling Strategies – Status Overview (G)	✓	ICS Board Partner Briefing – August 2022 (C)	✓

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Development of stakeholder feedback on UHNM as a partner, including adoption of revised Code of Governance in relation to system working
- Future CQC inspections on Well Led will incorporate the legal duty to collaborate through a focus on system working / engagement and partnership working
- Provider Collaborative to develop its work plan or road map to January 2023
- Provider Collaborative self-assessment to be undertaken once the maturity matrix is released by NHSE
- Progress against wider clinical partnerships / networks beyond the ICS to be provided through the system Provider Collaborative and UHNM internal governance structure
- Recruitment to a new ICS Chair and substantive recruitment to a number of NHS ICB executive roles – Chief Executive, Director of Strategy and Director of Nursing remain interim appointments

Further Actions (to provide 'Additional Assurance' or 'Control to Reduce Likelihood / Consequence)

No.	Action Required	Intended Outcome of Action	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Development of stakeholder feedback on UHNM as a partner, including adoption of revised Code of Governance in relation to system working.	Additional Assurance	Director of Strategy & Transformation	31/01/2023	**Original due date 30/09/2022:** Revised Code of Governance published and shared with Provider Collaborative. UHNM have completed self-assessment which will be shared through Audit Committee. Consideration being given to a session with system partners as part of our 2023/24 Board Development Programme.	
2.	Development of work plan or road map to January 2023 in relation to provider collaboration and self-assessment against the maturity matrix.	Control to reduce Likelihood	Chief Executive	28/02/2023	**Original due date 31/1/2023:** First draft of roadmap to October Provider Collaborative Board. Awaiting matrix from NHSE but Provider Collaborative Board in December agreed to commence the self-assessment based on current knowledge of requirements.	
3.	Progress against wider clinical partnerships / networks beyond the ICS to be provided through our governance structure.	Additional Assurance	Director of Strategy & Transformation / Chief Executive	31/12/2022	**Original due date 30/09/2022:** Arrangements made for reporting into Executive Strategy and Transformation Group and Transformation and People Committee.	
4.	Completion of system strategy.	Additional Control to reduce Likelihood	Director of Strategy & Transformation / Chief Executive	28/02/2023	Currently in draft and with system partners for comment.	

BAF 5: Delivering Responsive Patient Care

Internally Driven	✓
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to create sufficient capacity to deal with service demand	**Then** we may be unable to treat patients in a timely manner	**Resulting in** high hospital occupancy, delays to patient care and potential patient harm

Lead Director / s:	Chief Operating Officer	**Supported by:**	Chief Nurse and Medical Director
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Planned Care and Urgent Care Improvement Groups

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	5		Likelihood:	3	31/08/2023
Consequence:	4	4	4		Consequence:	4	
Risk Level:	Ext 16	Ext 16	Ext 20		Risk Level:	High 12	
Rationale for Risk Level:	There has been an increase in the likelihood due to not being able to create sufficient capacity due to seasonal pressures, compounded by an increase in the number of patients with infection prevention restrictions. In addition, due to a change in national guidance, we are unable to step down elective activity in order to accommodate non-elective patients.						

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	1 ↑	6 ↑	20 ↓	13 ↑	40 ↑

Position Statement

What progress has been made during the last quarter?

Your Next Patient flow model has been embedded and provisions are in place to enable safe corridor care to generate additional capacity to flow through the non-elective pathways and reduce harm. The front door reconfiguration has also commenced and completed its first stage which has created resuscitation and ambulatory capacity as well as generated efficiencies downstream through a more effective utilisation of estates. Finally, the Frailty Decision Unit has been implemented at the front door. This is staffed by multidisciplinary, cross organisational team which works to turnaround MFFD and complex discharge type patients, therefore preventing admission. In addition, County day case facilities are being utilised differently in order to facilitate increased flow through of patients. Changes in the cancer pathways have been implemented to facilitate more efficient patient treatment.

Key Controls Framework – 3 Lines of Defence

1st Line

- 4 x daily capacity calls with Head of Operations, Deputy Chief Operating Officer (COO) / COO attendance
- Monthly improvement meetings tracking the actions / milestones across the 3 the NEL improvement work streams supported by the Deputy COO with exec oversight
- Weekly weekend planning meetings to provide assurance of the safe delivery of services and to identify and mitigate risks throughout the weekend period
- Divisional accountable officers rota' d on a daily basis to provide a visible and accessible point of contact for operational management and risk mitigation
- Weekly cancer PTL meetings and twice weekly RTT meetings taking place
- Action plans are in place for any diagnostic work stream not meeting DM01 standards, any diagnostic work stream impacting on cancer waits, skin, colorectal, oncology, urology and any specially with a cohort of patients waiting over 104 weeks

2nd Line

- Monthly internal performance review meetings between Executive and Divisional Leadership Teams to ensure appropriate improvements, management of risk and accountability
- Executive led Non-Elective and Planned Care Improvement Groups to ensure ongoing performance improvement
- Standing up of executive led daily tactical response meetings when significant risks are identified and require corporate support
- Fortnightly winter planning group chaired by Deputy COO to ensure robust plan to provide resilience over winter. This group reports to Performance and Finance Committee for oversight and assurance.

3rd Line	• 3x weekly COO call chaired by ICB with representation from all system partners for urgent care • Weekly meetings with system partners including West Midlands Ambulance Service to identify opportunities for collaboration and to appropriately share risk across the system - to support the admission avoidance actions within Programme 1of the NEL improvement programme • Weekly call chaired by Regional NHSE with regards to planned care performance • System Planned Care Board in place to support system-wide elective improvements and provide opportunities for collaboration and management of risk across the system • System Urgent Emergency Care Board to support system-wide non-elective improvements and provide opportunities for collaboration and management of risk across the system • Weekly system Executive ambulance improvement Task and Finish Group to provide assurance of appropriate oversight and delivery of the ambulance handover improvement plan. Additional weekly meeting including NHSE representatives to provide oversight. • Weekly tier 2 NHSE performance review regarding elective recovery • Comprehensive capacity, demand, organisational and system bed model undertaken

Assurance Map

Assurances Received by the Committee (C) / Executive Group (G) during this quarter

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
Outpatients Highlight Report (G)	! ✓	Planned Care Highlight Report (C)	! ✓	NHSE Letter - Next steps on elective care for Tier One and Tier Two Providers (C)	-
Cancer Highlight Report (G)	! ✓	M6, M7, M8 Performance Report (C)	! ✓	PWC System Bed Model	!
Theatres Highlight Report (G)	! ✓	Non Elective Improvement Group Highlight Report(C)	!		
County Work Stream 4 Update (G)	!	Planned Care Improvement Dashboard (G)	! ✓		
County Hospital Planned Care Hub – Central Treatment Suite Phase (C)	✓	Cancer PTL Performance Position (G)	! ✓		
BC-0511 Purchase of Modular Building to provide Enhanced Primary Care and Out of Hours Primary Care Services at UHNM (C)	✓	Non-Elective Improvement Dashboard (G)	! ✓		
Acute Patient Flow Highlight Report (G)	-	Your Next Patient Update (G)	! ✓		
Elective Recovery Highlight Report (G)	-	UHNM Tier 2 Analysis (C)	✓		
Diagnostics Cell Highlight Report (G)	-	Capacity and Demand Implementation Update (G)	✓		
Elective Recovery -Extended ERF Funding to support the elective recovery of T&O Services (G)	-	Update on Operational Plan (G)	-		
Elective Recovery - Neurology services (G)	-	County Development (G)	-		
Virtual Outpatient Business Case (G)	-				

Other Assurances Received by the Committee / Executive Group annually / bi-annually / ad hoc

Emergency Department Medical Workforce Update (C)	!	Operational Delivery Group Highlight Report (C)	! ✓	Reducing Long Waits – 104 Week Waiters (C)	✓
Enhanced Primary Care Business Case (EhPC) Post Implementation Review (C)	!	Elective Recovery Fund (ERF) Month 3 Summary (G)	✓	Information on Support for Tier Two Providers (C)	!
Review of Urgent Care (C)	✓	Planned Care Plan on a Page (C & G)	✓	System Oversight Framework (SOF): Provider Segmentation	!
BC-0479 Expansion of County Elective Capacity (C)	✓	Non-Elective Plan on a Page (C & G)	✓		
Request for Funding – MRI Mobile Scanner (C)	✓	New Urgent Care Standards (G)	-		
Planned Care Improvement Deep Dive (C)	✓	Long Wait Harm Reviews - Option Appraisal (G)	-		
52 Week Breach Assurance Report (C) Colorectal Outsourcing Briefing (G)	✓ ✓				
BC-0480 Sustainability of Spinal Services (C)	✓				
CTS Phase 1 Short Form Business Case (C)	✓				
BC-0493 Additional CT Scanner	✓				

(CT8) (C)					
BC-0451 Oncology Clinical Workforce Business Case (C) Business Case: BC-0470 Extension of Respiratory Post Covid Follow Up Service (C) County ED Improvement Plan (G) Acute Front Door Highlight Report (G)	✓ ✓ - -				

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- High occupancy – unable to reduce our occupancy to facilitate planned and urgent care pathways
- Unreliable simple discharge delivery that supports flow through the organisation
- High MFFD as a % of bed occupancy
- General referral rates / demand for cancer and RTT
- Lack of sufficiently utilised alternate pathways to stream patients away from the Emergency Department who do not require urgent and emergency care

Further Actions (to provide 'Additional Assurance' or 'Control to Reduce Likelihood / Consequence)

No.	Action Required	Intended Outcome of Action	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Fully execute business cases that support non-elective and elective programmes of work.	Control to reduce Likelihood	Chief Operating Officer	31/03/2023	**Original Due Date 30/11/2022** The date has been changed as there are still ongoing business cases either not fully phased or executed and further investment may be needed in order to accelerate, sustain and generate improvements.	
2.	Develop and implement robust winter planning, integrated with wider system provisions	Additional Assurance	Chief Operating Officer	09/11/2022	**Original Due Date 5/10/2022 and 09/11/2022:** Complete. This will be restarted at the beginning of Q1 for 23/24 planning.	
3.	Deliver objectives as described in non-elective improvement programme	Control to reduce Likelihood	Chief Operating Officer	30/09/2023	**Original Due Date 31/02/2023:** Dates have been realigned in line with programme.	
4.	Develop comprehensive capacity, demand, organisational and system bed model to ensure data driven approach to improvement	Control to reduce Likelihood	Chief Operating Officer	31/10/2022	Complete.	
5.	Increase capacity of UHNM footprint through the development of County Hospital as an elective care centre	Control to reduce Likelihood	Director of Strategy & Transformation	31/03/2025	3 year project underway, 1st business case signed off in September and 2nd business case underway. Programme Board in place to ensure steer and leadership. Work streams now established and underway.	
6.	Ensure full exploration and development of opportunities to utilise data and technology to support the delivery of clinical services	Control to reduce Likelihood	Chief Operating Officer	31/03/2023	The process has begun to explore the procurement and implementation of a HIMSS Level 7 system wide EPR system.	
7.	Collaborate with ICS partners to ensure deployment of alternative pathways and admissions avoidance mechanisms in order to ensure appropriate patients attend and / or admitted to UHNM bed base.	Control to reduce Likelihood	Chief Operating Officer	31/03/2023	Action not yet due.	

BAF 6: Delivery of IM&T Services

Internally Driven	✓
Externally Driven	

Risk Description

Cause	Event	Effect
If our infrastructure and clinical systems are not sufficient or adequately governed or protected	**Then** this could compromise connectivity and access to key critical patient information **services such as clinical decision support**	**Resulting in** compromised patient care (including patient delays, cancellation of services, **clinical harm**), staff inefficiencies and breaches of confidentiality, reputational damage and potential fines.

Lead Director / s:	Director of Digital Transformation	**Supported by:**	Medical Director and Chief Finance Officer
Lead Committee:	Transformation and People Committee	**Executive Group:**	Executive Data Security & Protection Group

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3		Likelihood:	2	31/03/2024
Consequence:	4	4	4		Consequence:	4	
Risk Level:	High 12	High 12	High 12		Risk Level:	High 8	
Rationale for Risk Level:	• The Quarter 3 risk has remained unchanged in the period as there has been a delay in the Network and Communication Market testing, Commission of System Wide Security Operations Centre (SOC) service and implementation of new Firewalls at Royal Stoke • The target risk appetite has increased due to planning guidance being received and this will impact on future investments						

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	2 ↑	10 ↑	13 →	3 ↑	28 ↑

Position Statement

What progress has been made during the last quarter?

- Network and Communication Market Testing has been launched with the business case now being rescheduled to come to Trust Board in June 2023
- The business case for the System Wide Security Operations Centre is due to come to the Performance and Finance Committee on 31st January
- The Firewall replacement scheduled for 22nd January 2023 had to be stood down due to the requirement for a change freeze during the period of the ambulance service industrial action
- The procurement of professional consultancy services to support UHNM in the delivery of a system wide business case and requirement of specification has commenced and ends on 27th January 2023
- The resources business case which stated the case for a Chief Nurse Information Officer, Business Intelligence Capacity and Business Relationship Capacity was approved by the Executive Team in January and work is progressing on recruiting to these approved posts
- Go live date for Winpath Enterprise Microbiology agreed – 6th February 2023
- Patients Know Best (PKB) is live with 66, 038 patients registered

Key Controls Framework – 3 Lines of Defence

1st Line	• Compromised password tool deployed to identify accounts and passwords that are known on the dark web • Microsoft Azure administration accounts modified to adhere to security best practice • Pathology IT following service management standards • Patient Knows Best live and available for staff to use for patient communications and engagement pathways
2nd Line	• Cyber security action plan in place and updated to include the recommendations from the independent penetration test report • Third party commissioned to undertake SQL 2012 upgrades
3rd Line	• Independent penetration test completed and report received • Internal Audit report on the Digital Strategy development received

Assurance Map

Assurances Received by the Committee (C) / Executive Group (G) during this quarter

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
IM&T Financial Update (G)	!	Digital Strategy (C & G)	!✓	ICB EPR Digital Clinical System (DCS) Business Case & Statement of Requirements (G)	-
Siemens MES/PACS Service Extension Update (G)	-	IT Service Delivery Chairs Report (G)	!		
		IT Programmes Operational Assurance Report (G)	!		
		Data Security and Protection Chairs Report (G)	! ✓		
		Record Service Chairs Report (G)	!		
		Digital Clinical Safety National Focus (G)	!		
		Executive Digital and Data Security & Protection Group Assurance Report (C)	!		
		Digital Clinical Operational Group Chairs Report (G)	✓		
		Digital Systems A3 (G)	✓		
		Cyber Security Chairs Report (G)	✓		
		Clinical Systems Chairs Report (G)	✓		
		Executive Infrastructure Group Assurance Report (C)	-		
Other Assurances Received by the Committee / Executive Group annually / bi-annually / ad hoc					
Log4j progress update (C)	✓	Camera Incident ICO (G)	! ✓	IT Cyber Security Governance and Risk Management Framework Internal Audit (C)	✓
BC-0397 Network and Communications Strategic Outline Case (C)	✓	NASSTAR Network Incident Debrief (C)	✓	IT Asset Management Internal Audit Review (C)	✓
				Data Security and Protection Toolkit Internal Audit (C)	✓

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Office 365 migration
- Electronic prescribing and medicines administration solution
- Electronic patient record strategic outline case
- Network services outline business case
- Backup and firewall implementation
- iPortal rewrite into a supported platform
- Ward Information system rewrite onto a supported platform
- Recruit to the Commercial Manager post
- Recruit to the Chief Nurse Information Officer post
- Implement laboratory management information system
- Commission a 24 x 7 security operations centre

Further Actions (to provide 'Additional Assurance' or 'Control to Reduce Likelihood / Consequence)

No.	Action Required	Intended Outcome of Action	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Office 365 Implementation	Control to reduce the Likelihood	Director of Digital Transformation	31/03/2023	Project Manager assigned.	
2.	Network and Communication Market Testing	Control to reduce the Likelihood	Director of Digital Transformation	07/06/2023	**Original due date 28/09/2022:** Strategic Outline Case approved Requirements, specification completed. Procurement legal advice sought. Procurement commenced.	
3.	iPortal and WIS rewrite	Control to reduce the Likelihood	Director of Digital Transformation	31/03/2023	WIS in test and iPortal in development. IPortal alternative options being considered due to 48 month development estimate.	
4.	Commission 24 x 7 SOC service	Control to reduce the Likelihood	Director of Digital Transformation	31/01/2023	**Original due date 01/11/2022:** Proposal received from the ICB	

Further Actions (to provide 'Additional Assurance' or 'Control to Reduce Likelihood / Consequence)						
No.	**Action Required**	**Intended Outcome of Action**	**Executive Lead**	**Due Date**	**Quarterly Progress Report**	**BRAG**
					and request to proceed submitted. Business case approved at Executive Team and will be presented to Performance and Finance Committee on 31/01/23.	
5.	Backup solution implementation	Control to reduce the Likelihood	Director of Digital Transformation	31/03/2023	Project manager assigned	
6.	Firewall solution implementation	Control to reduce the Likelihood	Director of Digital Transformation	01/02/2023	**Original due date 01/11/2022:** Project manager assigned. Implementation date agreed, implementation cancelled due to change freeze due to industrial action.	
7.	Resources business case	Control to reduce the Likelihood	Director of Digital Transformation	03/01/2023	**Original Due Date 01/10/22 and 31/10/22:** Business case authored. Investment being considered by Execs. Investment approved by Executive Team. Recruitment activities commenced.	

	BAF 7:	Infrastructure to Deliver Compliant Estate Services	Internally Driven	✓
			Externally Driven	

Risk Description		
Cause	**Event**	**Effect**
If we are unable to sufficiently invest and develop our retained clinical and non-clinical estate	**Then** we may be unable to provide services in a fit for purpose healthcare environment	**Resulting in** the inability to provide high quality services in a safe, secure and compliant environment

Lead Director / s:	Director of Estates, Facilities and PFI	**Supported by:**	Director of Digital Transformation and Chief Finance Officer
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3		Likelihood:	3	31/03/2023
Consequence:	4	4	4		Consequence:	3	
Risk Level:	High 12	High 12	High 12		Risk Level:	High 9	

Rationale for Risk Level:

- Estates Workforce challenges continue
- Estates condition and backlog maintenance risks
- Sustainability / Net Zero Carbon – significant investment required
- Estates Strategy Refresh – to be informed by PWC Review and refreshed clinical strategy
- Cleaning collaborative – sustaining of cleaning standards and improvements (West Building)
- PFI market testing opportunities and concluding of VFM reviews
- The network and communication provision future solution informed by market test

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	0 ↓	15 ↑	15 ↑	1 →	31 ↑

Position Statement

What progress has been made during the last quarter?

Estates Workforce Recruitment/Retention Issues

- Estates workforce business case approved at December's PAF and focus now turned to implementation.

Estate Condition

- Backlog maintenance - items prioritised for targeted capital schemes; statutory maintenance and progression of capital schemes (including Lower Trent) to reduce estate condition risks. Continue to work with finance (CIG) to prioritise backlog against available capital funding and mitigate risks associated with delays. Ensure the priority items are documented to ensure if additional capital is available we can deliver against critical infrastructure elements.
- Project STAR – Construction of new multi-storey car park at Grindley Hill commenced and on programme. Work progressing on disposal strategy of Infirmary and Out-Patients, which is a critical enabler to funding the car park.

NCZ/Sustainability

- UHNM Green Plan 2022-25 complete and fully aligned to the Greener NHS Programme/NZC agenda. Significant capital investment required to ensure target delivery.
- Board Seminar held in October and agreed an action for PAF to receive a bi-annual progress report.
- Public Sector Decarbonisation Scheme bid submitted and Business Case approved at PAF in December in anticipation of potential bid award in January.

Estate Strategy / Clinical Strategy

- Independent reviews of estate at County and Royal now concluded and opportunities identified.
- PWC demand/capacity review completed. Stakeholder review of findings underway to inform degree to which identified bed gap can be closed without the need for new build physical beds. Outcome of this, alongside refresh of Clinical Strategy, will be used to inform the refresh of the Estate Strategy and future Development Control Plans for the site.
- County Hospital Programme (TIF2) – Good progress being made on delivering CTS works programme and progression of detailed design of daycase facility and breast relocation.

West Building

- Identified physical estates works completed to improve compliance, alongside refresh of service standards and monitoring arrangements to ensure cleaning standards improved and sustained.

Adoption of new National Standards of Healthcare Cleanliness

- Business Case produced, approved at PAF in December and focus now turned to implementation.

PFI Market Testing Opportunities

- Sodexo Business Case approval secured and now concluding legals/commercials.
- Siemens PACS/MES VFM completed to final draft and pending decision from Trust (end Jan) on preferred PACS/RIS solution.
- Network and Communications Service - Requirements specification and tender has been opened to the market place and

findings will be used to inform future service delivery model.

Key Controls Framework – 3 Lines of Defence

1st Line

- Project STAR **–** Approved Business Case and construction commenced
- Estate Condition**:** Planned Preventive Maintenance programme; competent estates staff/ Authorised Persons; KPI's monitored through CEF/ Environmental Audits**.** Maintenance Operational Board; Operational policies; Service Specifications PFI, 7 Facet Survey.
- Fire Safety/ Security Policies; Protocols; Guidelines; patrolling; CCTV; FRA's in place
- Sustainability / NZC – Sustainable Development Steering Group (biannual), Sustainability Working Groups (monthly), Performance and Finance Committee (PAF) commencing April 2023, NZC Trust Board Lead (Director EFP) and attendance at the ICS and Midlands Green Groups.

2nd Line

- Estate Condition - Capital bids prioritised against Estate 7 Facet Findings and approved at CIG.
- Estate Strategy – Clinical Strategy and independent review used to inform content.
  Fire/Security: 'On the spot' fire improvement notices, Fire Safety KPIs & ad-hoc audits/inspection
- Head of Fire Safety and Security close working with local Police and visibility on site
- Sustainability / NZC – Business case approved in anticipation of successful funding application for Public Sector Decarbonisation Scheme. Work with external partners regarding zero-capital solutions (EV strategy)
- Capital team / Capital programme Audit – RSM UK LLP.

3rd Line

- Statutory maintenance programme – Maintenance Operational Board
- Regulatory inspection/validation programmes including: CQC, PLACE, PAM and ERIC
- External audits including Fire and Police Service and external audit i.e. KPMG
- Authorising Engineers Audits of building services and associated maintenance regimes.
- Participation in National Programme (SSRM) hosted by Cabinet Office & HM Treasury
- Sustainability National Audits – ¼ Greener NHS Data Collections, Annual Fleet Data Collection; National Waste and Food Data Collections

Assurance Map

Assurances received by the Committee (C) / Executive Group (G) during this quarter

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
Estates Divisional Board Assurance Report (G)	! ✓	Fire Safety Highlight Report (G)	!✓	Fire Safety Considerations for an Increasing Estate (G)	-
BC-0510 Public Sector Decarbonisation Scheme (C)	✓	Executive Health and Safety Assurance Report (C)	✓!	Internal Audit Capital Programme (C)	✓
		Security Management Highlight Report (G)	!		
		Estates Capital Update (G)	!		
		Violence Prevention & Reduction Strategy (C & G)	✓		
		Capital Investment Group Assurance Report (G)	✓		
		Confirmation of Capital Reporting (G)	-		
		County Hospital Smiley's Crèche – Proposed Sale of Land to Smiley's (G)	-		
		Executive Infrastructure Group Assurance Report (C)	-		
Other Assurances Received by the Committee / Executive Group annually / bi-annually / ad hoc					
		Capital Programme Inflation Pressures (C)	!	Capital Programme Internal Audit (C)	✓
		Revised Capital Plan 2022/23 (C)	✓	UHNM PLACE Lite 2021 (G)	✓
		Health and Safety Annual Report 2021/22 (C)	✓		
		Fire Annual Report 2021/22(C)	✓		
		Capital Plan 2022/23 (C)	✓		
		Security Management Annual Report 21/22 (C & G)	✓		
		Statutory Maintenance, Testing and Validation Programme (G)	✓		

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Capital Programme – continued focus on mitigating risks of delay on capital schemes working closely with finance colleagues.
- Estates Business Case – move to implementation phase following approval in December.
- Project STAR – work to continue on firming up disposal strategy and programme for Infirmary and Outpatients sites
- Public Sector Decarbonisation Scheme – respond to queries through validation process and prepare for bid award.
- Estate Strategy – complete housekeeping refresh with detailed review and development control plans to follow, pending the outcome of the PWC review and Clinical Strategy refresh

- National Cleaning Standards Business Case – move to implementation following approval in December.
- PFI – conclude lender approvals Sodexo Market Test, determine PACS/RIS solution to inform concluding of Siemens VFM and await findings of procurement exercise for Network and Communications service to inform future service model

Further Actions (to provide 'Additional Assurance' or 'Control to Reduce Likelihood / Consequence)						
No.	**Action Required**	**Intended Outcome of Action**	**Executive Lead**	**Due Date**	**Quarterly Progress Report**	**BRAG**
1.	Energy Procurement Paper	Control to reduce Likelihood and Consequence	Director EF&P	30/04/2023	Discussions are underway with the UHNM Sustainability and Procurement Team as well as with Stoke on Trent City Council to produce buying strategy to ensure that forecast energy cost increase in April 2024 is mitigated as far as possible including potential connection to Stoke on Trent heat network (proposals currently at a high level).	
2.	RI Site demolition	Control to reduce Likelihood and Consequence	Director EF&P	31/03/2024	**Original due date 31/03/2023:** Phases 1-5 completed, Final building demolition reliant on ward 80/81 becoming vacant.	
3.	Car parking solution	Control to reduce Likelihood and Consequence	Director EF&P	31/06/2024	**Original due date 31/03/2023:** Construction of new multi-story car park at Grindley Hill has commenced.	
4.	RI/COPD - Release land for land sale	Control to reduce Likelihood and Consequence	Director EF&P	2024/2025	Work to continue on firming up disposal strategy and programme for Infirmary and Outpatients sites.	
5.	Lower Trent Business Case	Control to reduce Likelihood and Consequence	Director EF&P	26/01/2023	New ward to open January 2023.	
6.	PFI Market Testing Opportunities	Control to reduce Likelihood and Consequence	Director EF&P	31/12/2023	**Original due date 31/12/2022:** Formalise Sodexo Business Case and progress other investment led/VfM opportunities associated with N&C and MES/PACS.	
7.	Estate condition	Control to reduce Likelihood and Consequence	Director EF&P	31/03/2023	Deliver statutory maintenance & capital schemes mitigating risks of delays as far as possible.	
8.	Strategic Supplier Programme	Control to reduce Likelihood and Consequence	Director EF&P	31/03/2023	8 new initiatives identified and launched at EFP partnership day in December 2022.	
9.	Estates Workforce Reviews	Control to reduce Likelihood and Consequence	Director EF&P	31/03/2023	**Original due date 31/08/2022:** Business case approved 20th December 2022, recruitment process commenced.	
10.	Cleaning Collaborative / new National Standards of Healthcare Cleanliness	Control to reduce Likelihood and Consequence	Director EF&P	31/03/2023	Sustain improvements seen in West Building and implement new Cleaning Standards following approval of Business Case at PAF in December.	

BAF 8: Financial Performance

Internally Driven	✓
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we, or system partners, are unable to operate within available resources	**Then** the system financial plan for 2022/23 may not be delivered	**Resulting in** increasing Cost Improvement Programmes, and a lack of ability to invest in the development of future services

Lead Director / s:	Chief Finance Officer	**Supported by:**	Chief Operating Officer
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3		Likelihood:	2	~~30/09/2022~~ 31/03/2023
Consequence:	3	3	3		Consequence:	2	
Risk Level:	High 9	High 9	High 9		Risk Level:	Mod 4	
Rationale for Risk Level:	The risk score has remained the same as the previous quarter, however given the continuing identification of CIP and identification of non-recurrent benefits it is anticipated that the target score will be achieved by the end of quarter 4.						

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	0 →	1 ↓	8 →	0 →	9 ↓

Position Statement

What progress has been made during the last quarter?

The forecast deficit for the year has reduced from £9.1m to £6.6m during Q3 with continued underspends against pay budgets and slippage on investments, generating in year underspends. Non-recurrent CIP continues to be identified to support the in year position. Continued identification of non-recurrent benefits (cost reduction and additional income) during Q4 will support achievement of the target risk score by 31/03/2023.

