Trust Board (Open)

Meeting held on Wednesday 2nd August 2023 at 9.30 am to 11.50 am
In the Trust Boardroom, Third Floor, Springfield, RSUH

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
25 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.	A. Minutes of the Meeting held 5th July 2023 B. Minutes of the Extraordinary Meeting held 28th June 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 – July 2023	Information	Mrs T Bullock	Enclosure	
10:10		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (27-07-23)	Assurance	Prof A Hassell	Enclosure	1
10:15		**RESOURCES**				
5 mins	**8.**	Performance & Finance Committee Assurance Report (25-07-23)	Assurance	Dr L Griffin	Enclosure	5, 7, 8
10:20		**RESPONSIVE**				
40 mins	**9.**	Integrated Performance Report – Month 3	Assurance	Mrs AM Riley Mr O White Mrs J Haire Mr M Oldham	Enclosure	1, 2, 3, 5, 8
11:00 – 11:15 COMFORT BREAK						
11:15	**GOVERNANCE**					
5 mins	**10.**	Audit Committee Assurance Report (27-07-23)	Assurance	Prof G Crowe	Enclosure	
10 mins	**11.**	Board Assurance Framework – Quarter 1	Assurance	Mrs C Cotton	Enclosure	
10 mins	**12.**	Board Development Programme 2023/24	Approval	Mrs C Cotton	Enclosure	
11:40	**CLOSING MATTERS**					
10 mins	**13.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
	14.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 31st July to** Nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
11:50	**DATE AND TIME OF NEXT MEETING**					
	15.	**Wednesday 4th October 2023, 9.30 am, via MS Teams**				

Please note that the Annual General Meeting is taking place on Wednesday 6th September at 1.00 pm in the UGMS Lecture Theatre, Royal Stoke.

Trust Board (Open)

Meeting held on Wednesday 5th July 2023 at 9.30 am to 11.55 am via MS Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

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

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

In Attendance:		
Mrs F Dickson	FD	Matron / Professional Nurse Advocate (item 1)
Mrs K Griffiths	KG	Professional Nurse Advocate (item 1)
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mrs S Lomas	SL	Nurse (item 1)
Mrs K Thorpe	KT	Deputy Chief Operating Officer (item 11)
Mr O White	OW	Deputy Chief Operating Officer (item 11)

Members of Staff and Public: 3

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Staff Story**	
104/2023	Mrs Griffiths provided the background to the introduction of the Professional Nurse Advocate (PNA) roles, which were introduced in the Trust following the pandemic and subsequently advocated by Dame Ruth May, Chief Nursing Officer for England, whereby it was the aim to introduce a PNA for all specialities with 1 PNA per 20 nurses. Mrs Griffiths described the role which included clinical leadership advocacy and delivering restorative clinical supervision with the aim of supporting staff to develop, gently challenge and reflect, and decide how to move	

forwards positively. She stated that UHNM had 40 PNAs in post, against a trajectory of 150, and the work undertaken to date placed the Trust as a frontrunner.

Mrs Lomas highlighted how she had accessed a PNA for support, following issues at work with anxiety and certain factors triggering attacks. She explained that she had initially spoken to staff counselling but felt that due to the counsellor not having a healthcare background, they could sympathise but could not fully understand the problems she had faced. She subsequently accessed the PNA and felt like a 'switch' had gone off, as they understood her concerns and were able to advise her accordingly. She explained that she was now an advocate to others accessing PNAs for support.

Mr Wakefield thanked Mrs Lomas for joining the Board and sharing her story and queried how many people had spoken to PNAs that she was aware of. Mrs Lomas said that she was aware of 5 people who regularly accessed PNAs within the day case area.

Professor Hassell thanked Mrs Lomas and Mrs Griffiths and queried if individuals were expected to contact the PNAs or whether the PNA contacted individuals directly. Mrs Griffiths stated that staff and managers could refer to the PNAs and as they were a real time visible presence, they got to know the staff and see them on a daily basis. She added that an average of 100 staff a month were accessing PNA support.

Ms Bowen queried whether she would advise staff to seek counselling first or perhaps PNA given her experience. Mrs Lomas stated that it depended on the situation although as her issues were work-based she felt it was more helpful to speak to someone who knew the environment.

Mr Akid queried if the PNAs were full time, or done alongside existing duties. Mrs Griffiths stated that it was both and each Division had its own lead PNA as well as sessional PNAs.

Mrs Rodwell referred to the access for career progression and development and whether that was fully utilised. Mrs Griffiths stated that when visiting staff, a presentation was provided to explain the role and all career conversations were documented, therefore it was possible to identify how much time was being spent on professional development. She added that as part of the clinical supervision discussions, development opportunities would be highlighted as part of that.

Mrs Riley highlighted the importance of keeping people well and in work and given a lot of staff tended to leave in their first 3 years, this was an excellent way to support them through the transition. She thanked the PNAs for the job they do in supporting staff.

Professor Maddock welcomed the scheme and queried if this was available for Allied Health Professionals (AHPs). Mrs Griffiths explained that AHPs could access the service and some therapists had done so.

Mr Akid queried if the service stretched to visiting staff at home and whether those at home were aware of the support. Mrs Griffiths confirmed that this was available for staff at home.

Mrs Riley added that the Trust had appointed a Chief AHP and she expected that person to work with the PNAs as well as with external colleagues to take this more widely.

	Mr Wakefield thanked Mrs Griffiths for sharing the background to the role, thanked Mrs Lomas for sharing her personal story and Mrs Dickson for joining the Board. He also paid thanks to Theresa who had supported Mrs Lomas. He welcomed the initiative and the target to increase to 150 PNAs. Mrs Griffiths, Mrs Dickson and Mrs Lomas left the meeting **The Trust Board noted the staff story.**	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
105/2023	Mr Wakefield welcomed Board members to the meeting. Apologies were received as recorded above, and the meeting was confirmed as quorate. Mr Wakefield welcomed Mr Evans to the meeting as Interim Chief Operating Officer.	
3.	**Declarations of Interest**	
106/2023	Mr Evans highlighted that he was presently an Executive at Lincolnshire ICB until he was fully released in August 2023. There were no other declarations of interest raised.	
4.	**Minutes of the Previous Meeting held 7th June 2023**	
107/2023	The minutes of the meeting held 7th June 2023 were approved as a true and accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
108/2023	PTB/579 – Mrs Haire stated that the action had been deferred due to a vacancy within the team and added that a paper would be taken to the Transformation and People (TAP) Committee in August. PTB/581 – Mrs Riley explained that national data was available and this would be shared through the Maternity Quality Governance Committee.	
6.	**Chief Executive's Report – June 2023**	
109/2023	Mrs Bullock highlighted a number of areas from her report. Ms Bowen referred to Priority 3 of the Government 2023 Mandate and queried how this would be taken forward. Mrs Bullock stated that priority 3 was the least worked up part of the document and Mrs Freeman highlighted some of the areas which were in the digital strategy which would support this priority. She added that the plan aimed to explore more artificial intelligence, and whilst this was not specific in the digital strategy it was being used in some areas. Professor Hassell referred to the capacity to deliver the training elements referred to within the NHS Long Term Workforce Plan and given current pressures on acute Trusts, queried what the Trust's approach to this would be. Mrs Bullock stated that the approach had not yet been defined and multiple options would need to be considered such as hub and spoke arrangements and use of digital. In addition, discussions would need to take place regarding working with Universities and wider system partners.	

	Dr Griffin stated that he assumed system wide and Trust specific recovery plans would be required for each objective and queried if more was known about the choice objective. Mrs Bullock stated that this objective was not new and referred to existing patient choice guidance. She referred to the difficulties in terms of reducing the number of long waiters and therefore mutual aid was being considered at a regional level. Mr Wakefield welcomed the celebrations held for the National Estates and PFI day on 21st June. **The Trust Board received and noted the report and approved eREAF 10826.**	
HIGH QUALITY		
7.	**Quality Governance Committee Assurance Report (29-06-23)**	
110/2023	Professor Hassell highlighted the following: • The Committee welcomed the update provided by the neonatal service and the integrated action plan which included actions for all three reports which the committee found robust • The Committee considered the Care Quality Commission (CQC) maternity inspection report and shared the disappointment in the overall rating having dropped although recognised the large amount of work which had already been completed, including increasing the workforce and the focus on specialised training. The Committee recognised the impact the report would have on morale, and expressed its support with the work the leadership team were undertaking • The cardiothoracic action plan provided assurance in terms of the number of actions completed and underway and received further assurance with regards to the 3 problematic actions which related to workforce • The Committee welcomed the work which had been completed on the new Patient Safety and Incident Response Framework (PSIRF) which had been recognised as an exemplar both locally and nationally **The Trust Board received and noted the assurance report.**	
8.	**Care Quality Commission – Maternity Inspection**	
111/2023	Mrs Riley highlighted the following: • The inspection took place on 7th March 2023 and a number of follow up meetings subsequently took place via MS Teams • The final report was published in June 2023 and Mrs Riley expressed disappointment in relation to the downgrading of the overall service. Mrs Riley noted the report highlighted 6 must do and 2 should do actions. In terms of the must do actions, a number were aligned to the section 29 notice requirements and these were being robustly monitored. It was noted that at the time of the inspection, MAU was operating in the same way it had been when the service was previously inspected. The remaining must do actions predominately related to training and appraisals and a trajectory was to be identified to meet the required targets. It was noted that a number of factors had affected compliance such as COVID, flu and ongoing operational pressures which were not unique to midwifery • The service rating for safe moved from Requires Improvement to Inadequate and the service rating for well led moved from Good to Requires Improvement, with the overall service rating moving from Good to Requires Improvement. However, the overall Trust rating stayed the same.	

- An action plan was under development and progress will be monitored via Maternity Quality and Governance Committee
- A number of driver / watch metrics had already been identified in relation to induction of labour performance and triage times prior to the inspection and these were monitored at performance review meetings
- The report also highlighted some positives in terms of the management of infection prevention risks, record keeping, leadership and the work undertaken in relation to staffing to Birthrate Plus recommendations
- Mrs Riley was pleased to note that the Trust was aware of the issues the CQC raised and had established action plans in place and noted some actions were completed at the time of the inspection
- It was noted that the CQC were now assessing Trusts against their refreshed standards and learning from high profile investigations and as such a number of units nationally had also had their ratings downgraded. Mrs Riley noted that this was a positive move and anything that improved quality and safety for those using our maternity services was welcomed

Mr Wakefield referred to the 19 / 21 hospitals which had been inspected and had their ratings downgraded and queried if the change in standards were known. Mrs Riley stated that the Trust was aware of the change in standards but learning from early inspections was not known.

Professor Toor highlighted that in her role as maternity safety champion, she had been assured of the focus on completing the action plan and added that the discussion at the Quality Governance Committee (QGC) had recognised the change in standards and the work required to meet them. She added that anything focussing on supporting women's safety was to be welcomed.

Mr Akid queried where the Trust was in terms of ratings against others and Mrs Riley stated that she was unable to provide a national comparison but highlighted that issues such as triage were a common theme being identified in inspections throughout the Midlands.

Professor Hassell referred to the difficulties of benchmarking against others as Trusts could end up comparing against the wrong things and highlighted the recent changes in targets for caesarean sections and inductions, which now focussed on the clinical appropriateness of the caesarean section rather than numbers undertaken.

Mr Wakefield queried the progress made with Birthrate Plus and Mrs Riley stated that the Trust was on track with its trajectory, where it was anticipated that there would be a shortfall of circa 7 midwives by the end of quarter 3. She added that nationally there was a shortage across England of around 2,500 midwives and therefore the Trust was relying on students in addition to trying to recruit registered midwives. Mrs Riley again thanked board for supporting the business case last year to fund the establishment to Birthrate Plus recommendations, noting this was a significant investment in workforce expansion as there was no commitment to Birthrate Plus when the unit was previously inspected. Whilst there was concern in the report in respect of vacancies, Mrs Riley noted the increased vacancy position was as a result of the investment to achieve Birthrate Plus.

Professor Crowe referred to the wellbeing of current maternity staff and impact on retention given the current pressures and queried what was being done to support the staff. Mrs Riley referred to the range of actions being taken such as bolstering staffing and noted the agreement of funding to Birthrate Plus was a real positive for staff. In addition, Midwifery Nurse Advocates were in place and she outlined

	the work that the Director of Midwifery was doing on culture, such as the introduction of the leadership toolkit for leaders and training on human factors. **The Trust Board received the CQC Report for Maternity Services and noted that a full action plan was to be developed in response to the report which would be monitored via the Maternity and Neonatal Quality Governance Committee.**	
PEOPLE		
9.	**Transformation and People Committee Assurance Report (28-06-23)**	
112/2023	Professor Crowe highlighted the following: • The Committee had committed to adopting the Improving Together methodology in its reporting and the Chief People Officer had developed a new report which also aligned to the improvement methodology. Professor Crowe therefore noted some driver and watch metrics had been agreed • It had been agreed to incorporate some of the other reports in the new format • Positive assurance was provided on the annual fire safety update with some actions outstanding but the team were confident in the ability for these to be resolved • An update was provided on Freedom of Information requests and timeliness of responses, which was regularly tracked • An update was provided on the Digital Strategy which was to be considered in more detail at a future meeting • The Committee noted a broader point in terms of the need to embed current programmes into practice i.e. cultural improvement programme, people plan, Enable, Improving Together as well as receiving assurance as to how these were being utilised **The Trust Board received and noted the assurance report.**	
RESOURCES		
10.	**Performance & Finance Committee Assurance Report (27-06-23)**	
113/2023	Ms Bowen highlighted the following from the report: • The slight deterioration in urgent care metrics and challenge associated with decision to admit times which required the conclusion of bed modelling before confirmation of when performance was expected to improve • Cancer 62 day performance remained an area of concern and updated figures for 104 weeks and 78 weeks patients were provided • The adverse financial performance as at month 2 was highlighted and a detailed year-end forecast was to be undertaken • The Committee welcomed the positive performance in relation to cancer 2 week wait and the 28 day faster diagnosis standard **The Trust Board received and noted the assurance report.**	
RESPONSIVE		
11.	**Integrated Performance Report – Month 1**	
114/2023	Mrs Riley highlighted the following in relation to quality and safety performance: • There had been a sustained improvement in sepsis and duty of candour performance • The number of serious incidents were below the long term mean	

- With regards to the incidents reported as part of your next patient, patients were being identified with pressure damage which was not hospital acquired as this occurred prior to hospital admission and as such work was being undertaken across the system with the first meeting held on 26th June. It was noted that the progress was to be fed back through QGC. There was good attendance from across the system which was representative and attendees collaborated positively
- Timely observations had been identified as a driver metric for each Division using vitals, improving performance has stalled and a task and finish group had been set up to understand any missed root causes

Mr Wakefield referred to the number of reported safety incidents which was above the rate but stable and requested clarification of this. Mrs Riley stated that the rate per 1000 bed days took account of activity and it was therefore a better indicator.

Dr Griffin referred to the increase in the number of Serious Incidents including serious medication incidents and queried if there were any underlying issues associated with these incidents. Mrs Riley stated that when there was a run of incidents these were considered to establish if anything was driving them, although a number would remain under investigation and therefore the root causes may not yet be known. Professor Maddock added that an increase in medication incidents was positive, as the Trust was encouraging a higher reporting rate, therefore the focus needed to consider the associated level of harm.

Mr White highlighted the following in relation to urgent care performance:

- There had been a slight deterioration across most of the metrics in part due to a 12% rise in activity and 8% rise in admissions
- Improvements had been made on the urgent care pathway and the Trust was continuing to focus on the exit measures of the NHS Oversight Framework
- A refresh of the bed model was underway
- The Trust missed the non-admitted performance target by 1% and meetings were taking place with the Emergency Department leadership team to review the plan, consider the support required and identify how the Trust could get back on trajectory

Mr Wakefield referred to non-admitted patients and queried the ability to achieve the 85% target. Mr White stated that the 76% target was for all activity across the system and as such the Trust aimed to achieve 80% non-admitted performance at Royal Stoke.

Mr Wakefield referred to non-admitted patients and queried whether it was a lack of bays impacting on performance. Mr White stated that to a large degree the estate was not a limiting factor to this, unless in extremis, due to the improvements previously made to the front door which created more space for non-admitted patients.

Dr Griffin referred to the larger number of Bank Holidays in May which may have affected demand / performance in addition to industrial action and queried whether these had impacted performance. Mr White stated that the Bank Holidays did impact performance although it was difficult to quantify, but in terms of Industrial Action this had a minimal impact and in some cases a slight benefit on the day.

Professor Maddock queried why the number of 12 hour trolley waits doubled in May and Mr White stated that this was due to the Bank Holidays, and 8% increase in admissions as well as the rise in activity, which led to extended trolley waits.

He stated that this had been improving since December but the Trust had a long way to go. He expressed his disappointment in the rise of ambulance handovers during this period, although when considering the number of lost hours, this equated to approximately 300 hours a week which was a significant improvement from the winter baseline.

Mr Oldham queried whether the number of increased admissions and flat bed occupancy had been triangulated to understand whether the increase was due to readmissions and Mr White stated that this had not been reviewed and agreed to consider.

Mrs Thorpe highlighted the following in relation to cancer performance:
- Two week wait performance was 93.91% in April and 94% in May
- 62 day standard performance was 60.2% in April and 57.8% in May and this was expected to continue at that level for the next few months as the Trust focussed on treating longer waiting patients
- 28 day faster diagnosis performance for April was 63.2% and 63.6% in May
- A detailed recovery plan was in place for endoscopy including prioritisation of bookings, reviewing the administrative booking of patients and insourcing of work

Mr Wakefield queried if the workplan for endoscopy was robust and Mrs Thorpe stated that meetings took place three times a week to review the Patient Tracking List to ensure patients on the lists were being booked in the right way. In addition whilst actions were being undertaken, these would take some time before they had a positive impact on results. She highlighted that ring-fenced surgical capacity for colorectal patients was in place should they require surgery following an endoscopy.

Mrs Thorpe highlighted the following in relation to planned care performance:
- The 104 week validated position for May was 36 and the unvalidated position for June as 9
- The 78 week validated position for May was 522 and the unvalidated position for June was 312
- Actions for planned care were highlighted such as theatre productivity and additional locums
- The 65 week position was tracking positively against its trajectory

Dr Griffin referred to the unvalidated June figures and queried what proportion of these would have a date. Mrs Thorpe stated that all 104 week patients will have a date and for 78 week patients, these would be a combination of admitted and non-admitted patients and these patients would have their next step in place.

Mrs Thorpe highlighted that in terms of diagnostics the only area of concern was endoscopy and added that non-obstetric ultrasound continued to show improvements.

Mr Wakefield thanked Mrs Thorpe and Mr White for the depth of reporting, the assurance provided and the level of detail. He stated that whilst tackling the backlog was a national problem he welcomed the steps being taken.

Professor Hassell referred to the number of outstanding echocardiograms and queried whether this was cause for concern. Mrs Thorpe stated that there was a backlog and an insourcing solution was in place alongside a plan for overtime and noted patients were being clinically prioritised.

Mrs Haire highlighted the following in relation to workforce performance:

- The new people report to TAP included 3 driver and 5 watch metrics, which would be regularly reviewed
- Sickness absence had reduced to the lowest rate since Spring 2021
- There had been a slight reduction in performance and development reviews (PDRs) and statutory and mandatory training performance was slightly below the target, with a focus on essential to role training.
- There had been some improvement in turnover and vacancies which reflected the ongoing work regarding improving culture
- Following publication of the long term workforce plan, the Trust was to engage with internal and system/regional stakeholders to understand the impact on UHNM
- The Trust had launched new flexible retirement guidelines
- Over 1000 participants had taken part in the Being Kind sessions with excellent feedback received and a further 1200 colleagues booked for the July sessions

Mr Wakefield welcomed the reduction in sickness absence but highlighted the importance of addressing PDR and statutory and mandatory training compliance.

Ms Bowen congratulated the Trust on the roll out of the Being Kind training and queried the uptake. Mrs Haire stated that this was open to all staff although some groups were under represented such as medical and dental staff and this was being addressed by Dr Lewis in highlighting the importance of attending the training with this group of staff. She highlighted that e-learning would be subsequently introduced.

Mr Oldham highlighted the following in relation to financial performance:

- Month 2 delivered a deficit of £3.8 m against a surplus plan of 1.7 m
- Key drivers were delivery of the stretch element of the cost improvement programme (CIP) although this was being mitigated by provisions on annual leave which had not yet been transacted. In addition, CIP targets in Divisions were not seeing the right level of traction therefore these had been identified as a driver metric to be followed up in divisional performance reviews
- The other key driver to the financial position was the non-closure of escalation capacity due to increasing non-elective activity which incurred additional costs. It was noted that there was some funding in the ICB for discharge and this was being worked through whilst It was recognised that the discharge fund would not cover all costs.
- The final driver was the costs of cover for the industrial action which was estimated to date at £1.2 m.
- The year-end position was an unmitigated risk of between £10 m and £15 m
- The progress against CIPs against the overall £55 m was £47 m of schemes being identified and capital was on track with no concerns on cash

Dr Griffin queried if escalation capacity was expected to continue to be open and whether this had been factored into projections. Mr Oldham stated that the PwC bed model was correct during winter but there had been increases in April and May, therefore the bed model was being refreshed which would help in terms of the forecast and working through the assumptions.

Mr Akid queried if Get It Right First Time could help to inform CIPs and Mr Oldham explained that this was discussed as a system although the challenge was the backlogs and any productivity gains would be used for delivering more activity rather than taking cash out.

Mr Oldham highlighted that a formal forecast was being undertaken following the

	Month 3 position which would be considered in August / September. **The Trust Board received and noted the performance report.**	
CLOSING MATTERS		
12.	**Review of Meeting Effectiveness and Review of Business Cycle**	
115/2023	No further comments were made.	
13.	**Questions from the Public**	
116/2023	No questions were received from the public.	
DATE AND TIME OF NEXT MEETING		
14.	**Wednesday 2nd August 2023, 9.30 am, Trust Boardroom, Royal Stoke**	

Extraordinary Trust Board

Meeting held on Wednesday 28th June 2023 at 1.05 pm to 1.20 pm via MS Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

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

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

In Attendance:

Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mrs S Preston	SP	Strategic Director of Finance

Members of Staff and Public: 0

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
099/2023	Mr Wakefield welcomed Board members to the meeting. Apologies were received as recorded above, and the meeting was confirmed as quorate. Mr Wakefield thanked Mrs Cotton for pulling the Annual Report together and for the excellent document which had been prepared.	
2.	**Declarations of Interest**	
100/2023	There were no declarations of interest raised.	

GOVERNANCE		
3.	**Audit Committee Assurance Report (16-06-23)**	
101/2023	Mr Wakefield highlighted the main points from the report: • The Committee had recommended the Annual Report and Accounts for approval • The Committee wished to receive an update on the annual leave issue in addition to the revised valuation which was agreed to be picked up as part of the accounts item **The Trust Board received and noted the assurance report.**	
4.	**2022/23 Annual Report and Annual Governance Statement**	
102/2023	Mrs Cotton highlighted that the report had been consulted upon and prepared in line with the Group Accounting Manual. A review of the year presentation based on the highlights within the report was to be prepared for the Annual General Meeting. **The Trust Board approved the 2022/23 Annual Report.**	
5.	**2022/23 Annual Accounts**	
103/2023	Mr Wakefield queried the impact of the change in valuation and requested an update be provided. Mr Oldham highlighted the following: • Page 87 highlighted the changes made since presentation at the Audit Committee • The valuation of buildings was based on gross internal area in order to determine the Modern Equivalent Asset (MEA) valuation • The 2019/20 gross internal area had increased and the explanation for the movement was accepted by the auditors and the Trust • Testing had been undertaken this year which had highlighted the omission of some lines in the drawings, resulting in the gross internal area taking into account courtyards and as such this was incorrect • The error had resulted in a cumulative overvaluation of £22.5 m which was material to the accounts and therefore the accounts were adjusted to reflect this • A prior period adjustment to previous years was also required to restate the correct value • The External Audit remained ongoing and the draft Audit Findings Report (AFR) had been received with a partner review of the AFR taking place after which a final audit opinion was expected • The AFR highlighted the two changes; the unadjusted error due to depreciation associated with the revaluation equating to £470,000 and following sampling one error regarding an invoice of circa £700,000 but this had been challenged • A revised letter of representation was to be provided which required signing and took into account the minor changes regarding prior period adjustment Mr Wakefield referred to the valuation change and the changes to the valuation of assets on the balance sheet as well as depreciation. He summarised that whilst the P&L was not to be changed he queried if this would impact on the availability of capital funded via depreciation. Mrs Preston stated that this would not be	

	impacted as it was set on basic inflation for a period of time, but it could possibly have an impact in the future when it was reset. Mr Wakefield thanked the finance team for delivery of the accounts **The Trust Board approved the audited annual accounts, and agreed to sign off the following:** • **the Statement of Financial Position;** • **the accompanying certificates relating to the accounts and summarisation schedules; and** • **the Management Letter of Representation.** **The Trust Board requested to be notified of any further changes and it was agreed to circulate the Audit Findings Review to Board members for information. It was noted that that electronic signatures were deemed acceptable when signing both the accounts and Annual Report which were to be submitted to NHS England by 30th June 2023.**	
DATE AND TIME OF NEXT MEETING		
6.	**Wednesday 5th July 2023, 9.30 am, via MS Teams**	

Trust Board (Open)

Post meeting action log as at 27 July 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/579	03/05/2023	Integrated Performance Report - M12	To provide a summary to board members of the nuances associate with vacancy and sickness rates and links to the nursing uplift.	Jane Haire Ann Marie Riley	~~30/06/2023~~ 30/08/2023		A deferred date has been requested pending the start date of the Assistant Director of Workforce Information who took up post on 26th June 2023. It is proposed that a briefing paper is provided through the Transformation and People Committee for discussion and this will be further consisdered alongside the next nurse establishment review due in October 2023.	A
PTB/581	07/06/2023	Maternity Quality Governance Committee Assurance Report (23-05-23)	To provide comparisons of the percentage of women who smoke during pregnancy and the percentage of women with gestational diabetes with the national averages	Ann Marie Riley	~~05/07/2023~~ 23/08/2023		Update provided at July's meeting. Mrs Riley explained that national data was available and this would be shared through the Maternity Quality Governance Committee in August.	GB
PTB/582	07/06/2023	Integrated Performance Report – Month 1	An update be provided to PAF on the numbers of patients with a long length of stay and how this compared to peers.	Simon Evans Katy Thorpe	25/07/2023		**Update to be provided.**	GB

Chief Executive's Report to the Trust Board

July 2023

Part 1: Contract Awards and Approvals

2.1 Contract Awards and Approvals

Since 15th June to 13th July, 1 contract award over £1.5 m was made, as follows:

- **Supply of Sutures** supplied by Johnson & Johnson, Medtronic, for the period 01.07.23 – 30.06.26, at a total cost of £2,115,184.68, providing cost reduction savings of £22,734.81 and in-year negated inflation of £21,151.85 approved on 30.05.23

In addition, the following eREAF was approved at the Performance and Finance Committee on 25th July, and also requires Trust Board approval due to the value:

Linen and Laundry Services (eREAF 11312)

Contract Value	£7,394,861 incl. VAT
Duration	01/08/23 – 31/07/25
Supplier	Berensden (Elis)
Savings	For this period there is a cost avoidance saving of £147,035.

The Trust Board is asked to approve the above eREAF.

2.2 Consultant Appointments – July 2023

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant in Obstetrics and Gynaecology	Vacancy	TBC	TBC
Locum Consultant Clinical Oncologist - Breast & Colorectal	New	TBC	TBC
Consultant Urologist	Vacancy	TBC	TBC
Locum Consultant in ENT General & Paediatrics	New	Yes	TBC
Locum Consultant ENT Rhinology Surgeon	New	Yes	TBC
Consultant Paediatric Orthopaedic Surgeon	New	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Locum Consultant Spinal Surgeon	Extension	01/07/2023
Locum Consultant Obstetrician and Gynaecologist	Extension	01/07/2023
Locum Consultant Colorectal Surgeon	Extension	10/07/2023
Consultant Orthopaedic Foot and Ankle and Limb Reconstruction	New	17/07/2023

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

Post Title	Closing date	Note
Specialist Doctor in Body Imaging	New	No Suitable applicants
Specialist Doctor in Breast Radiology	Vacancy	No Suitable applicants

2.3 Internal Medical Management Appointments – July 2023

There were no interviews or medical management that joined the Trust during July 2023, and no medical vacancies closed without applications / candidates.

Part 2: Highlight Report

High Quality Responsive People Improving & Innovating System & Partners Resources

National / Regional

3.1 Care Quality Commission – Removal of Section 31

On 14th July I was pleased to receive formal confirmation from the Care Quality Commission that they have now completed their assessment and have taken the decision to remove their Section 31 conditions of registration. The conditions related to the triage of patients within 15 minutes of arrival to our Emergency Department at Royal Stoke and meant that from 26th June 2019 we have had to provide a weekly report to the Care Quality Commission on actions we have taken along with latest performance.

We will receive a new certificate of registration in due course. My thanks go to all staff involved in making and sustaining the improvements needed which currently put our performance a one of the top 5 in the Country.

3.2 Industrial Action

Junior Doctors Strike

The British Medical Association (BMA) Junior Doctor Industrial Action began on Thursday 13th July to Tuesday 18th July – the longest strike action in NHS history. We were able to maintain many services for emergencies and urgent care, including cancer treatments. However, the extended period of industrial action had a significant impact on our ability to look after some of our patients, with a large number of outpatient appointments rescheduled and elective procedures being postponed.

Once again, many staff have had to work flexibly to cover the gaps in junior doctors rotas and my thanks go to everybody who has helped to protect patient care during this time.

Consultant Strike Action

Consultant strike action began on Thursday 20th July until Saturday 22nd July, although in contrast to strike action among other staff groups, no other clinicians can provide cover for consultants which meant that planned care delivered by junior doctors or other healthcare professionals that required even remote consultant supervision had to be rescheduled. Whilst this strike had a greater impact on elective and planned care we were still able to undertake a number of such procedures as not all Consultants chose to strike

Society of Radiographers Ballot Outcome and Strike Action

On 7th July we received notification from NHS England that the Society of Radiographers (SoR) had issued a mandate in 40 organisations and that they planned to take industrial action from Tuesday 25th to Thursday 27th July.

UHNM received the ballot outcome letter and did not meet the threshold for action and therefore no notification of strike was received.

3.3 Midlands Allied Health Professional (AHP) International Recruitment Regional Advisor Post

On 28th June we received news from the Regional Lead for Professional Nurse Advocacy at NHS England that we had been successful in our expression of interest to host the Midlands AHP International Regional Advisor post.

This is another excellent development for our Centre for Research Education and Excellence (CeNREE) as the post will sit within that team. We are now in discussions with the region around taking this forward.

3.4 National Joint Registry (NJR) Quality Data Provider Award – County Hospital

On 10th July I received the excellent news that County Hospital had been awarded as an NJR Quality Data Provider for 2022/23. The scheme was devised to offer hospitals public recognition for achieving excellence in supporting the promotion of patient safety standards through compliance with the mandatory NJR data submission quality audit process and by awarding certificates, the scheme rewards those hospitals, including ourselves, who have met the targets.

My thanks go to all involved in this achievement.

3.5 Targeted Investment Funding (TIF) – County Hospital Elective Hub

On 19th July we received formal confirmation from NHS England of our TIF award for the construction of our new Elective Hub at County Hospital. Separation of elective activity is a key foundation of our elective recovery plan and there are already over 90 elective surgical hubs in operation across England.

It is an expectation that these hubs are set up as system wide assets and once fully operational, good theatre utilisation and clinical outcomes are expected in line with Getting it Right First Time (GIRFT) standards. An accreditation process in collaboration with the Royal College of Surgeons is being rolled out nationally and we have been urged to apply for this accolade, which brings benefits for both staff and patients.

3.6 NHS75 Celebrations

It was fantastic to see our teams celebrating the NHS 75th birthday. Our very own Consultant Orthodontist Dr Karen Juggins attended an event at 10 Downing Street for local NHS champions. Janet Hagan, Head of Nursing at our Staffordshire Children's Hospital, Filomena Flanagan, Biomedical Scientist and Angela Johnson, Sister at our Post Anaesthesia Care Unit were also invited to attend a celebratory service at Westminster Abbey.

I had the opportunity to judge the bake-off competition at Royal Stoke and our Chief Nurse took on the role at County Hospital. It was also great to have so many positive staff and patient experiences feature on BBC Radio Stoke and BBC online. My thanks go to everyone who got involved in making the day a special one here at UHNM.

System Focus

3.7 System Planning Event

On Friday 14th July, all healthcare partners across our system came together at a planning event to look at how we can address our finance, workforce and performance challenges. There was recognition that we all need to work together to provide the most efficient and effective care for the communities we serve, and this means us working differently to prevent duplication, provide speedy access to the right service first time and to collaborate on support functions.

I will keep the Board updated as this work progresses.

Organisational Focus

3.8 Staff Awards Judging

I am very much looking forward to our Night Full of Stars Staff Awards event on 15th October. During the month, nominations closed and I was delighted to be part of the judging panel for the Being Kind Award. I know that my Board colleagues have also enjoyed being part of this process as it is always very humbling to read the amazing things our staff do every day for each other and for our patients.

3.9 Medical Students

I was delighted to be invited by Fidelma O'Mahoney, Hospital Dean for Keele University and one of our Obstetrics and Gynaecology Consultants, to meet with Keele's year four medical students. Along with other UHNM colleagues, I had an opportunity to talk with more than 80 students, encouraging them to choose UHNM as the place for them to train and work in the future.

3.10 North Staffordshire Hand Centre / County Hospital Developments

I was able to congratulate the team working in the North Staffordshire Hand Centre on their first day of opening in their new facility and meet our very first patient just after her operation. I was also able to meet and say hello to some of our colleagues in outpatients and find out how things were going for them and their patients.

Exciting new developments continue to be planned for County Hospital and I am thrilled that we now have funding and approval from the national team to develop our Day Case Unit on the site. We have also put forward a case for funding a new breast unit at County Hospital although we have been asked to provide further information about this.

3.11 Stroke Association

I met with the Chief Executive of the Stroke Association, who was invited by Dr Sanjeev Nayak, Consultant Interventional Neuroradiologist, to see our leading thrombectomy and stroke services. The feedback was overwhelmingly positive, in particular around our excellent team and the impressive service on offer for our patients.

3.12 Women's Network

On 7th July we launched our Women's Network. More than 40 people joined the first meeting, chaired by Dr Ann-Marie Morris, Deputy Medical Director, to share their experiences and hear from guest speaker Professor Sunita Toor, Non-Executive Director.

Quality Governance Committee Chair's Highlight Report to Board

27th July 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • The Infection Prevention Healthcare Associated Infections report highlighted an unavoidable MRSA bacteraemia reported in April and one in May where some lapses in care were identified, although the patient made a full recovery. In addition the Trust was above the upper limit for clostridium difficile with the main actions focussing on antibiotic prescribing as well as identifying learning from other better performing organisations. • Readmissions remained higher than expected including higher number of readmissions for elective patients although no specific diagnostic codes had been identified as driving higher rates. The appropriateness of readmissions were discussed, in terms of this often being the most suitable patient pathway and the Committee noted the continued review of readmissions in identified specialities to identify potential causes for higher rates, and actions for improvement • The Quality performance report for Month 3 highlighted that the Trust continued to be below the target for the friends and family test in ED with a slightly reduced response rate and continued actions were being taken to explore the approach from other Trusts. • The continued high number of pressure ulcers was challenged as well as the lack of impact of the actions taken to date. An overview of the actions being taken by corporate nursing were highlighted as this remained an area of focus to identify the underlying factors and it was agreed to provide a further assurance on this to the meeting in August	• Ongoing work being identified with regards to continuing to communicate the importance of antimicrobial stewardship and the impact of antimicrobial prescribing for urinary tract infections on the number of clostridium difficile cases. • To consider whether an alert when prescribing co-amoxiclav could be added within the specification for clinical decision support • To continue to work upon the new format of the draft Infection Prevention Board Assurance Framework including obtaining additional assurance before being considered by the Trust Board • To continue to share the work which was being undertaken with the vulnerable patient Communications and Interactions Engagement Project • To discuss the readmissions report with the Data Quality Forum to improve coding and future reporting with the aim of identifying whether these were avoidable or not • To identify whether any benchmarking was available for the maternity friends and family test • To clarify the risk reduction trajectory for BAF 1 as to whether it was expected to reduce in Quarter 3 due to the impact of Industrial Action. In addition, to review the elements included within the progress statement to ensure these were relevant to the BAF as well as clarifying the rationale for including Executive Groups within the Divisional first line of defence
✓ Positive Assurances to Provide	**Decisions Made**
• The Committee welcomed the update provided in relation to the changes made to improve the current complaints process in terms of timeliness of responses and avoiding complaints moving to a formal complaint. This included the introduction of triaging complaints and co-producing improvements with patient representatives • UHNM had been identified as providing inconsistent reporting to the National Reporting and Learning System (NRLS) and this related to capacity issues within the Department in August 2022 although the Trust had subsequently provided regular reports and this was expected to be rectified in the next report and reported was expected to cease once the Learning from Patient Safety Events (LFPSE) system was implemented	• The Committee approved the Quarter 1 Board Assurance Framework
Comments on the Effectiveness of the Meeting	
• The Committee welcomed the robust discussions held particularly in relation to infection prevention and readmissions	

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Infection Prevention HAI Report – Q1 23/24	BAF 1	Ext 16	!	Assurance	6.	Quality Performance Report – Month 3 23/24	BAF 1	Ext 16	!	Assurance
2.	Infection Prevention Board Assurance Framework Q1 23/24	BAF 1	Ext 16	-	Assurance	7.	UHNM & National Reporting & Learning System Report	BAF 1	Ext 16	✓	Assurance
3.	Complaints Process Review - Position Statement			✓	Assurance	8.	Q1 Board Assurance Framework	All	Various	-	Approval
4.	UHNM Readmissions Analysis	BAF 1	Ext 16	!	Assurance	9.	Quality & Safety Oversight Group Assurance Report	BAF 1	Ext 16	-	Assurance

3. 2023 / 24 Attendance Matrix

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

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

Performance and Finance Committee Chair's Highlight Report to Board

25th July 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • Urgent care performance for June was flat due to high demand, a relative rise in medically fit for discharge patients, although this had since reduced, and elimination of outliers which supported the elective position. In terms of the lack of improvement in the 4 hour standard additional actions had been put in place with weekly meetings to review the detail • The mismatch between capacity and demand was highlighted and the options available for mitigation by working with system partners was discussed • The June cancer backlog position was highlighted as 513 which was the same as May • DM01 performance was maintained at 66% with endoscopy continuing to be the highest area of risk • Financial performance as at month 3 demonstrated a deficit of £5.9 m which was an adverse variance to plan of £8.3 m. Key drivers were continuing use of winter escalation capacity, industrial action escalation costs, cost improvement under-delivery and a risk associated with receipt of elective recovery monies • A presentation was provided on the output of the financial forecast which provided a draft best case, worst case and realistic year end position. A formal paper was to be presented to the Committee in August.	• A progress update was provided against the independent review of waiting list management which highlighted ongoing validation whereby the outputs would be provided to the Committee in due course • To provide a summary of the changes made to Community Diagnostic Centre Business Case to the Trust Board • It was agreed to clarify the impact and reasons for increased length of stay and conversion rates • New cancer standards expected to be released in July / August • A paper re-profiling the capital spend to be provided to the Committee in due course • With regards to the Board Assurance Framework, it was agreed to consider the inclusion of the additional actions being undertaken in relation to waiting list management within BAF 5. In addition, the assurance ratings were to be reviewed against the reported RAG ratings of actions to be taken to ensure these were consistent • Executive Strategy and Transformation Group to consider the Trust's approach to innovation and whether this reflected the Trust's Risk Appetite of 'Seek'
✓ Positive Assurances to Provide	**Decisions Made**
• Cancer performance demonstrated maintenance of the two week wait standard at 95% and the 28 day faster diagnosis standard reported an anticipated validated position of circa 67% which was on trajectory and hit the first national delivery milestone • In terms of planned care, the position for June for 104 week patients ended at 10 which was an improvement from 36 in May. July's position was forecast to be 5, including the impact of industrial action (IA). The number of 78 week patients reduced to 322 in June from 522 in May and 197 forecast for July, again including IA.	• The Committee approved BC-0529 Overseas Nurses Business Case and requested that a 6 month post implementation review be provided in due course • The Committee approved the changes to the Community Diagnostic Centre business case following national feedback and receipt of additional capital although there was a risk highlighted with regards to revenue • The Committee approved the following e-REAFs; 11247, 10718, 11346 and 11312 • The Committee approved the Quarter 1 Board Assurance Framework

Comments on the Effectiveness of the Meeting

- No further comments were 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.	BC-0529 2023/24 Overseas Nursing Business Case	BAF 2	Ext 16	-	Approval	5.	Performance Report – Month 3 2023/24	BAF 1 BAF 5	Ext 16 Ext 20	! ✓	Assurance
2.	CDC Business Case Approval Update	BAF 5	Ext 20	-	Approval	6.	Finance Report – Month 3 2023/24	BAF 8	High 9	!	Assurance
3.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	-	Approval	7.	Quarter 1 Board Assurance Framework 23/24	ALL	Various	-	Approval
4.	Independent Review Programme Governance	BAF 5	Ext 20	-	Assurance	8.	Planned Care Improvement Group Highlight Report	BAF 5	Ext 20	-	Information

3. 2023 / 24 Attendance Matrix

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

Attended | Apologies & Deputy Sent | Apologies

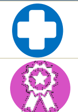
Executive Summary

Meeting:	Trust Board	Date:	2nd August 2023
Report Title:	Integrated Performance Report, Month 03 2023/24	Agenda Item:	
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & Safety; Operational Performance: Warren Shaw, Strategic Director of Performance & Information; Matt Hadfield, Associate Director of Performance & Information. Workforce: Jason Ahern, Assistant Director of Workforce Information; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Simon Evans: Interim 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

Quality & Safety

Situation

The report provides latest (June 2023) update on the different Quality Indicators. There have been updates to the report to include, where possible, peer benchmarking against various quality indicators. These indicators, where applicable, utilise SPC charts and to allow for comparisons allowing for activity and benchmarking, the rate per 1000 bed days. The use of rates per 1000 bed days allows comparison between organisation and national targets/benchmarking by allowing for different activity levels and not just the comparison of raw total numbers. The charts/indicators with only raw total numbers are used to provide internal analysis of the indicators so can also compare different months to set target totals i.e. C Diff Cases, E Coli cases, MRSA which have set target per month

already calculated and set nationally for the organisation.

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

Assessment

Friends & Family Test for A&E has declined during June 2023 and remains below the 85% target of patients recommending the service. Whilst there has been decline in the results in recent months the June figure is still around the mean recommending rate. There has also been a reduced response rate with 8% (818 returns) in May 2023 compared to 896 in May 2023. This is reduction from over 1200 in April 2023. In order to review the reasons for the reduced response rate and recommending score, the ED teams and Patient Experience Team have re established the individual workstreams to review the different processes and develop actin plan to increase responses rates and to address the latest National Urgent & Emergency Care 2022 survey results.

Inpatient FFT results are still above the 95% target. Whilst the results score has improved this month it is still slightly below the longer term mean. The response rate has remained steady at 23% in June 2023. There were over 2500 responses returned in June 2023 from 65 different inpatient and day case areas across UHNM. There are key improvement initiatives identified previously are continuing and focus on key priorities identified within the FFT returns – timely medications, better pain management and improving the involvement of patients and/or family in care and decision making

There has been slight in month reduction for Maternity FFT below the 95% target at 89.5%. However for the second month in a row (after text messaging service launched in February 2023), June 2023 saw increased numbers of returned surveys with 111 (91 in May 2023) and 46 completed from the Birth touchpoint.

Complaints rate was above the target/benchmark rate of 35 for first time since February 2021 but is still well within normal variation.

