University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 3rd May 2023 at 9.30 am to 12.30 pm
Trust Boardroom, Third Floor, Springfield, RSUH

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Staff Story	Information	Mrs J Haire	Verbal	
5 mins	**2.**	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 4th April 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 – April 2023	Information	Mrs T Bullock	Enclosure	
10:05		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (27-04-23)	Assurance	Prof K Maddock	Enclosure	1
10 mins	**8.**	Care Quality Commission Action Plan	Assurance	Mrs AM Riley	Enclosure	1
10 mins	**9.**	Nurse Staffing Establishment Review	Assurance	Mrs AM Riley	Enclosure	1, 3
10 mins	**10.**	PLACE Inspection Findings and Action Plan	Assurance	Mrs L Whitehead	Enclosure	7
10:40		**PEOPLE**				
5 mins	**11.**	Transformation and People Committee Assurance Report (26-04-23)	Assurance	Prof G Crowe	Enclosure	2, 3, 4, 6, 9
10:45		**RESOURCES**				
5 mins	**12.**	Performance & Finance Committee Assurance Report (25-04-23)	Assurance	Dr L Griffin	Enclosure	5, 7, 8
15 mins	**13.**	Annual Plan 2023/24	Approval	Ms H Ashley	Enclosure	All
11:05 – 11:20 COMFORT BREAK						
11:20		**RESPONSIVE**				
40 mins	**14.**	Integrated Performance Report – Month 12	Assurance	Mrs AM Riley Mr P Bytheway Mrs J Haire Mr M Oldham	Enclosure	1, 2, 3, 5, 8
12:00	**GOVERNANCE**					
5 mins	**15.**	Audit Committee Assurance Report (27-04-23)	Assurance	Prof G Crowe	Enclosure	
10 mins	**16.**	Board Assurance Framework – Q4	Assurance	Mrs C Cotton	Enclosure	All
10 mins	**17.**	Committee Effectiveness and Revised Rules of Procedure	Approval	Mrs C Cotton	Enclosure	
12:25	**CLOSING MATTERS**					
5 mins	**18.**	Review of Meeting Effectiveness and Review of Business Cycle	Information	Mr D Wakefield	Enclosure	
	19.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 2nd May to** Nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:30	**DATE AND TIME OF NEXT MEETING**					
	20.	**Wednesday 7th June 2023, 9.30 am, via MS Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 5th April 2023 at 9.30 am to 12.00 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												
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 L Thomson	LT	Director of Communications												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI												

In Attendance:	
Mr I Bodell	Patient (item 1)
Mrs N Hassall	Deputy Associate Director of Corporate Governance (minutes)
Mrs R Pilling	Head of Patient Experience (item 1)

Members of Staff and Public: 2

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
048/2023	Mr Bodell described his experience, whereby he started to have headaches and suffered migraines every couple of months in 1996 which he initially self-treated with over the counter medication. Following his return to work in the Police force he received various therapies all of which did not address the headaches. He described a number of medications which were prescribed by his General Practitioner over the years, none of which were successful and after some time he started to keep a headache diary and removed certain foods from his diet which again did not address the problem.	

	Mr Bodell described his headaches significantly worsening after a number of years, reaching a point where they were negatively affecting his mental health resulting in him having suicidal thoughts, due to the debilitating nature and severity of the headaches. He explained that after moving to Worcestershire he was referred to Dr Davies at Royal Stoke in 2016 and was initially treated with nasal sprays, which were successful at first. However, he stated that the headaches became so frequent that they were occurring on a daily basis and therefore in 2022 he contacted the National Migraine Centre, which suggested that some of the headaches were due to medication overuse. He explained that he had to stop all treatment for a period of a month before he was able to and commence injections in March 2022 which were successful and he was now experiencing 2 to 3 headaches a month which were mild or moderate in nature. Mr Bodell described how his life had been transformed as a result of this medication. Mr Wakefield thanked Mr Bodell for sharing his story and he queried what treatment was provided to help him while coming off the medication. Mr Bodell explained that he was provided with some medication for his upset stomach. Dr Griffin queried whether it was felt that the injections could have been provided more quickly or whether clinicians' understanding of migraines had improved over the years. Mr Bodell stated that he felt he may not have been forceful enough to try other medications and Mrs Bodell explained that she felt that the doctors were trying one thing before trying another and going through a process of elimination. Mrs Bullock also confirmed that Mr Bodell's current treatment was not available in 2016. Ms Bowen queried whether there was any learning about advising patients about such specialist centres in order to help future patients. Mrs Bodell agreed that there was more awareness to be raised although highlighted that the National Migraine Centre was a charity and did require payment. Mr Oldham reflected on the Trust's previous investments in new migraine treatments and stated that the story highlighted the value of the investment and impact on patients. Mr Wakefield thanked Mr and Mrs Bodell for sharing their experience and summarised the comments made in terms of timeliness of referrals, the need to raise awareness of the additional help and advice available as well as noting that the story positively demonstrated the value of the investments made in new treatments. Mr Wakefield asked Mrs Riley to consider inviting Mr Bodell onto the Hospital User Group to share his experiences going forwards. **The Trust Board noted the patient story.** Mr and Mrs Bodell and Mrs Pilling left the meeting.	**AMR**
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
049/2023	Mr Wakefield welcomed Board members to the meeting. Apologies were received as recorded above, and the meeting was confirmed as quorate.	
3.	**Declarations of Interest**	
050/2023	There were no declarations of interest raised.	

4.	**Minutes of the Previous Meeting held 8th March 2023**	
051/2023	The minutes of the meeting held 8th March 2023 were approved as a true and accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
052/2023	Mr Wakefield requested an update on the Trust's bid for additional capacity and Mrs Bullock stated that this had been approved by the region and the Trust was awaiting a national decision. Mr Bytheway stated that the Trust was working on the premise that agreement would be provided and as such had commenced looking at activity flows etc. PTB/546 – Mrs Riley confirmed that the information on sepsis screening had been provided to the Quality Governance Committee (QGC) and a further update was to be provided in August. PTB/572 – Mrs Riley explained that additional information had been provided within the serious incident report and this would continue to be refined as required. PTB/577 – Mrs Riley confirmed that she had met with Professor Maddock. Mr Wakefield referred to the target dates which had been extended and requested that these be completed within the revised timeframe.	
6.	**Chief Executive's Report – March 2023**	
053/2023	Mrs Bullock highlighted a number of areas from her report. Mr Wakefield referred to the transformation in theatres and queried whether this was linked to productivity. Mrs Bullock agreed and described the process undertaken and the initial actions taken. Mr Akid queried the length of time taken for the Procurement for blood sciences equipment and if an extension would be required and Mr Bytheway explained that an extension with the existing provider had previously been agreed by the Trust and added that the length reflected the nature and complexities of the tender. Mr Wakefield requested clarification that the Trust had acted on the concerns raised by the Care Quality Commission (CQC) following their inspection of maternity services to which Mrs Bullock confirmed that actions had been taken at the time of the inspection and that the CQC had confirmed that no additional action was required. **The Trust Board received and noted the report and approved eREAF 10501.**	
HIGH QUALITY		
7.	**Quality Governance Committee Assurance Report (30-03-23)**	
054/2023	Professor Hassell highlighted the following: • The Committee received the Organ Donation report which highlighted that UHNM was one of the top donating hospitals in the Midlands and second in the country • A national tissue pilot was underway in the UK looking to make it easier for	

	certain organ donations which UHNM was taking part in • Some of the challenges with organ donation were highlighted, particularly ICU capacity and a Standard Operating Procedure was being developed in respect of this • An update was provided on the Neonatal Action Plan following an internal review in 2021. It was noted that the number of neonatal deaths had reduced from 31 in 2021 to 19 in 2022. • The West Midlands was an outlier for neonatal mortality although there was a time lag in publishing the data and the latest report with benchmarked data was for 2020. The actions being taken were described to the Board and a further update had been requested to be provided to the Committee • In terms of nurse recruitment, 110 international nurses had been recruited and 80 graduates were planned to join the Trust, which aimed to keep the Trust at a steady state Mr Wakefield referred to neonatal data and West Midlands being an outlier and queried the reason for the lack of up to date data. Professor Hassell referred to the difficulties in comparing the data due to the complexity of neonates, therefore 2020 was the latest national data. Dr Lewis agreed that the data was so complex it needed to be standardised with other factors such as deprivation, age of mothers and other comorbidities which therefore takes time to analyse. He added that the team had reviewed the crude data which was not standardised, but provided an early indication of any concerns, which highlighted the reduction in neonatal deaths from 2021 to 2022. Professor Crowe referred to the importance of organ donation and suggested that this be promoted more widely within the Trust. He reflected that promoting this further would also demonstrate the Trust's culture and Professor Hassell added that it also reflected the ethos of Being Kind. Professor Crowe welcomed the approval of the clinical audit plan following receipt of the recommendations from the internal audit review. **The Trust Board received and noted the assurance report.**	
8.	**Infection Prevention Board Assurance Framework – Q3**	
055/2023	Mrs Riley highlighted the following: • Changes in mask wearing were highlighted and implemented in January • A new broader framework had been received and was being worked through and would be considered at QGC before being brought to the Board Mr Wakefield referred to the reference to the cleaning standards and requested confirmation that the action was complete given the due date was quarter 4, to which Mrs Riley confirmed. Ms Bowen queried the guidance for mask wearing for visitors and Mrs Riley explained that visitors were advised to wear a mask if visiting a patient as an extra precaution. She stated that not all organisations had taken the same action but it was advisable due to the local prevalence. Mrs Riley added that this was monitored and the guidance was reiterated on the ward although the Trust was not able to enforce this. **The Trust Board received and noted the report.**	
PEOPLE		

9.	**Transformation and People Committee Assurance Report (29-03-23)**	
056/2023	Professor Crowe highlighted that the discussion at the meeting focussed on two key areas; • The workforce plan provided a good understanding of the gaps in the workforce and provided emergent plans of how the gaps were to be filled, although the issue was developing a plan over the medium term which could fill the supply and demand gap. He summarised that the Committee welcomed the progress made in terms of improving understanding of the position, but was not fully assured that a plan was in place which would fully address the issue • An update on the cultural improvement programme provided assurance of the actions taken to date and the key areas were considered alongside the main areas of focus within the staff survey Dr Griffin referred to the workforce plan and the current vacancy position of 12% to 15%. He queried where the biggest gaps were and whether these affected particular disciplines or services. Mrs Haire stated that one of the biggest gaps related to nursing and midwifery, and efforts to close the gap focussed on grow your own and overseas recruitment, in addition to doubling efforts on seeking candidates from the marketplace. She added that there were some longstanding gaps in the medical and dental workforce as well as some hotspot areas such as pharmacy and pathology. Professor Crowe stated that the Committee received additional granularity of the plans to close the gap in hard to fill areas, demonstrating a growing understanding of the requirements. **The Trust Board received and noted the assurance report.**	
10.	**Staff Survey 2022**	
057/2023	Mrs Haire highlighted the following: • The response rate was 10% lower than anticipated and this reflected some initial technical issues. It was noted that an assurance paper was to be provided to the Transformation and People (TAP) Committee to confirm that these issues had been addressed in readiness for the 2023 survey • A number of areas had improved; being a team, reporting of physical violence and individuals identifying the value of appraisals • The areas where the Trust needed to improve on are we are flexible, we are a team and we are compassionate and inclusive. , with a focus on culture around all of those areas • Actions were being focussed on these 3 areas which would be underpinned by creating a sustainable workforce in the future • A focus on the Being Kind programme continued in addition to exploring broader training offers • The need for a sustained engagement programme to ensure colleagues understand the progress made on cultural improvement had been recognised and this was being supported by communicating positive stories throughout the Trust to help create a sense of belonging Dr Griffin referred to the need to understand the resolution of the technical issues affecting the response rate and suggested that the action plan be defined into specific measurables rather than the broader commitments. Mr Akid queried if the scale of the impact of the technical issues was known and Mrs Haire stated that she would have expected a further 10% response rate. She stated that some of the issues related to paper distribution and email distribution	

	and staff calling into question whether the responses were anonymous which was to be tackled for 2023. Mr Wakefield queried the assurances from the monthly results which could be used, given the difference to the national responses. Mrs Haire stated that the Trust was building momentum with the number of colleagues completing the local survey and highlighted that this was quicker and easier for colleagues to access than the national survey, however the Trust performance was ultimately tracked against the national responses. Mr Wakefield agreed with the focus to continue to encourage colleagues to complete the local survey so that the Trust could learn from the responses provided. Mr Wakefield referred to the actions which he felt did not always connect to the people promises and domains. Mrs Haire stated that these were to be reset and the actions were to be considered alongside the specific domains of the people strategy to ensure that there was a good line of sight between the national people promises and the UHNM people strategy. Professor Crowe stated that the points raised would be addressed and considered by TAP in due course. **The Trust Board noted the National Staff Survey Report and the corporate priorities planned for 2023/24 aimed at Making UHNM a Great Place to work by improving organisational culture, improving behaviours and supporting and maximising the potential of our people to improve patient outcomes.**	
RESOURCES		
11.	**Performance & Finance Committee Assurance Report (28-03-23)**	
058/2023	Dr Griffin highlighted the following: • The Committee expressed their frustration of the timeliness of receiving business case reviews and received assurance of more directive action being taken to receive these as planned • The Committee awaited the review of the winter de-brief although an initial challenge had been highlighted in terms of the ability to enact planned levels of discharges over the Christmas period • Concerns regarding the number of long waiters and the current position were raised, including the need to consider the impact of the ability for the Independent Sector to undertake the work as well as the impact of patient choice • Concerns regarding the financial outlook for the system for 2023/24 were highlighted • There had been a steady improvement in urgent care performance and positive improvements in cancer performance • The Committee was to increase its focus at future meetings on productivity including consideration of benchmarking **The Trust Board received and noted the assurance report.**	
RESPONSIVE		
12.	**Integrated Performance Report – Month 11**	
059/2023	Mrs Riley highlighted the following in relation to quality and safety performance: • In terms of the inpatient friends and family test the Trust was above the target but the position had deteriorated, therefore a deep dive had commenced to	

understand where changes in feedback were being provided and where there were opportunities for improvement. The results of this were to be considered by QGC in Quarter 1
- Work remained ongoing with regards to patient safety incidents being reported in relation to tissue damage which was not hospital acquired, and the data was being reviewed across the system and actions being taken to prevent pressure damage before patients were transferred into hospital

Mr Wakefield requested further information in terms of the pressure ulcer review and actions being taken in the system and Mrs Riley stated that it was not clear whether the contributing factor related to long waits or was due to issues in care homes and therefore this was being reviewed.

Mr Wakefield referred to the reduction in nosocomial infections in February 2023 compared to the reference to an increase in the number of deaths reported in January and queried whether these deaths were due to covid. Mrs Riley stated that any death of a patient who had Covid-19, where this did not cause the death would still have Covid-19 listed as a factor.

Mr Wakefield referred to timely observations performance and queried when it was expected this would improve. Mrs Riley stated that each Division had this as a driver metric and analysis was to be undertaken to understand the breadth of delays. She added that this also formed part of monthly Tendable audits and was part of the Clinical Excellence Framework review process.

Mr Bytheway highlighted the following in relation to urgent care performance:
- Performance in February and March saw improvements in some of the most challenged areas, including a reduction in 60 minute holds, a reduction in the average and total time spent in the department and the improvements were not attributed to decreased activity.
- Weekly ambulance handover meetings continue to be held and there had been an improvement in ambulance handovers for the past 6 weeks
- The number of simple discharges before noon had seen some improvement and the number of medically fit for discharge patients had standardised
- The Trust was in the upper quartile for time to triage and had also improved on time to be seen

Dr Griffin welcomed the improvements highlighted and queried the progress made with the capital bid for the SDEC modular build. Mr Bytheway reiterated that this had been agreed regionally but was going through national procurement and work to rearrange activity flows had commenced.

Ms Bowen queried the impact on the non-elective plan due to the planned Industrial Action and Mr Bytheway stated that this continued to be ongoing.

Mr Wakefield summarised that improvements were being made despite the unit remaining busy and as such there was a need to continue with corridor care on occasion. He referred to Consultants being present during the previous strike action and associated improvement in performance and queried whether this presented any learning in terms of decision making. Mr Bytheway stated that it was known that having senior decision makers in the department helped with decision making due to their experience and training, therefore the previous Emergency Department business case had included putting additional senior decision makers on shift to ensure flow was maintained. Dr Lewis stated any further changes would need to consider the best use of resources and added that using Consultants at night would have a negative impact due to the nature of the Consultant contract. Dr Lewis added that it was also important to focus on

training of staff and Mrs Bullock stated that non Emergency Department Consultants were used during the strike period due to the reduction in activity which was not usual practice and to do this on a more consistent basis would significantly impact on general activity. Mrs Riley added that clinical and operational teams worked 24/7 in a different way to support staff which also helped with performance and again if this was done more consistently it would impact on other activities as a lot of things had been cancelled to accommodate this.

Professor Crowe thanked the workforce for coming together to manage the industrial action including the way in which they reorganised themselves to provide the support required. Mr Bytheway reflected on the joint multidisciplinary teamwork that was in place and Mr Wakefield reiterated his thanks for the teams working during that period.

Mr Bytheway highlighted the following in relation to cancer performance:

- The Trust achieved the 2 week standard for the second month despite increasing referrals
- The faster diagnosis standard was likely to end at 72% compared to the target of 75%
- The Trust was expected to come out of tier 2 for cancer and the total backlog had reduced from 17% to 18% to just above 8%
- Under 100 people were waiting over 104 days

Ms Bowen thanked the teams who had helped to progress the improvements in performance.

Mr Bytheway highlighted the following in relation to planned care performance:

- The Trust did not achieve the targets for 104 and 78 weeks, with 48 patients waiting over 104 weeks and 552 patients waiting over 78 weeks
- The Trust was expected to move into tier 1 due to this performance
- Particular challenges had been identified in Trauma and Orthopaedics and a trajectory for improvement for quarter 1 was to be established
- The theatre improvement plan was to be taken to Performance and Finance Committee (PAF)
- An independent review was ongoing in relation to the long wait patients which was expected to report at the end of May
- A new process was in place for regular oversight of performance

Mr Wakefield stated that other Trusts were reporting that they aimed to clear their long waits by the end of April compared the Trust's trajectory of end of June and queried the reasons for this. Mr Bytheway stated that this was due to the specialist work required such as orthopaedics and spinal surgery, which created additional complexity. He stated that the Trust continued to work with the Independent Sector but that was not the main challenge, and rather the requirement for specialist work which required associated HDU facilities. He added that some mutual aid was being provided by other specialist centres.

Mr Wakefield referred to being put in tier 1 and queried if regulators accepted the reasons for not improving performance until June. Mr Bytheway referred to the weekly meetings which considered the position and stated that the national target remains zero and therefore the Trust needed to reach this as soon as possible.

Dr Griffin queried if the Trust had a daily tally of performance and queried what level of mitigation had been factored into the position. Mr Bytheway stated that performance was tracked twice a week due to the small numbers of patients, via

	the planned care oversight group and the mitigation in place was the theatre improvement plan, working with insourcing teams and working with the Independent Sector, as well as ensuring patients had their diagnostics in a timely manner. Mr Bytheway added that until a patient had been formally accepted by the Independent Sector or for mutual aid with an agreed date of admission, they were not taken off the waiting list. Professor Maddock queried if the impact of the strike action had been modelled into the trajectory and Mr Bytheway stated that this had not been included, although the last action did not significantly deteriorate the position. However, it was expected to be different for this strike action and he confirmed that day cases had started to be cancelled. Mr Bytheway highlighted the change in diagnostics performance particularly ultrasound performance. He added that endoscopy continued to be an area of focus which included identifying an associated improvement plan. Mrs Haire highlighted the following in relation to workforce performance: • Turnover remained below target • Vacancies, sickness and PDR rates had improved • A number of open days had been held including one for maternity whereby 30 new starters were recruited on the day and other possible candidates were being interviewed for other positions. A further open day had been held at Newcastle and Stafford College Mr Wakefield welcomed the success of the open day and Professor Crowe welcomed the innovative actions being taken at the recruitment days to appoint staff. Mrs Haire confirmed that the success of the open days continued to be publicised and communicated. Mr Oldham highlighted the following in relation to financial performance: • The Trust delivered a break even compared to the planned surplus of £1.2 m • The run rate continued to be positive and the Trust was expected to achieve the forecast break even position at year end • In terms of capital, the Trust was slightly behind but mitigation was in place and a lot of activity was expected in month 12 due to the bringing forward of equipment spend Mr Wakefield welcomed the work undertaken to deliver the expected break-even. Mr Oldham added that the system financial plan for 2023/24 was expected to be £40 m deficit, but this included a number of significant assumptions which held some risk. He stated that the deficit was expected to be allocated across providers with the UHNM share expected to be less than £10 m although this remained subject to discussion. **The Trust Board received and noted the report.**	
CLOSING MATTERS		
13.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
060/2023	It was noted that the business cycle would be confirmed at the meeting in May as part of the Rules of Procedure, to enable this to be updated following the conclusion of the Committee Effectiveness reviews.	
14.	**Questions from the Public**	

	Mr Syme referred to the recent CQC maternity visit and referred to the national shortage of midwives. He referred to the Board meeting in January 2023 where it was explained that 22 new midwives commenced work at UHNM in October 2022 and the next 'intake' in February 2023 would mean UHNM would attain minimum safe staffing levels in maternity. He queried if maternity minimum safe staffing levels had been attained at UHNM. Mrs Riley referred to the business case which had been agreed to fund to Birthrate+ requirements. She stated that at that time staffing was significantly short, therefore a trajectory was put in place to address the gap which was expected to take until Summer 2023. She confirmed that the Trust was on track to meet the trajectory and any gaps were being filled by temporary staffing. Mr Syme referred to the Board Assurance Framework paper presented to the meeting in February 2023 whereby delayed induction of labour was identified as a significant risk with extreme risk ratings. He referred to the Staffordshire and Stoke Integrated Care Board (ICB) meetings in November 2022, January and March 2023 whereby risks were highlighted regarding the delays in Induction of Labour at UHNM. He stated that the CQC in reports of maternity services elsewhere in England had also indicated that such delays are deeply concerning and queried the actions being implemented to reduce both delays.	
061/2023	Mrs Riley referred to the earlier backlogs in terms of induction of labour in 2022 which was similar to all maternity units and added that this was compounded by pressures in neonatal services. She stated that the Trust had commenced work with the Local Midwifery and Neonatal Systems (LMNS) and NHS England to understand what could be done to make Trust systems and processes more efficient in order to reduce delays. She stated that as such the position had since improved which had been recognised by the LMNS and ICB Chief Nurse. It was noted that further work was required, but the foundations were in place and in terms of reducing the risk, the Trust needed to be assured that sustained improvement had taken place. Mr Syme referred to UHNM being an outlier for neonatal mortality and queried when the business case was likely to be finalised, to assist with mitigating the risk. Dr Lewis stated that the business case was being prepared for medical staffing which would establish whether adequate staffing was in place as well as determining whether an expansion of the workforce would be required. He stated that he expected the case to take a couple of months to go through the associated governance process. Mr Syme referred to the Quality Governance Committee Report and readmission rates being higher than expected. He queried if there was indication as to why this was happening in the specific areas identified especially Paediatrics. Dr Lewis stated that measure against comparator Trusts was undertaken routinely and this had identified that further detail was required for readmission rates in particular within paediatrics, as patients on certain pathways may require regular re-attendance and it has been queried whether this was being classed as a readmission, therefore this analysis remained ongoing.	
DATE AND TIME OF NEXT MEETING		
15.	**Wednesday 3rd May 2023, 9.30 am, in the Trust Boardroom, Third Floor, RSUH**	

Trust Board (Open)

Post meeting action log as at 27 April 2023

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/546	08/06/2022	Integrated Performance Report - Month 1	To take an update to a future QGC meeting regarding measuring the impact on patients who had not received appropriate sepsis screening within the Emergency Department	Ann-Marie Riley	~~02/03/2023~~ 27/04/2023	05/04/2023	Provided to QGC and a further update is to be provided in August.	B
PTB/569	09/11/2022	CQC Action Plan	To discuss the assurance map with Professor Crowe in order to highlight the work being undertaken to assess the adequacy of assurance.	Claire Cotton	~~31/01/2023~~ 31/05/2023		Target date moved - template drafted and discussed with AMR. Whilst the template continues to be populated CC to discuss the proposed approach with Professor Crowe.	GB
PTB/571	07/12/2022	Well-Led Self-Assessment	To update the document to include additional narrative for the actions within Section 6, including target dates and to discuss at a future NED meeting.	Claire Cotton Nicola Hassall	~~31/01/2023~~ 31/05/2023		The document has been updated to include additional narrative for the actions within Section 6. Target dates continue to be identified and initially scheduled for NED Away Day which was cancelled. Awaiting revised day for Away Day.	GA
PTB/572	07/12/2022	Q2 Maternity Serious Incident Report	To expand on the ethnicity chart within the report, to clarify reasons for increases and whether any themes reflected national themes. In addition to identify the associated denominators and the total number of deliveries per ethnic group.	Ann Marie Riley Donna Brayford	~~08/03/2023~~ 24/05/2023	05/04/2023	This was discussed at the Maternity QGC meeting in February. Additional information has been provided within the serious incident report and this would continue to be refined as required.	B
PTB/574	04/01/2023	Patient Story	To provide an update on the actions being taken to prevent deconditioning to a future meeting.	Matthew Lewis Amit Arora	05/04/2023	06/04/2023	Actions remain ongoing with regards to deconditioning, which includes considering equipment and promotional material which may be funded via charitable funds. In addition, the team is discussing the possibility of a pilot for an activity coordinator for the West Building and the Trust continues to utilise UHNM volunteers promoting patient activity. The Trust continues to raise the profile of deconditioning via taking part in such things as #ReconditionTheNation with 300 medals awarded nationally.	B
PTB/575	04/01/2023	Corridor Care	To identify key metrics associated with corridor care and report on these to future QGC meetings.	Ann Marie Riley	30/03/2023	27/04/2023	This has been included in the quarterly staffing paper to TAP/QGC which will be presented at the end of Q1.	B
PTB/577	08/02/2023	Integrated Performance Report – Month 9	To discuss pressure ulcer reporting with Professor Maddock	Ann Marie Riley	05/04/2023	06/04/2023	Complete.	B
PTB/578	05/04/2023	Patient Story	To confirm whether Mr Bodell had been invited to participate in the Hospital User Group	Ann Marie Riley	07/06/2023	27/04/2023	Complete.	B

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

April 2023

Part 1: Trust Executive Committee (TEC)

The Trust Executive Committee is next due to meet on 2nd May 2023.

Part 2: Contract Awards and Approvals

2.1 Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 14th March to 13th April, 7 contract awards, which met these criteria, were made, as follows:

- **Enhanced Primary Care: GP Federation Service extension up to 30/04/2023** supplied by North Staffordshire GP Federation, for the period 01.11.22 – 30.04.23, at a total cost of £564,767, approved on 20/02/2023
- **Franking Machine Postage Charges** supplied by Pitney Bowes, for the duration 01.04.23 – 31.03.24, at a total cost of £770,000, providing cost avoidance savings of £50,000, approved on 13/03/2023
- **National Blood Service** supplied by NHS Blood and Transplant, for the period 01.04.23 – 31.03.24, at a total cost of £4,100,000, approved on 16/02/2023
- **Supply of IV Fluids** supplied by Baxter Shared Services, Movianto, AAH, Fresenius Kabi, B Braun, TPS Healthcare, for the period 01.06.23 – 31.05.24, at a total cost of £764,951, approved on 20/02/2023
- **Additional Funds for Salary Sacrifice Home Electronics** supplied by Akira/Vivup, for the period 03.06.22 – 31.01.23, at a total cost of £971,000, approved on 06/03/2023
- **DaVinci XI Dual Console System Maintenance** supplied by Intuitive Surgical, for the period 01.04.23 – 31.03.28, at a total cost of £990,000, providing negated inflation from 01/04/24 onwards, approved on 13/03/2023
- **Respiratory Consumables – Breas** supplied by Breas, for the period 01.04.23 – 31.03.24, at a total cost of £556,012, providing negated inflation £924.98, approved on 09/03/2023

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

Histopathology Outsourcing of Laboratory Specimens and Reporting (eREAF 10554)

Contract Value	£3,202,500 incl. VAT
Duration	01/09/23 – 31/08/25
Supplier	Source Bioscience

The Trust Board is asked to approve the above eREAF.

2.2 Consultant Appointments – April 2023

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Consultant, Colorectal	New	TBC	TBC
Consultant Gastroenterologist	Vacancy	TBC	TBC
Locum Plastic Surgeon	New	TBC	TBC
Consultant Thoracic Radiologist	Vacancy	TBC	TBC
Specialist Doctor in Cellular Pathology	New	TBC	TBC

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Consultant Benign Upper GI Surgery	New	Yes	TBC
Consultant MSK Radiologist	Vacancy	Yes	TBC
Imaging Consultant - Neuro Radiologist	New	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Specialist Doctor in Vascular Surgery	New	19/04/2023
Consultant in Gynaecology Oncology	Extension	27/04/2023
Consultant Orthopaedic Surgeon	Extension	27/04/2023
Consultant Gastroenterologist	Extension	01/04/2023
Medical Examiner	Vacancy	01/04/2023
Consultant Urologist	Vacancy	01/04/2023
Consultant Urologist	Vacancy	01/04/2023
Locum Consultant T&O / General Anaesthetist	New	03/04/2023
Locum Consultant Obstetrician and Gynaecologist	Extension	01/04/2023
Consultant Intensivist	Vacancy	03/04/2023
Consultant Geriatrician with an interest in Ortho Geriatrics	Extension	06/04/2023
Consultant Fetal Medicine Obstetrician	Extension	11/04/2023
Locum Consultant Cardiothoracic Anaesthetist	New	13/04/2023

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

Post Title	Closing date	Note
Respiratory Consultants with Specialist Interests	14/04/2023	No Applications

2.3 Internal Medical Management Appointments – April 2023

The following table provides a summary of medical management interviews which have taken place during April 2023:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Foundation Training Programme Director	New	TBC	TBC

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

Post Title	Reason for advertising	Start Date
Deputy Medical Director	Vacancy	01/04/2023

There were no medical vacancies which closed without applications / candidates during April 2023.

Part 3: Highlight Report

National / Regional

3.1 Centre of Excellence for Myeloma Care

I was delighted to be informed we have received a Centre of Excellence Award for the service provided by our Myeloma team. The reviewing team commented on the excellent service provided to our patients and stated that the award was well deserved. A plaque presentation is being organised with our Communications Team and the good news will also be shared via the Myeloma Spotlight newsletter and on social media.

3.2 NHS Pastoral Care Quality Award

We have also been award the NHS Pastoral Care Quality Award for International Nurses and Midwives. The award was given in recognition of our work in international recruitment and our commitment to providing high quality pastoral care to internationally recruited nurses and midwives during the recruitment process and their employment.

3.3 NHS Chief Executive's Meeting

During the month I attended the national NHS meeting of all Chief Executives from providers and Integrated Care Boards. While everyone was clear about the challenges facing the whole of the NHS, improvements nationally are being made in terms of reducing elective waiting times, cancer care being delivered faster and the number of ambulances having to wait at hospitals to offload patients. There is recognition that there is a great deal of work still to do but there are signs that patient delays are reducing and the NHS is heading in the right direction. The national team took time to thank everyone working in the NHS for their efforts.

Amanda Pritchard also took the opportunity to launch the NHS Impact – Improving Patient Care Together. NHS England has launched a new framework for quality improvement and delivery, including a national improvement board that will pick a small number of shared national priorities on which NHSE, with providers and systems will focus our improvement-led delivery work.