Key Controls Framework – 3 Lines of Defence

1st Line	• Performance Management meetings in place with Divisions • SFIs and scheme of delegation • Planned care board approving and monitoring spend against ERF • Exec Team approval of additional investment up to £250k
2nd Line	• Finance report in place to performance and Finance Committee with associated scrutiny; enhanced to include run rate performance and analysis of additional COVID related expenditure • ICS CFO meeting to review system position • Non-recurrent mitigations confirmed
3rd Line	• Consideration of Internal audit programme to reflect changing risks in financial plan • Varying the pace of investment to provide additional mitigation • External audit programme in place

Assurance Map

Committee Assurances received by the Committee (C) / Executive Group (G) during this quarter

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		M6, M7, M8 Finance Report (C)	! ✓	Internal Audit Financial Sustainability (C)	✓
		Q2 Losses and Special Payments (C)	!		
		Investment Assurance (C)	!		
		Draft Financial Plan Assumptions (G)	!		
		Financial Outlook 2023/24 (C)	!		
		Changes to in-year Revenue Financial Forecasts (C)	!		
		Advanced System Business Continuity	!✓		

		Incident (C)			
		Q2 SFI Breaches and Single Tender Waivers (C)	✓		
		Executive Infrastructure Group Assurance Report (14-10-22) (C)	-		
		Agency Cost Reduction Plans (G)	-		
Other Assurances Received by the Committee / Executive Group annually / bi-annually / ad hoc					
Procurement Update Report (C)	✓	Financial Plan 2022/23 (C)	✓	System Plan 2022/23 (C)	!
		Annual Plan 2022/23 (C)	✓	Capital Programme Internal Audit (C)	✓
		Investment Assurance (C)	!	Staffordshire and Stoke on Trent Final System Operating Plan for 2022/23 (C)	✓
		2022/23 I&E Year End Forecast (C)	!		
		Agency Expenditure 2022-23 (G)	!		

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

The system has submitted a breakeven plan for 2022/23 but has an underlying deficit of £133m of which UHNM represents £30m. UHNM plans include recurrent CIPs of £13.6m which have not all been identified. The forecast for the year shows a £6.6m deficit, at month 8, before any further mitigation or non-recurrent underspends including slippage against the winter plan, virtual wards and ERF. In year non-recurrent flexibility is available to support in-year but the underlying position will need addressing going forward into 2023/24.

Further Actions (to provide 'Additional Assurance' or 'Control to Reduce Likelihood / Consequence)

No.	Action Required	Intended Outcome of Action	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Identification of recurrent CIP	Control to Reduce Likelihood	Deputy CEO	31/03/2023	**Original Due Date 30/6/2022 and 31/12/2022:** Director of Strategy and Chief Finance Officer meeting regularly with Divisions to develop their plans; limited progress on identification of recurrent CIP has resulted in underlying position worsening.	
2.	Quantification of Non Pay inflation in 2022/23.	Control to Reduce Consequence	Chief Finance Officer	31/03/2023	Trust has been protected during 2022/23 to some extent from excessive non-pay inflation due to a number of high value contracts being over multiple years. The Trust's underlying position accounts for these costs to be incurred in future years.	
3.	Reduce level of recurrent investment to mitigate on non-delivery of CIP.	Control to Reduce Consequence	Chief Finance Officer	31/03/2023	**Original due date 01/11/2022:** PAF approved recurrent investments in December 2022 following a prioritisation process that were affordable to the Trust; additional investments were also approved subject to recurrent CIP identification.	

BAF 9: Research & Innovation

Internally Driven	✓
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to secure sufficient capacity, resource and skills needed	**Then** we may be unable to deliver the Research and Innovation Strategy	**Resulting in** a failure to maintain our reputation as successful researching university hospital, offering patients the opportunity to participate in research and to provide high quality innovative care and our ability to attract and retain highly skilled staff due to our research profile

Lead Director / s:	Medical Director	**Supported by:**	Chief Nurse
Lead Committee:	Transformation & People Committee	**Executive Group:**	Research & Innovation Group

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	5	5		Likelihood:	2	~~31/03/2023~~ 31/09/2023
Consequence:	3	3	3		Consequence:	2	
Risk Level:	High 12	Ext 15	Ext 15		Risk Level:	Mod 4	
Rationale for Risk Level:	Delays in interpreting the findings of the OD review, coupled with staff turnover and limited recruitment have made the likelihood of the risk almost certain. Whilst there has been some progress with research delivery capacity, there remain a number of high level vacancies (Matron / Directorate Manager) to be filled. It is anticipated that these posts will be filled during quarter 1 23/24, although not substantively for the Matron.						

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	0 →	1 →	2 →	0 →	3 →

Position Statement

What progress has been made during the last quarter?

A3's to improve clinical trial activity have now been completed and the focus is now on the action planning. Recruitment is now underway for the managing director who will then lead the business case to address broader workforce challenges. Funding has been identified within some Directorates for Research Practitioners. A new appointment made in collaboration with Keele commenced post in October 2022. HEI engagement is underway with both Keele and Staffordshire University, with particular progress being made with Staffordshire University. Patient recruitment into clinical trials has increased during the last quarter.

Key Controls Framework – 3 Lines of Defence

1st Line

- Steering Groups established at Speciality level to increase engagement with the central department
- Engagement with individual Divisional Boards has commenced
- Engagement with Directorates now established
- Research practitioners funded by the Directorates within Haematology, Neurology and ENT

2nd Line

- Research Strategy developed with key objectives and key performance metrics defined
- Departmental leadership team meeting structure in place to oversee delivery of research strategy and priorities
- Executive Research and Innovation Group in place
- A3 developed on participation in clinical trials which has been identified as a Strategic Initiative as part of our Improving Together Strategy Deployment Room
- Financial return review with Divisional Business Advisors on a monthly basis
- A new appointment made in collaboration with Keele commenced post in October 2022

3rd Line

- Partnership Group with West Midlands Clinical Research Network (WMCRN)
- Engagement with higher education – i.e. Keele / Staffordshire Universities with particular progress being made with Staffordshire University
- Annual review of academic grants with NIHR (Finance Committee)

Assurance Map

Assurances Received by the Committee (C) / Executive Group (G) during this quarter

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
Performance and Operational Update – Research (G)	!	Centre for Research and Innovation Excellence (CenREE) – Update (C & G)	✓		
Update from R&I – Innovation (G)	✓	Approach to Monitoring Delivery of R&I Strategy (G)	✓		
Quality Assurance Steering Group Highlight Report (G)	✓	Executive Research & Innovation Group Assurance Report (C)	✓		

Clinical Oversight Group Highlight Report (G)	✓				
Other Assurances Received by the Committee / Executive Group annually / bi-annually / ad hoc					
		Research Strategy (C)	✓		

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Review of governance arrangements and membership of Executive Research and Innovation Group to ensure that the agendas are aligned to the new objectives of the strategy with clear Terms of Reference and accountability arrangements
- Substantive recruitment to vacant posts

Further Actions (to provide 'Additional Assurance' or 'Control to Reduce Likelihood / Consequence)

No.	Action Required	Intended Outcome of Action	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Review of governance arrangements and membership of Executive Research and Innovation Group to ensure that the agendas are aligned to the new objectives of the strategy with clear Terms of Reference and accountability arrangements.	Control to reduce Likelihood	Medical Director	25/11/22 31/03/22	**Original due date 30/9/22 and 25/11/22:** To be completed as part of Executive Group Effectiveness Review which will be led by the Corporate Governance Team.	
2.	Desktop review of R&I structure being undertaken.	Control to reduce Likelihood	Medical Director	25/11/22	**Original due date 30/9/22:** This is almost complete and awaiting the final report after completion of external visits. Review completed although new managing director once in post will need to implement the changes proposed	
3.	Develop a report which provides assurance against key performance metrics set out within the Research Strategy.	Additional Assurance	Medical Director	31/12/23	**Original due date 30/9/22:** Work in progress although a further 6 months is needed to complete this due to turnover of staff within the department and the need to enact the findings of the review. A3's have been produced and these will form the basis of the report.	
4.	A review needs to be undertaken to determine levels of compliance with GCP training requirements.	Additional Assurance	Medical Director	30/9/2022	Review completed and requires ongoing monitoring.	
5.	Substantive recruitment to vacant posts.	Additional Control	Medical Director	30/09/2023	Action not due.	
6.	Managing Director, once in post to develop and deliver plan arising from the desktop review.	Additional Control	Medical Director	30/6/2023	Action not due.	
7.	Review of the Research Governance structure beneath the Executive Group to ensure that there is a forum with appropriate representation from divisions and support services to ensure oversight and scrutiny.	Additional Control	Medical Director	31/4/2023	Action not due.	
8.	Research to form part of Divisional Performance Management Reviews / watch metrics.	Additional Control and Assurance	Medical Director	31/6/2023	Action not due.	
9.	Research to form part of Divisional Board agendas.	Additional Assurance	Medical Director	31/6/2023	Action not due.	

Appendix 1: Risk Appetite Matrix

Sub Category of Risk		Risk Appetite	Risk Score Tolerance
Impact on Quality	Patient Safety (e.g. patient harm, infection control, pressure sores, learning lessons)	Cautious	Mod 4 – Mod 6
	Effectiveness (e.g. outcomes, delays, cancellations or operational targets and performance)	Open	High 8 – High 12
	Service User and Carer Experience and the ability to manage quality (e.g. complaints, audit, surveys, clinical governance and internal systems)	Open	High 8 – High 12
Impact on Regulation & Compliance	Statutory Regulation and Requirements (e.g. Information Commissioner, Care Quality Commission, Health and Safety Executive, Professional Regulatory Bodies such as General Medical Council, Nursing & Midwifery Council, external certifications such as JAG and ISO).	Cautious	Mod 4 – Mod 6
	National Guidance and Best Practice (e.g. National Institute for Health and Care Excellence, GIRFT)	Open	High 8 – High 12
Impact on Reputation	Day to day activity (e.g. standards of conduct, ethics and professionalism and delivery of services)	Cautious	Mod 4 – Mod 6
	Risk as a result of protecting and improving the safety of patients	Seek	Ext 15 – Ext 25
Impact on Workforce	Staff recruitment (e.g. compliance with regulations such as visa requirements, Equal Opportunities and Diversity, that ensure staff are recruited fairly and competent to deliver services)	Cautious	Mod 4 – Mod 6
	Employment practice	Cautious	Mod 4 – Mod 6
	Staff retention (e.g. attractiveness of Trust as an employer of choice)	Open	High 8 – High 12
Impact on Infrastructure	Estates Infrastructure	Cautious	Mod 4 – Mod 6
	Security (e.g. access and permissions to systems and networks)	Cautious	Mod 4 – Mod 6
	Control of Assets (e.g. purchase, movement and disposal of ICT equipment)	Cautious	Mod 4 – Mod 6
	Business continuity (e.g. cyber-attack, maintenance of networks, alternative solutions)	Cautious	Mod 4 – Mod 6
	Data (e.g. integrity, availability, confidentiality and security, unintended release)	Cautious	Mod 4 – Mod 6
Impact on Finance & Efficiency	Value for money and sustainability (including cost saving)	Cautious	Mod 4 – Mod 6
	Standing Financial Instructions (SFI's) and financial control	Cautious	Mod 4 – Mod 6
	Fraud and negligent conduct	Minimal	Low 1 – Low 3
	Contracting	Seek	Ext 15 – Ext 25
Impact on Partnerships / Collaboration	Partnerships	Open	High 8 – High 12
Impact on Innovation	Innovation (e.g. new ways of working, new products, new and realigned services, new models of staffing and realignment of services, international recruitment, new ICT systems and improvements)	Seek	Ext 15 – Ext 25
	Financial Innovation (e.g. new ways of working, new products, new and realigned services)	Open	High 8 – High 12

LEVELS OF RISK APPETITE	
Avoid **Risk Score Tolerance 0**	We are not prepared to accept any risk.
Minimal **Risk Score Tolerance 1 – 3**	We accept that risks will not be able to be eliminated, therefore these should be reduced to the lowest levels, with ultra-safe delivery options, recognising that these may have little or no potential for reward/return.
Cautious **Risk Score Tolerance 4 – 6**	We are willing to accept some low levels of risk, while maintaining overall performance of safe delivery options, recognising that these may have restricted potential for reward/return.
Open **Risk Score Tolerance 8 – 12**	We are willing to accept all potential delivery options, recognising that these may provide an acceptable level of reward.
Seek **Risk Score Tolerance 15 - 25**	We are eager to be innovative, choosing options with the potential to offer higher business rewards.

Appendix 2: Links to Risk Register

ID	EIG	DDSP	QSOG	H&S	EWAG	Risk Description	Division	Q1	Q2	Q3	Q4	Target Risk Score	BAF Link
16432			✓		✓	Covid 19 & Compliance with CNST Maternity Safety Actions	CWCSS	15	15	15		5	1
8877			✓			Hospital Acquired Infections	Central Functions	12	12	12		8	1
25152			✓		✓	Insufficient trained staff in Pharmacy Technical Services to deliver aseptic products including chemotherapy to the Trust	CWCSS	16	20	20		4	1, 3
25467			✓		✓	HD capacity and workforce	Medical	NA	20	20		8	1, 3
18842			✓		✓	Gaps within the Junior Medical Rota	CWCSS	16	16	16		6	1, 3
21595			✓		✓	Insufficient technical staff in Microbiology	NMCPS	16	16	16		6	1, 3
22514			✓		✓	Nurse Staffing in the Emergency Department both Sites	Medical	16	16	16		6	1, 3
25228			✓		✓	Nurse Staffing CED	CWCSS	NA	20	16		4	1, 3
25455			✓		✓	Lack of ST1/2 to provide on call cover within Specialised Surgery Directorate	Surgical	NA	16	16		4	1, 3
21987			✓		✓	Wards 227 RN Workforce availability	Network Services	12	15	15		3	1, 3
23595			✓			Substantive nursing workforce on medical escalation wards	Medical	12	9	15		4	1 , 3
23834			✓		✓	Delayed Induction of Labour	CWCSS	20	15	15		4	1, 3
8822			✓		✓	Medical Workforce Staffing Oncology	Network Services	16	12	12		6	1, 3
13419			✓		✓	Midwifery safe staffing	CWCSS	16	20	12		4	1, 3
15664			✓			Liver Mortality - CQC actions	Medical	16	12	12		4	1, 3
18093			✓		✓	Nurse Staffing within the NNU	CWCSS	16	12	12		6	1, 3
21481			✓		✓	Reduced Breast service (Imaging), due to vacancy within Breast Radiologist workforce.	CWCSS	12	12	12		4	1, 3
21503			✓		✓	General Paediatric Consultant Rota	CWCSS	12	12	12		4	1, 3
23569			✓		✓	AMU ROYAL STOKE-Lack of pharmacy staff due to understaffing to meet demand of the increased bed base	Medical	12	12	12		2	1, 3
23570			✓		✓	No current pharmacy service to support AMRA	Medical	12	12	12		4	1, 3
23787			✓		✓	Gaps in Junior Doctor workforce	Medical	12	12	12		6	1, 3
24272			✓		✓	Junior Doctor Staffing	CWCSS	15	12	12		6	1, 3
24464			✓		✓	EPU Service/capacity/Management	CWCSS	12	12	12		4	1, 3
25120			✓		✓	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at MCHFT	NMCPS	NA	12	12		8	1, 3
25216			✓		✓	Ward 108 Registered Nurse Vacancies	Surgical	NA	12	12		6	1, 3
25229			✓		✓	Nurse Staffing CAU	CWCSS	NA	12	12		4	1, 3
25247			✓		✓	Nurse Staffing Ward 217	CWCSS	NA	12	12		4	1, 3
25795					✓	Vacant Consultant Neurology On-Call Gaps	Network Services	NA	12	12		4	1, 3
25857			✓		✓	AMU COUNTY-Lack of pharmacy staff to meet demand due to increased bed base	Medical	NA	12	12		2	1, 3
8615			✓		✓	Radiotherapy Radiographer Staffing Levels	Network Services	12	12	12		4	1, 3
9738					✓	Nursing training (both sites)	Medical	16	16	16		6	2

ID	EIG	DDSP	QSOG	H&S	EWAG	Risk Description	Division	Q1	Q2	Q3	Q4	Target Risk Score	BAF Link
16652					✓	Staff Wellbeing and Welfare	Medical	12	12	16		2	2
20616			✓		✓	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at Macclesfield H	NMCPS	16	16	20		4	3
11294			✓		✓	NMCPS Pathology Histology Medical Reporting Capacity (achieving TAT)	NMCPS	12	12	16		6	3
13725					✓	RSUH/CH Haematology shift service provision (Haematology)	NMCPS	16	16	16		4	3
21157			✓		✓	Haematology Service at MCHT Leighton	Network Services	16	16	16		6	3
24281			✓		✓	Cardiothoracic Theatre Staffing Establishment	Surgical	12	16	16		4	3
24032			✓		✓	Respiratory Physiology - risk to service delivery/wait times	Medical	12	15	15		3	3
24818			✓		✓	RSUH/CH Biochemistry Staffing	NMCPS	12	12	12		6	3
20809					✓	NMCPS Histology Admin & Office Capacity	NMCPS	16	12	12		4	3
21591			✓		✓	Insufficient Clinical Staff to Support the NMCPS Microbiology Service	NMCPS	16	12	12		6	3
21719			✓		✓	Medicine Safety Officer Vacancy	CWCSS	12	12	12		4	3
21947			✓		✓	Insufficient resource for the paediatric dietetic services	CWCSS	12	12	12		4	3
22969					✓	Radiology Physics expert level staffing (X-ray physics speciality)	Network Services	9	12	12		6	3
23024			✓		✓	Gaps in B5 radiographer rosters to provide 24/7 xray service	CWCSS	16	16	12		4	3
23506			✓		✓	Gastroenterology patients insufficient Pharmacy support for highly complex medication regimes	CWCSS	12	12	12		3	3
23843			✓		✓	Respiratory Consultant workforce (County)	Medical	16	16	12		4	3
24995					✓	Recruitment and Retention of Estates Operations skilled workforce	Estates, Facilities and PFI	12	12	12		6	3
25121					✓	NMCPS Blood Transfusion staffing	NMCPS	NA	12	12		8	3
26110			✓		✓	Renal clinic letters for Cheshire (Leighton) Patients	Medical	NA	NA	12		6	3
17437			✓			Elective Cardiac Surgery P2 patients	Network Services	16	20	20		4	5
24028			✓			Lack of flow across the Trust leading to congestion of ED (both sites) and UEC standards unable to be met	Medical	20	20	20		6	5
25512			✓		✓	Radiology reporting capacity gap between scanning and reporting	CWCSS	NA	16	20		4	5
25839			✓			Long Wait Patients in the Trauma Directorate	Network Services	NA	20	20		12	5
15788			✓			Delivery of RTT Performance - Diagnostic Capacity	Medical	12	16	16		8	5
23842			✓		✓	Delivery of RTT - Outpatient capacity/wait times	Medical	16	16	16		4	5
25053			✓			Access to Cardiac theatres	Network Services	16	16	16		16	5
25469			✓			Delivery of constitutional cancer quality standards	Surgical	NA	20	16		4	5
17873			✓			Inability to Off-load Patients from Ambulances (both sites)	Medical	15	15	15		4	5
25471			✓			Follow Up Delays	Surgical	NA	16	16		4	5
25980			✓			Your Next Patient Process	Medical	NA	NA	16		4	1, 5
26054			✓			Your Next Patient System	Network Services	NA	NA	16		4	1, 5
25470			✓			Increasing waiting list size and patients waiting greater than 18 weeks for treatment	Surgical	12	20	16		4	5
17637			✓			Decline in cancer performance	Surgical	12	12	12		6	5

ID	EIG	DDSP	QSOG	H&S	EWAG	Risk Description	Division	Q1	Q2	Q3	Q4	Target Risk Score	BAF Link
17805			✓			Lung Nodule Management	Medical	8	12	12		8	5
18664			✓			Gynaecology 52 Week Wait Patient Numbers	CWCSS	12	12	12		9	5
20134			✓			Specialised Surgery Follow Up Backlog	Surgical	12	12	12		4	5
20448			✓			Patient LOS above 24 hrs. on AMU - against Internal Standards	Medical	12	12	12		4	5
20739			✓			Endoscopy planned patients waiting list	Medical	12	12	12		6	5
21315			✓			Inability to achieve triage times within CED	CWCSS	12	12	12		6	5
21375			✓			Unvalidated Waiting lists	Surgical	9	9	12		4	5
23410			✓			Imaging reports for 2 week waits internal TAT failure	CWCSS	16	12	12		8	5
23568	✓		✓			Size of the AEC footprint	Medical	12	12	12		2	5
23647			✓			Reports for GI imaging for patients on cancer pathways are not within TAT target	CWCSS	12	12	12		8	5
26168		✓				Pathology IT support	NMCPS	NA	NA	20		8	6
25870		✓				Network and communication services provision for UHNM	Central Functions	NA	16	16		6	6
9036		✓				Vulnerability to Cyber Attack	Central Functions	15	15	15		5	6
8849		✓				Staff using unsecured and unlicensed personal phones for work email	Central Functions	12	12	12		4	6
21784		✓				Confidentiality, Integrity and Availability of Trust Information	Central Functions	12	12	12		4	6
23753		✓				Network failure due to multiple service providers	Central Functions	12	12	12		4	6
24580		✓				Lack of a centralised information asset (systems) register	Central Functions	12	12	12		4	6
26487		✓				Lack of a digital solution to maintain confidentiality of patient information with the GP	Central Functions	NA	NA	12		3	6
23331	✓			✓		MCHT Ceiling RAAC planks	NMCPS	15	15	15		4	7
20315	✓					Interventional Room 5 does not meet Ventilation Building Regulations	CWCSS	12	12	12		6	7
21697	✓					Recurrent CIP requirements for 22/23 and beyond not met in Trust due to lack of focus on CIP	Central Functions	12	12	12		8	8
21700	✓					Valuation of RI and COPD sites in relation to funding of Project Star MSCP Business Case	Central Functions	12	12	12		2	8
22949		✓				IM&T Contract Management	Central Functions	12	12	12		4	8

Executive Summary

Meeting:	Trust Board	**Date:**	8th February 2022
Report Title:	Policies for Approval: F01 Standing Financial Instructions, and F02 Scheme of Reservation and Delegation of Powers	**Agenda Item:**	15.
Author:	Sarah Preston, Director of Strategic Finance		
Executive Lead:	Mark Oldham, Chief Financial Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

ID	*Title of Risk [insert or delete rows as appropriate]*	*Risk Level*
ID	*Title of Risk [insert or delete rows as appropriate]*	*Risk Level*

Executive Summary

Policies F01 Standing Financial Instructions and F02 Scheme of Reservation and Delegation of Powers have been reviewed as per the agreed timetable.

The key staff consulted and changes made are set out in this report. The policy changes have been submitted to the Trust Policy Review Group for approval and 2 further changes were added.
The policy changes have been approved at Audit Committee on 2 February 2023.

A track change version of each policy is attached.

Key Recommendations

That the Trust Board give final approval for the policy changes and implementation from 1 March 2023.

Policies for Approval: F01 Standing Financial Instructions, and F02 Scheme of Reservation and Delegation of Powers
02 February 2023

1. Introduction
Policies F01 Standing Financial Instructions and F02 Scheme of Reservation and Delegation of Powers have been reviewed as per the agreed timetable, The key staff consulted and changes made are set out in this report for consideration and approval by Audit Committee.

2. Staff Consulted

The people in the table below reviewed the policies and set out where changes were required:

Department	Reviewer
Executive Team	All of the Executive Directors
Governance	Claire Cotton and Nicola Hassell
Internal Audit & LCFS	RSM (Assam Hussein)
External Audit	GT (Nicola Coombe)
Estates	David Ruscoe
Finance and Contracting	Clare Riley, Nick Sone, David Roper, Kay Farrugia, Dylan Davies, Paul Brown, Chris Morris and Jonathan Tringham
People	Jane Haire
Pharmacy	Susan Thomson
IM&T	Heidi Poole, Leah Carlisle
Charity	Steve Rushton
Procurement	Nathan Joy-Johnson and Joanne Roberts
Strategy	Julie Wheat-Hattersley

3. Generic Changes Made

The table below sets out the changes made to the policies to reflect update in department names and job titles:

Title / Generic changes made throughout both policies
All references to NHSI/E, NHS Improvement changed to NHSE, NHS England
All references to Director of Human Resources changed to Chief People Officer
All references to Director of Human Resources changed to Director of Digital Transformation
All references to Medical Director changed to Executive Medical Director
All references to Associate Director changed to Director of Operations
All references to Human Resources changed to People Directorate
All references to HR Manager changed to People Business Partner
All references to Director of Nursing Changed to Chief Nurse
All references to Director of Procurement changed to Group Director of Procurement
All references to His / Her changed to gender neutral
All references to Supplies and Procurement Department changed to Integrated Supplies and Procurement Department
All references to Associate Director of Governance changed to Associate Director of Corporate Governance
All references to Information Governance Team changed to Data, Security and Protection Team
All references to Designated Pharmaceutical Officer changed to Clinical Director of Pharmacy

4. Changes Made to Policy F01 Standing Financial Instructions

The changes to each policy have been separated into clarification changes, where additional clarification has been made around specific points, and process changes where the change proposed in the policy will result in a process change which is currently in place (ie changes to procurement rules to reflect the exit from the EU) or will be made upon ratification of the policy. The changes are set out in the tables below:

Clarification Changes Made (F01)				
Page	**Ref**	**Change made**	**By**	**Department**
4	1.7	Further clarification on non-compliance with SFIs re Fraud and Bribery	Assam Hussein	RSM
5	4.1	Removal of definition for his/her and she/he as these terms now removed in accordance with change 10 above	Nicola Hassall	Governance
8	7.2.1	Trust policy review timetable is 3 years post ratification	Sarah Preston	Finance
10	1.2.2 (d) (i)	Further clarification on the Internal Audit opinion	Assam Hussein	RSM
10, 11	1.2.2 (b) & 1.2.8	inclusion of adherence to adhere to the Public Sector Internal Audit standards for internal Audit	Assam Hussein	RSM
13,14 & 15	2	Specific inclusion of references to bribery (in addition to fraud)	Assam Hussein	RSM
13	2.1	Clarification on loss definition to include risk of loss	Assam Hussein	RSM
13	2.5	Update on definition relating to Corruption	Assam Hussein	RSM
14	2.9	Further detail on LCFS role	Assam Hussein	RSM
14	2.12	Clarification on fraud and corruption related policy	Jane Haire	HR
14	2.18	Update on Counter Fraud Specialist contact	Assam Hussein	RSM
15	2.19	Update on Anti bribery and Anti fraud policy title	Assam Hussein	RSM
19	4.3.2	Removed reference to vacancy control panels	Dylan Davies	Finance
24	5 and 5.4	Amended title of Annual Report and Accounts to reflect updated wording	Nick Sone	Finance
24	5.4	Amended ref to Manual for Accounts to Group Accounting Manual	Nick Sone	Finance
25	6.2 & 6.2.1 (a) & 6.3.1 (a) & 6.3.2	Updated reference of bank accounts to include Online Merchant Accounts and explanation	Nick Sone	Finance
27	7.2.1	Changing of contract charges to refer to general guidance rather than national tariff	Dylan Davies	Finance
28	7.4.4	Reference to Patient Property Policy (F16)	Sarah Preston	Finance
32	8.5.11	Inclusion of Equality Act 2010 in supplier requirements	Jo Roberts	Procurement
33	8.5.17	Further information on procurement requirements for temporary staff	Jo Roberts	Procurement
36	8.9.2	Further clarification added for the circumstances where only one tender is received	Nathan Joy-Johnson	Procurement
38	8.14.1	clarification of requirements for authorisation	Jo Roberts	Procurement
39	8.18.1 (b)	Change of EU directive to UK Public Procurement	Nathan Joy-Johnson	Procurement
49	11.2.4	Clarification of eReaf process in the authorisation of requisition for goods and services	Nick Sone	Finance
59	13.5.7	Illustrative narrative update to reflect increased NHSE authorisation limit	Sarah Preston	Finance
60	13.7.2	Clarification that assets are at a value as set by the Group Accounting Manual	David Roper	Finance
66	16.1.1	Data Protection act updated from 1998 to 2018	Policy Review Group	
66	16.1.3	FOI responsibility updated to Data Security and Protection Team	Policy Review Group	
68	17.1.10	Paragraph added to link patients property to section 7.4.4 Safekeeping	Sarah Preston	Finance
72	20.1.2	Reference to Records Management code updated from 2016 to 2021	Nicola Hassall	Governance
72	20.1.2	Update on policy numbers for Data Security and retention of documents	Leah Carlisle	IM&T /DSP