The number of reported patient safety incidents remain above the long term mean but has decreased very slightly this month although the rate per 1000 bed days has continued to remain relatively stable and is within normal variation limits.

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers continue to be Patient Falls, Medication, Patient Flow and then Clinical Assessment related incidents. There have been 102 (increase from 97 in May but reductions compared to previous months 117 in April, 157 in March, 170 in February and 228 in January 2023) of the incidents identified as related to 'Your Next Patient' which accounts for 4.8% the same as May 2023 (6.21% in April, 7.4%in March, 9.8% in February and 12% in(January 2023) of total patient safety incidents. 36.2% (34% previous month) were Tissue viability. However, 97% of these were NOT hospital acquired but recording pressure damage on admission/attendance at UHNM.

Moderate harm or above incidents, both raw numbers and rate per 1000 bed days have increased in June 2023 but remain within normal variation following previous increases reported in December 2022 and January 2023. There is still a longer term increase and remain above the long term mean although total and rate are now nearer to the mean averages. It is key to note that during JUne 2023 there have 2 'Your Next Patient' / patient flow related incidents however the harms were not as a result of utilising the YNP procedures. As noted in previous month's report previously the different working practices and patient flow pathways continue to show positive impacts.

Medication related incidents have continued to increase as part of the drive to improve reporting of medication errors/incidents. However, whilst there have been increases in the total numbers there have been continued longer term reductions in the percentage of these incidents that have resulted in moderate harm or above. This can be reflective of positive reporting culture with increased reporting but level of harm reducing

Serious incident numbers and rates continue to show longer term reduction trend which supports the noted reductions in incidents with moderate harm of above and overall patient safety incident reporting. Falls continue to be the main reason for serious incidents being reported during the current year but during June the largest category were Diagnostic related incidents. Some of these were notified following identification/reporting in retrospect of missed diagnoses.

There was 0 new Never Event reported during June 2023.

Duty of Candour compliance for evidence in written notification has improved to 84.2% and is the best performance for 9 months. The dedicated sessions with various Directorates and clinical teams appear to have had positive impacts along with the increased support and escalations from the Divisional Quality & Safety Managers.

Hospital Associated Thrombosis rate has reduced further in June 2023 with 15 cases and a rate of 0.74 per 10,000 admissions.

The current position for received patient Safety Alerts shows that there was 1 new Patient Safety Alerts issued during June 2023 and this remains under review with completion date of 01.12.2023. There remains 1 overdue Nat/PSA 2021 005 MHRA - Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particles and volatile organic compounds. Thus remains open whilst the final risk assessment is signed off. The risk is being managed and reviewed at the Medical Devices Steering Group and plan is for the risk assessment to be finally agreed at July 2023 meeting.

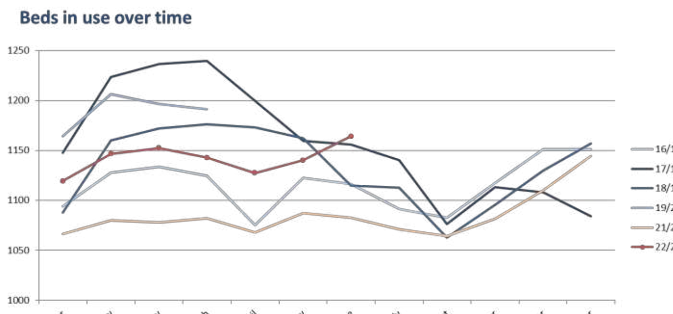
All data used in this report is as recorded on 7th July 2023 and figures may change following further review/investigation/update

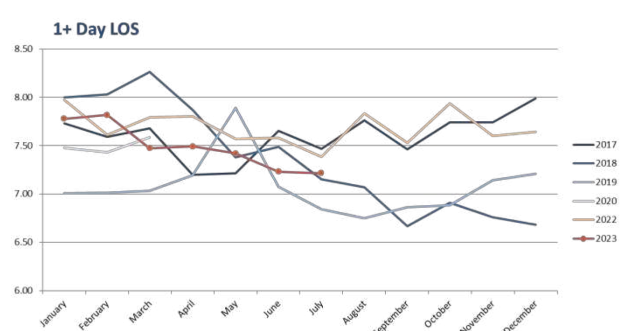
Operational Performance

Emergency Care

- June saw a maintainance of most metrics following slight deteriorations in May across the majority of Non-Elective Care KPI with an overall Four Hour Performance of 68.8% against a target of 70.0%. This represents a 1.2% negative variance to target and the first month in which the overall Four Hour Performance trajectory has not been achieved. This is primarily driven by a lack of improvement against the Four Hour Standard for non-admitted patients in RSUH ED, compounded by increasing conjestion as a result of unexpectedly high demand and an average 20%+ four week rise in MFFD patients (although at the time of writing this has now returned to baseline levels).

- It is apparent that the agreed actions described last month to support delivery of non-admitted performance focussed on non-clinical administrative support (productivity), additional consultant support during known hours of challenge (capacity), and the final expansion of the modular Fit2Sit area (infrastructure), have not precipitated the necessary improvments. In response to this weekly meetings the with Divisional and Departmental leadership teams, chaired by the Deputy Chief Operating Officer have now commenced in order to ensure appropriate oversight and support.





- It can be seen from the intial outputs of the Bed Model refresh that in unprecedented fashion, demand on our bed base has continued to rise with activity now officially returning to pre-pandemic levels. This can be seen to be against an improving LOS trend at a macro level, confirming that this is indeed an activity and demand challenge. This is further compounded by an elective bed usage that is 114% of 2019/20 levels, driven by a significant reduction in the number of outliers, and an increase in elective activity. This comes together to demonstrate an increasing pressure in particular on RSUH Medicine beds with a current estimated deficit of 88 beds against core bed base even going into summer months. The detail of this will be confirmed in the upcoming Bed Model Refresh presentation as per the P&F Action Log.

- It has now been confirmed that the £20m+ combined capital and revenue monies following a successful bid for the Additional Capacity Targeted Investment Fund will be utilised to develop the AMRA service and provide a dedicated and standalone unit outside the RSUH ED. This will release 30 G&A beds and 10 assessment trollies for the Medical Division in support of the previously described deficit. Early estimates continue to place completion of the unit between January and March 2024 and progress against delivery continues to be robustly managed through Workstream 2 reporting through the Non-Elective Improvement Group on a monthly basis.

Cancer

- Two week wait performance continues to book within standard at 14 days, currently at 95.69%. This has been maintained in the face of high referral volumes.
- The 28 Day Faster Diagnosis position is currently 68% for June unvalidated; this had been showing signs of improvement towards the 75%target, however is feeling the impact of the endoscopy bcklog. This standard is the focus of an Improving together project covering all pathways.
- In June the backlog of patients eneded at 513. This position had been improving, deteriorated but has now strated to improve again as the challenges in endoscopy are worked through. This is described in detail on slide 24.
- The incremental decrease of the Skin and Colorectal backlogs have been modelled to continue past March 2023, this has been taken forward into the annual plan for the coming year. Colorectal is a pathway of concern feeling the impacts in the endoscopy delays.
- Most recent submitted Cancer Waiting Times position is May which was 67.5% for 62 day performance. June is currently predicted to be 52.1% although this will improve post validation, this is due to the number of treatments for our longest waiting patients increasing.
- The 62 day target has slipped its improvement trajectory due to the impact of endoscopy delays on the colorectal pathway, however capacity has been sourced to managing the backlog.
- 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 has been escalated to Tier 1 for for elective care and cancer will be included within weekly meetings with the Regional NHSE team, however due to the significant improvement in the cancer position this will be at summary level.

Planned Care

- Day case as a % of all elective work is currently 87.5%.
- 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. There were 322 78 week patients at the end of June, an improvement from Mays 522. A number of 104 remain with 10 at the end of June, an improvement on Mays 36.
- The Trust is currently working on a route to elimination of 78 weeks, as this has been impacted by industrial action.
- Theatre transformation has been added as an additional workstream under Planned Care and begins with a focus on moving from a 6-5-4 to a 6-4-2 booking process with support from the regional theatres team. This is now a driver for the surgical Improving together programme

RTT

- The overall Referral To Treatment (RTT) Waiting list currently sits at 78,866, this has been relatively stable over the past few months, although significantly higher than were we would want it to be .
- The number of patients > 52 weeks currently sits at 4,490, this is a decrease on the May month end of 4,706.
- The Trust has been escalated to Tier 1 for 104> & 78> performance with weekly meetings with the National NHSE team and considerable scrutiny and on site presence.

Diagnostics

- Overall DM01 performance was 66%, a deterioration from last month. The significant shift has been within endoscopy.
- Within DM01, the greatest proportions of >6 week waits are within endoscopy.
- Full DM01 recovery plan agreed which sees a plan for the Trust achieving 6ww, the timeline on this is dependant on the modality. This will be monitored through the planned care group. Key risk has been identified in endoscopy with weekly performance meetings instigated for the specialty. They will now be receiving some on site support from the NHSE diagnostic team for support recovery.
- Radiology backlog of reporting risk remains.
- Activity has remained largely consistent against previous months. Incentive schemes starting to improve activity (non-obs ultrasound notably)

<u>Workforce</u>

Key messages

- The 12m turnover rate in June 2023 decreased to 8.8% (9.58% in May) which remains below the trust target of 11%.
- The M3 figure of 10.2% highlights a third consecutive month's decrease in the overall vacancy rate.
- For M3, the in-month sickness rate increased by 0.24% to 4.63% (4.39% in May 2023). The 12-month

cumulative rate decreased to 5.46% (5.56% in May 2023).

- Stress and anxiety continues to be the top reason for sickness in June, which saw an increase of 0.2% in the last month to 23.1% (22.9% in May). Chest & respiratory problems saw a decrease of 1.3% in the last month to 17.7% (19% in May 2023).
- June 2023's covid-related absences stood at 98, which was 5.08% of the 1,929 open absences. This is a 0.97% increase on the previous month.
- On 30th June 2023, the PDR Rate decreased by 0.6% to 83.2% (83.8% in May 2023).
- Statutory and Mandatory training rate on 30th June was 94% (94.1% on 31st May 2023) showing a very slight decrease. This compliance rate is for the 6 'Core for All' subjects only.
- The Staff Voice trust survey, for June 2023, received a total of 1629 submissions providing an overall colleague engagement score of 6.30.
- The Being Kind face-to face events took place in June and July with over 2,000 colleagues in attendance. The events evaluated extremely well including lots of positive feedback on social media.
- We had a successful PRIDE month (flying the progress flag, Rainbow Badge scheme, a large scale "Pride Flags" banner reveal and attendance at Stoke Pride) all showing UHNM's commitment to LGBTQ+ inclusion for our colleagues, patients and communities (everyone is welcome).
- We Launched new Men's Health Group (during Men's Health Week) this group will initially meet bimonthly and provide a safe space for our male colleagues to talk, support one another, share information and advice on a range of health and wellbeing topics such as exercise, nutrition, mental health, financial wellbeing, health mots etc.
- Our system wide health and care careers virtual work experience project has been highly commended for the HSJ Digital Awards.
- Junior doctors took industrial action in June which required extensive coordination and cover from across the whole organisation.

Finance

Key elements of the financial performance year to date are:

- For Month 3 the Trust has delivered a year to date deficit of £5.9m against a planned surplus of £2.4m; this adverse variance of £8.3m is primarily driven by underperformance against the Trust's in year CIP target, the impact of industrial action and unfunded additional winter escalation capacity that remains open.
- The Trust has incurred £2.6m of costs relating to winter escalation capacity remaining open in Quarter 1; the Month 3 position assumes that this additional cost will be not be funded by the local ICB.
- The industrial action (IA) by Junior Doctors in April and June has cost the Trust £1.5m in backfill arrangements. Whilst this cost is unfunded the ERF target for the year is being reduced by 2% in relation to the April IA with further guidance expected for subsequent IA.
- To date the Trust has validated £10.8m of CIP savings to Month 3 against a plan of £13.7m. The Trust has recognised £1.3m of CIP due to an assumed reduction in the annual leave provision; this delivers 50% of the NR ICB stretch CIP target. Schemes of £47m have been identified for delivery in 2023/24. The PMO is currently working with scheme leads to develop robust plan to deliver these savings. The £8.0m divisional schemes remain unidentified.
- There has been £8.7m of Capital expenditure which is £0.6m above plan.
- The cash balance at Month 3 is £102.7m which is £21.9m higher than plan; this is mainly due to the profile of cash receipts. The underlying cash position shows that cash is £3m behind the plan at Month 3.

Key Recommendations

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

Integrated Performance Report

Month 03 2023/24

Delivering Exceptional Care with Exceptional People

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3	Operational Performance	28
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A note on SPC

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

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

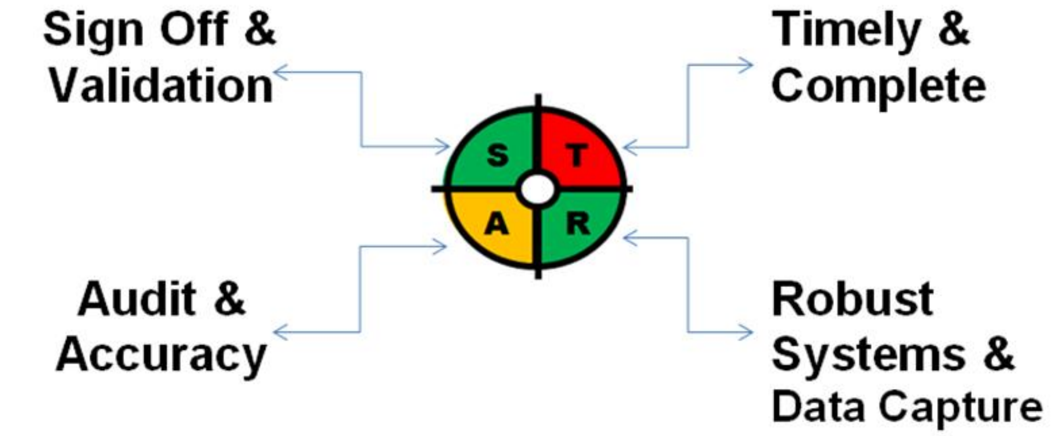
Assurance - how assured of consistently meeting the target can we be?

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

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

A note on Data Quality

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

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

Quality Spotlight Report

The Trust achieved the following standards in June 2023:

- Friend & Family (Inpatients) 96.0% and exceeds 95% target.
- Harm Free Care improved and continues to exceed 95% target rate with 97.8%
- 0 Never Event
- 100% verbal Duty of Candour compliance recorded in Datix
- Trust rolling 12 month HSMR continue to be below expected range.
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- Inpatient sepsis Screening and Sepsis IVAB within 1 hour achieved 92.8% and 100% respectively and above 90% target rate
- Children's Sepsis IVAB within 1 hour compliance maintained 100% and above the 90% target. IVAB within 1 hour also improved and achieved 100%

The Trust did not achieve the set standards for:

- Friend & Family (A&E) has declined and remains below 85% target at 71.4%
- Friend & Family (Maternity) 89.5% and below 95% target Falls rate was 6.2 per 1000 bed days for May 2023
- There were 27 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 84.2% compliance with Duty of Candour 10 working day letter performance following formal verbal notification and under review for completion and upload of letter on Datix
- Timely Observations remain below the 90% target but has seen improvement during recent months
- E. Coli Bacteraemia cases above trajectory with 23 in June compared to target of 16.
- C Diff YTD figures above trajectory with 14 against a target of 8.
- VTE Risk Assessment completed during admission below 95% target with 94.6% (via Tendable).
- Sepsis Screening compliance in Emergency Portals improved to 82.4% below the target 90%.
- Emergency Portals Sepsis IVAB in 1 hour improved to 73% but remains below the 90% target for audited patients
- Maternity Sepsis Screening compliance declined to 80% against 90% target
- Maternity IVAB compliance 67% and below the 90% target for audited patients
- 1 overdue and open Patient Safety Alert in relation to replacement of Phillips ventilator, CPAP/BiPAP machines. Issue of risk register and manage through MDSC

During June 2023, the following quality highlights are to be noted:

- The rate of complaints per 10,000 spells is 36.65and is above the target of 35 but within normal variation. The increase has seen the rate above the mean for the first time in 14. Majority of complaints in June 2023 continue to relate to clinical treatment.
- Total number of Patient Safety Incidents decreased in month (2112) but the rate per 1000 bed days has remained relatively constant at 51.92 and is within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents remain in control limits and normal variation levels. Rate of incidents have increased in month but is well below December 2022 peak.
- Rate of falls reported that have resulted in harm to patients currently at 1.5 per 1000 bed days. 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 8.3 which is higher than previous month but patient related 5.8 which are lower than previous month. The monthly variation is outside the normal expected variation but is in line with NRLS national rates. The % of medication incidents reported with moderate harm or above is 0 for June 2023 and reduction from previous 9 months.
- Pressure Ulcers per 1000 bed days with lapses in care developed under UHNM care is now 0.61 in June 2023 and above the target rate 0.5
- Hospital Associated Thrombosis has continued to decrease and is within normal variation and cases are under review.
- 11 Serious Incidents reported during with 8 falls related.
- SHMI has seen increases and under review for diagnosis groups but is within expected range (see funnel plot chart)

Quality Dashboard

Metric	Benchmark	Previous	Latest	Variation	Assurance
Patient Safety Incidents	N/A	2117	2112		
Patient Safety Incidents per 1000 bed days	50.70	51.09	51.92		
Patient Safety Incidents per 1000 bed days with no harm	N/A	34.56	34.98		
Patient Safety Incidents per 1000 bed days with low harm	N/A	13.97	14.16		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.81	1.79		
Patient Safety Incidents with moderate harm +	N/A	30	35		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.72	0.86		
Harm Free Care (New Harms)	95%	95.7%	97.8%		
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		
Patient Falls per 1000 bed days	5.6	6.2	5.3		
Patient Falls with harm per 1000 bed days	1.5	1.8	1.5		
Medication Incidents per 1000 bed days	6	7.4	8.3		
Medication Incidents % with moderate harm or above	0.50%	0.00%	2.90%		
Patient Medication Incidents per 1000 bed days	6	6.1	5.8		
Patient Medication Incidents % with moderate harm or above	0.50%	1.57%	0.00%		

Metric	Benchmark	Previous	Latest	Variation	Assurance
Serious Incidents reported per month	0	14	11		
Serious Incidents Rate per 1000 bed days	0	0.34	0.00		
Never Events reported per month	0	1	0		
Duty of Candour - Verbal/Formal Notification	100%	100.0%	100.0%		
Duty of Candour - Written	100%	80%	84.2%		
All Pressure ulcers developed under UHNM Care	TBC	76	64		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.40	2.10		
All Pressure ulcers developed under UHNM Care lapses in care	12	27	27		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.71	0.51		
Category 2 Pressure Ulcers with lapses in Care	8	6	6		
Category 3 Pressure Ulcers with lapse in care	4	3	2		
Deep Tissue Injury with lapses in care	0	8	7		
Unstageable Pressure Ulcers with lapses in care	0	7	5		

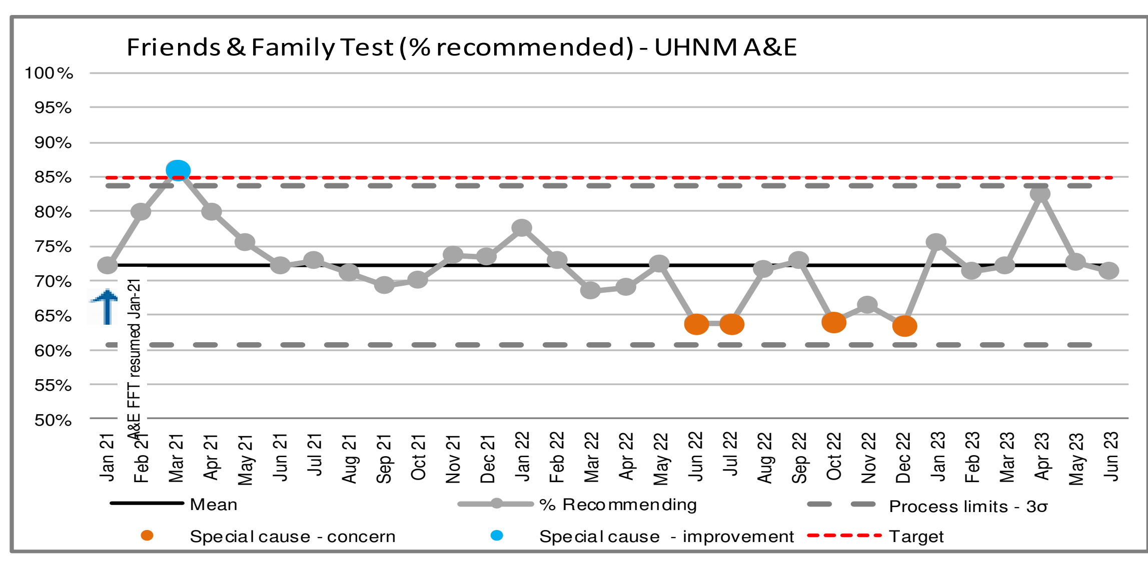
Quality Dashboard

Metric	Benchmark	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	72.5%	0.0%		
Friends & Family Test - Inpatient	95%	95.2%	0.0%		
Friends & Family Test - Maternity	95%	100%	100.0%		
Written Complaints per 10,000 spells	35	28.78	36.65		
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	95.73	96.49		
Rolling 12 Month SHMI (4 month time lag)	100	106.64	105.66		
VTE Risk Assessment Compliance	95%	98.0%	98.5%		
Timely Observations	90%	68.6%	70.7%		
Reported C Diff Cases per month	8	17	14		
Avoidable MRSA Bacteraemia Cases per month	0	0	0		
HAI E. Coli Bacteraemia Cases per month	16	19	23		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	50	7		

Metric	Benchmark	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	98.8%	92.8%		
Inpatient IVAB within 1hr (Contracted)	90%	97%	100.0%		
Children Sepsis Screening Compliance (All)	90%	93%	100.0%		
Children IVAB within 1hr (All)	90%	100%	100.0%		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	85.3%	75.3%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	71.43%	73.0%		
Maternity Sepsis Screening (All)	90%	89%	80.0%		
Maternity IVAB within 1 hr (All)	90%	100%	66.7%		

Delivering Exceptional Care with Exceptional People

Friends & Family Test (FFT) – A&E



Variation		Assurance	
Target	Apr 23	May 23	Jun 23
85%	82.4%	72.5%	71.4%

Background

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

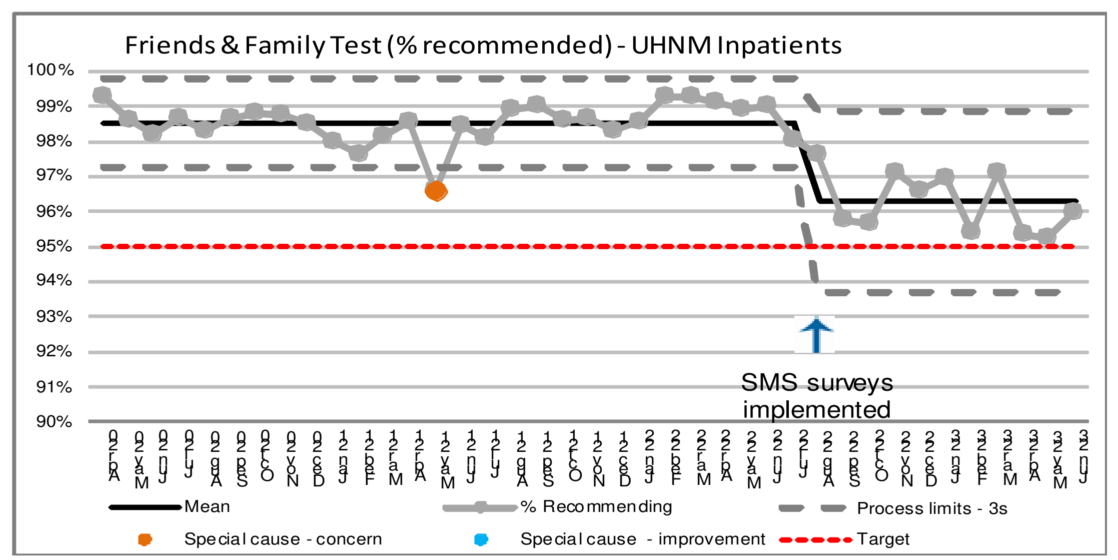
What do the results tell us?

- The overall satisfaction rate for our EDs remains below our internal target at 71.4% for June 2023 and remains on a downward trajectory.
- The Trust received 818 responses which is a decrease on the previous month with a 8% response rate for overall. The Trust's overall satisfaction rate is lower than the national average of 80% (NHS England February 2023- still the latest figure) at 71%. UHNM is 31st out of 125 Trusts for number of responses in ED (NHS England February 2023).
- Feedback from patient experience of using 111First and the kiosks is being monitored. 21% of respondents in June 2023 reported to have used 111First prior to attending ED, which is a slight decrease on previous months. Key themes from June 2023 remain the same: poor communication, long waits, especially related to Royal Stoke; lack of compassion and patient's feeling dismissed. And these are similar across RSUH and County Hospital.

Actions :

- Work streams have been re-established to look at individual processes
- Patient Experience Team have met with Senior Operational Services Manager regarding a plan to increase FFT response and satisfaction rates.
- ED team to create action plan based on National Urgent and Emergency Care 2022 survey results

Friends & Family Test (FFT) - Inpatient



Variation		Assurance	
Target	**Apr 23**	**May 23**	**Jun 23**
95%	95.4%	95.2%	96.0%

Background

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

What do the results tell us?

- The monthly satisfaction rate for inpatient areas continue to exceed both the internal target rate of 95% and the national average of 94% (February 2023 NHS England) at 96% for June 2023.
- In June 2023 a total of 2642 responses were collected from 65 inpatient and day case areas (11452 discharges) equating to a 23% return rate which is a the same as the previous month however remains lower than the internal target of 30%. UHNM remain the 14th highest response rate for all reporting Trusts in the country (154) NHS England February 2023 (still the most recent data available).

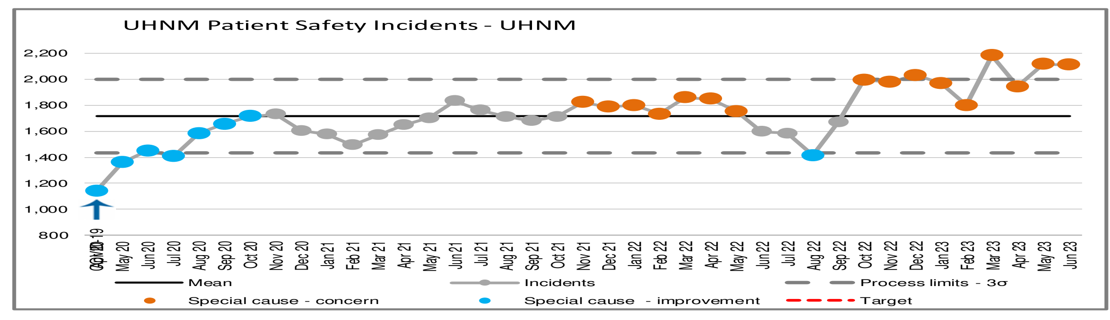
Actions:

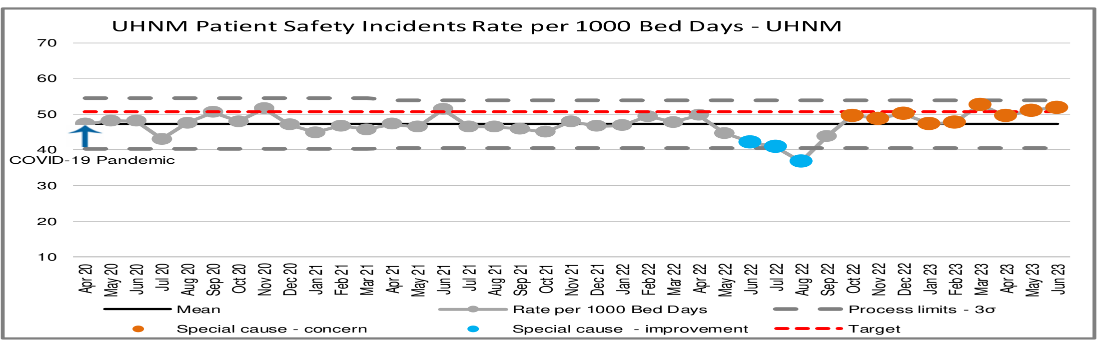
- Continue to ensure that FFT surveys are available in multiple formats to ensure accessibility for all patients.
- Focus on Medicine in June & July to try and increase response rate.

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

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

Reported Patient Safety Incidents





Variation	Assurance		
Target	**Apr 23**	**May 23**	**Jun 23**
N/A	1944	2117	2112
Background			
Total Reported patient safety incidents			

Variation	Assurance		
NRLS Mean	**Apr 23**	**May 23**	**Jun 23**
50.70	49.48	51.09	51.92

What is the data telling us:

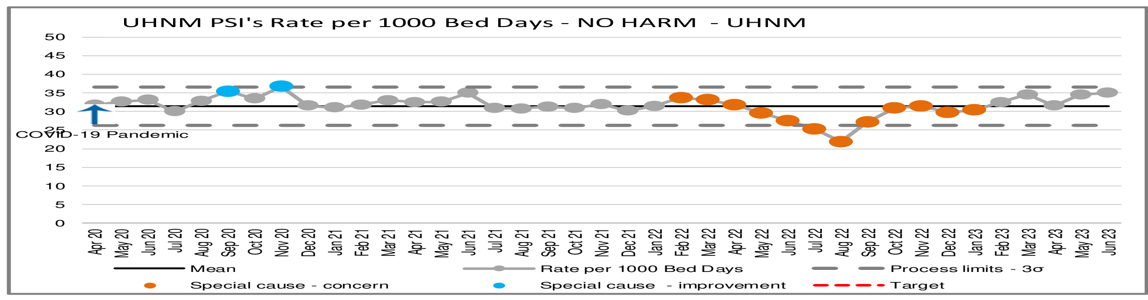
The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The June 2023 total is above the mean total since COVID-19 started but this may be due to increased activity throughout the Trust. The rate per 1000 bed days has, despite increase in total numbers remain relatively stable and is at NRLS rate.

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, Patient Flow, Medication, Clinical Assessment and Treatment related incidents. Medication related incidents were higher than Patient falls during June 2023 but otherwise no significant changes in these categories compared to previous months. There have been 102 (increase from 97 in May but reductions compared to previous months 117 in April, 157 in March, 170 in February and 228 in January 2023) of the incidents identified as related to 'Your Next Patient' which accounts for 4.8% the same as May 2023 (6.21% in April, 7.4%in March, 9.8% in February and 12% in(January 2023) of total patient safety incidents. 36.2% (34% previous month) were Tissue viability. However, 97% of these were **NOT** hospital acquired but recording pressure damage on admission/attendance at UHNM.

The rate of reported PSIs per 1000 bed days remains within control limits and normal variation.

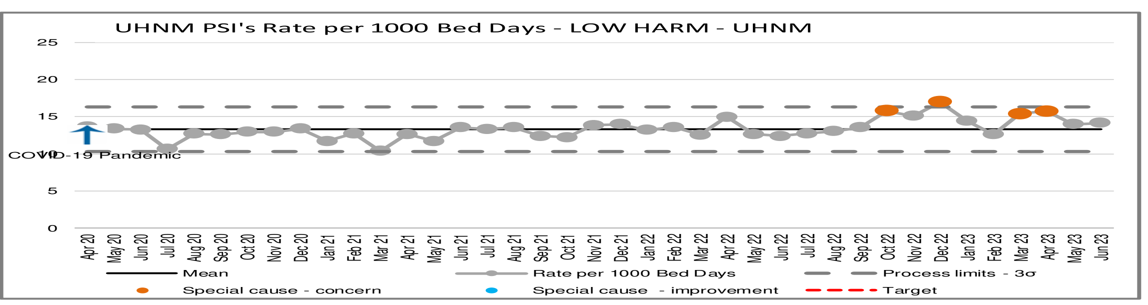
Reported Patient Safety Incidents with No / Low Harm or Near Misses per 1000 bed days



Variation		Assurance	
Target	**Apr 23**	**May 23**	**Jun 23**
N/A	31.59	34.56	34.98

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	**Apr 23**	**May 23**	**Jun 23**
N/A	15.76	13.97	14.16

Background

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

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

COVID-19 Pandemic

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

Variation		Assurance	
Target	**Apr 23**	**May 23**	**Jun 23**
N/A	1.53	1.81	1.79

Background

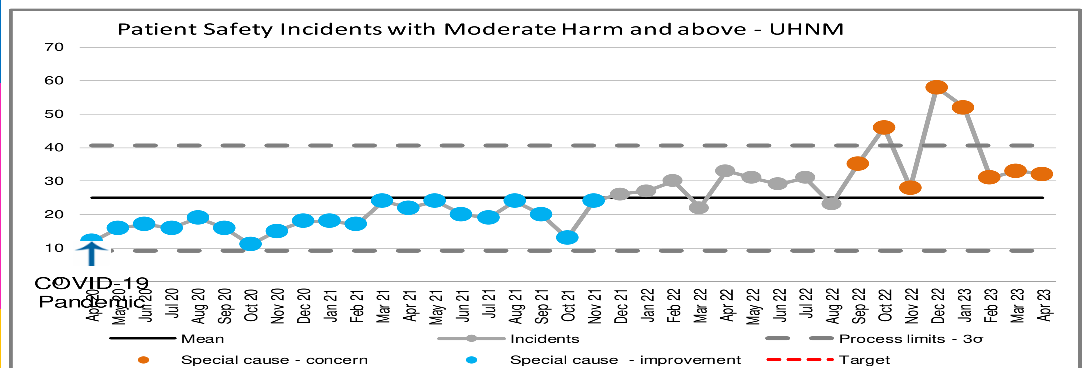
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

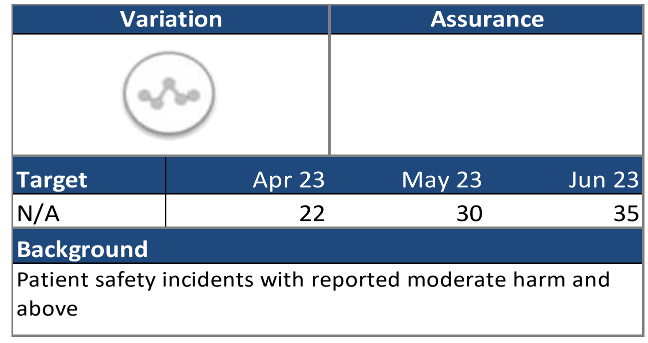
What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm have seen rates increase in recent months with decrease in recent months in low harm.

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

Reported Patient Safety Incidents with Moderate Harm or above



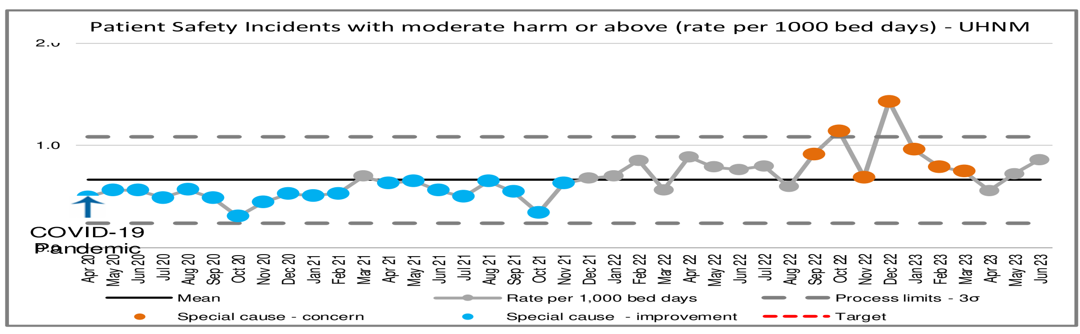


Variation	Assurance

Target	Apr 23	May 23	Jun 23
N/A	22	30	35

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Apr 23	May 23	Jun 23
N/A	0.56	0.72	0.86

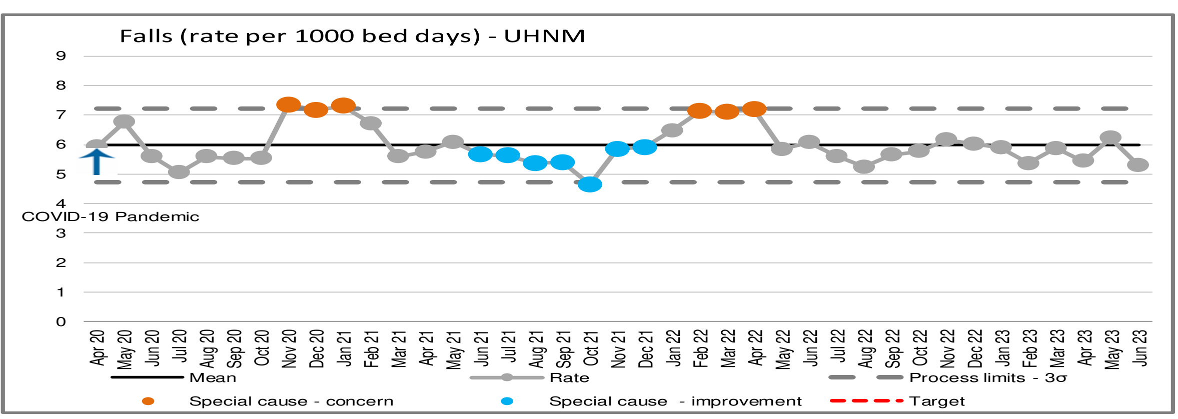
What is the data telling us:

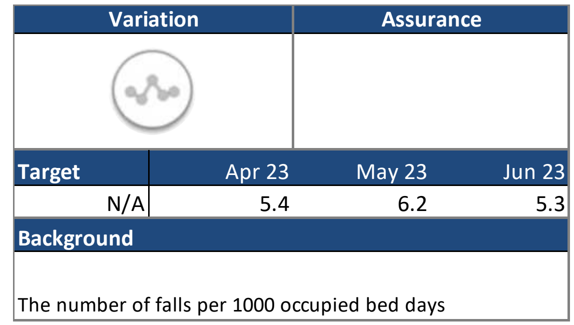
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within control limit but has shown increasing total numbers since August 2022. The rate of moderate harm and above has also increased in June but is also within normal variation.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 5 Treatment/procedure related,, 4 Treatment/Procedure, 3 Clinical assessment, 2 Pressure Ulcer (Hospital acquired)

Two of these moderate harm and above incidents were noted as relating to **'Your Next Patient'** but the harm was not as result of utilising YNP procedure. 1 was baby in NICU that bled when removing umbilical catheter (fully recovered) and second was patient on Ward 201 with CKD went into acute respiratory distress following 75% of second unit of blood transfusion (patient fully recovered)

Patient Falls Rate per 1000 bed days





Variation	Assurance

Target	Apr 23	May 23	Jun 23
N/A	5.4	6.2	5.3

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

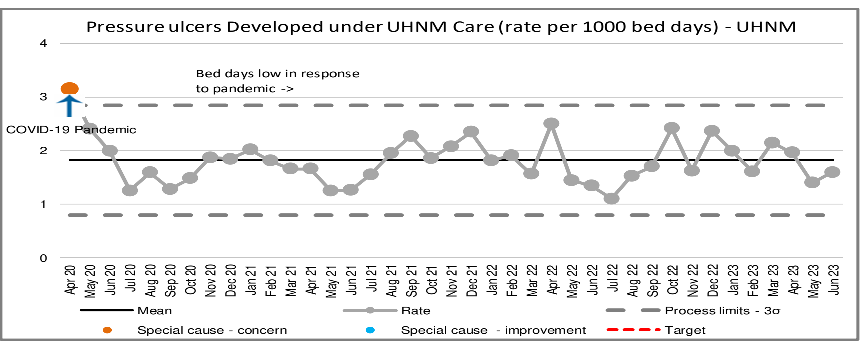
The Trust's rate of reported patient falls per 1000 bed days was within the normal range in June.

The areas reporting the highest numbers of falls in June 2023 were:
Royal Stoke ECC – 13 falls, Royal Stoke AMU – 12 falls, County AMU – 12 falls, Ward 228– 11 falls, Ward 15 – 10 falls, Ward 113 – 10 falls
ED falls numbers per month have doubled since Autumn 2020, however, the rate per 1000 attendances has also been 77% higher since Autumn 2020 indicating that increased activity may not be the only factor behind increased falls.

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

- Audits continue to be undertaken in all of the TOP 5 reporting areas. Results have been fed back to the ward managers and their teams. Time is given for the wards to action the findings and then there is a re-audit undertaken. Support is given to the areas where no improvement is made and communication is made with the matron of the area.
- Spot checks have been carried out in ECC to establish if the call bells have been given to the patient. Compliance has improved over the last few weeks. This topic remains on the daily handover.
- The audit on AMU identified that compliance with the completion of the multifactorial risk assessment and the recording of lying and standing blood pressures remained low. The team are awaiting the new risk assessment booklet which incorporated the multifactorial risk assessment to be printed.
- A meeting with the falls link in ECC has been made to discuss falls within the department.
- A falls champion training date is taking place this month for ECC, AMU, SSU, AMRA and AEC.
- A falls champion training date is taking place this month for staff from Ward 1, 12, 14 and 15.

Pressure Ulcers developed under care of UHNM per 1000 bed days



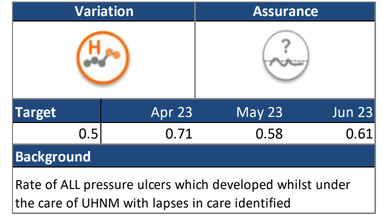
ALL Lapse in Care Ulcers (rate per 1000 bed days) - UHNM

Lapses flagged by TV on validation, including for DTI

Reduction Plan Amended & COVID-19

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

Variation	Assurance		
Target	Apr 23	May 23	Jun 23
N/A	1.96	1.40	1.60
Background			
Rate of Deep Tissue injuries and Category 2-4 and Unstageable pressure ulcers which developed under the care of UHNM			



Variation	Assurance		
Target	Apr 23	May 23	Jun 23
0.5	0.71	0.58	0.61
Background			
Rate of ALL pressure ulcers which developed whilst under the care of UHNM with lapses in care identified			

What the data is telling us

The rate of pressures ulcers reported as developed under UHNM care was within expected limits in June. The rate of cases with lapses in care identified has been above the average for 9 consecutive months, a pattern which can indicate significant change.

Where a patient can not be repositioned due to acuity, this must be documented, otherwise a potential lapse in care may be identified.