The review says NHSE will, among other actions:

- Create a national improvement board to agree a small number of shared national priorities and oversee the development and quality assure the impact of the NHS improvement approach;
- Set an expectation that all NHS providers, working in partnership with integrated care boards, will embed a quality improvement method aligned with the NHS improvement approach;
- Incentivise a universal focus on embedding and sustaining improvement practice, including with regulatory incentives alongside clearer and more timely offers of support; and
- Work with the [Care Quality Commission] to align the revised CQC well-led [inspection method] with the improvement approach.

The review also looked at how NHSE works with poorly performing organisations.

It will review its oversight framework – under which systems and trusts are rated from 1 (best) to 4 (worst) according to a range of measures – including how national and regional teams more consistently support organisations in segment 3 and offer longer-term support to organisations exiting segment 4.

System Focus

3.4 Chief Executive – Staffordshire County Council

Patrick (Pat) Flaherty has been appointed as Chief Executive of Staffordshire County Council. Pat is currently Chief Executive at the London Borough of Harrow, and previously served as Chief Executive of Somerset County Council for almost a decade. Pat was born and raised in Staffordshire with an excellent track record of local government experience and leadership. Pat replaces John Henderson, whose leadership has helped steer the council through a hugely challenging period.

I look forward to welcoming Pat when he takes up the post in the summer.

3.5 Nursing Research

We have been contacted by the Regional Chief Nurse at NHS England Midlands about what steps we might take regionally to begin a nursing development journey for Chief Nurses and Directors of Nursing. As a highly respected nurse researcher and innovators, our Chief Nurse has been asked to support this work which is linked to the excellent work we have undertaken through the establishment of CeNREE.

3.6 Executive Meeting with Combined Healthcare

As part of our ambition to work with partners across the system, we held an executive to executive meeting with North Staffordshire Combined Healthcare. On first impression there may not appear to be many opportunities for collaborative working as they are a mental health trust, however, we are already looking at how we can work together on research and development programmes and we are keen to support their work on integration with primary care. In addition, we want to work together on how we can all better support patients with mental health issues, especially those requiring urgent care needs who also need acute hospital care. We are also considering further opportunities around our enabling services and how we can support our Integrated Care Board to reduce their workforce costs. I will provide further updates as we continue to forge exciting new partnerships.

Organisational Focus

3.7 Staffordshire Children's Hospital

During the month we have celebrated a relaunch of our Staffordshire Children's Hospital. I met the team and introduced Rachel Reeves MP, Shadow Chancellor the Exchequer. It was lovely to be able to showcase the great work they do every day. Rachel joined us for an impromptu visit and took the opportunity to talk to many colleagues during her visit, which included the children's wards, imaging and the emergency department at Royal Stoke. Thank you to those who took part as I am aware that these visits often take time out but can be important in raising awareness of our successes.

3.8 Students Awarded First Class Honours

We recently received correspondence from the course lead at Staffordshire University highlighting that 13 students from UHNM have received first class honours nursing degrees and 7 with good degrees at 2:1. This was described as a huge achievement for the individuals involved but also for UHNM who have been instrumental in supporting their journey. We are looking at ways that we can celebrate their success.

3.9 RACE Equality Code Kite Mark

Again I was delighted to receive news that we have been awarded our RACE Equality Code quality mark, following completion of a detailed assessment process which we have previously advised board of. This was a rigorous assessment process which looked at where we were against best practice, national benchmarks and standards and what we had dome to date. We were then supported to develop a plan of action to support us moving forward. The quality mark demonstrates our commitment to driving forward clear action to address racial inequalities.

3.10 Junior Doctors Strike Action

Following the junior doctors strike action we saw an increase in the number of patients using our emergency departments. What is really pleasing to be able to report is that we have continued to ensure that ambulance crews are able to offload patients quickly and the numbers of people facing delays in the emergency department is also reducing. We are by no means there yet but all of the focussed effort by ward teams, divisions, the emergency team, site team, portering colleagues and more is having an impact. My thanks go to all staff for their continued effort in playing their part in delivering outstanding care to our patients.

Quality Governance Committee Chair's Highlight Report to Board

27th April 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Capacity within the Resuscitation Department to meet training demand, further compounded by recruitment challenges; a business case is being developed and a broader paper on Essential to Role training is being taken to TAP • C Difficile rates were above trajectory during quarter 4, emergency portals missed the 90% target for Sepsis screening and treatment within one hour and there was one ward closure for confirmed Norovirus in February • Vacancy rate for nurses and midwives is around 14% with £6.1m being spent on agency nursing during 2022/23 and the financial impact of increasing budgeted establishment in line with RCN recommendations would be circa £3.7m (at mid band 5) • Duty of Candour compliance for evidence of written notification remains below target although some improvement has been seen in uploading the letter to Datix • During quarter 4 there were 18 Care Excellence Visits and of those, 5 areas saw a decline in their rating (3 subject to validation) although this was anticipated as a result of the strengthened process • Section 29a received from the Care Quality Commission in relation to Maternity and Midwifery Services (following a national programme of visits) around timeliness of triage and induction of labour, with a requirement to provide evidence of significant improvement by 30th June 2023 – final report is awaited and will be used to inform the action plan • 7 Must Do and 9 Should Do actions within the Care Quality Commission action plan were highlighted as being either problematic or delayed against their target date for completion – Statutory and Mandatory Training was highlighted as a particular concern	• An ongoing action plan is in place and monitored by a PLACE Working Group which addresses any improvements identified which includes patient food testing • A business case will be developed to increase capacity within the Resuscitation Department and a training room has been identified to support ongoing training delivery – the Committee supported the development of a this case • Consideration will be given through the Clinical Group around future monitoring of Covid • An action plan is in place to improve Sepsis compliance and an ED consultant has been invited to join the working group • The latest staffing establishment review provided opportunity for Divisions to identify an uplifts needed and these will need to be developed into business cases, which the Committee supported but recognised they would need to be prioritised • Further focus on the way in which Duty of Candour is evidenced in addition to uploading of the letter to Datix • Consistency of reporting will be included within the Quality and Safety Report as an additional indicator in line with the NHS Oversight Framework; further work will also be undertaken around a refresh of the KPI's and how they are measured • Further improvements have been made to the Care Quality Commission Action plan and this continues to be implemented • The CQC Action Plan has been subject to Internal Audit Review with a number of areas having been strengthened • Discussions remain ongoing regarding a Never Event within Trauma & Orthopaedics which may result in a de-escalation • A stakeholder engagement event was held to focus on the Quality Account which was positive
✓ Positive Assurances to Provide	**Decisions Made**
• Excellent scores above the national average across all but one (by a less than 1% margin) of the eight domains assessed as part of the PLACE Inspection • There were no MRSA bacteraemia reported during quarter 4 • A dedicated C Difficile Nurse has now been recruited which will support multidisciplinary review, education and support for each case and a new Sepsis Nurse Specialist is now in post and is supporting the Emergency Department • Improved response rate to the Friends and Family Test for Emergency Department and Maternity Services with positive feedback being received • Ward 8 has maintained their 5 year of Platinum Award via the Care Excellence Framework and are being held up as a model of good practice	• Approval of the Quarter 4 Board Assurance Framework • Approval of the Committee Terms of Reference and Membership (including Maternity)

Comments on the Effectiveness of the Meeting

- Well chaired, to time. Positive feedback in relation to the papers submitted and time for discussion where needed. Very welcoming approach to subject experts attending the Committee.

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	UHNM PLACE Results 2022	BAF 7	High 12	✓	Assurance	7.	CQC Action Plan	BAF 1	Ext 20	!	Assurance
2.	Resuscitation Update	BAF 1	ID26815	!	Assurance	8.	Quality & Safety Oversight Group Assurance Report	BAF 1	Ext 20	-	Assurance
3.	Infection Prevention HAI Report Q4 22/23	BAF 1	Ext 20	! ✓	Assurance	9.	Q4 Board Assurance Framework	-	-	-	Approval
4.	Nurse Staffing Establishment Review	BAF 1/3	Ext 20 Ext 16	!	Assurance	10.	Committee Effectiveness 2022/23 • Quality Governance Committee • Maternity Quality Governance Committee	-	-	-	Approval
5.	Quality & Safety Report – Month 12 22/23	BAF 1	Ext 20	! ✓	Assurance	11.	Draft Quality Account	BAF 1	Ext 20	-	Approval
6.	Care Excellence Framework Summary Report Q4	BAF 1	Ext 20	! ✓	Assurance						

3. 2022 / 23 Attendance Matrix

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

Attended | Apologies & Deputy Sent | Apologies

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd May 2023
Report Title:	CQC Action Plan	**Agenda Item:**	8.
Author:	Debra Meehan, Lead Nurse Quality & Safety		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 1	Delivering Positive Patient Outcomes	Extreme 20

Executive Summary

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

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

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

The CQC rated the following services:

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

On Tuesday 4th October 2022, the CQC conducted an unannounced visit to UHNM to review immediate actions taken. Although the CQC were satisfied that the Trust had made significant improvements in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital they still had serious concerns about the assessment, recording and mitigation of risks associated with acute mental health concerns in medicine at County Hospital and subsequently issued a Section 29A Warning Notice under the Health and Social Care Act 2008. The Trust was required to provide evidence of significant improvement in relation to the Section 29A warning notice by 26th January 2023.

Although the CQC rated the safe and effective domains for medical care at County Hospital Inadequate,

the overall ratings for both County Hospital and the Trust overall remains as 'Requires Improvement'. Overall, the Trust also saw improvement in two domains:

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

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

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

Must Do Actions

Must Do Actions	As at 27th January 2023	As at 21st April 2023
Total number of actions	34	**38**
Total number complete	25 (73%)	**26 (68%)**
Total number on track	2 (6%)	**5 (13%)**
Total number problematic	4 (12%)	**2 (6%)**
Total number delayed	3 (9%)	**5 (13%)**

5 Actions (13%) are considered to be "delayed", which is an increase from the previous quarter. This is due to applying increased rigour to the target dates for completion and assigning progress Rating against Target Date for Completion rather than the revised target date. Mitigating actions are summarised in the action plan.

Improvements are currently being focussed in the areas of:

- SLT service provision (A deep dive paper is being presented at QSOG/QGC in May 2023).
- Assessment of patients with Mental Health Needs and Vulnerabilities- Monthly audits are showing improvement and further data analysis will be available end April 2023.

Should Do Actions

Should Do Actions	As at 27th January 2023	As at 21st April 2023
Total number of actions	28	**33**
Total number complete	17 (61%)	**17 (52%)**
Total number on track	4 (14%)	**7 (21%)**
Total number problematic	3 (11%)	**3 (9%)**
Total number delayed	4 (14%)	**6 (18%)**

6 Actions (18%) are considered to be "delayed", which is an increase from the previous quarter. This is due to applying increased rigour to the target dates for completion and assigning progress Rating against Target Date for Completion rather than the revised target date. Mitigating actions are summarised in the action plan.

Improvements are currently being focussed in the areas of:

- Compliance with Statutory & Mandatory Training
- Investigation and Management of Serious Incidents within agreed timescales
- Review of formal complaints process

The CQC also conducted a focussed visit to Maternity Services on 7th March 2023. The full report is awaited, which will contain the Must Do and Should Do actions. Concerns were raised in two areas:

1. Due to timeliness of maternity triage.
2. Management of induction labour.

This resulted in the issue of a Section 29A Warning Notice under the Health and Social Care Act 2008, on 28th March 2023 (Attached).

Immediate mitigating actions were put in place as follows:

Timeliness of maternity triage

Immediate Actions

- Immediate relocation of Maternity Assessment Unit (MAU) waiting area in order to increase visibility.
- UHNM MAU Triage guidance changed from 30 minutes initial assessment to 15 minutes.
- Immediate further bank shifts allocated to allow allocation of second triage midwife.
- A doctor is now rostered to MAU for each weekday shift. Additional medical shifts at the weekend are also now being offered.

- During the weekend we will offer out additional shifts for MAU cover.
- Full team safety huddle at 09:00hrs now extended to 7 days a week rather than 5 days, with effect from 11th March 2023
- New MAU Safety Huddle introduced at 15:00hrs daily 7 days a week, to be attended by MAU midwife in charge, flow-coordinator and inpatient matron. The huddle now includes the correct use of Birmingham Symptom Specific Obstetric Triage System (BSOTS) Board, the breach of triage assessment tool and the breach of medical review by priority rating tool. Identify and action as required, to include escalation to the senior leadership team or to on-call manager (out of hours)
- With effect from 11th March 2023, an update from the daily MAU Safety Huddle is given to the Maternity Escalation Group. This group includes the Chief Nurse, Divisional Associate Director, Director of Midwifery, Deputy Director of Midwifery, Directorate Clinical Director, Obstetric Clinical Lead, and Divisional Medical Director.
- 2 hourly oversight walkabouts/ assurance audit on MAU by a member of the senior leadership team daily, 7 days a week.
- BSOTS training package sent to all midwifery and medical staff on 10th March 2023.
- Clinical Education team allocated to support re enforcement of BSOTS training, with effect from 14th March 2023.
- Sarah Kenyon, National BSOTS lead, from Birmingham Women's Hospital asked to attend to perform a formal review of use of BSOTS at Royal Stoke University Hospital.

Actions already in progress:

- MAU breaches already part of escalation process, included in revised escalation guideline (currently in draft).
- MAU triage breach reporting already part of 09:00hrs Safety Huddle.
- Request to proceed for business case in draft (Increase in Obstetric Medical Cover)
- Quarterly MAU Triage Audit performed and shared with directorate, division and Executive team.
- Task and Finish steering group in progress to move activity of patients experiencing reduced foetal movements from MAU to Ante-natal Clinic. Estates commissioned to facilitate transfer. Urgency now escalated to Executive team.
- MAU Triage Assessment currently a divisional 'Watch Metric', utilising our Improving Together Quality Improvement methodology.

Management of induction labour

Immediate Actions

- With effect from 14th March 2023, prioritisation of inductions of labour will now take place at 08:30hrs daily prior to 09:00hrs Safety Huddle, so the risks can be discussed by the MDT at the Safety

Huddle. SOP to be amended to include revised timing of prioritisation. This process previously took place after the safety huddle and is why this was not observed during the inspection. Previously, this information was discussed between the Delivery Suite Co-ordinator, Inpatient Matron and the Lead Midwife for Inductions of Labour.

- With effect from 11th March 2023, an update from the daily MAU Safety Huddle, including management of induction labour, is given to the Maternity Escalation Group. This group includes the Chief Nurse, Divisional Associate Director, Director of Midwifery, Deputy Director of Midwifery, Directorate Clinical Director, Obstetric Clinical Lead, and Divisional Medical Director.

Actions already in progress

- NHSE/I and LMNS support offer accepted. Task and Finish group in progress with NHSE/I, LMNS, Maternity Neonatal Voice Partnership (MNVP), representative from all clinical areas.
- Deferred induction of labour is a divisional driver metric, utilising our Improving Together Quality Improvement methodology.

Place Work stream:

- Conversion of Midwife Birth Centre side rooms to Induction suite from 4 bedded bay to improve women/ birthing people's experience of induction. Equalities Impact Assessment performed to consider the impact of change of use.

Guidelines/Policy Work stream:

- Induction of labour (IOL) guideline revised in line with regional framework for gestational age and induction of labour including management of post-mature women/birthing people in line with NICE guidance.
- Escalation policy and IOL guidelines amended to include trigger point for divisional escalation/ regional escalation/ mutual aid request.
- Induction of Labour Prioritisation SOP continues to be developed. Daily prioritisation of all women awaiting induction of labour is completed by Consultant and Delivery Suite Co-ordinator in accordance with UHNM guidance. All women/birthing people contacted and safety netted and given the option to attend MAU for CTG.

People Work stream

- Business Case approved to secure budgeted establishment to birth rate plus assessment.
- Business Case in progress to align theatre staffing model with Association for Perioperative Practice (AFPP) guidance.
- Recruitment of Induction of Labour specialist midwife
- Maternity Neonatal Voice Partnership (MNVP) developing patient information leaflet for women who are having induction of labour.

Referral Process work stream:

- Electronic booking system implemented (previously paper) to include referral system, triage process and booking process.
- Twice weekly consultant MDT set up to review weekly inductions overview.
- Transition to 7 day booking system.

Delivery Suite Activity Work stream:

- Review of management of theatre activity list, Non–clinical hours agreed for Theatre Lead Midwife to manage caesarean section list.
- Agreed to participate in trial of mechanical method of induction, i.e Dilapan.

The Trust is required to provide evidence of significant improvement in relation to the Section 29A warning notice by 30th June 2023.

Key Recommendations

The Trust Board is asked to note the contents of the CQC action plan and the Section 29A Warning Notice relating to maternity Services.

CQC Action Plan 2022/23

As at 27 April 2023

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

Date of Visit	Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Number of times target date has changed	Current Progress Rating (As against Target Date for Completion not revised target date)	Date Completed	Assurance Mechanism	Assurance Based Progress Report	Audit results/compliance data (where appropriate)	Evidence Submitted	Responsible Committee / Group
Aug-21	A1	SAFE	Royal Stoke	Medicine	Urgent and Emergency	The Trust MUST ensure that there are enough suitably qualified, competent, skilled and experienced medical staff on each shift to deliver safe and effective care and treatment. **Regulation 18 (1)**	The Directorate will develop a Standard Operating procedure to mitigate gaps in the ED Medical Staffing Rota.	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete				Feb-22	Staffing figures Number of incidents relating to staffing levels	•SOP in use •New Rota System commencing in June 2022 which will demonstrate skill mix and gaps •Agreed rates of pay for rota cover		- ED Medical Vacancy Rates - Actual vs Planned Staffing - Medical staff tier rota - Staff turnover rates - Consultant cover for ED - Updated business case - Active training programme for Tier 3 - Monthly rota meetings - Seasor programme information - % Locum Cover	Quality Safety Oversight Group Quality Governance Committee
							The Directorate will continually monitor gaps in the rota and associated mitigation by the ED Senior Leadership Team.	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete				Oct-22	Staffing figures Number of incidents relating to staffing levels	•SOP in use •New Rota System commencing in June 2022 which will demonstrate skill mix and gaps •ANP's to be included on new rota as per Royal College Guidance			Quality Safety Oversight Group Quality Governance Committee
							The Directorate will introduce Emergency Department Operational and Safety Huddles (8 times each day)	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete				Feb-22	Minutes / actions from Safety Huddles	•Actions from huddles documented by progress chaser (in hours)			Quality Safety Oversight Group Quality Governance Committee
							The agreed actions to mitigate the risk to patient safety from Medical Staff Shortages in ED will be included as points of consideration for the ED Safety Huddles	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete				Feb-22	Staffing figures Number of incidents relating to staffing levels	•Medical staffing gaps also discussed three times daily at the Junior Doctor Handovers in a structured WHO checklist style approach			Quality Safety Oversight Group Quality Governance Committee
							To recruit to the approved establishment in the ED business case	Richard Hall Clinical Director Debbie Lowe Associate Directorate Manager	Complete				Mar-22	Recruitment against plan monitored through CQC action plan oversight group	•Junior and Middle Grade Medical Staff recruitment completed •A successful focus upon Consultant and Paediatric ED Consultants •Training Programme in place for Tier 3 to Tier 4 development			Quality Safety Oversight Group Quality Governance Committee
Aug-21	A2	SAFE	Royal Stoke	Medicine	Urgent and Emergency	The Trust MUST ensure they provide patients with a first assessment within 15 minutes of arrival to the ED in line with the conditions placed upon their registration. **Regulation 12 (1) (2) (a)**	Compliance with the 15 minute assessment times will be monitored following implementation of the new model that was developed following successful Emergency Department Test of Change.	Rebecca Viggars Deputy Associate Director	Dec-22	Dec-23	2			triage time data	•Ongoing Development of Enhanced Primary care service to afford UHNM autonomy of triage and recruitment. Plans for integration of EhPC and Out of Hours service •Relocation of Ambulatory patients close to triage to facilitate senior decision make support to triage •Development of Fit to Sit area • SOP recirculate to reception to outline their responsibilities • Ongoing discussions with the team regarding the actions required to further improve up on current triage performance **•Application to remove/vary section 31 made to CQC on 14/04/2023**	**• As of 14/04/2023 current performance for all ED patients is circa 67.5%, which is above regional average.**		Quality Safety Oversight Group Quality Governance Committee
							Compliance with the 15 minute assessment time will be reported to the CQC on a monthly basis in line with the Section 31 conditions placed upon our registration.	Rebecca Viggars Deputy Associate Director	Complete				Feb-22	Monthly Section 31 Reports	•Monthly Section 31 Reports available **•Application to remove/vary section 31 made to CQC on 14/04/2023**	**•As of 14/04/2023 current performance for all ED patients is circa 67.5%, which is above regional average.**		Quality Safety Oversight Group Quality Governance Committee
Aug-21	A3	SAFE	Royal Stoke	Medicine	Urgent and Emergency	The Trust MUST ensure that patients are risk assessed appropriately, in a timely way and provide mitigation for risks when identified. **Regulation 12 (1) (2) (b)**	The Trust will implement the new Triage Model that was developed following successful Emergency Department Test of Change	Joanne Allen Matron	Complete				Jun-22	Clinical audit of Documentation CEF	•New triage model in place •Successful recruitment to triage nurse posts		- Emergency Medicine CEF Report - April 2021 - Emergency Medicine CEF Report - April 2022 - Emergency Medicine CEF Action Plan - April 2022 - Emergency Medicine weekly catch up report - Trust Winter Plan - Crisis Care Centre - SOP - Monthly Section 31 report	Quality Safety Oversight Group Quality Governance Committee
							The Directorate will conduct harm reviews for patients experiencing long ambulance and trolley waits in order to identify any potential harm and areas for improvement in the standard of care delivered	Joanne Allen Matron/ Debra Meehan lead Nurse - Quality & Safety	Complete				Nov-22	Review of incidents relating to harm in the ED Department	•Harm Review Process in place supported by the Corporate Nursing Team •Summary Reports presented to patient Safety Group •Plan to redesign process in relation to new National Standards			Quality Safety Oversight Group Quality Governance Committee
							To review the MH proforma and actions to include the risk assessment of MH patients behind the cubicle doors	Joanne Allen Matron	Complete				Jan-23	Review of incidents relating to harm in the ED Department	•SOP developed for assessment of MH patients and included within the MH proforma • Business case has been rewritten and is going through the governance process			Quality Safety Oversight Group Quality Governance Committee
							Directorate Governance Meetings will ensure that all incidents are discussed in a timely manner and mitigating actions are put in place	Joanne Allen Matron	Complete				Jun-22	Meeting agenda Meeting minutes Review of incidents	•Meeting notes available •Incident reviews undertaken			Quality Safety Oversight Group Quality Governance Committee
							The Directorate will continue the daily Matron CEF reviews supported by the corporate nursing team assurance process	Joanne Allen Matron	Complete				Jun-22	Clinical Audit of Documentation	•Daily CEF reports available •Toolkit incorporated into Tendable process			Quality Safety Oversight Group Quality Governance Committee
Aug-21	A4	SAFE	Royal Stoke	Medicine	Urgent and Emergency	The Trust MUST ensure patients are kept safe from infection and avoidable harm and staff receive appropriate guidance and support to enable them to do this. **Regulation 12 (1) (2) (h)**	Infection Prevention poster which describes correct PPE for red and green areas to be displayed through ED	Joanne Allen Matron	Complete				Jun-22	Review of incidents relating to harm in the ED Department	•PPE Posters in place		- Emergency Medicine CEF Report - April 2021 - Emergency Medicine CEF Report - April 2022 - Emergency Medicine CEF Action Plan - April 2022 - Emergency Medicine weekly catch up report - Nurse in Charge Checklist - 06.02.2023 - Nurse in Charge Checklist - 07.02.2023 - Nurse in Charge Checklist - 08.02.2023 - Nurse in Charge Checklist - 09.02.2023 - Environmental Audit 09.02.2023 - Environmental Audit 14.02.2023	Quality Safety Oversight Group Quality Governance Committee
							The Directorate will ensure that all staff receive updates in PPE training/mask fit training, according to latest National Guidance	Joanne Allen Matron	Complete				Oct-22	Training figures	•Training programme in place			Quality Safety Oversight Group Quality Governance Committee
							Weekly CEF reviews to include equipment cleaning checks	Joanne Allen Matron	Complete				Jun-22	Environment Audit Results	•Audit results available			Quality Safety Oversight Group Quality Governance Committee
							The risk register will be updated to include all current risk relating to the ED Department	Richard Hall Clinical Director Joanne Allen Matron	Complete				Jun-22	Escalation paper to Divisional Governance Group	•Risk Register Review Process in place			Quality Safety Oversight Group Quality Governance Committee

Date of Visit	Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Number of times target date has changed	Current Progress Rating (As against Target Date for Completion not revised target date)	Date Completed	Assurance Mechanism	Assurance Based Progress Report	Audit results/compliance data (where appropriate)	Evidence Submitted	Responsible Committee / Group
Aug-21	A5	SAFE	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	the Trust **MUST** ensure all risks are appropriately identified, assessed and mitigation put in place where possible. **Regulation 17 (1)**	The Directorate will develop a harm review process	Richard Hall Clinical Director Joanne Allen Matron	Mar-23	Sep-23	1			Outcome of harm reviews	• Process in place to review harm for patients who have been subject to a long wait (i.e. 12 hour breaches, ambulance handover delay, Your Next Patient and Corridor Care) •Due to high numbers of 12 hour breaches, process currently being revised • CQC and ICB Chief Nurse invited to the Trust on 18th January 2023 to review safety measures in place for Corridor Care and Your Next Patient - positive feedback received.			Quality Safety Oversight Group Quality Governance Committee
Aug-21	A6	SAFE	**County**	**Medicine**	**Medical Care**	The Trust must ensure associated with acute mental health needs are assessed, recorded and mitigated. **Regulation 12 (1) (2) (a) (b)**	The Trust will further develop the ED Mental Health Assessment Tool to accompany the patient on admission and facilitate ongoing mental health assessment in assessment and ward areas.	Kirsty Smith Matron Vulnerable Patients	Complete				Jun-22	Clinical Audit of the Mental Health Assessment Tool Review of incidents relating to the provision of mental health assessments	• ED mental health assessment tool has been reviewed and updated • Review of the ward risk assessment booklet undertaken and all of the checklists relating to Mental Health/Dementia/Learning Disability and Autism have now been simplified and amalgamated and sit under the Vulnerable patient banner, at the front of the booklet. This includes Vulnerable Patient trigger questions and a nursing risk assessment related to mental health. This assessment supports the Registrant to make a judgement regarding whether the patient will require close supervision due to harm to themselves or potential harm to others.	**• Audit results are showing improvement and final analysis will be available end April 2023. As of 26th April 2023, compliance with ED Mental Health Proforma has improved to 60% and completion of ward checklists to 80%.**	- 7 day patient risk assessment booklet - MH training compliance data split by unit and staff group. - Evidence of information sharing/ learning undertaken with staff on medical wards other than AMU to ensure staff are familiar with the MH proforma - 3 sets of minutes for the MH and LD group - learning from internal and external reviews relating to mental health, MCA/ DOLS - outstanding practice relating to the care of patients with a diagnosis/ symptoms of MH. - Incident reports relating to MH patients on medical wards in the last 3 months and action plans - Re-audit of Mental Health Assessment Tool – Report - Project Brief – Audit of Mental Health Act Policy	Mental Health Working Group Trust Mental Health & Learning Disability Group Quality Safety Oversight Group Quality Governance Committee
							The Trust will report and monitor the number of mental health referrals via the Mental Health & Learning Disability Trust Group, which has representation from all clinical divisions, the mental health liaison team and psychiatric liaison team. Areas of escalation and assurance will be reported into the Trust Quality and Safety Oversight group.	Kirsty Smith Matron Vulnerable Patients	Complete				Jun-22	Mental Health & Learning Disability trust Group agenda and minutes Quarterly performance reports that are submitted by the Liaison teams. Escalation report to the Trust Quality & safety Oversight group.	•Reporting process in place via Trust mental health & Learning Disability Trust group			Trust mental Health & Learning Disability Group Quality Safety Oversight Group Quality Governance Committee
							The Trust will further develop the current audit tool of the ED Mental Health Assessment Tool (Report published June 2020) to reflect its use through to AMU and all Ward areas. The Revised audit will be prioritised on the Trust Clinical Audit Programme 2022 / 2023	Kirsty Smith Matron Vulnerable Patients	Nov-22	Jun-23				Clinical Audit of the Mental Health Assessment Tool Review of incidents relating to the provision of mental health assessments Tendable audit data relating to the Mental Health Assessment Tool being acknowledged on the wards. VPT monthly audits at County.	• Corporate Audit Process in place •Planned rollout to other emergency portals and ward areas through Tendable CEF audit • Following the Section 29 notice, we have recruited a senior nursing post: Head of Nursing - County Hospital in order to continue to embed significant improvements in the assessment, recording and mitigation of risks associated with acute mental health concerns. The post holder will be responsible for conducting spot checks and initiating relevant actions to improve practice with regard caring for patients with acute mental health concerns, vulnerabilities and requirements for an interpreter	**• Audit results are showing improvement and final analysis will be available end April 2023. As of 26th April 2023, compliance with ED Mental Health Proforma has improved to 60% and completion of ward checklists to 80%.**		Mental Health Working Group Trust Mental Health & Learning Disability Group Quality Safety Oversight Group Quality Governance Committee
							Development of a Trust-Wide Harm Free Care Alert	Kirsty Smith Matron Vulnerable Patients	Complete				Feb-22	Review of incidents relating to the provision of mental health assessments	Complete			
Aug-21	A7	SAFE	**County**	**Medicine**	**Medical Care**	The Trust MUST ensure nutritional risk assessments and care plans are completed in line with their policy. **Regulation 12 (1) (2) (b)**	The Trust will relaunch a training programme emphasising key learning around assessing, managing and monitoring patients nutrition	Ann Griffiths Chief Dietician	Complete				Jan-23	Training compliance CEF visits	•Nutrition and Hydration awareness training delivered within new NA programme. •Update training delivered at County by dietetics team. •Ward based training targeted to AMU and FEAU at Royal Stoke. •Ward staff have requested a video training to be available, this is currently being investigated. •Training programme delivered in Key admission areas, presentation added to Dietetics section of intranet		- Message from Vital Pac - MUST training pack - Must training sign in sheet - Nutritional Bundle Booklet - Nutritional Care Plan - Nutritional Incident Report	Quality Safety Oversight Group Quality Governance Committee
							A Focus Group will be convened to review the current Nutrition bundle (evidence of care planning). Representatives from Ward teams and Dietetics will explore the barriers to its use, how we can revitalise and consider its digitalisation journey.	Ann Griffiths Chief Dietician	Complete				Oct-22	CEF Visits Clinical Audit of Nutritional Management	•Audit of completion compliance undertaken. •Focus group identified. • Initial feedback, wards are happy with the document. •Nutrition Bundle updated, with Harlow for first proof			Quality Safety Oversight Group Quality Governance Committee
							The Trust will develop a process of sharing Vital Pac reports detailing MUST compliance with Ward teams	Ann Griffiths Chief Dietician	Complete				Oct-22	CEF Visits Clinical Audit of Nutritional Management	•Dashboard developed by BI team, initial validation completed, •Changes made include actual MUST scores, and risk category in addition to MUST completion within 24hrs and rescreening compliance. • Approval agreed by deteriorating patient group •Nutrition Dashboard from Vital now approved and live in UHNM Report centre	**•Data for 12 months 18/4/2022-18/3/2023 and shows:** **77.5% of patients had an initial MUST assessment within 24 hours of admission** **2.3% of patients had an initial MUST assessment completed with 24-31 hours of admission** **20.2% of patients had an initial MUST assessment completed more than 31 hours after admission** **65.4% of patients had their MUST re-assessed within 7 days of admission.**		Quality Safety Oversight Group Quality Governance Committee
							In order to promote on-going monitoring around the assessment and management of nutrition, a spot check audit will be developed using the Tendable Audit Programme	Ann Griffiths Chief Dietician	Jul-22	Apr-23	2			Tendable Audit Spot Check results	• Tendable has been rolled out to County. First audit submitted by 31st December 2022 and being further embedded. • Tendable being rolled out to Royal Stoke January / February 2023 • Further data and assurance to be obtained in terms of completion of nutritional risk assessments/care plans			Quality Safety Oversight Group Quality Governance Committee
Aug-21	A8	SAFE	**County**	**Medicine**	**Medical Care**	The Trust MUST ensure patients receive timely swallow assessments. **Regulation 12 (1) (2) (a) (b)**	A position paper will be presented at the Acute Patient Flow group which will highlights the shortfalls in the service provision to inpatient medical wards, across both sites	Lois Dale Head of Speech and Language Therapy	Complete				Jun-22	Acute Patient Flow Group Minutes	•The position paper was presented to the Acute Patient Flow group in April 2022		- Speech and Language Therapy Team Structure - Workforce Review document	Quality Safety Oversight Group Quality Governance Committee
							The Trust will develop an education programme to support ward teams regarding 'what makes a good referral' and how to escalate referrals	Lois Dale Head of Speech and Language Therapy	Complete				Oct-22	Review of incidents relating to insufficient referrals Review of the number of rejected referrals	•Guidance has been developed to advise wards how to escalate referrals •Circulated via Comms			
							MNP/ANP nurse swallow screening training will be implemented at RSUH to support service provision. Consider rollout at County Hospital	Lois Dale Head of Speech and Language Therapy	Sep-22	Sep-23	2			Review of incidents relating to SLT provision at Ward level	• MNP training at RSUH took place in Jan 2021 and was completed successfully. •ANP training was undertaken in September 2021 •Training has not been offered to County ANP's to date due to ongoing limited SLT resources over at County. There has been recent recruitment within SLT which will support this development. Target date amended to reflect the delay in providing the training at County. **•Due to ongoing concerns about delay in achieving this action, a Deep Dive into SLT services to be presented at QSOG in May 2023**			Quality Safety Oversight Group Quality Governance Committee
							To explore the options available to obtain data from OrderComms, so that assurance can be provided that timely swallowing assessments are being undertaken.	Lois Dale Head of Speech and Language Therapy	Mar-23	Sep-23	1			Review of OrderComms Data	**•Due to ongoing concerns about delay in achieving this action, a Deep Dive into SLT services to be presented at QSOG in May 2023**			Quality Safety Oversight Group Quality Governance Committee