Process Changes Made (F01)				
Page	**Ref**	**Change made**	**By**	**Department**
10	1.1.4 (f)	inclusion of audit committee role to review the write off of debts	Nick Sone	Finance
11	1.2.4 e	Removed as there are no specific assurance statements referred to by Internal Audit	Assam Hussein	RSM
11, 58, 62	1.2.5 & 13.8.3 & 15.2.5	Clarification that LCFS must be notified of any irregularities	Assam Hussein	RSM
18	4.2.7	Inclusion of Budget Manager to authorise additions to the authorised signatory list	Nick Sone	Finance
18	4.3.1	Removed budgetary reporting against NHSIE targets as they are no longer used	Dylan Davies	Finance
20	4.4.3 (e)	Included Medical Director authorisation for virement of medical establishments	Dylan Davies	Finance
21	4.4.5	Budget virements between income pay or non pay authorisation by Head of Financial Management	Dylan Davies	Finance
21	4.4.10	Removal of requirement to report budget virements to PFC on a regular basis	Dylan Davies	Finance
22	4.6.1	Clarification that additional costs through the PFI require authorisation as per the business case process	Kay Farrugia	Finance
22	4.6.6	Narrative updated to reflect increased FEM business case approval limit of £500k (from £250k)	Mark Oldham	Finance
22	4.6.7	Section removed re taking business case decisions to TEC for information	Helen Ashley	Strategy
22	4.6.7	Narrative updated to reflect increased FEM and PFC (£1m to £1.5m) business case approval limit	Mark Oldham	Finance
22, 23	4.6.8 & 4.6.9 & 4.6.11	Revenue Business Case approvals limits increased for FEM. PAF and Trust Board and to reflect NHSE uplift to £25m	Mark Oldham	Finance
24	5.3	Update of External Audit appointment from Public Sector Appointments body to the Trust	Nick Sone	Finance
25	6.3.1 ©	Inclusion of authorisation for ELFS within banking procedures	Nick Sone	Finance
27	7.2.7	Amended reference to national tariff to say where relevant	Dylan Davies	Finance
27	7.3.2	inclusion of audit committee consideration re write off of debts exceeding £1,000	Nick Sone	Finance
28	7.4.4	Updated to clarify Trust is not liable for items not handed in for safekeeping as per policy F16	Sarah Preston	Finance
30, 31	8.1.1 & 8.5.6	Update of EU tender threshold from £122,976 to £138,760	Jo Roberts	Procurement
30,31,32 ,49,50, 54	8.1 & 8.2 & 8.5.6 & 8.5.19 & 11.3.1 & 11.5.1 & 11.5.2 & 13.2.11	Update of OJEU process to Public Contract Regulations (2015)	Jo Roberts	Procurement
31,33	8.4 & 8.5.16	Update of Procure 22 Framework to Procure 23 now in place	Dave Ruscoe	Estates
32	8.5.9	Update of NHS Supplier Database to Contracts Finder	Jo Roberts	Procurement
35	8.8.1 (a)	Update of authority for the opening of e-procurement tenders	Nathan Joy-Johnson	Procurement
35	8.8.2 (a)	Update of authority for the opening of non e-procurement tenders	Nathan Joy-Johnson	Procurement
39	8.17	Section removed re PFI for capital procurement to reflect government announcement of no further PFI schemes (Oct 18)	David Roper	Finance
46	10.5.1 (d)	Further clarification of communication of pay rate variations to EDs	Ro Vaughan	HR
47	11.1.2	Update on requisition limit for PAF from £1m to £1.5m to align with revenue business case limits at 4.6.7	Mark Oldham	Finance
47	11.1.3	Update on Pharmacy Requisition limits to reflect updated structure and increasing cost and PFC limit uplift at 11.1.2	Sue Thomson (&MO)	Pharmacy
49	11.2.5	Clarification that additional costs through the PFI require authorisation as per the standard requisition process	Kay Farrugia	Finance
52	11.7.4 & 11.7.5 and removal of 11.7.8	Updated process and information re leases to reflect the requirements of IFRS 16	Nick Sone	Finance
56	13.5.2	Capital Business Case approvals limits increased for FEM. PAF and Trust Board and to reflect NHSE uplift to £25m	Mark Oldham	Finance
57	13.5.5	Update of narrative on CIG limit to reflect table at 13.5.2	Sarah Preston	Finance
57	13.5.6	Update on NHSE table to reflect increased authorisation limit of £25m (awaiting an updated table from NHSE)	Sarah Preston	Finance
60	13.6.1 & 13.6.2	Updated instruction on the requirement for Trust and NHSE approval with regard to PFI variations.	David Roper	Finance
60	13.6.2	Section removed re PFI for capital procurement to reflect government announcement of no further PFI schemes (Oct 18)	David Roper	Finance

5. Changes Made to Policy F02 Scheme of Reservation and Delegation of Powers

The changes to each policy have been separated into clarification changes, where additional clarification has been made around specific points, and process changes where the change proposed in the policy will result in a process change which is currently in place (ie changes to procurement rules to reflect the exit from the EU) or will be made upon ratification of the policy. The changes are set out in the tables below:

Clarification Changes Made (F02)

Page	Ref	Change made	By	Department
14	4.3	Quality governance clarification re maternity and neonates	Nicola Hassall	Governance
15	6.1	Updates definition of the role of Transformation and People Committee	Nicola Hassall	Governance
15	6.2	Updates the role of Transformation and People Committee	Nicola Hassall	Governance
15	7	Updates the title of Trustee Committee to Charity Committee	Nicola Hassall	Governance
15	7.1 (c	Update assurance of committee from Trust Board to Corporate Trustee	Nicola Hassall	Governance
20	3.4.1 (h)	Change reference to Council of Governors from previous title	Nicola Hassall	Governance
32	Appx A - 8	Clarification re the process for procurement of medicines	Sue Thomson	Pharmacy
33	Appx A - 10	Staff Retirement Policy amended to Flexible Retirement Guidelines	Jane Haire	HR
39	Appx A - 15.1	Change of definition of medical items to medical equipment items	Sarah Preston	Finance

Process Changes Made (F02)

Page	Ref	Change made	By	Department
15	8	Removal of Trust Executive Committee as a sub committee of the Trust Board	Nicola Hassall	Governance
32	Appx A - 8	Update of EU tender threshold from £122,976 to £138,760	Jo Roberts	Procurement
33	Appx A - 8	Update of OJEU process to Find a Tender Service	Jo Roberts	Procurement
33	Appx A -10	Clarification of authorisation of new staff appointed above the bottom of pay scale	Ro Vaughan	HR
36	Appx A - 11	Update on requisition limit for PAF from £1m to £1.5m to align with revenue business	Mark Oldham	Finance
36	Appx A - 11	Update on Pharmacy Requisition limits to reflect updated structure and increasing cost and PFC limit uplift above	Sue Thomson (&MO)	Pharmacy
38	Appx A - 13	Update on Capital Inverstment limits to reflect NHSE increased authorisation limit of £25m (awaiting an updated table from NHSE)	Sarah Preston	Finance
39	Appx A - 15.1	Inclusion of Director of Digital transformation for IM&T disposals	Sarah Preston	Finance
40	Appx A - 18	Update of Charitable limits and process to reflect structure in place	Steve Rushton	Charity
44		Review of MRHA Recommendations updated to include Clinical Director of Pharmacy	Sue Thomson	Pharmacy

This policy will also need to be updated in to the current Trust format.

6. Summary of Authorisation Changes

The changes to authorisation limits which are reflected in both policy F01 and F02 have been set out in the table below for ease of reference:

Policies F01 and F02 - Summary of Authorisation level changes

Authorisation limits up to £	Revenue B Cases	Capital only B Cases	Requisitions and non PO	Pharmacy Requisitions	Tender authorisation
Section (F01)	**4.6.11**	**13.8**	**11.1**	**11.1.3**	**8.14**
Version 10 April 2021					
B Holder			20k		50k
D of Pharmacy				170k	
DoF / CIG		100k	100k		
CFO	25k		250k	250k	500k
CEO / Formal EDs	250k	1m	500k	500k	1m
Perf & Finance Com	1m	3m	1m	1m	3m
Trust Board	15m	15m	1m +	1m +	3m +
NHSE	15m +	15m +			
Version 11 February 2023					
Budget Holder			20k		50k
Pharmacy				250k	
DoF / CIG		100k	100k		
CFO	25k		250k	500k	500k
CEO / Formal EDs	500k	1m	500k	1m	1m
Perf & Finance Com	1.5m	3m	1.5m	1.5m	3m
Trust Board	25m	25m	1.5m +	1.5m +	3m +
NHSE	25m +	25m +			

Table at 13.8 shows matrix	
e.g cap £3.5m, rev £75k = PFC	
e.g. rev £1.1m cap £1m = PFC	
	Denotes change

7. Recommendations

That the Board provides final approval of the policies for implementation from 1 March 2023.

Policy Document

Reference: F01

University Hospitals of North Midlands NHS Trust

Standing Financial Instructions

Version:	**1~~0~~**
Date Ratified:	**~~April 2021~~February 2023 by Audit Committee and Trust Board**
Minor Amends:	**~~March 2022~~**
Date of Next Review:	**February 202~~3~~**
Policy Author:	**Strategic Director of Finance**
Executive Lead:	**Chief Finance Officer**

Version Control Schedule

Final Version	Issue Date	Comments
1	March 1999	
2	March 1999	
3	June 2006	
4	March 2008	
5	December 2011	
6	November 2014	
7	June 2017	
8	February 2020	Approved by Audit Committee 23 January 2020. Approved by Trust Board 05 February 2020 with changes to budget virement approval table
9	April 2021	Minor amends – updated LCFS details
10	March 2022	Minor Amends - Reviewed the limits for capital business case requirements in relation to Investment Capital. This reflects the shift in role of the Executive Weekly meeting in signing off business cases, along with the change in role of the Capital Investment Group (CIG) which is now a more transactional meeting with no ED attendance.
11	February 2023	Review in line with agreed timetable – all changes and amendments as set out in paper to Audit Committee February 2023

Statement on Trust Policies

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

CONTENTS

1. INTRODUCTION 4
2. STATEMENT 4
3. SCOPE 4
4. DEFINITIONS 5
5. ROLES AND RESPONSIBILITIES 6
6. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION 8
7. MONITORING AND REVIEW ARRANGEMENTS 8
8. REFERENCES 8
Appendix A – STANDING FINANCIAL INSTRUCTIONS 9
1. AUDIT 9
2. FRAUD AND BRIBERY 13
3. SECURITY MANAGEMENT 16
4. ALLOCATIONS, BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING 17
5. ANNUAL REPORT AND ACCOUNTS ~~AND REPORTS~~ 24
6. BANK ACCOUNTS 25
7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS ....27~~26~~
8. TENDERING, CONTRACTING AND PURCHASING PROCEDURES ....30~~29~~
9. NHS SERVICE AGREEMENTS CONTRACTING FOR PROVISION OF SERVICES ....42~~41~~
10. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES ....44~~43~~
11. NON-PAY EXPENDITURE ....47~~46~~
12 EXTERNAL BORROWING ....52~~51~~
13 CAPITAL INVESTMENT, PRIVATE FINANCING, ASSET REGISTERS AND SECURITY OF ASSETS ....53~~52~~
14 STORES AND RECEIPT OF GOODS ....61~~59~~
15. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS ....63~~61~~
16. INFORMATION TECHNOLOGY (IT) ....65~~63~~
17. PATIENTS' PROPERTY ....67~~65~~
18. FUNDS HELD ON TRUST (DONATED /CHARITABLE FUNDS) ....68~~66~~
19 HOSPITALITY AND GIFTS (RECEIVING) ....70~~68~~
20. RETENTION OF DOCUMENTS ....71~~69~~
21. RISK MANAGEMENT AND INSURANCE ....72~~70~~

1. INTRODUCTION

1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree SFIs for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Reservation and Delegation of Powers adopted by the Trust.

1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Financial Officer.

1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Financial Officer **must be sought before acting**. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.5 The failure to comply with SFIs will be recorded by the Chief Financial Officer. **Failure to comply with SFIs is a disciplinary matter and could result in dismissal.**

1.6 Where appropriate, failure to comply with SFIs will be reported to the Audit Committee with full details of the non-compliance and any justification for the non-compliance. The Audit Committee will then either refer for action or ratify the non-compliance.

1.7 All members of the Trust Board and employees have a duty to disclose any non-compliance with these SFIs to the Chief Financial Officer as soon as possible. Any instances of non-compliance, where fraud or bribery are suspected will be reported to the Local Counter Fraud Specialist as soon as practicable and will be managed in line with the Anti-Bribery and Anti-Fraud Policy (G18).

2. STATEMENT

2.1 To provide detailed financial responsibilities, policies and procedures to be adopted by the Trust and its employees or representatives.

3. SCOPE

3.1 This policy applies to all areas of the Trust and all individuals employed by the Trust including contractors, voluntary workers, students, locum and agency staff and those holding honorary contracts.

4. DEFINITIONS

4.1 Detailed below is a list of terms used in this document and a definition of their meaning.

Term	Definition
Budget	Resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust. The budget should, where appropriate, also be supported by budgets relating to workforce and workload.
Budget Administrator	Employee with delegated authority from a Budget Manager (to a limit of £5,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Manager	Employee with delegated authority from a Budget Holder (to a limit of £25,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Holder	Director or employee with delegated authority from the Chief Executive (to a limit of £50,000 inclusive of VAT) to manage finances (income and expenditure) for a specific area of the organisation
Departmental Manager	Director or Employee at Band 8a or above responsible for authorisation in line with ~~Human Resources~~People Directorate policies
Chairman	The person appointed to lead the Trust Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole
Chief Executive	Chief officer of the Trust and Accountable Officer
Chief Financial Officer	Chief Financial Officer of the Trust
Director of Finance	Financial Director for the Trust with powers delegated from the Chief Financial Officer
~~He/she or his/her~~	~~Where this term appears this term is to be taken as referring to the post holder and is interchangeable as the gender of that post holder changes~~
Scheme of Reservation and Delegation of Powers. Policy number F02	Document which sets out the powers reserved by the Trust Board, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. Referred to as 'the Scheme of Delegation' within this document.
Standing Financial Instructions (SFIs). Policy number F01	Document detailing the financial responsibilities, policies and procedures adopted by the Trust. Referred to as 'the SFIs' within this document.
Standing Orders. Policy number G19	Document which sets out the regulation of the Trust proceedings and business. Referred to as the SOs in this document.
Trust	University Hospitals of North Midlands NHS Trust
Trust Board	Board of the Trust

Table 1

4.2 Wherever the title Chief Executive, Chief Financial Officer or other nominated officer is used in these SFIs, it shall be deemed to include such other Director or employees who have been duly authorised to represent them.

4.3 Wherever the term "employee" and the context permits, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

5. ROLES AND RESPONSIBILITIES

5.1 Role of the Trust Board

5.1.1 The Trust Board exercises financial supervision and control by:

(a) Formulating the financial strategy

(b) Requiring the submission and approval of budgets within approved allocations/overall income

(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money)

(d) Defining specific responsibilities placed on members of the Trust Board and employees as indicated in the Scheme of Delegation document

5.1.2 The Trust Board has resolved that certain powers and decisions may only be exercised by the Trust Board in formal session. These are set out in the 'Reservation of Matters Reserved to the Board' document. All other powers have been delegated to such other committees as the Trust Board has established.

5.1.3 Under the Trust's scheme of delegation, amendments to these instructions need to be approved at a Trust Board meeting.

5.2 Role of Chief Executive

5.2.1 The Chief Executive will, as far as possible, delegate ~~his/her~~their detailed responsibilities, but they remain accountable for financial control.

5.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Trust Board, and, as Accountable Officer, to the Secretary of State, for ensuring that the Trust Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Trust Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

5.2.3 It is a duty of the Chief Executive to ensure that Members of the Board, employees and all new appointees are notified of, and understand their responsibilities, within these SFIs.

5.3 Role of Chief Financial Officer (CFO)

5.3.1 The Chief Financial Officer will, as far as possible, their ~~delegate his/her~~ detailed responsibilities, but they remain accountable for financial control.

5.3.2 The Chief Financial Officer is responsible for:

(a) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies

(b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions

(c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time

(d) The provision of financial advice to other members of the Board and employees

(e) The design, implementation and supervision of systems of internal financial control

(f) The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

5.3.3 The Chief Financial Officer will maintain a register of the required readers of the SFIs. These readers will predominantly be any authorised signatory for the Trust.

5.4 Role of all Directors and Officers

5.4.1 Powers are delegated to Directors and Officers on the understanding that they would not exercise delegated powers in a matter in which their judgment was likely to be cause for public concern.

5.4.2 This policy shows only the "top level" of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other procedures within the Trust.

5.4.3 In the absence of a Director or Officer to whom powers have been delegated, those powers shall be exercised by that Director or Officers deputy unless alternative arrangements have been requested by the Trust Board.

5.5 Role of all Trust Board members and employees

5.5.1 All members of the Trust Board and employees, severally and collectively, are responsible for:

(a) The security of the property of the Trust

(b) Avoiding loss

(c) Exercising economy and efficiency in the use of resources

(d) Conforming to the requirements of SOs, SFIs, financial procedures and the Scheme of Delegation

5.5.2 Individuals who are included on the register of required readers of the SFIs are responsible for ensuring they understand the guidance and will acknowledge this in writing to the Chief Financial Officer.

5.5.3 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Trust Board and employees discharge their duties must be to the satisfaction of the Chief Financial Officer.

5.5.4 All members of the Trust Board and employees are expected to adhere to the Nolan Principles which are the basis of ethical standards expected of public office holders. The seven principles of public life apply to anyone who works as a public office holder and all people appointed to work in public services including all people working within the health sector.

5.5.5 The seven principles are:

(a) Selflessness – holders of public office should act solely in terms of the public interest

(b) Integrity – Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for

themselves, their family, or their friends. They must declare and resolve any interests and relationships

(c) Objectivity – Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias

(d) Accountability – Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this

(e) Openness – Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing

(f) Honesty – Holders of public office should be truthful

(g) Leadership – Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs

5.6 Role of contractors and their employees

5.6.1 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall comply with these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

6. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

6.1 The Finance Department will ensure that training is available to all authorised signatories and any other staff member who requires training.

7. MONITORING AND REVIEW ARRANGEMENTS

7.1 Monitoring Arrangements

7.1.1 In accordance with SOs, the Trust Board shall formally establish a committee of independent members, as an Audit Committee, with formal Terms of Reference, which includes ensuring compliance with the SFIs.

7.1.2 Failure to comply with this policy will be recorded by the Chief Financial Officer. Failure to comply with the policy is a disciplinary matter, which may be reported to the Audit Committee, and could result in dismissal.

7.1.3 All members of the Trust Board and employees have a duty to disclose any non-compliance with this policy to the Chief Financial Officer as soon as possible.

7.2 Review

7.2.1 This policy will be reviewed three~~wo~~ years post ratification, unless changes in national legislation override this or there has been a specific request to review earlier.

8. REFERENCES

Standing Orders – G19
Scheme of Reservation and Delegation of Powers – F02

Anti-Bribery and Anti-Fraud Policy (G18)
Disciplinary Policy (HR01).
Losses and Special Payments Policy (F09)
Management of Patient Property (F16)
Standards of Business Conduct Policy (G16)
ISPD Procurement Policy (SP01)
Charity Policy (F06)
Data Protection Security and Confidentiality Policy (DSP10)
Information Lifecycle and Records Management (Corporate Records) Policy (DSP16)
Risk Management Policy (RM01)

Appendix A – STANDING FINANCIAL INSTRUCTIONS

1. AUDIT

1.1 Audit Committee

1.1.1 The Audit Committee's primary role is to conclude upon the adequacy and effective operation of the Trust's overall internal control system. In performing that role the Committee's work will predominantly focus upon the framework of risks, controls and related assurances that underpin the delivery of the Trust's objectives.

1.1.2 As a result, the Committee has a pivotal role to play in reviewing the disclosure statements that flow from the Trust's assurance processes. In particular this includes the Annual Governance Statement, included in the Annual Report, and this document should be presented to the Committee before being submitted for approval to the Trust Board.

1.1.3 It is clearly the job of the Trust Board, Chief Executive and Executive Directors to establish and maintain process for governance. The Committee independently monitors, reviews and reports to the Trust Board on the processes of governance, and, where appropriate, facilitates, supports, through its independence, the attainment of effective processes.

1.1.4 In accordance with SOs, the Trust Board shall formally establish an Audit Committee, that includes independent members, with formal Terms of Reference to perform such monitoring, reviewing and other functions as are appropriate and following guidance from the NHS Audit Committee Handbook 2018, which will provide an independent and objective view of internal control by:

(a) Overseeing Internal and External Audit services and assessing the work and fees of external audit on an annual basis to ensure that the work is of a sufficiently high standard and that the fees are reasonable

(b) Reviewing financial systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments

(c) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives

(d) Monitoring compliance with SOs and SFIs

(e) Reviewing schedules of losses and compensations and making recommendations to the Trust Board

(f) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Trust Board and advising the Trust Board accordingly

(g) Reviewing schedules of the write off of debts and making recommendations to the Trust Board

1.1.5 The Trust Board should satisfy itself that at least one member of the Committee has recent and relevant financial experience.

1.1.6 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Trust Board. Exceptionally, the matter may need to be referred to the Department of Health and Social Care, Local Counter Fraud ~~Office~~ Specialist or the Ppolice (but should be referred to the Chief Financial Officer in the first instance).

1.2 Internal Audit

1.2.1 It is the responsibility of the Chief Financial Officer to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is re-appointed, extended or changed.

1.2.2 The Chief Financial Officer is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function

(b) Ensuring that the purpose, authority and responsibility of Internal Audit is adequate, meets the NHS mandatory audit standards, and is formally defined by the Trust in Terms of Reference with regard to professional best practice and adherence to the Public Sector Internal Audit standards

(c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption

(d) Ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Trust Board. The report must cover:

(i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards. The opinion should cover the overall adequacy and effectiveness of the organisation's framework for governance, risk management and control.

(ii) Major internal financial control weaknesses discovered

(iii) Progress on the implementation of internal audit recommendations

(iv) Progress against plan over the previous year

(v) Strategic audit plan covering the coming three years

(vi) A detailed plan for the coming year

(e) In line with best practice, the Trust will undertake a market testing exercise for the appointment of internal audit service provider at least once every 5 years

1.2.3 The Chief Financial Officer or designated internal and external auditors are entitled, without necessarily giving prior notice, to require and receive:

(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature

(b) Access at all reasonable times to any land, premises or members of the Board or employee of the Trust

(c) The production of any cash, stores or other property of the Trust under a member of the Board or an employee's control

(d) Explanations concerning any matter under investigation

1.2.4 Internal Audit will, in accordance with recognised professional best practice, review, appraise and report upon:

(a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures

(b) The adequacy, efficiency and application of management's systems of internal control (incorporating the Trust's system of internal financial control)

(c) The suitability of financial and other related management data

(d) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) Fraud and other offences

(ii) Waste, extravagance, inefficient administration

(iii) Poor value for money or other causes

~~(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and Social Care.~~

1.2.5 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately. . For any instances where fraud or bribery is suspected, the Local Counter Fraud Specialists must also be notified as soon as practicable.

1.2.6 The Head of Internal Audit or representative will attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

1.2.7 The Head of Internal Audit's formal annual report to the Chief Executive, as Accountable Officer, and the Audit Committee should present the opinion of the overall adequacy and effectiveness of the organisations risk management, control and governance processes.

1.2.8 The Head of Internal Audit shall be accountable to the Chief Financial Officer. The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply

with the guidance on reporting contained in the NHS Internal Audit Standards (encompassed by Public Sector Internal Audit Standards. ~~.~~

1.2.9 Internal Audit shall report findings of work completed, in the first instance, to the appropriate Executive Director who shall refer audit reports to the appropriate members of staff. Failure to take any necessary remedial action within a reasonable period shall be reported to the Audit Committee.

1.2.10 Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, the Head of Internal Audit shall seek the advice of the Chairman of the Audit Committee.

1.2.11 All reports and responses from relevant Executive Directors will be reported by the Head of Internal Audit to Audit Committee.

1.2.12 The Head of Internal Audit shall coordinate internal audit plans and activities with line managers, external audit and other review agencies to ensure the most effective audit coverage is achieved and duplication of effort is minimalised.

1.2.13 The Trust will provide the Head of Internal Audit with every facility and all information which they~~he~~ may reasonably require for the purposes of their~~his~~ function~~s~~ under the Terms of Reference.

1.3 External Audit

1.3.1 The External Auditor is paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditors and referred on if the issue cannot be resolved.

1.3.2 It is the responsibility of the Chief Financial Officer to ensure an adequate External Audit service is provided and the Audit Committee shall be involved in the selection process when/if an External Audit service provider is re-appointed, extended or changed.

2. FRAUD AND BRIBERY

2.1 Fraud is defined as "dishonestly making a false representation, failing to disclose information or abusing a position held, with the intention of making financial gain or causing a financial loss, or risk of loss" as defined in the Fraud Act 2006.

2.2 Frauds can take various forms, including:

(a) Fraud by false representation; by dishonestly making a false representation by making the representation to make a gain for yourself or another, or to cause loss to another or expose another to risk of loss. A representation is false if it is untrue or misleading, and the person making it knows that it is, or might be, untrue or misleading. An example of this would be an employee submitting a false expenses claim form for payment.

(b) Fraud by failing to disclose information; by dishonestly failing to disclose to another person information which you are under a legal duty to disclose and intends, by failing to disclose the information, to make a gain for themselves or another, or to cause loss to another or expose another to the risk of loss. An example of this would be an employee failing to disclose a criminal conviction that would affect their working practices.

(c) Fraud by abuse of position; by occupying a position in which you are expected to safeguard, or not to act against, the financial interests of another person, and dishonestly abusing that position, intending, by means of the abuse of that position, to make a gain for themselves or another, or to cause loss to another or to expose another to a risk of loss. An example of this would be a Chief Financial Officer diverting company monies from an employer's bank account into their own personal bank account.

2.3 The Bribery Act 2010 repealed previous corruption legislation and has introduced the offences of offering and/or receiving a bribe. It also places specific responsibility on organisations including NHS Trusts to have in place sufficient and adequate procedures to prevent bribery and corruption taking place. From July 2011 when the Aact came into force, the four main offences of Bribery are defined as:

(a) Offering a bribe;

(b) Receiving a bribe

(d) Bribing a foreign public official and;

(e) Failure to prevent bribery

2.4 Bribery is defined as "the offering, promising, giving, receiving, or soliciting of something of value for the purpose of influencing the action of an official in the discharge of ~~his/her~~their public or legal duties". Bribery occurs when an individual offers, promises or gives a financial or other advantage to another person and intends that advantage to a) induce a person to perform improperly a relevant functions of activity in order and/or b) knows or believes that acceptance of the advantage would itself constitute the improper performance of a relevant activity or function.

2.5 Corruption is broadly defined as "dishonest, fraudulent or morally unacceptable conduct by individuals, typically those with power, with the aim of obtain a benefit or cause influence~~where someone is influenced by bribery, payment or benefit in kind to unreasonably use their position to give some advantage to themselves or to another~~". Corruption does not always result in loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another.

2.6 In line with their responsibilities, the Chief Executive and Chief Financial Officer shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud, bribery and corruption. The Audit Committee shall oversee the function.

2.7 The Trust Board shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist whose role and responsibilities are determined by the NHS Counter Fraud Authority, the NHS Counter Fraud Authority NHS Anti-Fraud Manual and Service Condition 24 of the Standard NHS Contract

2.8 The Local Counter Fraud Specialist shall report to the Chief Financial Officer and shall work with staff in the ~~NHS Business Service Authority~~Trust in accordance with NHS Counter Fraud Authority's Anti-Fraud Manual

2.9 The Local Counter Fraud Specialist will provide a written report, and a work plan, at least annually, on counter fraud work within the Trust~~.~~ as well as completing the annual Counter Fraud Functional Standard Return and attending Audit Committees to present reports.

2.10 The Chief Financial Officer is responsible for providing detailed procedures to enable the Trust to minimise and, where possible, to eliminate fraud, bribery and corruption. These procedures are included in the Trust's Anti-Bribery & Anti-Fraud policy (G18) which sets out action to be taken by persons detecting a suspected fraud or bribe and persons responsible for investigating it.

2.11 The measures that are put in place shall be sufficient to satisfy all external bodies to whom the Trust is accountable to, through:

(a) Encouraging prevention

(b) Promoting detection

(c) Ensuring investigation and remedial actions are undertaken promptly, thoroughly and effectively

2.12 Fraud, bribery and corruption shall be dealt with as gross misconduct in line with Disciplinary Policy (HR01).

2.13 It is expected that all officers shall act with the utmost integrity, ensuring adherence to all relevant regulations and procedures. It is the responsibility of the Chief Financial Officer to produce and issue such procedures to the appropriate Directors and Line Managers who should ensure that all staff has access to these.

2.14 The ~~Director of Human~~Chief People Officer ~~Resources~~ is responsible for ensuring that steps are taken at the recruitment stage to establish as far as possible the previous record of potential employees in terms of their propriety and integrity.

2.15 Staff are expected to act in accordance with the Trust's SOs and the NHS Code of Business Conduct following guidance on the receipt of gifts and hospitality.

2.16 Independent members are subject to the same high standards of accountability and are required to declare and register any interests which might potentially conflict with those of the Trust.

2.17 The Local Counter Fraud Specialist shall be informed of all suspected or detected fraud and/or bribery so that they can consider the adequacy of the relevant controls and evaluate the implication of fraud for their opinion on the system of risk management, control and guidance.

2.18 Staff are required to raise any concerns they may have regarding suspected fraud, bribery and/or corruption by informing their line manager, Internal Audit, Chief Financial Officer, the Trust's Local Counter Fraud Specialist's at RSM (~~Sophie Coster~~Emily wood, RSM,

Emily.woodSophie.coster@rsmuk.com or the NHS National Fraud and Corruption Reporting line on 0800 0284060 or www.reportnhsfraud.nhs.uk. Further details can be found on the Counter Fraud intranet pages.