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

Actions

- Training continues for nursing assistants induction, ED mandatory training, Preceptorship days, and overseas nurses. ED agency paramedics have also received training for caring for patients in ED corridor
- Pressure prevention days are arranged for all trust staff to attend, it will be a rolling programe for the remainder of the year.
- Continence training is in place which will include education for urethral damage
- Requests being made by wards for further training on skin bundles, investigation process, categorisation and dressing selection
- ESR approved by Stat/mand group has been approved - package awaiting NWCSP updates on PU terminology
- Skin health booklet has been approved – again waiting NWCSP updates on PU terminology
- Stakeholder group created for patient seating. To update the chair and mattress audit with IP and start re-auditing areas
- A3 on urethral erosions is on-going work, actions identified. Catheter audits have been completed, currently awaiting continence audits

Pressure Ulcers with lapses in care

Category 2 Pressure Ulcers with Lapses in Care - UHNM

Lapses flagged by TV on validation, including for DTI

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

Variation	Assurance		
Target	Apr 23	May 23	Jun 23
8	7	6	6
Background			

Category 3 Pressure Ulcers with Lapses in care - UHNM

Lapses flagged by TV on validation, including for DTI

COVID-19 Pandemic

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

Variation	Assurance		
Target	Apr 23	May 23	Jun 23
4	2	3	0
Background			
Category 3 pressure ulcers which developed under the care of UHNM with lapses in care associated			

Deep Tissue Injuries with Lapses in Care - UHNM

Mean — Cases — Process limits - 3σ — Special cause - concern — Special cause - improvement

Variation	Assurance		
Target	Apr 23	May 23	Jun 23
N/A	15	8	14
Background			
Deep Tissue Injuries which developed under the care of UHNM with lapses of care associated			

Unstageable Pressure Ulcers with Lapses in Care - UHNM

Lapses flagged by TV on validation, including for DTI

COVID-19 Pandemic

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

Variation	Assurance		
Target	Apr 23	May 23	Jun 23
0	4	7	5
Background			
unstageable ulcers which developed under the care of UHNM with Lapses in care associated			

What is the data telling us:

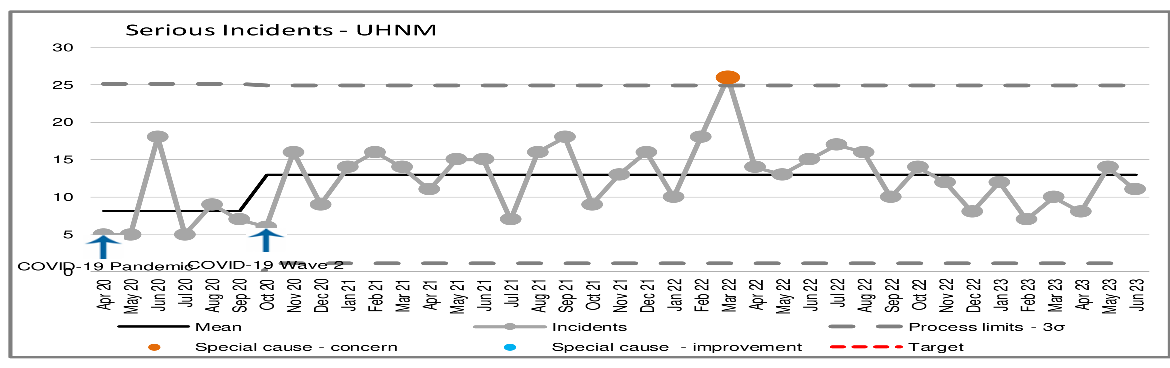
The charts above show numbers within expected limits for all individual categories of pressure damage with lapses. The table below shows the most common lapses identified last month.

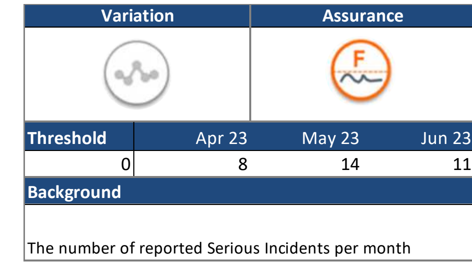
Root Cause(s) of damage - Lapses - Jun 2023	Total
Management of repositioning	10
Management of device	8
Management of heel offloading	7
Management of non-concordance	3
Management of continence	2
Clinical condition	1

Actions:

- Currently awaiting PSIRF template to commence implementation
- High reporting wards and wards of concern are visited by Quality and Safety and Tissue Viability to complete audits and deliver education
- Bespoke panels are held for areas of concern and multiple reporting areas and areas are encouraged to bring along staff for learning experience
- Tendable questions to be reviewed on high reporting areas to focus on lapses and learning
- Training video on accountability and documentation will be an action following RCA panel
- Training video has been made for care of catheters after an increase in urethral damage, along with the catheter life chart being updated to evidence care and prevention of damage

Serious Incidents per month





Variation	Assurance		
Threshold	Apr 23	May 23	Jun 23
0	8	14	11

Background

The number of reported Serious Incidents per month

Rate of SIs 1000 bed days - UHNM

COVID-19

COVID-19 2nd wave

Mean — Rate of SIs 1000 bed days — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Variation	Assurance		
Target	Apr 23	May 23	Jun 23
0	0.20	0.34	0.00

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. June 2023* saw 11 incidents reported:

- 6 Diagnostic related including delay making diagnosis
- 2 Falls related incidents
- 2 Maternity / Obstetric related Surgical/Invasive procedure related
- 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 is 0.27 and is lower than the long term mean of 0.4 since COVID-19 started in December 2020. The previous 9 months have seen reporting rate lower than log term mean.

**Reported on STEIS as SI in June 2023, the date of the incident may not be June 2023.*

Summary of new Maternity Serious Incidents

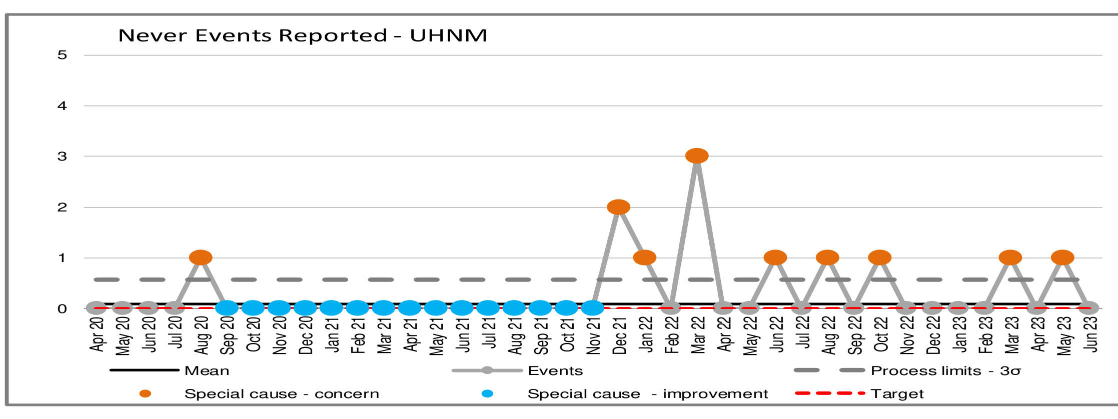
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during June 2023. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

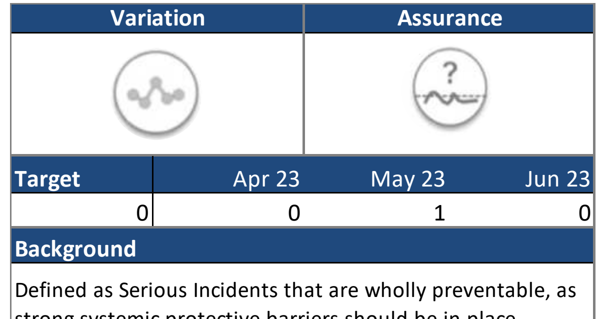
All Serious Incidents will continue to be are reported and investigated and the final Root Cause Analysis presented at Divisional meetings and Risk Management Panel for review and agreement prior to sharing with CCGs for closure.

There were 2 Maternity related Serious Incidents reported on STEIS during June 2023

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2023/1115	Asian / Asian British Pakistani	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	29.08.2023	Neonatal death
2023/11486	Asian / Asian British Pakistani	Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)	05.09.2023	Early neonatal death

Never Events





Variation	Assurance

Target	Apr 23	May 23	Jun 23
0	0	1	0

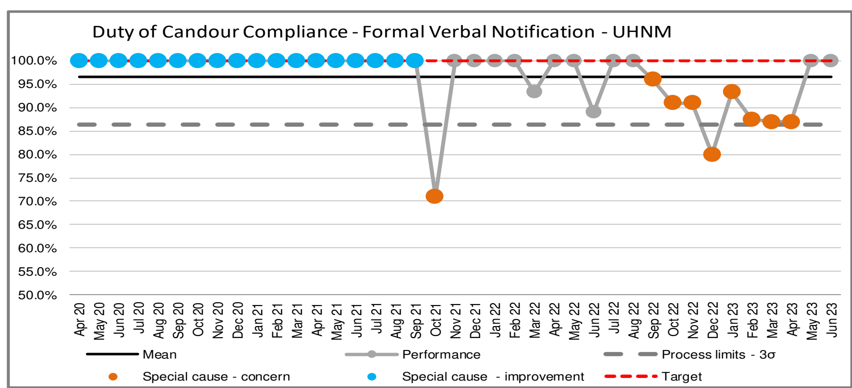
Background

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

There has been 0 Never Event reported in June 2023. The target is to have 0 Never Events.

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

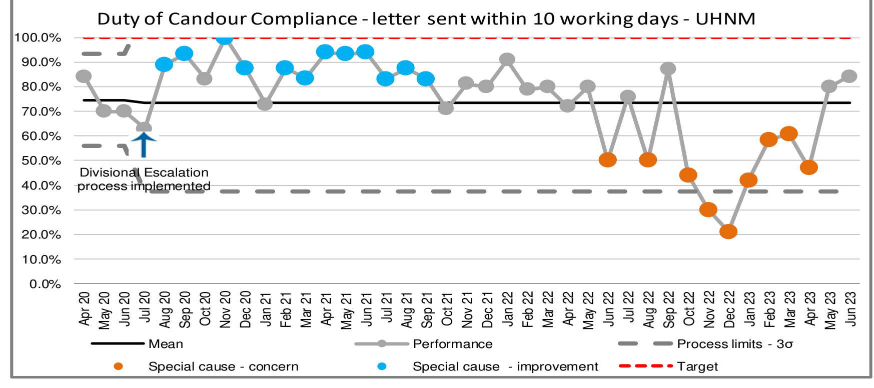
Duty of Candour Compliance



Variation	Assurance		
Target	**Apr 23**	**May 23**	**Jun 23**
100%	87.0%	100.0%	100.0%

Background

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



Variation	Assurance		
Target	**Apr 23**	**May 23**	**Jun 23**
100%	47.0%	80.0%	84.2%

Background

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

What is the data telling us:

During June there were 19 incidents reported and identified that have formally triggered the Duty of Candour. 100% have recorded that the patient/relatives been formally notified of the incident in Datix and within normal variation.

Confirmed Follow up Written Duty of Candour compliance* (i.e. receiving the letter within 10 working days of verbal notification **and recorded in Datix**) during June 2023 was 84.2% as at 6th July 2023 including those letters that are still within timescale. The cases that have not met the 10 day target have all had written notification forwarded and therefore 100% of the cases have received formal duty of candour follow up.

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

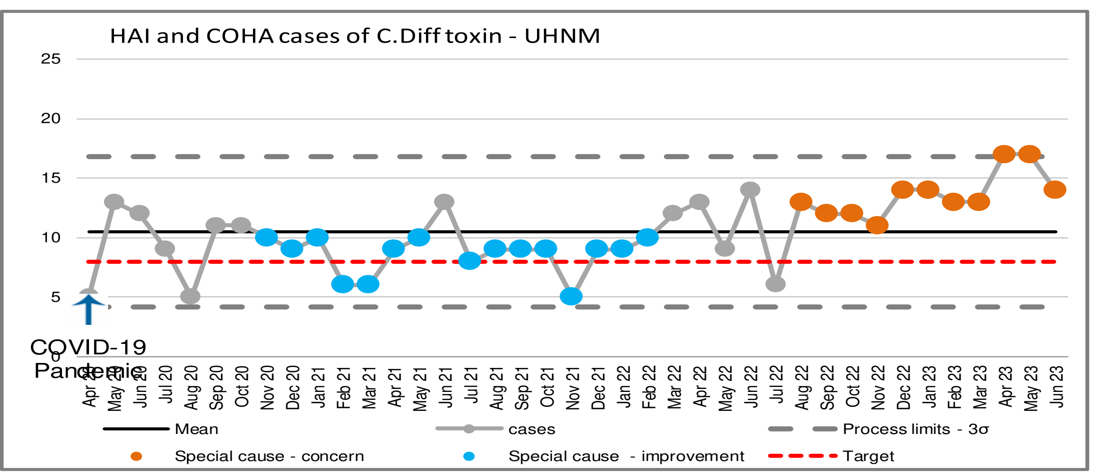
Actions taken:

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

Monitoring of compliance and update with evidence takes place at day 5 and 7 with a escalation process in place which is in the process of being formalised across the Divisions

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

Reported C Diff Cases per month



Variation	Assurance

Target	Apr 23	May 23	Jun 23
8	17	17	14

Background

Number of HAI + COHA cases reported by month

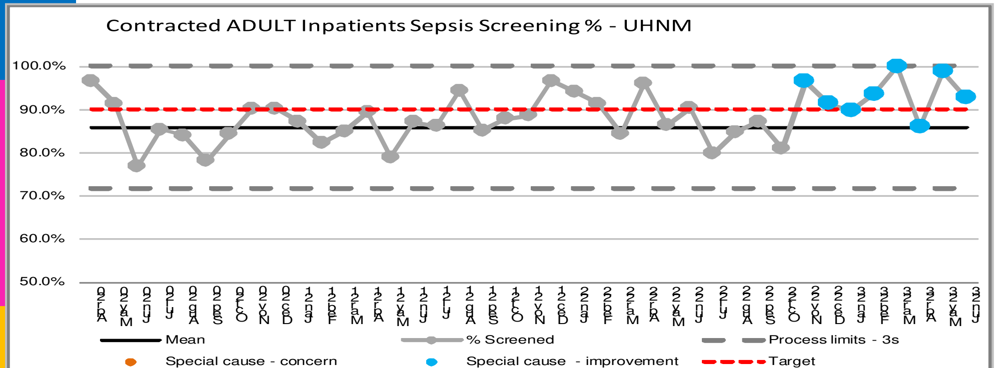
What do these results tell us?
Number of C Diff cases cases are within SPC limits and normal variation .

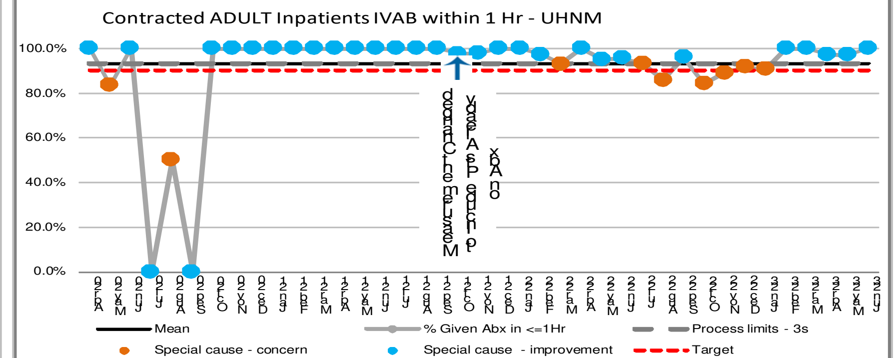
There have been 14 reported C diff cases in June 2023 with 8 being Hospital Associated Infection (HAI) cases and 6 COHA cases.
HAI: cases that are detected in the hospital three or more days after admission (day 1 is the day of admission)
COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
There has been three clinical areas that has had more than one Clostridium *difficile* case in a 28 day period. FEAU 2x toxin, Ward 78 1 x toxin HAI and 1 x COHA. ward 81 toxin HAI 1 and 1 x COHA, Ward 15 2 x toxin COHA.

The top 3 areas for C Diff toxin during May were FEAU , Ward 78, Ward 81

Actions:
- Routine ribotyping of samples continues
- Recruitment to the C Diff Nurse role has been successful and commenced 20th February 2023. This role is 50% patient reviews/50% staff training.
- The bi-weekly Cdiff MDT meeting has been re-commenced
- Review of the RCAs demonstrate that patients had received antibiotics prior to CDI results, with sepsis, UTI , pneumonia being the most common indications from antibiotics.
- To remind clinical areas send urine samples when UTI is suspected
- CDI Task and Finish Group for West Building to be reinstated
- RCAs continue to be reviewed by ICB in relation to avoidability

Sepsis Screening Compliance (Inpatients Contract)





Variation	Assurance		
Target	**Apr 23**	**May 23**	**Jun 23**
90%	86.0%	98.8%	92.8%

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

Variation	Assurance		
Target	**Apr 23**	**May 23**	**Jun 23**
90%	97.1%	97.0%	100.0%

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

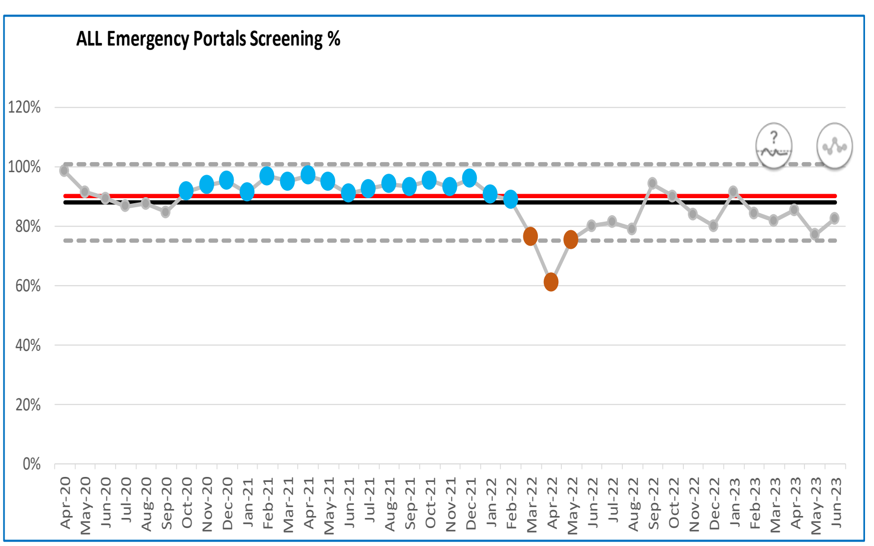
What is the data telling us:

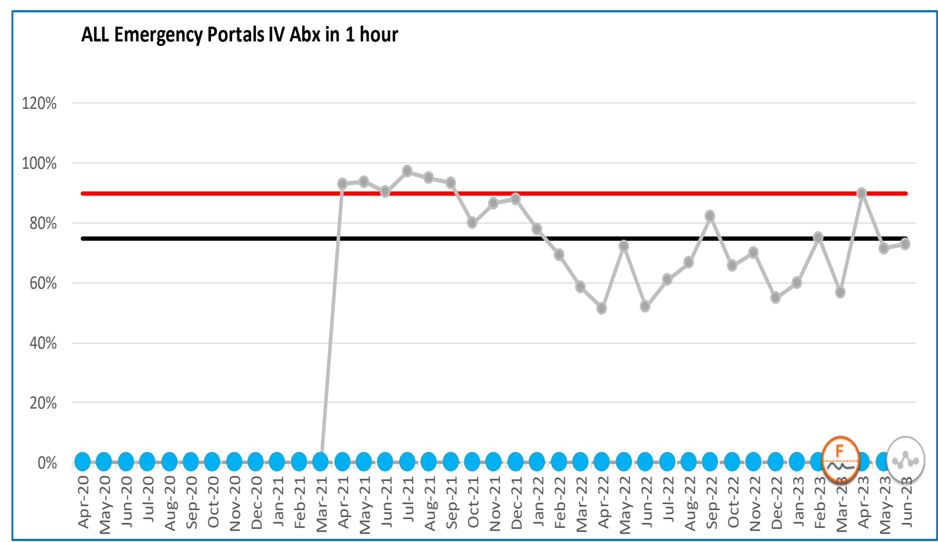
Inpatient areas achieved the screening and the IVAB within 1 hour target for June 2023. There were 97 cases audited with 7 missed screening from different ward areas or divisions. Out of 97 cases audited, 71 cases were identified as red flags sepsis with 39 cases having alternative diagnosis and 32 cases were true red flags. Out of 32 true red flag cases, 31 were already on IVAB treatment and 1 was given IVAB treatment within 1 hour target.

Actions:

- Sepsis training/ kiosks continue to all levels of staff
- The Sepsis Team continue to raise awareness the importance of sepsis screening and IVAB compliance by being involved in HCA, students and new nursing staff induction programmes; on-going
- The Sepsis team will continue to promote sepsis awareness in both sites and will prioritise areas to visit with the sepsis clinical lead consultant; on-going
- Sepsis Champion training (5 hours CPD) will be available to all level of clinical and medical staff, date arranged on 11th July 2023

Sepsis Screening Compliance (Emergency Portals Contract)





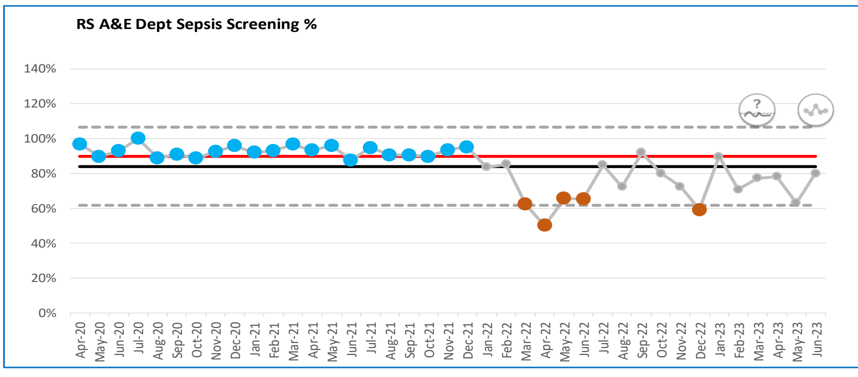
What is the data telling us:

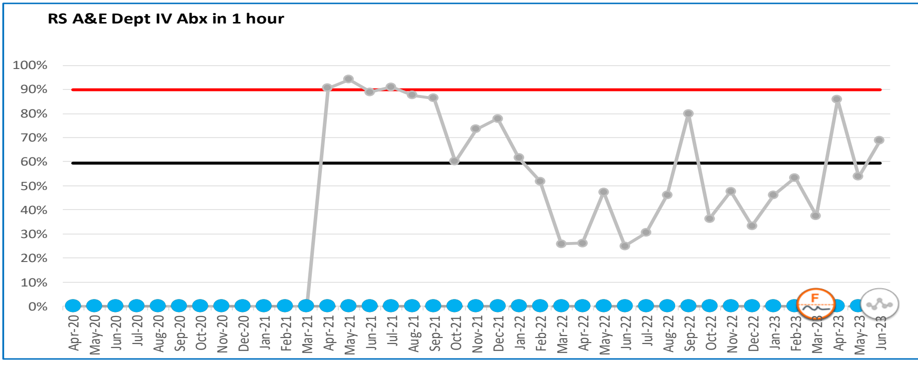
Adult Emergency Portals screening did not meet the target rate for June 2023. There were 90 cases audited with 16 missed screening in total from the emergency portals. The performance for IVAB within 1 hour achieved 73 %. Out of 90 cases, there were 78 red flags sepsis in which the 20 cases already on IVAB, 43 cases were newly identified sepsis and 15 cases have alternative diagnosis. There were 4 delayed IVAB within 1 hour and 13 within 2 hours, this is mainly contributed by both ED sites and SAU. Missed screening contributed by both ED sites, AMU (Stoke) , FEAU and SAU.

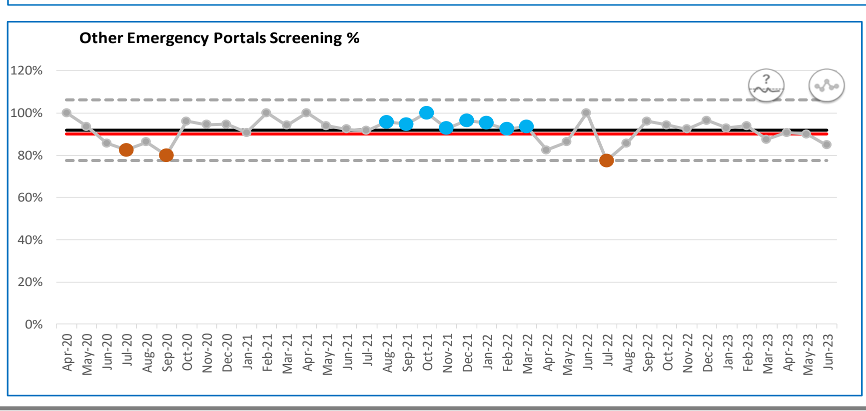
Actions:

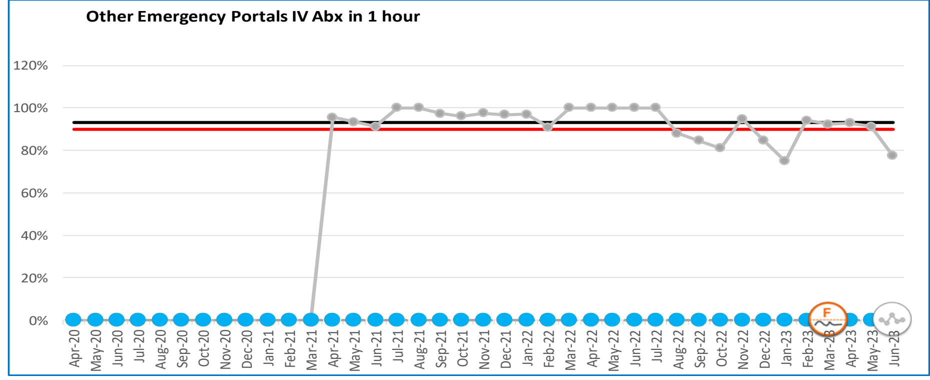
- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E daily. Provide sepsis session when staffing and acuity allows.
- Face to face A&E sepsis induction/ training for new nursing staff, nursing assistant and medical staff already recommenced. Sepsis kiosks also recommenced by the sepsis team.
- Monitoring impact of long ambulance waits on timely assessment and treatment of sepsis; on-going
- June focus of the month in ED Royal Stoke by ED Sepsis lead doctor and sepsis champions, supported by the sepsis team with good effect.
- Sepsis Champion training (5 hours CPD) was provided to all level of clinical and medical staff attended on the 11th July 2023.

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









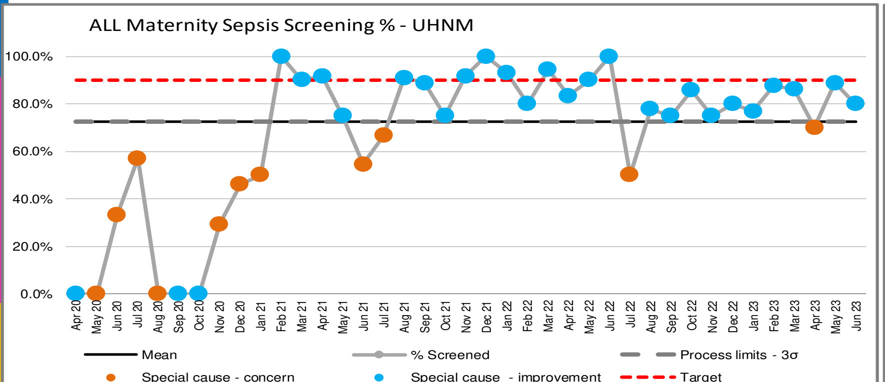
What is the data telling us:

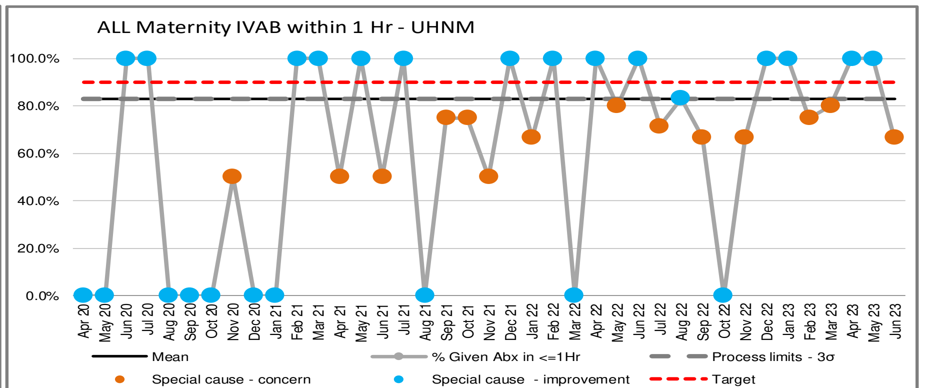
RSUH Emergency Department performance in June 2023 remains below target rate. This month both ED sites and SAU are driving the overall Emergency Portals performance as other emergency portals are achieving Screening compliance and IVAB within 1 hour. However, this month there is a slightly improvement for screening and IVAB within a hour for ED Royal Stoke.

Actions:

- CAS card has been further updated to reflect the sepsis pathway and to ensure all staff are following the correct guidance (awaiting new printing from Harlow)
- Directorate devised a SOP for nursing staff to advise of agreed actions of Ambulance assessment nurse to escalate NEWS and sepsis trigger to the Resus Consultant. The Vocera call system will be used throughout the department for patients sepsis trigger and to ensure correct urgent antibiotic prescription and administration.
- Sepsis kiosks re-instated in ED focusing the importance of sepsis screening documentation and urgent escalation for true red flag sepsis triggers

Sepsis Screening Compliance ALL Maternity





Variation	Assurance		
H	F		
Target	**Apr 23**	**May 23**	**Jun 23**
90%	70.0%	88.9%	80.0%

Background

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

Variation	Assurance		
L	F		
Target	**Apr 23**	**May 23**	**Jun 23**
90%	100%	100%	67%

Background

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

What is the data telling us:

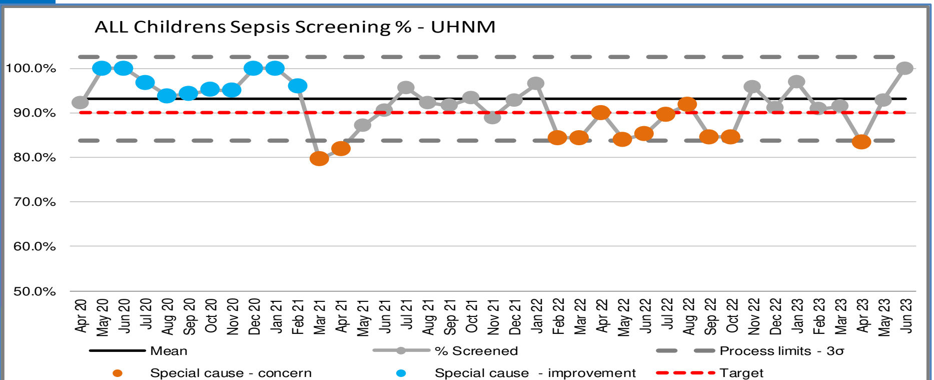
Maternity audits in screening compliance has achieved 100% and IVAB within 1 hour continue to improve to 100% in June 2023. This compliance score is based on a small number, however a regular spot checks audit is being conducted monthly.

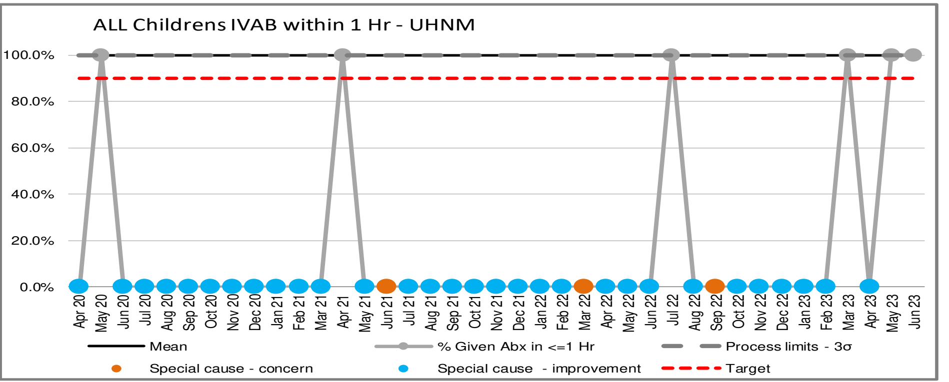
There were 15 cases audited from emergency portal (MAU) and inpatients with 3 missed screening. There were 3 true red flags identified from the randomise audits, 2 cases received IVAB within 1 hour and 1 delayed IVAB.

Actions:

- Maternity antibiotic PGD has been drafted and is currently under review by the Pharmacy Team; awaiting finalisation
- 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
- Monthly Maternity sepsis skills drill will be provided and delivered by the sepsis team and maternity clinical educator

Sepsis Screening Compliance ALL Children





Variation	Assurance
	?

Target	Apr 23	May 23	Jun 23
90%	83.3%	92.9%	100.0%

Background

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

Variation	Assurance
	P

Target	Apr 23	May 23	Jun 23
90%	N/A	100.0%	100.0%

Background

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

What is the data telling us:

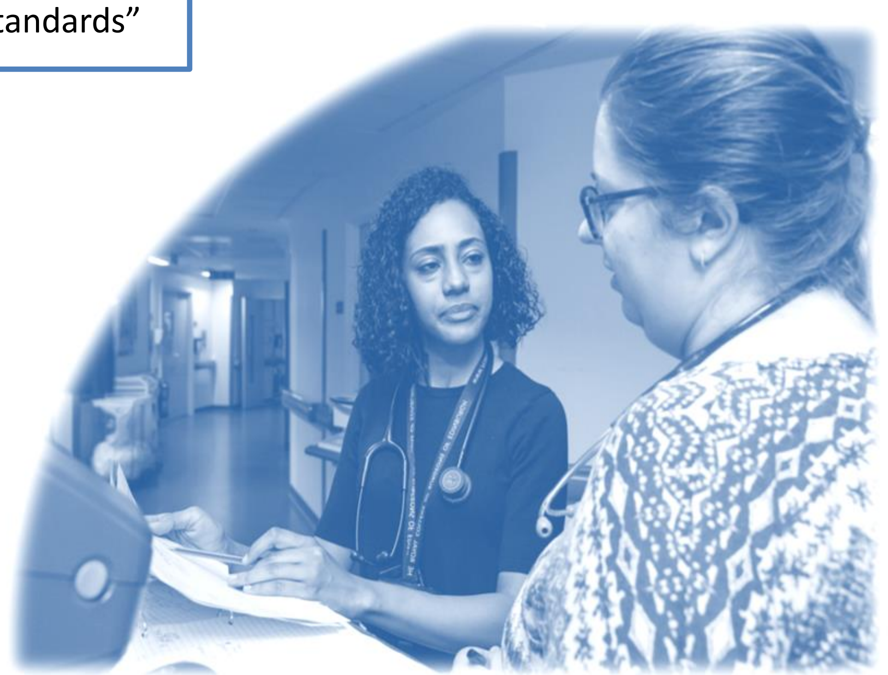
Children's Services target rate of > 90% was achieved for June. Still seen small numbers of children trigger with PEWS > 5 & above in Inpatients areas. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks). There were 27 cases audited for emergency portals and inpatients areas with 0 missed screening. Two true red flag sepsis was identified from the randomise audits in inpatients and emergency portals, both received IVAB within the hour.

Actions:

- 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

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"



Spotlight Report from Chief Operating Officer

Non-Elective Care

- Context
    - ED Conversion further decreased in June to 29%
    - 12 Hour Trolley Waits increased from 665 in May to 690 in June
    - Type 1 A&E Attendances decreased slightly from 14525 to 14202
- Driver Metrics
    - 12+ Hours In ED slightly improved from 1757 in May to 1734 in June
    - Ambulance Handovers <60 Minutes remained static at 89.6% (remaining above baseline performance)
    - Four Hour performance also remained relatively static at 68.8%

Cancer

- Trust overall 2WW Performance achieved 94% in May 23 – a sustained achievement since the beginning of the year.
- The Trust also predicted to achieve the 2WW in June. This sustained improvement is 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) achieved at 94.7% in May and is predicted to achieve the target again in June.
- The 62 Day Standard achieved better than predicted in May at 57.5%%. The current provisional position for June is 52.1%. 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 treatment and diagnostic capacity, with robust plans in place to tackle the most challenged specialties (LGI) over the next quarter.
- The 31 Day Standard achieved 88.6%% for May. It is predicted to land at 83% in June.
- The 31 day Subsequent Radiotherapy achieved 91% in May and is expected to achieve 90.3% in June.
- The 28 Day Faster Diagnosis Standard achieved 63.2% for all referral routes combined in May. The June position is currently incomplete and will be validated once Pathology confirms cancer or non cancer on high volume pathways such as Skin. Areas of best practice consistently achieving the standard are Breast and Upper GI.
- Suspected Breast Cancer, Skin and Lower GI continue to book 2WW referrals within 7 days, for first appointments.
- In August last year the PTL was over 6000 – this has now reduced to around 4000 in total.
- The number of patients waiting over 62 days on an open pathway at the month end was 513 – the same as last month.
- UHNM has received record 2WW referral volumes moving into the summer months, more than usual seasonal demand plus the predicted growth, with some weeks exceeding 1000 referrals received.

Spotlight Report from Chief Operating Officer

Planned Care

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

- Day Case activity and Elective Activity have moved from delivering 74.22% and 72.84% in May to 91% and 89% respectively for June. There is a real focus on the reintroduction of 6-5-4 with support from the regional theatres team. Day case as a % of all elective work is currently 87.5%.
- The focus has moved to 65 week waiters with an Annual Plan to reduce them to below 200 patients by end of March 2024. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge as soon as possible so any treatment can be carried out to meet the 65 week standard. The unvalidated 65 week position for June was 1529, down from May's 1701.
- The un-validated number of 78 week breaches for end of June was 322, a significant improvement from Mays 522.
- At the end of June the unvalidated numbers of >104 patients was 10, a significant decrease from 36 at the end of May. The Trust has continued to achieve the national standard of all eliminating all 104 week waits purely due to capacity. The Trust remains challenged in the delivery treating all patients waiting over 104 weeks, and the current unmitigated risk for the end of July is 9. This is predicted to be 5 with mitigating actions.
- There is considerable work now on the Trusts route to zero for 104 & 78 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment. Strike action continues to impact on the elective programme.

RTT

- The overall Referral To Treatment (RTT) Waiting has increased again from 76,851 in May to 78,866 (unvalidated) in June. This is within the normal monthly variation.
- The number of patients > 52 weeks has decreased again, currently standing at 4,490 (unvalidated), down from 4,706 in May.

Diagnostics Summary

- During June the reported activity for Diagnostics was just above plan when compared with 19/20 BAU. DM01 performance was 66%.
- Endoscopy remains a concern. CT and MRI have maintained 99% DM01 performance.

Histology position – as at 4th July 2023:

- **Urgent** (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day **16** (Previously day 20), with 80% of cases reported by Day **10** (Previously Day 11)
- **Accelerated** (include all Cancer Resections): 95% reported at Day **37** (Previously day 30) with 80% of cases reported by Day **21** (Previously day 20)
- **Routine** (all Specimens not in above categories): 95% Day reported at 35 (Previously day 29) 80% of cases reported by Day **22** (Previously day 22)
- 7 day reporting turnaround time (TAT) for Urgent cases is at 54.6% against the Royal College of Pathologists' target of 80% within 7 days (up from 50.2% previously)

Radiology reporting backlog:

- High risk relating to 'routine / non cancer reporting' due to reporting capacity and delays in diagnosis. The Risk register has been updated with separate risks relating to each reporting group 25512 highest scores 12 relating to MSK – an outsource reporting company has been sourced – awaiting ICT links via MES. Paediatric reporting backlog has seen good improvement. Body Radiology remains challenging.

Endoscopy:

- In-sourcing expanded from 4 to 6 all day lists per week
- Outsourcing being explored: identifying capacity and costs
- Booking Team skills bank continues to be developed and external booking provider use approved

Section 1: Non-Elective Care

Headline Metrics

Non-Elective Care – monthly *(context)*

ED Conversion rate - UHNM

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

Variation	Assurance

Target	Apr 23	May 23	Jun 23
30%	33.0%	31.0%	29.8%

Background

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

AE 12 hour trolley waits - UHNM

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

Variation	Assurance
H	F

Target	Apr 23	May 23	Jun 23
0	286	665	690

Background

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

Type 1 Attendances - UHNM

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

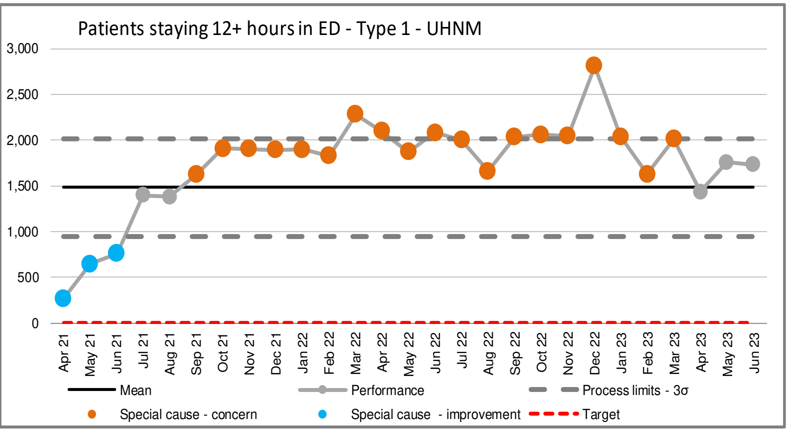
Variation	Assurance

Target	Apr 23	May 23	Jun 23
N/A	13024	14523	14202

Background

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

Non-Elective Care – Headline Metrics



Variation	Assurance

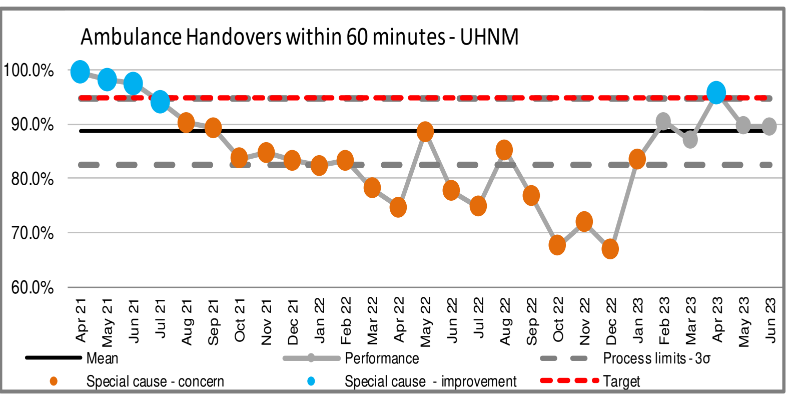
Target	Apr 23	May 23	Jun 23
0	1437	1757	1734

Background

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

What is the data telling us?

Patients waiting over 12 hours in ED has been relatively consistent over the last two months and within normal variation limits.



Variation	Assurance

Target	Apr 23	May 23	Jun 23
95.0%	95.8%	89.7%	89.6%

Background

The percentage of ambulance handovers completed within 60 minutes.

Ambulance handovers within 60 minutes has been relatively consistent over the last two months and within normal variation limits.

A&E 4 hour wait performance - UHNM

85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%

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

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

Variation	Assurance

Target	Apr 23	May 23	Jun 23
76%	70.1%	69.4%	68.8%

Background

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

4 hour performance remains below the 76% target but consistently during 2023 above the two year average.