Date of Visit	Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Number of times target date has changed	Current Progress Rating (As against Target Date for Completion not revised target date)	Date Completed	Assurance Mechanism	Assurance Based Progress Report	Audit results/compliance data (where appropriate)	Evidence Submitted	Responsible Committee / Group
Aug-21	A9	SAFE	**County**	**Medicine**	**Medical Care**	The Trust MUST ensure Mental Capacity Act Assessments are consistently completed in a timely and responsive manner. **Regulation 11 (1) (2) (3)**	The Clinical Audit Programme will be reviewed to ensure that all audits relating to the delivery of care include questions around whether mental capacity should have/was assessed	Victoria Lewis Quality Assurance Manager	Complete				Jun-22	Clinical Audit results	The additional question has been added to all data collection forms throughout 2022 / 23. A total of 51 audits have been completed to date, and mental capacity status is not routinely documented unless the patient is admitted with a mental health co-morbidity. There is currently no trigger question in the Nursing Assessment booklet to prompt staff to consider mental capacity concerns if patients are admitted with none vulnerable patient issues. An audit of the provision of a mental capacity assessment tool was published in June 2022 looking at the care of patients admitted with mental health concerns e.g. self harm. A Mental Capacity Assessment Tool commenced in 27.5% cases. The Audit has been considered by the ED Governance Meeting and the Vulnerable Adults Safeguarding Group with the following actions identified to improve compliance: 1) The Education Team will provide a communication campaign to ensure all staff are aware of: - the importance of documenting the initial level of mental health risk and mental capacity - the importance of completing the Mental Health assessment Booklet 2) Grand Rounds focussing on MCA and MHA will be prioritised and advertised amongst all Junior Doctors		- CEF Refresh Document - DoLS Submitting Application Appendix - Huddle SOP - Interpreter Information - MCA and DoLS Audit - MCA Factsheet - Mental Health Ambassador Training Appendix - Monday Message - Risk Assessment Process - Audit of Falls - Audit of VTE - Safeguarding Dashboard - Safety Huddle Action Log - MCA & DoLS intranet pages - Tendable Audit Data (County) - UHNM Learning Alerts (x2)	Safeguarding Adult Working Group Trust Safeguarding Group Quality Safety Oversight Group Quality Governance Committee
							The following audits will be prioritised on the Trust Clinical Audit programme to monitor compliance with Trust Policy: Audit of the Mental Capacity Act Audit of Deprivation of Liberty	Victoria Lewis Quality Assurance Manager	Complete				Jun-22	Clinical Audit results	At the request of Lead for Vulnerable Patients, the 2 audits have been combined into one project to provide ease of data collection. The audit involves the provision of a clinical review and is currently in data collection. The audit is expected to be completed by March 2023. The audit will be considered by the Safeguarding Vulnerable Adults Steering Group and the Clinical Effectiveness Sub Group. and shared across all Divisions			Safeguarding Adult Working Group Trust Safeguarding Group Quality Safety Oversight Group Quality Governance Committee
							The Trust will introduce a template to remind / guide staff through the MCA assessment process	Sarah Curran Lead for Vulnerable Patients Zia Din Deputy medical Director	Complete				Oct-22	Clinical Audit results	A MCA template and guide is available on the MCA Intranet page. Consideration for the Mental Capacity assessment to be built as a structured note on Iportal. Monitor outcome through audit results			Safeguarding Adult Working Group Trust safeguarding Group Quality Safety Oversight Group Quality Governance Committee
							The Trust will undertake a baseline review of current training compliance in relation consent training. A trajectory of improvement will be developed and monitored	Sarah Curran Lead for Vulnerable Patients Dr Zia Din, Deputy Medical Director	Apr-22	Jul-23	2			Clinical Audit of the Consent Process	•A consent compliance clinical audit has been included in the audit programme and scheduled to be completed by July 2023 •Identify training needs and develop trajectory for improvement according to audit results **•a structured note re MCA assessments has been designed for iportal, this will be live from 24/04/2023**			Quality Safety Oversight Group Quality Governance Committee
							A review of the current training packages will be undertaken to ensure that any training around the provision of care to vulnerable patients, includes MCA information	Sarah Curran Lead for Vulnerable Patients Dr Zia Din, Deputy Medical Director	Apr-22	Jul-23	2			Training records compliance	•Completion of Training Needs Analysis •Plan to identify appropriate training materials •Monitor outcome through training records/audit of medical records			Quality Safety Oversight Group Quality Governance Committee
Oct 2022	A10	SAFE	**County**	**Medicine**	**Medical Care**	The trust must ensure that where required, mental capacity assessments and Deprivation of Liberty Safeguards applications are made in line with the trust policy and legal frameworks. (Regulation 11 Need for Consent)	A weekly status exchange will be introduced to gain assurance of compliance with completion of MCA, DoLS applications and MH proforma.	Rebecca Ferneyhough Head of Nursing Matron Stacey Boyjoo	Jun-23					Audit results	•Safeguarding team are completing monthly audits on the wards at County. Audit outcomes are shared with HON for County and Medicine division		Raw audit data from both teams Tendable Audit results	Safeguarding Adult Working Group Trust Safeguarding Group Quality Safety Oversight Group Quality Governance Committee
Oct 2022	A11	SAFE	**County**	**Medicine**	**Medical Care**	The trust must ensure that all required assessments including the mental health proforma and within 'seven-day patient risk assessment booklet' are completed as per trust processes. (Regulation 12 Safe Care and Treatment)	The Patient Risk Assessment booklet will be reformatted to clarify the required assessments and move them to the front of the booklet for ease of use	Kirsty Smith Matron for vulnerable patients Rebecca Ferneyhough Head of Nursing Stacey Boyjoo Matron	Jun-23					Audit results	•Vulnerable patient team are completing monthly audits on the wards at County. Audit outcomes are shared with HON for County and medicine division			County Mental Health Group Mental Health Working group Trust Mental Health & Learning Disability Group Quality Safety Oversight Group Quality Governance Committee
Oct 2022	A12	SAFE	**County**	**Medicine**	**Medical Care**	The trust must ensure that where enhanced or therapeutic observations have been identified as necessary within patient care plans, staff are sourced to cover these. (Regulation 18 Staffing)	The Trust will ensure that shifts with patients requiring enhanced observations are red flagged on Safe Care (E-Roster) and that additional staffing is requested by the Nurse bank. Unfilled shifts will be escalated to relevant matron	Stacey Boyjoo Matron Rebecca Ferneyhough Head of Nursing	Jul-23					Audit results	•Head of Nursing/Matron working with ward teams to ensure that correct processes are put in place to identify and escalate additional staffing needs			Matrons Daily Staffing Meetings Deteriorating Patient Group
Oct 2022	A13	WELL LED	**County**	**Medicine**	**Medical Care**	The trust must ensure they maintain oversight of performance and risks in relation to the medicine core service when supporting patients with acute mental health needs or cognitive impairment. In particular, the trust must ensure that all risks relating to the care of patients with mental health conditions or symptoms are captured on the risk register for the service and staff follow trust policies and processes. The service must also ensure that learning from serious case reviews, audits and incidents is shared and embedded across the trust. (Regulation 17 Good Governance.)	•Risks associated with supporting patients with acute mental health needs or cognitive impairment will be discussed on a monthly basis at Directorate/Divisional Governance Meetings	Stacey Boyjoo Matron Lisa Underwood Head of Nursing Jill Ayres Divisional Nurse Director	May-22					Governance Meeting Minutes	•To be agreed as regular agenda item			Directorate and Divisional Governance Meetings

CQC Action Plan 2022/23

As at 27 April 2023

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

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Oct-23	B1	Safe	**Trust wide**	**Corporate**	**Trust wide**	The Trust SHOULD ensure it reviews and investigates significant incidents in a timely manner and in line with Trust Policy	The Trust has developed a twice weekly Serious Incident review meeting to review new incidents and ensure that 72 hour reports and plans for investigation are confirmed	Jamie Maxwell Head of Quality, Safety and Compliance	Feb-22	Aug-23	1			Quality and Safety Report	•Action log available from twice-weekly meetings •Correspondence with ICB available for submitting Serious Incidents •New PSIRF approaches are being implemented in preparation for September 2023 timeframe **•Action reopened following CQC visit in October 2022**		Project Management Plan SI Review Tracker SI Subgroup Presentation	SI Review Group Risk management Panel Quality Safety Oversight Group Quality Governance Committee
							The Trust will work collaboratively with the local ICB to monitor timescales for submission on STEIS and to redefine the TOR of the SI Sub-Group	Jamie Maxwell Head of Quality, Safety and Compliance	Jun-22	Aug-23	1			SI Sub Group Presentation	•SI Sub-group presentations and SI Reports available **•Action reopened following CQC visit in October 2022** •Issue is completion of RCAs and not initial review of incidents	**• As at end February 2023 performance demonstrates 49 RCAs are awaited by the ICB (previously 53) and over the 60 days target**		SI Review Group Risk management Panel Quality Safety Oversight Group Quality Governance Committee
Aug-21	B2	Responsive	**Trust wide**	**Corporate**	**Trust wide**	The Trust SHOULD ensure all complaints are reviewed, investigated and responses are managed in a timely manner and in line with Trust policy	The Trust are reviewing the current formal complaints process to improve the quality and timeliness of reports and to streamline the sign off process	Debra Meehan Lead Nurse: Quality and	Oct-22	Jul-23	2			Complaints Report	•Complaint triage process in place •Electronic sign off process under development **•Pilot of Matron early involvement in formal complaint process commencing in Network Services Division in May 2023**			Patient Experience Group Quality Safety Oversight Group Quality Governance Committee
Aug-21	B3	Well Led	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD ensure that measures are in place to keep patients records secure.	To undertake a risk assessment and improvement plan associated with records storage in ED and subsequently progress digitalisation of ED records.	Joanne Allen Matron Diane Adamson Clinical Lead	Oct-23					Review of incidents around record management and storage	•Digitalisation of ED records under development •Any incidents and impact of mitigating actions continue to be monitored by Record Services Operational Group			Urgent and Emergency Medicine Directorate Governance Meeting
Aug-21	B4	Well Led	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD ensure there is a recovery process in place to ensure all staff complete mandatory training and essential role training	The Directorate Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Richard Hall Consultant Joanne Allen Matron	Oct-22	Aug-23	3			Training figures	•Protected time allocated for training •Trajectory for improved compliance with annual Stat/Mand training and 3 yearly Stat/Mand training in place **•Currently achieving 91.47% for annual training and 95.2% compliance for 3 yearly training** . Directorate concerns about ability to achieve 95% overall compliance due to ongoing operational pressures in addition to the national mandate to undertake Learning Disability/Autism training	**Currently achieving 91.47% for annual training and 95.2% compliance for 3 yearly training**	- Divisional Quality and Safety Meeting minutes - Emergency Department Training Figures	Urgent and Emergency Medicine Directorate Governance Meeting
							The Departmental rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Richard Hall Consultant Joanne Allen Matron	Complete				Oct-22	Training figures	•Protected time allocated for training			Urgent and Emergency Medicine Directorate Governance Meeting
Aug-21	B5	Safe	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD ensure all staff follow best practice when completing care records to ensure they are an accurate record of care and treatment provided	The Trust will introduce digitalised care records to ensure the provision of individualised, accurate care plans.	Richard Hall Consultant Joanne Allen Matron	Mar-23	Oct-23				CEF Clinical Audit of documentation	•Digitalisation of ED records under development			Urgent and Emergency Medicine Directorate Governance Meeting
							The Department will continue daily Matron CEF reviews supported by the Corporate Nursing Team	Joanne Allen Matron	Complete				Jun-22	CEF Clinical Audit of documentation	•CEF reports available			Urgent and Emergency Medicine Directorate Governance Meeting
Aug-21	B6	Responsive	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD consider how they can improve information management for certain patient groups	A review of current documentation will be undertaken to ensure the provision of standardised templates for electronic referrals and Medical/Nursing handovers	Richard Hall Consultant Joanne Allen Matron	Oct-23					Clinical Audit of documentation	•Digitalisation of ED records under development •Development of standardised handover forms/processes underway			Urgent and Emergency Medicine Directorate Governance Meeting
Aug-21	B7	Safe	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD consider how the current layout of the Department is impacting on the safe running of the Department	The Directorate will conduct a feasibility Study to explore options to mitigate risk of patients being nursed in majors cubicles with doors, from both an infection prevention and avoidable harm perspective	Richard Hall Consultant Joanne Allen Matron	Complete				Jun-22	Review of incidents relating to harm in the ED Department	•ED Department reconfigured and business case re-written for removal of cubicle doors in Majors		Emergency Medicine Business Case - Major Doors	Quality Safety Oversight Group Quality Governance Committee
Aug-21	B8	Well Led	**Royal Stoke**	**Medicine**	**Medical Care**	The Trust SHOULD ensure that it continues to work toward meeting trust targets for all mandatory training	The Divisional Management Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Jill Ayres Divisional Nurse Director Tony Cadwgan Divisional Medical Director	Sep-22	Aug-23	2			Training figures	•Trajectory for improved compliance with annual Stat/Mand training and 3 yearly Stat/Mand training in place •Currently achieving 93% compliance . Divisional concerns about ability to achieve 95% compliance due to ongoing operational pressures in addition to the national mandate to undertake Learning Disability/Autism training	**•Currently achieving 93% compliance .**		Directorate and Divisional Governance Meetings
							The Divisional rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Jill Ayres Divisional Nurse Director	Complete				Oct-22	Training figures	•E-Roster enables training time to be displayed			Directorate and Divisional Governance Meetings
Aug-21	B9	Effective	**Royal Stoke**	**Medicine**	**Medical Care**	The Trust SHOULD ensure that all wards display up to date audit results such as results from hand hygiene audits	Up to date audit results to form part of Tendable Ward audit system	Jill Ayres Divisional Nurse Director	Jul-22	Apr-23	2			CEF Visits, Tendable Audits	• Tendable has been rolled out to County. First audit submitted by 31st December 2022 and being further embedded. • Tendable being rolled out to Royal Stoke January / February 2023 •The audits undertaken on Tendable include the opportunity to provide photographic evidence of wards displaying the hand hygiene audits			Directorate and Divisional Governance Meetings
Aug-21	B10	Safe	**Royal Stoke**	**Medicine**	**Medical Care**	The Trust SHOULD ensure medical wards are provided with adequate storage space	Ward teams will be encouraged to take part in "Dump the Junk" initiatives	Mike Brown Head of Soft Facilities Management	Mar-23	Aug-23	1			CEF Visits	•Under Development • Target date reset due to the action moving over to the responsibility of Mike Brown			Directorate and Divisional Governance Meetings
							Ward Teams will be encouraged to adopt Lean Methodologies with regard to equipment/storage as part of their Improving together/Shared Governance projects	Estates Team / Medical Division Matrons	Complete				Oct-22	CEF Visits	•Included as part of Improving Together methodologies			Directorate and Divisional Governance Meetings
Aug-21	B11	Safe	**Royal Stoke**	**Medicine**	**Medical Care**	The Trust SHOULD ensure patient records are kept in a structured and consistent format so that staff can easily access them	The Trust will conduct an options appraisal of available standardised formats for health records	Alison Legan Patient Records Manager	Complete				Jan-23	Record Keeping Clinical Audit	•Meeting has taken place to consider the options available and determined that digitalisation of patient records will be pursued rather than implementing new paper records / folders. Discussions on going with ward clerks to ensure awareness of responsibilities for filing information		- Documentary Evidence re. standardised health records	Quality Safety Oversight Group Quality Governance Committee

Date of Visit	Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Number of Time Target Date has Changed	Current Progress Rating (As against Target Date for Completion not revised target date)	Date Completed	Assurance Mechanism	Assurance Based Progress Report	Audit results/compliance data (where appropriate)	Evidence Submitted	Responsible Committee / Group
Aug-21	B13	Responsive	**Royal Stoke**	**Medicine**	**Medical Care**	The Trust SHOULD ensure that waiting times from referral to treatment and arrangement to admit, treat and discharge to be in line with national standards	Monitor waiting times and assign mitigating actions through Directorate, Divisional and Corporate meeting structures	Divisional Leadership Team	Complete				Oct-22	Divisional Performance Report	Marked as complete. However, UHNM are not consistently achieving the national standards in terms of waiting times and specific workstreams are in place, which include actions to address and improve performance for both urgent and planned care. These actions are reported separately via the updates to Performance and Finance Committee.			Quality Safety Oversight Group Quality Governance Committee
Aug-21	B15	Safe	**County**	**Medicine**	**Medical Care**	The Trust SHOULD ensure all serious incidents are investigated effectively and in a timely manner to reduce the risk of future harm	The Division will ensure that immediate mitigating actions are identified and shared, following all Serious Incidents	Jill Ayres Divisional Nurse Director Dr Tony Cadwgan Divisional Medical Director	Apr-23					Quality and Safety Report	• There has been an improvement in the completion of 72 hour reports for serious incidents. • Further data is to be obtained to provide assurance that this is being undertaken consistently		- ED Governance Report - AMU Governance Report - General Medicine Governance Report - Quality Performance Report - Specialised Medicine Governance Report - Medicine Divisional Quality Assurance / Board Report	Directorate and Divisional Governance Meetings
							The Division will monitor timeliness of investigations and share learning through Divisional Governance Structures	Jill Ayres Divisional Nurse Director Dr Tony Cadwgan Divisional Medical Director	Complete				Oct-22	Quality and Safety Report	•Monitored through governance meetings and performance review packs			Directorate and Divisional Governance Meetings
Aug-21	B16	Safe	**County**	**Medicine**	**Medical Care**	The Trust SHOULD consider taking action to ensure key information about patients care in consistently recorded. For example, ensuring clear wound care plans are in place for all patients with a wound	A review of the proposed Clinical Audit programme will be undertaken to ensure that appropriate documentation audits are in place to review the standards of patient documentation and identify areas for improvement	Victoria Lewis Quality Assurance Manager	Complete		Oct-22		Jun-22	Clinical Audit Progress Report	Clinical Audit prioritised on the 2022 / 23 audit programme. The audit will review practice against Trust policy in relation to the timely completion of assessments and care plans. The audit results will be considered by the Tissue Viability Steering Group and the Clinical Effectiveness Sub Group. The report and actions will be shared across all Divisions. In addition to the annual audit, the timely completion of assessments is reviewed as part of the Care Excellence Framework. **During Q3, a Team visited 21 clinical areas. Only 1 area had gaps in compliance in relation to wound care documentation. The development and completion of an action plan to address shortfalls is supported and monitored by the Corporate Nursing Team.** **During Quarter 3, a total of 1051 none hospital acquired pressure ulcer / damage were identified in the Emergency Portals, providing ongoing assurance that staff are carrying out effective assessment**	**During Q3, a Team visited 21 clinical areas. Only 1 area had gaps in compliance in relation to wound care documentation. The development and completion of an action plan to address shortfalls is supported and monitored by the Corporate Nursing Team.** **During Quarter 3, a total of 1051 none hospital acquired pressure ulcer / damage were identified in the Emergency Portals, providing ongoing assurance that staff are carrying out effective assessment**		Clinical Effectiveness Group
							The Trust has developed a Wound Care Document. The document is currently being ratified and a roll-out plan is being finalised	Katie Leek Lead Nurse: Tissue Viability	Complete				Jan-23	Review of Tissue Viability incidents	•Proof document received and roll out plan in place			Quality Safety Oversight Group Quality Governance Committee
Aug-21	B17	Safe	**County**	**Medicine**	**Medicine Care**	The Trust SHOULD consider making the speech and language therapy service provision equitable across County Hospital	A position paper will be presented at the Acute Patient Flow group which will highlight the shortfalls in the service provision to inpatient medical wards, across both sites	Lois Dale Head of Speech and Language Therapy	Complete				Jun-22	Meeting Minutes	•The position paper was presented to the Acute Patient Flow group in April 2022			Quality Safety Oversight Group Quality Governance Committee
							The Trust will develop an education programme to support ward teams regarding 'what makes a good referral' and how to escalate referrals	Lois Dale Head of Speech and Language Therapy	Complete				Oct-22	Review of incidents relating to insufficient referrals Review of the number of rejected referrals	•Guidance has been developed to advise wards how to escalate referrals •circulated via Comms			Quality Safety Oversight Group Quality Governance Committee
							MNP/ANP nurse swallow screening training will be implemented at RSUH to support service provision. Consider rollout at County Hospital	Lois Dale Head of Speech and Language Therapy	Sep-22	Sep-23	2			Review of incidents relating to SALT provision at Ward level	• ANP training for Respiratory ANP's was completed by SLT. A meeting is being arranged to discuss competency assessment process. •Training has not been offered to County ANP's to date due to ongoing limited SLT resources over at County. There has been recent recruitment within SLT which will support this development. **•Due to ongoing concerns about delay in achieving this action, a Deep Dive into SLT services to be presented at QSOG in May 2023**			Quality Safety Oversight Group Quality Governance Committee
Aug-21	B18	Safe	**County**	**Medicine**	**Medicine Care**	The Trust SHOULD continue to work towards the provision of a full multidisciplinary seven-day service at the County Hospital site	The Division will initiate a number of promotional activities to ensure that Ward staff are aware of the services available at County Hospital across seven days	Claire Mackirdy Site Director of Operations	Complete				Oct-22	Divisional Performance Report	•A presentation of the services available at County for all the wards has been developed and shared.			Operational Groups
							The Trust will include consideration of seven-day service provision in all service reviews at County Hospital	Claire Mackirdy Site Director of Operations	Complete				Jan-23	Divisional Performance Report	•Seven-Day service provision considered in all service reviews/developments •Any Datix incidents relating to lack of access to services at weekends are monitored and reviewed			Operational Groups
Aug-21	B19	Well Led	**County**	**Surgery**	**Surgical Care**	The Trust SHOULD ensure that medical staff are up to date with all mandatory training	The Divisional Management Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Dr Stephen Merron Clinical Director	Dec-22	Aug-23	2			Training Figures	•Trajectory developed •A letter has been circulated to Surgical Division seeking improved compliance. Divisional HR provide monthly update for S&M training. • **Current compliance is 93.38%**. Divisional concerns about ability to achieve the trajectory due to ongoing operational pressures in addition to the national mandate to undertake Learning Disability/Autism training	• **Current compliance is 93.38%.**		Directorate and Divisional Governance Meetings
							The Divisional rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Dr Stephen Merron Clinical Director	Complete				Oct-22	Training Figures	•All permanent staff have 1 SPA included in job plans for CEPD. This will include the completion of Statutory & Mandatory Training. Each Directorate also allocates time during Audit and Training afternoons to address some of the Stat & Mand maintenance. •Rotational trainees all undergo Stat & Mand Training as part of the induction process, and are required to maintain certain elements as a requirement for ARCP.			Directorate and Divisional Governance Meetings
Oct-22	B20	Effective	**Royal Stoke**	**Medicine**	**Medical Care**	The trust SHOULD consider reviewing the mental health training needs of staff so that they are assured they have the skills to meet the needs of patients.	Appropriate training programmes will be provided	Kirsty Smith Matron for Vulnerable patients Nadine Opinano Head of Nursing	Complete				Dec-22	Training Figures Vulnerable Patient Quarterly Assurance report	Trustwide mental health ambassador training launched Jan 23 Trustwide TEAS enhanced and therapeutic observation Training launched Jan 23 Trustwide Dementia Tier 2 face to face training launched Jan 23			Mental Health Working Group Trust Mental Health & Learning Disability steering group Quality Safety Oversight Group Quality Safety Committee

Date of Visit	Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Number of Time Target Date has Changed	Current Progress Rating (As against Target Date for Completion not revised target date)	Date Completed	Assurance Mechanism	Assurance Based Progress Report	Audit results/compliance data (where appropriate)	Evidence Submitted	Responsible Committee / Group
Oct-22	B25	Effective	**County**	**Medicine**	**Medical Care**	The trust should ensure they consistently check and record where a person has a power of attorney for health and welfare on behalf of the patient if that patient lacks capacity to consent for their own care and treatment.	Appropriate training programmes will be provided	Sarah Curran Lead for Vulnerable Patients Rebecca Ferneyhough Head of Nursing Trust legal team	Sep-23					Audit	Policy in place Awareness campaign to be designed			Mental Health Working Group Trust Mental Health & Learning Disability steering group Quality Safety Oversight Group Quality Safety Committee
Oct-22	B26	Effective	**County**	**Medicine**	**Medical Care**	The trust should ensure that all patients requiring an interpreter are provided with one as soon as is reasonably practical prior to undertaking care and treatment.	The Trust will promote available Interpreter services available and monitor provider performance	Rebecca Pilling Head of Patient Experience	Sep-23					Performance data	•Monthly meetings with Capita Contracts Manager to discuss performance •Trial of Interpreter on Wheels •Communications to ward teams			Patient Experience Group Quality Safety Oversight Group Quality Governance Committee
Oct-22	B27	Well Led	**County**	**Medicine**	**Medical Care**	The trust should ensure staff are consistently supported following incidents of violence and/or aggression.	The Divisional Management Team will ensure that sufficient staff are trained in CISM debrief	Lisa Underwood Head of Nursing Stacey Boyjoo Matron	Sep-23					Training Figures				Directorate and Divisional Governance Meetings
Oct-22	B28	Well Led	**County**	**Medicine**	**Medical Care**	The trust should consider that they work within the Use of Force Act as appropriate for acute settings	To consider working within the Use of Force Act relevant for Acute Settings	Kirsty Smith Matron for Vulnerable patients	Complete				Jan-23	Email received from Head of Quality Transformation NHS England	Regarding the Mental health Units (Use of Force Act) 2018. NHSE confirmed that they and DHSC do not think this Act applies to Acute Hospitals and will be updating their guidance to make this clearer. It would only be relevant if the specific Acute trust had a dedicated mental health ward where patients were admitted directly for assessment and treatment of their mental health.		Policy C33 and C08 acknowledges the use of Force act. Trust Clinical holding Train the trainer Training is delivered by CPI who meet the Restraint reduction Network standards. Email saved from NHSE	Trust Mental Health & Learning Disability Group Quality Safety Oversight Group Quality Safety Committee

CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

For the attention of
Ms Tracy Bullock Chief Executive,
University Hospitals of North Midlands NHS Trust,
Newcastle Road,
Stoke on Trent,
Staffordshire,
ST4 6QG

By email: Tracy.Bullock@uhnm.nhs.uk

Tuesday 28 March 2023

The Care Quality Commission
The Health and Social Care Act 2008
SECTION 29A WARNING NOTICE:
Provider:

Regulated activities: Maternity and Midwifery Services

Our reference: RGP1-15274827469
Account number: RJE

Dear Ms Bullock

This notice is served under Section 29A of the Health and Social Care Act 2008.

This warning notice serves to notify you that the Care Quality Commission has formed the view that the quality of health care provided by University Hospitals of North Midlands NHS Trust for the regulated activities above requires significant improvement.

The Commission has formed its view on the basis of its findings in respect of the healthcare being delivered in accordance with the above Regulated Activities, during our inspection on 7 March 2023 and following subsequent information received on 13 and 16 March 2023 at the locations identified below, we found the need for significant improvement:

Royal Stoke University Hospital
Newcastle Rd,
Stoke-on-Trent,
ST4 6QG

Following the inspection on 7 March 2023, we had urgent concerns and requested information by issuing a Letter of Intent. We received a response on 13 March 2023, and we have reviewed the additional information you submitted.

On 14 March 2023 we requested further clarification on the information, and we received a response on 16 March 2023.

We have concluded that significant improvement is still required to ensure service users receive safe care.

The reasons for the Commission's view that the quality of health care you provide requires significant improvement are as follows:

1. Staff did not effectively assess, document and respond to ongoing risks associated with safety through triage of service users attempting to access care in line with the services audit criteria (Re-Audit of MAU Triage Breaches 2022-2023 Q3 (Oct-Dec)). The document stipulates that service users attending the Maternity Assessment Unit (MAU) at the Royal Stoke University Hospital should be triaged within 30 minutes of attendance.

2. Staff did not have a clear prioritisation process to ensure risks associated with delays to induction of labour were escalated, monitored and effectively managed.

Why you need to make significant improvements in midwifery assessment unit and triage processes:

1.0 You do not have effective systems in place to ensure staff effectively assess, document and respond to ongoing risks associated with safely triaging service users attempting to access care in line with trust policy. This exposed service users and their babies to risk of harm. Evidence and plans provided in response to the letter of intent showed:

- Service users attending triage are now to be triaged within 15 minutes instead of 30 minute window in line with their chosen triage system which was the Birmingham Symptom Specific Obstetric Triage System (BSOTS).
- Formal review of triage Royal Stoke University Hospital maternity services to be reviewed by Sarah Kenyon, National BSOTS lead.
- 2 hourly oversight to complete audit on Maternity assessment unit by member of senior leadership 7 days a week.

- BSOTS training package sent to all medical and midwifery staff on 10th March 2023.

Despite changes being made, systems and process will not yet be embedded, and risk changes may be ineffective in addressing the concerns discussed in point 1.0.

1.1 During the inspection at approximately 1.30pm on 7 March 2023, we saw the list of service users attending for triage included 12 service users in the maternity assessment unit (MAU). Of those, 5 waited longer than the trust guidance which stated service users should be triaged within 30 minutes, with delays up to up to 55 minutes.

1.2 Information was not presented clearly on the triage list increasing the risk that service users would not be assessed within a safe and timely manner. The triage list did not clearly show if the service user had been seen by a midwife or a doctor.