2.19 The Chief Financial Officer is responsible for ensuring that action is taken to investigate any allegations of fraud, bribery or corruption through the Local Counter Fraud Specialist. The steps to be taken are detailed in the Trust's Anti-Bribery and Anti-Fraud Ppolicypolicy (G18).

2.20 Senior managers are expected to deal firmly and promptly and in accordance with the Trust's disciplinary procedure with anyone who attempts to defraud the Trust, or engages with bribery or acts in a corrupt manner.

3. SECURITY MANAGEMENT

3.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management and ensure compliance with the current NHS Standard Contract.

3.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management and in compliance with the current NHS Standard Contract.

3.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

4. ALLOCATIONS, BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

4.1 Preparation and Approval of Business Plans and Budgets

4.1.1 The Chief Executive will from time to time compile and submit to the Trust Board an Integrated Business Plan (IBP). In addition annual operating plans will be submitted to the Board in accordance with NHSI/E requirements which takes into account the IBP, financial targets and forecast limits of available resources. The IBP and annual operating plans will contain:

(a) A statement of the significant assumptions on which the plans are based

(b) Details of major changes in workload, delivery of services or resources required to achieve the plan

4.1.2 Prior to the start of the financial year, the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Trust Board. Such budgets will:

(a) Be in accordance with the aims and objectives set out in the IBP

(b) Be in accordance with workload and workforce plans

(c) Be produced following discussion and agreement with appropriate Budget Holders

(d) Be prepared within the limits of available funds

(e) Identify potential risks and mitigations

(f) Have due consideration of the impact on the quality and safety of patient care

4.1.3 The Chief Financial Officer shall continually monitor financial performance against budget and the IBP, periodically review them, and report to the Trust Board.

4.1.4 All Budget Holders must provide financial or non-financial information as required by the Chief Financial Officer to enable budgets to be compiled.

4.1.5 All Budget Holders will confirm acceptance to their allocated budgets prior to the start of the financial year (i.e. 1st April). The Trust will prepare documentation which summarises all internal financial plans by the end of April of each new financial year. The Chief Financial Officer will ensure that divisions are notified in writing of their budget with:

(a) A clear definition of the functions/services for which the budget is provided

(b) The amount of the budget

(c) The planned levels of the activity/service provision

4.1.6 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to Budget Holders to help them manage their budgets successfully.

4.2 Budgetary Delegation

4.2.1 The Chief Executive may delegate the management of a budget to a Budget Holder to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) The amount of the budget

(b) The purpose/s of each budget heading

(c) Individual and group responsibilities

(d) Authority to exercise virement

(e) Achievement of planned levels of service

(f) The provision of regular reports

4.2.2 Budgetary responsibility is delegated at the start of each financial year to the relevant Executive Director, Clinical Director or Head of Service. These are known as 'Budget Holders'.

4.2.3 In turn, an Executive Director, Clinical Director or Head of Service (Budget Holder) may make recommendations to the Chief Financial Officer to delegate the management of the budget (or any part of it) to a designated 'Budget Manager'. Account shall be taken of the scope and approximate value of resources and the seniority and management potential of a prospective Budget Manager

4.2.4 If individual cost centres are delegated further it will be to a designated 'Budget Administrator'. Although management of a budget can be devolved by Budget Holders, ultimate responsibility for delivery of the annual budget lies with the Budget Holder. Therefore, the Budget Manager or Budget Administrator will be responsible for the day-to-day management of the budget.

4.2.5 The Scheme of Delegation clearly sets out the authorisation limits for these levels of management. On no account can a member of staff authorise expenditure against a cost centre for which ~~he or she is~~they are not an authorised signatory. A list of authorised signatories is kept by the Chief Financial Officer.

4.2.6 The term "authorised signatories" referred to throughout these SFIs refers to Budget Administrators, Budget Managers and Budget Holders, along with the Chief Financial Officer and , Chief Executive who are all authorised signatories for the Trust.

4.2.7 Any additions to the authorised signatory list should be approved by the Budget Manager or Budget Holder and the Chief Financial Officer

4.2.8 The Trust Board, acting upon the advice of the Chief Financial Officer, will periodically review and approve the income and expenditure limits within which Budget Holders, Managers and Administrators operate. These limits will be laid down in the Scheme of Delegation.

4.2.9 The Chief Executive, in conjunction with the Chief Financial Officer, will periodically re-assess all functions of the Trust that incur financial consequences and ensure that responsibility for exercising budgetary control for each and every function is delegated to an appropriate Budget Holder.

4.3 Budgetary Control and Reporting

4.3.1 The Chief Financial Officer will devise and maintain systems of budgetary control and financial reporting. These will include:

(a) Monthly financial reports to the Trust Board in a form approved by the Trust Board containing:

~~(i) Performance against NHSI/E risk ratings~~

~~(ii)~~(i) Income and expenditure year to date, showing variances to plan, trends and forecast year end position

~~(iii)~~(ii) Statement of Financial Position (Balance Sheet) year to date, showing variances to plan and forecast year-end position

~~(iv)~~(iii) Cash flow statement year to date, showing variances to plan and forecast year-end position

~~(v)~~(iv) Contract performance year to date

~~(vi)~~(v) Cost improvement plan savings year to date and full year values / forecast outturn with analysis of the type of i.e. recurrent or non recurrent savings

~~(vii)~~(vi) Capital project spend year to date, showing variances to plan and projected outturn against plan

~~(viii)~~(vii) Explanations of any material variances from plan

~~(ix)~~(viii) Details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation

(b) The issue of timely, accurate and comprehensible advice and financial reports to each Budget Holder, covering the areas for which they are responsible

(c) Investigation and reporting of variances from financial, workload and workforce budgets

(d) Monitoring of management action to correct variances within agreed timeframes

(e) Arrangements for the authorisation of budget transfers in accordance with the virement rules

(f) The financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

4.3.2 Each Budget Holder is responsible for ensuring that:

(a) Ensuring expenditure is appropriately managed within budget escalating any issues and overspends through management structures

(b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement

(c) No permanent employees are appointed outside the funded establishment without the approval of the Chief Executive on recommendation from the Chief People Officer ~~Director of Human Resources~~ and the Chief Financial Officer or any locally or Trust-wide established control procedures ~~(such as vacancy control panels),~~ agreed by the Chief Executive and in line with delegated limits.

(d) No expenditure is incurred against a budget outside of their particular remit without the express consent of the delegated Budget Holder for the budget concerned

(e) The systems of budgetary control established by the Chief Financial Officer are complied with fully

4.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the IBP, annual operating plans and a balanced budget.

4.3.4 All employees of the Trust, especially those involved with the budgetary process, have a responsibility to the Trust Board for identifying all possible opportunities to make savings or to use Trust resources more effectively. All such opportunities should be brought to the attention of the appropriate Executive Director, Clinical Director or Head of Service for consideration and possible inclusion in the plans of the division.

4.3.5 The budgetary process requires adherence to particular timescales for the performance of routines and duties. These timescales change periodically and will be issued by the Finance Department annually. The Chief Financial Officer is responsible for issuing and reviewing guidance on budgetary timetables. It is the responsibility of all Executive Directors, Clinical Directors and Head of Services concerned to adhere to such timetables and to inform the Chief Financial Officer of any reasons preventing the achievement of a specific deadline.

4.3.6 The Trust Board is responsible for ensuring that the Trust's financial performance is within the targets agreed by the Department of Health and Social Care. In exercising this responsibility, the Trust Board will be guided by the advice of the Chief Executive and the Chief Financial Officer.

4.3.7 The Chief Financial Officer reserves the right to have access to all Budget Holders and has the authority to require explanations on performance and spending and income trends within the remit of the Budget Holder. In normal circumstances, access will be through the relevant Executive Director and/or Divisional Manager.

4.4 Virements

4.4.1 Virement is defined as the transfer of budget sums within the areas for which a budget holder is responsible, or transfers to other budget holders i.e. any redistribution of budgeted amounts.

4.4.2 There are occasions where virement is generally appropriate, these include:

(a) Adjustments to reflect changes that could not have been foreseen at the start of the financial year

(b) Where planned actions by managers mean that resources previously allocated for one purpose are no longer required for that purpose

4.4.3 There are occasions where virement is not 'generally' appropriate:

(a) Smoothing budget statements to mask underlying issues

(b) Using fortuitous underspends to support pressures in other areas

(c) Funding additional establishment through savings in non-pay budget.

(d) Changing nurse establishments within funding baseline without the prior agreement of the Director of Nursing

(e) Changing medical establishments within funding baseline without the prior agreement of the Medical Director

4.4.4 To maintain central control of funding and recognising the need for the Trust to meet its statutory financial duties, limitations on the extent to which virement can be applied are needed. These limits provide a degree of flexibility for budget holders whilst recognising the need for overall control of spending within the Trust.

4.4.5 The following types of virement will generally not be considered unless a very strong case of need is made by the Budget Holder with agreement by the Chief Financial Officer:

(a) Virement between non recurrent and recurrent resources

(b) Virement between income and any other category

(c) Virement from non pay to create additional establishment

The Trust Board has defined appropriate rules for virement between budgets. These rules are based upon an escalating basis of significance of the virement:

Virement	Authorisation Required from:
Re-phasing of Budgets	Chief Financial Officer
Budget moves between income, pay or non pay	Budget Holder and Head of Financial Management
Budget moves between pay to pay or non pay to non pay	Budget Holder and Deputy Director of Finance
CIP transactions	As above + Director of PMO
Changes to Nursing Establishment	As above + Chief Nurse
Changes to Medical Establishment	As above + Medical Director

Virement	Authorisation Required from:
Re-phasing of Budgets	Chief Financial Officer
Budget moves between income, pay or non pay	Budget Holder and Deputy Director of Finance
Budget moves between pay to pay or non pay to non pay	Budget Holder and Deputy Director of Finance
CIP transactions	As above + Director of PMO
Changes to Nursing Establishment	As above + Chief Nurse
Changes to Medical Establishment	As above + Medical Director

Table 2

4.4.6 All virements must be communicated to the appropriate Divisional Business Advisor/Financial Manager and authorised through completion of the required virement authorisation form.

4.4.7 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Trust Board.

4.4.8 Any budgeted funds not required for their designated purpose/s revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.4.9 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Financial Officer.

~~4.4.10 Any virement movements will be reported to the Performance and Finance Committee (PFC) on a regular basis.~~

4.5 Reserves

4.5.1 The Chief Financial Officer, on behalf of the Chief Executive, will endeavour to create such reserves as are deemed necessary to secure the ability of the Trust to meet its financial targets. Reserves may include sums to cover future pay awards, price inflation, unforeseen contingencies, non recurrent spending and other specific items as yet not allocated to individual budgets.

4.5.2 The Chief Financial Officer may exercise discretion to partly, or wholly, allocate reserves directly to the Divisions or subsequent allocation to specific budgets. In these circumstances, a clear definition of the rules governing the authority to apply the reserve/s will be required.

4.5.3 Applications to draw down reserves must follow the process specified by the Chief Financial Officer and be approved by the Budget Holder and Chief Financial Officer.

4.6 Revenue business cases

4.6.1 Revenue business cases are required to allocate additional revenue funding from that specified in the annual budget setting process (including supporting invest to save proposals that require additional funding with a view to producing additional income/savings (CIP)). This process includes the additional revenue cost of any PFI variations.

4.6.2 If a source of funds is deemed readily available then investments of £25,000 or less can be authorised by the Chief Financial Officer without the need to produce a full business case. If approved, the division will need to apply for a virement (see SFI 4.4).

4.6.3 For replacement consultant posts only, the Clinical Director and ~~Associate~~ Directors of Operations are responsible for approving the business case for such posts as such posts are deemed to be within the Trust's workforce plan. Any new consultant posts should follow the business case process as for any other revenue funding.

4.6.4 Any revenue business cases developed should have the support of the Divisional management team or Corporate Director as appropriate and should be in line with the Trust's priorities as outlined in the Integrated Business Plan and Annual Plan.

4.6.5 The Performance and Finance Committee (PFC) will approve the revenue business case process.

4.6.6 All completed business cases will be reviewed by the Formal Executive Meeting (FEM). FEM has delegated authority from the Trust Board to approve revenue business cases of up to £~~2~~500,000.

~~4.6.7 The FEM will report monthly to the Trust Executive Committee (TEC) to confirm decisions made at FEM and also take any business cases for revenue investment over £250,000 for final review and recommendation for approval to the Performance and Finance Committee.~~

~~4.6.8~~4.6.7 Cases between £~~2~~500,000 and £1,~~5~~000,000 will be taken to the Performance and Finance Committee (PFC) for approval. Any cases over £1,~~5~~000,000 will require Trust Board approval.

~~4.6.9~~4.6.8 NHS Improvement/England (NHS~~I~~/E) is also required to approve any revenue business cases which exceed £~~2~~5,000,000, following Trust Board approval being given. This limit can be reduced at the discretion of the NHS~~I~~/E where a Trust is reporting a year end deficit.

~~4.6.10~~4.6.9 Revenue business cases have to go through all the relevant approval groups dependent on values, so for example a case of over £~~2~~5,000,000 will require approval from FEM, who will recommend to PFC, who will recommend to Trust Board for approval. The case will then be recommended to NHS~~I~~/E for approval.

~~4.6.11~~4.6.10 The values quoted in SFI 4.6.2 and 4.6.6 to 4.6.9 are inclusive of VAT and represents either annual expenditure or annual income level, whichever the greater. No netting off between expenditure and income should be undertaken in identifying these annual values.

4.6.11 Business cases which have both capital and revenue funding requirements should be fully completed (i.e. including all capital and revenue implications) and the capital funding source

should be confirmed (via the Capital Investment Group (CIG)) prior to the business case being presented to FEM

Business Case Approval Limits	Incremental (additional) income or revenue (higher of) including VAT				
	<£25k	> £25k to £500k	> £500k to £1.5m	> £1.5m to £25m	> £25m
Authority Delegated to:	Chief Financial Officer	Formal Executive Meeting (FEM)	Performance and Finance Committee (PFC)	Trust Board	NHSE

Business Case Approval Limits	Incremental (additional) income or revenue (higher of) including VAT				
	<£25k	> £25k to £250k	> £250k to £1m	> £1m to £15m	> £15m
Authority Delegated to:	Chief Financial Officer	Formal Executive Meeting (FEM)	Performance and Finance Committee (PFC)	Trust Board	NHSI/E

Table 3

4.6.12 A benefits review will take place at a time determined by FEM at the time of approval for all approved business cases which will assess the success of the revenue business case based on Key Performance Indicators (KPIs) included within the revenue business case. Regular reports on benefits reviews undertaken will be submitted by FEM to PFC.

4.7 Monitoring Returns

4.7.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation in the format and timeframes required.

4.7.2 The internal monitoring of the Trust's and departmental business plans will take place through regular performance reviews at Executive level with appropriate support.

5. ANNUAL REPORT AND ACCOUNTS ~~AND REPORTS~~

5.1 The Chief Financial Officer, on behalf of the Trust, will:

(a) Prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care and the Treasury, the Trust's accounting policies, and generally accepted accounting practice

(b) Prepare and submit annual financial reports to the Department of Health and Social Care certified in accordance with current guidelines

(c) Submit financial returns to the Department of Health and Social Care for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care

5.2 The Trust's audited annual reports and accounts, and any report of the auditor on them, must be presented to the Trust Board for approval.

5.3 The Trust's annual accounts must be audited by an auditor appointed by the Trust following procurement procedures.~~Public~~Public Sector Audit Appointments body. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

5.4 The Trust will publish the~~an~~ annual report and accounts, in accordance with guidelines on local accountability. This will be presented to the Trust Board for approval.. The annual report and accounts will also be presented at a public meeting. The document will comply with the Department of Health and Social Care's Group Accounting Manual (GAM).~~Manual for Accounts.~~

6. BANK ACCOUNTS

6.1 General

6.1.1 The Chief Financial Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by the Department of Health and Social Care.

6.1.2 The Trust Board shall approve the banking arrangements.

6.1.3 The Trust operates one bank account under the Government Banking Service (GBS) with RBS.

6.2 Bank and Online Merchant Accounts

In line with public sector practice, the Trust's principal bank is the GBS. However, these SFIs will apply to any other accounts opened in the name of the Trust or its associated Charity from time to time referred to in 6.2.2(a) below

6.2.1 The Chief Financial Officer is responsible for:

(a) Bank accounts and online merchant accounts

(b) Establishing separate bank accounts for the Trust's non-exchequer (donated) funds as appropriate.

(c) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made

(d) Reporting to the Trust Board all arrangements made with the Trust's bankers for accounts to be overdrawn

(e) Monitoring compliance with Department of Health and Social Care guidance on the level of cleared funds

(f) Establishing treasury policies and procedures to ensure the effective management of cash and bank balances

6.3 Banking Procedures

6.3.1 The Chief Financial Officer will prepare detailed instructions on the operation of bank accounts which must include:

(a) The conditions under which each bank account and online merchant account is to be operated

(b) Those authorised to sign cheques or other orders drawn on the Trust's accounts

(c) Access for East Lancashire Financial Services (ELFS) to process bank transactions, payments and reconciliations on the Trust's behalf

6.3.2 All funds shall be held in accounts in the name of the Trust. No officer other than the Chief Financial Officer shall open any bank account or online merchant account in the Trusts name or include the name of the Trust.

6.3.3 The Chief Financial Officer shall advise the bankers in writing of the officer(s) and or Director(s) authorised to release money from, and draw cheques on, each bank account of the Trust.

6.3.4 All payments shall be supported by two authorised signatories on the cheque or authority to pay, as appropriate. Cheques will not be drawn for cash.

6.3.5 All bank cheques or other orders for payment shall be ordered only upon the authority of the Chief Financial Officer, who shall make proper arrangements for their safe custody.

7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 Income Systems

7.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

7.1.2 The Chief Financial Officer is also responsible for the prompt banking of all monies received.

7.1.3 Any income raised from income generation and from contracts with non NHS bodies will be reinvested in service provision.

7.2 Fees and Charges

7.2.1 The Trust shall follow the Department of Health and Social Care's Operating Framework ~~and National Tariff Payment system~~ in agreeing and setting prices for NHS service agreements.

7.2.2 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.2.3 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health and Social Care's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

7.2.4 All employees must ensure that the appropriate Trust financial procedures are followed with regards to accurately and promptly recording any money due to the Trust arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.2.5 The Chief Financial Officer shall be responsible for implementing any such guidance issued by the Department of Health and Social Care in relation to the costing and pricing of services, and in particular services provided to NHS commissioning bodies.

7.2.6 The preparation and signing of all tenancy agreements and licenses in respect of staff accommodation shall be the responsibility of the Chief Executive Officer.

7.2.7 Where applicable p~~P~~atient activity income will be subject to compliance with the latest applicable National Tariff Payment system guidance.

7.3 Debt Recovery

7.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

7.3.2 The Chief Financial Officer shall establish procedures for the write off of debts after all reasonable steps have been taken to secure payments, including debt recovery by external organisations. Where sums to be written off exceed £1,000, the Chief Financial Officer will seek the consent of the Chief Executive and items exceeding £50,000 will require consent of the Trust Board. The Audit Committee will consider the write off of all debts exceeding £1,000.

7.3.3 Income not received should be dealt with in accordance with the Trust's Losses and Special Payments Policy (F09).

7.3.4 Overpayments should be detected (or preferably prevented) and recovery initiated.

7.4 Security of Cash, Cheques and other Negotiable Instruments

7.4.1 The Chief Financial Officer is responsible for:

(a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable

(b) Ordering and securely controlling any such stationery

(c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines

(d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust

7.4.2 "Official money" shall not under any circumstances be used for the encashment of private cheques or IOUs.

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

7.4.4 The holders of safe keys shall not accept patient or other unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss in relation to items not handed in for safe keeping, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss. The rules around the Safekeeping of Patient Property are set out in Policy - Management of Patient Property (F16).

7.4.5 The opening of cash tills, telephone and coin operated machines, and the counting and recording of the takings shall be undertaken by two members of staff together. The coin box keys shall be securely held by a nominated member of staff.

7.4.6 The Chief Financial Officer shall prescribe the system for the transporting of cash and other negotiable instruments. Wherever practicable, the services of a specialist security firm will be employed.

7.4.7 All unused cheques and other orders shall be subject to the same security precautions as are applied as cash. Bulk stocks of cheques shall be retained by the Trust under appropriate security arrangements and a record maintained of cheques used.

7.4.8 All cheques shall be subject to special security precautions as may be required from time to time by the Chief Financial Officer.

7.4.9 Staff shall be informed in writing on appointment, by the appropriate departmental or senior member of staff of their responsibilities and duties for the collection, handling or disbursement of cash, cheques, etc.

7.4.10 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the Losses and Special Payments policy (F09).

7.4.11 All payments made on behalf of the Trust to third parties should normally be made using the Bankers Automated Clearing System (BACS) or by Faster Payments and drawn in accordance with these instructions, except with the agreement of the Chief Financial Officer, as appropriate, who shall be satisfied about security arrangements.

7.4.12 To comply with money laundering legislation, under no circumstances will the Trust accept cash payments in excess of £10,000 in respect of any single transaction. Any attempts by an individual to effect payment above this amount shall be notified immediately to the Chief Financial Officer.

8. TENDERING, CONTRACTING AND PURCHASING PROCEDURES

8.1 Duty to comply with SOs and SFIs

8.1.1 The procedure for making all contracts by, or on behalf of, the Trust shall comply with these SOs and SFIs (except where SO 3.13 Suspension of SOs is applied).

Detailed below is a summary table of the process to follow dependent upon the value of the intended expenditure. Please note this is purely a summary and the full SFI detail held within this section should be read and understood but the below is given as an aid for users.VAT, apply

Value of intended expenditure or income (total contract value)	£250 to £4,999	£5,000 to £19,999	£20,000 to £49,999	£50,000 and above
	N.B. Values stated above are inclusive of VAT, apply to both capital and revenue expenditure and relate to total contract life cycle spend (i.e. total amount of expenditure being committed)			
Competitive (i.e. formal)	N/A – formal competition not required	At least 3 quotations to be obtained where practicable	At least 3 formal quotes advertised via contracts finder	At least 2 individuals/firms to be invited to tender Spend over the Public Contract Regulations (2015) (PCR) limit of £138,760 (including VAT) is to follow the Public Contract Regulations (2015) (PCR)~~Spend over the OJEU limit of £122,976 is to follow the OJEU advertisement and procurement process~~
Non-competitive (i.e. informal)	At least 3 quotations to be obtained verbally	N/A	To be followed if circumstances detailed in SFI 8.13.3 met Single quotation documentation to be completed and authorised by Chief Financial Officer	To be followed if circumstances detailed in SFI 8.5.3 & 8.5.4 met Single tender documentation to be completed and authorised by Chief Financial Officer & Chief Executive (where appropriate)

Table 4

8.2 Public Contract Regulations (2015) (PCR)~~EU~~ directives governing public procurement

8.2.1 Directives in line with the Public Contract Regulations (2015) ~~by the Council of the European Union~~ promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SFIs.

8.3 Reverse eAuctions

8.3.1 The Trust will seek advice from a relevant collaborative partner on the operation of Reverse eAuctions via the Integrated Supplies and Procurement Department.

8.4 Capital Investment Manual and other Department of Health and Social Care guidance

8.4.1 The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care "Capital Investment Manual" and “Estate code” and “Procure 232” (normally to be considered for all schemes in excess of £1 million) in respect of capital investment and estate and property transactions.

8.4.2 In addition, “Concode (volume 1 – 3)” and “NHS Estates Agreement for the Appointment of Architects, Surveyors and Engineers for Commissions in the National Health Service” provides specific guidance relating to the procurement and execution of construction contracts and design consultant commissions.

8.4.3 In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS".

8.5 Formal competitive tendering

8.5.1 The Trust shall ensure that competitive tenders are invited for:

(a) The supply of goods, materials and manufactured articles

(b) The rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care)

(c) For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals

8.5.2 Where the Trust is obligated to invite tenders for the supply of healthcare services these SFIs shall apply as far as they are applicable to the tendering procedure.

8.5.3 Formal tendering procedures **need not be applied** where:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 (inclusive of VAT)

(b) Where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with

(c) Regarding disposals as set out in SFI 8.21

8.5.4 Formal tendering procedures **may be waived** in the following circumstances:

(a) In very exceptional circumstances where the Chief Executive or their nominated officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record

(b) Where the requirement is covered by an existing contract and the requirement does not constitute a material change of contract

(c) Where there are collaborative arrangements and market testing has already formally taken place. e.g., through Crown Commercial Services

(d) Where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender

(e) Where specialist expertise is required and is proven to be available from only one source

(f) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate

(g) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering

(h) Where allowed and provided for in the Capital Investment Manual

8.5.5 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award a further contract or work to a provider originally appointed through a competitive procedure.

8.5.6 Under no circumstances can procurement, with a total contract lifecycle value (i.e. minimum 3 years, if not specified), over the current minimum Public Contract Regulations (2015) ~~(PCR))~~ ~~Official Journal of European Union (OJEU)~~ spend threshold (currently £138,760 including VAT~~£122, 976~~) be waivered.

8.5.7 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record (i.e. a Single Tender waiver form contained within the electronic Request for Executive Approval Form (eReaf) system), authorised by the Chief Financial Officer and Chief Executive (where appropriate) and reported to the Audit Committee at each meeting.

8.5.8 Where the exceptions set out in SFI 8.5.4 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

8.5.9 The Trust does not maintain an approved supplier list, except for building and engineering works (see SFI 8.5.16) and temporary agency recruitment (see SFI 8.5.17). Firms who apply for consideration will be directed to the Contracts Finder (Find a Tender Service) ~~NHS Supplier Information Database (NHS SID)~~ in the first instance. Suppliers not on NHS SID will be assessed for technical and financial competence during the procurement process and the level of assessment will be comparable to the value of business being procured.

8.5.10 All suppliers must be made aware of the Trust's terms and conditions of contract.

8.5.11 Firms who apply to tender shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and the Equality Act 2010 and any amending and/or related legislation.

8.5.12 Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of

workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide, to the appropriate manager, a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

8.5.13 The Chief Financial Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

8.5.14 If in the opinion of the Chief Executive and the Chief Financial Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

8.5.15 An appropriate record contained within the eReaf system, should be made of the reasons for inviting a tender or quote other than from an approved procurement route / approved list.

8.5.16 The Trust will use contractors registered on Construction Line (www.constructionline.co.uk) as vetted and approved contractors for capital developments or the Procure 232 Framework.

8.5.17 The Trust has in place an approved supplier list for temporary agency recruitment which complies with nationally approved frameworks. Theseis frameworks havelist has been subject to due procurement process. Suppliers from this list must be utilised by the budget administrator/manager/holder in all cases of temporary staff recruitment via an external agency. Temporary agency recruitment should be booked using the Trust's contracted direct engagement and master vendor contracts where appropriate.

8.5.18 It is the budget administrators/manager/holder's responsibility to ensure full awareness of the supplier's terms and conditions of engagement before committing to recruit any temporary agency resource. Failure to understand the terms and conditions of engagement fully, could result by default, as an acceptance of the suppliers own Terms and Conditions of contract, exposing the Trust to unnecessary contractual risk and financial exposure (for example, significantly high introductory fees if the Trust proceeds to employ permanently the temporary agency resource).

8.5.19 If a budget administrator/manager/holder uses a supplier for temporary agency recruitment that is not on the approved supplier list, the use of such a supplier could lead to a contravention of Public Contract Regulations (2015) (PCR)Official Journal of European Union (OJEU) Procurement regulations. The noncompliance would also be a breach of these SFIs which could result in disciplinary proceedings and be reported to Audit Committee (as per SFI 1.5 and 1.6).

8.5.20 It is the responsibility of the budget administrator/manager/holder who is committing the trust to temporary resource to ensure that all relevant pre-employment checks have been completed to avoid exposing the Trust and patients to unnecessary risk. The use of suppliers for temporary agency resource who are not on the approved supplier list may not in some cases have adopted a policy of conducting these checks prior to supplying the temporary resource to the Trust.

8.5.21 Further commercial advice regarding the recruitment of temporary agency staff should be sought from the relevant category lead for agency within the Integrated Supplies and Procurement department.

8.5.22 Competitive tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

8.5.23 Items estimated to be below the limits set in these SFIs, for which formal tendering procedures are not used, which subsequently prove to have a value above such limits shall be reported to the Chief Executive or their nominated officer, and be recorded in an appropriate Trust record.

8.6 Contracting/tendering procedure

8.6.1 For all tenders (both e-procurement and non e-procurement):

(a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders and that no tender will be accepted beyond this date

(b) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Terms and Conditions as are applicable

(c) Every tender for building and engineering construction works (except in some circumstances for maintenance work only where HBN00-08 guidance should be followed), shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or New Engineering Contract (NEC) or Department of the Environment (GC/Wks) standard forms of contract amended to comply with Concode., When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. . The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. The NEC form of contract and the Model Form of Engineering Contract should be used whenever applicable. Tendering based on other forms of contract (P22) may be used following consultation with the Department of Health and Social Care.