Non-Elective Care – DTA waits over 12 hours

A&E - DTA to Admission >12 Hours

Apr 23 Performance: 5.3% | Rank: 78th of 131

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

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

A&E - DTA to Admission >12 Hours

Apr 23 Performance: 5.3% | Rank: 78th of 131

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

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 12 Hour Standard	Apr 23	1.0%	11.3%			29
A&E - 4 Hour Standard	Apr 23	76.00%	70.1%			34
A&E - 4 Hour Standard (Type 1)	Apr 23	76.0%	52.6%			19
A&E - 4 Hour Standard (Type 2 or 3)	Apr 23	95.0%	97.7%			44
A&E - Conversion Rate	Apr 23	25.0%	25.4%			20
A&E - DTA to Admission >12 Hours	Apr 23	0.0%	5.3%			41
A&E - DTA to Admission >12 Hours#	Apr 23	0.0	286.0			27
A&E - DTA to Admission >4 Hours	Apr 23	10.00%	32.1%			46
A&E - Left Without Being Seen	Mar 23	5.00%	5.3%			38
A&E - Reattendance Rate	Mar 23	5.0%	9.1%			23
A&E - Time to Initial Assessment	Mar 23	15.0	7.0			69
A&E - Time to Treatment	Mar 23	60.0	78.0			48
A&E - Total Time in A&E	Mar 23	160.0	175.0			64
A&E - Total Time in A&E (Admitted)	Mar 23	180.0	371.0			50
A&E - Total Time in A&E (Non-Admitted)	Mar 23	140.0	151.0			66

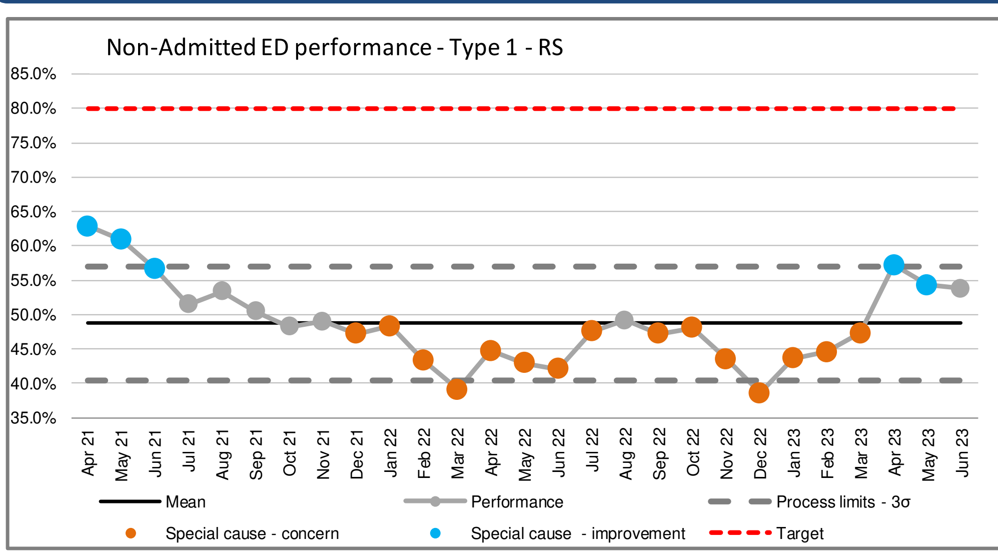
- Following the peak in the percentage of patients waiting over 12 hours from the point of DTA during Q3 2022/23, performance has since been aligned to other peer groups.
- UHNM are now following performance at the same level as it's Recommended peer.
- UHNM have moved to the second quartile.

Non-Elective Care - 4 hour standard

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	**Mar 23**	**76.00%**	**67.3%**			**40**
A&E - 4 Hour Standard	Mar 23	76.00%	**67.3%**			40
A&E - 4 Hour Standard (Type 1)	Mar 23	76.0%	**48.2%**			18
A&E - 4 Hour Standard (Type 2 or 3)	Mar 23	95.0%	98.1%			56
A&E - Conversion Rate	Mar 23	25.0%	24.5%			25
A&E - DTA to Admission >12 Hours	Mar 23	0.0%	**16.4%**			27
A&E - DTA to Admission >12 Hours#	Mar 23	0.0	**906.0**			6
A&E - DTA to Admission >4 Hours	Mar 23	10.00%	**33.2%**			61
A&E - Left Without Being Seen	Feb 23	5.00%	**5.1%**			43
A&E - Reattendance Rate	Feb 23	5.0%	**9.1%**			23
A&E - Time to Initial Assessment	Feb 23	15.0	8.0			58
A&E - Time to Treatment	Feb 23	60.0	**73.0**			51
A&E - Total Time in A&E	Feb 23	160.0	**174.0**			63
A&E - Total Time in A&E (Admitted)	Feb 23	180.0	**361.0**			55
A&E - Total Time in A&E (Non-Admitted)	Feb 23	140.0	**149.0**			68

- UHNM 4 hour performance continues to be below all peer groups and ranked in the third quartile.
- Since December 2022 UHNM have seen improvement in the 4 hour performance.

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



Variation	Assurance		
Target	**Apr 23**	**May 23**	**Jun 23**
80%	57.2%	54.3%	53.8%

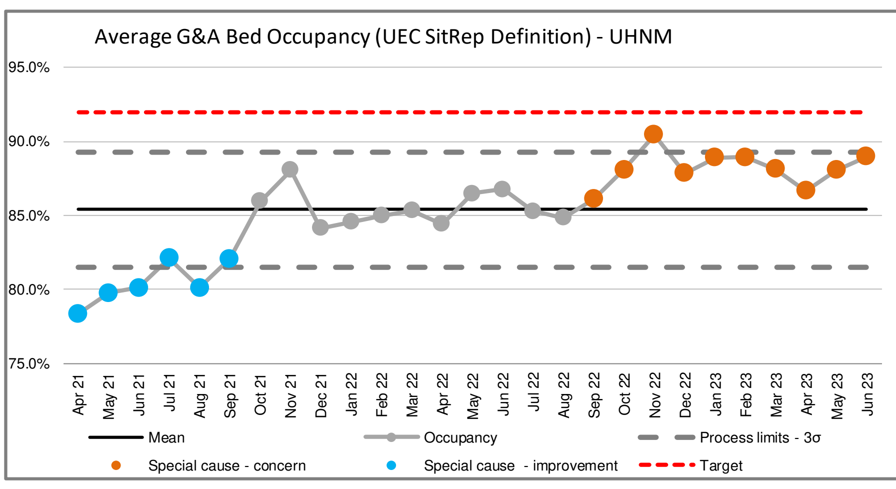
Actions

- Non-Admitted Consultant standard work has now been introduced and is embedding to ensure tasks supporting flow are completed and leadership is present where required. This will be further supported by the introduction of a dedicated Progress Tracker trial commencing in July.
- The maintenance of performance between midnight and the morning shift commencing remains a critical area for improvement. Options discussed within the ED Leadership Team to extend additional senior cover into the night (or to commence earlier in the morning) with a focus on non-admitted performance have been drafted and the outcome of this has been committed to be implemented in July.
- ED modular works were completed at the end of June which will allow for the final expansion of the ambulatory footprint and Fit2Sit area. This this will support further performance improvements across the ambulatory and CED footprint. This will commence in July with an agreed SOP to support.

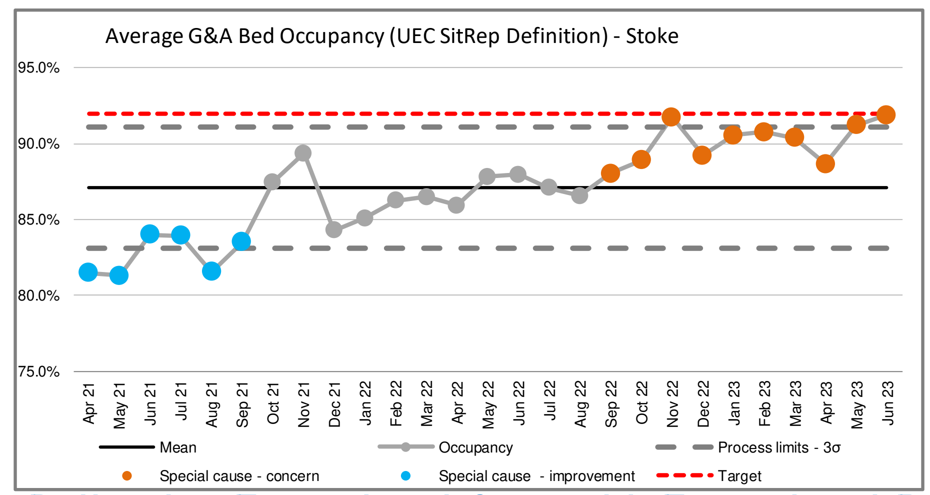
Summary

- The RSUH ED Non Admitted 4 Hour Performance is now significantly off track with a target of 60% for June. In order to provide assurances that the improvement trajectory will be recovered weekly meetings have now been agreed with the Divisional and Department leadership teams to be chaired by the Deputy Chief Operating Officer. These meetings will be to review progress against a small number of key actions, including ensuring that no further support is required. Continued departure from the stated improvement trajectory will be escalated directly to the Chief Executive.

Workstream 2; Acute Patient Flow
UHNM G&A Bed Occupancy



Variation		Assurance	
Target	**Apr 23**	**May 23**	**Jun 23**
92%	86.7%	88.1%	89.0%



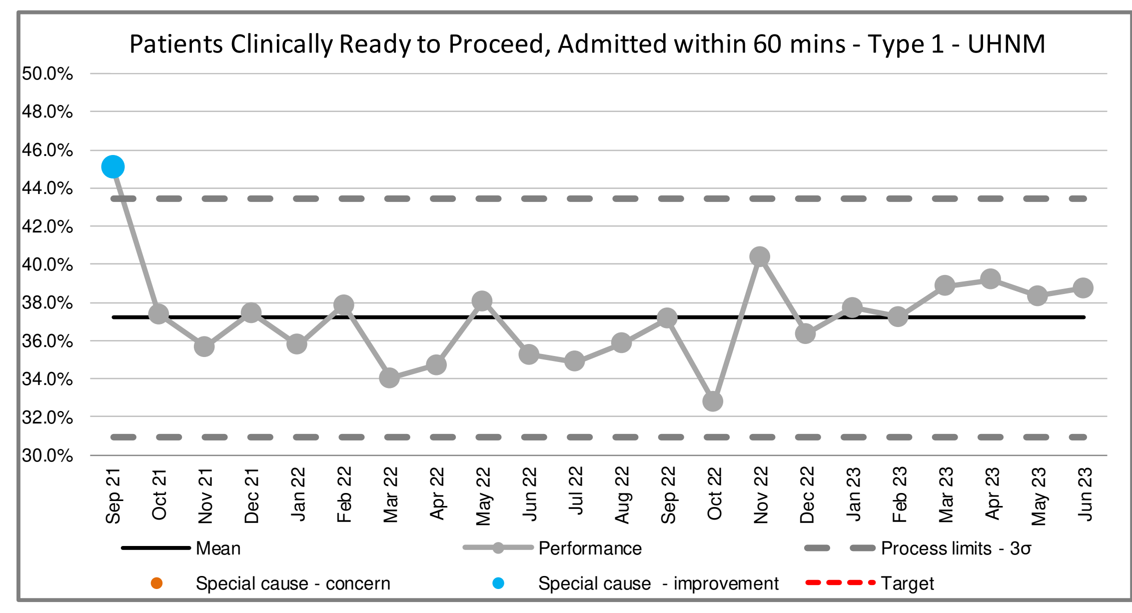
Actions

- The Bed Model refresh has now commenced with initial draft outputs shared with the Executive Team and actions agreed for further development. These draft outputs clearly demonstrate a return to pre-COVID levels of activity, an uncharacteristic continued rise in demand through recent summer months, and an increase in utilisation of beds for elective activity to support our elective recovery trajectory; all culminating in a significant flow bottle neck in Medicine on the RSUH site.
- It has now been confirmed that the national capacity monies allocated will be utilised to further develop the AMRA model which will release 30 medical beds and 10 assessment trollies. While this has now been confirmed as the preferred option there remains significant risk in the predicted timeline for delivery. Current estimates place the completion date between late January and early March, which means that the capacity may not be available to support the mitigation of peak winter demand.

Summary

- G&A Bed Occupancy rose slightly again by 0.9% in June against a recent and relative high in May. It can further be seen from the second SPC that RSUH occupancy is also increasing, further challenging performance improvements. Following confirmation from the Bed Model refresh that Medicine on the RSUH site is the single and extreme limiting factor for NEL patient flow the second SPC will be updated to reflect this occupancy specifically.
- The refinement of the underlying data to reflect recent reconfigurations, including the accurate reporting of escalation and closed capacity, has now been completed and will be reflected going forwards. This has been supported by a new ‘Bed Census’ process to ensure ongoing maintenance of accurate data.

Workstream 3; Acute Portals & Navigation
CRTP+1



Variation			Assurance
Target	Apr 23	May 23	Jun 23
90%	39.2%	38.3%	38.7%

Actions

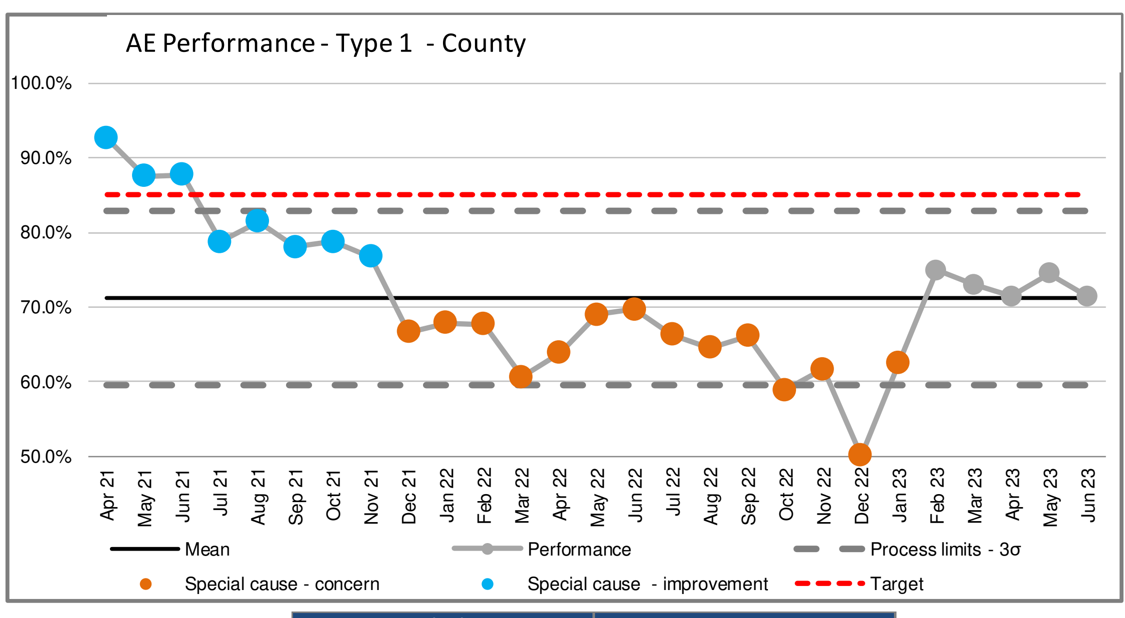
- Workstream 3 constituent Working Groups continue focussing on Portal Preparedness, Portal Standard Work, and Frailty. Project Plans have now been completed in each of these areas all focussed on contributing to the ambitious objective of 90% CRTP+1 with the exception of Frailty. Given the specific KPI of the Frailty Working Group (%Frail Conversation) Dr Zia Din has been nominated as the Workstream Lead in order to ensure clinical engagement and integration with the SDEC model.

- The leaders of the AMU, Site Operations Team, and the relevant Divisional Leadership Teams are continuing their regular meetings and are documenting progress against a Cultural Improvement Plan in order to ensure foundational work is completed that will be critical to the success of future improvement works.

Summary

- CRTP+1 improved slightly by 0.4% in June, however does remain largely static around the 38% mean for in excess of a year and a half. This demonstrates that significant improvements are still required. Following on from comments with regards to G&A Bed Occupancy data in April, and the significant variation in this KPI at both a Divisional and Site level, CRTP+1 will continue to require significant scrutiny applied to Divisional specific performance. This has been confirmed in the workstream meeting and will continue to be the focus of the working groups .

Workstream 4; County Hospital UEC



Variation		Assurance	
Target	**Apr 23**	**May 23**	**Jun 23**
85%	71.4%	74.5%	71.5%

Actions

There are a number of key actions agreed in order to deliver the next phase of required improvements in order to meet the ultimate target of 85% by March 2024.

These include the development and agreement of standard work for the non-admitted pathway, the expansion of SDEC services, the introduction of CRTP+1 as a KPI into the ED, the continued delivery of the AMU Improvement Plan, and Ward Standard Work in order to drive pre-noon discharges.

Workstream 4 continues to represent the most mature workstream with respect to the utilisation of the Improving Together methodology and is being used as an exemplar workstream in order to drive best practice.

Summary

County Hospital Four Hour performance has maintained between 70% and 75% since the rapid recovery post December and January closely mirroring improvement in Lost Ambulance Hours. This represents sustained improvements to levels of performance not seen since 2021. While this is encouraging, further improvements are now required in order to meet the improvement trajectory. If this is not delivered next month then similar structures to Workstream 1 will need to be considered in order to provide further assurance and necessary organisational support.

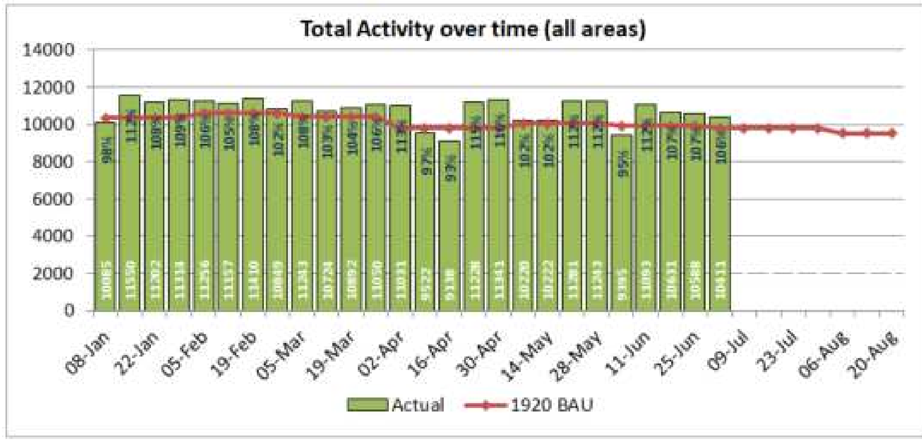
Section 2: ELECTIVE CARE

Planned Care - *Diagnostics*

Area	DM01 Test	Apr-23 (2019 Method For Imaging Activity)				May-23 (2019 Method For Imaging Activity)				Jun-23			
		Total WL	6+	%	Activity	Total WL	6+	%	Activity	Total WL	6+	%	Activity
Imaging	Magnetic Resonance Imaging	3,005	27	99.1%	7,051	3,315	33	99.0%	7,159	3,097	40	98.7%	
	Computed Tomography	3,351	41	98.8%	13,419	3,883	27	99.3%	14,215	3,824	11	99.7%	
	Non-obstetric ultrasound	7,032	2,567	63.5%	5,408	7,529	2,627	65.1%	5,947	7,911	2,793	64.7%	
	Barium Enema	0	0		0	0	0		0				
	DEXA Scan												
Physiological Measurement	Audiology - Audiology Assessments	438	12	97.3%	299	419	9	97.9%	422	462	29	93.7%	
	Cardiology - echocardiography	3,091	1,493	51.7%	982	3,668	1,854	49.5%	1,028	3,879	2,111	45.6%	
	Cardiology - electrophysiology	0	0		1	0	0		0	1	0	100.0%	
	Neurophysiology - peripheral neurophys	301	16	94.7%	257	330	0	100.0%	285	297	0	100.0%	
	Respiratory physiology - sleep studies	502	73	85.5%	275	593	77	87.0%	285	579	86	85.1%	
	Urodynamics - pressures & flows	0	0		0	0	0		0	0	0		
Endoscopy	Colonoscopy	1,339	798	40.4%	140	1,371	907	33.8%	172	1,505	1,238	17.7%	
	Flexi sigmoidoscopy	942	552	41.4%	59	968	671	30.7%	86	1,083	893	17.5%	
	Cystoscopy	135	5	96.3%	171	151	9	94.0%	208	263	88	66.5%	
	Gastroscopy	1,086	489	55.0%	342	1,059	587	44.6%	499	1,333	876	34.3%	
	Totals	21,222	6,073	71%	28,404	23,286	6,801	71%	30,306	24,234	8,165	66%	0

>> Sunday Snapshot - Unvalidated Waiting List [Imaging Is un Validated}

Area	DM01 Modality	13+	Total	% 13+
Imaging	Magnetic Resonance Imaging	3	2,973	0.1%
	Computed Tomography	1	3,769	0.0%
	Non-obstetric ultrasound	12	7,731	0.2%
	Barium Enema	0	0	
	DEXA Scan			
Physiological Measurement	Audiology - Audiology Assessments	22	477	4.6%
	Cardiology - echocardiography	521	3,873	13.5%
	Cardiology - electrophysiology	0	1	0.0%
	Neurophysiology - peripheral neurophysiology	0	297	0.0%
	Respiratory physiology - sleep studies	28	647	4.3%
	Urodynamics - pressures & flows	0	0	
Endoscopy	Colonoscopy	905	1,470	61.6%
	Flexi sigmoidoscopy	608	1,067	57.0%
	Cystoscopy	63	264	23.9%
	Gastroscopy	499	1,295	38.5%
	Total	2,662	23,864	11.2%



Pathology TAT chart will be added for July 23 report. While this is awaited the pathology performance currently is:

The following represents performance as at 4th July 2023;

- **Urgent** (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day **16** (Previously day 20), with 80% of cases reported by Day **10** (Previously Day 11)
- **Accelerated** (include all Cancer Resections): 95% reported at Day **37** (Previously day 30) with 80% of cases reported by Day **21** (Previously day 20)
- **Routine** (all Specimens not in above categories): 95% Day reported at 35 (Previously day 29) 80% of cases reported by Day **22** (Previously day 22)

Our 7 day reporting turnaround time (TAT) for Urgent cases is at 54.6% against the Royal College of Pathologists' target of 80% within 7 days (up from 50.2% previously)

Diagnostics - benchmarked

Diagnostics - 6 Week Standard

Apr 23 Performance: 28.64% | Rank: 103rd of 156

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

Diagnostics - 6 Week Standard

Target

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

	Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
16	**Diagnostics - 6 Week Standard**	**Apr 23**	**1.00%**	**28.6%**			**34**
	Audiology	Apr 23	1.00%	**2.7%**			70
	Colonoscopy	Apr 23	1.00%	**59.6%**			13
	Computed Tomography	Apr 23	1.00%	**1.2%**		2.13%	63
	Cystoscopy	Apr 23	1.00%	**3.7%**			84
	DM01 Waiting <13 Weeks	Apr 23	100.00%	**93.9%**			44
	Diagnostics - 6 Week Standard	Apr 23	1.00%	**28.6%**			34
	Diagnostics - 6 Week Standard Reversed	Apr 23	99.00%	**71.4%**			34
	Echocardiography	Apr 23	1.00%	**48.3%**			23
	Electrophysiology	Apr 23	1.00%	-			-
	Flexi Sigmoidoscopy	Apr 23	1.00%	**58.6%**			14
	Gastroscopy	Apr 23	1.00%	**45.1%**			21
	Magnetic Resonance Imaging	Apr 23	1.00%	0.9%			76
	Neurophysiology	Apr 23	1.00%	**5.4%**			62
	Non-obstetric Ultrasound	Apr 23	1.00%	**36.5%**			17
	Sleep Studies	Apr 23	1.00%	**14.6%**			55
	Urodynamics	Apr 23	1.00%	-			-

- UHNM had seen an improvement in performance against the 1% target during Q4 22/23.
- April 2023 saw a drop in performance across all peer groups including UHNM, resulting in an increase in patients waiting more the 6 weeks for a diagnostic test.
- UHNM are currently in the third quartile.

Planned care - *Diagnostics*

Diagnostics Summary

- During June the Diagnostic activity remained consistent with the May position.
- DM01 performance was 66% un-validated overall which was a decrease on May 71%. Endoscopy performance is the main contributor to this performance

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, this was March 23 and while some have met this trajectory action plans have been extended for others. To be monitored once complete by Planned Care Group.

7573 patients waiting 6 weeks+;

Top Contributors – in order of highest breach %

1. Flexi Sigmoidoscopy (17.5%) — 893 breaches of 1083 patients
2. Colonoscopy (17.7%) — 1238 breaches of 1505 patients
3. Gastroscopy (34.3%) — 876 breaches of 1333 patients
4. Echo (45.6%) — 2111 breaches of 3879 patients
5. Cystoscopy (66.5%) — 88 breaches of 263 patients

Actions - Imaging

Radiology reporting backlogs;

- 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 Scores are currently between 10 and 12 dependent on reporting group. MSK has the longest waits (scored 12 currently)
- Improvements in paediatric reporting backlog position

Non – obs Ultrasound capacity for routine patients:

Approval on 11.05.23 to procure outsourced capacity – progressing procurement process

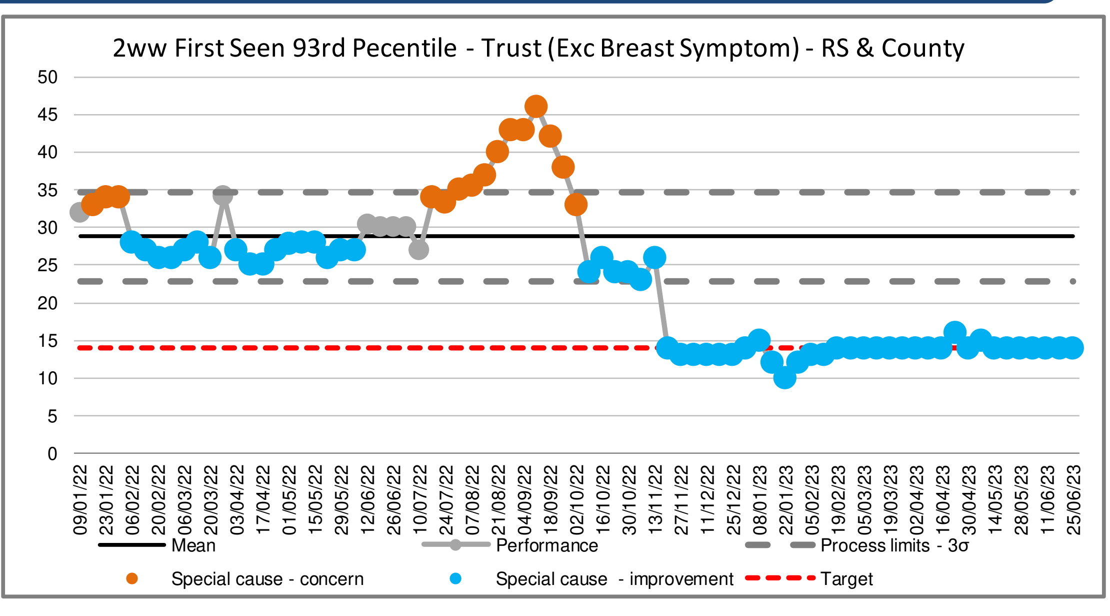
Approval to utilise bank rate until March 24. Plan to achieve DM01 trajectory by November 2023.

Actions - Endoscopy

Endoscopy;

- In-sourcing expanded from 4 to 6 all day lists per week
- Outsourcing being explored: identifying capacity and costs
- Booking Team skills bank continues to be developed and external booking provider use approved

Cancer – Headline metrics



Variation	Assurance

Target	11/06/2023	18/06/2023	25/06/2023
14	14	14	14

Background

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

What is the data telling us?

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

Cancer 28 day faster pathway - 62 day - UHNM

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

Variation	Assurance

Target	Apr 23	May 23	Jun 23
75%	63.1%	63.3%	68.0%

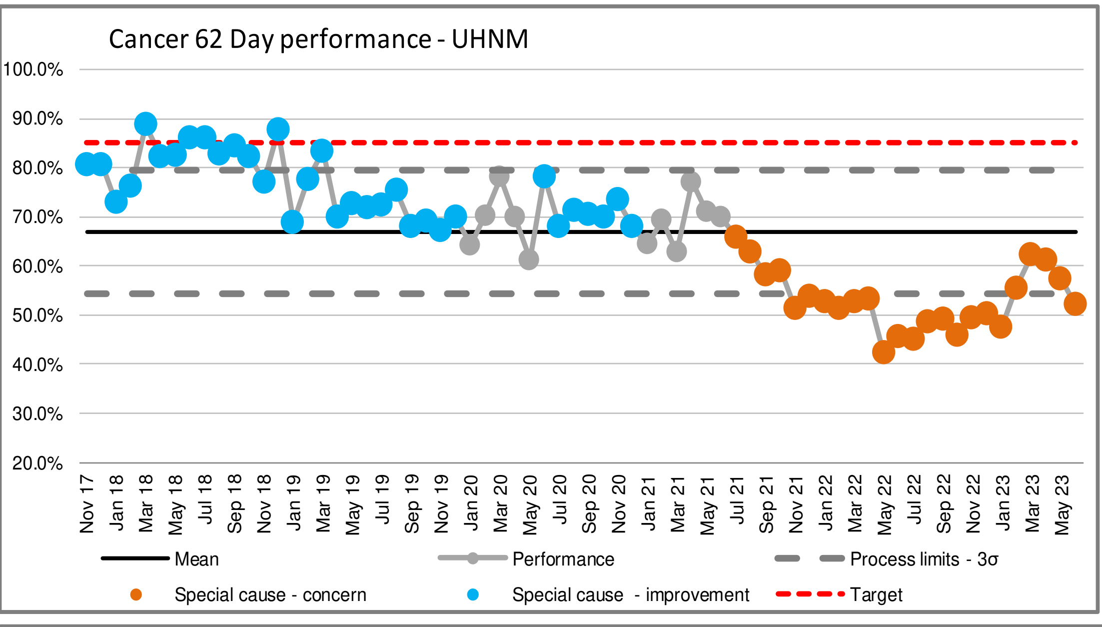
Background

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 . The May position landed at 63% - a special cause improvement on the SPC chart. June is currently incomplete.

Cancer – Headline metrics



Variation	Assurance

Target	Apr 23	May 23	Jun 23
85%	61.3%	57.5%	52.1%

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 May21 and landed at 57% in May 23, the June 23 position is still being validated.

Cancer - treated over 62 days - UHNM

110
90
70
50
30
10

Apr 19, Jun 19, Aug 19, Oct 19, Dec 19, Feb 20, Apr 20, Jun 20, Aug 20, Oct 20, Dec 20, Feb 21, Apr 21, Jun 21, Aug 21, Oct 21, Dec 21, Feb 22, Apr 22, Jun 22, Aug 22, Oct 22, Dec 22, Feb 23, Apr 23, Jun 23

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

Variation	Assurance

Target	Apr 23	May 23	Jun 23
N/A	63.5	85.5	89.5

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 has significantly reduced the backlog of patients waiting, the volume of patients treated over 62 days has reduced.

Cancer – benchmarked

Cancer - 28 Day Faster Diagnosis

Apr 23 Performance: 63.1% | Rank: 115th of 135

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

Target

Cancer - 28 Day Faster Diagnosis

80% 75% 70% 65% 60% 55% 50% 45% 40%

100 90 80 70 60 50 40 30 20 10 0

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

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

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer - 28 Day Faster Diagnosis	**Apr 23**	**75.0%**	**63.1%**			**15**
Cancer - 28 Day Faster Diagnosis	Apr 23	75.0%	63.1%			15
FDS Acute Leukaemia	Apr 23	75.0%	-			-
FDS Brain Tumours	Apr 23	75.0%	0.0%			3
FDS Breast Cancer	Apr 23	75.0%	89.3%			34
FDS Breast Symptoms	Apr 23	75.0%	91.1%			40
FDS Children's Cancer	Apr 23	75.0%	83.3%			23
FDS Gynaecological Cancer	Apr 23	75.0%	32.9%			6
FDS Haematological Malignancies	Apr 23	75.0%	43.4%			30
FDS Head & Neck Cancer	Apr 23	75.0%	65.2%			26
FDS Lower Gastrointestinal Cancer	Apr 23	75.0%	36.8%			14
FDS Lung Cancer	Apr 23	75.0%	78.8%			50
FDS Missing or Invalid	Apr 23	75.0%	-			-
FDS Other Cancer	Apr 23	75.0%	-			-
FDS Sarcoma	Apr 23	75.0%	50.0%			48
FDS Skin Cancer	Apr 23	75.0%	74.4%			21
FDS Testicular Cancer	Apr 23	75.0%	94.1%			64
FDS Upper Gastrointestinal Cancer	Apr 23	75.0%	85.8%			86
FDS Urological Malignancies	Apr 23	75.0%	41.3%			24

- The 28 Day Faster Diagnosis position for UHNM has been lower than all peer groups since May 2021.
- During Q2 and Q3 2022/23 UHNM improved significantly, aligning to other peer groups.
- Whilst all peer groups performance dropped in April 2023, UHNM dropped more significantly.
- UHNM remain in the bottom quartile.

Cancer – benchmarked

Cancer 2 Week Wait

Mar 23 Performance: 96.38% | Rank: 14th of 136

Ranking Trend Delta SPC ICS Siblings Data Detail

Cancer 2 Week Wait

100% 90% 80% 70% 60% 50% 40%

100 90 80 70 60 50 40 30 20 10 0

Target

Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23

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

Cancer 2 Week Wait

Mar 23 Performance: 96.38% | Rank: 14th of 136

Ranking Trend Delta SPC ICS Siblings Data Detail

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Mar 23	93.00%	96.4%			90
Cancer 2 Week Wait Breast Symptomatic	Mar 23	93.0%	92.9%			65
Cancer 31 Day First Treatment	Mar 23	96.00%	90.5%			26
Cancer 31 Day Subsequent Treatment	Mar 23	96.0%	91.0%			33
Cancer 62 Day All Sources	Mar 23	85.00%	68.0%			40
Cancer 62 Day Consultant Upgrade	Mar 23	85.0%	80.0%			52
Cancer 62 Day Screening	Mar 23	90.0%	71.0%			46
Cancer Sub Treat Drugs	Mar 23	96.0%	94.9%			14
Cancer Sub Treat Radiotherapy	Mar 23	96.0%	93.9%			41

- Since September 2022 UHNM have seen a significant improvement.
- Exceeding all other peers and the national target of 93% since December 2022.
- UHNM are ranked 14th in the country.

Cancer - Benchmarked

Cancer 62 Day Classic

Mar 23 Performance: 62.21% | Rank: 77th of 135

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

Target

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

Cancer 62 Day Classic

Mar 23 Performance: 62.21% | Rank: 77th of 135

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

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
Breast Cancer	Mar 23	85.00%	56.0%			11
Cancer 62 Day Classic	Mar 23	85.00%	62.2%			43
Lower Gastrointestinal Cancer	Mar 23	85.00%	52.6%			56
Lung Cancer	Mar 23	85.00%	65.0%			66
Other Cancer	Mar 23	85.00%	48.4%			22
Skin Cancer	Mar 23	85.00%	77.8%			21
Urological Cancer	Mar 23	85.00%	70.2%			75

- UHNM have seen an improvement since May 22, where other peer groups have either seen no improvement or seen a deterioration.
- In April UHNM's performance exceeded all peer groups.
- UHNM remain in the 3rd quartile.

Cancer Actions

For the month of June 2023, the weekending backlog position was 513 – which is a reduction of over 500 patients since August. This position includes patients with a decision to treat and a future treatment date scheduled. The majority of the backlog is attributable to Colorectal. A high proportion of patients waiting over 62 days in both tumour sites have future scheduled treatment dates. The June 23 position is challenged by increasing turn around times in diagnostic services, and additional capacity schemes being sustained. Business cases have been worked up to describe activity that will sustain the improvements in Skin, awaiting sign off. Further additional capacity cases have been funded through the Elective Recovery Fund, and the Cancer Alliance has also been approach for transformation funding, outcome awaited.

There are further multiple contributing factors to the backlog, including delays to diagnostic reporting in pathology and imaging, urology robotic surgery capacity, oncology capacity, complex pathways, and an increasing element of patient choice and outstanding clinical reviews. UHNM are working with GPs and commissioners to ensure all patients are aware of the urgency of their appointments and to attend when scheduled. Cancer Navigator positions have been implemented across the trust, acting as the single point of contact for patients referred on a cancer pathway. These positions have been proven to reduce DNAs and provide a better experience for patients, particularly on complex pathways and pathways with known diagnostic delays.

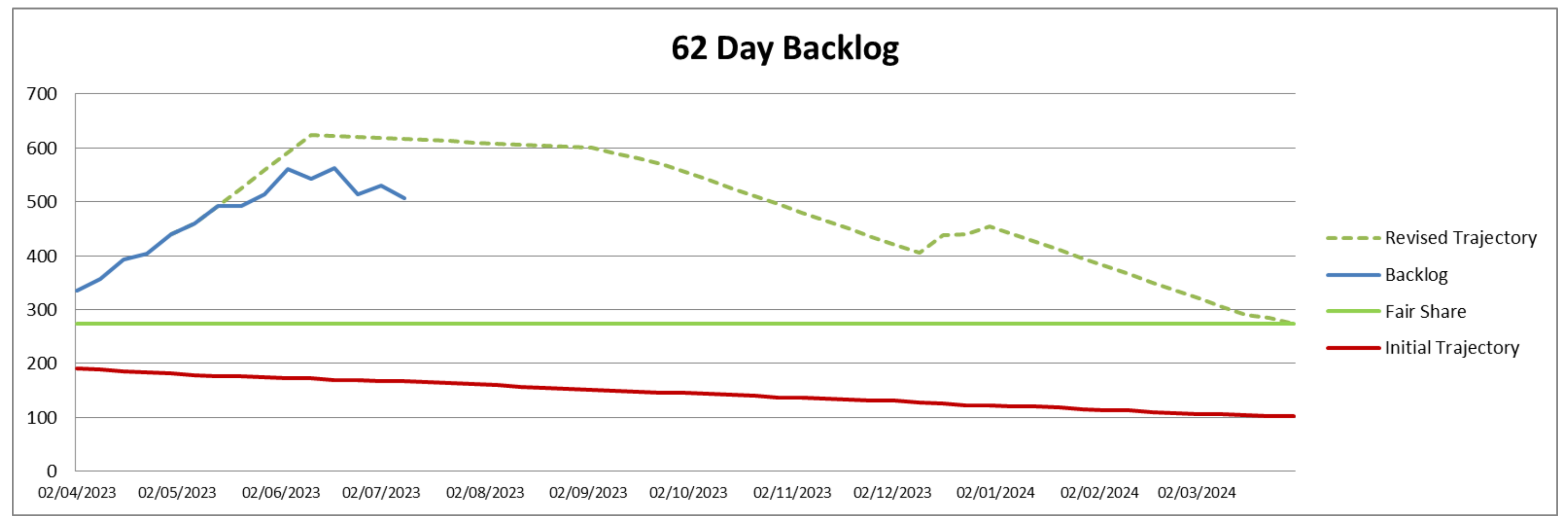
UHNM have presented their Prostate pathway as an example of best practice to UHDB. We have also shared operational details of the referral hub with neighbouring ICSs – which has optimised referrals and enabled specialist consultant triage within 3 days. The ambitions is that this referral hub could scale up to optimise referrals for all tumour sites, which is being discussed with the ICB. UHNM have also presented their Skin pathway to Lincolnshire due to the significant recovery of the PTL position which was enabled by community Teledermatology, whereby all Skin 2WW referrals are sent accompanied with photographs, enabling virtual triage by consultants.

All divisions are focusing on the backlog and discharge patients where appropriate. 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. Twice weekly PTL level meetings have been set up with Endoscopy – to review the inpatient waiting list triangulated against the Cancer PTL and including clinical urgency, to ensure priority booking and a reduction of the number of endoscopy investigations waiting to be scheduled.

The Cancer Delivery plan has been agreed with ICB colleagues and prioritises 28 Day faster diagnosis improvement plans, such as GP direct access to diagnostics, releasing capacity schemes such as Breast Pain clinics in the community, and increasing referrals on to the Non Site Specific pathway.

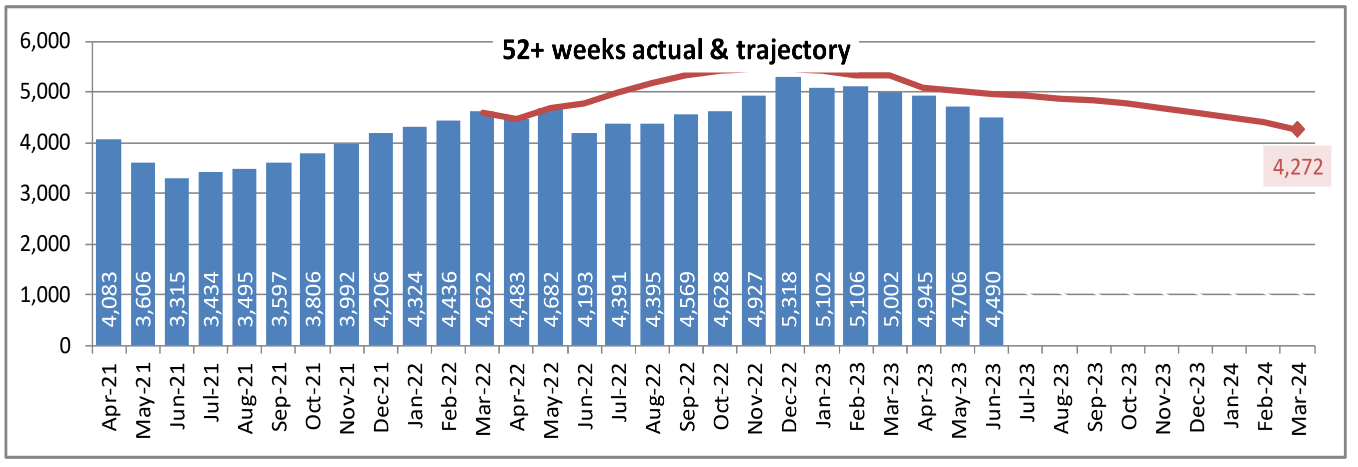
Cancer Trajectories

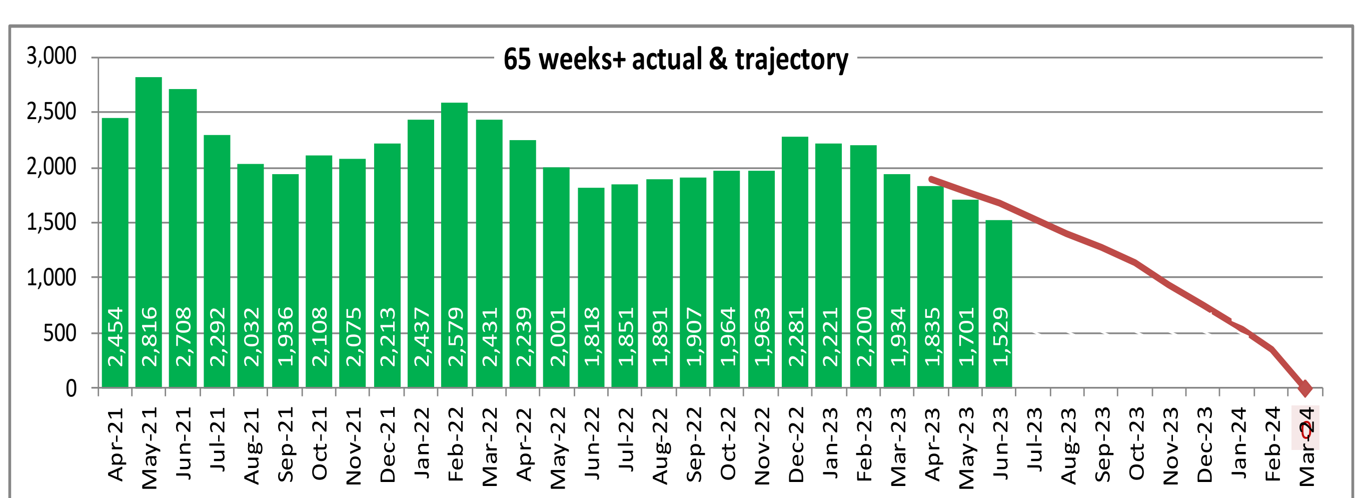
- National planning guidance 23/ 24 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. The guidance also allocated a fair share total to Trusts, shown in green on the graph below. An internal PTL Backlog trajectory for UHNM is shown by the green dotted line below, which was revised and modelled to bring us back in line with the fair share target by March 23 taking into account the unpredicted workforce challenges in Endoscopy.
- The actual total of patient waiting over 62 days on a 2WW pathway are shown in blue below, and are a snap shot in time of the PTL position. This is for the week ending last full week of the month per PAF report.
- UHNM provide assurance to the regional NHSEI team, with detailed plans on a weekly basis. Tiered Progress to date:
    - The 62 day backlog has reduced by over 500 patients since August.
    - The number of days waited for 1st OPA (93rd Percentile) has reduced by 35 days since August.
    - The total PTL has reduced by around 2300 since August.
    - The number of patients waiting over 104+ has halved.
    - The Faster Diagnosis Standard has improved from 46% in September to a final May23 position of 63%



- Impacting the position in 23/24 are new challenges such as strike action, additional capacity scheme continuity, and diagnostic capacity in Endoscopy and Pathology.
- The West Midlands Cancer Alliance have been approached to continue to fund the additional capacity which contributed to the significant recovery of the Cancer position.