1.3 During the inspection on on 7March 2023, inspectors found 2 service users in the waiting area at 11:32am awaiting triage. However, no names of people waiting were listed on the whiteboard as being seated in the waiting area.

1.4 During the inspection on 7 March 2023, inspectors returned around 12:25 to find 5 service users awaiting triage, the board had not been updated since speaking with staff about incomplete list of service users awaiting triage at 11:32am. We saw the names of Only 2 service users were written onto the board showing as waiting, this meant that the names of 3 service users had not been added to the board. By not updating the board it became less clear who was waiting and increasing the likelihood issues requiring escalation might be missed.

1.5 An incident report from Royal Stoke University Hospital June 2022 (Incident ID: 2022/12317/RJE) outlined an incident where service user A delivered a still born baby. A review of the triage assessment times in the maternity assessment unit showed that the mother/parent had waited 59 minutes for review.

1.6 An incident report from Royal Stoke University Hospital February 2022 University Hospital (Incident ID: 2022/2568/RJE) showed a delay in triage on the maternity assessment unit which ended with an intrauterine death for service user B. The Perinatal Mortality Review Tool (PMRT) graded the incident with a ‘C’, meaning there were care issues which may have made a difference.

1.7 According to report “Re-Audit of MAU Triage Breaches 2022-2023 Q3 (Oct-Dec)”, three recent Perinatal Mortality Review Tool (PMRT) reviews within University Hospitals North Midlands NHS Trust highlighted a MAU triage breach with service users being seen after 30+ minutes of attendance.

1.8 Findings reported by the trust “Re-Audit of MAU Triage Breaches 2022-2023 Q3 (Oct-Dec)” found 22% of admissions did not have times of triage recorded. This limited effective oversight reports and audits and showed that systems and process were not being followed by staff. This meant there was an increased likelihood that service users were not triaged within a safe timeframe leading to an increased risk of undesirable outcome/patient harm.

You are required to make the significant improvements identified above regarding the quality of healthcare by 30th June 2023.

Why you need to make significant improvements in the management of delays for induction of labour:

2.0 You do not have effective systems in place to ensure the safe management of delays for service users due for an induction of labour. Prioritisation processes to ensure risks associated with delays to induction of labour were escalated, monitored and effectively managed were unclear. This exposes service users and their babies to risk of harm. Evidence and plans provided in response to the letter of intent showed:

- Induction of labour prioritisation meeting to now take place prior to safety huddle to allow for discussion and risk mitigation.
- Plan to open 4 additional induction of labour bays in the midwifery led birthing unit.

Despite changes being made, systems and process will not yet be embedded, and risk changes may be ineffective in addressing the concerns discussed in point 2.0.

2.1 During the inspection on 7 March 2023, we found there were 18 service users scheduled for induction of labour that day, 7 of which had been delayed from the previous day.

2.2 The pregnancy of service user C was documented as high risk with high-risk indicators, and they had their induction of labour delayed for 5 consecutive days. When we asked a senior member of staff about the delay, they told us there were not enough neonatal cots.

2.3 Inspectors observed staff swapping the blood pressure cuffs used to measure the blood pressure cuff of service user C. The size of the cuff is known to alter the outcome. The cuff was swapped to a large cuff which altered the blood pressure result, giving the high-risk service user a lower Maternal Early Warning Score (MEWS) reading (0). Higher MEWS scores would require escalation as they indicate possible concerns which may require intervention. Without effective monitoring of service users with delayed inductions they were at higher risk of harm and unwanted outcomes.

2.4 An incident is reported from Royal Stoke University Hospital in December 2022 (Incident ID: 84049218) involving 3 service users with no safety netting completed for service users delayed for their induction of labour on K2 (electronic patient record system). Additionally, this was graded as No harm.

You are required to make the significant improvements identified above regarding the quality of healthcare by 30th June 2023.

Please note: If you fail to comply with the above requirement and thereby fail to make significant improvement to the quality of the health care you provide within the given timescale(s) we will decide what further action to take against you. Possible action includes requiring Monitor, now known as NHS England and NHS Improvement, to make an order under Section 65D (2) of the National Health Service Act 2006 (appointment of trust special administrator).

The Commission informing NHS England and NHS Improvement, that the Commission is satisfied that there is a serious failure by the trust to provide services that are of sufficient quality to be provided under the NHS Act 2006 and seeking to discuss and agree with NHS England and NHS Improvement that a recommendation be made to the Secretary of State for

the Secretary to appoint a trust special administrator in the interests of the health service because of that serious failure.

We will notify the public that you have been served this warning notice by including a reference to it in the inspection report. We may also publish a summary more widely unless there is a good reason not to.

You can make representations where you think the notice has been served wrongly. This could be because you think the notice contains an error, is based on inaccurate facts, that it should not have been served, or is an unreasonable response. You may also make representations if you consider the notice should not be published more widely.

Any representations should be made to us in writing within 10 working days of the date this notice was served on you. To do this, please complete the form on our website at: www.cqc.org.uk/warningnoticerepresentations and email it to: HSCA_Representations@cqc.org.uk

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making representations and make sure that you include the reference number <CRM process ID>.

If you have any questions about this notice, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Representations@cqc.org.uk

Write to: CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you contact us, please make sure you quote our reference number (<CRM process ID >) as it may cause delay if you are not able to give it to us.

Yours sincerely

Carolyn Jenkinson
Deputy Director of Secondary and Specialist Healthcare

cc.
NHS England
NHS Improvement
Regional Chief Midwife

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd May 2023
Report Title:	Nurse Staffing Establishment Review	**Agenda Item:**	9.
Author:	Jane Holmes: Deputy Chief Nurse		
Executive Lead:	Ann-Marie Riley: Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

No risks identified.

Executive Summary:

There is a significant body of evidence highlighting the relationship between registered nurse staffing levels and the resulting impact on care delivery and patient experience.

In 2013, following findings in the Francis Report the National Quality Board (NQB) set out 10 expectations and a framework within which organisations and staff should make decisions about safe staffing. The NQB guidance expects a review of the nursing and midwifery workforce to be presented to the Trust Board twice per year.

This bi-annual report reviews the nursing establishment for adult inpatient areas with the exception of midwifery who last year had an external review utilising nationally recognised Birth-Rate Plus methodology and a business case was approved late 2022 in relation to this.

Theatres, Dietetics and the Children's Hospital have been reviewed during this establishment review process.

The report excludes outpatients (with the exception of ENT clinics with the Surgery Division) and emergency departments which will be included in the next update in six months' time.

The establishment review was conducted during February and March 2023 and this report provides an overview of current staffing. It then drills down into staffing within individual divisions identifying where action needs to be taken to address skill mix issues or staffing deficits.

A paper detailing the current and proposed staffing for every area included in this review, alongside harm metrics reviewed over the last twelve months, was presented to both Transformation and People Committee and Quality Governance Committee during April.

Key assumptions to note:

1. Ward Sister allocation remains at 0.4wte supervisory and 0.6 wte clinical

2. A standard uplift is applied to the general adult ward based nursing establishment of 21.5%.

a) This does not however adequately cover the consistent level of absence caused by sickness, other absence or maternity/paternity leave.

b) The Royal College of Nursing now recommend an uplift of 25%(https://www.rcn.org.uk/About-us/Our-Influencing-work/Policy-briefings/pol-003870). If directed to add the uplift that the RCN recommend to current nurses and midwives (taking them from 21.5% to the recommended 25%) we would need to increase our budgeted establishment for staffing to 3,650 WTE registrants, which is an increase of 102 WTE nurses/midwives across UHNM. The financial cost of employing these nurses at a mid-point Band 5 would be circa £3.7million, (excluding out of hour's enhanced working). Current non-medical clinical agency spend for UHNM in 22/23 is £6.1million.

c) The RCN advise how this uplift should be built in to the budget to allow for annual leave, sickness absence, other types of leave, and staff training and development needs.

d) The UHNM total overall absence performance across nursing and midwifery over the last 6 months averages circa 30%.

e) For Registered Nurses and Midwives we are currently running at a vacancy under-fill rate of 14.07%. (March 2023

3. A nurse to patient ratio of 1:8 or above during the day is the level recognised at which care is likely to be delayed or missed, and harm is likely to occur. Any areas with this ratio are highlighted in blue.

4. There is no clear guidance regarding an appropriate nurse: patient ratio for night shifts. The paper highlights any ward with a ratio of 1:9 or more in blue.

5. CHPPD hours could not be included as part of this review. The data collection for CHPPD was paused nationally over the pandemic and this section of the model hospital data base is currently unavailable.

6. Any areas with a recommended RN and/or HCA uplift are highlighted in purple.

7. Divisional leadership teams will be responsible for producing any business cases relevant to recommended changes to budgeted establishment, and changes to the e-rostering system will not be made until business cases are approved.

8. There are some gaps to align all ward/department budgets with agreed rosters and this issue has been discussed at Performance and Finance Committee.

Key Recommendations notes:
The bulk of the recommendations relate to three key areas:

- Medicine: the key recommendations predominantly relate to escalation areas, which if are to remain open, will need consideration for ongoing funding.
- Staffordshire Childrens Hospital: the key recommendations are aligned to best practice guidance for staffing across paediatric areas. The Childrens Hospital see very little in terms of harms events currently. It remains an attractive area in terms of recruitment and retention.
- Dietetics: the analysis reflects the activity the team have absorbed without additional funding.

Ward area	Staff type	WTE uplift required	Comments
FEAU	Nursing Assistant	2.7 Band 2	New template increased harms due to visibility and layout.
Ward 121	Registered Nurse	2.7 Band 5	Additional RN on nights; however budget to be realigned as could use B2 monies – QIA required
Ward 122	Registered Nurse	4.39 Band 5	Additional RN on the early and additional RN every night – to mirror Ward 121
Ward 230	Nursing Assistant	2.7 Band 2	Additional NA on nights due to SI's and harm data for falls
Ward 14	Registered Nurse Nursing Assistant	2.7 Band 5 1.7 Band 2	Harm data, patient group and layout of the ward
Ward 15	Nursing Assistant	5.4 Band 2	Could be offset by reducing Band 5 budget by 2.7 WTE
Ward 120	Full establishment required	1.0 Band 7 3.0 Band 6 13.13 Band 5 19.05 Band 2 1.0 Band 3 DF 2.0 Band 2 A&C **Total**: 39.18	Current areas of escalation which are not funded post Winter 31st March. If we are to continue to use will require funding
Ward 123	Full establishment required	1.0 Band 7 3.0 Band 6 18.75 Band 5 19.05 Band 2 1.0 Band 3 DF 2.0 Band 2 A&C **Total** 44.62 WTE	Current areas of escalation which are not funded post Winter 31st March. If we are to continue to use will require funding
AMRA	Routinely opened at night up to 14	2.7 Band 5	Future of AMRA to be decided depending upon SDEC plans
AMU County Escalation beds	7 escalation beds	2.7 Band 5	Escalation beds frequently in use. Future County plans to be decided. MRU model also to be worked through
220	Health Care Assistant	5.4 WTE	To increase the HCA to patient ratio day and night by x1 HCA to support ward acuity and activity.
221	Registered Nurse	2.7 WTE	To increase the RN to Patient ratio from 1:9.7 to 1:7.25 at night.
225	Health Care Assistant	2.7 WTE	To increase the HCA to patient ratio at night by x1 HCA to support with falls prevention at night
228	Registered Nurse	2.7 WTE	To increase the RN to Patient ratio from 1:9.7 to 1:7.25 at night.
127	Registered Nurse	2.7 WTE	To increase the RN to Patient ratio from 1:10 to 1:66 at night. (Allows 2 RN for Level 1 Beds 1:4 / 3 RN for 20 ward based care 1:66)
SDU	Registered Nurse	2.0 WTE	To increase the RN to Patient ratio from 1:11 to 1:7.3 at peak demand to support SDEC care Monday – Friday.
PODS 1 &2	Health Care Assistant	5.4 WTE	Alignment to Critical Care PODS 3-6. Day ratio 1:5 / Night 1:8
Ward 111	Registered Nurse	1.34 WTE	To increase staffing establishment to allow for acuity of tracheostomy patients by 1.34 WTE.
Ward 106/107	Registered Nurse	3.19 WTE	Need to uplift by 3.19 WTE to cover the extra 4 beds that have remained open post COVID.
CED	Registered Nurse Nursing Assistant	5.4 WTE 5.4 WTE	Average 70 children seen within 24hours. Average 12 – 16 children seen post-midnight.
Children's Assessment Unit (216)	Registered Nurse Nursing Assistant	5.4 WTE 5.4 WTE	Profile of ICYP attending over a 24hr period with a resus area. Medication administration at SCH@RSUH is 2 registrants.
Ward 217	Registered Nurse Nursing Assistant	10.8 WTE 5.4 WTE	Ward level beds – Standard 1:4 daytime - 1:3 night time

			Based on data re <2years and >2 years 364 days utilising the bed base 24/7
217A – Surgical Daycase	Registered Nurse Nursing Assistant	5.4 WTE 5.4 WTE	Logistical distance from theatre and recovery. Multiple surgical specialities operate at the same time. List requiring additional support to deliver a recovery nurse model.
Ward 218	Registered Nurse	5.4 WTE	Ward level beds – Standard 1:4 daytime - 1:3 night time Based on data re <2years and >2 years 364 days utilising the bed base 24/7
CHDU	Nursing Assistant	5.4 WTE	The increase to the CRN's is monies from specialised commissioning
CICU	Registered Nurse	5.4 WTE	Standards require a supernumerary co-ordinator
Dietetics		30.23 WTE	The review of the team highlighted gaps in workforce as additional beds/ service developments have been introduced over time and within winter pressure planning without adequate funding. The team are not funded for a 7 day service or BH cover. There is no uplift for annual leave, sickness, maternity/paternity leave or any training

Potential Total Investment:

84.60 WTE Nursing Assistant's, uplifted at the current 21.50% and then at The RCN recommended 25.00%;

Nursing Assistants 84.60 WTE	**21.50% £2,690,625**	**25.00% £2,768,133**
94.63 WTE Registered Nurses, uplifted at the current 21.50% and then at The RCN recommended 25.00%;		
Registered Nurses 94.63 WTE	**21.50% £4,172,806**	**25.00% £4,293,011**
Dietetics 30.23 WTE	**(If 21.5% applied) £1,696,593**	

Key Recommendations:

The Board is asked to:

1. Note the progress made to ensure compliance with national guidance in relation to determining safe nursing and midwifery staffing levels.
2. Note that Divisional leadership teams will be responsible for prioritising requests and developing business cases in line with the recommendations from the establishment review and that no changes to establishments will be made before a business case is approved.

Nursing, Midwifery and AHP Establishment Review
April 2023

1. Introduction

There is a significant body of evidence to highlight the relationship between registered professional staffing levels and the resulting impact on care delivery, patient outcomes and experience, and staff satisfaction and experience.

In 2013, following findings of the Francis Report (2013) the National Quality Board (NQB) set out 10 expectations and a framework within which organisations and staff should make decisions about safe staffing. From 2016 to 2018 the NQB published updated safe staffing guidance and a set of expectations regarding nursing and midwifery staffing. The guidance emphasises that the NHS provider boards are accountable for ensuring that their organisations have the right skills in place for safe, sustainable and productive staffing. The NQB guidance makes explicit the requirements of NHS providers.

Expectation One Right Staff	Expectation Two Right Skills	Expectation Three Right Place and Time
• Evidence based workforce planning. • Professional judgement. • Compare staffing with peers.	• Mandatory training, development and education. • Working with the multi-disciplinary teams. • Recruitment and retention.	• Productive workforce and eliminating waste. • Efficient deployment and flexibilities. • Efficient employment and minimise agency.

Developing Workforce Safeguards was issued by NHSI in October 2018. This publication supports organisations to use best practice in effective staff deployment and workforce planning utilising evidence based tools and professional judgement to ensure the right staff, with the right skills, are in the right place at the right time. The Trust Board is expected to confirm their staffing governance processes are safe and sustainable through the Trust annual governance statement.

In 2021 the Royal College of Nursing (RCN) published 'Nursing Workforce Standards: supporting a safe and effective nursing workforce' which were designed to support a safe and effective nursing workforce.

There is no single tool that can be used to determine safe staffing levels for ward areas. The guidance recommends consideration and triangulation of a range of metrics including patient activity and acuity, harm incidents and environmental factors alongside professional judgement. This bi-annual report utilises this triangulated approach to review the nursing establishment for adult inpatient areas, with the exception of midwifery who have had an external review utilising the nationally recognised Birthrate Plus methodology and a business care was approved late 2022 in relation to this.

Inpatient wards, theatres, dietetics and the Children's Hospital have been reviewed during this establishment review process.

The report excludes outpatients (with the exception of ENT clinics with the Surgery Division) and emergency departments which will be included in the next update in six months' time

A detailed paper highlighting the methodology and data considered during the establishment review process, which was carried out during February and March 2023, has been presented in full to Quality Governance Committee and Transformation and People Committee in April 2023. That paper provided assurance that the methodology utilised to assess safe nurse staffing is in line with the national standards noted above however the Chief Nurse has added an assessment of our process to the external audit programme to seek independent assurance of the process.

2. Nursing and Midwifery Staffing Review April 2023

The NQB guidance expects a review of the nursing and midwifery workforce to be presented to the Trust Board twice per year. The last staffing review was undertaken in August 2022.

Studies have shown that appropriate nursing and midwifery staffing levels support achievement of clinical and economic improvements in patient care including enhanced patient satisfaction, reduction in medication errors, reduction in incidences of falls, reduction in pressure damage, reduction in healthcare associated infection rates, reduction in mortality, reduction hospital readmission and duration of stay, reduction in patient care costs, and reduction in nurse fatigue and burnout which affects recruitment and retention. There is also evidence to suggest a registered nurse (RN) to patient staffing ratio of 1:8 or more on adult inpatient wards is associated with patient care regularly being compromised with missed or delayed aspects of care, increased risk of harm and increased risk of excess mortality.

Additionally Royal College of Nursing guidance suggests on an acute ward there should be an RN: Nursing Assistant skill mix ratio of no less than 65:35 for base wards, 70:30 for specialty wards and 80:20 for specialty units e.g. ICU. This overview monitors wards against these standards.

Bed Provision	Description	Expected Staffing Level	Skill Mix Suggested
Intensive Care	Beds identified – critical care areas	1 Registered Nurse: 1 patient.	80:20
High Dependency	Designated beds in a defined unit/area.	1 Registered Nurse: 2 patients.	80:20
Level 1	Designated beds on general Wards.	1 Registered Nurse: 4 patients.	70:30
General Care	Majority of inpatient Wards	1 Registered Nurse: 7 or less patients	65:35

UHNM currently supports an uplift of 21.5% for the majority of areas (there are some areas with a higher uplift which reflects the required training time required for that area).

21.5% uplift does not adequately cover the consistent level of absence caused by sickness, study leave, other absence or maternity/paternity leave. The Royal College of Nursing now recommend an uplift of 25% (https://www.rcn.org.uk/About-us/Our-Influencing-work/Policy-briefings/pol-003870). This recommended uplift is to ensure establishments have an adequate allowance of at least 25 per cent built in to the budget to allow for annual leave, sickness absence, other types of leave, and training and development. The total overall absence performance for UHNM over the last six months averages circa 30%.

If we added the uplift that the RCN recommend to current Nurses and Midwives (taking them from 21.5% to the recommended 25%) we would need to increase our Budgeted Establishment for staffing to 3,650 WTE registrants, which is an increase of 102 WTE nurses/midwives across UHNM. The financial cost of employing these nurses at a mid-point Band 5 would be circa £3.7million, (excluding out of hour's enhanced working). Current non-medical clinical agency spend for UHNM in 22/23 is £6.1million so could be a cost saving opportunity for some areas.

3. Approach

The Chief Nurse and Deputy Chief Nurse led initial discussions with each Divisional Nurse and provided the Harm Review data for the last 6 months and a copy of the previous establishment review for reference. Each Divisional nurse was asked to lead discussions with the ward/dept. leaders in their division to review the data, collate professional judgements and determine the safe staffing levels required within their areas.

The information collected within Divisions included, funded establishment (as agreed by Finance), quality and HR metrics, shift patterns, key performance indicators for staff rostering and a discussion about ward layout and other professional judgement factors that might affect the number of registrants and non-registrants required.

Divisional Nurses each had a second meeting with the Chief Nurse and Deputy Chief Nurse to check and challenge proposed staffing levels.

Quality metrics for the previous 6-12 months were also considered, including harm free care metrics, Clinical Excellence Framework (CEF) score, relevant HR data and rostering key performance indicators. Key performance indicators for rostering were also included. The compliance with recording acuity for the safer care tool was recorded where possible and individual ward compliance was discussed at the review meetings.

All collated data and relevant guidance were triangulated to determine whether the current funded staffing levels were satisfactory, or whether additional staffing was recommended.

4. Review findings and recommendations

For Registered Nurses and Midwives we are currently running at a vacancy under-fill rate of 14.07%. (March 2023).

If directed to add the uplift that the RCN recommend to current Nurses and Midwives (taking them from 21.5% to the recommended 25%) we would need to increase our Budgeted Establishment for staffing to 3,650 WTE registrants, which is an increase of 102 WTE nurses/midwives across UHNM. The financial cost of employing these nurses at a mid-point Band 5 would be circa £3.7million, (excluding out of hour's enhanced working). Current non-medical clinical agency spend for UHNM in 22/23 is £6.1million.

Medicine:
There are areas of increased acuity which have seen numbers required for 1:1 therapeutic observations for patient support increase. The team have requested activity coordinators in an attempt to reduce harm, (in particular falls) within our Frail Elderly patients and to continue to prevent deconditioning, based across both hospital sites. The Medicine highlights a potential need for 45.2 WTE Registered Professionals and 44.1 WTE non-registered nursing workforce. The bulk of this relates to escalation areas which, if they are to remain open, will require consideration to the on-going funding.

Surgery:
Not requested any uplifts within theatres as they would like to review the theatre template to align with theatre productivity enabling ability to meet cancer targets and national waiting times. This will be reviewed in 6 months' time at the next Establishment Review. Surgery, therefore are requesting in total 4.53 WTE Registrants and no non-registrants.

Network Service Division:
There is an increase in patient acuity and dependency (current ratio is 1 NA for 29 patients) request for 13.5 non-registered workforce has been made to address this inconsistency and ensure quality is provided in Pods 1 and 2 which will give workforce alignment across all critical care pods.10.1 WTE Registrants to support the reduction in nurse patient ratio's to bring in line with National Standards for level 1 care.

Women's, Children's and Clinical Support Services:
Staffordshire Children's Hospital has identified that the requirements to address the presenting demand, presentation and acuity of Infants, Children's and Young Adults (ICYP) has changed since the last review some years ago. The data of those presenting shows that there is a greater number of <than 2 years utilising our bed base, which based on the guidance (1:4 > than 2 years of age. 1:3 < than 2 years of age.) requires consideration for investment for 37.8 WTE Registrants and 27 WTE non-registrants. The Childrens Hospital is not an area of concern in relation to incidents or harm events and the assessment of staffing reflects best practice staffing guidance.

Dietetics:
For the first time we are including the Trust Dietetic Service within the establishment review process. Where national guidance exists the standard was included as part of the review; where there was no national guidance we benchmarked with peers where possible. The review of the team highlighted gaps in workforce as additional beds/ service developments have been introduced over time and within winter pressure planning without adequate funding. The team are not funded for a 7 day service or Bank holiday cover. There is currently no uplift for annual leave, sickness, maternity/paternity leave or any training (including statutory and mandatory). The Dietetics team are requesting 30.23 WTE.

5. Recommendations

The Board is asked to:
1. Note the progress made to ensure compliance with national guidance in relation to determining safe nursing, midwifery and AHP staffing levels
2. Note that Divisional leadership teams will be responsible for prioritising requests and developing business cases in line with the recommendations from the establishment review and that no changes to establishments will be made before a business case is approved.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd May 2023
Report Title:	UHNM PLACE Results 2022	**Agenda Item:**	10.
Author:	Nan Sharp, Head of Governance & Compliance, EFP Division/Teresa Platt, Deputy Head of Governance and Compliance, EFP Division		
Executive Lead:	Lorraine Whitehead, Director of Estates, Facilities and PFI		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

ID	*BAF 7 Infrastructure to Deliver Compliant Estate Services*	*High 9*

Executive Summary

The results of the PLACE inspections were published on 23rd March 2023 and this report provides a summary of findings from the inspections that took place at UHNM in October and November 2022.

Our patient assessors were welcomed back to our County and Royal Stoke sites over a series of inspection dates during October and November 2022 to visually inspect our hospital environment. The inspection team assessed how the environment supports the provision of clinical care, inspecting things such as cleanliness, food, general building maintenance, privacy and dignity and the specific needs of our patients with dementia, or with a disability.

UHNM have achieved excellent scores and scores above the national average across all bar one of the eight domains and only missing that domain by a narrow margin (less than 1%) These scores recognise that good environments and services that respond to the needs of our patients really do matter.

Key Recommendations

- To receive and note the contents of this report and its findings following PLACE inspections undertaken during October and November 2022 and to note the actions identified to improve the patient environment and experience which have been provided to Quality Governance Committee.

University Hospitals of North Midlands NHS Trust

UHNM PLACE RESULTS 2022

March 2023

1. Introduction

The Patient-Led Assessments of the Care Environment (PLACE) is an annual voluntary system for assessing the quality of the hospital environment. Introduced in April 2013 it replaced Patient Environment Action Team (PEAT) and was reviewed in 2018/19 providing clearer guidance, improved form design and the introduction of a web based collection tool PLACE-Lite.

Annual PLACE collections were suspended nationally in 2020 and 2021 due to the COVID19 pandemic. During this time desktop exercises were undertaken comparing PLACE inspection scores from 2019 to patient satisfaction survey comments on those wards for 2020 and 2021. In the Summer of 2022 it was confirmed that PLACE inspections were able to resume to the full process.

This report provides a description of the process and summarises the scores achieved for 2022 full UHNM PLACE inspection undertaken in Autumn 2022.

2. PLACE Process

PLACE covers NHS Trusts, voluntary, independent and private healthcare providers. It is completed by teams of staff and patient assessors (minimum of 50%) and covers a selection of wards and departments, communal and external areas. Questions score towards one or more of the following non-clinical domains:-

- Cleanliness;
- Food/Hydration;
- Privacy, Dignity and Wellbeing;
- Condition, Appearance and Maintenance;
- Dementia;
- Disability.

NHS Digital manages the data collection, validation and publication of results from assessments and provides guidance within which inspections must take place. The inspections cover a range of compulsory areas and those that the patient assessors can choose. A&E, food tasting, outpatient areas are included as compulsory areas and the number of wards to be inspected is determined on the size of the overall site. Patient Assessors choose on the day of inspection where they would like to inspect from the non-compulsory options.

Trusts were notified in August 2022 that the dates for the 2022 collection was planned to run from 5th September to 11th November 2022. Inspection dates were coordinated with the availability of patient assessors and relevant Trust and ward department staff with representatives from Estates, Facilities and PFI and Nursing Departments in line with guidance. The inspections were supported by an External Verifier from Combined Health Care NHS Trust.

The collection assessment forms and guidance documents are available for information at https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place

The deadline for data submission was 16th December 2022 and UHNM successfully submitted its data on Thursday 15th December 2022.

3. PLACE Scores and Patient Assessor Comments

PLACE scores, were published nationally on 23rd March 2023 and are recorded in the table below. Scores are generated by the national database system based on the information submitted from the inspections. Scores are not generated by Trusts and are in the public domain at the link above.

Nationally a total of 1,046 assessments were undertaken in 2022 compared to 1,144 in 2019. There were 110 assessments that were excluded due to missing mandatory assessment components (e.g. external areas) or an insufficient number of patient assessors. The findings were based on the 936 remaining assessments and results are not comparable with previous years due to different areas having been inspected.

The table below outlines the site scores for Royal Stoke University Hospital and County Hospital plus the overall UHNM Trust organisation score alongside the national average for 2022.

UHNM achieved above the national average for all but one of the domains which was ward food which marginally fell below the national average score. An action plan has been identified to support improvement in this area.

Site Name	CLEANING Score %	FOOD Score %	Organisation Food %	Ward Food %	PRIVACY, DIGNITY & WELLBEING Score %	CONDITION & MAINTENANCE Score %	DEMENTIA Score %	DISABILITY Score %
THE ROYAL STOKE UNIVERSITY HOSPITAL	99.71	91.60	97.57	90.05	91.94	99.82	87.50	90.96
THE COUNTY HOSPITAL	99.75	97.06	94.79	98.59	94.33	97.54	93.17	92.64
UHNM TRUST SCORE	99.72	92.31	97.21	91.17	92.25	99.52	88.24	91.18
NATIONAL AVERAGE	98.05	91.27	91.15	91.94	87.94	95.99	83.21	84.32

Patient Representative Comments

In addition to completing score sheets on a pass, fail or qualified pass basis, patient assessors are encouraged to provide any supporting comments that the Trust may take on board. Below is a summary of some of the comments received for each site:-

County Hospital:-

"Despite their age buildings maintained to a very high standard, very clean in all areas inspected, standard of decoration high".

"Walking through the communal areas was a really pleasurable experience; they were all clean and well signposted".

Royal Stoke Hospital:-

"Allowing for the constraints place upon the Royal Stoke from the pandemic and staffing issues, the hospital has managed to maintain and improve on their level and standard of cleanliness and also in the maintenance of the fabric of the estate".

"We found no issues of substantial concern on the day of the inspection".

"The oral clinic deserve a special credit for maintaining standards and practices together with their helpful information boards".

"Overall all staff deserve credit for what they have achieved".

"Just want to say thanks for inviting and allowing myself to take part in this year's place inspections, I really appreciate it and feel privileged to take part in inspecting such a great hospital and all the work that goes into it by the staff".

4. Conclusion

The PLACE scores achieved in 2022 for UHNM and its sites Royal Stoke and County Hospitals demonstrate that the hospital environment for patients from a non-clinical perspective at UHNM continues to provide a positive experience for our patients. In addition to the reasons referred to above Trusts are encouraged not to compare scores with previous year's inspections due to different areas being inspected and different patient assessors undertaking the inspections. Inspections are based on what is seen on that particular day. Changes to questions made each year to improve upon feedback regarding the inspections also makes comparing previous year's data difficult.

Good environments and services that respond to the needs of our patients really do matter and thanks go to all staff for their continued hard work and commitment in this area. Special recognition goes to our Estates, Facilities and PFI Division for the vital part they play every day in continuing to maintain an excellent care environment and impacting positively on our patient and staff experience.

An action plan has been developed to address the areas where action is necessary to make further improvements. It should be noted that the Trust's winter pressure challenges in 2022 and changes to the environment to accommodate the "Your Next Patient" initiative has impacted on some of the responses to questions regarding communal spaces for patients. A PLACE working group is well established and will meet to review the scores achieved and actions identified in conjunction with the Food Standards Group and Ward and Department Managers.

5. Recommendations

To receive and note the contents of this paper and the scores achieved for PLACE 2022 and to support in delivering the actions outlined across the organisation.