8.7 Receipt and safe custody of tenders

8.7.1 For e-Procurement tenders:

(a) All tenders received through the e-Procurement portal will be stored within the system until the time appointed for their opening, the e-Procurement function will not allow any member of the originating department or the wider Trust to access tenders before the specified date

(b) The e-Procurement function will automatically create a log that records the date and time of receipt of each tender

8.7.2 For non e-Procurement tenders:

(a) A member of the originating department (band 5 or above) will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening

(b) The date and time of receipt of each tender shall be endorsed on the tender envelope/package

(c) The ‘originating’ Department will be taken to mean the Department sponsoring or commissioning the tender. Any person directly involved in the tender process or subsequent evaluation should be the person responsible for the receipt and safe custody and tenders

8.8 Opening tenders and register of tenders

8.8.1 For e-Procurement tenders:

(a) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the Group Director of Procurement or a delegated officer have the authority to ~~an authorised person within the originating department (band 5 or above) who was duly named during the tendering process, will access~~open tenders via the Trust electronic ~~-~~procurement system ~~and authorise the electronic opening of all submitted tenders~~

(b) The e-Procurement system will automatically register the details of opening i.e. date, time, authorised person

(c) The e-Procurement system will retain a log for each set of competitive tender invitations dispatched:

(i) The name of the individuals invited

(ii) The names of firms individuals from which tenders have been received

(iii) The price shown on each tender

(d) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, should be dealt with in the same way as late tenders (see SFI 8.10).

8.8.2 For non e-Procurement tenders:

(a) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders~~, an authorised person~~ the Group Director of Procurement or a delegated officer ~~within the originating department (band 5 or above) who was duly named during the tendering process, will~~ have the authority to open ~~all~~ tender offers received at the Trust

(b) Every tender received shall be marked with the date of opening and initialled by those present at the opening

(c) A register shall be maintained to show for each set of competitive tender invitations despatched:

(i) The name of all firms individuals invited

(ii) The names of firms individuals from which tenders have been received

(iii) The date the tenders were opened

(iv) The persons present at the opening

(v) The price shown on each tender

(vi) A note where price alterations have been made on the tender

(d) Each entry to this register shall be signed by those present

(e) A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood

(f) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon ~~his~~ their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders (see SFI 9.10).

(g) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender. Any person directly involved in the tender process or subsequent evaluation should be the person responsible for the opening or registration of tenders

8.9 Admissibility

8.9.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended or incomplete) no contract shall be awarded without the approval of the Chief Executive or their nominated officer.

8.9.2 Where only one tender is sought and/or received, the Chief Executive or their nominated officer and Chief Financial Officer shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust by utilising, for example, comparable commercial information from historic benchmarking data, other Trust information or market intelligence available at that point in time.~~.~~

8.10 Late tenders

8.10.1 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

8.10.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not been received by the person carrying out the tender process or if the process of evaluation and adjudication has not started.

8.10.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody either by the duly authorised person within the originating department or within the relevant portal of the e-procurement system.

8.11 Acceptance of formal tenders

8.11.1 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their~~his~~ tender before the award of a contract will not disqualify the tender.

8.11.2 The lowest acceptable tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons, which may include technical suitability, adherence to the specification, service record of the proposed successful supplier and other non-financial factors that have a bearing on the total cost and are relevant to the procurement in question, shall be recorded in either the contract file, or other appropriate record.

8.11.3 It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) Experience and qualifications of team members

(b) Understanding of client's needs

(c) Feasibility and credibility of proposed approach

(d) Ability to complete the project on time

8.11.4 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

8.11.5 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these SFIs except with the authorisation of the Chief Executive or their nominated officer

8.11.6 The use of these procedures must demonstrate that the award of the contract was:

(a) Not in excess of the going market rate/price current at the time the contract was awarded

(b) That best value for money was achieved.

8.11.7 All tenders should be treated as confidential and should be retained for inspection. Records may be kept electronically in accordance with the HSC 1999/053.

8.12 Tender reports to the Trust Board

8.12.1 Reports to the Trust Board will be made on an exceptional circumstance basis only.

8.13 Quotations: Competitive and non-competitive

8.13.1 Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £20,000 but not exceed £50,000 (inclusive of VAT).

8.13.2 For competitive quotations, quotations should be :

(a) Obtained from at least 3 firms/individuals based on specifications or Terms of Reference prepared by, or on behalf of, the Trust (where this number of suppliers exist for the requirement)

(b) In writing unless carried out using the e-procurement system, or unless the Chief Executive or their nominated officer determines that it is impractical to do so, in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record

(c) Treated as confidential and be retained for inspection

(d) Evaluated by the nominated person from the originating department and the quote which gives the best value for money should be selected

(e) If the selected quote is not the lowest quotation, if payment is to be made by the Trust or the highest, if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record

8.13.3 For non-competitive quotations, quotations in writing may be obtained in the following circumstances:

(a) The supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations

(b) The supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts

(c) Miscellaneous services, supplies and disposals

(d) Where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e. (a) and (b) of this SFI) apply

8.13.4 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these SFIs except with the authorisation of either the Chief Executive, or their nominated officer, or the Chief Financial Officer.

8.14 Authorisation of tenders and competitive quotations

8.14.1 Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows (noting the formal delegated responsibility of authorising/signing of all commercial contracts outlined in section 8.18.2 below). These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.

Contract value (Inclusive of VAT)	**Authorisation by**
£0 - £50,000	Budget Holder
£50,001 - £100,000	Director of Finance
£100,001 to £500,000	Chief Financial Officer
£500,001 to £1,000,000	Chief Executive
£1,000,001 to £3,000,000	Performance and Finance Committee
£3,000,001 and above	Trust Board

Table 5

8.14.2 Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

8.14.3 The Group Director of Procurement will report proposed procurements over the value of £1m to the Performance and Finance Committee prior to the award of any contract, and also provide a contract award report for all procurements over a value of £500,000 to the Chief Executive Officer on a monthly basis.

8.15 Instances where formal competitive tendering or competition quotation is not required

8.15.1 Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) The Trust shall use the "nominated national NHS Logistics provider" for procurement of all goods and services unless the Chief Executive or their nominated officer deems it inappropriate. The decision to use an alternative source must be documented

(b) If the Trust does not use "nominated national NHS logistics provider" – where tenders and quotations are not required, because expenditure is below £5,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer

8.16 Procurement processes for pharmacy medicines

8.16.1 Where a Commercial Medicines Unit (CMU) hospital framework contract exists, the Trust will purchase medicines under this contract.

8.16.2 The CMU is part of the Medicine, Pharmacy and Industry Group of the Department of Health and Social Care. The focus of the work of the CMU is on strategic supply management and procurement of medicines for use in secondary care. The CMU works in partnership with hospital procurement colleagues across the NHS in England; this includes leading a selective competitive tendering work plan for the implementation of hospital framework contracts.

8.16.3 Where no CMU contract exists, and where applicable, the Trust will comply with the quotation, tendering and contract procedures detailed in SFI 18 and support will be provided by the Integrated Supplies and Procurement Department accordingly. However, for many medicines there is only one supplier and therefore the conditions where formal tendering procedures may be waived (detailed in SFI 8.5.4) are applicable.

8.17 ~~Private Finance for capital procurement~~ Removed

~~8.17.1 The Trust should normally market-test for PFI (Private Finance Initiative) funding when considering capital procurement. When the Trust Board proposes, or is required, to use finance provided by the private sector the following should apply:~~

~~(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector~~

~~(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health and Social Care for approval or treated as per current guidelines~~

~~(c) The proposal must be specifically agreed in accordance with the delegated authorisation limits specified in the Scheme of Delegation~~

~~(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations~~

~~(e) Any schemes involving PFI (new schemes or contract variations), irrespective of value, will also require discussion with the NHSI/E to agree the approval requirements.~~

8.18 Compliance requirements for all contracts

8.18.1 The Trust Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's SOs and SFIs

(b) ~~E~~ UK Public Procurement~~U~~ Directives and other statutory provisions

(c) Any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants

(d) Such of the NHS Standard Terms and Conditions as are applicable

(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited

(g) In all contracts made by the Trust, the Trust Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust

8.18.2 The Chief Executive Officer delegates the responsibility of authorising/signing of all commercial contracts to the Group Director of Procurement, with the exception of building and works contracts which is delegated to the Director of Estates, Facilities and PFI'. The conditions set out in 18.18.1 must be satisfied.

8.19 Personnel and Agency or Temporary Staff Contracts

8.19.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

8.20 Healthcare Services Agreements

8.20.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

8.20.2 The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

8.21 Disposals

8.21.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

(a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their~~his~~ nominated officer

(b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the ISPD Procurement P~~p~~olicy (SP01) of the Trust

(c) Items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed on a periodic basis

(d) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract

(e) Land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance

8.22 In-house services

8.22.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

8.22.2 In all cases where the Trust Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support

(c) Evaluation team, comprising normally a specialist officer, a Supplies and Procurement officer and a Chief Financial Officer representative. For services having a likely annual expenditure exceeding £100,000, a Non-executive Director should be a member of the evaluation team

8.22.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

8.22.4 The evaluation team shall make recommendations to the Trust Board.

8.22.5 If in-house services are outsourced, the Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8.23 Applicability of SFIs on tendering and contracting to funds held in trust

8.23.1 These SFIs shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

8.24 Use of local and smaller suppliers

8.24.1 The Trust will strive to ensure that local and smaller suppliers are not discriminated against in the procurement process and specifications.

8.25 Delegated Orders

8.25.1 The Estates, Facilities and PFI Division have delegated authority in regard to the raising of purchase orders in relation to MTC related purchase orders and emergency orders only. (These can be emergency orders required at any time, but should not be confused with urgent orders). As outlined in section 11.5.1 all emergency orders must subsequently be confirmed by an official purchase order and clearly marked "Confirmation Order".

It should also be noted that a fully authorised electronic Request for Executive Approval Form (eReaf) is still required for all MTC related purchase order and emergency order expenditure exceeding £20,000 (including VAT).

9. NHS SERVICE AGREEMENTS CONTRACTING FOR PROVISION OF SERVICES

9.1 Contractual agreements

9.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring contracts are suitably negotiated with commissioners for the provision of services to patients in accordance with the Integrated Business Plan and subsequent Annual Business Plan, and for establishing the arrangements for providing extra-contractual services.

9.1.2 These contracts are not legally binding.

9.1.3 In carrying out these functions, the Chief Executive should take into account the advice of the Chief Financial Officer regarding:

(a) Costing and pricing of services

(b) National Tariff Payment system

(c) Payment terms and conditions

(d) Penalty and fine implications

(e) Billing systems and cash flow management

(f) Any other matters of a financial nature

(g) The contract negotiation process and timetable

(h) The provision of contract data

(i) Contract management and monitoring arrangements

(j) Amendments to contracts and extra-contractual arrangements

(k) Targets and performance/quality standards specified in the contract

(l) Any other matters relating to contracts of a legal or non-financial nature

(m) Any other / new innovative payment methodologies

9.1.4 Contracts should be so devised as to minimise the risk whilst maximising the Trust's opportunity to generate income.

9.1.5 Any pricing of contracts at marginal cost must be undertaken by the Chief Financial Officer and where material reported to the Trust Board.

9.1.6 Contracts with NHS commissioning bodies require the signature of the Chief Executive or the Chief Financial Officer.

9.1.7 The Trust will maintain a public and up to date schedule of the authorised goods and services which are being currently provided, including non-mandatory health services.

9.2 Reports to Trust Board on contractual agreements

9.2.1 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Trust Board detailing actual and forecast income from the contractual

agreements. This will include information on costing arrangements, in line with the National Tariff Payment system. Where specific services are outside the scope of National Tariff Payment system, all parties should agree a common currency for application across the range of contractual agreements.

9.2.2 The report should also include information regarding the risks and mitigations in place relating to the contract.

10. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

10.1 Nominations and Remuneration Committee

10.1.1 In accordance with SOs the Trust Board shall establish a Nominations and Remuneration Committee, with clearly defined Terms of Reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

10.1.2 The Committee will:

(a) Advise the Trust Board about appropriate remuneration and terms of service for the Executive Directors (i.e. Trust Board voting and non-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework. This will include:

(i) All aspects of salary (including any performance-related elements/bonuses)

(ii) Provisions for other benefits, including pensions and cars

(iii) Arrangements for termination of employment and other contractual terms

(b) Monitor and evaluate the performance of individual Directors (with the advice of the Chief Executive)

(c) Advise on and oversee appropriate contractual arrangements for Executive Directors, and when required, consider issues relating to remuneration, terms of service and performance issues for senior management staff

10.1.3 The Committee Chairman shall report to the Closed Trust Board the basis for its recommendations. The Trust Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Trust Board's meetings should record such decisions.

10.1.4 The Trust Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

10.1.5 The Trust will pay allowances to the Chairman and Non-Executive members of the Trust Board in accordance with instructions issued by the Secretary of State for Health.

10.2 Funded Establishment

10.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

10.3 Staff Appointments

10.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) Unless authorised to do so by the Chief Executive and Chief People Officer~~Director of Human Resources~~; and

(b) And is within the limit of their approved budget and funded establishment, and

(c) And is in accordance with any local or Trust-wide controls placed on recruitment to vacant positions, such as vacancy control panels

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

10.3.3 A manager may only action such a change against those cost centres/budgets for which theyhe/she haves formal responsibility.

10.3.4 Advertisements for all posts must be placed via the Human ResourcesPeople Directorate

10.4 Processing Payroll

10.4.1 The Chief Financial Officer is responsible for:

(a) Performance managing the outsourced payroll provision to ensure it is in line with the contract and service continuity in maintained

(b) Where necessary reporting any variations to the contract or significant areas of risk in relation to the service to the Trust Board

(c) Specifying timetables for submission of properly authorised time records and other notifications

(d) The final determination of pay and allowances

(e) Making payment on agreed dates

(f) Agreeing method of payment

10.4.2 The Chief Financial Officer will issue instructions regarding:

(a) Verification and documentation of data

(b) The timetable for receipt and preparation of payroll data and the payment of employees and allowances

(c) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay

(d) Security and confidentiality of payroll information

(e) Checks to be applied to completed payroll before and after payment

(f) Authority to release payroll data under the provisions of the Data Protection Act

(g) Methods of payment available to various categories of employee and officers. This will be by bank credit direct to a bank or other financial institution nominated by the employee

(h) Procedures for payment by cheque or bank credit to employees and officers

(i) Procedures for the recall of cheques and bank credits

(j) Pay advances and their recovery

(k) Maintenance of regular and independent reconciliation of pay control accounts

(l) Separation of duties of preparing records and handling cash

(m) A system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust

10.4.3 Appropriately nominated managers, including HR representatives have delegated responsibility for:

(a) Submitting time records, and other notifications in accordance with agreed timetables

(b) Completing time records and other notifications in accordance with the Chief Financial Officer's instructions and in the form prescribed by the Chief Financial Officer

(c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of employees or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the appropriate Director or Budget Holder and payroll must be informed immediately

10.4.4 Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of Employment

10.5.1 The Board shall delegate responsibility to the ~~Human Resources Director~~Chief People Officer for:

(a) Ensuring that all employees are issued with a Contract of Employment which complies with employment legislation

(b) Ensuring controls are in place for actioning variations to, or termination of, contracts of employment. The transacting of this responsibility has been delegated to the line manager

(c) Any pay rates outside national terms and conditions will need prior agreement by the Chief Financial Officer and the Chief People Officer~~Human Resources Director~~; this will include changes to bank rates as well as substantive posts.

(d) The Chief People ~~Human Resources Director will~~Officer will maintain a schedule of all pay rates outside the national terms and conditions and will notify payroll of any changes. The Chief People officer will notify Executive Directors of this schedule at least on an annual basis.

11. NON-PAY EXPENDITURE

11.1 Delegation of Authority

11.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to Budget Holders prior to the start of the financial year to which the budget relates.

11.1.2 The Chief Executive will set out in the Scheme of Delegation:

(a) The list of employees who are authorised to place requisitions for the supply of goods and services

(b) The maximum level of each requisition and the system for authorisation above that level.

Authority Delegated To	Requisition of Goods and Services	Authorisation of Non Purchase Order Invoices *
Budget Administrators	£0 to £5,000	£0 to £5,000
Budget Managers	£0 to £20,000	£0 to £20,000
Budget Holders	£0 to £20,000	£0 to £20,000
Director of Finance	£20,001 to £100,000	£20,001 to £100,000
Chief Financial Officer	£100,001 to £250,000	£100,001 to £250,000
Chief Executive	£250,001 to £500,000	£250,001 to £500,000
Performance and Finance Committee	£500,001 to £1,500,000	£500,001 to £1,500,000
Trust Board	£1,500,001 and above	£1,500,001 and above

Authority Delegated To	Requisition of Goods and Services	Authorisation of Non Purchase Order Invoices *
Budget Administrators	£0 to £5,000	£0 to £5,000
Budget Managers	£0 to £20,000	£0 to £20,000
Budget Holders	£0 to £20,000	£0 to £20,000
Director of Finance	£20,001 to £100,000	£20,001 to £100,000
Chief Financial Officer	£100,001 to £250,000	£100,001 to £250,000
Chief Executive	£250,001 to £500,000	£250,001 to £500,000
Performance and Finance Committee	£500,001 to £1,000,000	£500,001 to £1,000,000
Trust Board	£1,000,001 and above	£1,000,001 and above

Table 6 *As per the agreed Non PO lists (section 11.2.21)

11.1.3 The authorisation levels for pharmacy drugs requisitions are separately agreed as set out in the table below. Requisitions up to a value of £25170,000 are authorised within the Pharmacy team.

Pharmacy Only : Authority Delegated To	Requisition of Goods and Services (Drugs and Pharmacy Consumables)
Senior Assistant Technical Officer (Band 3) Procurement or Senior Assistant Technical Officer (Band 3) Cancer Services	£0 to £35,000

Senior Pharmacy Technician (Band 5) Procurement or Senior Pharmacy Technician (Band 5) Cancer Services	£0 to £65,000
Lead Procurement Pharmacy Technician (Band 6) or Lead Cancer /Technical Services Pharmacy Technician (Band 6) or Chief Clinical Information Pharmacy Technician (Band 7) or Chief Pharmacy Technician Cancer / Technical Services (Band 7) or Pharmacy Supply Chain Manager (Band 7) or Procurement and Renal Pharmacist (Band 7) or High Cost and Homecare Pharmacist (Band 8a) or Clinical Commissioning and Medicines Value Lead (Band 8b) or Advanced Specialist Pharmacist Cancer (Band 8a/8b)	£65,001 to £150,000
Clinical Director of Pharmacy or Deputy / Principal Pharmacist (8c).	£120,001 to £250,000
Chief Financial Officer	£250,001 to £500,000
Chief Executive	£500,001 to £1,000,000
Performance and Finance Committee	£1,000,001 to £1,500,000
Trust Board	£1,500,001 and above

~~11.1.3~~

Pharmacy Only : Authority Delegated To	**Requisition of Goods and Services (Drugs and Pharmacy Consumables)**
Senior Assistant Technical Officer (ATO) Procurement and Senior Pharmacy Technician	£0 to £35,000
Lead Procurement Technician (Band 6) or Chief Clinical Information Technician (Band 7) or Pharmacy Supply Chain Manager (Band 7) or High Cost and Homecare Pharmacist (Band 8a) or Clinical Commissioning and Medicines Value Lead (Band 8b).	£35,001 to £120,000
Clinical Director of Pharmacy or Deputy / Principal Pharmacist (8c).	£120,001 to £170,000
Chief Financial Officer	£170,001 to £250,000
Chief Executive	£250,001 to £500,000
Performance and Finance Committee	£500,001 to £1,000,000
Trust Board	£1,000,001 and above

Table 7

11.1.4 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

11.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Integrated Supplies and Procurement department shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

11.2.2 The Integrated Supplies and Procurement Department, with input from the Finance Department, will be responsible for maintaining the list detailing the areas of expenditure that do not require a

Purchase Order. This list will be known as the 'Agreed Non Purchase Order List' and will list specific suppliers. Any suppliers contained within the Agreed Non Purchase List will not require a purchase order and will therefore be exempt from the Trusts requisition approval process.

11.2.3 Under no circumstances should a requisition be split in such a way to circumvent particular spending limits attached as per the Scheme of Delegation.

11.2.4 The limits set out for the requisition of goods and services in table 6 are managed by the use of the Trust eREAF approval system.

~~11.2.3~~11.2.5 A separate system will be in place within the Estates, Facilities and PFI Department for the requisition of additional goods and services through the PFI. This will maintain delegated limits and authorization levels as shown in Table 7 above.

~~11.2.4~~11.2.6 The Chief Financial Officer shall be responsible for the prompt payment of accounts, invoices and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

~~11.2.5~~11.2.7 The Chief Financial Officer will:

(a) Advise the Trust Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SFIs and regularly reviewed

(b) Prepare procedural instructions, or guidance within the Scheme of Delegation, on the obtaining of goods, works and services incorporating the thresholds

(c) Be responsible for the prompt payment of all properly authorised accounts and claims

(d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board employees (including specimens of their signatures) authorised to certify invoices against specific cost centre codes

(ii) Certification that goods have been duly received, examined and are in accordance with specification or work done or services rendered have been satisfactorily carried out in accordance with the order, the prices are correct and, where applicable, the materials used are of the requisite standard and the charges are correct

(iii) In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time worked, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined

(iv) Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained

(v) The account is arithmetically correct

(vi) The account is in order for payment

(vii) A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(viii) Instructions to employees regarding the handling and payment of accounts within the Finance Department

(e) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI 11.3.

11.3 Prepayments

11.3.1 Prepayments for goods and services where the Trust is paying in advance of receipt of the goods or services, excluding payments for training courses, subscriptions and membership fees up to the value of £5,000 (inclusive of VAT) are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages and with the explicit approval of the Chief Financial Officer

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments

(c) The Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contract Regulations (2015) (PCR) ~~EU public procurement rules~~ where the contract is above a stipulated financial threshold)

(d) The Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered

11.4 Official purchase orders

11.4.1 Official purchase orders must:

(a) Be consecutively numbered

(b) Be in a form approved by the Chief Financial Officer

(c) State the Trust's terms and conditions of trade

(d) Only be issued to, and used by, those duly authorised by the Chief Executive

11.5 Duties of Managers and Officers

11.5.1 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

(a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made

(b) Contracts above specified thresholds are advertised and awarded in accordance with Public Contract Regulations (2015) (PCR) ~~EU rules~~ on public procurement

(c) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care

(d) In accordance with the Trust's Standards of Business Conduct Policy (G16), no order shall be issued for any item or items to any firm which has made an offer of gifts (see SFI 19), reward or benefit to Directors or employees, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars

(ii) Conventional hospitality, such as lunches in the course of working visits

(e) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive

(f) All goods, services, or works are ordered on an official purchase order except for purchases from petty cash or with explicit approval of the Chief Financial Officer

(g) Verbal orders must only be issued very exceptionally, by an employee designated by the Chief Executive and only in cases of emergency. These must be confirmed by an official purchase order and clearly marked "Confirmation Order"

(h) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds and should be placed for the value for the life of the contract.

(i) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase

(j) Purchases from petty cash are restricted to a maximum value of £50 and by type of purchase in accordance with instructions issued by the Chief Financial Officer

(k) Petty cash records are maintained in a form as determined by the Chief Financial Officer

11.5.2 Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Public Contract Regulations (2015) (PCR)~~EU regulations~~, PFI and P22 (including NEC contracts) and Health Building Note 00-08. The technical audit of these contracts shall be the responsibility of the relevant Director.

11.6 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

11.6.1 Payments to local authorities and voluntary organisations, made under the powers of section 28A of the NHS Act, for the provision of social care for people who otherwise would be the responsibility of the NHS, shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with these Acts.

11.6.2 Where NHS Trusts are proposing to enter into partnership arrangements e.g. joint ventures, joint arrangements or special vehicles. NHS~~I~~/E will reserve the right to review these on a case by case basis and these schemes may require NHS~~I~~/E approval to proceed.

11.7 Leases

11.7.1 The Chief Financial Officer must ensure that any lease entered into on behalf of the Trust represents value for money.

11.7.2 A commercial lease is a legally binding contract made a landlord and a business tenant. The lease gives a tenant the right to use certain property for a business or commercial activity for a period of time (minimum 6 months) in exchange for consideration (i.e. money) paid to the landlord. A commercial lease offers exclusive possession of a defined area (demise), with the main legislation being the Landlord and Tenant Act 1954.

11.7.3 A licence to occupy is a legal agreement between the licensor (the party who owns the property/land) and the licensee (the party seeking to occupy the property/land), giving the licensee the right to occupy a designated area of the property for a defined length of time (i.e. there is no minimum of maximum period but is usual for licences to be for 1 day to 6 months or more). Licences do not offer exclusive possession but rather the designated area can be relocated.

11.7.4 Contracts for goods and services can also contain leases under IFRS16, which defines a lease as as "a contract, or part of a contract, that conveys the right to use an asset for a period of time in exchange for consideration". These contracts will contain a lease if the following three criteria are met

- there is an 'identified asset';
- we obtain substantially all of the economic benefits from the use of the asset; and

we have the right to direct the use of the asset

~~. These contracts, mainly for equipment or vehicles, will contain a lease if the Trust has the right to obtain substantially all of the economic benefits from use of a an asset, for example by having exclusive use of the asset over the period of the lease, and the Trust has the right to direct the use of the identified asset. In effect, the Trust decides how the asset will be used and for what purpose~~.

~~11.7.4~~11.7.5 These three main indicators will determine whether an arrangement is a lease, and a balanced judgement needs to be taken which considers the indicators as a whole. Guidance must be obtained from the Finance Department regarding the accounting treatment of leases and all other contracts that may be defined as a lease as described in 11.7.4 above

~~11.7.5~~11.7.6 Once appropriate guidance has been obtained all~~lll~~All leases and contracts for goods and equipment must be forwarded to the Integrated Supplies and Procurement Department to validate the legal content of the lease/contract and for inclusion on the goods and equipment Lease Contracts Register.

~~11.7.6~~11.7.7 Once appropriate guidance has been obtained all~~lll~~All leases and contracts for premises must be forwarded to the Estates, Facilities and PFI Department to validate the legal content of the lease/contract and for inclusion on the premises Lease Contracts Register.

~~11.7.7~~11.7.8 ~~Further guidance must be obtained from the Finance Department regarding the accounting treatment of leases and the definition of a finance lease and an operating lease.~~

12 EXTERNAL BORROWING

12.1 Borrowings

12.1.1 The Chief Financial Officer will advise the Trust Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health and Social Care. The Chief Financial Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans.

12.1.2 The Trust Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Financial Officer.

12.1.3 The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans.

12.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money and comply with the latest guidance from the Department of Health and Social Care.

12.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Financial Officer. The Trust Board must be made aware of all short term borrowings at the next Board meeting.

12.1.6 All long-term borrowing must be consistent with the plans outlined in the Integrated Business Plan and be approved by the Trust Board.

13 CAPITAL INVESTMENT, PRIVATE FINANCING, ASSET REGISTERS AND SECURITY OF ASSETS

13.1 Capital Investment

13.1.1 The Chief Executive:

(a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans

(b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost

(c) Shall ensure that the capital investment is not undertaken without confirmation of purchaser/s support and the availability of resources to finance all revenue consequences, including capital charges. Any resource requirements outside of agreed budgets will be taken through the required authorisation process

(d) That a Capital Investment Programme, produced on an annual basis, is submitted to and approved by the Trust Board prior to the start of the financial year

13.1.2 The approval of a capital programme shall not constitute approval for expenditure on any scheme, i.e. a completed capital bid and, where applicable, capital business case will still be required.

13.1.3 For all capital expenditure proposals the Chief Executive shall ensure that:

(a) A capital bid is prepared and approved through the agreed process

(b) All proposals to lease, hire or rent tangible and intangible assets have been subject to appraisal of their impact on the Trust's ability to achieve its financial targets and, where appropriate, subject to legal advice from the Trust's legal advisor on the terms of the proposed contract

13.1.4 The Chief Executive shall issue to the manager responsible for any scheme:

(a) Specific authority to commit expenditure

(b) Authority to proceed to tender

(c) Approval to accept a successful tender

13.1.5 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's SOs and SFIs.

13.1.6 The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 246.

13.2 Delegation and reporting

13.2.1 The general rules applying to delegation and reporting shall also apply to capital expenditure.

13.2.2 Expenditure on tangible and intangible assets for the Trust must follow the correct delegation and reporting lines specifically designed for approval of capital expenditure detailed in the

Scheme of Delegation. Accounting for tangible and intangible assets must comply with the DHSC Group Accounting Manual

13.2.3 A separate capital budget must be prepared for each capital scheme.

13.2.4 Each capital allocation is made on an expenditure basis for a specific financial year. Any proposed/anticipated slippage or variation in cost on a capital scheme must be reported to the Chief Financial Officer at the earliest opportunity.