Planned Care – *RTT*

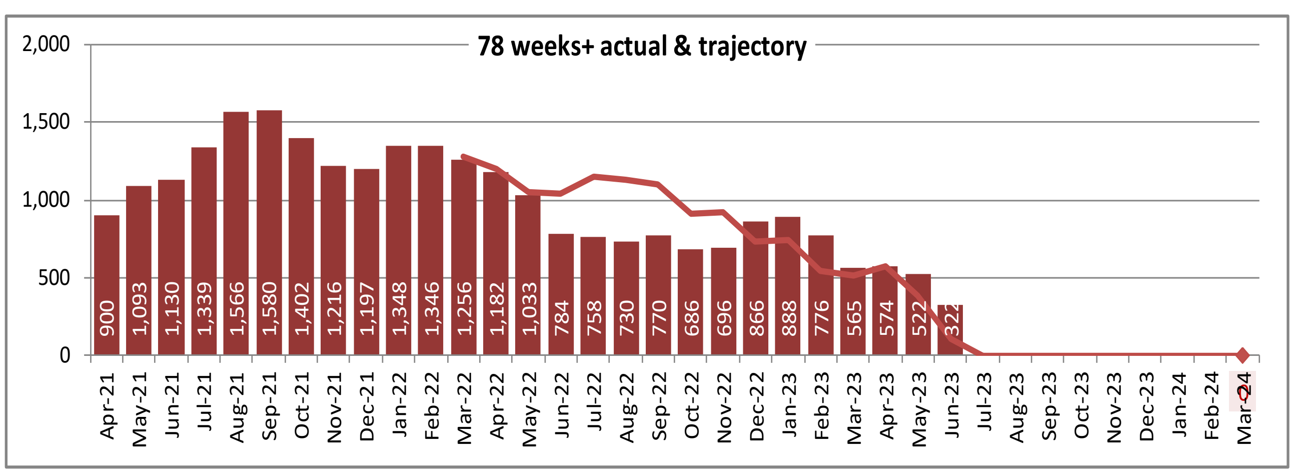




52+ week waiters continue to see a reducing trend and remain within trajectory.

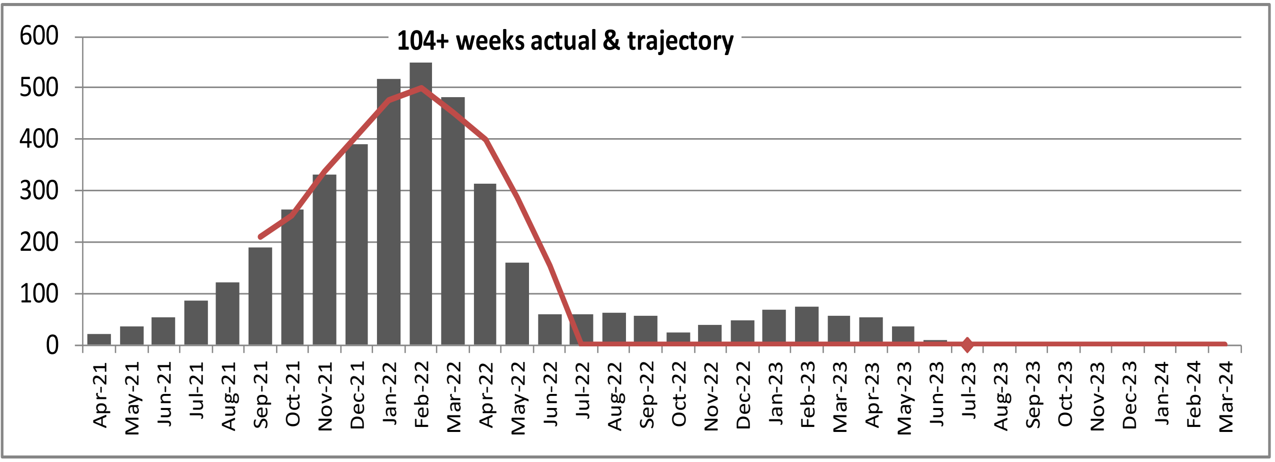
65+ week waiters also continue to reduce and are within trajectory volumes.

Planned Care – *RTT Long Waiters*



The number of patients waiting over 78 weeks continues to reduce, with the volume from May to June reducing by 40%.

June data is unvalidated.



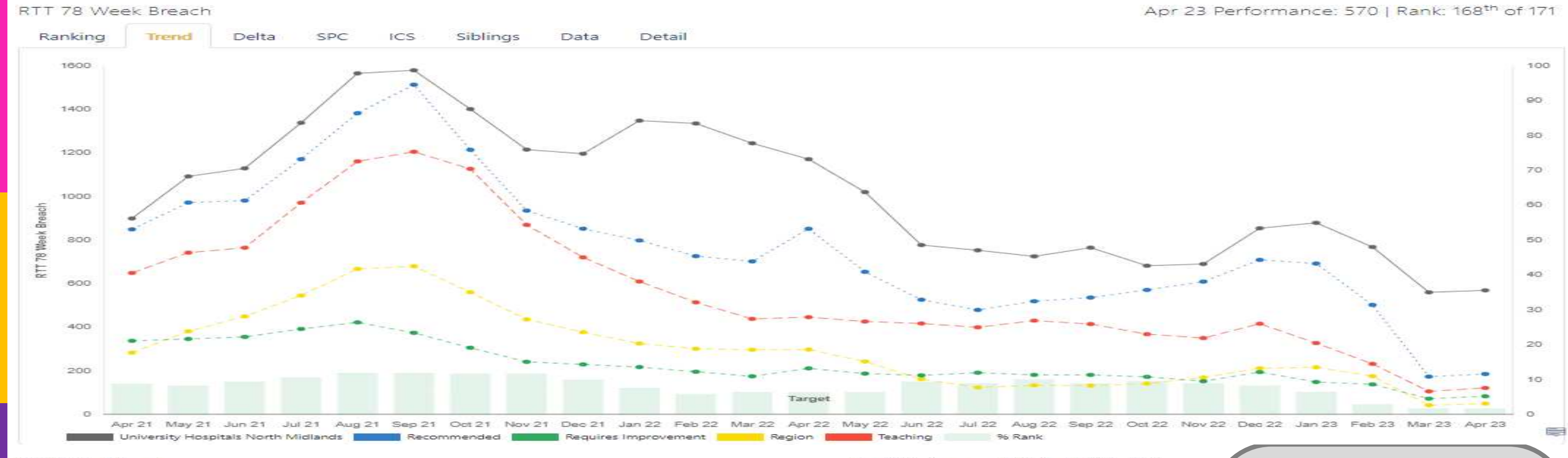
The number of patients waiting 104+ weeks continues to reduce, with the volume reducing by 72% between May and June 2023.

There are 10 patients in June, which is made up of patient choice, patients presenting unwell or complex pathways.

June data is unvalidated.

Delivering Exceptional Care with Exceptional People

RTT - Benchmarked



RTT 78 Week Breach

Apr 23 Performance: 570 | Rank: 168th of 171

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

Key Performance Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT 104 Week Breach	Apr 23	0	51			1
RTT 52 Week Breach	Apr 23	0	4,935			10
RTT 65 Week Breach	Apr 23	-	1,830			6
RTT 78 Week Breach	Apr 23	0	570			2
RTT 95th Percentile Admitted Waiting Time	Apr 23	18.0	82.8			2
RTT 95th Percentile Non-Admitted Waiting Time	Apr 23	18.0	56.8			25
RTT Admitted Treatment Within 18 Weeks	Apr 23	90.0%	50.8%			22
RTT Average (Median) Admitted Waiting Time	Apr 23	9.0	17.2			24
RTT Average (Median) Non-Admitted Waiting Time	Apr 23	5.0	8.0			54
RTT Average Wait for Incomplete	Apr 23	7.00	15.4			24
RTT Incomplete 92nd Percentile	Apr 23	-	48.6			24
RTT Incomplete Pathways With a DTA	Apr 23	25.0%	15.5%			39
RTT Non-Admitted Treatment Within 18 Weeks	Apr 23	95.0%	69.9%			52
RTT Total Clock Starts	Apr 23	-	14,148			84
RTT Total Clock Stops	Apr 23	-	11,663			86
RTT Total Incompletes	Apr 23	-	77,594			14

- Since the increase during Dec 22/Jan 23, volumes at UHNM have reduced, with all peers and UHNM following a similar trend.
- UHNM remain significantly above all peer groups and the 3rd worst performing Trust in the country.

Planned care - *RTT*

Summary

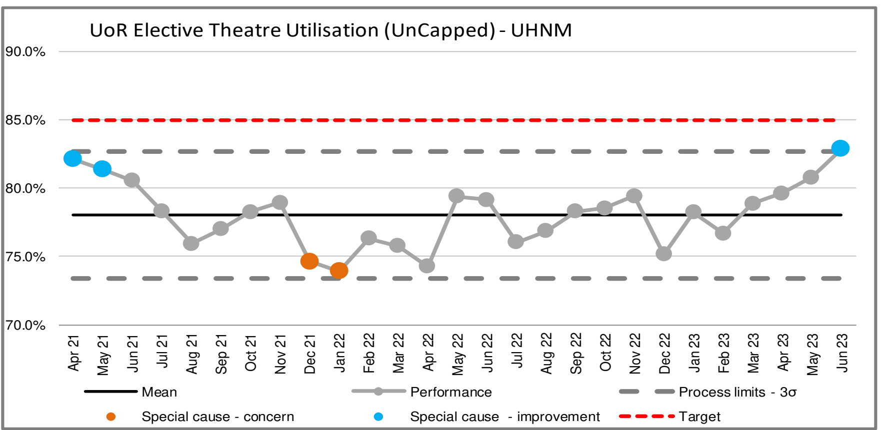
- 52+ week patients increased during June to 4,490 (un-validated)
- 78+ patients have been gradually reducing, but had reached a plateau in November at 725. This has increased in December to 863, due to winter pressures in combination with industrial action and in January rose to at 936. The number has decreased throughout since February, achieving 565 at March month end, 574 for April, 522 for May and projected to be around 322 for June (as yet un-validated).
- The trust did not achieve the national ask of eliminating 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. Trajectories have been updated, and are predicting mid-September for delivering 0 78 week breaches.
- The overall Referral To Treatment (RTT) Waiting list now sits 78,866 end of June (un-validated).
- 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 with the introduction of a weekly elective management oversight group.
- At the end of June the number of > 104 weeks was 10, a further significant improvement from 36 in May and 53 in April. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity. There is a challenge for some specific directorates in treating some of our long waiting complex patients within timeframe due to the size of the backlog. Current forecast for July is x patients, a further significant improvement.
- The IS have taken 141 patients from Orthopaedics & Spinal (out of over 300 considered), with a further 140 patients being worked through to contact & transfer.

RTT

- Validation has increased slightly with some additional resource in the short term. The team are currently looking at validation capacity to provide an accurate picture of the resource required in the medium term to reduce the list, this may include electronic solutions.
- RTT Performance sits at 54.81%, an improvement from 53.85% for May.
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.
- The Trust is currently at 93.4% of all pathways over 52 weeks having ben validated within the last 12 weeks. The next national ask was to have all patients waiting longer than 12 weeks validated by 28th April 2023. The number currently not validated in the last 12 weeks last month was is 37,400, but we are now at 38,028.
- 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.
- NHSE's RTT training lead to deliver lecture style training and engagement sessions with specialty groups to enhance shared knowledge and address issues where national rules are not always followed.
- RTT Training now available on 'Articulate' eLearning software.
- Active reporting focus on ensuring the right patients (urgent and longest waiters) are the patients booked into all available capacity so that the limited resource available continues to be used for the right patients by clinical need. This is being scrutinised through a divisional weekly meeting with COO/Deputy
- Patient by patient monitoring by each specialty and by the corporate team on the patients at risk of the breaching 104 and 78 weeks by end of month, and month following.
- Key enablers to the continued focus on long waiting patients are ring fencing of beds for Orthopaedics as RSUH, modular theatre at County and improvement in theatre utilisation and booking.
- Increased focus on non-admitted patients and increasing outpatient & diagnostic capacity, improving utilisation and business processes to move patients to a decision to admit. This will be supported by the IST RTT training programme which takes place in Spring
- Roll-out of Palantir's Foundry platform underway, with working group to be up and running.

Planned Care – *Theatres*

University Hospitals of North Midlands NHS Trust

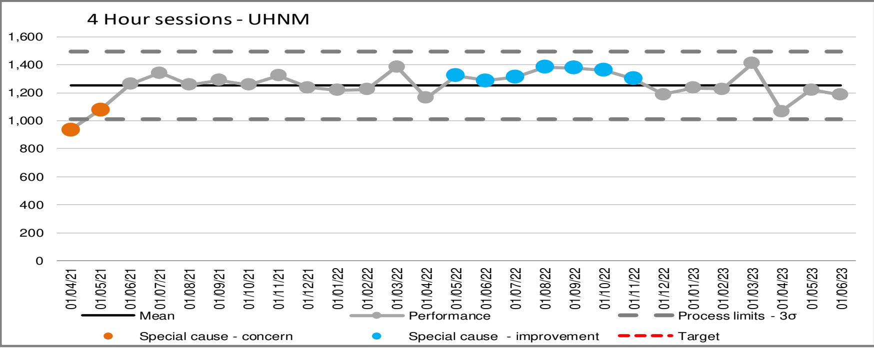


Variation	Assurance

Target	Apr 23	May 23	Jun 23
85%	79.6%	80.8%	82.9%

Background

The percentage of theatre time used (capped).

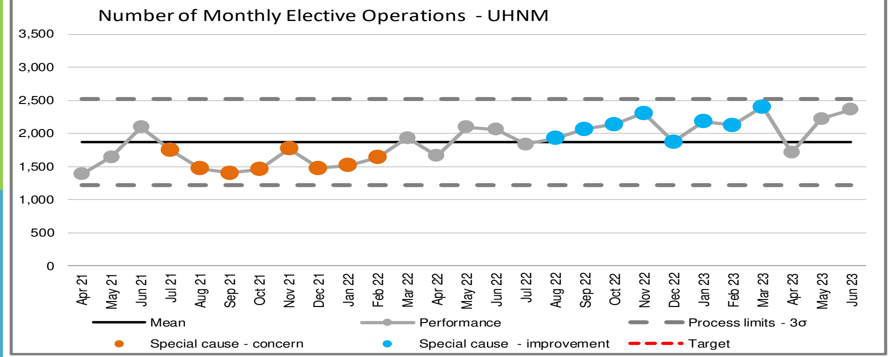


Variation	Assurance

Target	01/04/23	01/05/23	01/06/23
N/A	1069	1221	1186

Background

The number of 4 hour sessions during the month.



Variation	Assurance

Target	01/04/23	01/05/23	01/06/23
N/A	1709	2222	2361

Background

The total number of elective operations during the month.

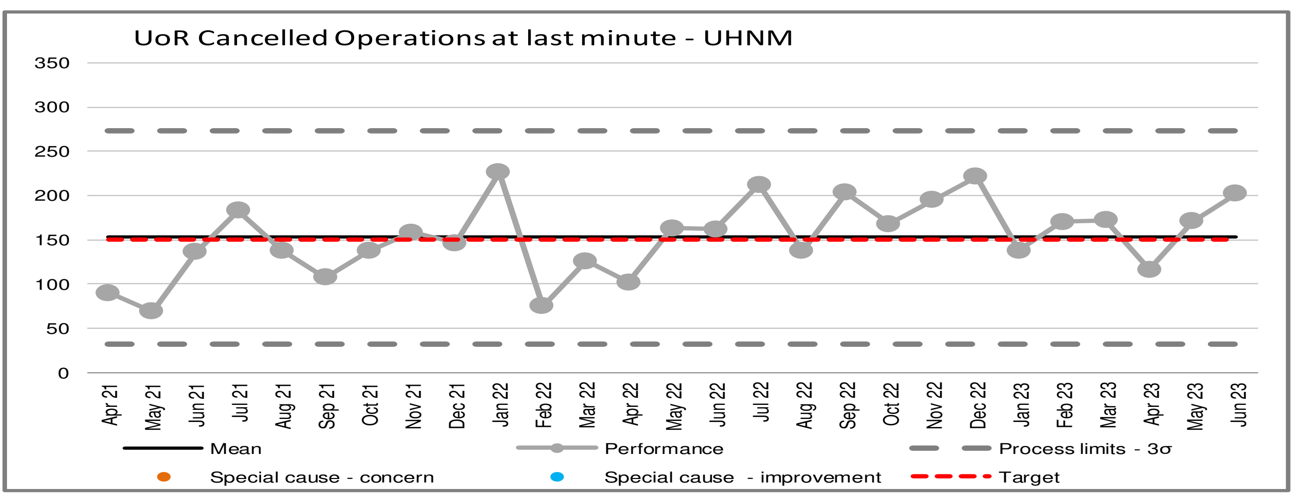
Theatre Utilisation performance has been on an improving trend since February 2023, reaching 82.9% in June against an 85% target.

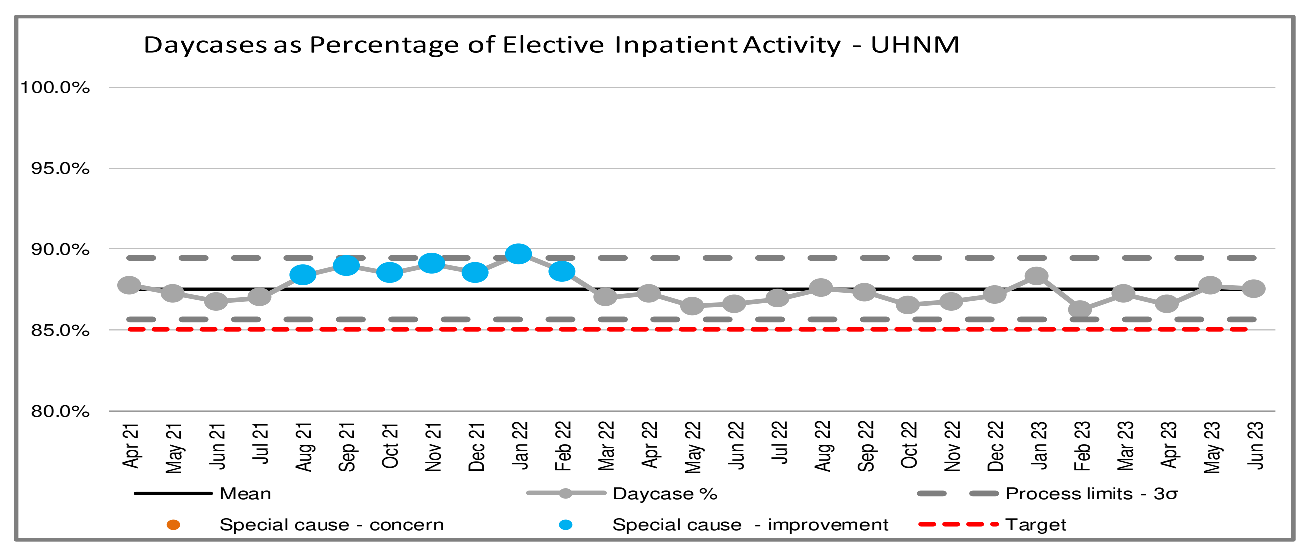
The number of 4 hour sessions has been relatively stable during 2022, with June seeing levels aligned to the two year average.

Following the dip in Elective Operations in April, May and June see volumes returning to levels seen since October 2022.

Planned Care – *Theatres*

University Hospitals of North Midlands NHS Trust





The numbers of patients cancelled has seen an increase over the last two months, exceeding the two year average.

The proportion of Daycase activity continues to remain above the 85% target. *(total Trust split).*

Theatres - Benchmarked

University Hospitals of North Midlands NHS Trust

Include independent provider data? Chart View Table View

Select level: Provider

Highlight system providers

Providers in Midlands All providers (national)

Select chart type: Variation Chart

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

Download

Quartile 1 - Lowest 25% | Quartile 2 | Quartile 3 | Quartile 4 - Highest 25%

University Hospitals of North Midlands NHS Trust (My Provider)
Capped Theatre Utilisation %: Touch time within planned session vs planned session time : 73.5%

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

110.0% 100.0% 90.0% 80.0% 70.0% 60.0% 50.0% 40.0% 30.0% 20.0% 10.0% 0.0%

In order of Capped Theatre Utilisation %: Touch time within planned session vs planned session time (n=112)

My Provider | My Peers | Non-Peer Providers | Peers (Recommended Peers) Median (75.2%) | Top/Best Decile (82.4%) | Provider Median (75.3%)

- UHNM remain in Quartile 2 following the recent improvement from Quartile 1.

Source data: Model Hospital 10/07/23

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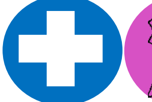


Planned Care - *Theatres*

Elective inpatients Summary

- Day case as a % of all elective work for June is currently 87.5%.
- Productivity in terms of Touchtime Utilisation & Case numbers is equal or above Pre-Covid (April-June)& Metrics continue to show an improving trend
- Weekend activity continues for numerous specialties including Colorectal, Plastics, Urology, T&O, Breast & Ophthalmology supported by both UHNM staff as ECH and SHS
- Uncapped Utilisation 83%, Capped Utilisation 77.2%, Start times 59% (within 15mins), OTD cancellations 10.4%.
- Session uptake remains consistently high at 93% in June

Actions

- Non-elective activity and bed availability have challenged productivity over last few weeks however all efforts to reduce cancellations and maintain productivity have been taken.
- "List Lockdown" process at 1 week commenced for al County elective lists'
- Statutory Maintenance programme progressing across PFI Theatres and CCU, impact being managed and minimised alongside Jr Dr and Cons IA
- Contract review of Portering service progressing with agreement to trial enhanced model for the Hub Theatres pending Business case to adjust contract .
- On-going trial of PACU step down area for patients deemed fit for transfer back to ward –aim to reduce bottlenecking in theatre.
- NHSE Theatre Specialists supporting transformation work based 2 days per week on –site. Initial focus on enhancing scheduling and forward loading process to maximise bookings.
- Initial conversations regarding development of cross speciality "Enhanced Recovery Programme" to support Elective Hub activity - agreed ownership through Planned Care Board
- Exit strategy for SHS confirmed for Theatres "core activity" –ending 28th July 2023. Contract for weekend work continues

Planned Care – *Outpatients*

New Outpatient Performance to Plan

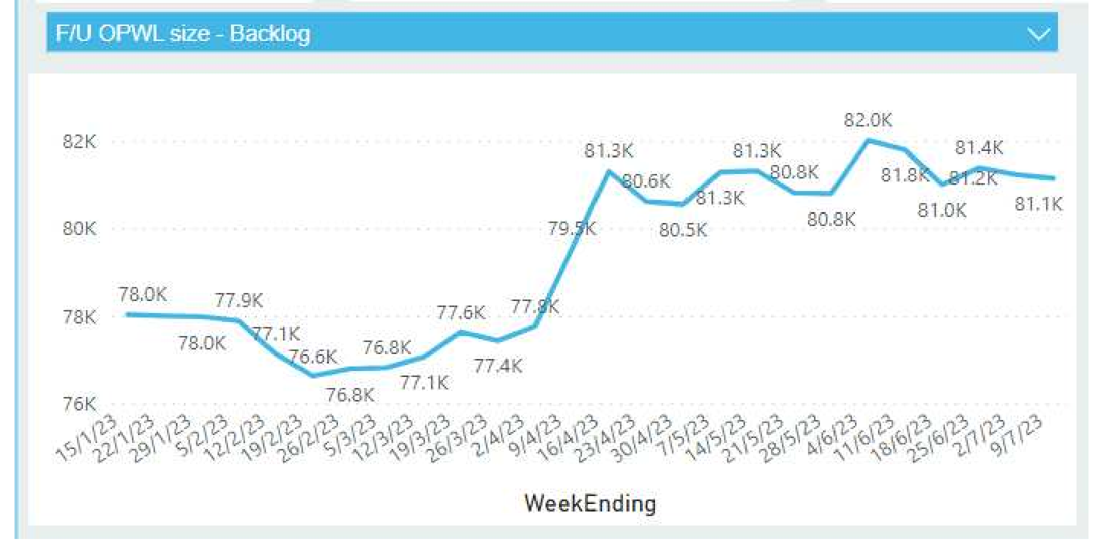
Follow Up Outpatient Performance to Plan

Rolling Performance - Plan V Actual (New Outpatient)

2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07
95.51%	98.24%	96.70%	97.97%	104.23%	89.36%	104.56%	101.20%	104.75%	87.13%	100.03%	96.91%	22.62%

Rolling Performance - Plan V Actual (Follow Up Outpatient)

2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07
98.04%	108.15%	103.75%	105.65%	113.36%	95.61%	108.56%	102.94%	104.22%	97.50%	109.97%	101.23%	21.47%



Planned care – *Outpatients*

Actions

- **OP Cell Programme Structure** revising to reflect latest Elective Recovery Guidance (reducing follow ups). Meeting with NHSE confirmed main elements all covered from Reducing F Ups focus slide. A3 drafted by task & finish group with OP Cell. Engaging with Faster First Appointment NHSE network initiative.
- **Work stream 1 Outpatient Service Delivery & Performance**

  Utilisation; OP Cell Dashboard revised, alongside booking & DNA Divisional / UHNM target & trajectories. Utilisation June 90.0% vs 90.0% plan. Focussed utilisation review at session code level with each specialty continues. From NHSE 'Action on DNAs' initiative, 2 Way Messaging (see below).

  Unoutcomed; DQ leading remedial actions, escalating to Divisions. Tail broadly cleared, prior to previous month at 850 (11/07), but circa 600 are respiratory device patients. This is a known temporary issue where the cohort does not represent a safety risk.
- **Work stream 2 Outpatient Transformation**

  OP GIRFT: issued Nov/Dec, aimed at clinicians & operational teams in 15 specialties. Seen as key enabler for OP Transformation. UHNM baseline assessment vs customised maturity model. Initial review of actions & comments held with clinician & mgt leads for 11/15 specialties. Working vs timeline for further Specialty Meetings & Reviews to challenge ongoing progress. Identifying clinical lead for OP GIRFT.

  PIFU; Benchmarking vs national median May - UHNM: 23rd of 143 providers (5.2% vs 2.3%). >5% June 2023 vs PIFU target 23/24 for UHNM. Action on Outpatients PIFU initiative started June 2023, round table specialties engaged. Additional PIFU pathway opportunities from OP GIRFT guidance & specialties to target from 'Action On' Data Pack. Clarifying requirements for new CDS from July 2023. Identifying clinical lead for PIFU.

  Enhanced Advice & Guidance ICS Referral Optimisation Steering Group re-launched in April. Focus expected to be specialty & pathway-specific. Referral Optimisation Data Pack received, currently being validated and specialty data packs being developed identifying opportunities.

  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. One Consultation now live, IM&T updated at OP Cell April.

  Digital Enablers

  - **Waiting List Validation (OP/IP) & 2 Way Messaging; DNA reduction / Short Notice Booking**

    Now confirmed that PKB to have functionality required. Validation & 2 Way SMS will be included in the funding approved from NHSE/I – IM&T to submit an internal business case. Risk around timescales vs waiting list pressures.
  - **Robotic Process Automation (RPA); OP Outcomes** c.200K attendances annually with 'simple' outcomes eg discharge, could be completed via RPA. & **RPA; PIFU Discharge Letters (at Review Date) -** Scoping with UHNM BI (where pre-agreed by specialties), to pilot with Neuro & Urology.

    Agreed IM&T to lead on requesting funds for robots to cover these two Outpatient-wide RPA approaches.
  - **Patient Portal (PKB)**; IM&T monthly slot at OP Cell for updates. Digital letters live from June 2023 with patient letter to encourage enrolment.

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. PKB functionality to support waiting list validation and 2 way SMS: timeline risk.
- Lack of pace on schemes linked to System Partners, escalated at Planned Care Improvement Board.

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	10.37%	9.51%	9.04%	7.57%	7.79%	11.42%	12.92%	10.17%	13.86%	6.71%	0.67%
Weeks Waited- 78-104	12.33%	11.39%	8.16%	9.68%	6.74%	11.10%	10.44%	10.44%	11.67%	7.40%	0.66%
Weeks Waited- 52-77	13.90%	11.68%	10.03%	9.69%	7.88%	11.04%	9.96%	8.62%	11.41%	4.71%	1.08%
Weeks Waited- Under 52	13.69%	11.42%	10.56%	8.97%	7.62%	10.60%	10.11%	9.07%	11.19%	5.44%	1.34%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.04%	10.11%	9.36%	8.85%	8.05%	10.94%	11.24%	10.09%	12.88%	6.46%	0.99%
Weeks Waited- 78-104	11.60%	10.62%	9.34%	8.94%	8.09%	11.06%	10.76%	9.00%	11.98%	7.31%	1.30%
Weeks Waited- 52-77	12.76%	11.44%	10.00%	8.64%	7.45%	10.85%	10.61%	9.22%	11.69%	6.01%	1.35%
Weeks Waited- Under 52	13.34%	11.31%	10.10%	8.90%	7.49%	10.47%	10.62%	9.10%	11.35%	5.97%	1.33%

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	0.14%	0.36%	0.08%	0.36%	0.28%	0.64%	0.06%	0.11%	0.25%	0.33%	0.39%	0.28%	0.03%	#N/A	93.49%	0.33%	0.72%	1.86%	0.30%
Weeks Waited- 78-104	0.38%	0.47%	0.28%	0.47%	0.57%	0.57%	#N/A	0.09%	0.19%	0.57%	1.33%	#N/A	#N/A	#N/A	89.47%	0.66%	2.85%	1.42%	0.66%
Weeks Waited- 52-77	0.30%	0.64%	0.34%	0.74%	0.50%	1.18%	0.13%	0.27%	0.13%	0.57%	1.55%	0.37%	0.03%	0.34%	87.04%	0.17%	2.36%	1.58%	#N/A
Weeks Waited- Under 52	0.49%	0.70%	0.34%	0.74%	0.60%	1.40%	0.12%	0.17%	0.15%	0.51%	1.62%	0.35%	0.15%	0.23%	83.83%	0.31%	2.75%	2.40%	3.12%

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	0.29%	0.61%	0.20%	0.42%	0.40%	0.79%	0.12%	0.14%	0.10%	0.53%	1.39%	0.28%	0.14%	0.18%	87.97%	0.29%	2.67%	2.09%	1.41%
Weeks Waited- 78-104	0.33%	0.52%	0.24%	0.57%	0.48%	1.23%	0.17%	0.18%	0.18%	0.62%	1.57%	0.30%	0.13%	0.21%	86.15%	0.35%	2.91%	1.94%	1.91%
Weeks Waited- 52-77	0.50%	0.53%	0.19%	0.63%	0.62%	1.25%	0.14%	0.11%	0.14%	0.57%	1.74%	0.31%	0.18%	0.21%	84.70%	0.34%	2.83%	2.45%	2.55%
Weeks Waited- Under 52	0.52%	0.68%	0.22%	0.65%	0.59%	1.32%	0.16%	0.17%	0.15%	0.63%	1.79%	0.34%	0.18%	0.24%	82.52%	0.30%	3.25%	2.69%	#N/A

APPENDIX 1

Operational Performance

Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	Percentage of Ambulance Handovers within 15 minutes	0%	60.40%			
	Ambulance handovers greater than 60 minutes	1	1		F	
	Time to Initial Assessment - percentage within 15 minutes	85%	62.31%	H	F	
	Average (mean) time in Department - non-admitted patients	180	266		F	
	Average (mean) time in Department - admitted patients	180	364		F	
	Clinically Ready to Proceed	90	443	H	F	
	12 Hour Trolley Waits	0	690	H	F	
	Patients spending more than 12 hours in A&E	0	1734		F	
	Median Wait to be seen - Type 1	60	96		F	
	Bed Occupancy	92%	88.98%			
Cancer Care	Cancer 28 day faster pathway	75%	68.03%	H	F	
	Cancer 62 GP ref	85%	52.14%	L	F	
	Cancer 62 day Screening	90%	38.89%	L	?	
	31 day First Treatment	96%	83.49%	L	?	
	2WW First Seen (exc Breast Symptom)	93%	95.69%	H	?	

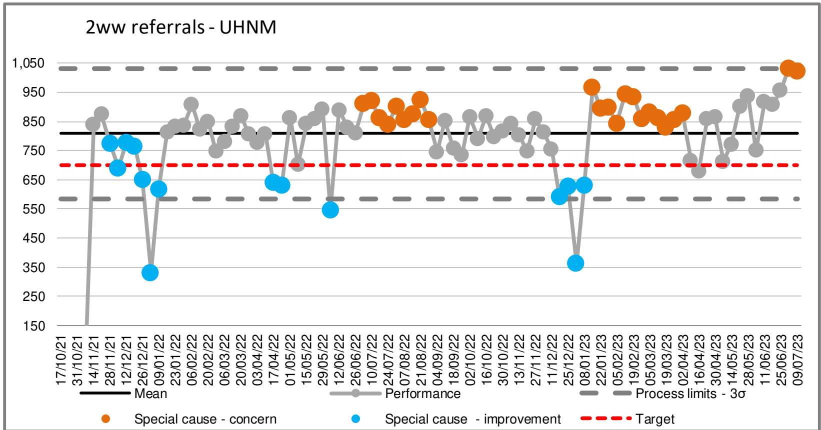
	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.2%	L	?	
	Cancelled Ops	150	202		?	
	Theatre Utilisation	85%	82.9%			
Inpatient / Discharge	Same Day Emergency Care	30%	38%	H	?	
	Super Stranded	183	202		?	
	MFFD	100	109	L	?	
	Discharges before Midday	25%	19.5%		F	
	Emergency Readmission rate	8%	10.0%	L	F	
Elective waits	RTT incomplete performance	92%	53.90%	L	F	
	RTT 52+ week waits	0	4837	H	F	
	Diagnostics	99%	66.31%		F	

Cancer – 62 Day

Target	Apr 23	Jun 23	Jul 23
700	955	1030	1022

Background

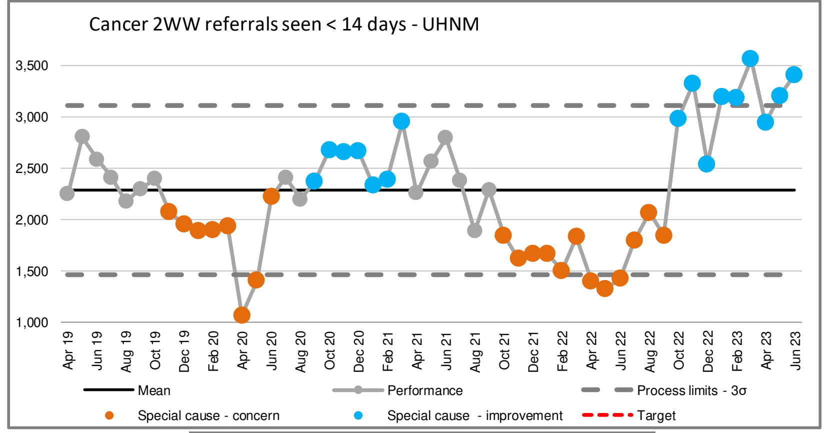
The number of patients referred on a cancer 2ww pathway.



Target	Apr 23	May 23	Jun 23
N/A	2945.0	3208.0	3415.0

Background

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



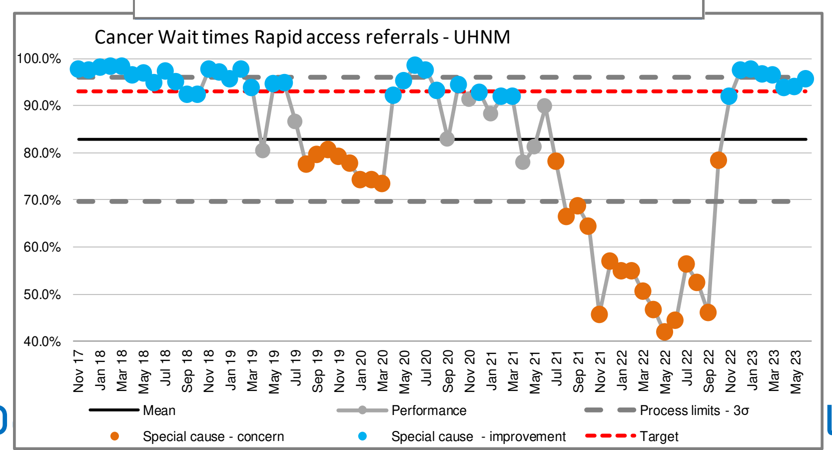
Target	Apr 23	May 23	Jun 23
93%	93.7%	94.1%	95.7%

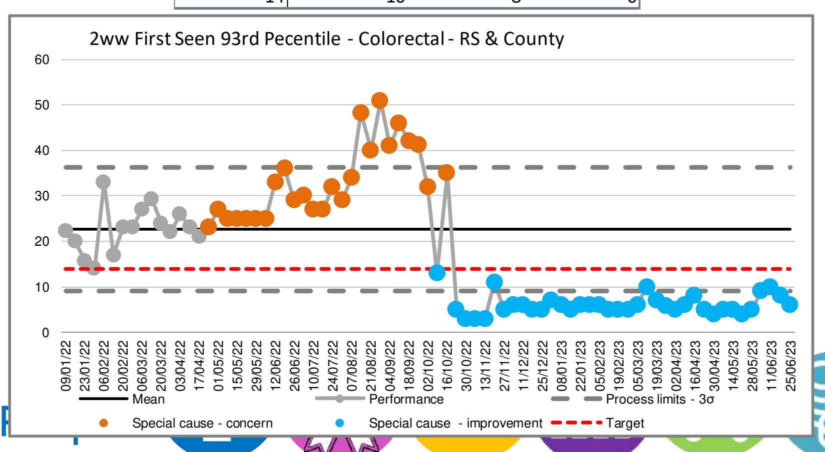
Background

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

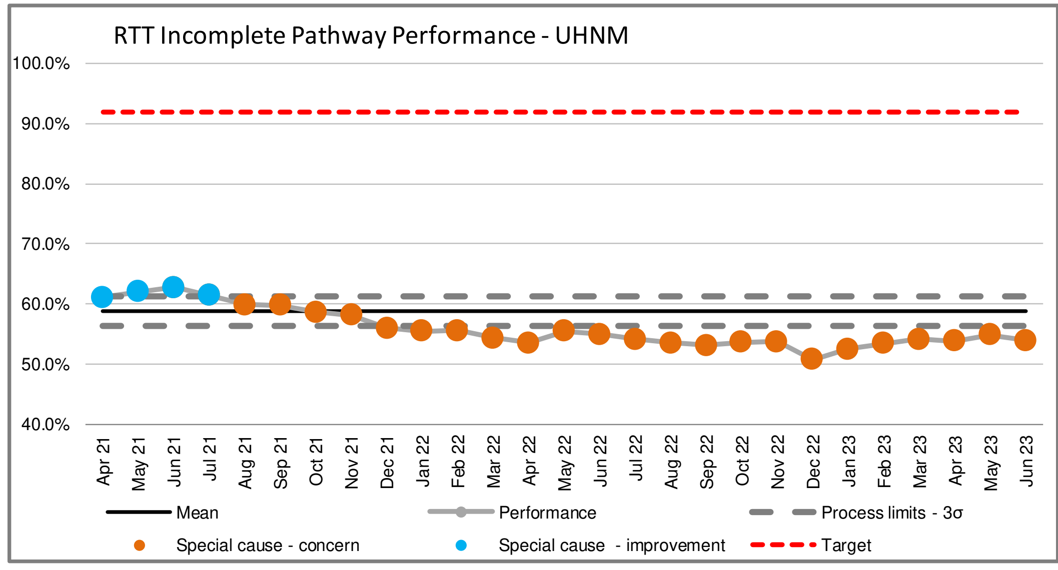
Variation	Assurance

Target	Jun 23	Jun 23	Jun 23
14	10	8	6





Referral To Treatment



Variation	Assurance

Target	Apr 23	May 23	Jun 23
92%	53.9%	54.8%	53.9%

Background

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

What is the data telling us?

RTT performance has stabilised at c. 54% during 2023.

RTT Incomplete Pathways - UHNM

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

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

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

Variation	Assurance

Target	Apr 23	May 23	Jun 23
N/A	78219	78013	79144

Background

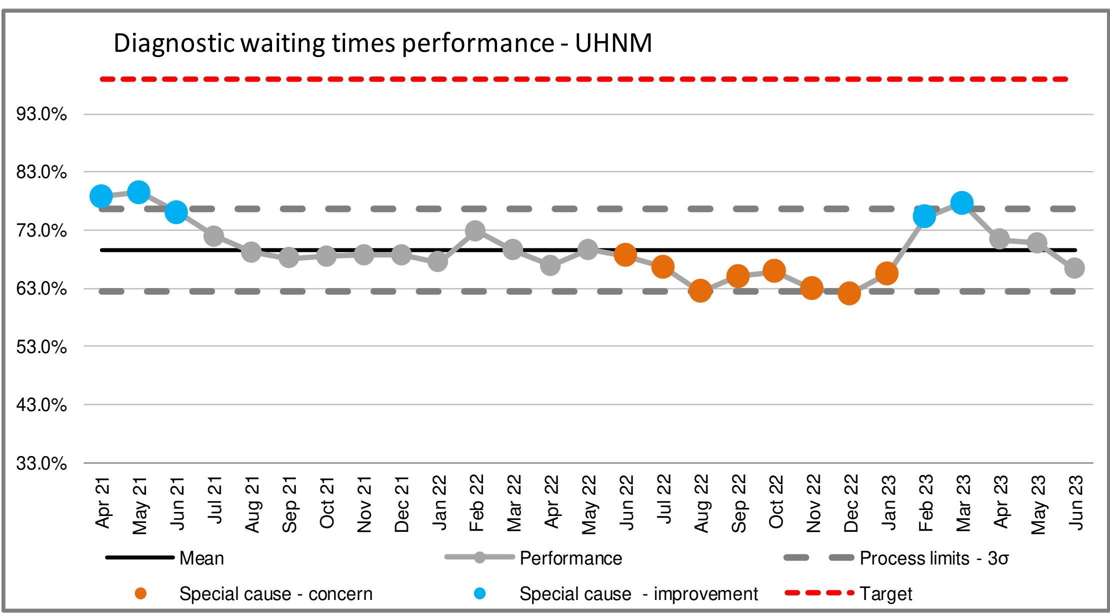
The number of patients waiting over 18 weeks for treatment since their referral.

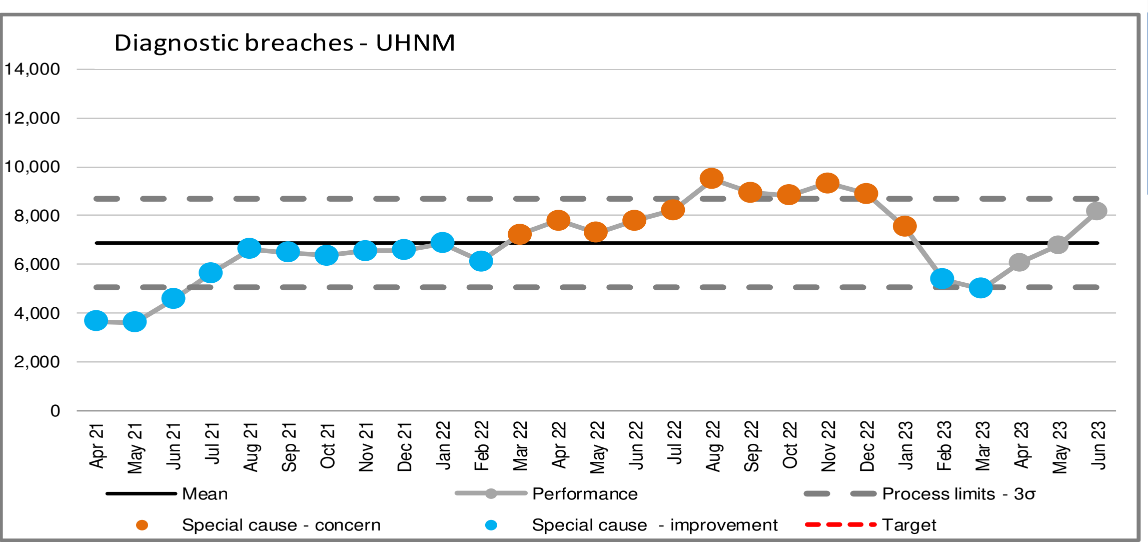
What is the data telling us?