Appendix 1 – Inspection schedule

Appendix 1 – Inspection Schedule 2022

UHNM PLACE Inspection – Royal Stoke Wards/Outpatients

Inspection Requirements: 14 Wards, 14 Outpatients, 14 Public Areas, 5 Meal Services, Emergency Dept, External Area

PFI Wards	Lyme Building Wards	Outpatient Departments	Outpatients Departments Cont
210	100	Outpatients 1	202 Day Case
215	101	Outpatients 2	Early Pregnancy unit
216	102	Outpatients 3	Maternity Assessment unit
217	103	Eye Clinic	Radiotherapy
218	104	Discharge Lounge	Chemotherapy suite
220	105	Poswillo	Haemodialysis
221	106	PreAms	Fracture Clinic
222	107	REHAB	Kidney Unit
223	108	Cath Labs	Ambulatory Emergency Centre (AEC)
225	110	Children's Outpatients Clinic	**West Building Wards**
226	111	Cardiac Clinic	76b
227	113	Endoscopy	78
228	117	Neurophysiology Clinic	79
230	ITU Pod 6	Heart and Lung Clinic	80
231	**Trent Building**	Ear Nose Throat	81
232	122	Oral orthodontic Clinic	**Maternity Wards**
233	123	Nuclear Medicine	205
CCU	124	Shine Clinic	206
Critical Care Unit	126	Breast clinic	Maternity Birthing Centre
Compulsory Areas	127	Hearing & Balance	**Cancer Centre Ward**
External Area			201
Emergency Dept			

Team 1 – 2 PFI Wards including public Areas, 3 Outpatient Areas	**Team 2 –** 2 PFI wards including public areas, 3 Outpatient areas, 1 Meal Service
Team 3 – ED, 1 External Area, 2 Trent Wards including public areas, 1 Meal Service	**Team 4 –** 2 Lyme wards including public areas, 3 Outpatient Areas, 1 meal service
Team 5 – 2 West Build Wards, 1 Maternity Ward, 1 Cancer Centre Ward including public areas, 2 Outpatient Areas and 1 meal service	**Team 6 –** 2 PFI Wards including public areas, 3 Outpatient areas, 1 Meal Service

UHNM PLACE Inspection – County Wards/Outpatients

PLACE 2022 - County	Essential Area	In Patient area	Outpatient area	Communal Area	External Area
Ground Floor					
Shine/clinical Investigations			x		
Renal			x		
Physiotherapy			x		
Endoscopy			x		
Outpatients Area	x				
Outpatients Garden					x
Chemotherapy Unit			x		
Chemotherapy Garden					x
Remembrance Garden					x
Dermatology			x		
Stairwells					
Toilets					
Main Reception				x	
MRU			x		
X - Ray	x				
CT Unit			x		
A&E	x				
1st Floor					
Ward 8		x			
Ward 7		**X**			
Ward 1		x			
AMU		x			
Breast Care Unit			x		
Elective Orthopaedic Unit		x			
Chapel				x	
Nightingales				x	
2nd Floor					
Ward 12		x			
Ward 14		x			
Ward 15		x			
Neurological Unit			x		
Womens Health			x		
Totals	**3**	**8**	**9**	**4**	**3**

Transformation and People Committee Chair's Highlight Report to Board

26th April 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • A verbal update was provided in relation to a recent network outage highlighting that a root cause analysis was being undertaken to establish the reason for failure as well as identifying any lessons learned. • An update in relation to the Data Security and Protection (DSP) Toolkit was provided, highlighting a risk in the ability to achieve the 95% DSP statutory and mandatory training target, which needed to be achieved by June 2023. The consequences of not achieving this target were outlined which could in turn affect the Trust's well led score and also affect the Trust's reputation, although this was mitigated by a robust improvement programme • The quarter 4 formal disciplinary report highlighted a trend regarding data security breaches and noted the estimated cost of exclusions. • The Improving Together update highlighted 35% adoption of tools and a number of countermeasures for improvement were ongoing with an additional countermeasure identified in relation to training more colleagues during summer, and during winter focussing on training teams which were less clinically dependent • The digital and data security and protection group highlighted that timelines for a number of developments had been requested, which included the improvements to VPN, rollout of Office 365 and work on a digital Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)	• Internal audit to undertake a review in 2023/24 with regards to the nursing establishment review process • Cultural Improvement Programme and Staff Survey Action Plan to be brought together in one simplified plan • Being Kind statutory and mandatory training to be launched in May 2023 • Community Diagnostic Hub business case continuing to be written in preparation for being presented to the Trust Board in June 2023 and NHS England • Regular update to be provided in relation to transformation of services at the Committee and further consideration required in terms of timing of updates provided to the Committee versus the Board • Recommendations from the NHS England Improvement approach to be reviewed • Report authors to be invited to attend Effective Report Writing Training
✓ Positive Assurances to Provide	**Decisions Made**
• Assurance was provided to the Committee in respect of international maternity recruitment and the associated competency testing programme which mirrored the nursing Objective Structured Clinical Examination (OSCE) approach. It was noted that 3 / 5 international midwives had arrived in the UK. • The outcome of the six monthly nursing establishment review was provided which highlighted the progress made in ensuring compliance with national guidance and an expansion of the areas reviewed. It was recognised that further discussions were required as to funding the uplift, availability of workforce and impact on quality and safety • Additional assurance was provided in relation to the actions being taken in response to the Staff Survey with the primary focus on accelerating the actions aimed at addressing the three lowest performing areas • Month 12 workforce performance highlighted slight improvements in PDR and statutory and mandatory training compliance, although there had been a increase in the sickness absence metric • The Strategy and Transformation Group highlighted ongoing progress in relation to County Hospital, Community Diagnostic Hub and Urgent Treatment Centre • The Committee welcomed the output of the Committee effectiveness review and noted the ongoing actions being taken to provide more time for discussion of key priority areas such as the strategic workforce plan, transformation programme and staff engagement / cultural improvement.	• The Committee approved the increase in risk score for BAF 6 as a result of an increase in likelihood of incidents occurring, as well as the decrease to BAF 4 to its target risk score. In addition the Committee agreed with the top 3 risks which were to be reported within the Annual Governance Statement • The Committee approved the revised Terms of Reference which were due to be included within the Rules of Procedure, whilst noting that the business cycle was subject to change, taking into account the ongoing work to streamline reports being considered at the meeting

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.	International Recruitment (Maternity) - Competency Assessments and Failure Rate	BAF 3	ID13419 ID15993	✓	Assurance	7.	Executive Strategy and Transformation Group Assurance Report	BAF 4	Mod 6	✓	Assurance
2.	Nursing Establishment Review	BAF 1/3	Ext 20 Ext 16	✓	Assurance	8.	Improving Together Countermeasure Summary	-	-	!	Assurance
3.	Q4 Formal Disciplinary Activity	BAF 2	High 12	!	Assurance	9.	Data, Security & Protection Toolkit	BAF 6	Ext 16	!	Assurance
4.	Staff Survey Action Plan	BAF 2/3	High 12 Ext 16	✓	Assurance	10.	Executive Digital and Data Security and Protection Group Assurance Report	BAF 6	Ext 16	!	Assurance
5.	Workforce Report – M12 2022/23	BAF 2/3	High 12 Ext 16	✓	Assurance	11.	Board Assurance Framework Q4 2022/23	-	-	-	Approval
6.	Community Diagnostic Centre – Stoke-on-Trent	-	-	-	Information	12.	Committee Effectiveness Review 2022/23	-	-	-	Approval

3. 2022 / 23 Attendance Matrix

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

Attended | Apologies & Deputy Sent | Apologies

Performance and Finance Committee Chair's Highlight Report to Board

25th April 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate

For information:

- Whilst urgent care performance has improved, trolley waits remain a significant concern
- UHNM will be classified as Tier 1 for Cancer as a result of being in Tier 1 for elective; this will be against two key areas of monitoring
- Size of the waiting list, which will be confirmed following the independent review
- NHSE deep dive into the Endoscopy Department being undertaken in May (via the diagnostic recovery team)
- Financial Plan carries risk including delivery of CIP, meeting the activity target for the ERF, recurrent investments and capital
- Overseas visitor activity and income identified a trajectory of outstanding amounts increasing year on year (although there is provision within the financial plan to mitigate)

Major Actions Commissioned / Work Underway

- Surgical Division to present to the Committee the reasons for delays in theatre and the work being undertaken as part of the broader programme
- Have begun to pull together KPI's for Urgent Care with the Trust being 57th nationally and 10th regionally (middle quartile) when compared with others
- Independent review of elective data remains underway; some themes identified and the findings/ recommendations will be presented to the Committee in May
- Elective patients are currently prioritised on clinical need and time of wait although work is being explored in relation to health inequalities
- A significant amount of work is being undertaken around validation of data
- Development of Risk Reduction Trajectories will form part of the 2023/23 BAF along with strengthened assurance mapping / planning
- Update to be provided on progress with the Pathology Network as there has been an overspend against its non-pay budgets

✓ Positive Assurances to Provide

- Increase in 4 hour performance in March (68%) has continued throughout April against the target of 76%
- Improving trend of lost ambulance hours; now in 10th week of maintaining around 300 lost hours which is a significant improvement which is being sustained
- The amount of time where corridor care has been required has decreased
- Simple and timely discharges have improved by around 15%
- Additional revenue investment will be available through the Cancer Alliance as a result of being in Tier 1
- 2ww performance has been maintained
- Joint working with the ICB on development of a system wide Board Assurance Framework
- £7.31m procurement savings were made during 2022/23 which was above target
- Breakeven income and expenditure position achieved in line with plan
- Delivery of capital expenditure at year end in line with the 22/23 capital plan

Decisions Made

- Revised Non-Elective and Planned Care Plans for 2023/24 agreed (the metrics will form part of the revised Integrated Performance Report)
- Approval of the revised Terms of Reference and Membership for 2023/24 (which will form part of the Rules of Procedure which will be presented to the Board)
- Histopathology Outsourcing of Laboratory Specimens and Reporting (eREAF 10554)
- Supply of Hearing Aids (eREAF 10690)
- Approval of financial plan submission
- Approval of the financial plan submission (with a £39.4m deficit for the system) – this has been agreed by CEO's and Chief Financial Officers whilst recognising the challenges

Comments on the Effectiveness of the Meeting

- Committee Effectiveness Review concluded that the Committee was generally effective, with some actions for improvement identified and a need to be clear around assurance

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Board Assurance Framework Q4 22/23	All	-	✓	Approval	7.	Finance Report – Month 12 22/23	BAF 8	Mod 4	✓	Assurance
2.	Committee Effectiveness Review 22/23	-	-	-	Approval	8.	Overseas Visitor Activity and Income	BAF 8	Mod 4	!	Assurance
3.	Performance Report – Month 12 22/23: • Update on Discharges / Ambulance Holds • Non-Elective and Planned Care Plans on a Page	BAF 1 / 5	Ext 20	✓ !	Assurance	9.	Community Diagnostic Centre – Stoke on Trent	-	-	-	Assurance
4.	Procurement Update Report	BAF 8	Mod 4	✓	Assurance	10.	Planned Care Improvement Group Highlight Report	BAF 1 / 5	Ext 20	-	Information
5.	Authorisation of New Contract Awards, Contract Extension and Non Purchase Order (NPO) Expenditure	-	-	-	Approval	11.	Non-Elective Improvement Group Highlight Report	BAF 1 / 5	Ext 20	-	Information
6.	Financial and Capital Plan Update 23/24	BAF 8	Mod 4	!	Approval						

3. 2022 / 23 Attendance Matrix

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

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd May 2023
Report Title:	Annual Plan 23-24	**Agenda Item:**	13.
Author:	Helen Ashley, Director of Strategy & Transformation		
Executive Lead:	Helen Ashley, Director of Strategy & 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

Executive Summary

As part of the Improving Together Programme, the Executive have reviewed the Trusts Strategic Priorities and the programmes of work that are in place to support their delivery.

The attached Annual Plan seeks to draw together the Strategic Priorities that are in place to support the delivery of the Trusts Vision, as well as a number of breakthrough objectives and Strategic Initiatives, the plan also sets out how these are aligned to the Board Assurance Framework and NHS Priorities.

For 2023/24 the process of review of priorities and initiatives has been undertaken at the same time as a review of Divisional priorities, and their contribution to the Trusts Strategic Priorities and objectives.

The key priorities contained within the plan have been shared with Board Members previously and are now contained within the attached document for Board approval and communication to the wider organisation.

Key Recommendations

The Trust Board is asked to approve the Annual Plan and seek assurance of its delivery through the Transformation and People Committee, over the course of 2023/24

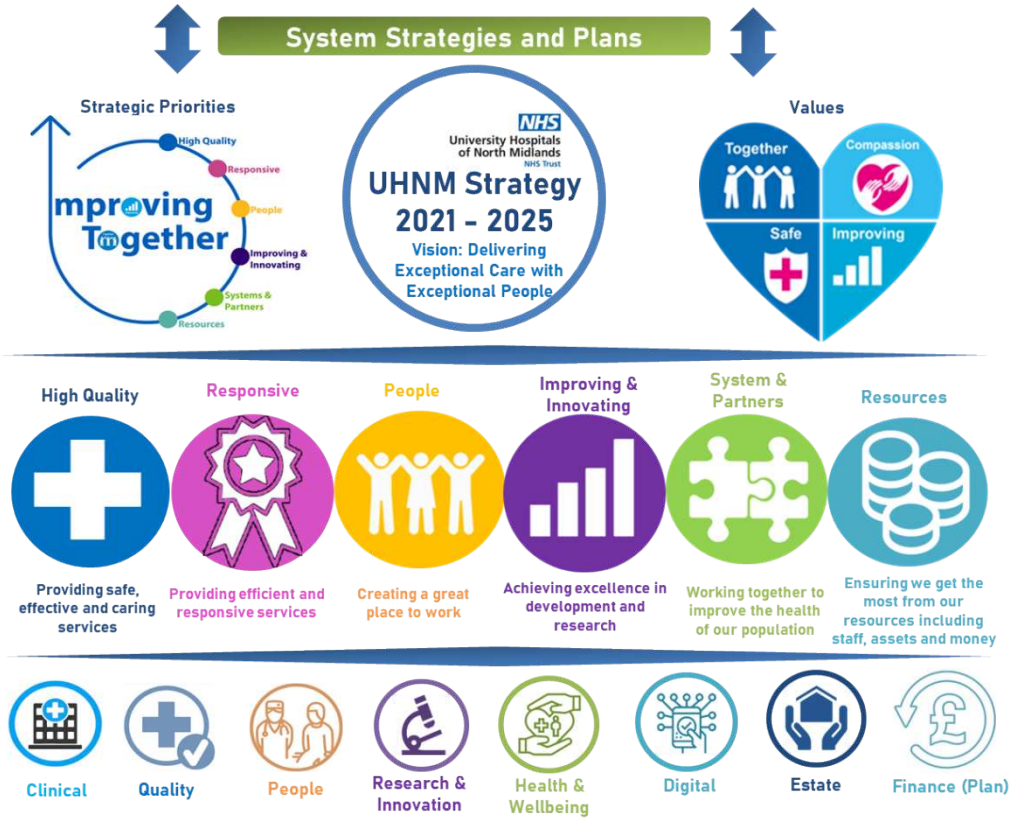
Annual Plan 2023/2024

Contents

Introduction

This **Annual Plan 2023/24** sets out our intentions and priorities for the coming year.

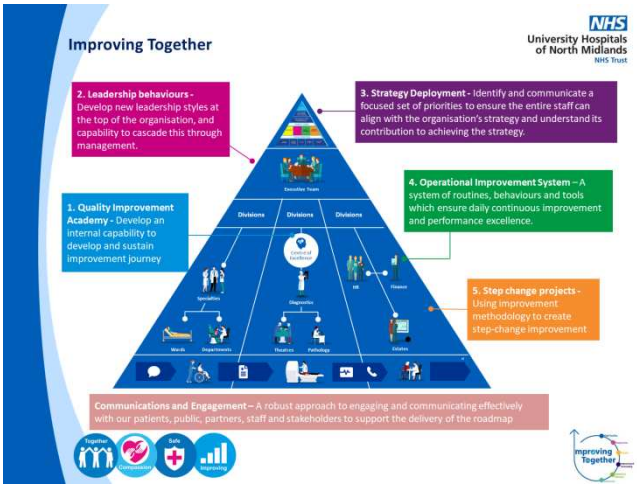
As with the previous year, the Plan is aligned to our Strategic Framework (as shown below) and seeks to set out key deliverables for the coming year against the Trusts Strategic Priorities. During the course of the year further work has been undertaken to strengthen the alignment of all elements of the framework including the refresh of the Strategic Priority descriptors, and the alignment of the organisations key enabling strategies with the strategic priorities.



Though the Trust continues to work towards the current strategy set out in the **2025 Vision**, which was initially developed in 2014 following our integration with Mid Staffordshire NHS Foundation Trust, it is recognised that whilst much remains relevant, priorities have changed. Despite Covid-19 setting the Trust back somewhat in terms of refreshing our strategy, during 2023/24 the Trust will embark upon a review of its strategy and vision to ensure that it remains relevant to the challenges facing the NHS in its 75th year. The review, that will take place over the next 12 months, will seek to engage the views of stakeholders, both internal and external, in shaping the vision and direction for the Trust for the next 10 years.

Until that time the **strategy deployment framework** will continue to focus on improvement activity against key priorities, objectives and initiatives identified from data on Trust performance, and in doing so, complement other aspects of the Improving Together programme in achieving the vision of **Delivering Exceptional Care with Exceptional People.**

The Improving Together programme has a number of additional components to support this:



- The establishment of a **Quality Improvement Academy** team to build greater capacity and support for all of our staff to use established quality improvement methodologies and lead change
- Developing our **Executive Team as 'Lean'** leaders with behaviours and skills that will cascade through the organisation, supporting all staff to lead quality improvement at whatever level and role they perform
- Introduction of an **Operational Improvement System** – a new set of skills, routines and behaviours which enables all staff to contribute to small changes each day that will improve the care we provide to our patients

Context

We are a large, modern Trust in Staffordshire, **providing care in state of the art facilities**. We provide a full range of general hospital services for approximately 1.1 million people locally in Staffordshire, South Cheshire and Shropshire. We employ around 11,000 members of staff and we provide specialised services for a population of around 3 million, including neighbouring counties and North Wales.

We are one of the largest hospitals in the West Midlands and have one of the **busiest Emergency Departments** in the Country, with an average of around 14,000 patients attending each month across both of our sites. Many emergency patients are brought to us from a wide area by both helicopter and ambulance because of our **Major Trauma Centre status**; as we are the specialist centre for the North Midlands and North Wales.

As a University Hospital, we work very closely with our partners at Keele and Staffordshire University and we are particularly proud of our **Medical School**, which has an excellent reputation. We also have strong links with our local schools and colleges. As a major teaching Trust, we hold a large portfolio of commercial research, which provides us with an additional source of income. **Our research profile** enables us to attract and retain high quality staff.

Our **specialised services** include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care, paediatric intensive care, trauma, respiratory conditions, spinal surgery, upper gastro-intestinal surgery, complex orthopaedic surgery and laparoscopic surgery.

We play a key role within the **Staffordshire and Stoke-on-Trent Integrated Care System (ICS)**, which has partnership working at its very core as we work closely together to transform the way health care is delivered for the benefit of our population. This includes leadership and participation in partnership boards which bring together health, social care, independent and voluntary sector organisations across Staffordshire.

We look to **involve our service users** in everything we do, from providing feedback about the services we provide, to helping to share our priorities. This work is co-ordinated by our dedicated Patient Experience Team.

Risks to Delivery

Through our annual review of the **Board Assurance Framework (BAF) for 2023/24**, we have identified a number of strategic risks which might compromise our ability to delivery our Plan. These risks will be monitored through our Board and Committees and are summarised below:

Strategic Priority Domains	
High Quality	Providing safe, effective and caring services
Response	Providing efficient and responsive services
People	Creating a great place to work
Improving & Innovating	Achieving excellence in development and research
Systems and Partners	Improving the health of our population by working with partners
Resources	Ensuring we get the most from the resources we have, including staff, assets and money

Summary Board Assurance Framework 2023/24		
No.	**Summary of Risk Description**	**Impact on Strategic Priorities**
BAF 1	Delivering Positive Patient Outcomes	
BAF 2	Sustainable Workforce	
BAF 3	Leadership, Culture and Values	
BAF 4	Improving the Health of our Population	
BAF 5	Delivering Responsive Patient Care	
BAF 6	Digital Transformation	
BAF 7	Fit for Purpose Estate	
BAF 8	Financial Sustainability	
BAF 9	Research & Innovation	

System Working

Staffordshire and Stoke-on-Trent has recently developed its Integrated Care Strategy, which focuses on long-term priorities to prevent ill health, reduce inequalities, and deliver better health and care services for our population.

The Strategy has been developed on behalf of the **Integrated Care Partnership (ICP)** which is an alliance of NHS Providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs, social care and independent and third sector providers.

The pursuit of 'integration' is about ensuring that the right partnerships, policies, incentives and processes are in place to support practitioners and local organisations to work together to help people live healthier and more independent lives for longer. ICPs will play a critical role in making this happen.

The strategy outlines how the Staffordshire and Stoke-on-Trent (SSOT) Integrated Care Partnership (ICP) will work over the next five years to improve services for our people and communities. By working closely together we can spot new opportunities and have a greater impact than any partner can achieve on their own.

There are four **aims** that have been set out to achieve this strategy:

Improve outcomes in population health and healthcare

Tackle inequalities in outcomes, experience, and access

Enhance productivity and value for money

Help the NHS to support broader social and economic development.

The ICS has sought to establish a number of programme areas to support delivery of the ICP strategy and its deliverables. The Programme areas are intended to bring together **delivery and local transformation** Portfolios are aligned to 8 key focus areas: Population Health Prevention and Health inequalities; Planned care; Children & Young People and Maternity; Urgent and Emergency Care; Frailty and Long-Term Conditions; Primary Care; Mental Health, Learning Disabilities and Autism.

Improving Outcomes in population health & health inequalities

Improving delivery of elective care services

Improving cancer services & outcomes in cancer care

Delivering improvements in Children & Young People services & maternity care

Improving Urgent & Emergency Care & delivering more care at home

Promoting Healthy ageing and managing frailty

Delivering more services through primary care to support system transformation

Growing and improving mental health services

Each of the portfolios has an agreed set of senior leadership roles including an Executive Sponsor, an SRO, a Portfolio Director and a Clinical Director.

National NHS Priorities

In 2023/24 the NHS has set itself three key tasks. Our immediate priority is to recover our core services and productivity. Second, as we recover, we need to make progress in delivering the key ambitions in the NHS Long Term Plan. Third, we need to continue transforming the NHS for the future.

We have taken the national **NHS priorities** into account when developing our Strategic Priorities and have mapped them accordingly:

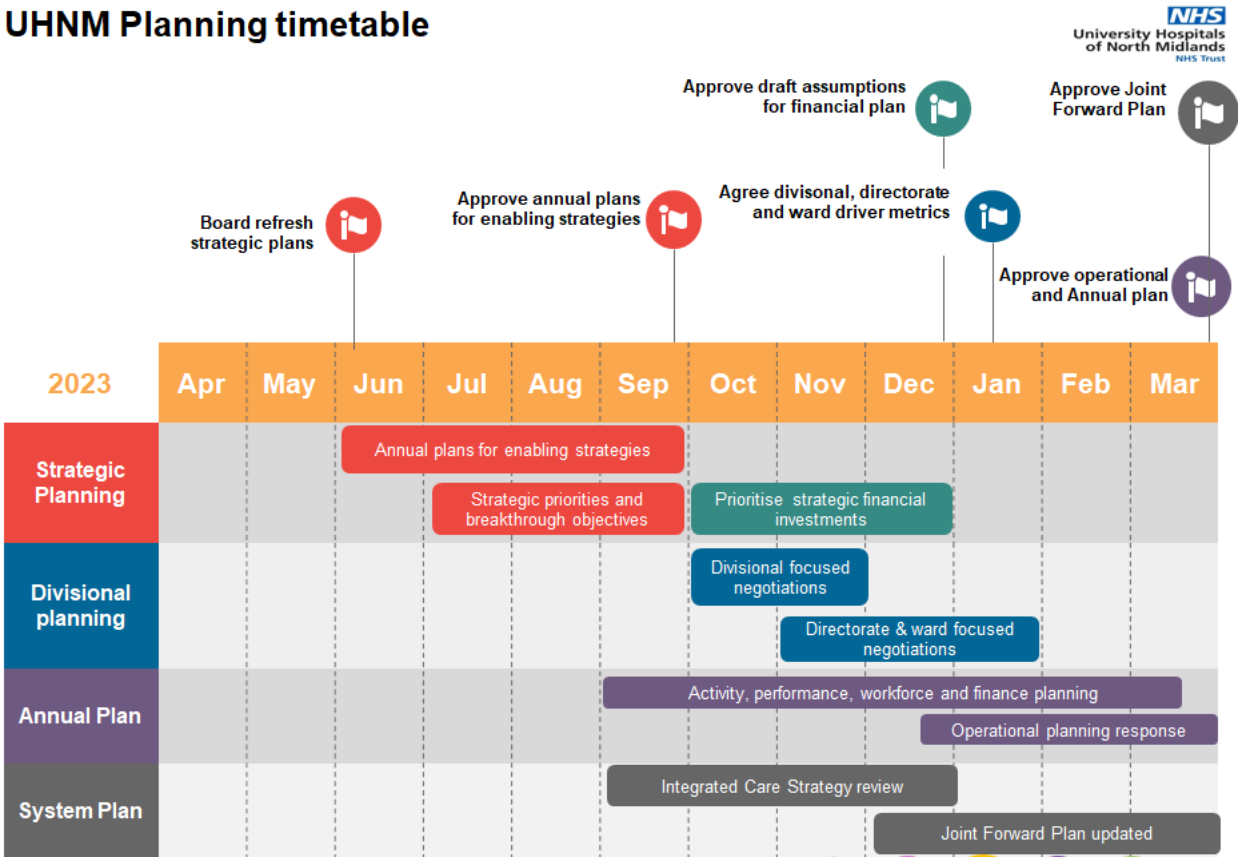
NHS Priorities and Mapping to our Strategic Priority Domains	
NHS	improve ambulance response and A&E waiting times
NHS	reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
NHS	make it easier for people to access primary care services, particularly general practice
NHS	maintain quality and safety in our services, particularly in maternity services
NHS	improve staff retention and attendance through a systematic focus on all elements of the NHS People Promise
NHS	continue to narrow health inequalities in access, outcomes, and experience
NHS	support the physical and mental wellbeing of people will support more people return to work
NHS	support delivery of the primary and secondary prevention priorities set out in the NHS Long Term Plan
NHS	level up digital infrastructure and drive greater connectivity

A summary of more detailed system requirements to deliver these National Priorities can be found at appendix 1.

Improving Together

2023/24 will be the third year of our Trust-wide organisational development programme, Improving Together. **Improving Together** will build capacity and capability for improvement at all levels in the Trust, and ensure that we define, align and cascade goals across the organisation that will drive improvement efforts.

The Trust has taken the opportunity to review its planning cycle and timetable in order to ensure appropriate alignment of all planning and priority setting that going forward will culminate in the production and sign off of this plan.



2023/24 Priorities

Developed through the processes outlined above, and taking into account the context in which we work, this section sets out our **priorities for 2023/24**. We will be developing our 'A3's' for each of these areas to understand where the root cause of non-achievement lies and the biggest contributors. From those A3's we will identify a number of 'countermeasures' which may require a step change and therefore require a Corporate Project to be initiated in order to achieve.

Divisional Priorities

Through a process of 'focussed negotiation', each clinical division has agreed their priority metrics, these priorities were discussed and developed towards the end of 22/23. These are referred to as 'Driver Metrics' (although we have a number of additional metrics referred to as 'Watch Metrics). Driver Metrics for each Division are summarised below:

2023 /2024 Priorities - Aligned to Divisional Priorities

NHS University Hospitals of North Midlands NHS Trust

Division						
Medicine & Urgent Care	➢ Patient safety incidents with moderate harm or above ➢ Timely response to clinical observations	➢ Endoscopy performance % waiting over their due date ➢ Pre noon discharges	➢ Staff Engagement score ➢ Sickness Absence		➢ Reducing length of stay for patients >65 years	➢ Performance to budget
Surgery, Theatres and Critical Care	➢ Timely response to clinical observations ➢ Duty of candour - written (10 working days)	➢ 28 Day Faster Diagnosis Standard ➢ RTT> 65 weeks	➢ Staff Engagement score ➢ Sickness Absence		➢ Outstanding Discharge Summaries	➢ Performance to budget ➢ Theatre Productivity
Network Services	➢ Timely response to clinical observations	➢ CRTP+1 ➢ P2 Breaches ➢ Follow-up backlog (52 weeks) ➢ RTT> 65 weeks	➢ Staff Engagement score			➢ Performance to budget
Women's, Children's & Clinical Support	➢ Timely induction of labour ➢ Maternity Assessment unit triage within 30 mins	➢ Imaging Turnaround times	➢ Appraisal rates (PDRs) ➢ Staff Engagement score			➢ Performance to budget

Appendix 1 – NHS System Requirements

	Area	Objective
Recovering our core services and improving productivity	Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
LTP and transformation	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

Executive Summary

Meeting:	Trust Board	**Date:**	3rd May 2023
Report Title:	Integrated Performance Report, Month 12 2022/23	**Agenda Item:**	14.
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & Safety; Operational Performance: Warren Shaw, Strategic Director of Performance & Information; Matt Hadfield, Associate Director of Performance & Information. Workforce: Paul Williams, Assistant Director of Human Resources; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse / Paul Bytheway: Chief Operating Officer / Jane Haire: Chief People Officer / Mark Oldham: Chief Finance Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Executive Summary

Situation

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

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

Quality & Safety

Assessment

During the increased operational pressures experienced by UHNM and health system there has been continued pressure on the achievement of the various quality and safety indicators but March 2023 has seen some improvements in areas whilst other indicators have continued to fail the agreed targets.

Friends & Family Test for A&E has improved slightly during March 2023 but remains below the 85% target of patients recommending the service. Whilst there has been slight improvement in the results it is important to note that there has been further increases in the response rate with 10.5% response rate and over 1000 responses received during March 2023. These improvements are following the continued work by the Patient Experience Team with the ED Teams to promote the FFT surveys and improve feedback. The completed surveys continue identify the long waits in ED as main reason for poorer experience.

Inpatient FFT results are still above the 95% target. There was a 24% response rate for Inpatient related FFT with over 2700 responses received. There are key improvement initiatives underway to try and improve these results which are focussing 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

Following improvement last month, Maternity FFT has again achieved the 95% target and the text messaging service going live during February 2023. During March, 100% of the completed responses recommended the service and 79 completed responses and 39 from the Birth touchpoint.

The number of reported patient safety incidents remain above the long term mean and have increased again during March following February reduction, however the rate per 1000 bed days has remained relatively stable. The increase in raw numbers compared to February is a result of longer month, 31 days from 28 days and increased activity.

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. Within these incidents 157 (reduction from 170 in February and 228 in January 2023) of the incidents identified as related to 'Your Next Patient' which accounts for 7.4% (9.8% in February and 12% in(January 2023) of total patient safety incidents. 61.8% (68.6% previously) were Tissue viability. However, 74.2% of these were NOT hospital acquired but recording pressure damage on admission/attendance at UHNM.As the extreme operational and capacity pressures were slightly reduced in March the number of incidents reported relating to Your Next Patients has also reduced.

Moderate harm or above incidents, both raw numbers and rate per 1000 bed days have reduced again in March and are 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. It is key to note that during March 2023 there have been zero patient flow related incidents following 1 in February and 8 in January at the peak of the operational pressures. The different working practices and patient flow pathways that have been introduced to mitigate the risks and to keep patients as safe as possible and these changes appear to have started to take effect with further reductions noted during March 2023 compared to previous months.

Although there has been in month increase from February 2023, serious Incidents have also seen continued longer term reductions 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.

Duty of Candour compliance for evidence in written notification has improved to 60.9% and is the best performance for 5 months since September 2022. 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.

Whilst there have been continued improvements in evidencing and uploading the evidence to Datix, there is still large improvements required. Enhanced support is continuing to be provided at Divisional and Corporate levels. Divisions include updates on local actions being undertaken to improve compliance at QSOG and individual Divisional Performance Reviews.

Nosocomial COVID infections have seen reduction in March 2023, and there has also been a reduction in the number of deaths reported.