13.2.5 Any proposed advancement of all, or part of, a capital scheme must receive the authorisation of the Chief Financial Officer prior to its execution. The Chief Financial Officer may, in consultation with the responsible Director, approve variations to schemes included within the capital programme as approved by the Trust Board.

13.2.6 Progress on each capital scheme should be reviewed at least monthly and a projection to the year end updated. Any significant changes must be notified to the Trust Board at the earliest opportunity.

13.2.7 The Chief Financial Officer will specify the process and timetable to be followed by the Trust for compiling the annual and future capital plans for the Trust.

13.2.8 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode".

13.2.9 The Chief Financial Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance.

13.2.10 The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.2.11 The relevant capital project Director is responsible for the selection of architects, quantity surveyors, consultant engineers, IT engineers, other professional advisors and service providers within procurement and Public Contract Regulations (2015) (PCR)~~EU regulations~~.

13.3 Capital charges

13.3.1 Prior to the commencement of a financial year, at a time determined by the Chief Financial Officer, an estimate of capital values and capital charges incurred by the Trust for the ensuing year will be calculated. This will be based on the current asset register and will take account of known future purchases, sales, revaluations and any other anticipated transactions.

13.3.2 During the financial year the capital charges will be calculated on a monthly basis. Projections for the remainder of the financial year will be updated taking into account any revised expectation of the timing and value of transactions on the asset register.

13.4 Capital definition and criteria

13.4.1 Capital expenditure is defined as expenditure on a tangible or intangible productive resource with an expected life in excess of one year.

13.4.2 The capitalisation limit is expenditure of £5,000 (inclusive of VAT) or more on:

(a) A discrete asset

(b) A collection of assets which individually may be valued at less than £5,000 but which together form a single collective asset because the items fulfil all of the following criteria:

(i) The items are functionally interdependent

(ii) The items are acquired at about the same date and are planned for disposal at about the same date

(iii) The items are under single managerial control

(iv) The items have an individual value of £250 or more

(c) At the Trust discretion, a collection of assets which individually may be valued at less than £5,000 but which form part of the initial equipping and setting up of a cost of a new building

13.4.3 Capital budgets must not be used to cover purchases that do not conform to the current capital definition as specified by the Department of Health and Social Care.

13.4.4 Major expenditure on maintaining the condition of an asset will normally be treated as a revenue item except that any proportion relating to an enhancement to the asset will be treated as capital.

13.4.5 For land and building payments the amount capitalised can include lump sum payments for related rights (including capitalised rents) and payments made under the Land Compensation Act 1973.

13.4.6 Bids for capital spend should be made following the process as specified by the Chief Financial Officer. Capital bids will be classified as either investment capital or replacement capital, these are defined as:

(a) Investment capital - this is capital spend for new assets where it likely that the Trust will incur additional revenue consequences for example. staffing, consumables etc. A supporting case, relevant to the level of investment is required for investment capital funding – see 13.5.2

(b) Replacement capital – this is capital spend which is replacing an existing asset that the Trust already holds, it is unlikely that a result of this additional capital spend, additional revenue consequences will be incurred. Business cases may be required at the discretion of the Chief Financial Officer

13.5 Capital business cases

13.5.1 A supporting case, relevant to the level of investment, is required for all new capital investment, investment capital, if it is not relating to the replacement of an existing asset

13.5.2 The annual budget will detail the Capital schemes for the coming year. A summary of the internal capital approval limits for schemes included in the annual plan is as below:

Capital Approval Limits	Investment Value £	Incremental (additional) income or revenue (higher of) included within ALL Capital bids			
		<£25k	£25k to <£500k	£500k to <£1.5m	£1.5m to <£25m
- - Investment capital	<£100k	Statement of Need to CIG	Business case to Exec Team	Business case to PFC	Business case to Trust Board
	£100k - <£1m	Business case to	Business case to	Business case to	Business case Trust

-		Exec Team	Exec Team	PFC	Board
- -	£1m - <£3m	Business case to PFC	Business case to PFC	Business case to PFC	Business case to Trust Board
- -	£3m - <£25m	Business case to Trust Board	Business case to Trust Board	Business case to Trust Board	Business case to Trust Board
Maintenance Capital	ALL	No case required	Business case to Exec Team	Business case to PFC	Business case to Trust Board

Capital Approval Limits	Investment Value £	Incremental (additional) income or revenue (higher of) included within ALL Capital bids			
		<£25k	£25k-<£500k	£500k - <£1m	£1m - <£15m
Investment capital	<£100k	Statement of Need to CIG	Business case to Exec Team	Business case to PFC	Business case to Trust Board
	£100k - <£1m	Business case to Exec Team	Business case to Exec Team	Business case to PFC	Business case Trust Board
	£1m - <£3m	Business case to PFC	Business case to PFC	Business case to PFC	Business case to Trust Board
	£3m - <£15m	Business case to Trust Board	Business case to Trust Board	Business case to Trust Board	Business case to Trust Board
Maintenance Capital	ALL	No case required	Business case to Exec Team	Business case to PFC	Business case to Trust Board

Table 8

~~13.5.2~~13.5.3 Schemes not identified in the annual plan will require Executive Team sign off, unless agreed as part of the business case process or agreed by the Trust Board.

~~13.5.3~~13.5.4 The Performance and Finance Committee (PFC) will approve the capital business case process.

~~13.5.4~~13.5.5 The Trust Board will approve the capital programme as part of the annual plan. The Trust's Capital Investment Group (CIG) has delegated authority from the Trust Board to approve capital investment cases up to £1~~,0~~00,000 as identified in the programme approval table at 13.5.2

13.5.6 NHS~~I~~/E is also required to approve any individual capital investments which exceed £2~~1~~5,000,000, following Trust Board approval being given. The limit can be reduced at the

discretion of NHSI/E where a Trust is reporting a year end deficit. A summary of the external business case approval limits is shown below. The approval process for investments below the values quoted but falling within the exceptions criteria will be agreed with NHSI/E on an individual basis.

Investment value	Approval body	Key stage documentation	Self assessment Business case core checklist required	Indicative Review Timescales
Up to £25m	Internal	Trust's internal governance process	No	Internal
£25m to £30m	NHSE and DHSC	OBC and FBC required (SOC also required for any scheme requiring DHSC finance)	Yes, plus the clinical quality checklist for all business cases with a patient facing or business case aspect.	8 weeks
£30m to £50m	NHSE Resources Committee and DHSC	SOC,OBC and FBC required (or SOC, ABC, CBC or Lift stage 1 and 2 equivalent for PFI/PF2 or LIFT)	Yes, plus the clinical quality checklist for all business cases with a patient facing or business case aspect.	8 - 12 weeks
Over £50m	NHSE Resources Committee and Board, DHSC and HMT	SOC,OBC and FBC required (or SOC, ABC, CBC or Lift stage 1 and 2 equivalent for PFI/PF2 or LIFT)	Yes, plus the clinical quality checklist for all business cases with a patient facing or business case aspect.	8 - 12 weeks Plus

Investment value	Approval body	Key stage documentation	Self assessment Business case core checklist required	Indicative Review Timescales
Up to £15m	Internal	Trust's internal governance process	No	Internal
£15m to £30m	NHSI/E and DHSC	OBC and FBC required (SOC also required for any scheme requiring DHSC finance)	Yes, plus the clinical quality checklist for all business cases with a patient facing or business case	8 weeks
£30m to £50m	NHSI/E Resources Committee and DHSC	SOC,OBC and FBC required (or SOC, ABC, CBC or Lift stage 1 and 2 equivalent for PFI/PF2 or LIFT)	Yes, plus the clinical quality checklist for all business cases with a patient facing or business case	8 - 12 weeks
Over £50m	NHSI/E Resources Committee and Board, DHSC and HMT	SOC,OBC and FBC required (or SOC, ABC, CBC or Lift stage 1 and 2 equivalent for PFI/PF2 or LIFT)	Yes, plus the clinical quality checklist for all business cases with a patient facing or business case aspect.	8 - 12 weeks Plus

Table 9

~~13.5.5~~13.5.7 Capital business cases have to go through all the relevant approval groups dependent on values, so for example, a case of over £2~~1~~5,000,000 will require approval from CIG, who will then recommend to PFC, who will recommend to Trust Board for approval. The case will then be recommended to NHS~~I~~/E for approval.

~~13.5.6~~13.5.8 The values quoted in SFI 13.8 are inclusive of VAT.

~~13.5.7~~13.5.9 For capital schemes relating to I.T, leased equipment, leased property, managed equipment and managed service schemes, the delegated limits apply to whole life costs, not just the capital cost. Schemes with whole life costs in excess of NHS Trust delegated limits will require NHS~~I~~/E approval in line with the delegated limits.13.5.9 For leased property; the limits apply to the whole-life cost of the transaction, rather than just capital cost.

~~13.5.8~~13.5.10 Total capital cost to the private sector (i.e. Private Finance Initiatives (PFI)) includes the cost of construction, equipment, professional fees, rolled-up interest and financing costs such as bank arrangements fees, bank due diligence fees, banks lawyers' fees, and third party equity costs plus irrecoverable VAT. Any capital cost that will be incurred directly by the NHS in progressing the schemes must also be included. Typical examples include land purchased from outside the NHS, equipment and enabling works.

~~13.5.9~~13.5.11 Where NHS Trusts are requesting transfers of assets and/or services between organisations NHS Trusts are asked to contact the relevant NHS~~I~~/E Director of Delivery and

Development and/or Business Support teams who will advise on how to take these forward. Asset transfers with a value in excess of NHS Trust delegated limits will require a business case and NHSI/E approval in line with the delegated limits detailed in SFI 13.5.5.

13.6 Private Finance Initiatives (PFI)

13.6.1 Any contract variations to the PFI schemes ~~involving PFI (new schemes or contract variations)~~require approval in line with trust processes. Any additional cost impact of these variations will require business case and requisition approval as set out in 4.6.1 and 11.2.5.

13.6.2 If the Trust was classified as being in distress, any variations, irrespective of value, will also require discussion with the NHSI/E to agree the approval requirements. This approval would not apply to variations which relate to building or service changes where there is no change in risk profile required to deliver the changing requirements of NHS services.

~~13.6.3 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its allocations, the following procedures shall apply:~~

~~(a) The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector~~

~~(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health and Social Care or in line with any current guidelines~~

~~(c) The proposal must be specifically agreed by the Trust Board (except for additional capital spending to existing PFI contracts which will follow the Trust's authorisation thresholds that are in place for non PFI capital)~~

~~(d) The proposed capital spend must be approved in accordance with the Trust's business planning and capital approval thresholds that are in place for procuring assets through the non PFI route~~

13.7 Asset Registers

13.7.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted on a rolling programme detailed within financial procedures for tangible and intangible assets.

13.7.2 The Trust shall maintain an asset register recording tangible and intangible assets at a value as required by the Group Accounting Manual.

13.7.3 Additions to the tangible and intangible asset register must be clearly identified to an appropriate asset manager and be validated by reference to:

(a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties

(b) Stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) Lease agreements in respect of assets held under a right of use asset.

13.7.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.7.5 The Chief Financial Officer shall approve procedures for reconciling balances on the relevant general ledger against balances on the asset registers.

13.7.6 The carrying value of each asset shall be assessed and impaired or revalued to current values in accordance with the Trust's Accounting Policies and relevant accounting standards.

13.7.7 The value of each asset shall be depreciated using methods and rates as specified in the Trust's Accounting Policies and relevant accounting standards.

13.8 Security of Assets

13.8.1 The overall control of assets is the responsibility of the Chief Executive.

13.8.2 Asset control procedures (including tangible and intangible assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

(a) Recording managerial responsibility for each asset

(b) Identification of additions and disposals

(c) Identification of all repairs and maintenance expenses

(d) Physical security of assets

(e) Verification of the existence of, condition of, and title to, assets recorded

(f) Identification and reporting of all costs associated with the retention of an asset

(g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments

13.8.3 All discrepancies revealed by verification of physical assets to the asset register shall be notified to the Chief Financial Officer. Where instances of theft or fraud are suspected, a report will be made to the Local Security Management Specialist or the Local Counter Fraud Specialist, as applicable.

13.8.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Trust Board members and senior employees in all disciplines to apply such appropriate routine security practices as may be determined by the Trust Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

13.8.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by employees and officers in accordance with the policy for reporting losses.

13.8.6 Where practical, assets should be marked as Trust property.

13.8.7 All budget and department managers are responsible for confirming the accuracy of the asset register of all assets of the Trust within their area of responsibility.

14 STORES AND RECEIPT OF GOODS

14.1 General position

14.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) Kept to a minimum

(b) Subjected to minimum annual stock take

(c) Valued at the lower of cost and net realisable value

14.2 Control of stores, stocktaking, condemnations and disposal

14.2.1 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer. The control of any Pharmaceutical stocks shall be the responsibility of thea ~~designated Pharmaceutical Officer~~Clinical Director of Pharmacy, the control of theatre stocks shall be the responsibility of the designated theatres manager and the control of any fuel, oil and coal of a designated estates manager.

14.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/~~Pharmaceutical Officer~~Clinical Director of Pharmacy. Wherever practicable, stocks should be marked as NHS property.

14.2.3 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

14.2.4 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year

14.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

14.2.6 The designated Manager shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14.3 Goods supplied by NHS Supply Chain

14.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Financial Officer who shall satisfy himself that the goods have been received before accepting the recharge.

14.4 Consignment stock

14.4.1 Consignment stocks are those items that remain the property of the supplier until used, but remain on the Trust's site for practical reasons.

14.4.2 Any consignment stock held must have been approved in accordance with the delegation of authority and must be kept to an agreed minimum level. Consignment stock must not be included in the Trust's stock value but separate records must be kept

14.4.3 It is the responsibility of the authorised senior manager / ~~Associate Director~~Director of Operations to ensure that SFI 14.4 is followed.

14.4.4 Any documentation that sets out the terms and conditions of the consignment stock arrangements must be approved by the Trust's Integrated Supplies and Procurement Department.

15. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

15.1.1 The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of a Trust asset, the Budget Manager or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice from the Integrated Supplies and Procurement department where appropriate.

15.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer

(b) Recorded by the Condemning Officer (Budget Manager) in a form approved by the Chief Financial Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer. For any tangible and intangible asset disposals this should be accompanied by a completed asset disposal form.

15.1.4 The Condemning Officer (Budget Manager) shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

15.1.5 A business case will need to be submitted to NHS~~I~~E where disposal proceeds are above the Trust's delegated limits. The business case will need to make the case for both the disposal and the retention of proceeds. The Trust will retain and reinvest the proceeds subject to business case approval by NHS~~I~~E. As a minimum the disposal and retention business case will need to give indication of what the retained receipts will be used for example reinvested in healthcare buildings/infrastructure. The authorisation limits applicable to capital disposals are in line with those for capital investment as detailed in SFI 13.5.

15.2 Losses and Special Payments

15.2.1 The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for losses and special payments.

15.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department who must immediately inform the Chief Executive and the Chief Financial Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Financial Officer and/or the Chief Executive.

15.2.3 If any level of theft or criminal damage is suspected the Chief Financial Officer must immediately inform the police and Security Management Director

15.2.4 For losses or special payments caused or apparently caused by theft, fraud (see SFI 2), criminal damage (including arson), and neglect of duty or gross carelessness (except if trivial /immaterial) the Chief Financial Officer must immediately notify the Trust Board and the External Auditor.

15.2.5 In all cases of alleged fraud, bribery or corruption the Local Counter Fraud Specialist must be notified, as well as the ~~NHS Counter~~NHS Counter Fraud Authority ~~must be informed~~ in accordance with the Secretary of State directions.

15.2.6 Within limits delegated to it by the Department of Health and Social Care, the Trust Board shall approve the writing-off of losses and special payments.

15.2.7 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.8 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made against insurers.

15.2.9 The Chief Financial Officer shall maintain a Losses and Special Payments Register and the Audit Committee may at any time request to see this register.

15.2.10 All losses and special payments must be reported to the Audit Committee at every meeting.

15.2.11 The Scheme of Delegation details the financial limits in respect of losses and special payments.

16. INFORMATION TECHNOLOGY (IT)

16.1 Responsibilities and duties of the Director of ~~IM&T~~Digital Transformation

16.1.1 The Director of ~~IM&T~~Digital Transformation, who is responsible for the security of the computerised financial data of the Trust, shall:

(a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they are~~he/she is~~ responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act ~~1998~~2018

(b) Ensure the safe environment of the system, its security, privacy, data back-ups and protection against viruses,

(c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment

(d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out

16.1.2 The Chief Financial Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation following Information Technology Infrastructure Library (ITIL) procedures. Information and guidance on these procedures can be obtained from the ICT Service Delivery Manager. Where this is undertaken by another organisation, Trust ITIL procedures must be followed by them prior to implementation and assurances of adequacy obtained.

16.1.3 The ~~Clinical Governance, Audit and Risk Department~~Data Security and Protection team shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

16.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

16.2.1 The Director of ~~IM&T~~Digital Transformation manages the Information Technology (IT) function.

16.2.2. In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the region wish to sponsor jointly) all responsible Directors and employees will send to the Chief Financial Officer:

(a) Details of the outline design of the system

(b) In the case of packages acquired either from a commercial organisation, from the NHS or from another public sector organisation, the operational requirement

16.2.3 The Director of Digital ~~IM&T shall~~Transformation shall ensure that all computer software held by the Trust is properly licensed and operated in accordance with the terms of the license.

16.3 Contracts for Computer Services with other healthcare bodies or outside agencies

16.3.1 The Director of Digital ~~IM&T shall~~Transformation shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness,

and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

16.4 Risk Assessment

16.4.1. The Director of Digital ~~IM&T shall~~Transformation shall ensure that risks to the Trust arising from the use of IT systems are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

16.5 Requirements for computer systems which have an impact on corporate financial systems

16.5.1 Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall need to be satisfied that:

(a) Systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy

(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists

(c) Finance staff have access to such data

(d) Such computer audit reviews, as are considered necessary, are being carried out

16.5.2 Any changes to such systems must be notified to and approved by the Chief Financial Officer.

17. PATIENTS' PROPERTY

17.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

(a) Notices and information booklets (notices are subject to sensitivity guidance)

(b) Hospital admission documentation and property records

(c) The oral advice of administrative and nursing staff responsible for admissions

(d) Trust website

17.1.3 The Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.1.4 The Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

17.1.5 Property handed over for safe custody shall be placed into the care of the Chief Financial Officer, or their~~his~~ nominee, except where there are no administrative staff present, in which case the property shall be placed into the care of the most senior member of the nursing staff on duty. A member of staff receiving patients' property handed over to him/her by other staff shall sign for its receipt.

17.1.6 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Financial Officer.

17.1.7 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less forms of indemnity shall be obtained.

17.1.8 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.1.9 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17.1.10 Patient Property must be managed as set out in Policy - Management of Patient Property (F16) and as per section 7.4.4 of this policy.

18. FUNDS HELD ON TRUST (DONATED /CHARITABLE FUNDS)

18.1 UHNM Charity

18.1.1 UHNM Charity was set up by the Department of Health and Social Care as the official Charity for the Trust to receives all voluntary income (donated funds) given in support of UHNM NHS Trust (its hospitals, divisions and research etc.)

18.1.2 Donated funds include legacies, donations, grants, trading and money from fundraising activities (including gaming). These may be received from patients, families, members of the public, community groups, grant making trusts and foundations, and businesses, the donated funds are held, on trust, in separate charitable funds that meets the wishes of the donor.

18.1.3 As established by the Secretary of State for Health, UHNM Charity is managed by the UHNM Trust Board as a Corporate Trustee.

18.2 Corporate Trustee

18.2.1. SOs outline the Trust's responsibilities as a corporate trustee (all voting members of the Trust Board are defined as Trustees) for the management of funds it holds on trust, along with SFIs that defines the need for compliance with Charities Commission latest guidance and best practice.

18.2.2 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

18.2.3 The Chief Financial Officer shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

18.3 Accountability to Charity Commission and Secretary of State for Health

18.3.1. The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

18.3.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

18.4 Applicability of Standing Financial Instructions to funds held on Trust

18.4.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

18.4.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

18.4.3 The Trust Board, through delegation to a Sub-Committee, shall approve and monitor spend against an annual budget for the charitable fund.

18.4.4 A schedule of the balances of all general and specific funds will be regularly maintained and periodically published to all appropriate responsible officers. Details of any current proposals for deployment of fund balances will be included in the schedule.

18.4.5 The Charity's audited annual reports and accounts, and any report of the auditor on them, must be presented to the Trust Board in its capacity as the Corporate Trustee for approval.

18.4.6 The Chief Executive will, in respect of each separate specific fund, nominate an appropriate Director, Consultant or Manager to exercise first level authorisation up to the prescribed limit. For expenditure above this level the authorisation of appropriate managers, Executive Directors, Chief Financial Officer or Chief Executive will be required. The limits for authorisation are specified within the Scheme of Delegation.

18.4.7 Further details regarding donated funds held on trust, including the responsibility staff have when receiving a donation, are detailed in policy ~~F06~~ UHNM Charity Policy (F06).

19 HOSPITALITY AND GIFTS (RECEIVING)

19.1 General

19.1.1 The Chief Financial Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff, as set out in Policy on Standards of Business Conduct (G16). This policy is deemed to be an integral part of these SFIs and should be referred to in conjunction with these SFIs.

20. RETENTION OF DOCUMENTS

20.1.1 All NHS records are public records under the terms of the Public Records Act 1958 Sections 3 (1) – (2).

20.1.2 The Trust has a duty under the Public Records Act along with the Records Management Code of Practice for Health and Social Care 2021~~16~~ to ensure the safekeeping and eventual disposal of all types of document. The requirements of all staff members are set out in the Trust's Data Protection Security and Confidentiality Policy (~~IG10~~DSP10) and Information Lifecycle and Records Management (Corporate Records) Policy (DSP16)~~Corporate Records Management Policy (G11).~~ These policies are deemed to be an integral part of these SFIs and should be referred to in conjunction with these SFIs

20.1.3 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health and Social Care guidelines.

20.1.4 The records held in archives shall be capable of retrieval by authorised persons.

20.1.5 Records held in accordance with latest Department of Health and Social Care guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

20.1.6 Where records are required to be stored off-site the Trust will use approved suppliers. Detail available from the Data, Security and Protection ~~Information Governance~~ Team.

21. RISK MANAGEMENT AND INSURANCE

21.1 Risk Management Policy

21.1.1 The Chief Executive shall ensure that the Trust has a Risk Management Policy that meets legal, regulatory and best practice standards, which must be approved and monitored by the Trust Board.

21.1.2 The Trust's Risk Management Policy (RM01) is deemed to be an integral part of these SFIs and should be referred to in conjunction with these SFIs

21.1.3 Compliance with the Risk Management Policy (RM01) supports the Trust's Annual Governance Statement included within the Annual Report and Accounts.

21.2 Insurance: Risk Pooling Schemes administered by NHSLA

21.2.1 The Trust Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks covered by the risk pooling schemes. If the Trust Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

21.3 Insurance Arrangements with Commercial Insurers

21.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) Trust's may enter into commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use

(b) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into

(c) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Financial Officer should consult the Department of Health and Social Care

21.4 Trust Board Procedures for Insurance Cover

21.4.1 Where the Trust Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and necessary. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

21.4.2 Where the Trust Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Trust Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

21.4.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible limit in each case.

University Hospitals of North Midlands NHS
NHS Trust

Policy No. F02
Trust Policy for Scheme of Reservation and Delegation of Powers

The following personnel have direct roles and responsibilities in the implementation of this policy:

- **All Trust Staff**

Version:	**6~~5~~**
Ratified By:	**Trust Audit Committee and Trust Board**
Date Ratified:	**February 2023~~0~~**
Date of Issue via Intranet:	**February 2023~~0~~**
Date of Review:	**February 2026~~2~~**
Trust Contact:	**Strategic Director of Finance**
Executive Lead:	**Chief Financial Officer**

Version Control Schedule

Final Version	Issue Date	Comments
1	December 2014	Document issued to create a standalone policy, previously integrated with F01. Document updated to reflect current practices and adherence to current Department of Health and Social Care guidelines
2	January 2017	Approved by Audit Committee 27 January 2017
3	April 2017	Approved by Audit Committee 28 April 2017
4	January 2020	Approved by Audit Committee 23 January 2020
5	February 2020	Approved by Trust Board 05 February 2020
6	February 2023	Amendments Approved by Audit Committee 02 February 2023 and Trust Board 08 February 2023. Amendments as set out in papers to the Committee /Board.

University Hospitals of North Midlands NHS
NHS Trust

Statement on Trust Policies to be included in all policies

Staff Side and Trade Unions
The University Hospitals of North Midlands NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Equality and Diversity
The University Hospitals of North Midlands aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

Equality Impact Assessment
The organisation aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment tool is designed to help you consider the needs and assess the impact of your policy.

Information Governance
Any Trust policy which impacts on or involves the use and disclosure of personal information (patient or employee) must make reference to and ensure that the content of the policy is comparable with the relevant statutory or legal requirement and ethical standards

Data Protection Bill, General Data Protection Regulations (GDPR) and the NHS Code of Confidentiality
GDPR replaces the EU Data Protection Directive of 1995 and supersedes the law of member states that were developed in compliance with the Data Protection Directive 95/45/EC. Its purpose is to protect the “right and freedom” of natural persons (i.e. livening individuals) and to ensure that personal data is not processed without their knowledge, and, wherever possible, that it is processed with their consent.

Processing includes holding, obtaining, recording, using and disclosing of information and applies to all forms of media, including paper and images. It applies to confidential patient information but is far wider in its scope, e.g. it also covers personal records

Whiles GDPR applies to both patient and employee information, the Confidentiality Code of Practice (COP) applies only to patient information. The COP incorporates the requirements of GDPR and other relevant legislations together with the recommendations of the Caldicott report and medical ethics considerations, in some cases extending statutory requirements and provides detailed specific guidance.

Freedom of Information Act 2000
The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway and timetable for the disclosure, to the public, of the **majority** of corporate information held (but not necessarily created) by this Trust. The Trust has a legal responsibility to proactively provide a large amount of information to the public and to pro-actively respond to specific requests for information. Information will not be disclosed when the Trust can claim legal exemption. Any non-disclosure must be conveyed in writing; quoting the relevant exemption together with signposting to internal and external methods of compliant. Locally, guidance on the DPA, FOIA and COP can be obtained from the Information Governance Manager or the Caldicott Guardian.

Mental Capacity Act

Any Trust policy which may affect a person who may lack capacity should comply with the requirements of the Mental Capacity Act 2005 (MCA)

The MCA and its associated Code of Practice provides the framework for making decisions on behalf of individuals who lack the mental capacity to do these acts or make these decisions for themselves. Everyone working with and/or caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act.

In a day to day context mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear, what to eat etc. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do this for themselves. In particular, it focuses on those who will have a duty of care to a person lacking capacity and explains how the legal rules set out in the Act will work in practice.

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections
The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Care Quality Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.
The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.

Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff.

Human Rights
The Trust is committed to the principles contained in the Human Rights Act. We aim to ensure that our employment policies protect the rights and interests of our staff and ensure that they are treated in a fair, dignified and equitable way when employed at the Trust.

Sustainable Development
The University Hospitals of North Midlands NHS Trust (UHNM) is committed to demonstrating leadership in sustainability and has a Trust Board approved Sustainable Development Management Plan (SDMP): Our 2020 Vision: Our Sustainable Future which sets out the route to developing a world-class healthcare system that is financially, socially and environmentally sustainable.

There are three 'Key Priorities' to aim for by 2020. With the help of employees, key partners and other stakeholders the trust will embed opportunities to:

1. Reduce our environmental impact, associated carbon emissions and benefit from a healthier environment;
2. Improve the resilience of our services and built environment as a result of severe environmental and climatic changes;
3. Embed sustainable models of care and support our local community to be well-connected, healthy, resilient, independent and managing their lives in a positive way.

The SWITCH campaign is designed to achieve these priorities. It is relevant to all departments and all members of staff. The focus is on using resources sustainably in order to provide better patient care, improve health and our working environment.