The number of RTT Open pathways continues to see slow growth.

Delivering Exceptional Care with Exceptional People

Diagnostic Standards





Variation	Assurance
	F

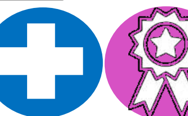
Target	Apr 23	May 23	Jun 23
99%	71.4%	70.8%	66.3%

Background

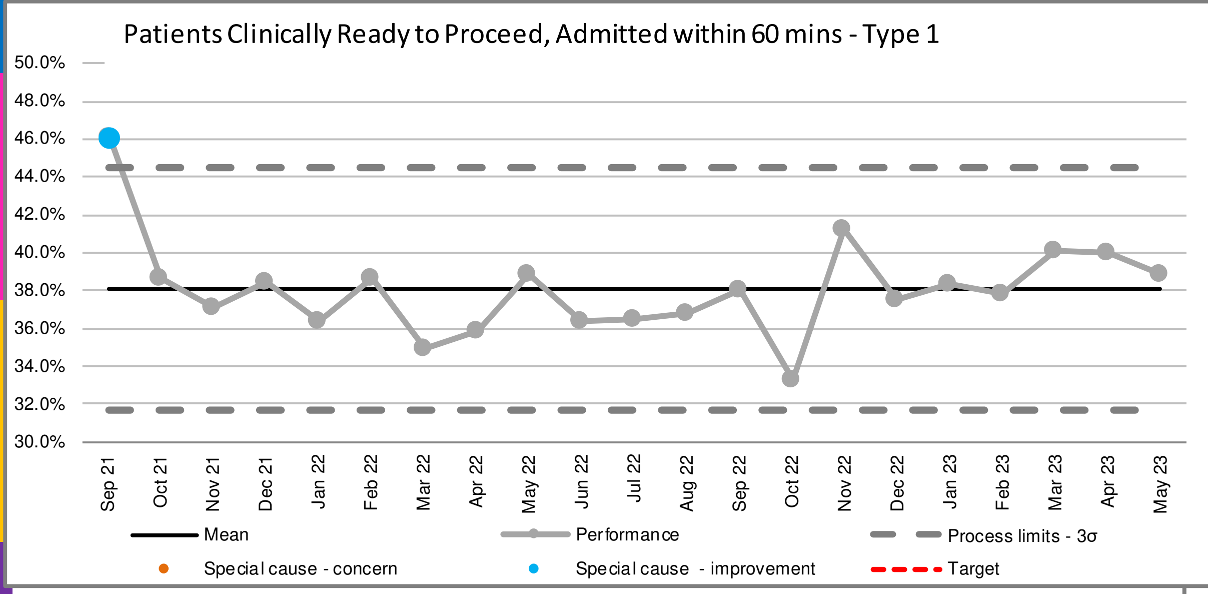
The percentage of patients waiting less than 6 weeks for the diagnostic test.

What is the data telling us?

Waiting times performance saw a sharp improvement during early 2023, since April this has deteriorated to below the 2 year average.
The volume of breaches continues to see a sharp increase, predominantly due to Endoscopy modalities.



Workstream 3; Acute Portals & Navigation
CRTP+1



Variation		Assurance	
Target	Mar 23	Apr 23	May 23
90%	40.1%	40.0%	38.9%

Actions

Workstream 3 constituent Working Groups have now commenced focussing on Portal Preparedness, Portal Standard Work, and Frailty. Project Plans are being completed in each of these areas all focussed on contributing to the ambitious objective of 90% CRTP+1.

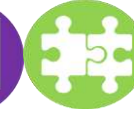
In advance of completion of Working Group Project Plans it has been identified that immediate steps to support the collaborative working between the Acute Medical Portal (AMU), and both the ED and Site Operations Team is required. The leaders of these three teams now are in regular meetings and are documenting progress against a cultural improvement plan in order to ensure foundational work is completed that will be critical to the success of future improvement works.

Summary

- CRPT+1 deteriorated slightly by 1.1% to 38.9% in May from 40.0% in April. This represents poorer performance from the previous month CRPT+1 has been largely static around the 38% mean for in excess of a year and a half. While performance remains slightly above the mean for the third month in a row, the slight deterioration in May & demonstrates the scale of significant improvement still required. Following on from comments with regards to G&A Bed Occupancy data in April, CRTP+1 will continue to require significant scrutiny applied to Divisional specific performance given the variation of quantity and performance.

Workforce

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



Workforce Spotlight Report

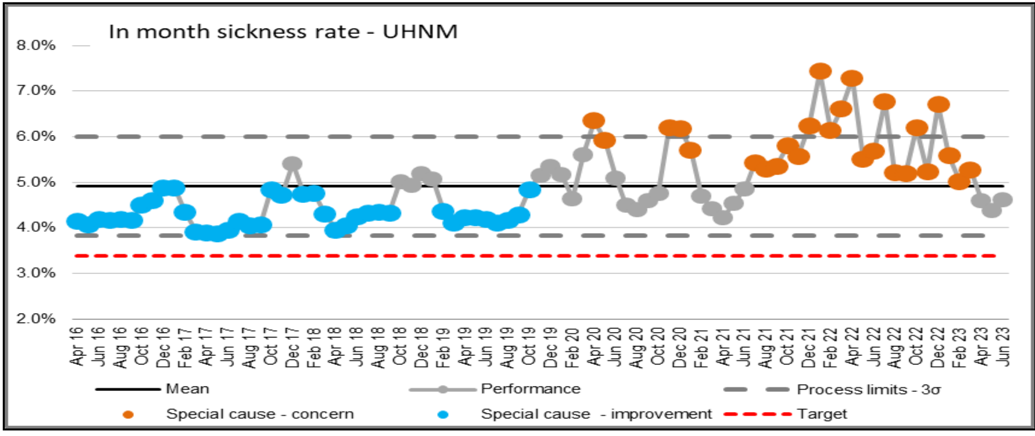
Key messages

- The 12m turnover rate in June 2023 decreased to 8.8% (9.58% in May) which remains below the trust target of 11%.
- The M3 figure of 10.2% highlights a third consecutive month's decrease in the overall vacancy rate.
- For M3, the in-month sickness rate increased by 0.24% to 4.63% (4.39% in May 2023). The 12-month cumulative rate decreased to 5.46% (5.56% in May 2023).
- Stress and anxiety continues to be the top reason for sickness in June, which saw an increase of 0.2% in the last month to 23.1% (22.9% in May). Chest & respiratory problems saw a decrease of 1.3% in the last month to 17.7% (19% in May 2023).
- June 2023's covid-related absences stood at 98, which was 5.08% of the 1,929 open absences. This is a 0.97% increase on the previous month.
- On 30th June 2023, the PDR Rate decreased by 0.6% to 83.2% (83.8% in May 2023).
- Statutory and Mandatory training rate on 30th June was 94% (94.1% on 31st May 2023) showing a very slight decrease. This compliance rate is for the 6 'Core for All' subjects only.
- The Staff Voice trust survey, for June 2023, received a total of 1629 submissions providing an overall colleague engagement score of 6.30.
- The Being Kind face-to face events took place in June and July with over 2,000 colleagues in attendance. The events evaluated extremely well including lots of positive feedback on social media.
- We had a successful PRIDE month (flying the progress flag, Rainbow Badge scheme, a large scale "Pride Flags" banner reveal and attendance at Stoke Pride) all showing UHNM's commitment to LGBTQ+ inclusion for our colleagues, patients and communities (everyone is welcome).
- We Launched new Men's Health Group (during Men's Health Week) this group will initially meet bimonthly and provide a safe space for our male colleagues to talk, support one another, share information and advice on a range of health and wellbeing topics such as exercise, nutrition, mental health, financial wellbeing, health mots etc.
- Our system wide health and care careers virtual work experience project has been highly commended for the HSJ Digital Awards
- Junior doctors took industrial action in June which required extensive coordination and cover from across the whole organisation

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	4.63%		
Staff Turnover	11%	8.79%		
Statutory and Mandatory Training rate	95%	93.98%		
Appraisal rate	95%	83.16%		
Agency Cost	N/A	6.19%		

Sickness Absence



Variation	Assurance

Target	Apr 23	May 23	Jun 23
3.4%	4.6%	4.4%	4.6%

Background

Percentage of days lost to staff sickness

Sickness rate is consistently above the target of 3.4%.

Summary

Org L2	Divisional Trajectory - March 2024	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trajectory
205 Central Functions	3.39%	4.19%	4.21%	4.20%	3.74%	3.71%	3.85%	3.79%	3.90%	3.88%	3.73%	3.66%	3.59%	↓
205 Women's, Children's & Clinical Support Services	5.25%	6.03%	6.07%	6.25%	6.35%	6.29%	6.32%	6.22%	6.19%	6.01%	5.72%	5.68%	5.62%	↓
205 Estates, Facilities and PFI Division	5.25%	5.85%	5.98%	6.04%	6.20%	6.22%	6.15%	6.02%	6.00%	5.75%	6.02%	6.07%	5.99%	↓
205 Medicine and Urgent Care	5.25%	6.76%	6.82%	6.85%	6.94%	6.86%	6.90%	6.55%	6.41%	6.22%	5.98%	5.87%	5.76%	↓
205 Division of Network Services	5.25%	5.89%	5.81%	5.78%	5.73%	5.75%	5.80%	5.59%	5.48%	5.34%	5.06%	4.96%	4.82%	↓
205 Division of Surgery, Theatres and Critical Care	4.50%	7.45%	7.39%	7.31%	7.30%	7.20%	7.12%	6.94%	6.81%	6.73%	6.53%	6.37%	6.23%	↓
205 North Midlands & Cheshire Pathology Service (NMCPS)	5.25%	N/A	N/A	N/A	5.57%	5.61%	5.64%	5.65%	5.68%	5.56%	5.37%	5.34%	5.36%	↑

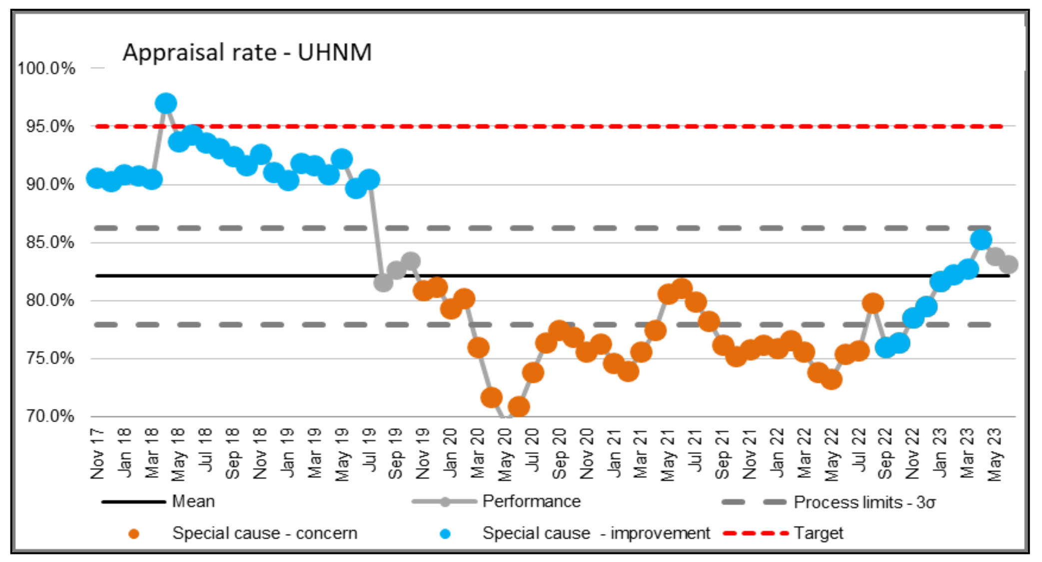
- For M3, the in-month sickness rate increased by 0.24% to 4.63% (4.39% in May 2023).
- The 12-month cumulative rate decreased to 5.46% (5.56% in May 2023).
- Stress and Anxiety continues to be the top reason for sickness in June, which saw an increase of 0.2% in the last month to 23.1% (22.9% in May).
- All of the Divisions apart from North Midlands & Cheshire Pathology Service (NMCPS) saw a decrease in sickness against the previous month.

Actions

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

Appraisal/Performance Development Review (PDR)

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Apr 23	May 23	Jun 23
95.0%	85.3%	83.8%	83.2%

Background

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

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

Summary

- On 30th June 2023, the PDR Rate decreased by 0.6% to 83.2% (83.8% on May 2023).
- There is a decrease from the previous month figure and this figure remains below the overall target and divisions have been asked to review key issues and actions to work towards meeting target.
- The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance and making the process enhance employee experience.

Actions

The focus on ensuring completion of PDRs is continuing with:

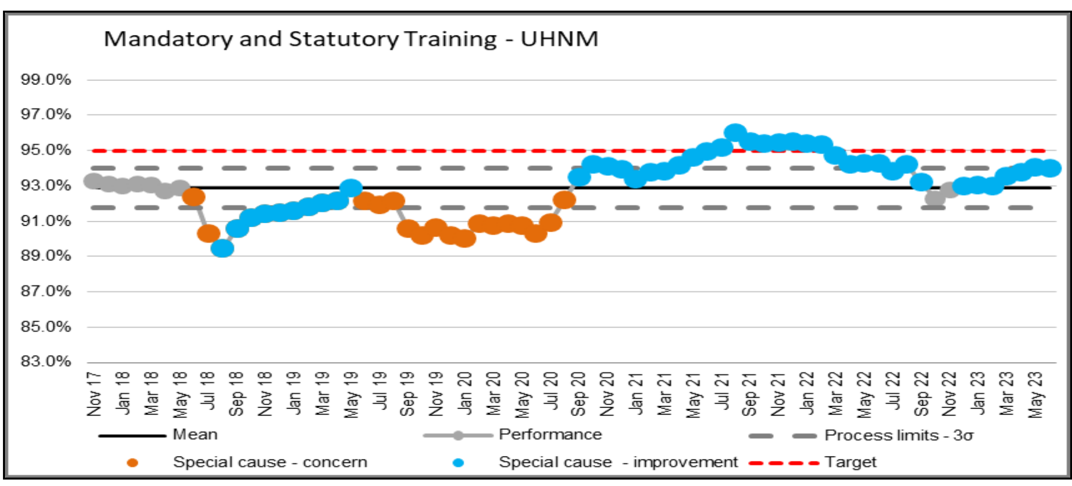
NMCPS - All out of date PDR's to be scheduled with line managers, and ESR hierarchy changes and training gaps to be identified.

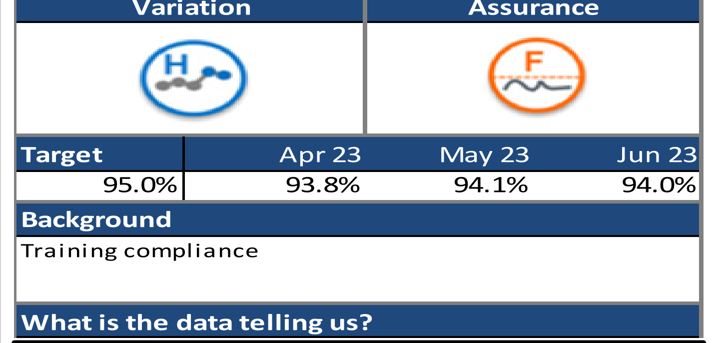
Network Division - Hold a dedicated weekly PDR compliance hotspot and assurance meetings

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

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

Statutory and Mandatory Training





At 94.0%, the Statutory and Mandatory Training rate remains just below the Trust target for the core training modules

Summary

Statutory and Mandatory training rate on 30 June 2023 was 94.0% (94.1% on 31 May2023) showing a very slight decrease. 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|	11386	11386	10671	93.72%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	11386	11386	10716	94.12%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	11386	11386	10694	93.92%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	11386	11386	10718	94.13%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	11386	11386	10813	94.97%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	11386	11386	10590	93.01%

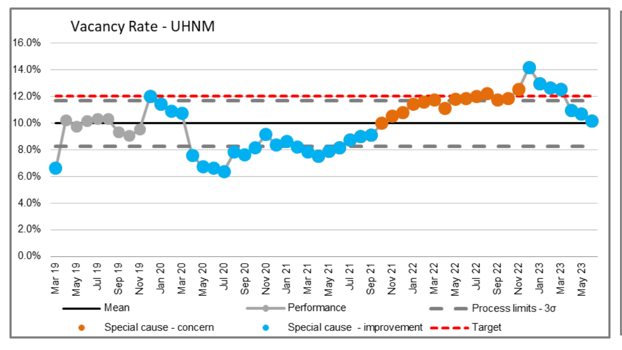
Compliance rates for the Annual competence requirements were as follows:

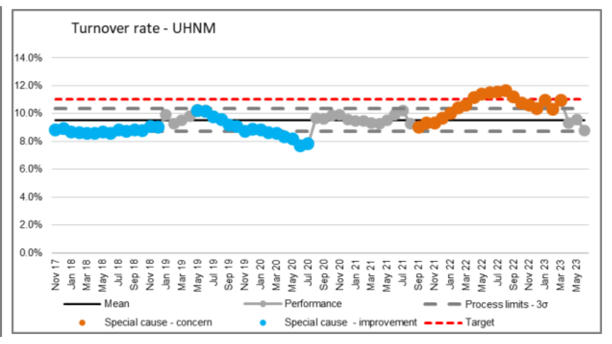
Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	11386	11386	9813	86.18%
NHS|CSTF|Information Governance and Data Security - 1 Year|	11386	11386	10612	93.20%

Actions

- We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.
- Compliance is monitored and raised via the Divisional performance review process.
- The Being Kind e-learning is now mandated from 1 April 2023 and face-to face sessions started from June 2023, with a total of 2,178 individuals who have already attended, of which 1,039 attended in June 2023.

Workforce Vacancies and Turnover





Variation	Assurance		
Target	Apr 23	May 23	Jun 23
11.0%	9.3%	9.6%	8.8%

Background

Turnover rate

What is the data telling us?

The turnover rate for June 2023 remains below the trust target of 11%.

Vacancy rate has decreased from 10.65% last month to 10.16%

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

Summary

- The 12m Turnover rate in May 2023 sat at 9.58% figure sitting below the trust target of 11%.
- The summary of vacancies by staff groupings highlight a small decrease in the vacancy rate over the previous month.
- The M3 figure of 10.2% highlights a third consecutive month's decrease in the overall vacancy rate. Colleagues in post increased in June 2023 by 47.93 FTE, budgeted establishment decreased by 10.86 FTE, which decreased the vacancy FTE by -58.79 FTE overall [*Note: the Staff in Post FTE is a snapshot at a point in time, so may not be the final figure for 30/05/23]

Vacancies at 30-06-23	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,560.86	1,361.34	199.52	12.78%	12.84%
Registered Nursing	3597.47	3142.50	454.97	12.65%	12.56%
All other Staff Groups	6592.73	6052.89	539.84	8.19%	9.11%
Total	11,751.06	10,556.72	1,194.34	10.16%	10.65%

Actions

- Significant amount of recruitment events targeting specific roles across multiple divisions. July events focused on midwifery, nursing assistants and housekeepers
- Continued targeted social media campaign. Recruitment are actively updating LinkedIn pages and have created a new UHNM recruitment Facebook group.
- Targeted spotlight on UHNM colleagues continue and supplement the recruitment campaigns

Finance

2025 Vision	"Ensure efficient use of resources"

Delivering Exceptional Care with Exceptional People

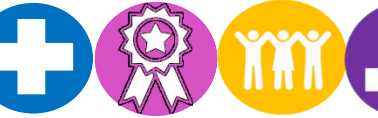
Finance Spotlight Report

Key elements of the financial performance year to date are:

- For Month 3 the Trust has delivered a year to date deficit of £5.9m against a planned surplus of £2.4m; this adverse variance of £8.3m is primarily driven by underperformance against the Trust's in year CIP target, the impact of industrial action and unfunded additional winter escalation capacity that remains open.
- The Trust has incurred £2.6m of costs relating to winter escalation capacity remaining open in Quarter 1; the Month 3 position assumes that this additional cost will be not be funded by the local ICB.
- The industrial action (IA) by Junior Doctors in April and June has cost the Trust £1.5m in backfill arrangements. Whilst this cost is unfunded the ERF target for the year is being reduced by 2% in relation to the April IA with further guidance expected for subsequent IA.
- To date the Trust has validated £10.8m of CIP savings to Month 3 against a plan of £13.7m. The Trust has recognised £1.3m of CIP due to an assumed reduction in the annual leave provision; this delivers 50% of the NR ICB stretch CIP target. Schemes of £47m have been identified for delivery in 2023/24. The £8.0m divisional schemes remain unidentified.
- There has been £8.7m of Capital expenditure which is £0.6m above plan.
- The cash balance at Month 3 is £102.7m which is £21.9m higher than plan; this is mainly due to the profile of cash receipts. The underlying cash position shows that cash is £3m behind the plan at Month 3.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	89.8		
	Expenditure - Pay	variable	53.6		
	Expenditure - Non Pay	variable	33.5		
Activity	Daycase/Elective Activity	variable	9,320		
	Non Elective Activity	variable	10,767		
	Outpatients 1st	variable	29,293		
	Outpatients Follow Up	variable	43,752		



Income & Expenditure

Income & Expenditure Summary Month 03 2023/24	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	981.2	81.8	82.8	1.0	245.0	244.3	(0.7)
Other Operating Income	84.5	7.5	7.0	(0.5)	21.5	20.8	(0.6)
Total Income	1,065.7	89.3	89.8	0.5	266.4	265.1	(1.3)
Pay Expenditure	(645.6)	(51.7)	(53.6)	(1.9)	(159.2)	(161.8)	(2.6)
Non Pay Expenditure	(357.9)	(31.8)	(33.5)	(1.7)	(89.0)	(93.9)	(4.9)
Total Operational Costs	(1,003.6)	(83.5)	(87.1)	(3.6)	(248.2)	(255.7)	(7.5)
EBITDA	62.1	5.8	2.7	(3.0)	18.2	9.4	(8.8)
Depreciation & Amortisation	(35.7)	(3.0)	(3.0)	0.0	(9.2)	(9.2)	0.0
Interest Receivable	2.8	0.2	0.4	0.2	0.7	1.2	0.5
PDC	(10.3)	(0.7)	(0.7)	(0.0)	(2.6)	(2.6)	0.0
Finance Cost	(19.0)	(1.6)	(1.6)	(0.0)	(4.7)	(4.7)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Total	0.0	0.7	(2.1)	(2.8)	2.4	(5.9)	(8.3)

- Key issues to note within the Month 3 position include the following
- The overspend of £8.3m is mainly driven by
  - an under delivery of CIP by £2.9m
  - unfunded costs of £2.6m relating to additional winter escalation capacity that has remained open in Quarter 1.
  - costs relating to industrial actions of £1.5m
- The two main CIP schemes behind plan at Month 3 are the ICB non-recurrent stretch of £1.3m and the recurrent divisional schemes of £2.0m. The Trust has transacted £1.3m of the stretch target in Month 3 through a reduction in the Annual Leave provision.
- Additional costs of £2.6m have been incurred for winter escalation capacity that has remained open in Quarter one. It has been assumed in the Month 3 position that no additional funding will be received from the local ICB. Discussion are on-going across the system on the level of funding available for additional escalation capacity and the actual and potential commitments against this funding with a clear position expected for Month 4.
- The Month 3 pay costs include payment of Agenda for Change staff at the agreed 2023/24 pay rate that has been nationally agreed. The Month 3 pay costs also include the non-consolidated payment for Agenda for change staff relating to 2022/23.

Capital Spend

UHNM Capital Expenditure Plan	2023/24 Plan/forecast £000	YTD Plan M03 £000	YTD Actual M03 £000	YTD Variance M03 £000
Total PFI & Loan Commitments	(19.6)	(4.3)	(4.3)	-
Pre-committed investment items (ICB allocation)				
PFI enabling costs	(0.2)	-	-	-
Project Star	(20.7)	(2.2)	(2.2)	0.0
Emergency Department (restatement costs)	(0.2)	-	(0.1)	(0.1)
Air heat boiler replacement Trust Contribution	(0.7)	-	-	-
Wave 4b Funding - Lower Trent Wards	(0.2)	-	-	-
EPMA (Electronic Prescribing) BC	(0.7)	(0.1)	(0.1)	0.0
Pathology LIMS BC	(0.6)	(0.2)	(0.2)	(0.0)
Pathology MSC Siemens refresh	(0.1)	-	-	-
Patient Portal roll out costs (BC 462)	(0.4)	(0.0)	(0.0)	0.0
Bi plane enabling (BC 425)	(0.2)	-	-	-
CT8 enabling works	(0.6)	(0.1)	(0.1)	0.0
Nasstar equipment refresh/buy out	(1.2)	-	-	-
Pharmacy Robot BC487 - equipment	(0.5)	-	-	-
Pharmacy Robot BC487 - enabling and other	(0.8)	-	-	-
Electronic Patients records BC/specification	(0.8)	-	-	-
ED ambulance off - enabling ward moves	(0.7)	(0.0)	(0.1)	(0.1)
County CTS equipment (TIF) remaining equipment	(0.2)	(0.2)	(0.1)	0.1
County Modular remaining equipment	(0.1)	(0.1)	(0.1)	0.0
I-refer	(0.0)	(0.0)	-	0.0
Investment funding - minor cases *	(0.4)	-	-	-
Funding to be confirmed (on-call, PODS, ED doors)	-	-	-	-
Central Contingency & risk	-	-	-	-
Required NHSE plan re-phasing adjustment	7.2	1.2	-	(1.2)
Endoscopy works - 22/23 PDC ICB allocation	(0.4)	-	-	-
Remaining 2022/23 commitments	(0.3)	(0.2)	(0.1)	0.1
Total Pre committed Investment items	(22.7)	(2.0)	(3.1)	(1.1)
Capital sub-group (ICB allocation)				
IMT Sub Group Total Funding	(2.3)	(0.2)	(0.1)	0.1
Medical Devices Sub Group Total Funding	(2.4)	(0.3)	(0.1)	0.2
Estates Sub Group Total Funding	(3.6)	(0.2)	(0.1)	0.1
Health & Safety compliance	(0.2)	-	-	-
Net zero carbon initiatives	(0.1)	-	-	-
Central funding beds, mattresses, hoists	(0.1)	-	-	-
Total Sub Groups	(8.7)	(0.7)	(0.3)	0.4
New IFRS16 leases (previously classified as operating leases and charged to revenue)				
Lease liability re-measurement	(0.2)	-	-	-
IFRS 16 leases	(0.9)	(0.2)	(0.2)	0.1
Total Internal Capital Expenditure programme	(52.1)	(7.2)	(7.8)	(0.6)
Additional CRL / Externally Funded PDC				
Wave 4b Funding - Lower Trent Wards	(1.6)	0.0	(0.0)	(0.0)
TIF 2 PDC CTS phase 1 - enabling slippage	(0.4)	(0.2)	(0.0)	0.1
TIF 2 PDC (Day Case Unit)	(2.7)	(0.0)	(0.0)	(0.0)
TIF 2 PDC (Women's Hospital)	(1.2)	(0.0)	(0.0)	0.0
PDC - UEC SDEC facility	(13.4)	-	-	-
CDC - diagnostic centre	(0.4)	-	-	-
Air heat boiler replacement PSDS Grant BC 510	(2.9)	-	(0.0)	(0.0)
Charitable funded expenditure	(2.1)	(0.7)	(0.7)	(0.0)
Total Additional CRL / PDC Funded expenditure	(24.7)	(0.9)	(0.9)	0.0
Total Capital Expenditure	(76.8)	(8.1)	(8.7)	(0.6)
Planned (under)/over spend	5.9			

The table above sets out the capital plan for 2023/24 as per the plan resubmitted to NHSE on 4 May 2023. The planned overspend of £5.9m has reduced from the previous plan submission of £13.6m as the ICB was required to submit a balanced capital plan over 2 years (within the allowable 5% over commitment). The underspend of £5.9m in 2024/25 has been reduced from £13.6m in the previous plan.

As a result of the changes required by NHSE a re-phasing of £7.2m between the 2 financial years has been included in the plan but has not been allocated against specific schemes. NHSE has acknowledged in writing the capital pressures facing the ICB and that;

It is expected the ICS will continue to review phasing of expenditure on an on-going basis to minimise the over commitment against allocation. However, if no further slippage is possible, a CDEL adjustment of up to £7.2m will be required for the ICS. This will be managed as an allowable over commitment against the Staffordshire ICS capital envelope as part of the regional position, with an expectation that an equivalent under commitment resulting from disposal receipts will be seen in year 3.

In Month 4 a review of the capital programme will be undertaken to review the year end forecast position and the timing of key schemes. If the review identifies a significant level of movement from forecast the options will need to be considered particularly where slippage is identified and as to whether this should;

-be re-allocated to other schemes;

-reduce the forecast overspend in year by re-phasing (and therefore reduce the required underspend); or

-be held as contingency against capital receipts currently included in the plan as funding.

Balance sheet

Balance sheet as at Month 3	31/03/2023 Actual £m	30/06/2023 Plan £m	30/06/2023 Actual £m	Variance £m	
Property, Plant & Equipment	627.6	623.0	626.0	3.0	Note 1
Right of Use Assets	18.8	18.0	17.7	(0.2)	Note 1
Intangible Assets	18.4	17.5	16.6	(0.8)	Note 1
Trade and other Receivables	1.4	1.4	1.4	-	
Total Non Current Assets	666.1	659.8	661.7	1.9	
Inventories	16.8	16.8	16.9	0.1	
Trade and other Receivables	57.9	38.7	44.5	5.9	Note 2
Cash and Cash Equivalents	84.0	80.8	102.7	21.9	Note 3
Total Current Assets	158.7	136.3	164.1	27.8	
Trade and other payables	(134.0)	(107.0)	(144.3)	(37.2)	Note 4
Borrowings	(14.0)	(13.6)	(13.6)	(0.0)	
Provisions	(5.6)	(5.6)	(5.6)	0.0	
Total Current Liabilities	(153.5)	(126.2)	(163.5)	(37.3)	
Borrowings	(256.8)	(253.6)	(253.6)	(0.1)	
Provisions	(2.7)	(2.7)	(2.6)	0.0	
Total Non Current Liabilities	(259.5)	(256.2)	(256.3)	(0.0)	
Total Assets Employed	411.7	413.7	406.1	(7.6)	
Financed By:				-	
Public Dividend Capital	665.0	665.0	665.0	-	
Retained Earnings	(427.5)	(425.5)	(433.1)	(7.6)	Note 5
Revaluation Reserve	174.2	174.2	174.2	-	
Total Taxpayers Equity	411.7	413.7	406.1	(7.6)	

Note 4. Payables are £37.2m higher than plan mainly at Month 3 and is mainly due to increases in deferred income and payroll deductions.

Note 5. Retained earnings are showing a £7.6m variance from plan and reflects the revenue variance from plan at Month 3 of £8.3m which is partly mitigated by higher than plan capital donated income of £0.8m (relating to donated capital expenditure).

The balance sheet plan reflects the forecast included within the 2023/24 Financial Plan submitted on 4 May 2023. Variances to the plan at Month 3 are explained below:

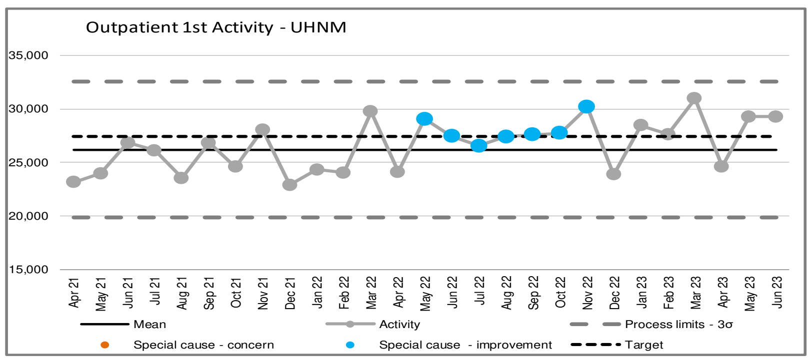
Note 1. Non-current assets are £1.9m higher than plan. The main variance is on property, plant and equipment which is showing a variance of £3m. This is mainly due to the phasing of capital expenditure required in the capital plan submitted to NHSE in relation to Project Star, the spend is in line with the Trust's internal plan. Donated capital expenditure is £0.8m ahead of plan at Month 3, which includes expenditure on the County Imaging Academy.

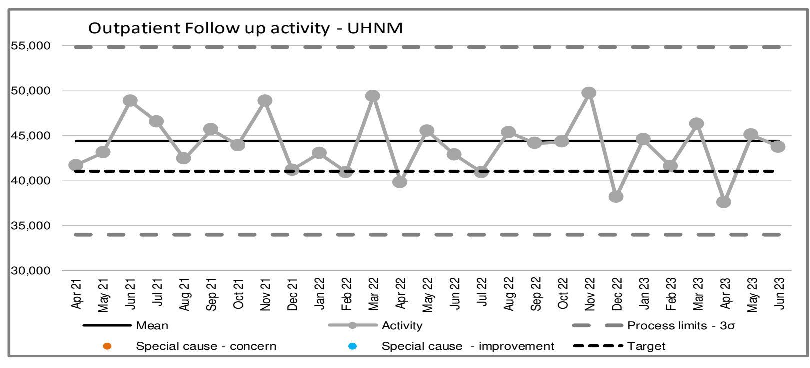
Note 2. Trade and other receivables are £5.9m higher than plan at Month 3 (£7.7m at Month 2) and reflects a £4.9m increase in non-NHS prepayments compared to Month 12. The main reason for the increase is the payment of annual business rates for the 2023/24 financial year of £4.7m for the Royal Stoke and County sites in April 2023. The remaining increase reflects the payment of other annual and quarterly invoices in April 2023 including for pathology managed service contracts.

Note 3. At Month 3 our cash balance was £102.7m, which is £21.9m higher than plan, however the underlying cash position shows that cash is £3m behind plan at Month 3. The year to date variance is due to higher than plan cash received of £40.6m and higher than plan payments of £18.7m. Cash received from Stoke and Staffordshire ICB's is £18m higher than plan at month relating to cash received for 23/24 non-recurrent items including the ERF Marginal Gains Transfer (£14.9m). Cash received and payments are both higher than plan due to the impact of the Agenda for Change pay award in Month 3.

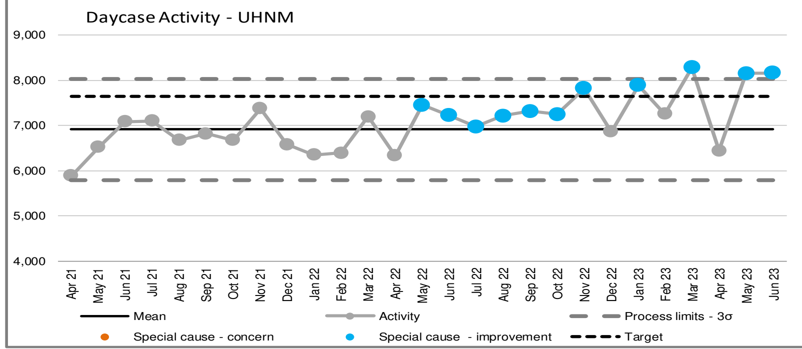
Activity

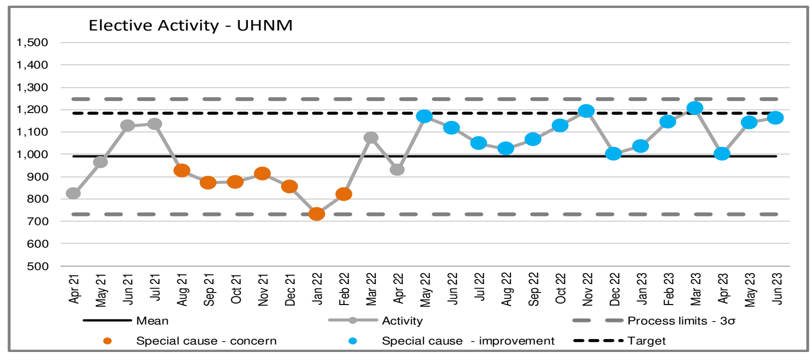
Planned care Outpatient



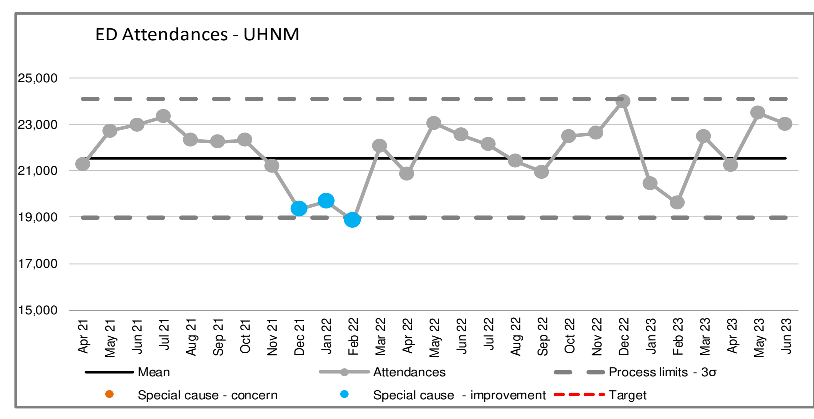


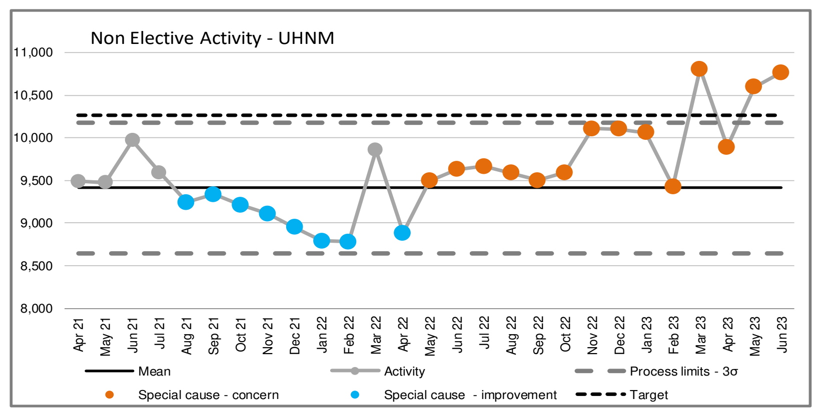
Planned care Inpatient





Urgent Care





Audit Committee Chair's Highlight Report to Trust Board

27th July 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • The Internal Audit Review into Data Quality: Annual Leave Indicators concluded with partial assurance and the Care Quality Commission Implementation of Agreed Actions concluded with reasonable assurance, with a number of management actions identified for improvement • Further assurance was requested in terms of ensuring the timely completion of previous internal audit recommendations, particularly for those which had been delayed. It was noted that an improved process for monitoring recommendations was to be implemented, whereby oversight would be provided by the respective Committees • Losses and special payments for quarter 1 totalled £202,960 the majority of which related to stock write off. The Committee were informed of the actions continuing to be taken with regards to stock write offs within interventional radiology given the particularly high costs • During quarter 1 there were 4 single tender waivers (STW) greater than £50,000 which reflected previous trends. There were 163 standing financial instruction (SFI) breaches due to late purchase orders whereby 13 exceeded £100,000 and £120,000 salary overpayments had been made during the quarter. Further assurance on actions taken was requested by the Committee in addition to the progress made to review historic salary highlighting the actions taken to recover the balances. • The LCFS update highlighted 4 ongoing referrals with the majority of cases relating to working whilst sick and any learning was shared as appropriate in addition to an awareness session having been held with Human Resources	• Recently completed internal audit reviews to considered by respective Committees for ongoing monitoring of progress made against the recommendations • Further assurance to be obtained on out of date policies from Policy Authors as to seeking an assessment of whether the current policies remain fit for purpose and the achievability of the revised review dates • It was agreed to monitor the risks associated with cyber security via the internal audit programme, the Board Assurance Framework and updates from the Local Counter Fraud Specialist (LCFS) • Future iterations of the Board Assurance Framework to reflect upon the impact and outputs of bed modelling and capacity and demand • Progress with job planning to be highlighted to the Transformation and People Committee • To take the 'Value for Money' assessment to a future Board meeting so that further consideration of the recommendations could be made in addition to assigning oversight to the Board/Committee(s)
✓ Positive Assurances to Provide	**Decisions Made**
• The Internal Audit Reviews into Board Assurance Framework and Risk Management and Data Security Protection Toolkit concluded with a continued rating of Substantial Assurance • The Committee welcomed the revisions and amendments made to the Board Assurance Framework which would continue to be embedded in terms of assessing the assurance ratings compared to the ratings assigned to the action plan. It was recognised that further testing was to be undertaken by Committees in terms of assessing the achievability of the risk score trajectory and ability to reach to the target risk score by the target date • An update on 2022/23 financial accounts was provided following the Boards consideration of an updated Audit Findings Report. The issues with the valuation and reduction in assets were confirmed to result in a position of £22.5 m for 2022/23 and £20.2 m for 2021/22. However, there was no impact on income and expenditure due to depreciation charges and an unqualified audit opinion was provided • The External Audit 'Value for Money' assessment highlighted no significant weaknesses although six improvement recommendations had been identified • The Counter Fraud Functional Standard return had been submitted with an overall green rating highlighting compliance against the functional standards	• The Committee approved the Board Assurance Framework for Quarter 1

Comments on the Effectiveness of the Meeting
• The Committee noted a full agenda however were able to provide assurance of the capacity and effectiveness of the Committee to deliver the requirements and duties as set out within its Terms of Reference

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	BAF 1, 2, 3, 5, 6	Various	✓!	Assurance	6.	Losses and Special Payments Q1 2023/24	BAF 8	High 9	!	Assurance
2.	Internal Audit Action Tracker	Various	-	!	Assurance	7.	SFI Breaches and Single Tender Waivers Q1 2023/24	BAF 8	High 9	!	Assurance
3.	Corporate Governance Report	-	ID10836	-	Assurance	8.	External Audit Progress Report / Annual Report	BAF 8	High 9	✓	Assurance
4.	Board Assurance Framework Q1	ALL	Various	✓	Approval	9.	Local Counter Fraud Specialist (LCFS) Progress Report	BAF 8	High 9	! ✓	Assurance
5.	Issues for Escalation from Committees			!	Assurance	10.	2023/24 Clinical Audit Programme	Various	ID26887 ID8877 ID8500		Information

3. 2023 / 24 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					
3.	Prof A Hassell	Associate Non-Executive Director					
4.	Mrs A Rodwell	Associate Non-Executive Director					
	Other Attendees:						
5.	Ms N Coombe	External Audit – Grant Thornton		LM			
6.	Mr G Patterson	External Audit – Grant Thornton					
7.	Mr M Gennard	Internal Audit - RSM					
8.	Mr A Hussain	Internal Audit - RSM					
9.	Ms E Sims	LCFS - RSM			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

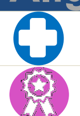
Executive Summary

Meeting:	Trust Board (Open)	Date:	2nd August 2023
Report Title:	Quarter 1 Board Assurance Framework 23/24	Agenda Item:	11.
Author:	Claire Cotton, Associate Director of Corporate Governance		
Executive Lead:	Chief Nurse, Medical Director, Chief People Officer, Chief Operating Officer, Director of Strategy & Transformation, Chief Finance Officer, Director of Digital Transformation		

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	*A full register of linked risks scoring 12 and above can be found at Appendix 2.*

Executive Summary

Situation

The Board Assurance Framework (BAF) is designed to focus the Board on the key strategic risks which might compromise the achievement of our Strategic Priorities and to set out the controls and assurances in place to manage those risks and to measure the effectiveness of those controls. The BAF is updated on a quarterly basis and has been presented to Committees of the Board for scrutiny ahead of being presented to the Board.