Hospital Associated Thrombosis have reduced further in March 2023 but these remain under review are under review with deep dive at the VTE Steering group. There have been 87 investigations that have been completed all have been unavoidable. It was previously noted last month that there has been an increase in COVID/RSV and FLU positive patients amongst the incidents and whether this is of significance is to be assessed as part of the ongoing investigations.

All data used in this report is as recorded on 5th April 2023 and figures may change following further review/investigation/update

Operational Performance

Emergency Care

- March was overall a relatively static month for Non-Elective Care following significant improvements from December in January and February. Reasonable increases in attendances, combined with the first Junior Doctor Industrial Actions, and once again increasing IP restrictions have meant that while modest improvements continue to be made in metrics less impacted by reduced Trust flow (such as Four Hour Performance and Non-Admitted Mean Time In ED), stagnation or slight deterioration was

seen in Trolley Waits and One Hour Ambulance Handovers.

- While One Hour Ambulance Handovers saw a slight deterioration this month the overall trend of 'Lost Ambulance Hours' (the headline KPI for the now Regional Ambulance Handover Improvement Group) has now seen a sustained and significant improvement since January. UHNM had an October to December baseline of approximately 1000 lost hours per month, and following a January of rapid improvement we have now sustained a circa 70% improvement since February with an average of approximately only 300 hours lost per month for our tenth consecutive week. This improvement has moved UHNM from consistently the poorest performing out of the West Midlands monitored cohort. This has been achieved by reducing extreme handover delays, and further work remains in the short term to target delays 'just over' the hour which have not seen proportional improvements.

- The UHNM Annual Operational Plan has now been submitted detailing our ambitious but achievable trajectory to both 76% Four Hour Performance and 92% G&A Occupancy by March 2024. Two critical elements of achiving these national targets will be the delivery of 80% non-addmitted performance against the Four Hour Standard on the RSUH site and the implementation of the SDEC Modular structure supported by national monies.The former of these is a priority of Workstream 1 and will be championed by the ED Clinical Lead and the latter will be managed through Workstream 2 and is currently undergoing high level conversations to determine the optimum clinical model.

- To note the time required to prepare for and execute the safe management of the Junior Doctor Industrial Actions is substantial and will undoubtedly challenge available capacity to delivery transformational work, particularly as actions escalate. However, the extreme and extended operational oversight has provided an unforeseen opportunity to drive operational improvements and has facilitated continued improvements in a variety of metrics.

Cancer

- Two week wait performance is now booking within standard at 14 days, currently at 96.35%. This has been maintained in the face of high referral volumes.
- The 28 Day Faster Diagnosis position is currently 71.6% for March; this is showing signs of improvement towards the 75%target. This standard is the focus of an Improving together project covering all pathways.
- In February the backlog of patients has seen a significant reduction from 1041 at the end of August to 313 at the end of March.
- The incremental decrease of the Skin and Colorectal backlogs have been modelled up to the end of March 2023, this has been taken forward into the annual plan for the coming year.
- Most recent submitted Cancer Waiting Times position is Februay which was 55.5% for 62 day performance. March is currently predicted to be 50.9% although this will improve post validation, this is due to the number of treatments for our longest waiting patients increasing.
- The 62 day target is expected to continue an improvement trajectory as additional capacity is put into 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 and Elective Activity delivered 95% and 107% respectively for March 23 against the national ask of 110%/108%. Day case as a % of all elective work is currently 87.3%.
- 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 however and number of 104 remain and the March 104 position ended at 58.
- 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
- The focus has moved to 78 week waiters and the Trust Annual Plan submitted an initial position of 292

patients by March 2023, the National ask is to achieve 0 patients waiting over 78 weeks by the end of March. All non-admitted (Outpatient) patients have an appointment booked to ensure they get a decision to treat or discharge however the majority will move to our admitted pathway. March ended with 558 78 breaches.

RTT

- The overall Referral To Treatment (RTT) Waiting list currently sits at 77487, 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 continues to increase – from 4377 in August to now 5,425 in March.
- At the end of March the numbers of > 104 weeks was 58. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment.
- The Trust 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.
- At the end of March, the Trust reported 78> week waits at 558 and 104> week waits at 58.

Diagnostics

- Overall DM01 performance was 75%, an increase in performance on last month's 74%.
- Within DM01, the greatest proportions of > 6 week waits are within endoscopy. Non-obstetric ultrasound while still not meeting target have shown considerable improvements, however Endoscopy remains a concern.
- 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 and a risk to the March delivery target. 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)

Workforce

Key messages

- Our two main areas of focus continue to be on addressing staff availability in relation to absence rates and turnover.
- The 12m Turnover rate in March 2023 sat at 10.9% figure sitting below the trust target of 11%.
- The trust vacancy rate decreased to 12.5%.
- For March 2023, the in-month sickness rate increased by 0.26% to 5.28% (5.02% in February 2023). The 12 month cumulative rate marginally decreased to 5.86% (5.99% in February 2023).
- Anxiety and Stress at 22.5% sits is the top reason for absence closely followed by Chest and respiratory (which includes Covid) at 21.9%.
- On 26th March 2023 covid-related absences stood at 117, which was 17.6% of the 664 open absences. This is 2.1.% decrease on same time the previous month.
- At 31 March 2023, the PDR Rate increased 0.5% by to 82.7% (82.2% at 28 February 2023). This continues the small upward trend; however, this figure still sits below the overall target.
- The Statutory and Mandatory training rate on 31 March 2023 was 93.6% (93.0% at 28 February 2023) showing a slight increase. This compliance rate is for the 6 'Core for All' subjects only.
- The Being Kind e-learning will be mandated from 1 April 2023 and this will be communicated Trust wide with large scale face-to face sessions being planned for June and July.
- The Staff Voice trust survey for March 2023 received a total of 919 submissions providing an overall staff engagement score of 6.60.
- The Loop app officially launched on the 3rd April, Fully integrated with our eRostering solution, it allows your people to view their personal schedule anytime.
- The Rota team managed the extra pressures due to the Junior Doctor industrial action.

Finance

Key elements of the financial performance year to date are:

- For the year to date the Trust has delivered a breakeven income and expenditure position in line with its plan; this has been heavily reliant on non-recurrent mitigations.
- The Trust incurred £0.6m of costs relating to COVID-19 in month; with £0.5m of this being chargeable for COVID-19 testing costs. The Trust has overspent by £3.3m against its original in envelope allocation due to the in envelope funding allocation ceasing after Month 2.
- To date the trust has validated £12.1m CIP savings in year; these schemes have a full year impact of £5.3m, which presents a considerable variance to the Trust's recurrent target of £13.6m which was identified as a key risk in the Trust's financial plan submission. This variance was reflected in the revised underlying position presented to the Committee in December.
- Capital expenditure at year end is £63.4m which is in line with the 2022/23 capital plan.
- The cash balance at Month 12 is £84.0m which is £7.0m higher than plan. Cash received is above plan due to Capacity, Surge and Virtual Ward income received from the ICB.

Key Recommendations

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

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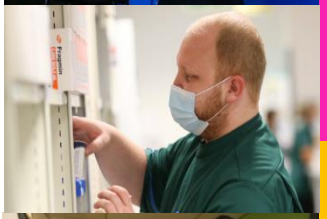


Integrated Performance Report

Month 12 2022/23

Delivering Exceptional Care with Exceptional People

Contents

A note on SPC

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

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

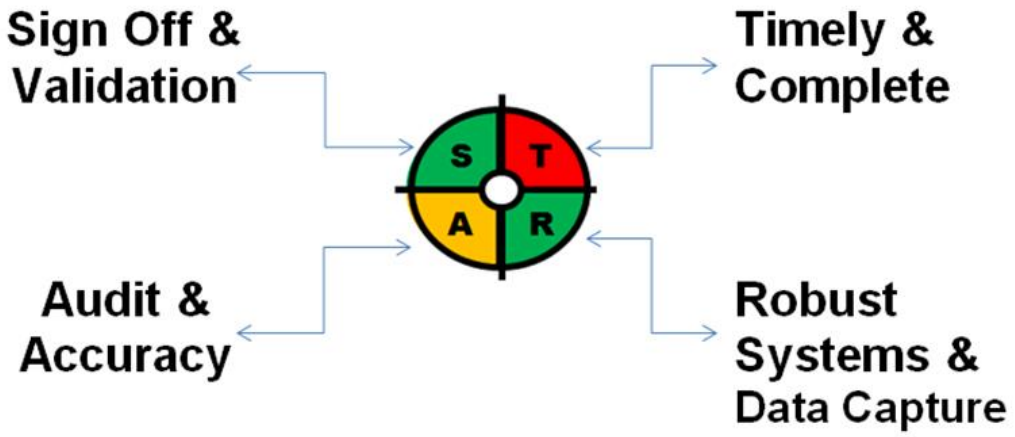
Assurance - how assured of consistently meeting the target can we be?

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

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

A note on Data Quality

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



Explaining each domain

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

RAG rating key

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

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Quality

Caring and Safety

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

Quality Spotlight Report

NHS
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The Trust achieved the following standards in March 2023:

- Friend & Family (Inpatients) 97.1% and exceeds 95% target.
- Friend & Family (Maternity) 100%.
- Harm Free Care achieved 96.7% against 95% target rate
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 98.7% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- E. Coli Bacteraemia cases below trajectory with 9 in March compared to target of 16.
- Inpatients Sepsis Screening above 90% target rate at 100%.
- Inpatient Sepsis IVAB within 1 hour achieved 100% and above 90% target rate
- Children's Sepsis Screening compliance 91.4% and above the 90% target and IVAB compliance at 100%

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E remains below 85% target at 72.1%, despite improvement in month
- Falls rate was 5.9 per 1000 bed days for March 2023
- 1 Never Event
- There were 24 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 87.o% verbal Duty of Candour compliance recorded in Datix
- 60.9% compliance with Duty of Candour 10 working day letter performance following formal verbal notification and under review for completion and upload of letter on Datix
- C Diff YTD figures above trajectory with 13 against a target of 8.
- Sepsis Screening compliance in Emergency Portals declined to 81.8% below the target of 90%.
- Emergency Portals Sepsis IVAB in 1 hour improved to 56.8% but remains below the 90% target for audited patients
- Maternity Sepsis Screening compliance improved to 86.2% against 90% target
- Maternity IVAB compliance 80% and below the 90% target for audited patients

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

- The rate of complaints per 10,000 spells is 23.25 and is below the target of 35 and within normal variation. Majority of complaints in March 2023 continue to relate to clinical treatment.
- Total number of Patient Safety Incidents increased in month (2110) and the rate per 1000 bed days has also increased at 50.84 but 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 continue to reduce following peak in December 2022.
- Rate of falls reported that have resulted in harm to patients currently at 2.0per 1000 bed days in March 2023. The rate of patient falls with harm continues to be within the control limits and normal variation.
- Medication related incidents rate per 1000 bed days is 5.1 and patient related 4.4 which are higher than previous month and mean rates. The monthly variation is within the normal expected variation and consistent with Trust mean rates.
- Pressure Ulcers per 1000 bed days developed under UHNM care has seen a decrease during March 2023 to 0.58
- Hospital Associated Thrombosis has decreased and is within normal variation and cases are under review.
- Slight increased numbers of Definite Hospital Onset / Nosocomial COVID-19 cases reported with 50 in total.
- 4 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 10 Serious Incidents reported during with 7 falls related.
- SHMI has seen increases and under review for diagnosis groups but is within expected range (see funnel plot chart)

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1794	2110		
Patient Safety Incidents per 1000 bed days	50.70	47.47	50.84		
Patient Safety Incidents per 1000 bed days with no harm	N/A	31.81	32.43		
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.97	15.49		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.72	2.05		
Patient Safety Incidents with moderate harm +	N/A	34	34		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.90	0.82		
Harm Free Care (New Harms)	95%	94.4%	96.7%		
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		
Patient Falls per 1000 bed days	5.6	5.4	5.9		
Patient Falls with harm per 1000 bed days	1.5	1.7	2.0		
Medication Incidents per 1000 bed days	6	5.3	5.1		
Medication Incidents % with moderate harm or above	0.50%	1.51%	0.00%		
Patient Medication Incidents per 1000 bed days	6	4.8	4.4		
Patient Medication Incidents % with moderate harm or above	0.50%	1.67%	0.00%		

Metric	Target	Previous	Latest	Variation	Assurance
Serious Incidents reported per month	0	7	10		
Serious Incidents Rate per 1000 bed days	0	0.19	0.24		
Never Events reported per month	0	0	1		
Duty of Candour - Verbal/Formal Notification	100%	87.5%	87.0%		
Duty of Candour - Written	100%	58%	60.9%		
All Pressure ulcers developed under UHNM Care	TBC	59	92		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.56	2.22		
All Pressure ulcers developed under UHNM Care lapses in care	12	23	24		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.61	0.58		
Category 2 Pressure Ulcers with lapses in Care	8	7	3		
Category 3 Pressure Ulcers with lapse in care	4	2	0		
Deep Tissue Injury with lapses in care	0	10	17		
Unstageable Pressure Ulcers with lapses in care	0	4	4		

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Quality Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	71.2%	72.1%		
Friends & Family Test - Inpatient	95%	95.4%	97.1%		
Friends & Family Test - Maternity	95%	100%	95.3%		
Written Complaints per 10,000 spells	35	27.70	23.25		
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	98.54	97.27		
Rolling 12 Month SHMI (4 month time lag)	100	107.57	107.00		
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	8	4		
VTE Risk Assessment Compliance	95%	97.9%	99.5%		
Timely Observations	90%	66.7%	67.8%		
Reported C Diff Cases per month	8	13	13		
Avoidable MRSA Bacteraemia Cases per month	0	0	0		
HAI E. Coli Bacteraemia Cases per month	16	10	21		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	68	50		

Metric	Target	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	93.6%	100.0%		
Inpatient IVAB within 1hr (Contracted)	90%	100%	100.0%		
Children Sepsis Screening Compliance (All)	90%	91%	91.4%		
Children IVAB within 1hr (All)	90%	N/A	100.0%		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	84%	81.8%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	75%	56.8%		
Maternity Sepsis Screening (All)	90%	88%	86.2%		
Maternity IVAB within 1 hr (All)	90%	75%	80.0%		

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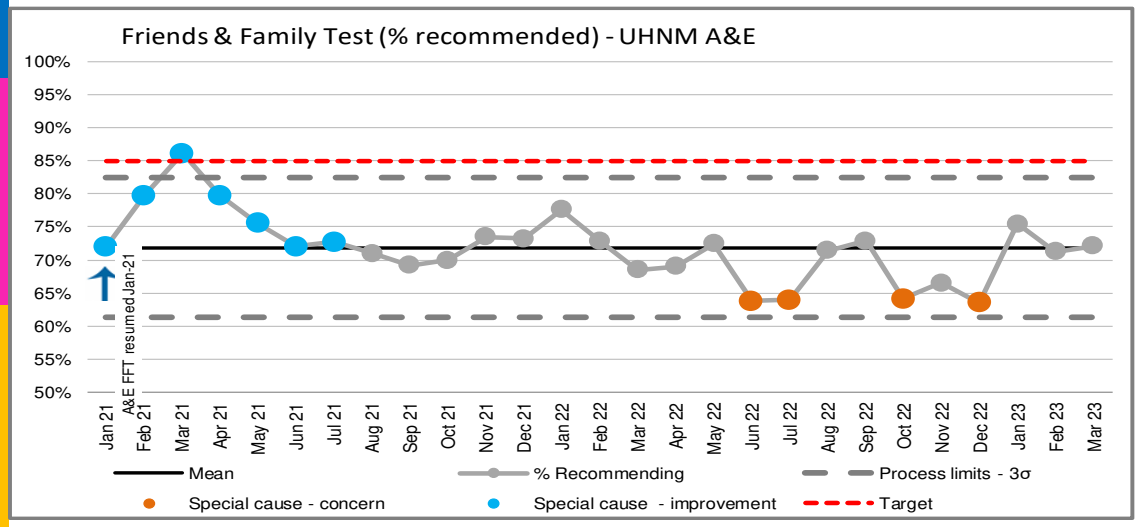
Friends & Family Test (FFT) – A&E



Variation	Assurance
L	F

Target	Jan 23	Feb 23	Mar 23
85%	75.4%	71.2%	0.0%

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?

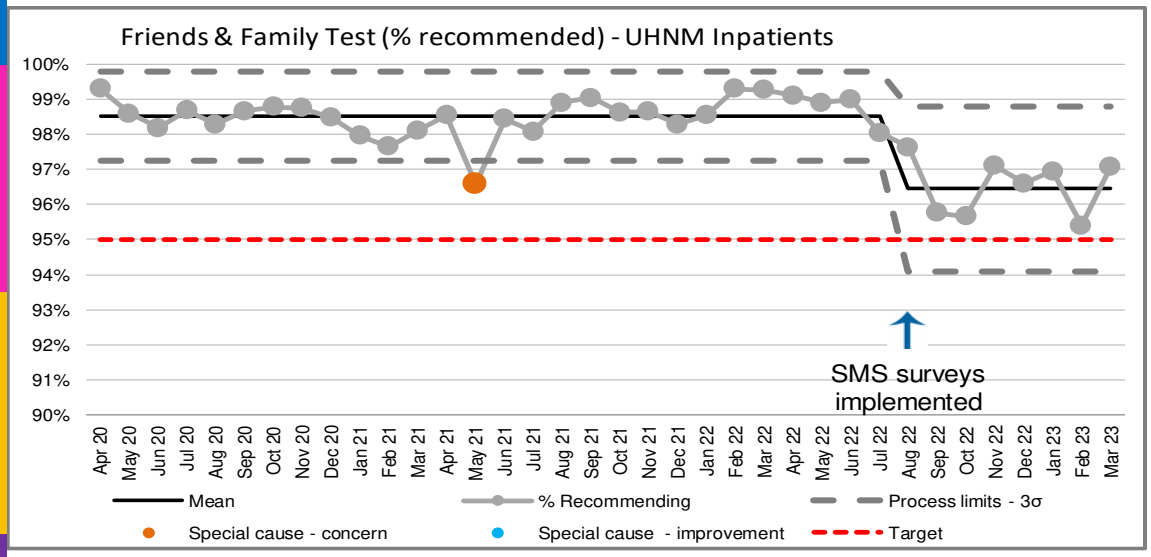
- The overall satisfaction rate for our EDs remains below our internal target at 72% for March 2023.
- The Trust received 1019 responses which is an increase on the previous month with a 10.5% response rate for overall. The Trust's overall satisfaction rate is slightly lower than the national average of 80% (NHS England February 2023 latest figure). 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. Only 22% of respondents in March 23 reported to have used 111First prior to attending ED, which is down on February 23. Key themes from March 2023 are 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
- A new audio announcement has been put in place to support with keeping patient's updated regarding wait times.
- On-going work with the team to increase FFT response rate.

Friends & Family Test (FFT) - Inpatient

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jan 23	Feb 23	Mar 23
95%	96.9%	95.4%	97.1%

Background

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

What do the results tell us?

- The monthly satisfaction rate for inpatient areas continue to exceed both the internal target rate of 95% and the national average of 94% (February 2023 NHS England) at 97% for March 2023.
- In March 2023 a total of 2786 responses were collected from 65 inpatient and day case areas (11790 discharges) equating to a 24% return rate which is an slight decrease on the previous month and 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).

Actions:

- Continue to ensure that FFT surveys are available in other formats to ensure accessibility for all patients.

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

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Reported Patient Safety Incidents

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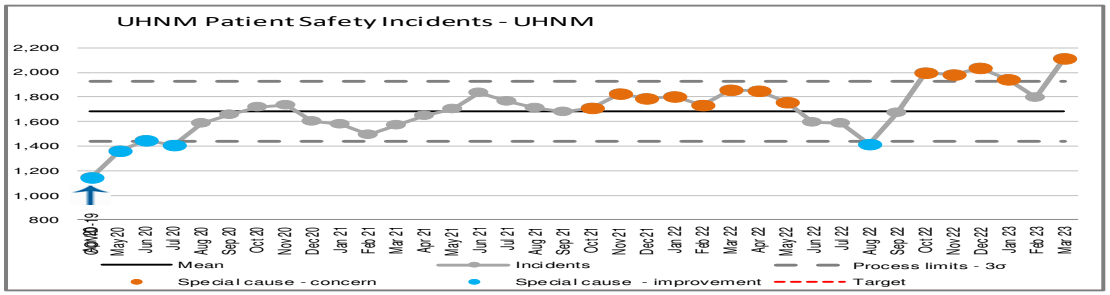
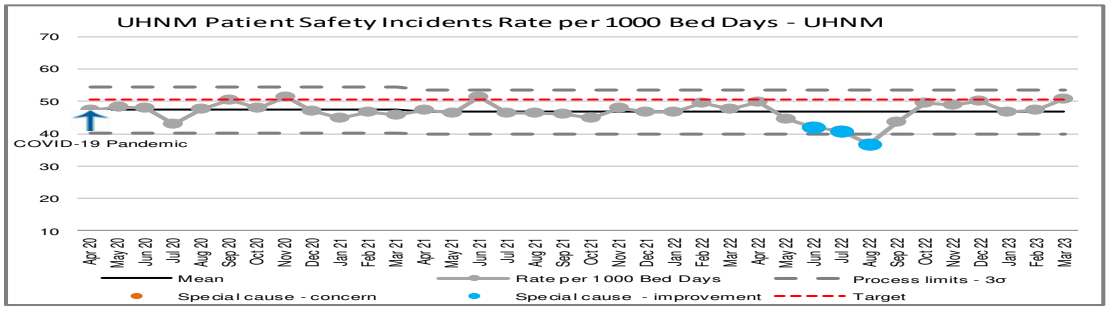


Variation	Assurance
H	

Target	Jan 23	Feb 23	Mar 23
N/A	1943	1794	2110

Background

Total Reported patient safety incidents



Variation	Assurance
	?

NRLS Mean	Jan 23	Feb 23	Mar 23
50.70	46.68	47.47	50.84

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The March 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 increases in total numbers remain relatively stable.

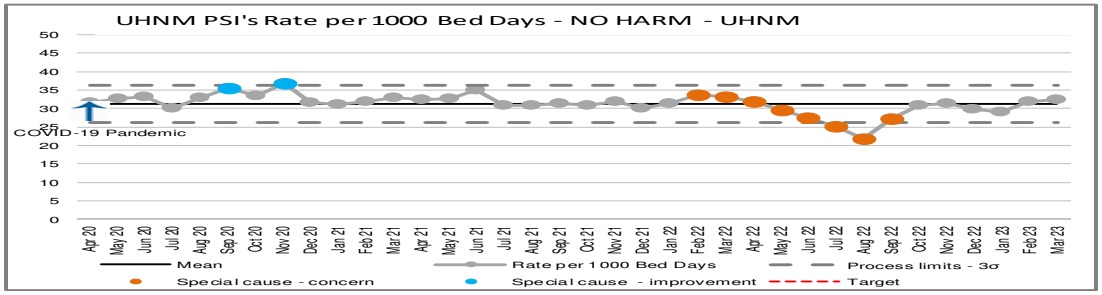
However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers are Patient Falls, Medication, Patient Flow and Treatment related incidents. There has been no significant changes in these categories compared to previous months. There have been 157 (reduction from 170 in February and 228 in January 2023) of the incidents identified as related to 'Your Next Patient' which accounts for 7.4% (9.8% in February and 12% in(January 2023) of total patient safety incidents. 61.8% (68.6% previously) were Tissue viability. However, 74.2% 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 similar to the long term mean rate and well within control limits and normal variation

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

NHS University Hospitals of North Midlands NHS Trust

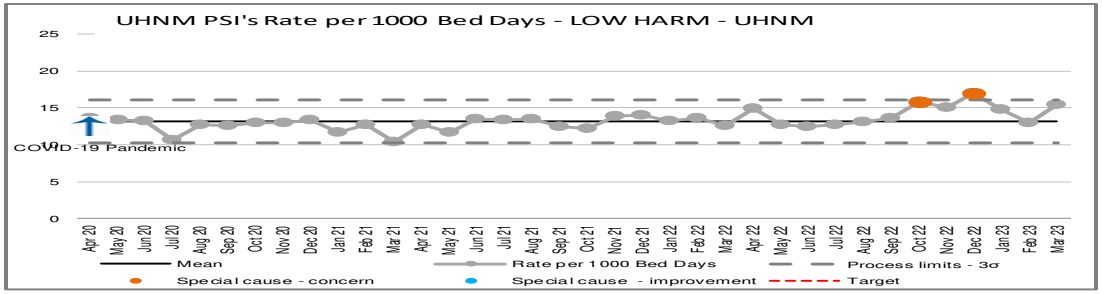


Variation	Assurance

Target	Jan 23	Feb 23	Mar 23
N/A	29.00	31.81	32.43

Background

are reported as resulting in No Harm to the affected patient.

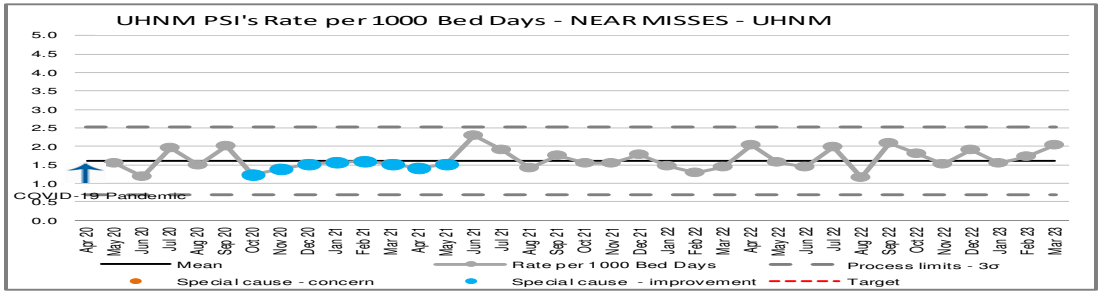


Variation	Assurance

Target	Jan 23	Feb 23	Mar 23
N/A	14.82	12.97	15.49

Background

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



Variation	Assurance

Target	Jan 23	Feb 23	Mar 23
N/A	1.54	1.72	2.05

Background

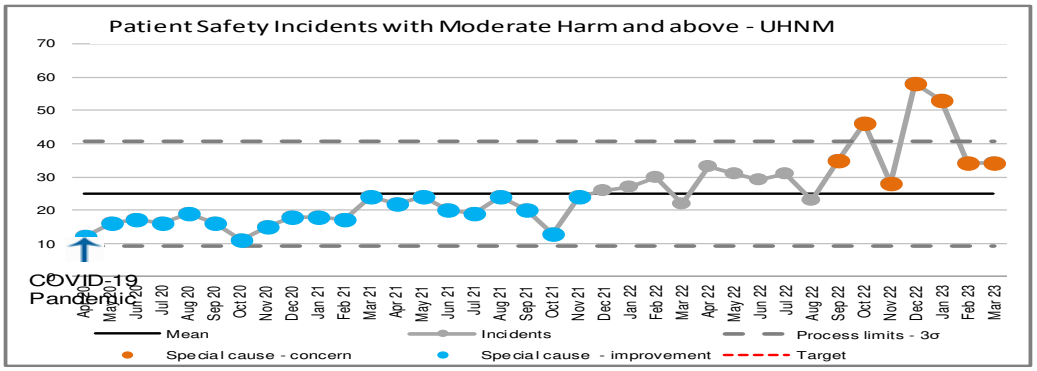
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with low harm or near misses are showing more consistent trends. The no harm incidents have seen rates back to the mean rate in recent months. With slight increase in low harm and near misses.

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

Reported Patient Safety Incidents with Moderate Harm or above

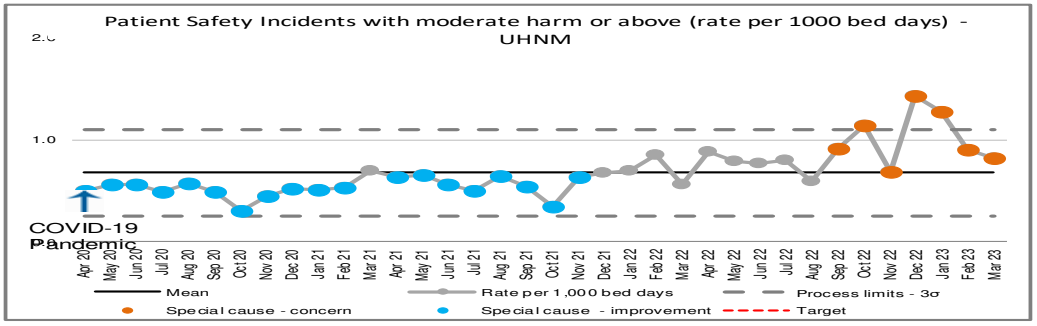


Variation	Assurance
	

Target	Jan 23	Feb 23	Mar 23
N/A	53	34	34

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance
	

Target	Jan 23	Feb 23	Mar 23
N/A	1.27	0.90	0.82

What is the data telling us:

The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is above the upper process control limit and has shown increasing total numbers since August 2022. February 2023 total has seen reductions from previous months. The rate of moderate harm and above has also reduced in February so is not just a result of less days per month but is reduction based on standardised activity rates too.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 8 Falls (11 in January 2023), 6 Clinical Assessment (4 in January 2023) , 2 Pressure Ulcer (Hospital acquired) (10 in January 2023), 1 Patient Flow (reduced from 8 in January 2023), 4 treatment related (6 previously), 1 Medication (5 previously),

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

Patient Falls Rate per 1000 bed days

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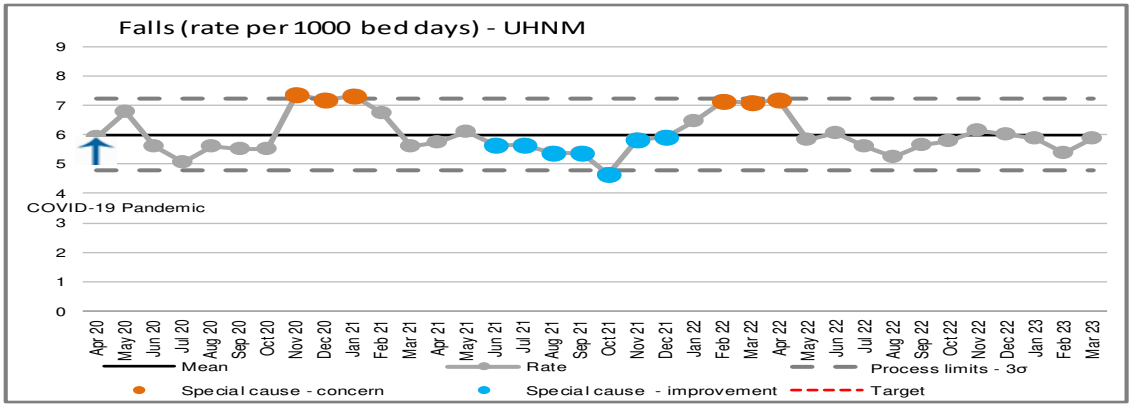
NHS Trust



Variation	Assurance

Target	Jan 23	Feb 23	Mar 23
N/A	5.9	5.4	5.9

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

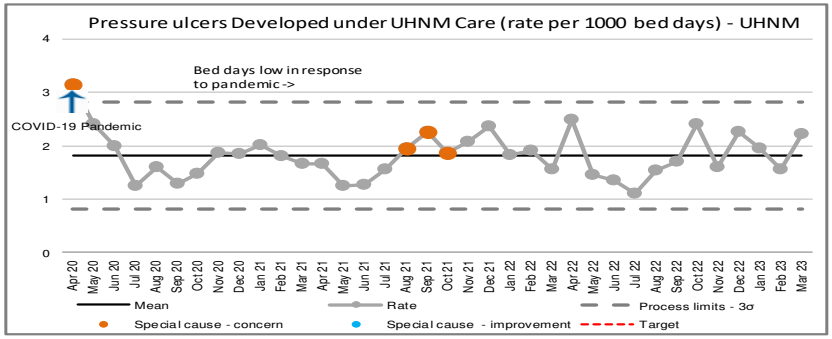
The Trust's rate of reported patient falls per 1000 bed days was within the normal range in March.