CONTENTS

CONTENTS 5
1. INTRODUCTION 7
2. STATEMENT 7
3. SCOPE 7
4. DEFINITIONS 7
5. ROLES AND RESPONSIBILITIES 8
6. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION 9
7. MONITORING AND REVIEW ARRANGEMENTS 9
8. REFERENCES 9
Appendix A – RESERVATION OF POWERS TO THE TRUST BOARD 10
1.2 General Enabling Provision 10
1.3 Regulation and Control 10
1.4 Appointments and dismissals 11
1.5 Policy determination 11
1.6 Strategy and Business Plans and Budgets 11
1.7 Direct Operational Decisions 12
1.8 Financial and Performance Reporting Arrangements 12
1.9 Audit Arrangements 12
Appendix B – RESERVATION OF POWERS TO THE COMMITTEES OF THE TRUST BOARD 13
1. Delegation to Committees 13
2. Audit Committee 13
3. Nominations and Remuneration Committee 13
4. Quality Governance Committee 14
5. Performance and Finance Committee 14
6. Transformation and People Committee 15
7. ~~Trustee~~ Charity Committee 15
~~8. Trust Executive Committee ..... 15~~
Appendix C - SCHEME OF DELEGATION 16
1. General 16
2. Duties delegated as per the Accounting Officer Memorandum 16
2.2 Chief Executive 16
2.3 Chief Executive and Chief Financial Officer 17
2.4 Chief Financial Officer 17
2.5 Chairman and Associate Director of Corporate Governance 17
3. Duties delegated from the Code of Conduct and Accountability 18

3.2 Trust Board....18
3.3 All Trust Board Members....19
3.4 Chairman....19
3.5 Chief Executive....20
3.6 Non-Executive Directors....20
3.7 Chairman and Directors....20
4. Duties delegated from the Trust's Standing Orders (SOs)....21
5. Duties delegated from the Trust's Standing Financial Instructions (SFIs)....22
6. Detailed scheme of delegation....30

1. INTRODUCTION

1.1 Standing Order (SO) 4 "Arrangements for the exercise of Trust functions by delegation" states that subject to such directions as may be given by the Secretary of State, the Trust Board may make arrangements for the exercise, on behalf of the Trust Board, of any of its functions by a Committee, Sub-Committee appointed by virtue of SO 4, or by an officer of the Trust, or by another body as defined in SO 4.1.2, in each case subject to such restrictions and conditions as the Trust thinks fit.

1.2 The purpose of this policy is to set out the powers reserved by the Trust Board, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. The Trust Board remains accountable for all of its functions; even those delegated to the Chairman, individual directors or officers and therefore, expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

2. STATEMENT

2.1 To provide details of the powers reserved by the Trust Board and the powers delegated to other officers of the Trust.

3. SCOPE

3.1 This policy applies to all areas of the Trust and all individuals employed by the Trust including contractors, voluntary workers, students, locum and agency staff and those holding honorary contracts.

4. DEFINITIONS

4.1 Detailed below is a list of terms used in this document and a definition of their meaning.

Term	Definition
Budget	Resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust. The budget should, wherever possible, also be supported by budgets relating to workforce and workload.
Budget Administrator	Employee with delegated authority from a Budget Manager (to a limit of £5,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Manager	Employee with delegated authority from a Budget Holder (to a limit of £25,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Holder	Director or employee with delegated authority to manage finances (Income and expenditure to a limit of £50,000) for a
Departmental Manager	Director or Employee at Band 8a or above responsible for authorisation in line with ~~Human Resources~~People Directorate policies

Term	Definition
	specific area of the organisation
Chairman	The person appointed to lead the Trust Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole
Chief Executive	Chief officer of the Trust
Chief Financial Officer	Chief Financial Officer of the Trust
Director of Finance	Financial Director for the Trust with powers delegated from the Chief Financial Officer
~~He/she or his/her~~	~~Where this term appears this term is to be taken as referring to the post holder and is interchangeable as the gender of that post holder changes~~
Scheme of Reservation and Delegation of Powers. Policy number F02	Document which sets out the powers reserved by the Trust Board, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. . Referred to as 'the Scheme of Delegation' within this document.
Standing Financial Instructions (SFIs). Policy number F01	Document detailing the financial responsibilities, policies and procedures adopted by the Trust. . Referred to as 'the SFIs' within this document.
Standing Orders. Policy number G19	Document which sets out the regulation of the Trust proceedings and business. Referred to as the SOs in this document.
Trust	University Hospital of North Midlands NHS Trust
Trust Board	Board of the Trust

Table 1

4.2 Wherever the title Chief Executive, Chief Financial Officer or other nominated officer is used in this Scheme of Reservation and Delegation of Powers, it shall be deemed to include such other Director or employees who have been duly authorised to represent them.

4.3 Wherever the term "employee" and the context permits, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

5. ROLES AND RESPONSIBILITIES

5.1 Role of Chief Executive

5.1.1 All powers of the Trust which have not been retained as reserved by the Trust Board or delegated to an Executive Committee or Sub-Committee shall be exercised on behalf of the Trust Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally and which functions have been delegated to other Directors and Officers.

5.1.2 All powers delegated by the Chief Executive can be reassumed by him/her should the need arise. As Accounting Officer the Chief Executive is accountable for the funds entrusted to the Trust.

5.2 Role of all Directors and Officers

5.2.1 Powers are delegated to Directors and Officers on the understanding that they would not exercise delegated powers in a matter in which their judgment was likely to be cause for public concern.

5.2.2 This policy shows only the "top level" of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other procedures within the Trust.

5.2.3 In the absence of a Director or Officer to whom powers have been delegated, those powers shall be exercised by that Director or Officers deputy unless alternative arrangements have been requested by the Trust Board.

6. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

6.1 Training or support on the use of this policy can be obtained from the ~~Assistant~~ Deputy Director of Finance – Financial Controller and the Director of Strategic Finance~~.~~

7. MONITORING AND REVIEW ARRANGEMENTS

7.1 Monitoring Arrangements

7.1.1 In accordance with SOs, the Trust Board shall formally establish a committee of independent members, as an Audit Committee, with formal Terms of Reference, which includes ensuring compliance with the Scheme of Reservation and Delegation of Powers.

As well as ensuring policy compliance through the Trust's own internal systems and controls, this policy is also audited as part of the key financial systems and controls annual audit and any such breaches are reported to audit committee

7.1.2 Failure to comply with this policy will be recorded by the Chief Financial Officer. Failure to comply with the policy is a disciplinary matter, which may be reported to the Audit Committee, and could result in dismissal.

7.1.3 All members of the Trust Board and employees have a duty to disclose any non-compliance with this policy to the Chief Financial Officer as soon as possible.

7.2 Review

7.2.1 This policy will be reviewed two years post ratification, unless changes in national legislation override this or there has been a specific request to review earlier.

8. REFERENCES

Standing Orders ~~–~~(G19)
Standing Financial Instructions (~~-~~F01)

Appendix A – RESERVATION OF POWERS TO THE TRUST BOARD

1. GENERAL

1.1 The Code of Accountability which has been adopted by the Trust requires the Trust Board to determine those matters on which decisions are reserved unto itself. These reserved powers are set out in 1.2 – 1.9 below.

1.2 General Enabling Provision

1.2.1 The Trust Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.

1.3 Regulation and Control

1.3.1 Approval of Standing Orders (SOs), a schedule of matters reserved to the Trust Board and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business.

1.3.2 Suspend SOs.

1.3.3 Vary or amend the SOs.

1.3.4 Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 4.2.

1.3.5 Approve a scheme of delegation of powers from the Trust Board to Committees.

1.3.6 Require and receive the declaration of Trust Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration.

1.3.7 Require and receive the declaration of officers' interests that may conflict with those of the Trust.

1.3.8 Disciplining Directors who are in breach of statutory requirements or SOs.

1.3.9 Approve arrangements for dealing with complaints.

1.3.10 Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.

1.3.11 Receive reports from Committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on.

1.3.12 Confirm the recommendations of the Trust's Committees where the Committees do not have executive powers.

1.3.13 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

1.3.14 Establish Terms of Reference and reporting arrangements of all Committees and Sub-Committees that are established by the Board.

1.3.15 Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.

1.3.16 Authorise use of the seal.

1.3.17 Ratify or otherwise instances of failure to comply with SOs brought to the Chief Executive's attention in accordance with SO 4.6.

1.3.18 Approval of disciplinary procedure for Directors and Officers of the Trust.

1.4 Appointments and dismissals

1.4.1 Appoint and dismiss Committees (and individual members) that are directly accountable to the Trust Board.

1.4.2 Appoint the Vice Chairman of the Board.

1.4.3 Appoint, appraise, discipline and dismiss Executive Directors.

1.4.4 Confirm appointment of Members of any Committee of the Trust as representatives on outside bodies.

1.4.5 Appoint, appraise, discipline and dismiss the Associate Director of Corporate Governance.

1.4.6 Approve proposals from the Remuneration and Nominations Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration and Nominations Committee.

1.5 Policy determination

1.5.1 The approval of management policies including People Directorate ~~Human Resources~~ policies incorporating the arrangements for the appointment, removal and remuneration of staff.

1.6 Strategy and Business Plans and Budgets

1.6.1 Define the strategic aims and objectives of the Trust.

1.6.2 Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State.

1.6.3 Approve and monitor the Trust's policies and procedures for the management of risk.

1.6.4 Approve the Capital Programme.

1.6.5 Approve annually plans in respect of health investment & services provision and the application of available financial resources.

1.6.6 Approve annually Trust's proposed organisational development proposals.

1.6.7 Ratify proposals for acquisitions and disposals.

1.6.8 Approve PFI proposals for new PFI schemes.

1.6.9 Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature as per scheme of delegation approved limits.

1.6.10 Approve proposals for action on litigation against or on behalf of the Trust.

1.6.11 Review use of NHS Litigation Authority (NHSLA) risk pooling schemes (LPST/CNST/RPST).

1.7 Direct Operational Decisions

1.7.1 Acquisition, disposal or change of use of land and/or buildings.

1.7.2 The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross (i.e. including VAT) annual income or expenditure (that is before any set off) of £500,000.

1.7.3 Approval of individual compensation payments over £25,000.

1.7.4 Agree action on litigation against or on behalf of the Trust.

1.8 Financial and Performance Reporting Arrangements

1.8.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from Directors, Committees and officers of the Trust as set out in management policy statements. All monitoring returns required by NHS Improvement and the Charity Commission shall be reported, at least in summary, to the Trust Board.

1.8.2 Approve the opening and closing of bank accounts.

1.8.3 Receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive.

1.8.4 Receipt and approval of the Trust's Annual Report including the annual accounts.

1.9 Audit Arrangements

1.9.1 Receipt of the annual management letter received from the external auditor and agreement of action on the recommendations, where appropriate, of the Audit Committee.

1.9.2 Receipt of the annual report received from the internal auditor and agreement of action on the recommendations, where appropriate, of the Audit Committee.

1.9.3 Ratify the approval of the appointment or dismissal of the external auditor.

1.9.4 Approval of external auditor's arrangements for the separate audit of funds held on Trust.

Appendix B – RESERVATION OF POWERS TO THE COMMITTEES OF THE TRUST BOARD

1. Delegation to Committees

1.1 The Trust Board may determine that certain powers shall be exercised by Standing Committees. The composition and Terms of Reference of such committees shall be that determined by the Trust Board from time to time taking into account where necessary the requirements of Department of Health and Social Care, NHS Improvement and/or the Charity Commission. The Trust Board shall determine the reporting requirements in respect of these committees. In accordance with SO 4.3 committees may not delegate executive powers to their sub groups unless expressly authorised by the Trust Board.

2. Audit Committee

2.1 The Audit Committee will support the Trust Board in their responsibilities for issues of risk control and governance by reviewing the comprehensiveness of assurances in meeting the Trust Board and Accounting Officer's assurance needs and review the reliability and integrity of these assurances.

2.2 The Committee will advise the Trust Board and Accounting Officer on:

(a) The strategic processes for risk, control and governance and the Annual Governance Statement

(b) The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors

(c) The planned activity and results of both internal and external audit including Counter Fraud arrangements

(d) Adequacy of management response to issues identified by audit activity, including external audit's management letter

(e) Assurances relating to the corporate governance requirements for the organisation

(f) (Where appropriate) proposals for tendering for either internal or external audit services, or for purchase of non-audit services from contractors who provide audit services

(g) Anti-fraud policies, whistle-blowing processes, and arrangements for special investigations

3. Nominations and Remuneration Committee

3.1 The Committee will:

(a) Advise the Trust Board about appropriate remuneration and terms of service for the Executive Directors (i.e.: Trust Board voting and no-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework. . This will include:

(i) All aspects of salary (including any performance-related elements/bonuses)

(ii) Provisions for other benefits, including pensions and cars

(iii) Arrangements for termination of employment and other contractual terms

(b) Monitor and evaluate the performance of individual Directors (with the advice of the Chief Executive)

(c) Advise on and oversee appropriate contractual arrangements for Executive Directors, and when required, consider issues relating to remuneration, terms of service and performance issues for senior management staff

3.2 The Committee Chairman shall make recommendations to the Trust Board regarding the Composition of the Trust Board to ensure there are robust processes in place to review the role and performance of Non-Executive Directors and the Chairman, and to advise the Chairman regarding the filling of Non-Executive Vacancies.

3.3 The Committee is also responsible for reviewing and advising the Trust Board on the appointment process for Non-Executive Directors.

4. Quality Governance Committee

4.1 The Quality Governance Committee will assure the Trust Board of the organisation's performance against quality and research objectives. This assurance is secured through the Assurance Framework, the Corporate Risk Register and the audit plans, which focus on the quality and research objectives of the Trust.

4.2 The primary duties of the Committee are:

(a) To provide assurance to the Trust Board, of the level, adequacy and maintenance of integrated governance, risk management and internal control across quality and research governance activities

(b) In respect of this Committee, quality is defined as made up of three elements; patient safety, clinical best practice and patient experience.

4.3 Matters specifically related to maternity and neonates will be considered on a quarterly basis via a separate Maternity Quality Governance Committee meeting

5. Performance and Finance Committee

5.1 The Performance and Finance Committee will oversee all aspects of the Trust's financial, workforce and performance management arrangements, and provide robust assurance in these areas to the Trust Board. The Trust Board will continue to have primary responsibility for the financial, organisational development and business performance of the Trust and all Trust Board Directors will continue to be accountable in this respect.

5.2 The Committee will:

(a) Consider financial, operational and workforce strategies, prior to submission to the Trust Board for approval

(b) Approve business cases in accordance with delegated authority from the

Trust Board

(c) Review progress against the delivery of business plans

(d) Oversee financial, operational and workforce related strategic risks, and their mitigation plans, through the Board Assurance Framework on a quarterly basis

(e) Escalation of matters to Trust Board as agreed by the Committee

6. Transformation and People Committee

6.1 The Committee will assure the Trust Board ~~in relation~~ that strategic transformation and people matters are considered and planned into the Trust Strategy and service delivery~~to the strategic impact of the Transformation Programmes and People and Organisational Development Strategy on the delivery of the Trust's strategic objectives~~.

6.2 The Committee will:

~~(a) Ensure that strategic transformation, workforce and organisational development matters are considered and planned into Trust Strategy and service delivery~~

~~(b)~~(a) Approve new Workforce / Organisational Development projects and practices and monitor progress and effectiveness of these, paying particular attention to the impact on patient experience, quality, efficiency, equality and diversity and workforce

~~(c)~~(b) Approve the development implementation and evaluation of Leadership and Management Development, Talent Management & Succession Planning, Wellbeing Plans and Apprenticeship and Widening participation activity.

(c) Approve mandated workforce reporting returns including workforce equality, revalidation and Safe Staffing reports

(d) Ensure direction and priorities for internal and external system wide transformation, including partnership working, aligns with both the Trust's overall strategy and future developments and with the developing Integrated Care System Strategy

7. ~~Trustee~~ Charity Committee

7.1 The Committee will:

(a) Be responsible for all aspects of the management of the investment of funds held in the Trust (i.e. Charitable Funds) and for the effective utilisation of those funds

(b) Ensure Charities Commission requirements are fulfilled

(c) Provide assurance to the ~~Trust Board~~Corporate Trustee that systems have been established to manage the funds ensuring that the identification, assessment and management of risk is linked to the achievement of the charity's operational objectives.

~~8. Trust Executive Committee~~

~~8.1 The Committee will execute actions delegated from the Trust Board and to support the operational management of the Trust in accordance with the Trust's Standing Orders and the Standing Financial Instructions.~~

~~8.2 The Committee:~~

~~(a) Is the executive arm of the Trust through which all officer-led Forum/Steering Groups within the Trust report~~

~~(b) Is the Trust's nominated risk committee~~

~~(c) Will advise the Chief Executive on key issues, which affect the delivery of services within the Trust to reach clear executive decision and action~~

Appendix C - SCHEME OF DELEGATION

1. General

1.1.1 The Scheme of Delegation has been designed to be a comprehensive response to the range of delegated matters identified in nationally promulgated guidance to the NHS and in the Trust's own SFIs and SOs.

1.1.2 Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted within the written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate.

1.1.3 Certain matters needing to be covered in the Scheme of Delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are included in the Detailed Scheme of Delegation (section 5).

1.1.4 This Scheme of Delegation covers only matters delegated by the Trust Board to Directors and certain other specific matters referred to in SFIs. Each Director is responsible for the delegation within ~~his/her~~their directorate. ~~He/she~~ They must produce a scheme of delegation for matters within ~~his/her~~their directorate, which must receive the written approval of the Chief Executive. In particular the Scheme of Delegation should include how the directorate budget and procedures for approval of expenditure are delegated.

2. Duties delegated as per the Accounting Officer Memorandum

2.1 The Accounting Officer Memorandum is strictly applicable to NHS bodies accountable to the Secretary of State.

2.2 Chief Executive

2.2.1 Duties delegated:

(a) Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources

(b) Sign a statement in the accounts outlining responsibilities as the Accountable Officer

(c) Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers:

(i) Have a clear view of their objectives and the means to assess achievements in relation to those objectives

(ii) Be assigned well defined responsibilities for making best use of resources

(iii) Have the information, training and access to the expert advice they need to exercise their responsibilities effectively

(d) Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities

(e) Follow through the implementation of any recommendations affecting good practice as set out in reports from such bodies as the External Auditors

(f) Primary duty to see that Chief Financial Officer discharges this function.

(g) Ensuring that expenditure by the Trust complies with Parliamentary requirements.

(h) If the Chief Executive considers the Trust Board or Chairman is doing something that might infringe probity or regularity, ~~he/she~~they should set this out in writing to the Chairman and the Trust Board. If the matter is unresolved, ~~he/she~~they should ask the Audit Committee to inquire and if necessary NHS Improvement (NHS~~I~~/E) and Department of Health and Social Care

(i) If the Board or Chairman is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Trust Board. If the outcome is that the Chief Executive is overruled it is normally sufficient to ensure that the Chief Executive's advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform NHS Improvement (NHS~~I~~/E) and the Department of Health and Social Care. In such cases, and in those described in paragraph 19 of the Accountable Officer Memorandum, the Chief Executive should, as a Member of the Trust Board, vote against the course of action rather than merely abstain from voting.

2.3 Chief Executive and Chief Financial Officer

2.3.1 Duties delegated:

(a) Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs

(b) Sign the accounts on behalf of the Trust Board

(c) Chief Executive, supported by Chief Financial Officer, to ensure appropriate advice is given to the Trust Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness

2.4 Chief Financial Officer

2.4.1 Duties delegated:

(a) Operational responsibility for effective and sound financial management and information

2.5 Chairman and Associate Director of Corporate Governance

2.4.1 Duties delegated:

(a) Implement requirements of Corporate Governance

3. Duties delegated from the Code of Conduct and Accountability

3.1 The Codes of Conduct and Accountability represent standard good practice within the NHS and are applicable to the behaviour or Directors and officers of the Trust.

3.2 Trust Board

3.2.1 Duties delegated:

(a) Approve procedure for declaration of hospitality and sponsorship

(b) Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns

(c) Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities

(d) The Board has six key functions for which it is held accountable by the Department of Health and Social Care on behalf of the Secretary of State:

(i) To ensure effective financial stewardship through value for money, financial control and financial planning and strategy

(ii) To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation

(iii) To appoint, appraise and remunerate senior executives

(iv) To ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them

(v) To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary

(vi) To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs

(e) It is the Trust Board's duty to:

(i) Act within statutory financial and other constraints

(ii) Be clear what decisions and information are appropriate to the Board and draw up, approve, implement and communicate SOs, a schedule of decisions reserved to the Board and SFIs to reflect these

(iii) Ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against

programmes to be monitored and senior executives held to account

(iv) Establish performance and quality measures that maintain the effective use of resources and provide value for money

(v) Specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities

(vi) Establish Audit and Remuneration Committees on the basis of formally agreed Terms of Reference that set out the membership of the Sub-Committee, the limit to their powers, and the arrangements for reporting back to the main Board

(f) NHS Trust Boards must comply with legislation and guidance issued by the Department of Health and Social Care on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money

3.3 All Trust Board Members

3.3.1 All Trust Board Members must subscribe to the Code of Conduct and share corporate responsibility for all decisions of the Trust Board

3.4 Chairman

3.4.1 It is the Chairman's duty to:

(a) Provide leadership to the Trust Board

(b) Enable all Trust Board members to make a full contribution to the Trust Board's affairs and ensure that the Trust Board acts as a team

(c) Ensure that key and appropriate issues are discussed by the Trust Board in a timely manner

(d) Ensure the Trust Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions

(e) Lead Non-Executive Trust Board members through a formally-appointed Remuneration Committee of the main Trust Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members

(f) Appoint Non-Executive Trust Board members to an Audit Committee of the main Board

(g) Advise the Secretary of State on the performance of Non-Executive Trust Board members

(h) Chair the Council of Governors ~~Membership Council/Shadow Membership council~~ when established

3.5 Chief Executive

3.5.1 The Chief Executive is accountable to the Chairman and Non-Executive members of the Trust Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship

3.5.2 The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board

3.5.3 The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum

3.6 Non-Executive Directors

3.6.1 Non-Executive Directors are appointed by Appointments Commission to bring independent judgment to bear on issues of strategy, performance, key appointments and accountability through the Department of Health and Social Care to Ministers and to the local community

3.7 Chairman and Directors

3.7.1 It is the duty of the Chairman and all Directors to declare any conflicts of interest.

4. Duties delegated from the Trust's Standing Orders (SOs)

4.1 Detailed below is a summary of the items held within the SFIs which are delegated and details are provided as to who these matters are delegated to. The below is not intended to replace the detail included within the SFIs and is to be read alongside the SFIs.

SO Ref.	Authority delegated to	Duties delegated
4.1	Chairman	Final authority in interpretation of SOs
1.4	Trust Board	Appointment of Vice Chairman/Senior Independent Director (If either appointed)
2.1	Chairman	Call meetings
2.9	Chairman	Chair all Trust Board meetings and associated responsibilities
2.10	Chairman	Give final ruling in questions of order, relevancy and regularity of meetings
2.12	Chairman	Having a second or casting vote
2.13	Trust Board	Suspension of SOs
2.13	Audit Committee	Audit Committee to review every decision to suspend SOs (power to suspend SOs is reserved to the Trust Board)
2.14	Trust Board	Variation or amendment of SOs
3.5	Trust Board	Formal delegation of powers to Sub-Committees or joint committees and approval of their constitution and Terms of Reference. (Constitution and Terms of Reference of Sub Committees may be approved by the Chief Executive)
4.2	Chairman & Chief Executive	The powers which the Trust Board has retained to itself within these SOs may in emergency be exercised by the Chairman and Chief Executive after having consulted with at least two Non-Executive members
4.4.2	Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying ~~his/her~~their proposals that shall be considered and approved by the Trust Board, subject to any amendment agreed during the discussion
4.6	All Staff	Disclosure of non-compliance with SOs to the Chief Executive as soon as possible
5.1.2	Trust Board	Declare relevant and material interests
5.2	Chief Executive	Maintain Register(s) of Interests.
5.4.1	All Staff	Comply with national guidance contained in NHS England's "Managing Conflicts of Interest in the NHS"
5.4.4	All Staff	Disclose relationship between self and candidate for staff appointment. (Chief Executive to report the disclosure to the Trust Board)
6.1/6.3	Chief Executive	Keep seal in safe place and maintain a register of sealing
6.4	Chief Executive and Executive Director	Approve and sign all documents which will be necessary in legal proceedings

5. Duties delegated from the Trust's Standing Financial Instructions (SFIs)

5.1 Detailed below is a summary of the items held within the SFIs which are delegated and details are provided as to who these matters are delegated to. The below is not intended to replace the detail included within the SFIs and is to be read alongside the SFIs.

SFI Ref.	Authority delegated to	Duties delegated
1.3	Chief Financial Officer	Approval of all financial procedures
1.4	Chief Financial Officer	Advice on interpretation or application of SFIs
1.7	All members of the Trust Board and employees	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible
5.2.2	Chief Executive	Responsible as the Accountable Officer to ensure that the Trust Board meets its obligations to perform its functions within the available financial resources and has overall responsibility for the System of Internal Control
5.2.1 & 5.3.1	Chief Executive & Chief Financial Officer	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities
5.2.3	Chief Executive	To ensure all Board members and officers, present and future, are notified of and understand Standing Financial Instructions.
5.3.2	Chief Financial Officer	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action. b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared, documented and maintained. c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position. d) Providing financial advice to members of Trust Board and staff. e) Maintaining such accounts, certificates etc. as are required for the Trust to carry out its statutory duties.
5.5.1	All Trust Board members and employees	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
5.6.1	Chief Executive	Ensure that any contractor or employees of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of the SFIs and their requirement to comply.
Appx A – 1.1	Audit Committee	Provide independent and objective view on internal control and probity.
Appx A – 1.1.6	Chairman of Audit Committee	Raise the matter at the Trust Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts

SFI Ref.	Authority delegated to	Duties delegated
Appx A – 1.2.1	Chief Financial Officer	Ensure an adequate Internal Audit service, for which ~~he/she~~ they are~~is~~ accountable, is provided (and involve the Audit Committee in the selection process when/if an Internal Audit service provider is changed.)
Appx A – 1.2.2 (c)	Chief Financial Officer	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption
Appx A – 1.2.4	Head of Internal Audit	Review, appraise and report in accordance with recognised professional best practice
Appx A – 1.3.1	Audit Committee	Ensure cost-effective External Audit service
Appx A – 2.6	Chief Executive & Chief Financial Officer	Monitor and ensure compliance with Directions issued by the Secretary of State on Fraud and Corruption
Appx A – 2.7	Trust Board	Nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist
Appx A – 3.1 & 3.2	Chief Executive	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist
Appx A – 4.1.1	Chief Executive	Compile and submit to the Trust Board an Integrated Business Plan (IBP) which takes into account financial targets and forecast limits of available resources. The Business Plan will contain a statement of the significant assumptions on which the plan is based and details of major changes in workload, delivery of services or resources required to achieve the plan
Appx A – 4.1.2	Chief Financial Officer	Submit budgets to the Trust Board for approval
Appx A – 4.1.3	Chief Financial Officer	Monitor performance against budget
Appx A – 4.1.6	Chief Financial Officer	Ensure adequate training is delivered on an on-going basis to budget holders
Appx A – 4.2.1	Chief Executive	Delegate budget to budget holders.
Appx A – 4.3.1	Chief Financial Officer	Devise and maintain systems of budgetary control
Appx A – 4.3.2	Budget Holders	Ensure that: (a) . Expenditure is appropriately managed within budget escalating any issues and overspends through management structures, (b) Approved budget is not used for any other than specified purpose subject to rules of virement (c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and workforce establishment (d) No spend is incurred against a budget outside of the Budget Holders remit (e) Systems of budgetary control are complied with fully
Appx A – 4.3.3	Chief Executive	Identify and implement cost improvements and income generation activities in line with the IBP

SFI Ref.	Authority delegated to	Duties delegated
Appx A – 4.4.8	Chief Executive & Budget Holders	Must not exceed the budgetary total or virement limits set by the Trust Board
Appx A – 4.7.1	Chief Executive	Submit monitoring returns
Appx A – 5.1	Chief Financial Officer	Prepare annual reports and accounts
Appx A – 6.1 – 6.3	Chief Financial Officer	Manage banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories
Appx A – 7	Chief Financial Officer	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash
Appx A – 7.2.4	All employees	Duty to follow Trust's financial procedures with regards to accurately and promptly recording money due from transactions which they initiate/deal with
Appx A – 8.5.4 (a)	Chief Executive	Can waive formal tendering procedures if Chief Executive decides such procedures would not be practicable or estimated expenditure/income would not warrant formal tendering procedures
Appx A – 8.5.7	Chief Financial Officer	Authorise waivers of tendering procedures
Appx A – 8.5.14	Chief Executive	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote
Appx A – 8.9.2	Chief Executive and Director of Finance	Where one tender is received will assess for value for money and fair price
Appx A – 8.11.5	Chief Executive	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive
Appx A – 8.13.4	Chief Executive or Chief Financial Officer	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive
Appx A – 8.17.1 (a)	Chief Executive	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector
Appx A – 8.18.2	Chief Executive	The Chief Executive shall nominate an officer who shall oversee and manage all contracts on behalf of the Trust
Appx A – 8.19.1	Chief Executive	Nominate officers, with delegated authority, to enter into contracts of employment, regarding staff, agency staff, temporary staff service contracts
Appx A – 8.22.1	Chief Executive	Ensure that best value for money can be demonstrated for all services provided on an in-house basis
Appx A – 8.22.5	Chief Executive	If in-house services are outsourced, the Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust

SFI Ref.	Authority delegated to	Duties delegated
Appx A – 9.1.1	Chief Executive	Responsible for negotiating contracts with commissioners for the provision of services to patients
Appx A – 9.2.1	Chief Executive	Ensure that regular reports are provided to the Trust Board detailing actual and forecast income from Service Level Agreements.
Appx A – 10.1.1	Trust Board	Establish a Nominations and Remuneration Committee
Appx A – 10.1.2 (a)	Nominations and Remuneration Committee	Advise the Trust Board and make recommendations on the remuneration and terms of service for the Chief Executive, other officer members and senior employees, ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements
Appx A – 10.1.2 (b)	Nominations and Remuneration Committee	Monitor and evaluate the performance of individual Directors
Appx A – 10.1.2 (c)	Nominations and Remuneration Committee	Advise and oversee appropriate contractual arrangements for senior employees when required.
Appx A – 10.1.4	Trust Board	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Nominations and Remuneration Committee
Appx A – 10.3.1	Chief Executive	Give authorisation to Trust Board members and employees to engage, re-engage or re-grade employees, either permanently or temporarily, and hire agency staff
Appx A – 10.4.1	Chief Financial Officer	Responsible for processing of payroll including performance managing the outsourced provision of services to ensure it is in line with the contract, where necessary report any variations to the contract to Trust Board, specify timetables for submission of properly authorised time records and other notifications, final determination of pay and allowances, making payments on agreed dates, agreeing method of payment and issuing instructions regarding payroll
Appx A - 10.4.3	Nominated Managers	Submit time records in line with timetable, complete time records and other notifications in required form and submit termination forms in prescribed form and on time.
Appx A – 10.4.4	Chief Financial Officer	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
Appx A – 10.5.1	~~Human Resources Director~~Chief People Officer	Ensure that all employees are issued with a Contract of Employment which complies with employment legislation and deal with variations to, or termination of, contracts of employment.
Appx A – 11.1.1	Chief Executive	Determine the level of delegation of non-pay expenditure to Budget Holders, including a list of employees authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level
Appx A – 11.1.3	Chief Executive	Set out procedures on the seeking of professional advice regarding the supply of goods and services

SFI Ref.	Authority delegated to	Duties delegated
Appx A – 11.2.1	Requisitioner	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Integrated Supplies and Procurement Department shall be sought
Appx A – 11.2.4	Chief Financial Officer	Advise the Trust Board regarding setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained, prepare procedural instructions on the obtaining of goods/services incorporating the thresholds, responsible for the prompt payment of all properly authorised accounts and claims, responsible for designing and maintaining a system of verification, recording and payment of all amounts payable and be responsible for ensuring that payment is only made when goods/services have been received
Appx A – 11.3.1 (a) – (c)	Chief Financial Officer	Approve proposed prepayment arrangements for goods/services excluding training courses/subscriptions/membership fees up to £5,000
Appx A – 11.3.1 (d)	Budget Holder	Ensure that all items due under a prepayment contract are received
Appx A – 11.4.1	Chief Executive	Authorise who may use and be issued with official purchase orders
Appx A – 11.5.1	Managers and officers	Ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer in relation to non-pay expenditure
Appx A – 11.5.2	Chief Executive and Chief Financial Officer	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within EU regulations, PFI and P22 (including NEC contracts) and Health Building Note 00-08. The technical audit of these contracts shall be the responsibility of the relevant Director.
Appx A – 11.6.1	Chief Financial Officer	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
Appx A – 11.7.1	Chief Financial Officer	Ensure that any lease entered into on behalf of the Trust represents value for money
Appx A – 12.1.1	Chief Financial Officer	Advise the Trust Board on the Trust's ability to pay dividend on Public Dividend Capital (PDC) and report, periodically, concerning the PDC debt and all loans.
Appx A – 12.1.2	Trust Board	Approve a list of employees authorised to make short term borrowings on behalf of the Trust (this must include the Chief Executive and Chief Financial Officer)
Appx A – 12.1.3	Chief Financial Officer	Prepare detailed procedural instructions concerning applications for loans.
Appx A – 12.1.5	Chief Executive or Chief Financial Officer	Be on an authorising panel, comprising one other member, for short term borrowing approval
Appx A – 13.1.1	Chief Executive	Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities,

SFI Ref.	Authority delegated to	Duties delegated
		responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost, ensuring that capital investment is not undertaken without availability of resources to finance all revenue consequences and that a Capital Investment Programme is produced on an annual basis which is submitted and approved by Trust Board
Appx A – 13.1.4	Chief Executive	Issue managers responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender
Appx A – 13.1.5	Chief Executive	Issue a scheme of delegation for capital investment management
Appx A – 13.1.6	Chief Financial Officer	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes
Appx A – 13.2.8	Chief Executive	For capital schemes that stipulate stage payments will issue procedures for their management
Appx A – 13.2.9	Chief Financial Officer	Assess the requirement for the operation of the construction industry taxation deduction scheme
Appx A – 13.2.10	Chief Financial Officer	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure
Appx A – 13.6.1 (a)	Chief Financial Officer	Demonstrate that the use of Private Finance Initiatives (PFI) represents value for money and genuinely transfers significant risk to the private sector
Appx A – 13.6.1 (c)	Trust Board	Proposal to use PFI must be specifically agreed by the Trust Board (except for additional capital spending to existing PFI contracts which will follow the Trust's authorisation thresholds that are in place non PFI capital)
Appx A – 13.7.1	Chief Executive	Responsible for maintenance of asset registers (on advice from Chief Financial Officer)
Appx A – 13.7.5	Chief Financial Officer	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers
Appx A – 13.8.1	Chief Executive	Overall control of security of fixed assets
Appx A – 13.8.2	Chief Financial Officer	Approval of asset control procedures
Appx A – 13.8.4 & 13.8.5	Trust Board members and all senior staff	Responsibility for security of Trust assets including notifying discrepancies to Chief Financial Officer, and reporting losses in accordance with Trust procedure
Appx A – 14.2.1	Chief Executive	Delegate overall responsibility for control of stores
Appx A – 14.2.1	Chief Financial Officer	Responsible for systems of control over stores
Appx A – 14.2.1	~~Designated Pharmaceutical Officer~~Clinical Director of Pharmacy	Responsible for control of pharmaceutical stocks
Appx A 14.2.1	Designated theatres manager	Responsible for control of theatres stocks

SFI Ref.	Authority delegated to	Duties delegated
Appx A – 14.2.3	Chief Financial Officer	Set out procedures and systems to regulate the stores including receipt of goods, issues and returns to stores and losses
Appx A – 14.2.4	Chief Financial Officer	Agree stocktaking arrangements
Appx A – 14.2.5	Chief Financial Officer	Approve alternative arrangements where a complete system of stores control is not justified
Appx A – 14.2.6	Chief Financial Officer	Approve system for review of slow moving and obsolete stock items and for condemnation, disposal and replacement of all unserviceable items
Appx A – 14.3.1	Chief Executive	For goods supplied via the Supply chain central warehouses identify persons authorised to requisition and accept goods from stores
Appx A – 15.1.1	Chief Financial Officer	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers
Appx A – 15.2.1 & 15.2.3	Chief Financial Officer	Prepare procedures for recording and accounting for losses and special payments and informing Police and Security Management Director in cases of suspected theft or criminal damage
Appx A – 15.2.2	All staff	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Executive and Chief Financial Officer
Appx A – 15.2.4	Chief Financial Officer	Immediately notify Trust Board and External Auditor for losses caused or apparently caused by theft, fraud, criminal damage, neglect of duty or gross carelessness (unless trivial/immaterial)
Appx A – 15.2.5	Chief Financial Officer	In cases of fraud and corruption inform NHS Counter Fraud Authority
Appx A – 15.2.6	Trust Board	Approve write off of losses and special payments (within limits delegated by Department of Health and Social Care)
Appx A – 15.2.8	Chief Financial Officer	For any loss, consider whether any insurance claim can be made against insurers
Appx A – 15.2.9	Chief Financial Officer	Maintain losses and special payments register
Appx A – 16.1.2	Chief Financial Officer	Satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation
Appx A – 16.3.2	Chief Financial Officer	Where another health organisation or any other agency provides a computer service for financial applications periodically seek assurances that adequate controls are in operation
Appx A – 16.4.1	Director of ~~IT~~Digital Transformation	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place

SFI Ref.	Authority delegated to	Duties delegated
Appx A – 16.5.1	Chief Financial Officer	Where computer systems have an impact on corporate financial systems satisfy themselves that systems acquisition, development and maintenance are in line with corporate policies, data produced for use with financial systems is adequate, accurate, complete and timely, and that a management trail exists, Director of Finance staff have access to such data and such computer audit reviews are being carried out as are considered necessary.
Appx A – 17.1.2	Chief Executive	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission
Appx A – 17.1.4	Chief Financial Officer	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients
Appx A – 17.1.8	Departmental managers	Inform staff of their responsibilities and duties for the administration of the property of patients
Appx A – 18.2.3	Chief Financial Officer	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately
Appx A – 19.1.1	Chief Financial Officer	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
Appx A – 20.1.3	Chief Executive	Maintaining archives for all records required to be retained in accordance with Department of Health and Social Care guidance.
Appx A – 21.1.1	Chief Executive	Ensure that the Trust has a risk management programme
Appx A – 21.1.1	Trust Board	Approve and monitor risk management programme
Appx A – 21.2.1	Trust Board	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority provider or to self-insure for some or all of the risks covered by the risk pooling schemes
Appx A – 21.4.1	Chief Financial Officer	Where the Trust Board decides to use the risk pooling schemes administered by the NHS Litigation Authority, shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme and ensure that documented procedures cover these arrangements.
Appx A – 21.4.2	Chief Financial Officer	Where the Trust Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, shall ensure that the Trust Board is informed of the nature and extent of the risks that are self-insured as a result of this decision
Appx A – 21.4.2	Chief Financial Officer	Draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed
Appx A – 21.4.3	Chief Financial Officer	Ensure documented procedures cover management of claims and payments below the deductible limit.

6. Detailed scheme of delegation

6.1 Detailed below is a summary of the delegated limits as per the Standing Financial Instructions (SFIs). The below is not intended to replace the detail included within the SFIs and is to be read alongside the SFIs.

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
Appx A - 4.2		**Budgetary Delegation**
		Responsibility for management of:
	Chief Executive	Total of operational and corporate budgets
	Budget Holder (Executive Director, Clinical Director or Head of Service)	Total of budgets at other specified level (e.g. for the totality of services covered by the Division)
	Budget Manager	At individual budget level (e.g. department/function or collective specialty group)
	Budget Administrator	At individual cost centre/s level
Appx A - 4.4		**Virements**
		Types of virement:
	Budget Holder and Deputy Director of Finance	Budget moves between income, pay or non-pay
	Budget Holder and Deputy Director of Finance	Budget moves between pay to pay and non-pay to non-pay
	Chief Financial Officer	Re-phasing of budgets
Appx A - 4.6		**Revenue business cases**
	Chief Financial Officer	If source of funds deemed readily available and investment < £25,000
	Clinical Director and ~~Associate Directors~~Director of Operations	Replacement consultant posts
		Revenue business cases with investment of: 25,001 to £250,000
	Formal Executive Team	£250,001 to 1,000,000
	Performance and Finance Committee	

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	Trust Board NHS ~~Improvement~~ England (NHS~~I~~/E)	£1,000,001 to £15,000,000 £15,000,001 and above
Appx A - 7	 Chief Financial Officer Chief Executive and Chief Financial Officer	**Income, fees and charges** For setting income, fees and charges relating to: Private patients, overseas visitors, income generating activities and all other patient and non patient related services For prices of all NHS contracts
Appx A - 7.2.3	 Chief Executive or Chief Financial Officer Charitable Funds Committee	**Authorisation of sponsorship deals:** For the Trust For the Charitable fund
Appx A - 8	 Budget Holder/Manager or Group Director of Procurement	**Tendering, contracting and purchasing procedures** (note : the national and regional procurement of medicines is excluded as this is dealt with at a regional and national level via Commercial Medicines Unit) Values stated below are inclusive of VAT and apply to both capital and revenue expenditure £0 to £4,999 -"verbal" informal quotes should be obtained wherever practicable. £5,000 - £19,999 – "formal quotes" should be obtained from a minimum of three (3) suppliers where practicable. £20,000 to £49,999 – "formal quotes" should be obtained from a minimum of three (3) suppliers and the opportunity advertised through "contracts finder" £50,000 to 138,760 (Including VAT) ~~£122,976~~ – "formal tenders" should be obtained and the opportunity advertised through "contracts finder" above 138,760 (Including VAT) ~~£122,976~~ – "formal tenders" should be obtained and

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
		there is a legal requirement to advertise the contract through the Find a Tender Service (FTS)~~Official Journal of Europe (OJEU)~~
	Chief Financial Officer Chief Executive or Chief Financial Officer Band 5 level or above within originating department	Waivering of Quotations subject to SFIs Waivering of Tenders subject to SFIs Opening tenders and opening quotations
Appx A - 10	 Chief Financial Officer and ~~Director of Human Resources~~Chief People Officer Chief Executive and Chief People Officer~~Director of Human Resources~~ Budget Holder and People Business Partner Budget Holder and Chief People Officer or Deputy Chief People Officer Budget Manager or Budget Holder	~~**Human Resources**~~**People and pay** Granting additional increments to existing staff outside of AfC structure ~~within budgets~~ Authorisation of upgrading or re-grading staff in accordance with Trust procedure Appointment of staff above the bottom of the pay scale (up to band 8a) Appointment of staff above the bottom of the pay scale (Band 8b to 9) Regarding pay documentation, authorise standing data forms effecting pay, new starters, variations and leavers, time and attendance submissions, travel and subsistence expenses and authorise with-holding of annual increments in line with appraisal policy
Appx A - 10	 Budget Holder	**Authorised mobile phone users** Requests for new posts to be authorised as requiring a Trust mobile phone
Appx A - 10	 Departmental Manager	**Staff Retirement – Flexible Retirement Guidelines ~~Policy~~** Authorisation for flexible retirement including retire and return
Appx A - 10		**Redundancy** Approval of redundancy payments:

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	Chief People Officer~~Director of Human Resources~~ or Chief Executive and Chief Financial Officer	£0 to £10,000
	Nominations and Remuneration Committee	£10,000 and above
	NHS~~/~~E	Redundancy Payment to a Director or redundancy payment over £100,000
Appx A - 10	Budget Manager	**Ill health retirements** Decision to pursue retirement on the grounds of ill-health
Appx A - 10	Nominations and Remuneration Committee Executive Medical Director and Chief Executive Departmental Manager	**Dismissals** Dismissal of: a) Executive Director b) Senior medical staff c) All other staff
Appx A - 10.2	Chief Executive on recommendation from Chief People Officer~~Director of Human Resources~~ and Chief Financial Officer	**Engagement of staff not in the establishment** Approval of engagement of staff that are not in the permanent establishment (regardless of value)
Appx A - 10.3	Budget Manager, Budget Holder, ~~HR Manager~~People Business Partner and Divisional Business Advisor	**Engagement of permanent staff in the establishment** Approval to appoint to agreed establishment (other than senior medical staff) if the post is or will be vacant and the post is funded recurrently and budget is available

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	Executive Director following approval by Budget Holder	Approval to appoint where, exceptionally, the post is not on the agreed establishment, providing that the appointment is vital for the service and a source of recurrent funding has been identified and is available. The post must be established in the budget in accordance with the virement rules set out in SFIs at 4.4.6
	Chief Executive and Chief Financial Officer following approval by appropriate Executive Director and appropriate Budget Holder	Approval to satisfactorily appoint senior medical staff (Consultant Staff Grade, Associate Specialist, Hospital Practitioner and Trust Doctor) to agreed establishment providing that the post is or will be vacant and the post is funded and supporting costs are funded recurrently and budget is available
Appx A - 10.3.1		**Engagement of temporary staff and renewal of fixed term contracts**
	Budget Holder	Engagement of temporary staff (excluding senior medical staff and NHSP/nurse agency) where the cover is vital for the service, is for a vacant post (which is funded recurrently and budget is available and can accommodate these costs)
	Budget Holder and relevant Executive Director	Engagement of temporary staff where the cover is vital for service and the cover is for a vacant post which is funded recurrently and budget is not available or cannot accommodate these costs
	Budget Holder and relevant Executive Director	Where in exceptional circumstances it is necessary to engage temporary staff in an emergency situation, the above approvals must be sought retrospectively. This must include securing the alternative sources of funding where appropriate (for example on-call Managers).
Appx A - 11		**Non-Pay Expenditure** This includes committing the Trust to expenditure by raising purchase orders and the payment of goods or services The values detailed below are gross values (i.e. the total cost inclusive of VAT) The values detailed below are relevant to **all non-pay costs (excluding pharmacy drugs)**:

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	Budget Administrators	£0 to £5,000
	Budget Manager	£0 to £20,000
	Budget Holders	£0 - £20,000
	Director of Finance	£20,001 to £100,000
	Chief Financial Officer	£100,001 to £250,000
	Chief Executive	£250,001 to £500,000
	Performance and Finance Committee	£500,001 to £1,5~~0~~00,000
	Trust Board	£1,5~~0~~00,001 and above
		NB – Requisitions require authorisation of **all** of the above up to the financial limit
		The values detailed below are relevant to all pharmacy drug costs and consumables and values are inclusive of VAT:
	Senior Assistant Technical Officer (~~ATO~~Band 3) Procurement and ~~Senior Pharmacy Technician~~/or Cancer Services	£0 to £35,000
	Senior Pharmacy Technician (Band 5) Procurement and /or Cancer Services	£0 to £65,000
	Lead Procurement and /or Cancer Technician (Band 6) or Chief Clinical Information Technician (Band 7) or Chief Technician Cancer/ Technical Services (Band 7) or Pharmacy Supply Chain Manager (Band 7) or Procurement and Renal Pharmacist (Band 7) or High Cost and Homecare Pharmacist (Band 8a) or Clinical Commissioning and Medicines Value Lead (Band 8b) or Advances	£ 6~~3~~5,001 to £15~~2~~0,000
		£15~~2~~0,001 to £25~~17~~0,000

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	Specialist Pharmacist Cancer (Band 8a/b). ~~Lead Procurement Technician (Band 6) or Chief Clinical Information Technician (Band 7) or Pharmacy Supply Chain Manager (Band 7) or High Cost and Homecare Pharmacist (Band 8a) or Clinical Commissioning and Medicines Value Lead (Band 8b).~~ Clinical Director of Pharmacy or Deputy / Principal Pharmacist (8c). Chief Financial Officer Chief Executive Performance and Finance Committee Trust Board	 £25~~17~~0,001 to £~~2~~500,000 £~~2~~500,001 to £1,~~5~~00,000 £1,0~~5~~00,001 to £1,~~50~~00,000 £1,~~50~~00,001 and above NB – Requisitions require authorisation of **all** of the above up to the financial limit
Appx A - 11.5.1	 Director of Estates, Facilities & PFI, and Chief Financial Officer Director of Estates, Facilities & PFI, Chief Financial Officer or Chief Executive	**Agreements and licenses relating to accommodation at the Trust** Preparation and signature of all tenancy agreements/licenses for all staff subject to Trust Policy on accommodation for staff and extensions to lease agreements Letting of premises to outside organisations
Appx A - 11.5.1	 Petty cash holder Chief Financial Officer	**Petty cash disbursements** Expenditure up to £50 per item Expenditure over £50 per item

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
Appx A – 11.7		**Leases** Granting and terminating of leases:
	Chief Executive or any Executive Director	where a legal document
	Any two Executive Directors	where the document requires sealing
Appx A- 13		**Capital Investment** This includes committing the Trust to capital spend, raising purchase requisitions and the payments for capital spend All capital spend must be approved as part of the Trust's annual capital programme For all capital expenditure proposals a capital bid must be prepared A capital business case is required for all new capital investment if it is not relating to the replacement of an existing asset The approval limits for capital only business cases are detailed below (these values are Gross values i.e. the total cost inclusive of VAT and are for all capital business cases regardless of funding source (i.e. are for both non PFI and PFI funded capital):
	Capital Investment Group (CIG)	£0 to £1,000,000
	Performance and Finance Committee (PFC)	£1,000,001 to £3,000,000
	Trust Board	£3,000,001 to £2~~1~~5,000,000
	NHS ~~Improvement~~ England (NHS~~I~~E) and DH	£2~~1~~5,000,00~~0~~1 ~~1~~ and above
Appx A - 15.1		**Disposals and condemnations** The person responsible for condemning items at the Trust is dependent on the item as detailed below:
	Director of Estates, Facilities & PFI	For electrical items

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	~~Associate Director~~Director of Operations	For furniture items
	Executive Medical Director	For medical equipment items
	Director of Digital Transformation	For IM&T items
		Authorisation for method of disposal (excluding land and buildings):
	Associate Director and Group Director of Procurement	£0 to £10,000
	Group Director of Procurement and Director of Finance	£10,001 to £500,000
	Group Director of Procurement and Chief Financial Officer and Trust Board	£500,000 and above
	Chief Financial Officer and Chief Executive and Trust Board and NHS(NHS~~I~~/E) where appropriate	Disposal of land or buildings
Appx A - 15.2		**Losses and special payments** Limits and authorisation levels are dependent on the type of loss and special payment. All losses and special payments must be reported to the Audit Committee at every meeting and Audit Committee will prospectively approve all such compensatory payments valued at £25,000 and above **Losses and special payments of:** (a) Losses of cash:
	Chief Financial Officer	£0 to £50,000
	Chief Executive and Chief Financial Officer	£50,001 to £250,000
	Chief Executive and Chief Financial Officer	£250,001 and above

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	and Trust Board	
Appx A - 15.2.3 & 15.2.4		**Reporting of losses and special payments**
	Chief Financial Officer	Where the theft/fraud relating to a loss/special payment is suspected inform the police and Security Management Director
	Chief Financial Officer	For losses/special payments caused or apparently caused by theft, fraud, criminal damage (including arson), neglect of duty or gross carelessness (except if trivial /immaterial) immediately notify the Trust Board and the External Auditor
Appx A - 18		**Funds held on trust (donated / charitable funds)** This relates to any expenditure relating to Charitable Funds. The values detailed below are gross values (i.e. the total cost including VAT where applicable for the Charity).
	Fund Manager and Directorate or Departmental Manager and ~~Charity Manager~~Head of Charity and Director of Charity	£0 to £25,000
	~~Fund Manager and Directorate or Departmental Manager and Charity Manager and Chief Financial Officer~~	~~£5,001 to £25,000~~
	Fund Manager and Directorate or Departmental Manager and Head of Charity ~~Manager~~ and ~~Chief Financial Officer~~Director of Charity and ~~Chairman of~~ Charitable Funds Committee	£25,001 and above

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
Appx A - 19.4.4 Policy G16 Standards of Business Conduct		**Receiving hospitality** This applies to both individual and collective hospitality receipt items
	Associate Director of Governance	Any employee of the Trust receiving hospitality of in excess of £25 per item received is to declare this in the Hospitality Register maintained by the Associate Director of Corporate Governance
Appx A - 20.1.3	Chief Executive	Responsibility for retention of records
Annual leave and Public Holiday Leave Policy (Except Medical Staff) HR52	Departmental Manager	**Annual, Public Holiday Leave** Approval of annual leave and approval of carry forward up to a maximum of 5 days or up to statutory entitlement in the case of individuals unable to take leave due to sickness
HR15 Career Grade Doctors Annual Leave Policy	Clinical Director or Clinical Lead	**Annual, Public Holiday Leave (Medical Staff)** Approval of medical staff leave of absence (paid)
HR55 Junior Doctors Annual Leave Policy	Rota Co-coordinator/Directorate Manager/ Consultant (for Specialist Registrars only)	Approval of medical staff leave of absence (unpaid)
HR61 Special Leave Policy	Departmental Manager	Approval of bereavement leave up to one working week or, in exceptional circumstances, up to two working weeks Approval of emergency leave (in line with the categories as set out in HR52) arrangements (up to 3 days). Any additional leave required above the 3 working days may be taken at manager's discretion Approval of short term carer/domestic need up to 3 days (on a time owing basis, subject to payback)

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
		Study leave
HR40 Study leave/professional leave for career grade doctors	Clinical Director (or delegated individual)/Departmental Manager/Budget Holder Clinical director (or Executive Medical Director in absence) and Budget Holder	Approval of study leave: N.B. Any study leave which is to take place outside the UK is to be approved by those individuals noted below and the Chief Financial Officer. (see policy for guidance on approval levels)
HR49 Learning and Education Policy For all Trust Staff	Departmental Manager or Budget Holder Budget Holder and Clinical Director Departmental Manager or Budget Holder Departmental Manager or Budget Holder	a) For non medical/non clinical staff b) For medical staff (excluding Clinical Directors c) For nursing/midwifery staff d) For Clinical Directors
		Maternity and Paternity Leave
HR11 Paternity and Maternity Leave Policy	Departmental Manager	Approval of unpaid parental leave Maternity leave – paid and unpaid
F14 Trust Removal Expenses Policy		**Relocation expenses** Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing approval is sought prior to the offer being made in writing to the candidate)
	Budget Holder and Chief People Officer~~Director of Human Resources~~	Up to £8,000
	Budget Holder and Chief People Officer~~Director of Human Resources~~ and Chief Executive	£8,001 and above
	Chief Executive and Executive Medical Director	**Research Projects** Authorisation of research projects

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	Chief Executive and Executive Medical Director and Chief Operating Officer	**Clinical Trials** Authorisation of clinical trials
	Chief Executive	**Patients and Relatives Complaints** Overall responsibility for ensuring that all complaints are dealt with effectively.
	Director of Communications and Executive Director/Executive Director On-Call Director of Communications or Chief Executive or Executive Director/ Executive Director On-Call	**Relationship with the press** Non-emergency general enquiries within or outside hours Emergency within or outside hours
Nurse/Midwives/ Health Visitors Act Midwives Rules/ Code of Practice UKCC Code of Professional Conduct	Chief Executive and Chief Nurse	**Extended Role Activities** Approval of Nurses to undertake duties/procedures which can properly be described as beyond the normal scope of Nursing Practice.
	Chief Operating Officer Chief Operating Officer and Chief Executive On Call Manager or Chief Executive	**Patient services** Variation of operating and clinic sessions within existing numbers: d) Temporary variations e) Permanent variations All proposed changes in bed allocation and use for both temporary and permanent changes
	Chief People Officer~~Director of Human Resources~~	Facilities for staff not employed by the Trust to gain practical experience - Professional Recognition, Honorary Contracts, and Insurance of Medical Staff

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	Director of Estates, Facilities & PFI	Review of fire precautions
	Chief Nurse	Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations
	Executive Medical Director or Clinical Director of Pharmacy	Review of Medicines Inspectorate Regulations
	Director of Estates, Facilities & PFI	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal
	Director of ~~IT~~Digital Transformation	Review of Trust's compliance with the Data Protection Act
	Chief Financial Officer	Monitor proposals for contractual arrangements between the Trust and outside bodies
	Director of ~~IM&T~~Digital Transformation	Review the Trust's compliance with the Freedom of Information Act
	Chief Financial Officer	Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" as per Caldicott, the IG Toolkit and future guidance from the General Data Protection Regulation.
SO 5.2 and Policy G16 Standards of Business Conduct	Associate Director of Corporate Governance	The keeping of a Declaration of Interests Register
SO 6.2	Chairman and Chief Executive	Attestation of sealing's in accordance with Standing Orders
SO 6.3	Associate Director of Corporate Governance	The keeping of a register of sealing

Trust Board

2022/23 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		6	4	8	6	3	7	5	9	7	11	8	8	
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse					Staff		Staff		Staff				
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Quality Strategy Update	Chief Nurse													
Clinical Strategy	Director of Strategy													To be provided to TAP before being brought to Board
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse						→							Next due April 2023
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													Update provided via QGC Highlight Report Feb 2023
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													TBC
Infection Prevention Board Assurance Framework	Chief Nurse													Moved to Quarterly from Dec 22
RESPONSIVE														
Integrated Performance Report	Various	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
PEOPLE														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Chief People Officer													
People Strategy Update	Chief People Officer													
Revalidation	Medical Director													
Workforce Disability Equality Report	Chief People Officer													
Workforce Race Equality Standards Report	Chief People Officer													
Staff Survey Report	Chief People Officer													
Raising Concerns Report	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
IMPROVING AND INNOVATING														
Research Strategy	Medical Director				→									Taken to TAP in April. Final version to be presented to Board in September (due to annual leave during August)
SYSTEM AND PARTNERS														
System Working Update	Chief Executive / Director of Strategy													
RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy		N/A									N/A		
Digital Strategy Update	Director of Digital Transformation													
Going Concern	Chief Finance Officer													Taken to Audit Committee
Estates Strategy Update	Director of Estates, Facilities & PFI													Date to be confirmed

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		6	4	8	6	3	7	5	9	7	11	8	8	
Annual Plan	Director of Strategy													Sign off Trust Annual Plan at Board April 2023
Board Approval of Financial Plan	Chief Finance Officer													Sign off Trust Annual Plan at Board April 2023
Activity and Narrative Plans	Director of Strategy													Guidance received end of Dec 22 and being reviewed
Final Plan Sign Off - Narrative/Workforce/Activity/Finance														Sign off Trust Annual Plan at Board April 2023
Capital Programme 2022/23	Chief Finance Officer													Taken to PAF
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
Accountability Framework	Associate Director of Corporate Governance													
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													Deferred from Nov. due to number of items on the agenda
Well-Led Self Assessment	Associate Director of Corporate Governance													