Background

An annual process is in place to review the content of the BAF; sessions were held with the Executive Team and the Board in March 2023 where the outline Strategic Risks were reviewed and confirmed. The most notable change was in relation to BAF 4 which previously focussed on 'System Working'; this now looks at 'Improving the Health of our Population' which is better aligned with our Strategic Priorities and that of the system.

Further changes to the format and function of the BAF have been made and these are summarised within section 1 of the report. Most notably we have introduced Assurance Ratings and a forward looking Assurance Map aligned with our Business Cycles, to provide a clear line of sight to the assurances planned for the year. Risk reduction trajectories have also been introduced and a new Summary Board Assurance Framework has been produced at Section 2; this will form part of a summarised BAF which is being developed for the Board, whilst retaining the detailed BAF for Committee scrutiny.

Assessment

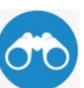
The Internal Audit of BAF and Risk Management for 2022/23 has been completed and was presented to the Audit Committee in July. The audit has again concluded with **'Substantial Assurance'.**

The **highest scoring** risks are:

- BAF 4: Improving Population Health (which has been scored at **Extreme 20** in line with the ICB Board Assurance Framework); this has been given a **Partial Assurance** rating and has limited sources of assurance planned for the year
- BAF 5: Responsive Patient Care, also scored at **Extreme 20** which remains unchanged ➔ when compared to Quarter 4 2022/23; this has been given a **Partial Assurance** rating

BAF 1: Patient Experience and Outcomes, scored at **Extreme 16** with **Acceptable Assurance,** has a trajectory for reduced risk score during Quarter 3 although this is anticipated to increase during Q4 due to seasonal pressures

- 5/9 risks have a trajectory for risk reduction over the remainder of the year
- 3/9 risks have a trajectory which will see the risk score remain unchanged for the remainder of the year

	High Quality continues to be our most threatened Strategic Priority, now with all strategic risks identified as posting a threat to it and 4 of those risks are **Extreme**. This is followed by **People** and **Resources,** each with 7/9 risks posing a threat.
	BAF 1: Patient Experience and Outcomes has the highest number of linked risks on the risk register (126) of which 13 are scored as **Extreme.** This is followed by BAF 5: Responsive Patient Care which has 105 linked risks, of which 14 are scored as **Extreme**.

Key Recommendations

- The Board is asked to consider whether the Quarter 1 Risk Scores and Assurance Assessments are an accurate reflection of the position
- The Board is asked to consider whether the actions identified are sufficient to either reduce the risk score in line with trajectory / target or to provide additional assurance
- The Board is asked to consider whether the Assurance Map is sufficient in terms of planned assurances for the remainder of the year

Board Assurance Framework (BAF)

Quarter 1 2023/24

Delivering Exceptional Care with Exceptional People

1. Introduction

Situation

The Board Assurance Framework (BAF) provides a structure and process that enables a focus for the Board on the key risks which might compromise the achievement of our Strategic Priorities (see illustration below). 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 business undertaken through our 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).

UHNM Strategic Framework

NHS University Hospitals of North Midlands NHS Trust

System Strategies and Plans

Organisational Strategy

Strategic Priorities

Improving Together

UHNM Strategy 2021 - 2025

Vision: Delivering Exceptional Care with Exceptional People

Values: Together, Compassion, Safe, Improving

Strategic Priorities

High Quality: Providing safe, effective and caring services

Responsive: Providing efficient and responsive services

People: Creating a great place to work

Improving & Innovating: Achieving excellence in development and research

System & Partners: Working together to improve the health of our population

Resources: Ensuring we get the most from our resources including staff, assets and money

Enabling Strategies

Clinical, Quality, People, Research & Innovation, Health & Wellbeing, Digital, Estate, Finance (Plan)

Supporting and Service Specific Strategies

Updated February 2023

Background

The strategic risks contained within the 2022/23 BAF were refreshed by the Executive Team and agreed by the Board in March 2023 in line with our annual review process. The BAF has continued to be improved in terms of format and function and during Quarter 1; the following changes have been made:

- A refresh of the risks and risk descriptions (most notably BAF 4 previously 'System Working' now 'Improving the Health of our Population')
- New summary Board Assurance Framework (section 2)
- Revised Heat Map (now displaying current versus target Risk Score) (section 3)
- New Assurance Outcomes chart setting out total number of assurance and outcome as included within the relevant Committee Highlight Report to Trust Board (section 3)
- Introduction of Assurance Ratings
- Introduction of Risk Trajectories
- Introduction of Assurance Overview and forward looking Assurance Map aligned to Business Cycles

Internal Audit of BAF and Risk Management 2022/23

The Internal Audit of BAF and Risk Management for 2022/23 has been completed and is being presented to the Audit Committee in July. The audit has again concluded with 'Substantial Assurance'; their opinion is described here:

> "Taking account of the issues identified, the Trust Board can take **substantial assurance** that the controls upon which the organisation relies upon to manage the identified area are suitably designed, consistently applied and operating effectively."

The review highlighted eighteen specific points of good control design, which based on testing, were being complied with in practice. Two 'low priority' management actions were identified:

- Performance and Finance Committee to include a standing agenda item to provide additional assurance in relation to BAF 7 (Compliant Estate, now Fit for Purpose Estate)
- Transformation and People Committee to include a standing agenda item in relation to BAF 9 (Research and Innovation)

Both of these actions have been incorporated into the Performance and Finance Committee and Transformation and People Committee Business Cycles for 2023/24.

Assessment

There are a number of key observations to draw out from the updated BAF for quarter 1; these are summarised as follows:

The highest scoring risks are:

- BAF 4: Improving Population Health (which has been scored at Extreme 20 in line with the ICB Board Assurance Framework); this has been given a Partial Assurance rating
- BAF 5: Responsive Patient Care, also scored at Extreme 20 which remains unchanged ➔ when compared to Quarter 4 2022/23; this has been given a Partial Assurance rating

BAF 1: Patient Experience and Outcomes, scored at Extreme 16 with Acceptable Assurance, has a trajectory for reduced risk score during Quarter 3 although this is anticipated to increase during Q4 due to seasonal pressures

- 5/9 risks have a trajectory for risk reduction over the remainder of the year
- 3/9 risks have a trajectory which will see the risk score remain unchanged for the remainder of the year

High Quality continues to be our most threatened Strategic Priority, now with all strategic risks identified as posting a threat to it and 4 of those risks are Extreme. This is followed by People and Resources, each with 7/9 risks posing a threat.

BAF 1: Patient Experience and Outcomes has the highest number of linked risks on the risk register (126) of which 13 are scored as Extreme. This is followed by BAF 5: Responsive Patient Care which has 105 linked risks, of which 14 are scored as Extreme.

Recommendations

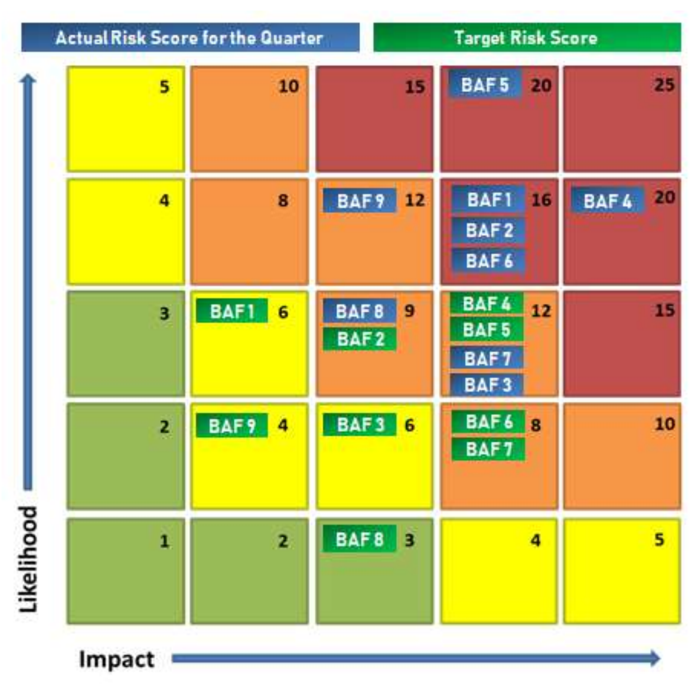
- Consider whether the Quarter 1 Risk Scores and Assurance Assessments are an accurate reflection of the position
- Consider whether the actions identified are sufficient to either reduce the risk score in line with trajectory / target or to provide additional assurance
- Consider whether the Assurance Map is sufficient in terms of planned assurances for the remainder of the year

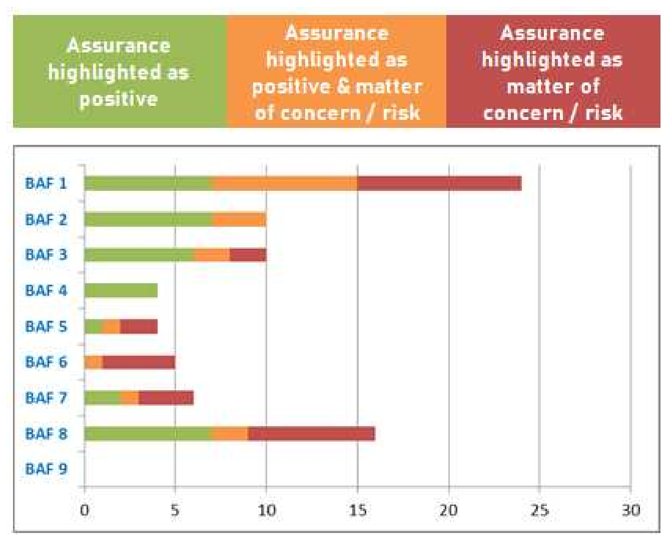
BAF Action Plans – Key to Progress Ratings	
On Track	Improvement on trajectory, either: GA – 'On track – not yet completed' or GB 'On track – not yet started'
Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement
Delayed	Off track /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

2. Summary Board Assurance Framework

	BAF Risk Title	Risk Score & Assurance Assessment	No. Linked Risks		High Quality	Responsive	People	Improving & Innovating	System & Partners	Resources	Trajectory
BAF 1	Patient Outcomes & Experience	Ext 16 Acceptable Assurance	13, 78, 33, 2	126	✓	✓	✓	✓			
BAF 2	Sustainable Workforce	Ext 16 Acceptable Assurance	14, 65, 25, 1	105	✓		✓			✓	
BAF 3	Leadership, Culture & Values	High 12 Partial Assurance	1, 4, 1, 1	7	✓	✓	✓				
BAF 4	Improving Population Health	Ext 20 Partial Assurance	0, 2, 0, 0	2	✓				✓	✓	
BAF 5	Responsive Patient Care	Ext 20 Partial Assurance	8, 37, 5, 0	50	✓	✓	✓	✓	✓	✓	
BAF 6	Digital Transformation	Ext 16 Partial Assurance	7, 33, 23, 10	73	✓	✓		✓		✓	
BAF 7	Fit for Purpose Estate	High 12 Acceptable Assurance	2, 29, 22, 3	56	✓	✓	✓	✓	✓	✓	
BAF 8	Financial Sustainability	High 9 Partial Assurance	4, 11, 4, 0	19	✓	✓	✓	✓	✓	✓	
BAF 9	Research & Innovation	High 12 Partial Assurance	0, 2, 1, 0	3	✓		✓	✓	✓	✓	
				441	9/9	6/9	7/9	6/9	5/9	7/9	

3. Risk Heat Map & Assurance Outcomes





The Assurance Outcomes chart here represents the total number of assurances considered by Committees during the quarter and the outcome which was recorded in the Committee Highlight Report to the Trust Board.

4. Board Assurance Framework 2023 / 24

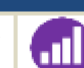
	BAF 1: Delivering Positive Patient Outcomes and Experience	Internally Driven	✓
		Externally Driven	

Risk Description

Cause	Event	Effect
If we do not create the right organisational environment to review quality outcomes, demonstrate safe and effective care and develop appropriate responses	Then we will not be able to demonstrate to employees, patients, population and regulators that we are delivering optimal patient care	Resulting in patients receiving adverse outcomes and poor experience (that could have been avoided), associated with increased complaints and litigation, reputational damage, poor staff morale and failure to deliver statutory and regulatory compliance

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 Priorities

		✓			✓			✓			✓					Resources	

Risk Scoring

Quarter	Q1 Actual	Q2 (Plan)	Q3 (Plan)	Q4 (Plan)	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	4	4	3	4	Likelihood:	3	31/03/2025	Low 1 - 3	2	Mod 4 - 6	33
Consequence:	4	4	4	4	Consequence:	2		High 8 - 12	78	Ext > 15	13
Risk Level:	Ext 16	Ext 16	High 12	Ext 16	Risk Level:	Mod 6		Total No. Linked Risks:			126

Rationale for Risk Level:

- During Quarter 1, services have continued to face considerable operational pressure including the effects of industrial action.
- We have continued to see nursing, midwifery and allied health professional (NMAHP) workforce challenges through staff absence and vacancies. Significant recruitment has taken place; however, many of the recruits are students and are not due to be on-boarded until September 2023.
- We continue to utilise Your Next Patient (YNP) and corridor care, as part of our operational escalation process.
- Unfunded escalation areas have been required to remain open.
- Industrial action has impacted on the restoration and recovery programme and has seen patient cancellations for surgery and outpatients.
- CQC inspection to Maternity, formal escalation on day of visit. All concerns addressed immediately. However, the Trust received a Section 29A Warning Notice. Final report received.
- Clinical Effectiveness expectations are not yet embedded within Divisions.
- Staffing in Maternity Services is progressing against the Trajectory to recruit against Birthrate +. However, it is not anticipated that required numbers will be in post until Quarter 4. This is affecting the home birth service, which remains paused at the current time.
- Tendable roll out is on track against a trajectory to achieve full delivery by August 2023.

Position Statement

What progress has been made during the last quarter?

- Establishment review process was reported to Trust Board in April 2023
- Care Excellence Framework (CEF) Team have been shortlisted for the HSJ Awards - Patient Safety Team of the Year 2023
- Alison Cooke, Assistant Director of Nursing (NMAHP) Research & Academic Development has been nominated for Nursing Times Award – Nurse Leader of the Year
- 90 NMAHPs currently receiving support from CeNREE with work-based projects, academic and research development opportunities (20 additional over last quarter)
- NIHR Senior Research Leader – involved in national initiatives such as Maternity Regional Research Networks and National Webinars to reach under-served professions to promote research opportunities
- Two successful prestigious NIHR PCAF awards ongoing – both recipients are building their teams and projects for application to the next level NIHR Doctoral Research Fellowship
- Two further NIHR PCAF awards submitted in current round
- Three NIHR PCAF applications under development for next round
- One successful applicant to Mary Seacole Programme
- Successful bids to host one NHSE Nursing Clinical Leadership Fellow and one NHSE Neonatal Clinical Leadership Fellow.

- Successful bid to host the ICS AHP International Recruitment Regional Advisor.
- Member of Chief Nurse's Office for England Research Transformation Leaders Network - involved in SORT tool development (Organisational Readiness for Research), encouraging NMAHP-led research and development of clinical academic career opportunities
- Member of Chief Nurse's Office for England Policy Network – advisory contribution to a range of policy and strategy initiatives
- Member of the Council of Deans for Health Clinical Academic Roles Implementation Network (CARIN) – maintaining momentum in the agenda for NMAHP clinical academic careers
- Research collaborations continue to grow – John Hopkins, Keele and Staffs Universities
- CeNREE 'hub and spoke' model – in talks with four Trusts interested in being a 'CeNREE spoke'
- Eleven NMAHPs developing work-based projects aligned to Trust priorities on the Chief Nurse Fellow programme
- Two NIHR Research for Patient Benefit grants submitted in May 2023 (awaiting outcome)
- New Associate Deputy Chief Nurse/CNIO commences in September 2023.
- New Chief AHP commences in July 2023
- Continue to progress Baby-Friendly accreditation (NNU – Level 3 and Maternity –Gold)
- Improving Together Executive Development Forum for Divisional Teams has now commenced
- Continued roll-out of Tendable Audit process, due for completion in August 2023
- Review of formal complaints process concluded and position statement will be reported to QGC in July 2023.
- Progression of PSIRF plans including development of thematic review templates and appointment of two Patient Safety Partners. Positive feedback from the ICB has been received about the progress made by UHNM
- Acute patient flow A3 in development with key focus on occupancy, length of stay and simple/timely discharge
- Maternity CQC inspection completed early March, a section 29A warning notice was received in relation to this inspection in relation to induction of labour and Triage in MAU. All actions completed before the inspection team left. CQC final report received and action plan in development
- Application to CQC submitted to remove Section 31 regarding 15 minute triage in ED at Royal Stoke University Hospital. Awaiting response
- First UHNM Chief Healthcare Scientist appointed July 2023 with responsibility to raise profile of issues relating to scientists, including recruitment, training, development, research and retention
- Internal review of Quality, Safety and Compliance functions at UHNM commissioned (including Clinical Effectiveness); conclusions from Deputy Medical Director (Quality) and Deputy Chief Nurse anticipated July 2023
- Internal review of divisional quality governance processes anticipated; conclusions anticipated from Deputy Medical Director (Quality) July 2023
- Regular meeting set up to engage with local GP representatives – terms of reference revised and approved through ICS Provider Collaborative. This forum will allow exploration of issues with shared governance and impact across primary and secondary care. First meeting of new group due July 2023
- University of Keele recently reviewed undergraduate education at UHNM and reported that 'the Trust provides an effective learning environment for medical and PA students, through the expert leadership and excellent management provided by the UHNM Dean and her team. The Trust's senior management team clearly values and supports education and training
- Detailed multidisciplinary action plan prepared by the Neonates team (to address mortality, LMNS insights review and culture) presented and approved at QGC

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
- Patient Experience team in place
- Crude Mortality rates monitored through Mortality Assurance Group
- Scrutiny of circumstances surrounding deaths from Medical Examiner +/- Structured Judgement Review
- 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 (shared with the CQC)
- Business case agreed for Maternity so service funded to meet Birthrate+ 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. • Clinical Effectiveness Group in place to guide the development and oversight of divisional quality improvement plans, based on analysis of data relating to performance, patient experience, outcomes, audit, national guidelines, risks, litigation and incidents. • 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 structure in place 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. Rollout in progress –due to complete August 2023 • SOPS approved and implemented for Corridor Care and Your Next Patient • Refresh of Workstream 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 • Divisions currently working to develop annual Clinical Effectiveness action plans, based on analysis of key risks and opportunities, informed by data from incidents, complaints, nationally reported comparative data review, national guidance (including NICE), audits, litigation and research
3rd Line	• Registered and regulated by CQC • Process in place with ICB to undertake Clinical Quality Review Meetings (CQRM) • ICB Quality and Safety Committee • Patient Safety Specialists participating with development programme by NHSI as part of national NHS Patient Safety Strategy. Induction / Training

Assurance Map	● Seen as per Business Cycle	● Seen but delayed	● Not seen as per Business Cycle	● Planned on Business Cycle
	Assurance highlighted as positive	Assurance highlighted as positive & matter of concern / key risk	Assurance highlighted as matter of concern / key risk	Assurance not rated

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Divisional)	Highlight Report from Quality & Safety Oversight Group	●	●	●	●
	Highlight Report from Clinical Effectiveness Group	●	●	●	●
	Highlight Report from Maternity & Neonatal Quality & Safety Oversight Group	●	●	●	●
	Quality Impact Assessment Report	●	●	●	●
2nd Line (Corporate)	Monthly Quality and Safety Report	●	●	●	●
	Nurse Staffing Establishment Review	●		●	
	Nursing & Midwifery Staffing Quality Report	●	●	●	●
	Serious / Adverse Incident Report	●	●	●	●
	Infection Prevention Report	●	●	●	●
	Infection Prevention, Vaccination & Sepsis Team Annual Report		●		
	Mortality Report	●	●	●	●
	Medical Examiner Update	●		●	
	Readmissions Update	●		●	
	Resuscitation Annual Report			●	

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
	Care Excellence Framework (CEF) Summary	●	●	●	●
	Compliance and Effectiveness Report		●		
	Research & Innovation Update	●		●	
	Annual Clinical Audit Plan				●
	Medicines Optimisation Report	●	●	●	●
	Organ Donation and Transplantation		●		●
	CQUIN Report	●	●	●	●
	7 Day Services Board Assurance Report				●
	End of Life Annual Report			●	
	Patient Experience Report	●	●	●	●
	Mental Health & Learning Disability Annual Report		●		
	Safeguarding Children Annual Report		●		
	Safeguarding Adults Annual Report		●		
	Infection Prevention Board Assurance Framework	●	●	●	●
	Resuscitation Update	●			
	Patient Safety Incident Response Plan (PSIFP)	●			
	Maternity Dashboard	●	●	●	●
	Maternity Serious Incident Report	●	●	●	●
	Maternity Family Experience Report	●	●	●	●
	Ockenden Report Update	●	●	●	●
	Saving Babies Lives Care Bundle	●	●	●	●
	Perinatal Mortality Report	●	●	●	●
	NHS Resolution Maternity Incentive Scheme			●	
	Update on the Suspension of the Home Birth Service	●			
3rd Line (External / Independent)	Get it Right First Time (GIRFT) Update	●	●	●	●
	CQC Inspection Update	●	●	●	●
	Litigation Report			●	
	Quality Account (including stakeholder feedback)	●			
	Maternity CQC Report	●			
	Cardiothoracic Surgery Review Update	●		●	
	Neonatal Service – Overview and Action Plan Update	●	●	●	●
	Internal Audit Review of Care Quality Commission Actions	●			
	Internal Audit Review of Clinical Risk Management – Incident Reporting	●			
	Internal Audit Review of Safe Staffing				●
	Internal Audit Review of Data Quality ICB Metrics				●
	Internal Audit Review of CQC Actions Outcomes Framework				●
	Internal Audit Review of Mental Capacity Assessment Framework			●	
	NHS Oversight Framework (NOF) – Assessment Process, Governance, Exit Criteria & Indicators	●	●	●	●
	Maternity Rapid Quality Review	●			
	NHS Maternity Services Survey and Improvement Plan	●			

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

Gaps in Control or Assurance

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

- Development of mature annual Clinical Effectiveness plans at Divisional level, to be approved and tracked through Clinical Effectiveness Group
- 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
- Delivery of CQC action plan
- Recruitment to current vacancies; focus on retention (flexible working, retire and return)
- Await outcome of internal review into Quality, Safety and Compliance

- Await report into divisional quality governance structures
- Risk score may increase during Q4 due to need to staff winter escalation areas

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	31/12/23	Original due date 30/09/22. 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	30/09/23	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	31/12/23	Business case approved Dec 2022. Recruitment underway. 22 students recruited Sept 22; further 30 at recruitment event March 2023.	
4.	Recruitment against Emergency Department Business Case to be completed.	Control to Reduce Likelihood	Chief Nurse	31/12/23	Recruitment ongoing	
5.	Conclude the Integrated discharge function with system partners	Control to reduce likelihood	Chief Operating Officer	31/6/23	Inaugural meeting took place Jan 23. System partner participation and shared vision	
6	Delivery of Workstream 2 actions focusing on LOS, occupancy and simple and timely discharge	Control to reduce likelihood	Chief Nurse	30/09/23	A3 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	
7	Continued focus on recruitment and retention strategies	Control to reduce likelihood	Chief Nurse	31/03/25	Agreement to recruit to newly developed trainee Healthcare assistant role (to support those without healthcare experience; or maths/English to commence work in the NHS) Planning recruitment event in the community (April/May) Focus on flexible working – partnership with Chief Nurse and Chief People Officer	

BAF 2: Sustainable Workforce

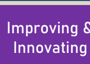
Internally Driven	✓
Externally Driven	✓

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, Chief Operating Officer & Chief Medical Director
Lead Committee/s:	Transformation & People Committee	Executive Group:	Executive Workforce Assurance Group

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 (Plan)	Q3 (Plan)	Q4 (Plan)	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	4	4	4	3	Likelihood:	3	31/3/2025	Low 1 - 3	1	Mod 4 - 6	25
Consequence:	4	4	4	4	Consequence:	3		High 8 - 12	65	Ext > 15	14
Risk Level:	Ext 16	Ext 16	Ext 16	High 12	Risk Level:	High 9		Total No. Linked Risks:			105
Rationale for Risk Level:	We continue to experience challenges in workforce supply. Whilst vacancy rates have shown a steady improvement over the last 6 months, there remains a workforce supply gap locally and nationally. This situation is being experienced across the NHS and in industry due to high turnover of key workforce groups, ambitious operational recovery plans resulting in a demand for workforce, the cost-of-living situation, which is resulting in wage increases in other sectors. Ongoing industrial action across the NHS for medical and dental workers.										

Position Statement

What progress has been made during the last quarter?

- Continued social media presence on UHNM as a Great Place to work through our new Careers@UHNM social media addresses and are using stories to help promote roles
- Attendance at large scale events to promote UHNM as a Great Place to Work
- UHNM Basic Digital Skills programme commissioned for our staff and Sodexo this is in partnership with Stoke on Trent College
- SIM Study skills days for local disadvantaged secondary school students in partnership with Staffordshire University taking place this month this will then build in a cycle of sessions per year
- Our system wide health and care careers virtual work experience project has been shortlisted for two HSJ Digital Awards, with the final being held on 22 June
- The ICS Retention Partner has undertaken a robust fact find regarding UHNM retention activities and provided recommendations. This will be formalised into a broader retention strategy by Sept 23, this incorporates, recruitment, flexible working, stay conversations, self-rostering and staff voice
- Staff Benefits Portal (Rewards and Recognition, Vivup) is now open all year round, with an added 9% savings on each order. We are currently updating the platform to ensure that employees can also access Health Service Discounts and Blue Light loyalty discounts. To date from 1st February 352 purchases have been made by employees, with savings of over £30,000 being made by the trust and by those who purchase
- Preparation for launch of women's network to focus on key issues to support colleagues at work.
- Launch of new LOOP app to support rostering and work life balance

Key Controls Framework – 3 Lines of Defence

1st Line

- Work on initiatives focussing on the retention of our workforce
- Directorate and divisional management teams monitor staffing levels
- 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
- Work-flow recruitment management system to track and optimise on-boarding processes
- Experienced medical rota coordinators aligned to Divisions to support operational planning

2nd Line	
	• People Strategy for 2022-2025 highlights key strategic areas of workforce activity. • Review of 2023/24 Workforce Plan reported to Transformation & People Committee • Digital Staff Passport to hold staff verified employment and training credentials. • Established Banks are in place – including Nursing, Medics and other staff groups • Nurse Establishment Reviews reported twice yearly to the Trust Board and relevant Committees • Pipeline of approved business cases in key areas from 2022/23 profiled into the workforce establishment to enable tracking of vacancies and workforce supply. • 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 • National target to agency reduction set which is a key metric reviewed monthly through the Transformation and People Committee • Insourcing contracts in place in key areas to support the recovery plan. • Continuing work with education teams and providers across the system to enhance opportunities for learning and the education experience for our trainees • Daily tracking of unplanned absences to support local planning • Internal redeployment of staff to support safer staffing levels • Vacancy levels is a key driver metric for the Trust and will be reviewed monthly through our Transformation and People Committee • Winter planning group stood up at the appropriate time in the year
3rd Line	• ICS Retention Partner fact find • National and system controls for non-clinical agency expenditure

Assurance Map	● Seen as per Business Cycle	● Seen but delayed	● Not seen as per Business Cycle	● Planned on Business Cycle
	Assurance highlighted as positive	Assurance highlighted as positive & matter of concern / key risk	Assurance highlighted as matter of concern / key risk	Assurance not rated

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Divisional)	Executive Workforce Assurance Group Highlight Report	●	●	●	●
2nd Line (Corporate)	Chief People Officer Report	●	●	●	●
	Workforce Performance Report	●			
	International Recruitment (Maternity) – Competency Assessments and Failure Rate	●			
	People Strategy Update	●	●	●	
	Talent & Succession Planning Update		●		●
	Nursing & Midwifery Staffing and Quality Report	●	●	●	●
	Staff Survey Action Plan	●			
	Nursing Establishment Review	●		●	
	Guardian of Safe Working Report	●	●	●	●
	Midwifery Workforce Paper	●			
3rd Line (External / Independent)	Staff Survey Report				●
	Gender Pay Gap Report				●
	Internal Audit Review of Bank and Agency	●			
	Internal Audit Review of Data Quality: Annual Leave Indicators	●			
	Internal Audit Review of Safe Staffing				●
	NHS Oversight Framework (NOF) – Assessment Process, Governance, Exit Criteria & Indicators	●	●	●	●

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

Gaps in Control or Assurance

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

- Engage with local organisations and events across Staffordshire to offer support and sharing skills (Job Centre, DWP, Local Schools, Colleges and Universities)
- Define and promote the benefits package on offer
- Increase social media presence on UHNM as a Great Place to work
- Review all placements currently offered by the trust and where appropriate create a new career pathway through guaranteed

interview and job schemes, mirroring the current Newly Qualified Nurse pathway
- Develop, promote and deliver retention plan
- Divisions report increased staffing challenges due to operational pressures and the opening of additional capacity, combined with high sickness rates and vacancy levels

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.	Engage with local organisations and events across Staffordshire to offer support and sharing skills (Job Centre, DWP, Local Schools, Colleges and Universities)	Control to Reduce Likelihood	Chief People Officer	31/10/2023	• SIM Study skills days for local disadvantaged secondary school students in partnership with Staffordshire University taking place; this will then build in a cycle of sessions per year • Talks by UHNM Staff at Stoke on Trent College • T Level Placement Coordinator funding at ICS system level secured	
2.	Define and promote the benefits package on offer	Control to Reduce Likelihood	Chief People Officer	30/09/23	• Staff Benefits Portal (Rewards and Recognition, Vivup) is now open all year round, with an added 9% savings on each order. We are currently updating the platform to ensure that employees can also access Health Service Discounts and Blue Light loyalty discounts. • Why Work at UHNM Campaign developed and ready for launch in July • New Recruitment Landing page for applicants promoting the benefits of working at UHNM	
3.	Increase social media presence on UHNM as a Great Place to work	Control to Reduce Likelihood	Chief People Officer	31/10/23	• Spotlight profiles of UHNM colleagues promoted on social media • Spotlight 'we are hiring' on different roles at UHNM through our Careers@UHNM feeds	
4.	Work with TRAC Supplier to identify application redesign opportunities	Control to Reduce Likelihood	Chief People Officer	31/12/23	Work not commenced	
5.	Review all placements currently offered by the trust and where appropriate create a new career pathway through guaranteed interview and job schemes, mirroring the current Newly Qualified Nurse pathway.	Control to Reduce Likelihood	Chief People Officer	31/10/23	Planning work underway	
6.	Develop, promote and deliver retention plan		Chief People Officer	30/11/23	The ICS Retention Partner has undertaken a robust fact find regarding UHNM retention activities and provided recommendations. This will be formalised into a broader retention strategy by Sept 23, this incorporates, recruitment, flexible working, stay conversations, self-rostering and staff voice.	

BAF 3: Leadership, Culture and Values

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

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 (Plan)	Q3 (Plan)	Q4 (Plan)	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	3	3	3	3	Likelihood:	2	31/3/2025	Low 1 - 3	1	Mod 4 - 6	1
Consequence:	4	4	4	4	Consequence:	3		High 8 - 12	4	Ext > 15	1
Risk Level:	High 12	High 12	High 12	High 12	Risk Level:	Mod 6		Total No. Linked Risks:			7

Rationale for Risk Level:

The level of risk has remained the same during Quarter 1; 3,343 colleagues completing the Staff Voice over the three-month period returning a staff engagement score of 6.36. This is the national staff survey staff engagement score of 6.6.

The highest scoring categories over the quarter are:

- I enjoy working with colleagues in my team
- My immediate line manager helps me with problems I face

The lowest scoring categories over the quarter are:

- I would recommend my organisation as a place to work
- I look forward to coming to work

The three areas of significant focus from the 2022 National Staff Survey are:

- Promise 1: We are Compassionate and Inclusive
- Promise 6: We Work Flexibly
- Promise 7: We are a Team

Position Statement

What progress has been made during the last quarter?

- We have made progress on some key long standing issues with a focus on restoring working relationships
- We have undertaken a review of long-standing cases with key stakeholders and have agreed a set of continuous improvement recommendations and an improvement action plan.
- We have continued to focus on areas where high support is needed in accordance with our Trust Accountability Framework with Executive Director Sponsors, Divisional leads, People Business Partners and OD consultants. Where indicating scrutiny and Board oversight of specific service areas is underway through the Quality Governance Committee.
- Divisional Workforce Governance groups continue to meet to drive forward with local culture programmes and upward assurance to the Executive Workforce Assurance Group
- Team Brief has been launched with a focus on verbal feedback to aid two-way dialogue
- The employee engagement campaign has been launched with a pack that has been socialised at Divisional level and with the specific campaigns well underway such as EDI Week, PRIDE month, NHS75 We are a Team week.
- Being Kind Large Scales now have over 2000 booked places, with trained colleagues now embedded at divisional level for local support.
- Team effectiveness toolkit has been developed and is ready to deploy
- The micro aggressions toolkit has been launched and will continue to be promoted throughout the year to ensure that this is socialised as widely as possible to reinforce the behaviours we want to see.
- Development of the Culture Heat Map to show trend analysis at Divisional level
- We have launched the 2023/24 Gold and Platinum Leadership Programme

- We have launched the 2023/24 Staff Awards
- Launch of the employee engagement calendar to support the key areas of focus from the national Staff Survey
- We have held our Staff Experience Network Event with over 130 participants
- We have held out first Leaders Network Event with over 300 participants
- We held our first Men's Network Meeting

Key Controls Framework – 3 Lines of Defence

Line	Controls
1st Line	• Executive Routines monthly review of our people driver metrics. • Each Division has staff engagement as a key driver metric with monthly scrutiny through Divisional Performance Meetings • Divisional Staff Engagement Plans set out the tailored actions to improve staff experience • Culture Improvement Programme • Improvement Plans in place for each hot spot area • Divisional Workforce Groups in place
2nd Line	• Three driver metrics of specific focus agreed by the Transformation and People Committee and will be tracked monthly for scrutiny, accountability and assurance on these critical areas of work – Staff Engagement, Culture and Vacancies. • People Strategy • People Plan (year 2 of the People Strategy) with monthly reporting on high level progress at the Transformation and People Committee • Staff Voice Monthly Survey • Employment Engagement Campaign for 2023/24 in line with 3 Staff Survey priorities set out above • Resolution Policy which sets out the new approach to resolving disputes at work • Being Kind Behavioural Framework and toolkit • Team effectiveness toolkit • Mandatory Being Kind training for all employees • RACE Equality Code action plan and self-assessment • The Trust wellbeing plan and wellbeing offer is refreshed and communicated monthly • Culture heat map trends at Divisional and Trust level to support development of interventions • Staff Networks to help shape our people practices and support culture improvement programme • Leadership Development Framework including Enable Leadership Course, Connects Programme, High Potential Programme, Master Classes, Insights Programmes • Well established cohort of Professional Nurse Advocates • Well established Staff Experience Champions network
3rd Line	• The culture review has been completed and the Cultural Improvement Programme amended with refreshed objectives for 23/24 • Annual National Staff Survey

Assurance Map

● Seen as per Business Cycle	● Seen but delayed	● Not seen as per Business Cycle	● Planned on Business Cycle
Assurance highlighted as positive	Assurance highlighted as positive & matter of concern / key risk	Assurance highlighted as matter of concern / key risk	Assurance not rated

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Divisional)	Executive Workforce Assurance Group Highlight Report	● (positive)	●	●	●
2nd Line (Corporate)	Chief People Officer Report	● (positive & matter of concern / key risk)	●	●	●
	Workforce Performance Report	● (positive & matter of concern / key risk)			
	People Strategy Update	● (positive)	●	●	
	Education / Apprenticeship Report			●	
	Formal Disciplinary Activity Report	● (matter of concern / key risk)	●	●	●
	Annual Equality & Inclusion Report	● (not seen)			
	Quarterly Speaking Up Report	● (positive)	●	●	●
	Postgraduate Medical and Dental Education Report			●	
	Undergraduate Medical School Report			●	
	Revalidation / Appraisal Report		●		
	Staff Survey Action Plan	● (positive)			
	Postgraduate Education and Governance Structure	● (positive)			
	Statutory and Mandatory Training – Essential to Role update	● (matter of concern / key risk)			
3rd Line (External / Independent)	Staff Survey Report				●
	Gender Pay Gap Report				●
	Workforce Race Equality Standard (WRES)			●	
	Internal Audit Review of Freedom to Speak Up				●
	Workforce Disability Equality Standard (WDES)		●		

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
	NHS Oversight Framework (NOF) – Assessment Process, Governance, Exit Criteria & Indicators	●	●	●	●

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

Gaps in Control or Assurance

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

- Enhanced Staff Survey Campaign 2023
- Employee Engagement Plan and Supporting Activities for 2023/24
- Improve and increase awareness of how a 'being kind 'culture creates a better and safer working environment, with a positive impact on patient care
- Improve employee experience specifically through the work of our Equality, Diversity and Inclusion Delivery Plan 2023-24 Focus on anti-racist behaviour, managing conflict/show racism the red card Campaign and reinforce through targeted interventions. Improve leadership effectiveness at all levels in the organisation
- Develop and launch cultural review/team effectiveness framework and tools.

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.	Enhanced Staff Survey Campaign 2023	Control to Reduce Likelihood	Chief People Officer	30/11/2023	Data analysis of the staff survey completion rates to develop engagement plan for 23 survey round. Tender process underway for staff survey supplier to meet our requirements.	
2.	Employee Engagement Plan and Supporting Activities for 2023/24	Control to Reduce Likelihood	Chief People Officer	31/3/2024	Campaign well developed and rolled out. Share. Social Media campaigns, divisions aligning to the corporate campaigns, campaign for May was Equality, Diversity & Inclusion and June PRIDE.	
3.	Improve and increase awareness of how a 'being kind 'culture creates a better and safer working environment, with a positive impact on patient care	Control to Reduce Likelihood	Chief People Officer	30/9/2023	Being Kind Large Scale sessions commenced in June 2023. Good attendance, excellent feedback.	
4.	Improve employee experience specifically through the work of our Equality, Diversity and Inclusion Delivery Plan 2023-24. Focus on anti-racist behaviour, managing conflict/show racism the red card Campaign and reinforce through targeted interventions.	Control to Reduce Likelihood	Chief People Officer	31/3/2024	Trust support for national EDI and Human Rights Week Leaders Network event discussing values at work and presentations from overseas nurses Overseas Nurses presentation at Board Work on going on Race Code, planning commenced for anti-racism/red card campaign in the Autumn.	
5.	Improve leadership effectiveness at all levels in the organisation	Control to Reduce Likelihood	Chief People Officer	31/3/2024	Enable Training places behind plan. Focused work with divisions to target attendance to increase participation rate. Review of supervisors/non-supervisor who are attending to ensure that supervisors are targeted.	
6.	Develop and launch cultural review/team effectiveness framework and tools.	Control to Reduce Likelihood	Chief People Officer	30/7/2023	Toolkit developed and ready for launch in Q2	

BAF 4: Improving the Health of our Population

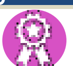
Internally Driven	✓
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to work together with system partners across organisation and sector boundaries	Then we will have minimal impact on improving the wider determinants of health and addressing health inequalities for the population we serve	Resulting in missed opportunities to improve the health of our population and sustained or increased health inequalities, potentially increased pressure on health care services

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

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 (Plan)	Q3 (Plan)	Q4 (Plan)	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	4	4	4	3	Likelihood:	3	31/03/2025	Low 1 – 3	1	Mod 4 – 6	0
Consequence:	5	5	5	5	Consequence:	4		High 8 – 12	2	Ext > 15	0
Risk Level:	Ext 20	Ext 20	Ext 20	Ext 15	Risk Level:	High 12		Total No. Linked Risks:			3
Rationale for Risk Level:	This is a new priority for the Trust and as such plans are still relatively underdeveloped. Though activities are taking place across the Trust they are not co-ordinated and overseen at organisational level in order that their overall impact can be measured.										

Position Statement

What progress has been made during the last quarter?

Priorities for the Trust Health and Wellbeing Strategy have been agreed which are focussed around population health management, data collection, ICS health and inequalities programmes and health inequalities as core business. A Trust Health Inequalities and Prevention Group has been established with representatives from across a number of disciplines. The Group is responsible for overseeing the development of our strategy and reports to the Executive Strategy and Transformation Group.

Key Controls Framework – 3 Lines of Defence

1st Line	• Estates and Sustainability Programme, Workforce, Community Engagement, Elective Recovery and Patient Engagement leads identified as part of the Health Inequalities and Prevention Group
2nd Line	• Health Inequalities and Prevention Group in place to drive development of the Health and Wellbeing Strategy • Deputy Director of Strategy and Transformation given specific responsibilities for Health and Wellbeing / Reducing Health Inequalities
3rd Line	• ICP Strategy approved with a focus on '5P's' across the life course which all centre on reducing health inequalities across Staffordshire and Stoke-on-Trent • Public Health Speciality Registrar appointed jointly with the ICB • Health Inequalities Programme established at ICB level with representation from UHNM

Assurance Map

● Seen as per Business Cycle	● Seen but delayed	● Not seen as per Business Cycle	● Planned on Business Cycle
Assurance highlighted as positive	Assurance highlighted as positive & matter of concern / key risk	Assurance highlighted as matter of concern / key risk	Assurance not rated

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Divisional)	Executive Strategy and Transformation Group Highlight Report	●	●	●	●
2nd Line (Corporate)	ICS Transformation Update	●	●	●	●
	Community Diagnostic Centre – Stoke-on-Trent	●			
3rd Line	NHS Oversight Framework (NOF) – Assessment Process, Governance, Exit Criteria &	●	●	●	●

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
(External / Independent)	Indicators				

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

Gaps in Control or Assurance

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

- Approval of the Health and Wellbeing Strategy
- Development of a programme structure with identified individuals to lead and deliver on the specific elements of the Health and Wellbeing Strategy
- Development of metrics to provide a means of measuring progress and delivery of the strategy
- Stocktake of health inequalities activity and opportunities across the organisation

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.	Approval of the Health and Wellbeing Strategy.	To reduce likelihood	Director of Strategy & Transformation	31/12/2023	Strategy under development and has undergone extensive consultation including presentation to Trust Board seminar. Work undertaken to ensure alignment with system strategy.	
2.	Development of a programme structure with identified individuals to lead and deliver on the specific elements of the Health and Wellbeing Strategy.	To reduce likelihood	Director of Strategy & Transformation	31/12/2023	This being done alongside development of the strategy.	
3.	Development of metrics to provide a means of measuring progress and delivery of the strategy.	To provide assurance	Director of Strategy & Transformation	31/12/2023	This being done alongside development of the strategy.	
4.	Undertake a stocktake of health inequalities activity and opportunities across the organisation.	To provide assurance	Director of Strategy & Transformation	31/09/2023	Stocktake has commenced during quarter 1 and is expected to conclude at the end of quarter 2. The outputs of this work will be used to further inform the strategy and associated work programme / KPI's.	

BAF 5: Delivering Responsive Patient Care

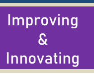
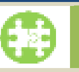
Internally Driven	✓
Externally Driven	✓

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 delays to patient care, poor outcomes and potential patient harm.

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

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 (Plan)	Q3 (Plan)	Q4 (Plan)	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	5	5	4	4	Likelihood:	3	31/3/24	Low 1 – 3	0	Mod 4 – 6	5
Consequence:	4	4	4	4	Consequence:	4		High 8 – 12	37	Ext > 15	8
Risk Level:	Ext 20	Ext 20	Ext 16	Ext 16	Risk Level:	High 12		Total No. Linked Risks:			50
Rationale for Risk Level:	The risk has carried forward at the same level as Q4 2022/23 due to ongoing strike action alongside the continued requirement to increase elective work in order to reduce waiting times for our patients.										