The areas reporting the highest numbers of falls in March 2023 were:
Royal Stoke AMU – 23 falls, Royal Stoke ED – 18 falls, Ward 230 – 15 falls, Ward 201 – 10 falls , Ward 123 – 9 falls
ED falls numbers per month have doubled since Autumn 2020, however, the rate per 1000 attendances has been 77% higher since Autumn 2020 indicating that the increased activity is a significant factor in increased falls. During this period 17 ED cubicles were converted into side rooms with solid doors due to infection prevention mitigation actions during COVID-19. This has made observation of patients more difficult and may have contributed to increased falls

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

- Audits have been undertaken in all of these 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.
- Following the ECC team disseminating education on one aspect of falls for 2 weeks an audit by the quality team was undertaken. Unfortunately results had not improved. Therefore a discussion has taken place with matron and the falls links, education by the team continues and Q&S are attending the unit to support the staff with 1:1 guidance. The ECC quality nurse is taking another aspect of poor compliance from the monthly falls audit summary to action and educate the team. The ECC team and Q&S will then meet to discuss the results before further plans for improvements are made.
- Audit results have shown improvement in some areas of falls on AMU. Discussions have taken place with Sister and the Quality and Education team and plans have been made, further audits will take place once the education has been disseminated. The team had stated that due to sending patients has to the wards that were not confused has "YNP", that this had resulted with more patients left on the unit that required 1:1 care or close supervision bays and therefore this was increasing the falls on the unit. A chart has been produced to indicate that there has been no significant change in the rate of falls.
- Ward 230, 201 and 123 have all had audits undertaken and this information has been fed back. Unfortunately all wards have also had recent Serious Injuries and therefore learning from RCA information has also been cascaded to the ward to disseminate to their teams.

Pressure Ulcers developed under care of UHNM per 1000 bed days

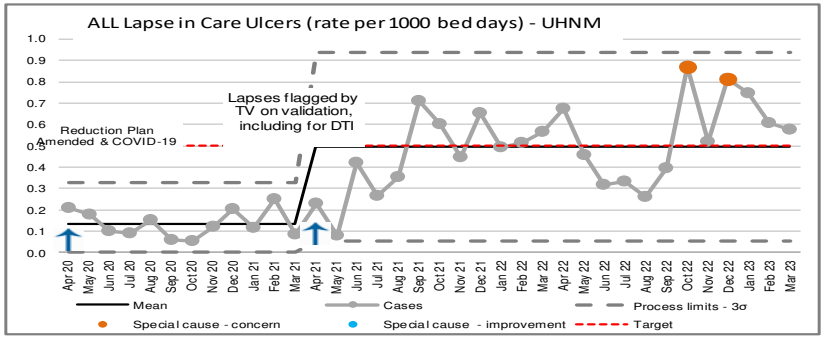


Variation	Assurance

Target	Jan 23	Feb 23	Mar 23
N/A	1.95	1.56	2.22

Background

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



Variation	Assurance

Target	Jan 23	Feb 23	Mar 23
0.5	0.74	0.61	0.58

Background

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

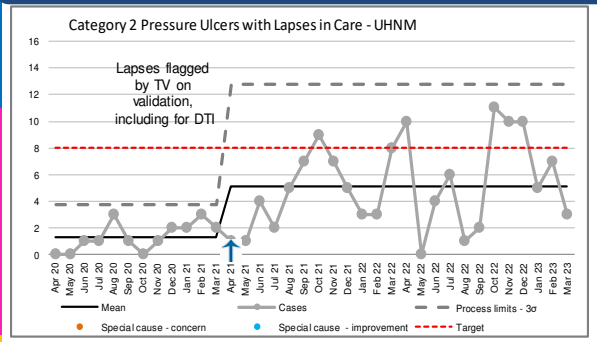
What the data is telling us

The rate of pressures ulcers reported as developed under UHNM care, and cases with lapses were within expected limits in March.
Acuity for ward areas is taken into account in line with lapses in care.
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.
Pressure Ulcer prevention is an annual objective and a key driver metric as part of the Trust's Improving Together programme.

Actions

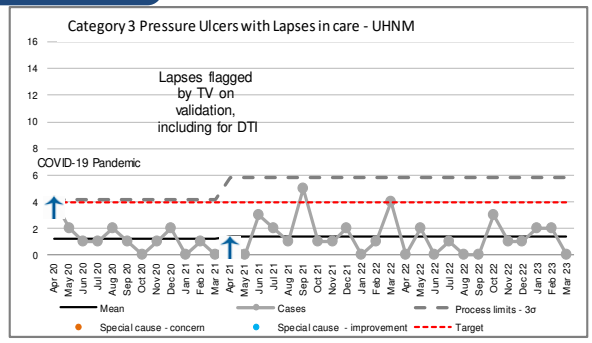
- Training continues for nursing assistants induction, ED mandatory training, Preceptorship days, and oveseas nurses
- The trialling of Respose proning overlay mattresses is continuing within Surgery Division
- Requests being made by wards for further training on skin bundles, investigation process, categorisation and dressing selection
- ESR training has been approved, however on hold due to waiting for new strategy for categorising pressure ulcers
- Stakeholder group created for patient seating
- Potential deep dive into increase into unstageable damage and deep tissue injuries for Q3 and Q4
- CQUIN audit to commence 23/24 on pressure ulcer risk assessment and documentation
- Clinical Audit underway to cover period of October – December 23
- A3 to be commenced following the reporting of urethral damage

Pressure Ulcers with lapses in care



Variation	Assurance

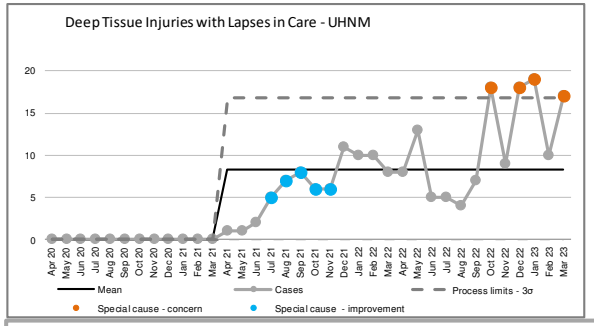
Target	Jan 23	Feb 23	Mar 23
	8	5	7	3
Background			



Variation	Assurance

Target	Jan 23	Feb 23	Mar 23
	4	2	2	0
Background			

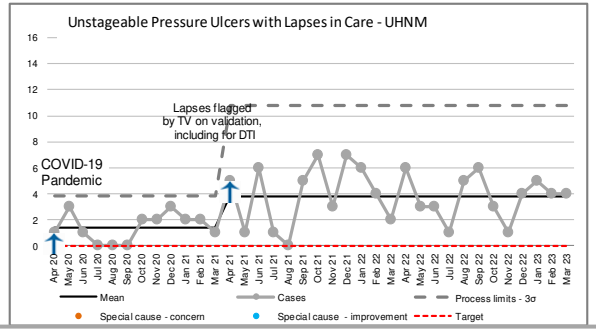
Category 3 pressure ulcers which developed under the care of UHNM with lapses in care associated



Variation	Assurance

Target	Jan 23	Feb 23	Mar 23
N/A	19	10	17
Background			

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



Variation	Assurance

Target	Jan 23	Feb 23	Mar 23
	0	5	4	4
Background			

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

What is the data telling us:

The numbers of DTIs with lapses identified was again significantly above average in March 2023. As shown in the table below, unusually the most common lapse identified was management of device in March 2023.

Root Cause(s) of damage - Lapses - Mar 2023	Total
Management of device	9
Management of heel offloading	8
Management of repositioning	6
Management of non-concordance	3

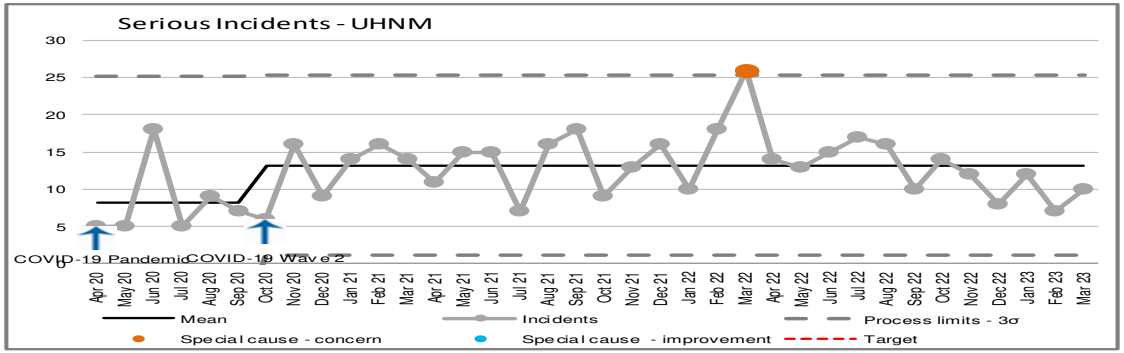
Locations with more than 1 lapse in March 2023 were:
Ward 225 (5), ED Stoke (3), Ward 227 ARTU (2)

Actions:

- Plans are underway to align investigation process with PSIRF
- High reporting wards will be visited to complete audits, action plans to be implemented to support improvement. Visit will involve education to staff during the visit
- Categorisation training dates have now been confirmed for this year. Training has now been provided to registered nurses and nursing assistants through nurse bank.
- Training video on accountability and documentation was sent to Patient Safety Group in March and 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 and plans to re-launch. Continence master classes have released dates for training. This will be proposed as an action through RCA panels

Serious Incidents per month

University Hospitals of North Midlands NHS Trust

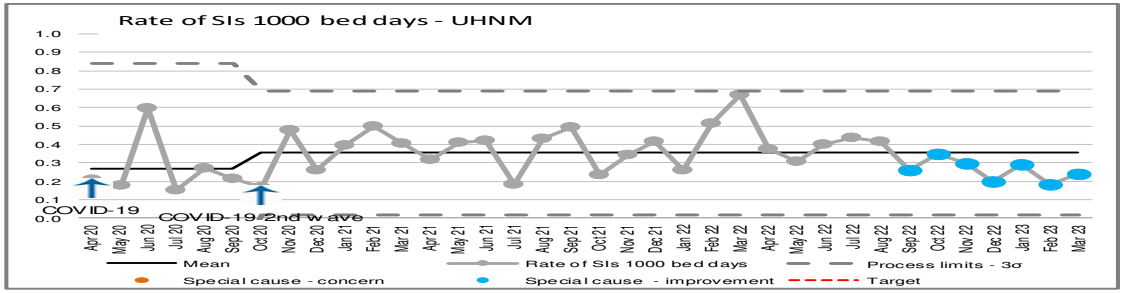


Variation	Assurance
	F

Threshold	Jan 23	Feb 23	Mar 23
0	12	7	10

Background

The number of reported Serious Incidents per month



Variation	Assurance
L	F

Target	Jan 23	Feb 23	Mar 23
0	0.29	0.19	0.24

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

Monthly variation is within normal limits but has been consistently below the average rate for the past 7 consecutive months. Target has been set at 0 for serious incidents but this remains under review to develop trajectory for reducing serious incidents across UHNM. March 2023* saw 10 incidents reported:

7 Falls related incidents

1 Maternity related

1 surgical / invasive procedure related

1 diagnostic 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 0.24 and is lower than the long term mean of 0.4 since COVID-19 started in December 2020. The previous 7 months have seen reporting rate lower than log term mean.

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

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

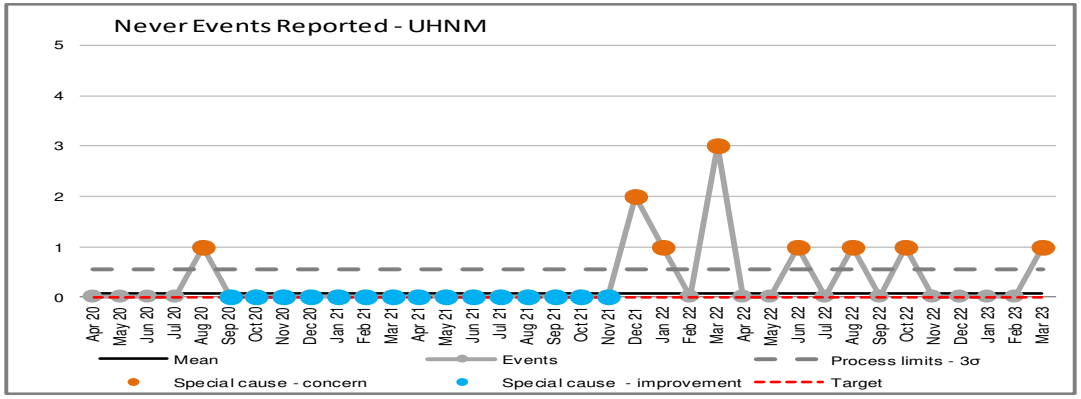
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during March 2023. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary 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 was 1 Maternity related Serious Incidents reported on STEIS during March 2023

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2023/4418	White - British	Maternity/Obstetric incident (mother & baby only)	24/05/2023	Stillbirth while inpatient on Ward 205. Attended hospital for treatment prior to emergency caesarean delivery. Known heart condition

Never Events



Variation	Assurance
	

Target	Jan 23	Feb 23	Mar 23
0	0	0	1

Background

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

There has been 1 reported Never Event in March 2023. The target is to have 0 Never Events.

Log No.	STEIS Category	Never Event Category	Description	Target Completion date
2023/6299	Surgical / invasive procedure incident meeting SI criteria	Wrong implant / prosthesis	Following successful open reduction and internal fixation, the images were reviewed as per routine and identified that 1 of the 6 screws used was a different type than requested by the operator. The plan was to use cortical screws to fit the tubular plate and a cancellous screw was visible on the images. The key difference between a cortical and cancellous screw is pitch of the screw. A cortical screw has a fine pitch whereas the cancellous screw has a coarse pitch. Mechanically, there is no determent to the patient recovery and will not compromise the fixation. No further impact/consequence for the patient as the type of screw incorrectly selected and used will not affect stability, fixation, pain or risk of infection.	16/06/2023

Duty of Candour Compliance

NHS
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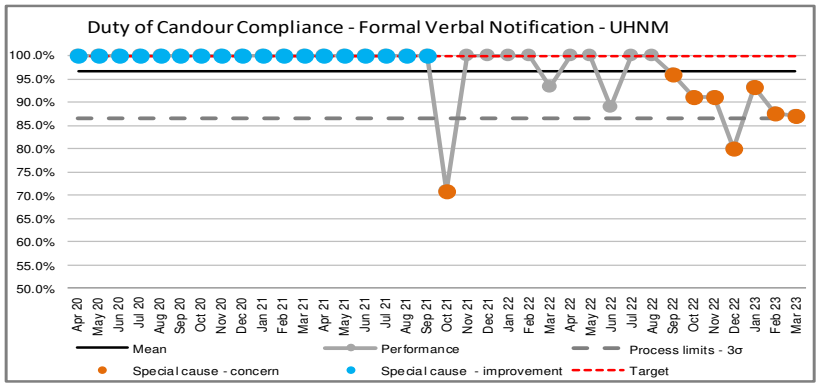
NHS Trust

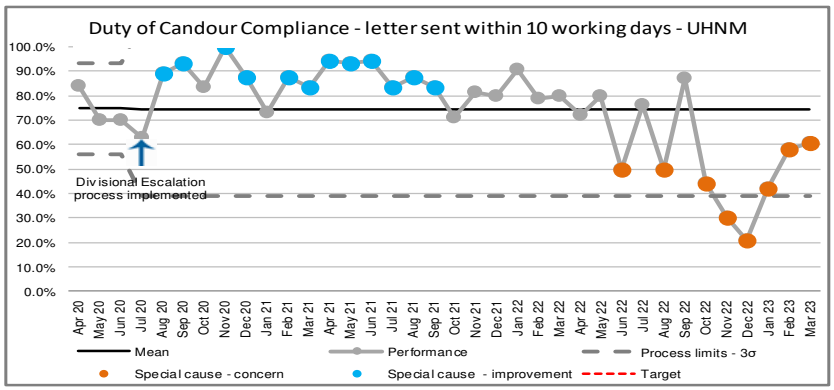


Variation	Assurance
	

Target	Jan 23	Feb 23	Mar 23
100%	93.3%	87.5%	87.0%

Background

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



Variation	Assurance
	

Target	Jan 23	Feb 23	Mar 23
100%	42.0%	58.3%	60.9%

Background

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

What is the data telling us:

During March there were 23 incidents reported and identified that have formally triggered the Duty of Candour. 87% have recorded that the patient/relatives been formally notified of the incident in Datix and within normal variation although remains below target rate.

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 March 2023 has improved to 60.9% as at 6th April 2023 including those letters that are still within timescale. Outstanding letters / information uploaded to Datix has been escalated with individual wards/departments and via Directorate/Divisional structures. Medicine Division, in particular Specialised and General Medicine, have lowest compliance for written evidence of completion.

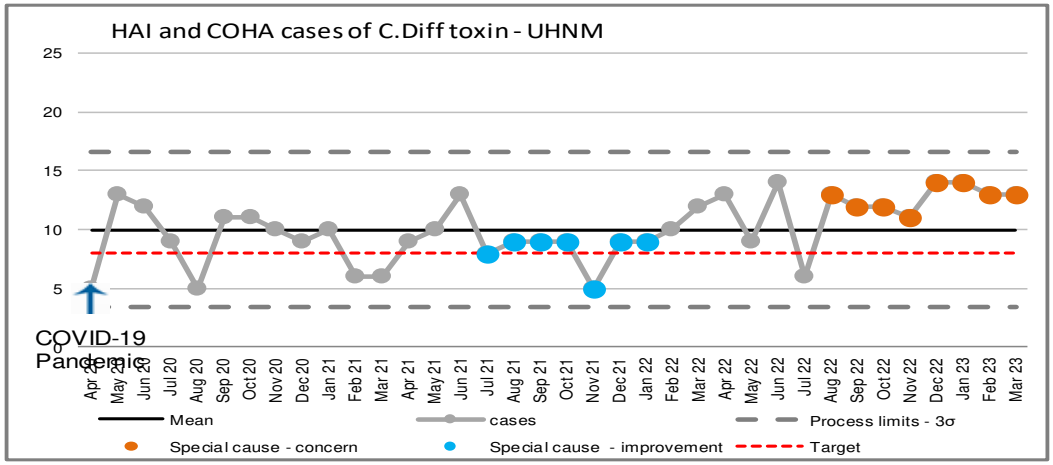
Actions taken:

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.

The initial actions taken within Emergency Medicine to support the clinicians with uploading and updating on Datix to evidence Duty of Candour completed especially during the continued increased extraordinary operational pressures have seen improvements locally.

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
H	?

Target	Jan 23	Feb 23	Mar 23
8	14	13	13

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 13 reported C diff cases in March 2023 with 7 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

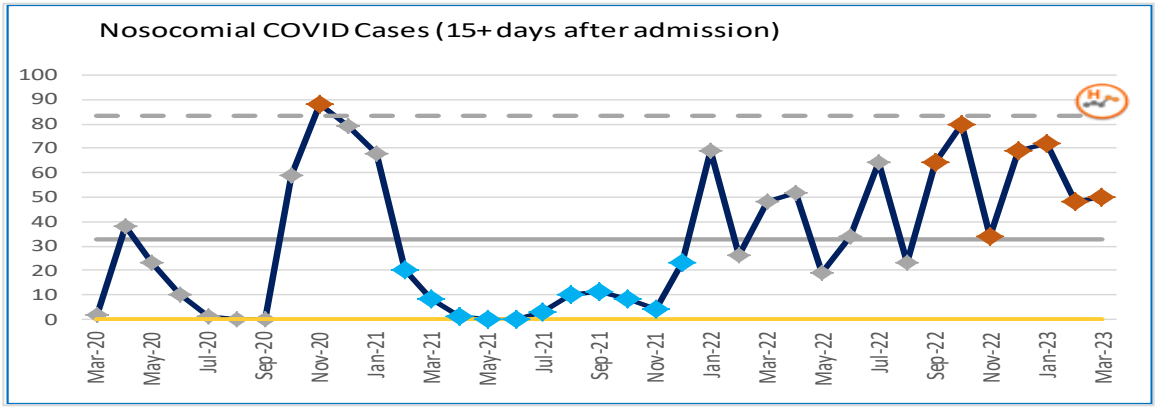
There has been one clinical area that has had more than one Clostridium *difficile* case in a 28 day period. Ward 201, one HAI and one COHA , awaiting ribotyping results

The top 3 areas for C Diff during March 2023 were Ward 108, Ward 122 and Ward 201 during March 2023

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 a theme where patients have been admitted with documented diarrhoea, yet a sample is not submitted until day 3 or later – this then becomes hospital apportioned. At the clinical group meeting all clinicians were reminded of the importance of early sampling, and the Alert Group is exploring any options for an electronic alert for early sampling
- RCAs continue to be reviewed by ICB in relation to avoidability

HAI Nosocomial COVID Cases per Month



What do these results tell us?

- increase in cases throughout March 2023 with 50 definite Healthcare Acquired COVID-19 cases.
- Monthly total is within normal variation
- Follows national profile for increasing cases within the community
- COVID screening guidance changed 14/09/2022. Patients only swabbed on admission if being admitted to high risk area, immunocompromised or symptomatic for COVID. Otherwise patients are now not routinely screened. Asymptomatic cases are being identified when screening patients as part of an outbreak but currently

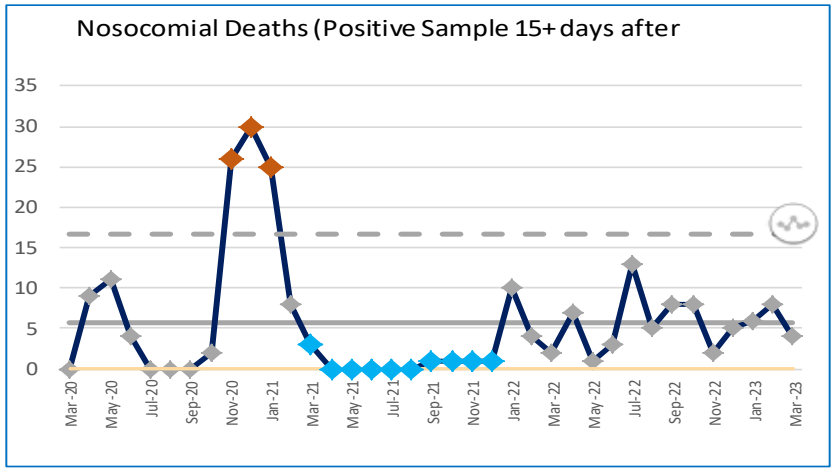
Actions :

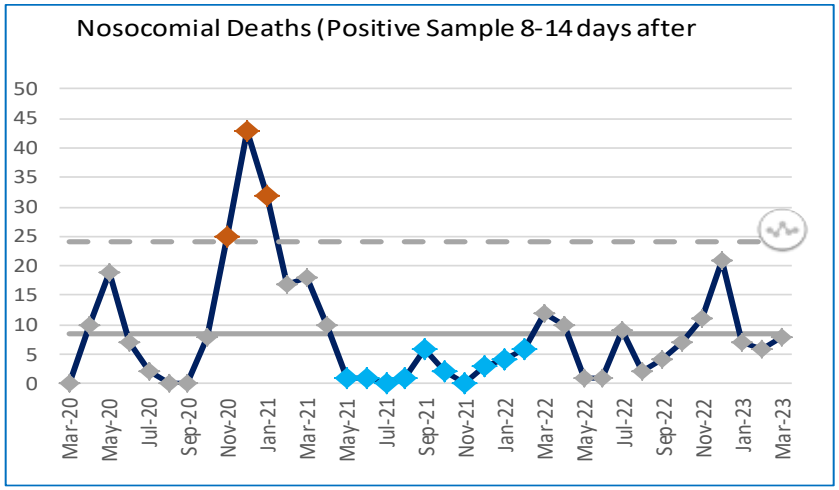
- UHNM COVID screening changed in line with National guidance 14th September.
- No routine asymptomatic admission screening for COVID
- Screening for symptomatic, admission to high risk areas and immunocompromised patients
- In addition close patient contacts of a COVID case are also screened and patients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

	UHNM		
	Total Admissions	COVID cases	
		Prob	Def
Mar 21	17105	12	8
Apr 21	16554	3	1
May-21	17273	0	0
Jun-21	18527	0	0
Jul-21	18168	4	3
Aug-21	17160	14	10
Sep-21	17327	11	10
Oct-21	17055	8	8
Nov-21	17700	4	4
Dec-21	16688	13	23
Jan-22	16109	67	69
Feb-22	16278	39	26
Mar-22	18518	71	48
Apr-22	16538	72	52
May-22	18484	14	19
Jun-22	18380	34	34
Jul-22	17983	45	64
Aug-22	18247	16	24
Sep-22	18279	58	64
Oct-22	18351	81	80
Nov-22	19607	29	34
Dec-22	18240	78	69
Jan-23		81	72
Feb-23		65	46
Mar-23		87	50

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

University Hospitals of North Midlands NHS Trust





What do these results tell us?

Increase in monthly total but within normal variation limits

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

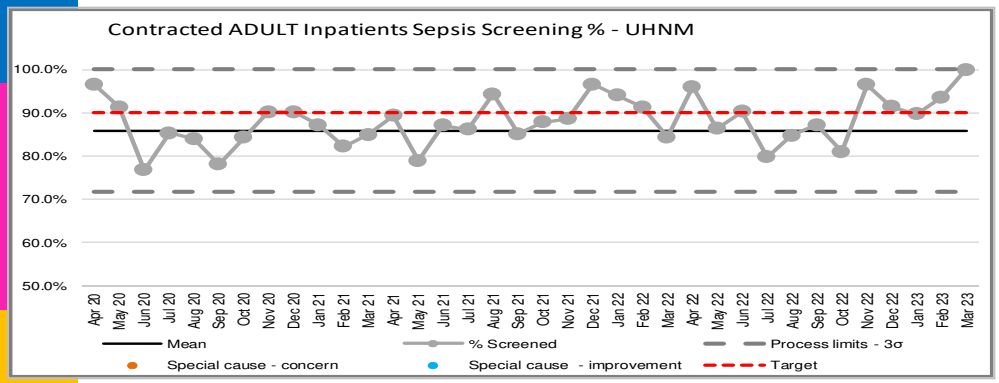
- 4 recorded definite hospital onset COVID-19 deaths in March 2023
- 70 Definite Hospital acquired COVID-19 deaths during 2022/23 YTD
- The mean number of deaths per month since March 2020 is 6.

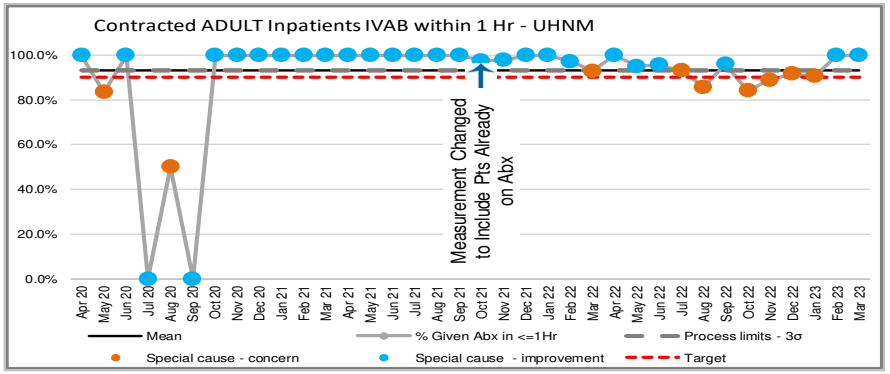
Actions :

Nosocomial COVID-19 deaths are continuing to be reviewed as part of Trust mortality review processes.

Sepsis Screening Compliance (Inpatients Contract)

NHS
University Hospitals of North Midlands
NHS Trust





Variation	Assurance
	

Target	Jan 23	Feb 23	Mar 23
90%	89.7%	93.6%	100.0%

Background

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

Variation	Assurance
	

Target	Jan 23	Feb 23	Mar 23
90%	90.6%	100.0%	100.0%

Background

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

What is the data telling us:

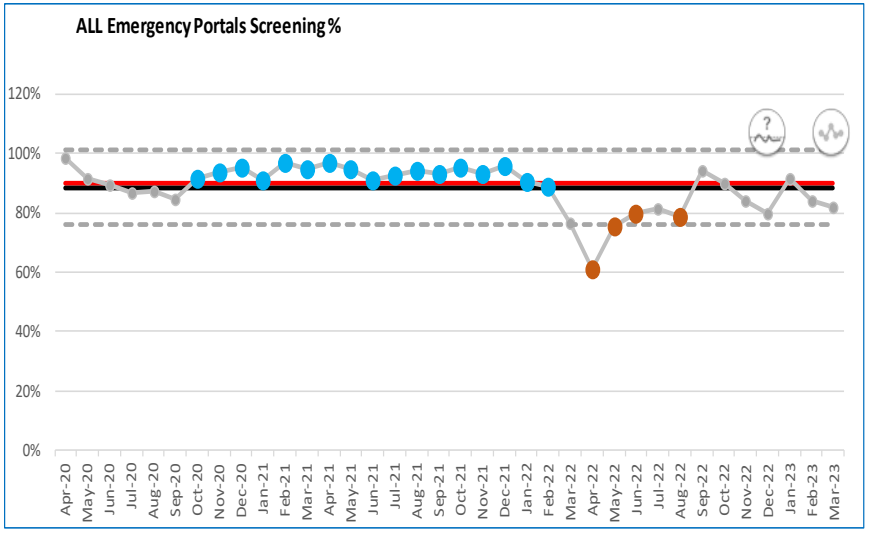
Inpatient areas achieved the screening and the IVAB within 1 hour target in March 2023. There were 52 cases audited with 0 missed screening from different ward areas or divisions. Out of 52 cases audited, 34 cases were identified as red flags sepsis with 20 cases having alternative diagnosis and 14 cases were true red flags. Out of 14 true red flag cases, 12 were already on IVAB treatment and 2 were given IVAB treatment within 1 hour.

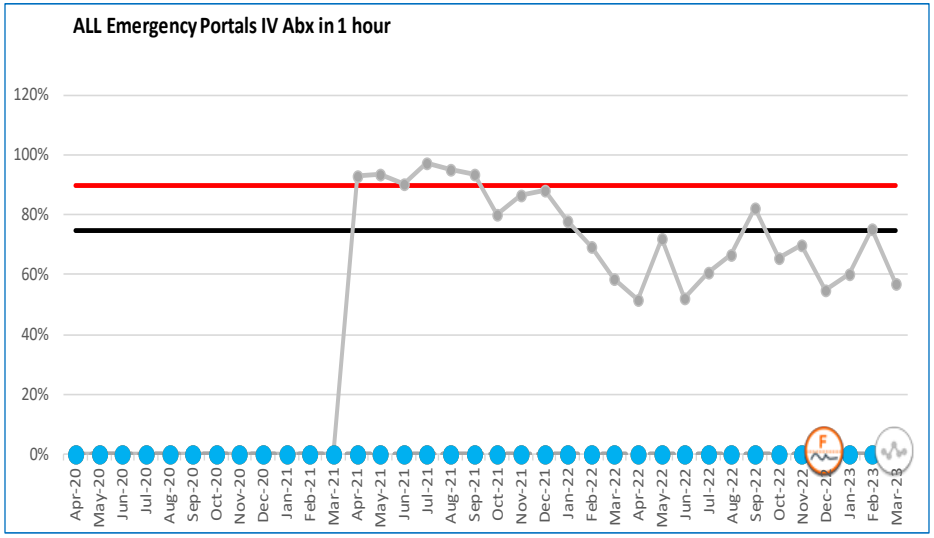
Actions:

- To commence departmental/ divisional sepsis presentation to all level of clinicians from April 2023
- Collaborative work continued with the Vitalpac team to further improve the sepsis modules and new enhancement work for new IVAB guidelines; on-going
- The Sepsis Team continue to raise awareness the importance of sepsis screening and IVAB compliance by being involved in HCA, students and new nursing staff induction programmes; on-going
- The Sepsis team will continue to promote sepsis awareness in both sites and will prioritise areas to visit with the clinical lead consultant; on-going
- Sepsis Champion training (5 hours CPD) will be available to all level of clinical and medical staff soon (spring-summer 2023)

Sepsis Screening Compliance (Emergency Portals Contract)

NHS
University Hospitals of North Midlands
NHS Trust





What is the data telling us:

Adult Emergency Portals screening did not meet the target for March 2023. There were 55 cases audited with 10 missed screening in total from the 6 emergency portals .