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 daycase 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. External support has been instigated for our most challenged elective and diagnostic pathway. A review has concluded on the management of and accuracy of our elective waiting lists with subsequent action plan agreed.

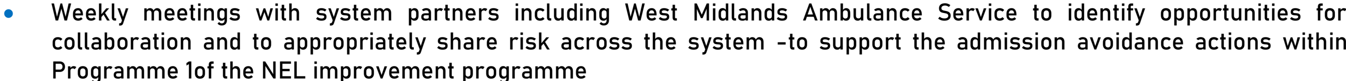
Key Controls Framework – 3 Lines of Defence

1st Line

- 4 x daily capacity calls with Head of Operations, Deputy Chief Operating Officer (COO) / COO attendance
- Various improvement meetings tracking the actions / milestones across the 4the 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; 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
- Weekly elective oversight management group supported by Deputy COO and CEO

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



3rd Line	
	• Daily 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 1 NHSE performance review regarding elective recovery • Comprehensive capacity, demand, organisational and system bed model undertaken • Weekly meeting between UHHM and ICB CEO, COO and Deputy COO to confirm and challenge process against key non-elective and elective targets

Assurance Map	● Seen as per Business Cycle	● Seen but delayed	● Not seen as per Business Cycle	● Planned on Business Cycle
	Assurance highlighted as positive	Assurance highlighted as positive & matter of concern / key risk	Assurance highlighted as matter of concern / key risk	Assurance not rated

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Divisional)	Non-Elective Improvement Group Highlight Report	●	●	●	●
	Planned Care Improvement Group Highlight Report	●	●	●	●
2nd Line (Corporate)	Operational Performance Report	●	●	●	●
	Business Case Review: Colorectal Cancer Pathway Redesign	●			
	BC-0442 Urology Nephrectomy Demand Business Case Review	●			
3rd Line (External / Independent)	NHS Oversight Framework (NOF) – Assessment Process, Governance, Exit Criteria & Indicators	●	●	●	●
	Independent Review of Waiting List Management, Data & Reporting	●			
	Internal Audit Review of Data Quality (Urgent Care Standards)			●	
	Internal Audit Review of Planned Care Waiting List Management			●	
	Internal Audit Review of Productivity Reporting			●	

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

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 though the organisation
- High MFFD as a % of bed occupancy
- Challenges consistently staffing inpatient areas to template to support efficient care
- General referral rates / demand for cancer and RTT
- Lack of available or sufficiently utilised alternate pathways to stream patients away from ED who do not require emergency care
- Gap in external provision supporting theatre staffing and previous models supporting the elective pathway no longer being viable

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 This remains ongoing.	
2.	Develop and implement robust winter planning, integrated with wider	Additional Assurance	Chief Operating Officer	31/10/2023	Winter planning for 23/24 has started.	

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
	system provisions					
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	30/09/2023	Original Due Date 31/02/2023: The Strategy UEC Delivery and Strategy Groups have now been established as the two constituent groups of the System UEC Board. These groups are tasked with the delivery of this objective aligned to the System 7 UEC priorities.	

BAF 6: Digital Transformation

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, staff inefficiencies and breaches of confidentiality, reputational damage and potential fines

Lead Director / s:	Chief Digital Information Officer	Supported by:	Deputy Director IM&T
Lead Committee/s:	Transformation & People Committee	Executive Group:	Executive Digital and Data Security and Protection Group

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 (Plan)	Q3 (Plan)	Q4 (Plan)	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	4	4	3	3	Likelihood:	2	31/3/25	Low 1 - 3	10	Mod 4 - 6	23
Consequence:	4	4	4	4	Consequence:	4		High 8 - 12	33	Ext > 15	7
Risk Level:	Ext 16	Ext 16	High 12	High 12	Risk Level:	High 8		Total No. Linked Risks:			73
Rationale for Risk Level:	The service has been impacted by network outages in the period which has impacted clinical service provision. The financial position for 23/24 is likely to result in a slow down in progress against the Digital Strategy										

Position Statement

What progress has been made during the last quarter?

- The network and communication full business case has been authored and the approvals process has commenced. MPFT have completed their business case approvals process
- The System Wide Security Operations Centre procurement has completed and the project has started with Staffordshire and Shropshire Health Informatics Services and ANS Group
- Patients Know Best (PKB) has been enhanced and now includes appointment letters and clinical pathways for pre-surgery weight management, Alcohol Care Services and Hereditary Angioedema
- Data Privacy Impact Assessments have been completed for Foundry by Palantir to support PTL validation
- £300K awarded from NHSE for PKB Amplify
- FOI performance below national standard
- Information Security training levels below national target

Key Controls Framework – 3 Lines of Defence

Line	Controls
1st Line	• IM&T policies are up to date • Rubrik Office 365 backups in place
2nd Line	• Peer review of National Digital Maturity Assessment • MPFT Network and Communication Business Case approval
3rd Line	• Internal Audit on the data protection toolkit has been completed and assurance provided • Independent wireless audit conducted at Royal Stoke – Paediatric wards • Data Security and Protection Information Toolkit approved for submission

Assurance Map

● Seen as per Business Cycle	● Seen but delayed	● Not seen as per Business Cycle	● Planned on Business Cycle
Assurance highlighted as positive	Assurance highlighted as positive & matter of concern / key risk	Assurance highlighted as matter of concern / key risk	Assurance not rated

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Divisional)	Executive Infrastructure Group Highlight Report	●	●	●	●
	Executive Digital and Data and Security Protection Group Highlight Report	●	●	●	●
2nd Line	Freedom of Information (FOI) Improvement Report	●			

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
(Corporate)	Digital Strategy Progress Report / Project Update	●	●	●	●
	Data Security & Protection Toolkit Submission	●			
	Cyber Security Assurance Report	●		●	
3rd Line (External / Independent)	Internal Audit Review of Digital Strategy Development	●			
	Internal Audit Review of Digital Strategy Implementation				●
	Internal Audit Review of Data Security and Protection (DSP) Toolkit		●		
	Internal Audit Review of IT Systems Managed by Operational Areas				●
	Internal Audit Review of Service Management Process (ITIL)				●

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

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 approval
- Backup and firewall implementation
- iPortal rewrite into a supported platform or additional security measures
- Ward Information system rewrite onto a supported platform
- Recruit to the Commercial Manager post
- Implement laboratory management information system
- Go live with 24 x 7 security operations centre
- Trust wide phishing exercise to improve cyber security awareness

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	Reduce Likelihood	Chief Digital Information Officer	01/11/2023	Awaiting wide area network connection installation, tenant configured, pilot group agreed, phases agreed and communications plan started.	
2.	Network and Communication Business Case Approval	Reduce Likelihood	Chief Digital Information Officer	01/08/2023	Full business case authored, approved at ICS DCF and approved by Performance & Finance Committee / Board.	
3.	SOC Service Go Live	Reduce Likelihood	Chief Digital Information Officer	01/11/2023	Contract in place with SSHIS hosted by MPFT.	
4.	LIMS Go Live	Reduce Likelihood	Chief Digital Information Officer	31/03/2024	BT go live BHI go live Cell Path go live	
5.	EPR Outline Business Case	Reduce Likelihood	Chief Digital Information Officer	31/03/2024	Procure consultancy services.	

BAF 7: Fit for Purpose Estate

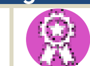
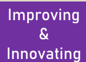
Internally Driven	✓
Externally Driven	

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 & PFI	Supported by:	n/a
Lead Committee/s:	Performance and Finance Committee	Executive Group:	Executive Infrastructure Group

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 (Plan)	Q3 (Plan)	Q4 (Plan)	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	3	3	3	3	Likelihood:	2	31/03/2025	Low 1 - 3	3	Mod 4 - 6	22
Consequence:	4	4	4	4	Consequence:	4		High 8 - 12	29	Ext > 15	2
Risk Level:	High 12	High 12	High 12	High 12	Risk Level:	High 8		Total No. Linked Risks:			56

Rationale for Risk Level:

- Estates condition and backlog maintenance risks remain due to limited identified funding available to address the significant and moderate elements identified via the Estate 7 Facet Survey
- Estates capital programme delivery presenting real challenges given size, scope, scale and timelines imposed for nationally funded schemes - £53m value across 123 projects
- Some estates workforce challenges but an improving position following R&R Business Case approval.
- Sustainability/Net Zero Carbon (NZC), ever growing mandatory requirements, significant investment required, and further workforce capacity required (in line with a benchmarking exercise)
- Accredited Specialists commissioned by Project Co to complete intrusive surveys of PFI building fabric ahead of latent defect period end. Survey findings to be used to inform any remediation works
- Estates Strategy Refresh to be informed by PWC Review and Clinical Strategy refresh that are now planned.
- Progress deployment of facilities aspects of National Cleaning Standards following approval of Business Case and sustain improvements in West Building
- Progression of PFI market testing opportunities and concluding of VFM reviews
- Concluding of N&C future service solution informed by the procurement exercise now concluded and informed the Business Case being considered by Board in July

Position Statement

What progress has been made during the last quarter?

Estate Condition

- Backlog maintenance - items prioritised for targeted capital schemes; statutory maintenance and progression of capital schemes to reduce estate condition risks. Continue to work with finance (CIG) to prioritise backlog against available capital funding. 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.

Capital Programme

- Responded to challenging timelines for bid submissions and information requests (costs and programme) to support nationally funded schemes of which the Trust has now been successful in securing external funding.

Estates Workforce Recruitment/Retention Issues

- Estates Workforce Business Case approved at December's PAF and focus now turned to implementation, recruitment progressing against vacant posts and improving position seen.

Net Zero Carbon (NZC) / Sustainability

- UHNM Green Plan (2022-25) is fully aligned to the national Greener NHS Programme and NZC agenda. Progress against delivery of the UHNM Green Plan and Net Zero trajectory has commenced at PAF (April 2023) and the next meeting will be in September (bi-annual progress report).
- Significant capital investment is required to ensure target delivery. All currently known decarbonisation schemes that require

capital investment have now been collated as part of the Sustainability and NZC capital investment subgroup for 23/24 (total value of schemes is £12million which are now being prioritised against the available £100k allocation).
- Public Sector Decarbonisation Scheme: Delivery of the schemes to expend the £5.4m grant award is now underway.
- Forecast energy cost rises: Work is underway to mitigate forecast cost rises (April 2024) through an innovative Procurement strategy that proposes a partnership with SoT City Council and connectivity to the local Geothermal District Heat Network. In addition, a strategy is being developed to expand the current provision of solar PV panels across both sites.

Estate Strategy / Clinical Strategy
- Independent reviews of estate at County and Royal now concluded and opportunities identified.
- PWC demand/capacity review completed and refresh 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 Phase 1 STS works programme and progression of detailed design of day case facility and breast relocation.

PFI Latent Defect Period
As the Trust is approaching the end of the PFI contract latent defect period where the accountability transfers to Project Co from the builders for the building structure, accredited specialists have been appointed to assess the building fabric related to the latest standards. These specialists have been appointed by Project Co and they will be looking at any gaps which may require further investigation. Once any are identified they will be assessed for any specific risks with the proposed rectifications needed outlined.

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 facilities National Standards of Healthcare Cleanliness
Business Case produced, approved at PAF in December and focus now turned to implementation, with a go live of the new facilities standards from June 2023.

PFI Market Testing Opportunities
- Sodexo Business Case approval secured and in final stages of concluding formal variation documentation.
- Siemens PACS/MES - VFM completed and informed Business Case which will be taken through Trust governance arrangements in July/August 2023.
- Network and Communications Service – Procurement exercise has now concluded and informed a Business Case considered at Trust Board in July 2023.

Key Controls Framework – 3 Lines of Defence

1st Line	• Project STAR – Approved Business Case and construction underway. • 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, 2 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) (biannual), Energy Procurement Working Group established (in readiness for April 24), PSDS stakeholder meetings established (monthly, to meet grant T&Cs), 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/inspections. • Head of Fire Safety and Security close working with local Police and visibility on site. • Sustainability / NZC: Work with external partners regarding zero-capital solutions. • 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. • Accredited Specialist review of building infrastructure.

Assurance Map	● Seen as per Business Cycle	● Seen but delayed	● Not seen as per Business Cycle	● Planned on Business Cycle
	Assurance highlighted as positive	Assurance highlighted as positive & matter of concern / key risk	Assurance highlighted as matter of concern / key risk	Assurance not rated

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Divisional)	Executive Infrastructure Group Highlight Report	●	●	●	●
	Executive Health & Safety Group Highlight Report	●	●	●	●
2nd Line (Corporate)	Financial and Capital Plan Update 2023/24	●	●	●	●
	Estates Strategy Progress Report			●	
	Fire Annual Report	●			
	Sustainability Bi-Annual Report	●		●	
3rd Line (External / Independent)	PLACE Inspection Findings and Action Plan	●			
	Internal Audit Review of Capital Programme: Planned & Backlog Maintenance			●	

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

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 schemes working closely with finance colleagues and bringing in external project management support to supplement existing team given size, scope and scale.
- PFI latent defect – to understand the findings from the intrusive surveys and respond to any remediation works required.
- Estates Workforce Business Case – continue to build on progress made following approval in December.
- Project STAR – work to continue on firming up disposal strategy and programme for Infirmary and Outpatients sites.
- Sustainability / NZC – workforce review in order to increase resource allocated to the Sustainability Team
- 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 – continue to build on progress made on facilities elements following approval of Business Case.
- PFI – conclude lender approvals Sodexo Market Test, determine PACS/RIS solution to inform concluding of Siemens VFM and support Chief Digital Information Officer on progression of actions associated with N&C future service delivery 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	31/07/2023	Discussions are underway with the UHNM Sustainability and Procurement Teams as well as with SoT CC to establish a strategy to ensure that forecast energy cost increase in April 2024 is mitigated as far as possible including potential connection to the local district heat network. Options paper is currently underway.	
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 a decant solution to RSUH.	
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 opened January 2023. Completion of Business case reliant on wards 80/81 closure in June. Still being used for clinical activity.	
6.	PFI Market Testing Opportunities	Control to reduce Likelihood and	Director EF&P	31/12/2023	Original due date 31/12/2022: Formalise Sodexo Business Case variation and progress other investment led/VfM	

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
		Consequence			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 as far as possible.	
8.	Strategic Supplier Programme	Control to reduce Likelihood and Consequence	Director EF&P	31/03/2024	8 new initiatives identified and launched at EFP partnership day in December 2022. Teams continuing to work through opportunities.	
9.	Estates Workforce Reviews	Control to reduce Likelihood and Consequence	Director EF&P	31/06/2023	Original due date 31/08/2022: Business case approved 20th December 2022, recruitment process continuing.	
10.	Cleaning Collaborative / new National Standards of Healthcare Cleanliness	Control to reduce Likelihood and Consequence	Director EF&P	31/06/2023	Sustain improvements seen in West Building and implement new Facilities Cleaning Standards following approval of Business Case at PAF in December.	
11.	Capital Programme Delivery	Control to reduce Likelihood and Consequence	Director EF&P	31/03/2024	Continue to look at ways of expediting programmes on nationally funded schemes with timescale delivery being key condition of funding.	

BAF 8: Financial Sustainability

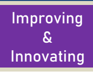
Internally Driven	✓
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we, or system partners, are unable to manage within the assumptions made in the financial plan for 2023/24	Then the underlying financial position for the system will deteriorate	Resulting in an increased level of efficiencies needing to be identified and a reduced ability to invest in the development of future services.

Lead Director / s:	Chief Finance Officer	Supported by:	n/a
Lead Committee/s:	Performance and Finance Committee	Executive Group:	n/a

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 (Plan)	Q3 (Plan)	Q4 (Plan)	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	3	3	3	3	Likelihood:	1	31/3/24	Low 1 - 3	0	Mod 4 - 6	4
Consequence:	3	3	3	3	Consequence:	3		High 8 - 12	11	Ext > 15	4
Risk Level:	High 9	High 9	High 9	High 9	Risk Level:	Low 3		Total No. Linked Risks:			19
Rationale for Risk Level:	The financial plan for 2023/24 contains some challenging assumptions particularly around activity levels and recurrent CIP delivery; early indications are that significant work remains if these assumptions to be met.										

Position Statement

What progress has been made during the last quarter?

A financial plan that is acceptable to regulators has been agreed which delivers an in-year breakeven position for all part partners. The PMO is issuing weekly updates on CIP identification which is showing significant progress in the identification of the non-recurrent element of the CIP. The Trust has agreed and that it will revert back to the pre-COVID Annual Leave policy of not allowing staff to carry forward annual leave; the financial impact of this is expected to deliver the NR stretch CIP target of £10.2m.

Key Controls Framework – 3 Lines of Defence

1st Line
- Performance Management meetings in place with Divisions with financial performance included as a driver metric.
- SFIs and scheme of delegation
- Executive Team 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 impact of activity levels of income recovery.
- ICS CFO meeting to review system position
- The level of non-recurrent mitigations currently being assessed and quantified

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

● Seen as per Business Cycle	● Seen but delayed	● Not seen as per Business Cycle	● Planned on Business Cycle
Assurance highlighted as positive	Assurance highlighted as positive & matter of concern / key risk	Assurance highlighted as matter of concern / key risk	Assurance not rated

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Divisional)	Executive Infrastructure Group Assurance Report	●	●	●	●
	Executive Business Intelligence Group Assurance Report	●	●	●	●
	Supplies and Procurement Report	●	●	●	●
	Medicines Finance, Procurement and Supplies Report	●		●	
2nd Line (Corporate)	Finance Report (including CIP)	●	●	●	●
	Financial and Capital Plan Update 2023/24	●			
	Draft Financial Outlook			●	●

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
	Overseas Visitors Activity and Income	●		●	
	Annual Audit into Overseas Visitors Policy Compliance			●	
	Business Case Review Schedule	●	●	●	●
	Overview of 2022/23 Financial Statements and Analytical Review	●			
	Analytical Review and Draft Accounts	●			
	Losses and Special Payments and Stock Write Offs	●	●	●	●
	Going Concern				●
	Audited Accounts and Financial Statements	●			
	Single Tender Waiver / SFI Breaches	●	●	●	●
3rd Line (External / Independent)	NHS Oversight Framework – Assessment Process, Governance, Exit Criteria & Indicators	●	●	●	●
	Internal Audit Review of Key Financial Controls	●			●
	Internal Audit Review of Capital Programme: Planned & Backlog Maintenance			●	
	Valuation of Land and Buildings 2023/24				●
	External Audit Progress Report	●	●	●	●
	External Audit Findings Report and Letter of Representation	●			
	External Audit Annual Report		●		
	Local Counter Fraud Progress Report	●	●	●	●

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

Gaps in Control or Assurance

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

The Month 2 position is showing an adverse variance to plan of £5.5m for the year to date mainly driven by under delivery against the CIP requirement; non-recurrent mitigations will need to be identified to manage the in-year impact of this and a focus of the identification of recurrent CIP to ensure the underlying position does not deteriorate. The Trust is not delivering it's activity plan for the year resulting in an increased risk of a loss ERF funding.

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	30/09/23	The PMO has established regular meetings with Divisions to support the identification of CIP. Weekly CIP tracker being issued.	
2.	Reduce level of recurrent investment to mitigate on non-delivery of CIP.	Control to reduce consequence	Chief Finance Officer	30/09/23	PAF receives quarterly investment assurance paper identifying the source of funding for new investments	
3.	Ensure the delivery of elective activity targets	Control to reduce the likelihood	Chief Operating Officer	30/09/23	Work ongoing as reported though PAF.	
4.	Reset of the bed model and final allocation of system capacity funding.	Control to reduce consequence	Chief Finance Officer / Chief Operating Officer	31/07/2023	System agreed analysis of forecast calls on the funding. Awaits final bed model to consider de-escalation opportunity prior to allocation being finalised.	

BAF 9: Research & Innovation

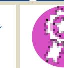
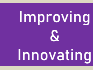
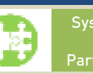
Internally Driven	✓
Externally Driven	

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, offer 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/s:	Transformation & People Committee	Executive Group:	Executive Research & Innovation Group

Impact on Strategic Priorities

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

Risk Scoring

Quarter	Q1 Actual	Q2 (Plan)	Q3 (Plan)	Q4 (Plan)	Target (Appetite)		Target Date	Linked Risks			
Likelihood:	4	4	3	3	Likelihood:	2	30/09/24	Low 1 - 3	0	Mod 4 - 6	1
Consequence:	3	4	3	3	Consequence:	2		High 8 - 12	2	Ext > 15	0
Risk Level:	High 12	High 12	High 9	High 9	Risk Level:	Mod 4		Total No. Linked Risks:			3
Rationale for Risk Level:	New senior managers came into post May (Research Matron) and June (R&I Manager) reducing the risk from Q4 (22/23) of likelihood from 5 to 4. The directorate still has vacancies to fill leaving a capacity shortfall within the delivery team, the Research Matron post is not substantive due to an active secondment being backfilled.										

Position Statement

What progress has been made during the last quarter?

The incoming R&I manager is reviewing the current meeting structure to ensure strategic and operational activities are actively supported, increasing operational communication as a direct result receiving feedback through the Staff Voice questionnaire, including whole departmental meetings with R&I Director/Manager/Matron and Medical Director.

The R&I directorate have been introduced to the Improving Together philosophy and will be undertaking the training in October, early engagement from the team has seen a positive response, showing a willingness to move forward as a co-creative and cohesive team. Increasing capacity within CeNREE with the appointment of a CeNREE Senior Health Researcher/ CeNREE Deputy Lead.

Key Controls Framework – 3 Lines of Defence

1st Line

- Research Operations and Leadership Meeting established to co-ordinate, communicate and support operational activities
- Monitoring and forecasting of recruitment to align with strategic objectives of growth, with forecasting to contribute to feasibility processes
- Reviewing the current meeting structures to ensure Strategy, Operational and Governance activities are actively supported and communicated
- Appointment of CeNREE Senior Health Researcher/CeNREE Deputy lead
- Individual department jointly appointing additional resources to embed research activity within their service, through externally funded opportunities.
- Chief AHP appointment to empower and encourage research
- Chief Healthcare Scientist appointed (to assist in identifying and championing research contributions from scientists at UHNM)

2nd Line

- Establishing a Strategic Development Committee with Senior positions from CeNREE, R&I and Wider Senior UHNM Research active staff.
- Establishing an R&I Board to oversee, Strategic, Operational & Governance (including financial governance) Activity
- Widening out the staff recruitment for delivery beyond nursing to include AHP's and other research active professions an example of this is the recent appointment of a Paramedic and Physician Associate.
- Managers being trained in budget management and forecasting to allow for co-production of the annual plan.
- 1:1 Wellbeing and Personal Development meetings put in place between the R&I manager and her direct reports.
- Undertaking the Improving together introduction has begun with a start of October 2023 planned

3rd Line	
	• UHNM represented on SSHERPA which contributes to the ICS research agenda • Member of the West Midlands R&D Research Forum • Increasing PPIE investment. • Commissioning an external specialist to review Research Quality Management Systems prior to the MHRA inspection • Prioritising the estates need of incorporating all research teams and functions within one space

Assurance Map	● Seen as per Business Cycle	● Seen but delayed	● Not seen as per Business Cycle	● Planned on Business Cycle
	Assurance highlighted as positive	Assurance highlighted as positive & matter of concern / key risk	Assurance highlighted as matter of concern / key risk	Assurance not rated

Defence Line	Sources of Planned Assurance	Q1	Q2	Q3	Q4
1st Line (Divisional)	Executive Research and Innovation Group Assurance Report	● (Not seen as per Business Cycle)	● (Planned)	● (Planned)	● (Planned)
2nd Line (Corporate)	Research and Innovation Strategy		● (Planned)		● (Planned)
3rd Line (External / Independent)					

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

Gaps in Control or Assurance

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

- Review of Directorate Structure to align operational, delivery and strategic objectives, allowing for the creation and recruitment into considered roles

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.	Desktop review of R&I structure being undertaken.	Control to reduce Likelihood	Medical Director	25/11/23	Original due date 30/9/22: This is almost complete and awaiting the final report after completion of external visits. Review completed although new R&I manager once in post will need to implement the changes proposed New R&I manager started June 2023. Need to allow 2-3 months before implementing changes	Amber
2.	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.	Amber
3.	Substantive recruitment to vacant posts.	Additional Control	Medical Director	30/09/2023	Current vacancies to be advertised or at shortlisting stage: Band 8b Deputy R&I Manager Band 7 Senior Research Delivery Practitioner Band 7 Senior Research Delivery Practitioner (MND specialist 0.4 FTE) Band 5 Research Practitioner Band 3 Research Administrator	Green
4.	R&I Manager, once in post to develop and deliver plan	Additional Control	Medical Director	30/6/2023	New R&I Manager started June 2023. Need to allow 2-3 months before	Green

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
	arising from the desktop review.				implementing changes	
5.	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	31/3/2024	Original due date 31/03/2023 To be completed following the Effectiveness Review. Implementing meeting/governance structures with appropriate role representation	
6.	Research to form part of Divisional Performance Management Reviews / watch metrics.	Additional Control and Assurance	Medical Director	31/6/2023	Metrics and communication to feed into Strategy development committee through divisional membership	
7.	Research to form part of Divisional Board agendas.	Additional Assurance	Medical Director	31/6/2023	Communication to feed into Strategy development committee through divisional membership and R&I board.	
8.	Commissioning an external specialist to review QMS prior to the MHRA inspection.	Additional Assurance	Medical Director	31/12/2023	Working with providers of pre-inspection consultants to commission an external review.	
9.	Increasing PPIE investment and developing a strategy, involving all R&I, CeNREE and Divisional representation Ensuring patient voice is at the heart of Research development	Additional Control and Assurance	Medical Director	31/03/2024	Producing a template of action for 23/24 to deliver a co-created strategy, with investment and sustainability goals	

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	Title	Risk Score as at End Q1	Risk Score as at End Q2	Risk Score as at End Q3	Risk Score as at End Q4	Division	BAF Risk
26887	Ineffective Clinical Effectiveness Provision	16				Central Functions	1
23731	Shared care of polytrauma patients	15				Network Services	1
27411	ReSPECT	15				Central Functions	1
12268	Nephrostomy Tubes Pathway Monitoring	12				Surgical	1
15993	Maternity Assessment Unit Triage	12				Children's, Women's & Support Services	1
17952	Dispensing errors at County Hospital	12				Children's, Women's & Support Services	1
23361	Number of open adverse incidents and root cause analysis investigations	12				Children's, Women's & Support Services	1
23500	Inadequate Pharmacy support to emergency portals to meet national benchmarking for 7 days	12				Children's, Women's & Support Services	1
23546	Increase in CYP accessing acute services within ED and inpatient ward beds due to a mental health diagnosis	12				Children's, Women's & Support Services	1
24035	Delay in timely ante-natal booking in line with service specifications of screening programmes	12				Children's, Women's & Support Services	1
20180	Controlled drugs management	12				Medical	1
21320	No robust system in place for safety netting abnormal imaging for MRU at County	12				Medical	1
26815	Resuscitation Training	12				Central Functions	1
8877	Hospital Acquired Infections	12				Central Functions	1
8901	Ensure correct blood sample management	12				Central Functions	1
9783	Incident Investigation	12				Central Functions	1
26238	Industrial Action 22/23	16				Central Functions	2
20616	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at Macclesfield H	16				North Midlands and Cheshire Pathology Service	2
21157	Haematology Service at MCHT Leighton	16				Network Services	2
23843	Respiratory Consultant workforce (County)	16				Medical	2
24032	Respiratory Physiology - risk to service delivery/wait times	15				Medical	2
11294	NMCPS Pathology Histology Medical Reporting Capacity (achieving TAT)	12				North Midlands and Cheshire Pathology Service	2
13725	RSUH/CH Haematology shift service provision (Haematology)	12				North Midlands and Cheshire Pathology Service	2
20809	NMCPS Histology Admin & Office Capacity	12				North Midlands and Cheshire Pathology Service	2
21591	Insufficient Clinical Staff to Support the NMCPS Microbiology Service	12				North Midlands and Cheshire Pathology	2

ID	Title	Risk Score as at End Q1	Risk Score as at End Q2	Risk Score as at End Q3	Risk Score as at End Q4	Division	BAF Risk
						Service	
21947	Insufficient resource for the paediatric dietetic services	12				Children's, Women's & Support Services	2
23506	Gastroenterology patients insufficient Pharmacy support for highly complex medication regimes	12				Children's, Women's & Support Services	2
24323	Neurosciences SHO Rota	12				Network Services	2
24837	Cystic Fibrosis workforce/service delivery	12				Medical	2
26110	Renal clinic letters for Cheshire (Leighton) Patients	12				Medical	2
16652	Staff Wellbeing and Welfare	16				Medical	3
23842	Delivery of RTT - Outpatient capacity/wait times	16				Medical	5
25469	Delivery of constitutional cancer quality standards	16				Surgical	5
25471	Follow Up Delays	16				Surgical	5
28325	Endoscopy delays - cancer and long waits	16				Surgical	5
25839	Long Wait Patients in the Trauma Directorate	16				Network Services	5
28365	Overall Management Resource Capacity deficit - Imaging	15				Children's, Women's & Support Services	5
20634	Histology - Bowel Cancer Screening Age Extension	12				North Midlands and Cheshire Pathology Service	5
21013	Histology laboratory workload capacity	12				North Midlands and Cheshire Pathology Service	5
8660	Follow up back log	12				Medical	5
17805	Lung Nodule Management	12				Medical	5
20448	Patient LOS above 24 hrs on AMU - against Internal Standards	12				Medical	5
20739	Endoscopy planned patients waiting list	12				Medical	5
23568	Size of the AEC footprint	12				Medical	5
24028	Lack of flow across the Trust leading to congestion of ED (both sites) and UEC standards unable to be met	12				Medical	5
18066	Cardiology follow up backlog	12				Network Services	5
25053	Access to Cardiac theatres	12				Network Services	5
26529	Leighton Hospital Hyper-Acute Stroke Pathway	12				Network Services	5
18664	Gynaecology 52 Week Wait Patient Numbers	12				Children's, Women's & Support Services	5
20435	Paediatric Follow up Backlog	12				Children's, Women's & Support Services	5
25790	Diagnostic Sleep Service	12				Children's, Women's & Support Services	5
26921	Radiology Reporting Backlog - MSK	12				Children's, Women's & Support Services	5
26554	LAC - IHA compliance	12				Children's, Women's & Support Services	5

ID	Title	Risk Score as at End Q1	Risk Score as at End Q2	Risk Score as at End Q3	Risk Score as at End Q4	Division	BAF Risk
20134	Specialised Surgery Follow Up Backlog	12				Surgical	5
25470	Increasing waiting list size and patients waiting greater than 18 weeks for treatment	12				Surgical	5
25585	Lack of Cone Beam CT scans being reported	12				Surgical	5
25628	Ophthalmology Service Delivery	12				Surgical	5
26168	Pathology IT System Expertise	20				North Midlands and Cheshire Pathology Service	6
28451	Network outage affecting accessibility of clinical systems	20				Central Functions	6
25454	EPMA and/or Clinical Narrative System not fit for purpose	16				Central Functions	6
25893	Delay in EPMA roll out	16				Central Functions	6
25870	Network and communication services provision for UHNM	16				Central Functions	6
25932	Non-compliance with NHS Digital Guidance DCB0160	15				Central Functions	6
23755	System failure due to lack of Information Technology Infrastructure Library (ITIL)	12				Central Functions	6
23759	Inappropriate clinical decisions due to large number of digital systems in place	12				Central Functions	6
8849	Staff using unsecured and unlicensed personal phones for work email	12				Central Functions	6
21784	Confidentiality, Integrity and Availability of Trust Information	12				Central Functions	6
25457	Lack of regular audit of IT assets	12				Central Functions	6
23753	Network failure due to multiple service providers	12				Central Functions	6
24580	Lack of a centralised information asset (systems) register	12				Central Functions	6
26487	Lack of a digital solution to maintain confidentiality of patient information with the GP	12				Central Functions	6
28573	End of support for SQL Server 2012 and Windows Server 2012/2012 R2	12				Central Functions	6
23258	IT Leighton Hospital	12				Network Services	6
23648	RSUH/CH Current LIMS reliability and licence availability	12				North Midlands and Cheshire Pathology Service	6
25668	Risk of Patient Information changing between Pathology LIMS and ICE	12				North Midlands and Cheshire Pathology Service	6
27146	Lack of compatibility between iportal and other systems	12				Surgical	6
23331	MCHT Ceiling RAAC planks	15				North Midlands and Cheshire Pathology Service	7
22717	Space in Pathology Directorate RSUH	12				North Midlands and Cheshire Pathology Service	7
24835	Neurosciences Office Space for clinical teams	12				Network Services	7
25890	Cystic Fibrosis office accommodation	12				Medical	7
27410	Fire escape in Transitional Discharge Lounge (TDL)	12				Medical	7

ID	Title	Risk Score as at End Q1	Risk Score as at End Q2	Risk Score as at End Q3	Risk Score as at End Q4	Division	BAF Risk
26022	No further co-located geographical space to develop children' services	12				Children's, Women's & Support Services	7
20315	Interventional Room 5 does not meet Ventilation Building Regulations	12				Children's, Women's & Support Services	7
27145	Theatre doors not compliant with fire safety regulations	12				Surgical	7
27497	System C (careflow) cost pressure	20				Central Functions	8
28105	Interventional Radiology Stock - Financial risk	16				Children's, Women's & Support Services	8
21697	Recurrent CIP requirements for 23/24 and beyond not met in Trust due to lack of focus on CIP planning	12				Central Functions	8
21700	Sale price of RI and COPD sites is lower than expected in relation to funding of project star expenditure	12				Central Functions	8
22949	IM&T Contract Management	12				Central Functions	8
25347	Reduction in planned elective Recovery Income	12				Central Functions	8
25348	Excess Non pay Inflation	12				Central Functions	8
28550	Funding for new revenue investments	12				Central Functions	8
22514	Nurse Staffing in the Emergency Department both Sites	16				Medical	1, 2
25467	HD capacity and workforce	16				Medical	1, 2
25120	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at MCHFT	16				North Midlands and Cheshire Pathology Service	1, 2
27696	Consultant Obstetricians workforce	16				Children's, Women's & Support Services	1, 2
25152	Insufficient trained staff in Pharmacy Technical Services to deliver aseptic products including chemotherapy to the Trust	15				Children's, Women's & Support Services	1, 2
23595	Substantive nursing workforce on medical escalation wards	15				Medical	1, 2
26920	Inability to always provide extra observational staff for patients who require it which could lead to patient harm	15				Medical	1, 2
27141	Risk of serious harm due to patient falls on FEAU	15				Medical	1, 2
15664	Liver Mortality - CQC actions	12				Medical	1, 2
17710	Pharmacy staffing for Inpatient gastroenterology	12				Medical	1, 2
23569	AMU ROYAL STOKE-Lack of pharmacy staff due to understaffing to meet demand of the increased bed base	12				Medical	1, 2
23570	No current pharmacy service to support AMRA	12				Medical	1, 2
23787	Gaps in Junior Doctor workforce	12				Medical	1, 2
27472	Inadequate Nurse Staffing in Children's ED Compromising Ability to Provide Basic CQC Nursing Requirements	12				Medical	1, 2
25857	AMU COUNTY-Lack of pharmacy staff to meet demand due to increased bed base	12				Medical	1, 2
13419	Midwifery safe staffing	12				Children's, Women's & Support Services	1, 2
18842	Gaps within the Junior Medical Rota	12				Children's, Women's &	1, 2

ID	Title	Risk Score as at End Q1	Risk Score as at End Q2	Risk Score as at End Q3	Risk Score as at End Q4	Division	BAF Risk
						Support Services	
21481	Reduced Breast service (Imaging), due to vacancy within Breast Radiologist workforce.	12				Children's, Women's & Support Services	1, 2
21503	General Paediatric Consultant Rota	12				Children's, Women's & Support Services	1, 2
22651	Inability to provide a TC service within the TC footprint	12				Children's, Women's & Support Services	1, 2
23834	Breach of Induction of Labour Guidance	12				Children's, Women's & Support Services	1, 2
24272	Junior Doctor Staffing	12				Children's, Women's & Support Services	1, 2
25228	Nurse Staffing CED	12				Children's, Women's & Support Services	1, 2
25229	Nurse Staffing CAU	12				Children's, Women's & Support Services	1, 2
25247	Nurse Staffing Ward 217	12				Children's, Women's & Support Services	1, 2
26995	Radiology Reporting Backlog – Body Radiology	12				Children's, Women's & Support Services	1, 2
26996	Radiology Reporting Backlog – Paed Rad	12				Children's, Women's & Support Services	1, 2
21595	Insufficient technical staff in Microbiology	12				North Midlands & Cheshire Pathology Service	1, 2
21987	Wards 227 RN Workforce availability	12				Network Services	1, 2
25795	Vacant Consultant Neurology On-Call Gaps	12				Network Services	1, 2
25455	Lack of ST1/2 to provide on call cover within Specialised Surgery Directorate	12				Surgical	1, 2
27754	Non-compliance of DM01 performance for NOUS	12				Children's, Women's & Support Services	1, 2, 5
27953	Lack of provision for patients requiring DIEP surgery	15				Surgical	1, 2, 5
17967	Medical Cover Cardiothoracic ICU	12				Network Services	1, 3
25980	Your Next Patient Process	16				Medical	1, 5
26832	Your Next Patient (Corridor Queues) Acute Medicine	12				Medical	1, 5
28304	Financial penalty due to using unsupported Outlook 2010	16				Central Functions	6, 8
25353	Sale of RI and COPD Land later than NHSE funding requirement of 24/25	20				Central Functions	7, 8

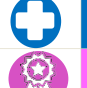
Executive Summary

Meeting:	Trust Board (Open)	Date:	2nd August 2023
Report Title:	Board Development Programme 2023/24	Agenda Item:	12.
Author:	Deputy 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	✓

Executive Summary

Situation

This paper is to provide the Board with an overview on progress against the topics identified to be delivered within the 2023/24 Board Seminar Programme.

Background

The outputs of the Board Effectiveness Review were presented to the Trust Board at the Seminar on 12th July 2023. This identified a number of areas of development which subsequently informed the topics within the Board Development Programme for 2023/24. This includes a variety of business and developmental topics including 'must dos', emerging developments and operational/strategic challenges, aligned to our Strategic Priorities.

Assessment

A review of the Board Development Programme has been undertaken and the attached demonstrates the topics which have been covered as planned or deferred. Two items have recently been added to the programme; the timings for which are yet to be confirmed.

As per previous years, there is opportunity to expand the programme by utilising time currently allocated to Closed Trust Board sessions, should the need to be identified by the Board or its Committees during the course of the year.

Key Recommendations

The Trust Board is asked to consider and approve the Board Development Programme and to note the timing of the remaining sessions, highlighting where any changes are required and whether any additional items should be included.

Board Development Programme 2023 - 2024

Topic	Session Lead	Development / Business	Purpose / Outcome	21st April Time Out	10th May Seminar	7th June Closed Bd	12th July Seminar	2nd Aug Closed Bd	13th Sept Seminar	4th Oct Closed Bd	13th Nov Time Out	6th Dec Closed Bd	7th Feb Closed Bd	9th Feb Seminar	15th March Seminar	Strategic Priorities					
Team Building - External	Associate Director of Corporate Governance	Development	Team Building Activities - Away Day.	■														●			
CQC Maternity Report	Chief Nurse	Business	To consider the initial report from the CQC visit to Maternity		■											●					
Development of Trust Strategy	Director of Strategy & Transformation / Director of Communications	Business	To engage the Board in the process for development of the new Trust Strategy.		■	→	■									●	●	●	●	●	●
Board Development	Associate Director of Corporate Governance	Development	To consider the findings of our Board Effectiveness Evaluation and agree further development needs.		■	→	■									●	●	●	●	●	●
Integrated Performance Reporting	Associate Director of Corporate Governance	Business	To agree the metrics and next steps associated with the IPR and future reporting				■									●	●	●	●	●	●
Culture Review	Chief People Officer	Business	Update provided on progress made against the culture improvement programme and next steps				■											●			
CNST Maternity Scheme	Chief Nurse	Business	To consider the new metrics and standards associated with Maternity CNST				■									●					
ICB Joint Forward Plan	Director of Strategy	Business	To consider the joing forward 5 year plan for the ICB					■								●	●	●	●	●	●
Freedom to Speak Up	Associate Director Corporate Governance / FTSUG	Development and Business	To complete the self-reflection tool and consider our Speaking Up Strategy.						■							●		●			
Well Led Assessment (External)	Associate Director Corporate Governance	Development	To consider the findings of our External Developmental Review against the Well Led Framework and agree our Development Plan.						■							●	●	●	●	●	●
Operational Planning 23-24	Director of Strategy	Business	Progress and associated risks following the closedown letters						■							●	●	●	●	●	●
Approach to Partnership Working	Chief Executive / External Facilitator	Development and Business	To challenge our thinking and approach to partnership working.							■										●	
Clinical Research Network and CENREE	Chief Nurse & Medical Director	Business	An update on progress with CENREE and the Clinical Research Network.								■					●			●	●	
Sustainability	Director of Estates, Facilities and PFI	Development and Business	An update on delivery of the Green Plan and key priorities.								■									●	●
Enabling Strategies	Director of Strategy plus Executive Leads	Business	A review of progress against delivery of our Enabling Strategies.								■					●	●	●	●	●	●
Digital Maturity, Cyber Security and Digital Clinical Safety	Director of Digital Transformation / External Lead	Business	Annual training and development on Cyber Security / Risk.								■										●
Board Insights / Personalities	Chief People Officer	Development	Understanding personalities.											■				●			
Strategic Risks - Board Assurance Framework	Associate Director Corporate Governance	Business	To agree the Strategic Risks for 2023/24 Board Assurance Framework.												■	●	●	●	●	●	●
Annual Plan and Focus Confirmation (local priorities)	Director of Strategy and Associate Director of Quality Improvement	Business	To agree the Annual Plan, Annual Delivery Plans for Enabling Strategies and to confirm priorities agreed through focussed negotiation.												■	●	●	●	●	●	●
Improving Together - Learning from Berkshire Health	Chief Nurse	Business	TBC													●	●	●	●	●	●
Update on Bed Modelling & Mitigation	Chief Operating Officer	Business	To provide an update on the PwC bed model, including the plans and mitigation to address the bed gap in addition to an update on actions to improve decision to admit times														●				

Trust Board

2023/24 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 5	May 3	Jun 7	Jul 5	Aug 2	Sep 6	Oct 4	Nov 8	Dec 6	Jan 10	Feb 7	Mar 6	Notes
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse		Staff		Staff				Staff			Staff		
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Quality Strategy Update	Chief Nurse													TBC
Clinical Strategy	Director of Strategy													TBC
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													
Quality Account	Chief Nurse													
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													
Infection Prevention Board Assurance Framework	Chief Nurse	Q3		Q4		Q1			Q2			Q3		
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													TBC
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													TBC
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 £1,500,001 and above	Director of Strategy	N/A	N/A			N/A								
Digital Strategy Update	Director of Digital Transformation													TBC
Going Concern	Chief Finance Officer													
Estates Strategy Update	Director of Estates, Facilities & PFI													TBC
Annual Plan	Director of Strategy													
Board Approval of Financial Plan	Chief Finance Officer													Approved at PAF April 2023
Final Plan Sign Off - Narrative/Workforce/Activity/Finance														Approved at PAF April 2023
Activity and Narrative Plans	Director of Strategy													Approved at PAF April 2023
Capital Programme 2022/23	Chief Finance Officer													Approved at PAF April 2023

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		5	3	7	5	2	6	4	8	6	10	7	6	
Standing Financial Instructions	Chief Finance Officer													Next due for review February 2026
Scheme of Reservation and Delegation of Powers	Chief Finance Officer													Next due for review February 2026
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	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													Board review considered at Trust Board Seminar in July
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													
Well-Led Self Assessment	Associate Director of Corporate Governance													
Risk Management Policy	Associate Director of Corporate Governance													
Complaints Policy	Chief Nurse													Next due for review June 2024