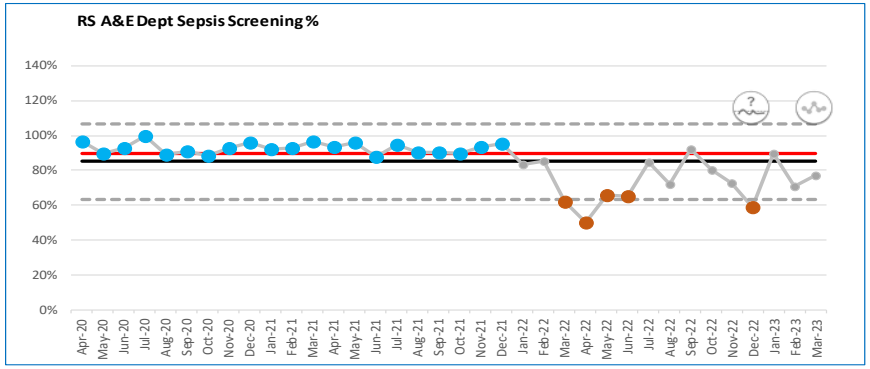
The performance for IVAB within 1hr below target rate in March 2023 is at 56.8%. Out of 55 cases, there were only 44 red flags sepsis in which the 10 cases already on IVAB, 37 cases were newly identified sepsis and 7 cases have alternative diagnosis. There were 16 delayed IVAB with10 cases delayed within 2 hours and 6 cases above 2 hours. Delayed IVAB within 1 hour is mainly contributed by both ED sites, and missed screening by both ED sites, FEAU and SAU.

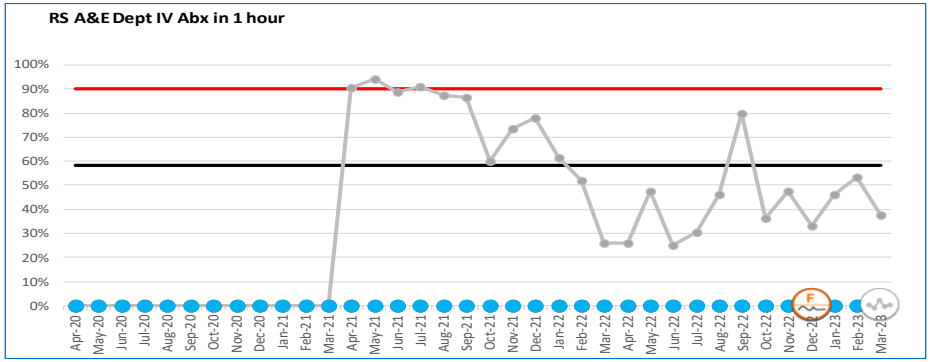
Actions:

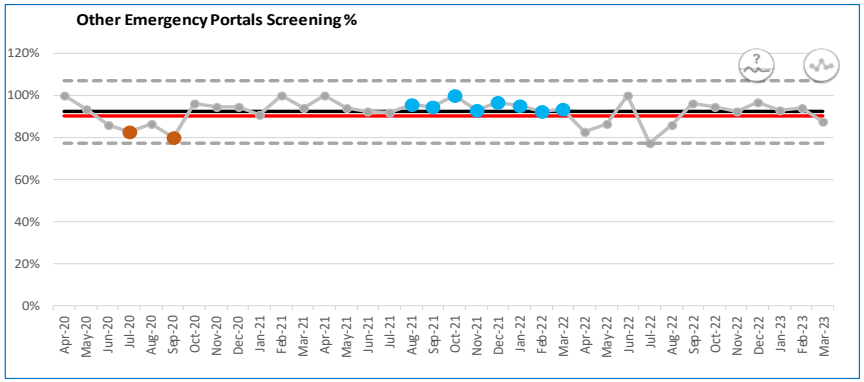
- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E regularly. Provide sepsis session when staffing and acuity allows.
- The Sepsis team is working collaboratively with the A&E Quality nurses, sepsis champions, senior team and A&E sepsis clinical lead to provide support with late IVAB incidents and missed screens. Issue with holding ambulances remain a challenge.
- Face to face A&E sepsis induction for new nursing staff, nursing assistant and medical staff will recommence once capacity pressure/flow improve in the department. Sepsis kiosks/ sessions recommence from April 2023 by the sepsis team.
- Regular meeting with A&E senior team reinstated to review current process and actions; on-going
- Monitoring impact of long ambulance waits on timely assessment and treatment of sepsis

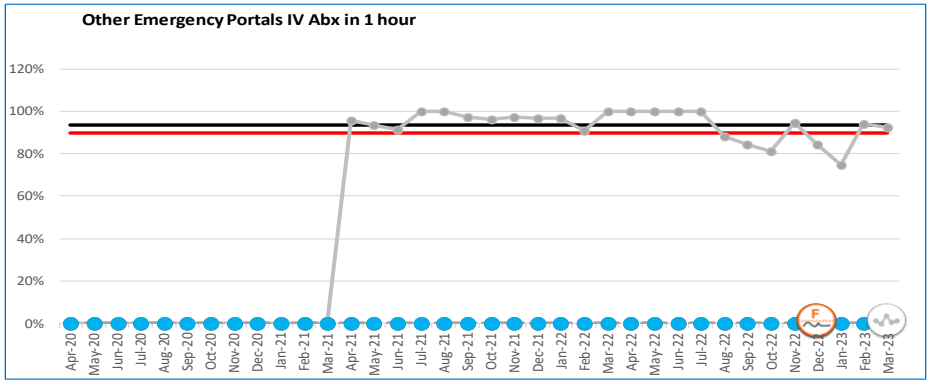
Sepsis Screening Compliance (Emergency Portals RSUH ED & Other Portals)

NHS
University Hospitals of North Midlands
NHS Trust









What is the data telling us:

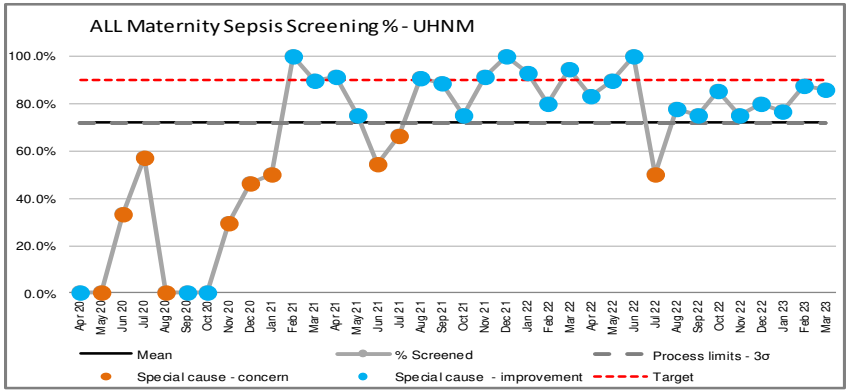
RSUH Emergency Department performance in March 2023 remains below target rate and compliance is significantly lower than control limits. The RSUH ED is driving the overall Emergency Portals performance as other emergency portals are achieving Screening compliance and IVAB within 1 hour. However, this month is slightly below target for (ED County, FEAU & SAU) for screening. During March 2023 there have been further dipped at RSUH for IVAB in 1 hour.

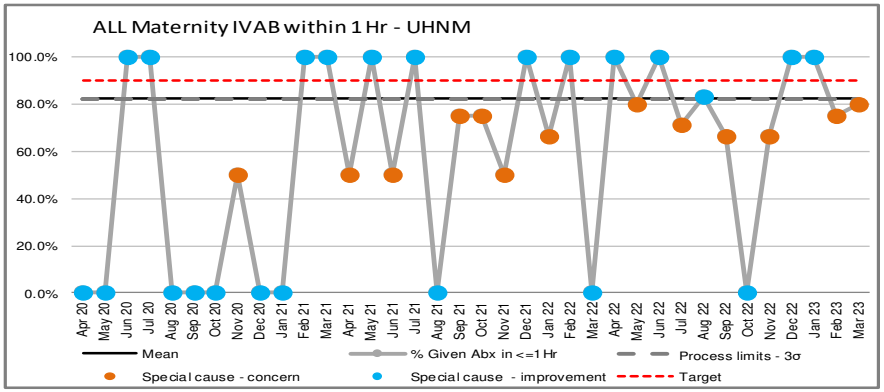
Actions:

- 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 between the hours of 8am-12midnight, EPIC 12midnight to 8am using the Vocera call system. This will enable accurate and safe assessment of the patients sepsis trigger and to ensure correct urgent antibiotic prescription and administration.
- Sepsis kiosks re-instate in ED focusing the importance of sepsis screening documentation and urgent escalation for true red flag sepsis triggers

Sepsis Screening Compliance ALL Maternity

NHS
University Hospitals of North Midlands
NHS Trust





Variation	Assurance
H	F

Target	Jan 23	Feb 23	Mar 23
90%	76.9%	87.5%	86.2%

Background

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

Variation	Assurance
L	F

Target	Jan 23	Feb 23	Mar 23
90%	100%	75%	80%

Background

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

What is the data telling us:

Maternity audits in screening compliance is below the target at 86.2% and IVAB within 1 hour has improved to 80% during March 2023. This compliance score is based on a small number, however a regular spot checks audit is being conducted monthly.

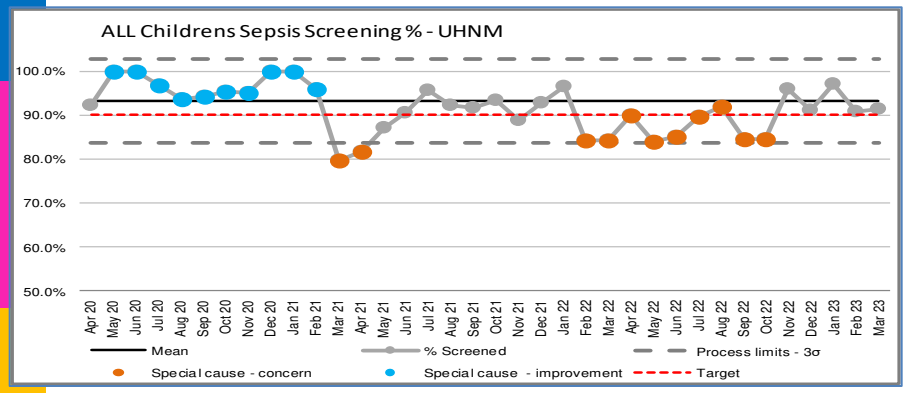
There were 29 cases audited from emergency portal (MAU) and inpatients with 3 missed screening. There were 10 true red flags identified from the randomise audits, 1 is already on IVAB treatment, 0 with alternative diagnosis and 7 cases received IVAB within 1 hour and 2 delayed IVAB given within 2 hrs.

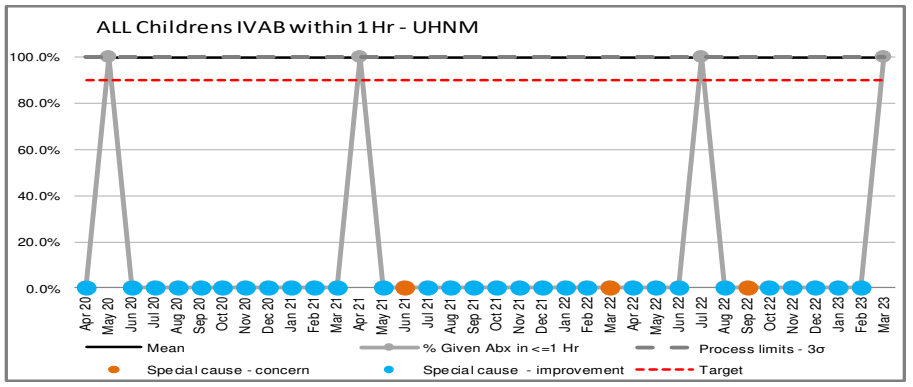
Actions:

- Maternity antibiotic PGD has been drafted and is currently under review by the Pharmacy Team; awaiting update
- Maternity educator is supporting the sepsis team by conducting independent / in-depth sepsis audits in the whole Maternity department , staff who had missed the screening documentation will be given constructive feedback and offered support/ training: on-going
- Monthly Maternity sepsis skills drill will be provided and delivered by the sepsis team and maternity clinical educator; on-going
- Sepsis awareness in the clinical areas will commence in spring-summer 2023

Sepsis Screening Compliance ALL Children

NHS
University Hospitals of North Midlands
NHS Trust





Variation	Assurance

Target	Jan 23	Feb 23	Mar 23
90%	97.0%	90.9%	91.4%

Background

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

Variation	Assurance

Target	Jan 23	Feb 23	Mar 23
90%	N/A	N/A	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 show normal variation and higher than target of 90%. Still seen small numbers of children trigger with PEWS > 5 & above in Inpatients areas.

Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks).

There were 35 cases audited for emergency portals and inpatients areas with 3 missed screening (from CAU, 217 & 218). Two true red flags were identified from the randomise audits (both emergency & inpatients), both given IVAB within 1 hour.

Actions:

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

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Non-Elective Care

- March saw an improvement or static position in the majority of the Non-Elective metrics against a backdrop of increased attendances from previous months, the first Junior Doctor Industrial Actions taking place over three days, and increasing IP restrictions once again. There were however a few notable slight deteriorations in metrics indicative of poor hospital flow.
    - Four Hour performance increased again from 64% to 68%
    - 12 Hour Trolley Waits unfortunately increased from 690 to 900
    - ED WTBS remained static around 100 minutes with performance in March at 99 minutes
    - 12+ Hours In ED declined from 1631 to 2010

Cancer

- Trust overall 2WW Performance achieved 96.7% in February – a sustained achievement since last month.
- The Trust also predicted to achieve the 2WW in March. 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) has also achieved at 96.3% in February.
- The 62 Day Standard achieved better than predicted in February at 55%. The current provisional position for March is 50.9%. 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 (Skin & LGI) over the next quarter.
- The 31 Day Standard improved since last month and achieved 90.5% for February. It is predicted to land at 90% in March.
- The 31 day Subsequent Radiotherapy achieved the standard in February at 97.5% and is expected to achieve again in March.
- The 28 Day Faster Diagnosis Standard for all referrals was reported at 71.5% in February. The March position is currently incomplete and will be validated once Pathology confirms cancer or non cancer on high volume pathways such as Skin.
- Suspected Breast Cancer, Skin and Lower GI continue to book 2WW referrals within 7 days, for first appointments.
- The backlog has reduced since last month and total PTLs in Skin and LGI has significantly reduced.
- In August the PTL was over 6000 – this has now **reduced by around 2500** patients to around 3500 in total.

Spotlight Report from Chief Operating Officer

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Planned Care

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

- Day Case activity and Elective Activity have moved from delivering 97% and 100% in February to 95% and 107% respectively for March. A small decrease due to winter pressures, but early indications show that the trust was on course to reach 112% elective activity for March before IA impact. 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 87.3%.
- The focus has moved to 78 week waiters with an Annual Plan to reduce them to below 300 patients by March 2023. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge as soon as possible so any treatment can be carried out to meet the 78 week standard. The unvalidated number of 78 week breaches for end of March is 558.

RTT

- The overall Referral To Treatment (RTT) Waiting has increased from 76,502 February to 77,487 in March. This is within the normal monthly variation.
- The number of patients > 52 weeks had decreased for the first time since summer 2022 4377 in August, 4,569 in September, 4,628 in October, 4,979 in November, 5,318 in December, 5,389 in January , 5,122 in February, now rising to 5,425 in March.
- At the end of March the numbers of >104 patients was 58. An decrease of 11 from 69 at the end of February. The Trust has continued to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment. The Trust remains challenged in the delivery treating all patients waiting over 104 weeks, and the current unmitigated risk for the end of March is 74. This is predicted to be 48 with mitigating actions.

Diagnostics Summary

- During March the reported activity for Diagnostics was on plan when compared with 19/20 BAU.
- DM01 performance was 76 %, an improvement on the finalised February position of 75%. Non-obstetric ultrasound while still not meeting target have shown considerable improvements, however Endoscopy remains a concern.

Histology position – as at 23rd March:

- Urgent (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day 21 (previously Day 25), 80% reported by Day 13
- Accelerated (include all Cancer Resections): 95% reported at Day 46 (previously Day 46), with 80% reported by Day 38
- Routine (all Specimens not in above categories): 95% reported at Day 44 (previously Day 54), 80% of cases reported by Day 37

Radiology reporting backlog:

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

Endoscopy:

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

Section 1: Urgent Care

Headline Metrics

Urgent Care – monthly *(context)*

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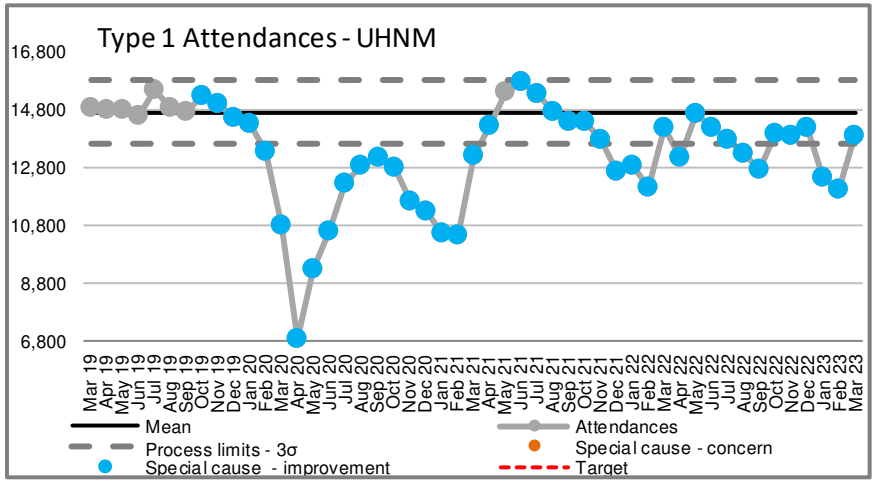
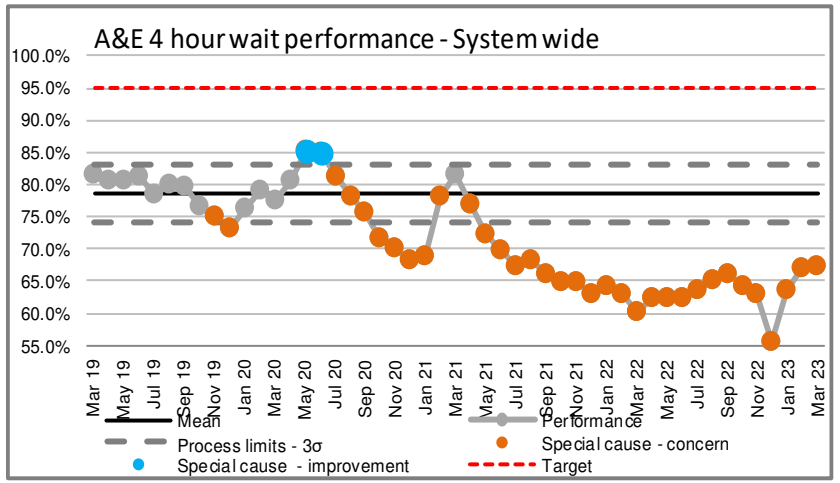
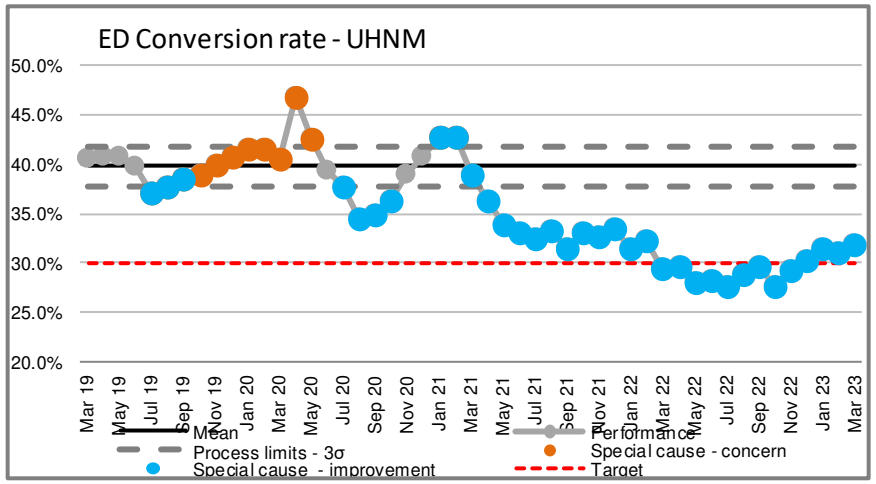
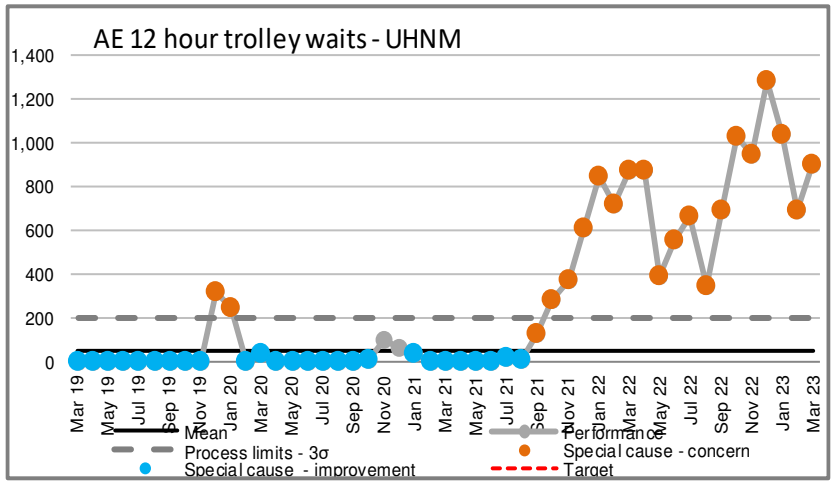
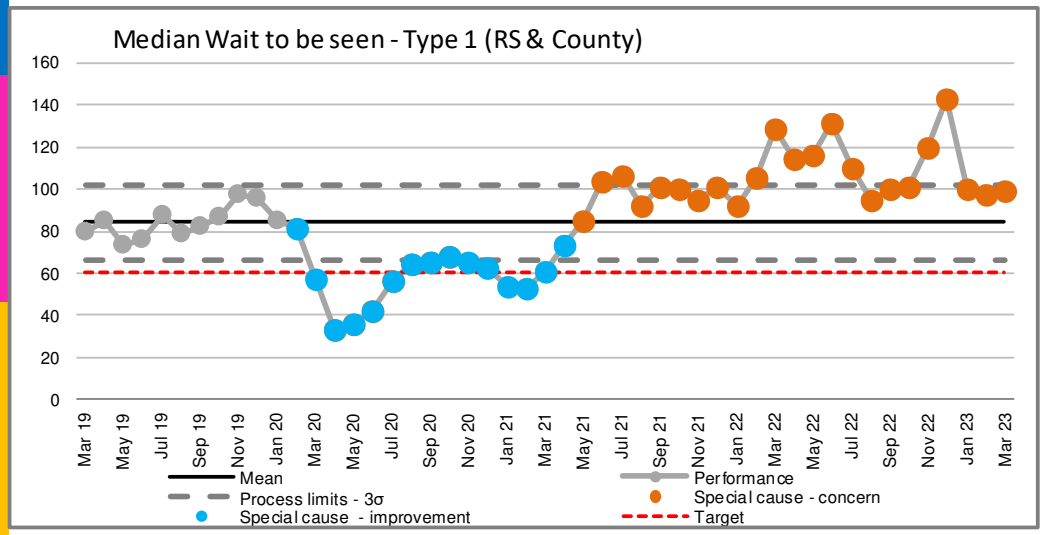








WTBS & 12 Hour in department



Variation	Assurance
H	F

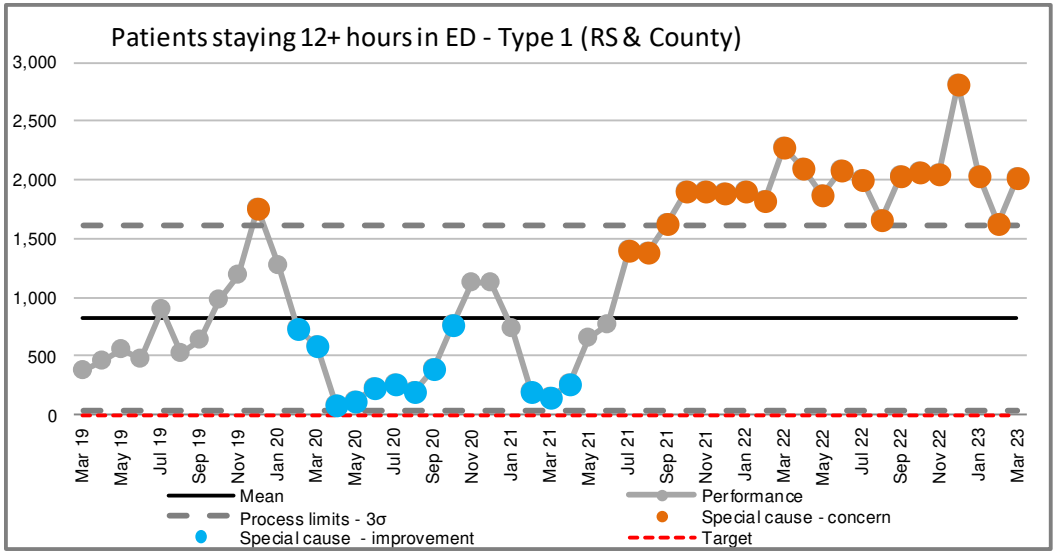
Target	Jan 23	Feb 23	Mar 23
60	100	97	99

Background

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

What is the data telling us?

Median wait to be seen continues to remain within the upper control limit.



Variation	Assurance
H	F

Target	Jan 23	Feb 23	Mar 23
0	2038	1631	2010

Background

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

What is the data telling us?

Volumes in March to levels seen at the end of 2022.

Urgent Care – Time to Treatment

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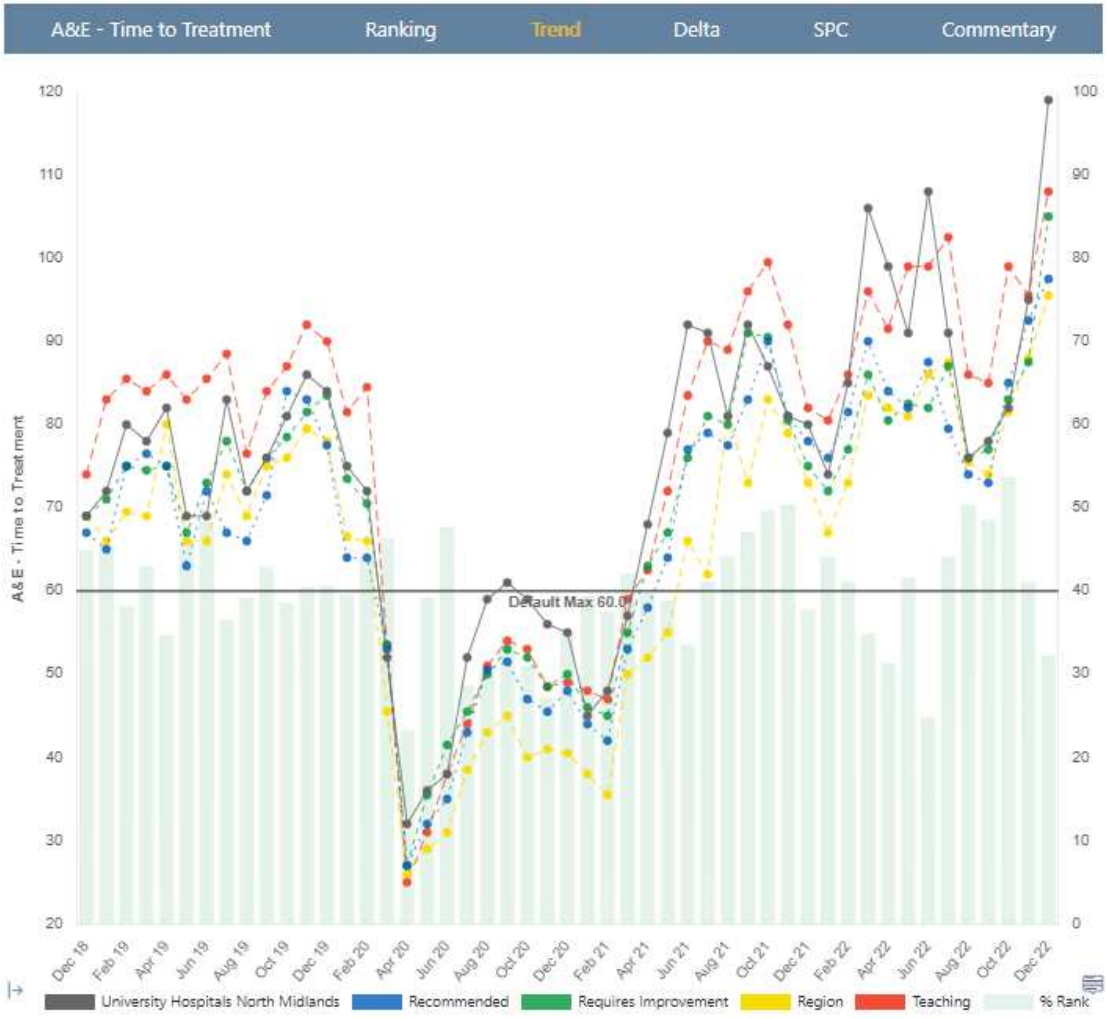
Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Dec 22	95.00%	55.6%	L	27
A&E - 4 Hour Standard (Type 1)	Dec 22	95.0%	36.4%	L	7
A&E - 4 Hour Standard (Type 2...	Dec 22	95.0%	83.3%	L	19
A&E - Conversion Rate	Dec 22	25.0%	22.0%	L	30
A&E - DTA to Admission >12 H...	Dec 22	0.0%	24.4%	H	27
A&E - DTA to Admission >12 H...	Dec 22	0.0	1,289.0	H	3
A&E - DTA to Admission >4 Ho...	Dec 22	10.00%	39.6%	H	63
A&E - Left Without Being Seen	Dec 22	5.00%	10.7%	C	18
A&E - Reattendance Rate	Dec 22	5.0%	9.4%	H	17
A&E - Time to Initial Assessment	Dec 22	15.0	11.0	H	52
A&E - Time to Treatment	Dec 22	60.0	119.0	H	32
A&E - Total Time in A&E	Dec 22	160.0	222.0	H	54
A&E - Total Time in A&E (Admi...	Dec 22	180.0	502.0	C	51
A&E - Total Time in A&E (Non-...	Dec 22	140.0	200.0	C	48



- Time to treatment pre pandemic was in line with peers
- Throughout 2022 UHNM have generally been higher than all peer groups.

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Urgent Care – DTA waits over 12 hours

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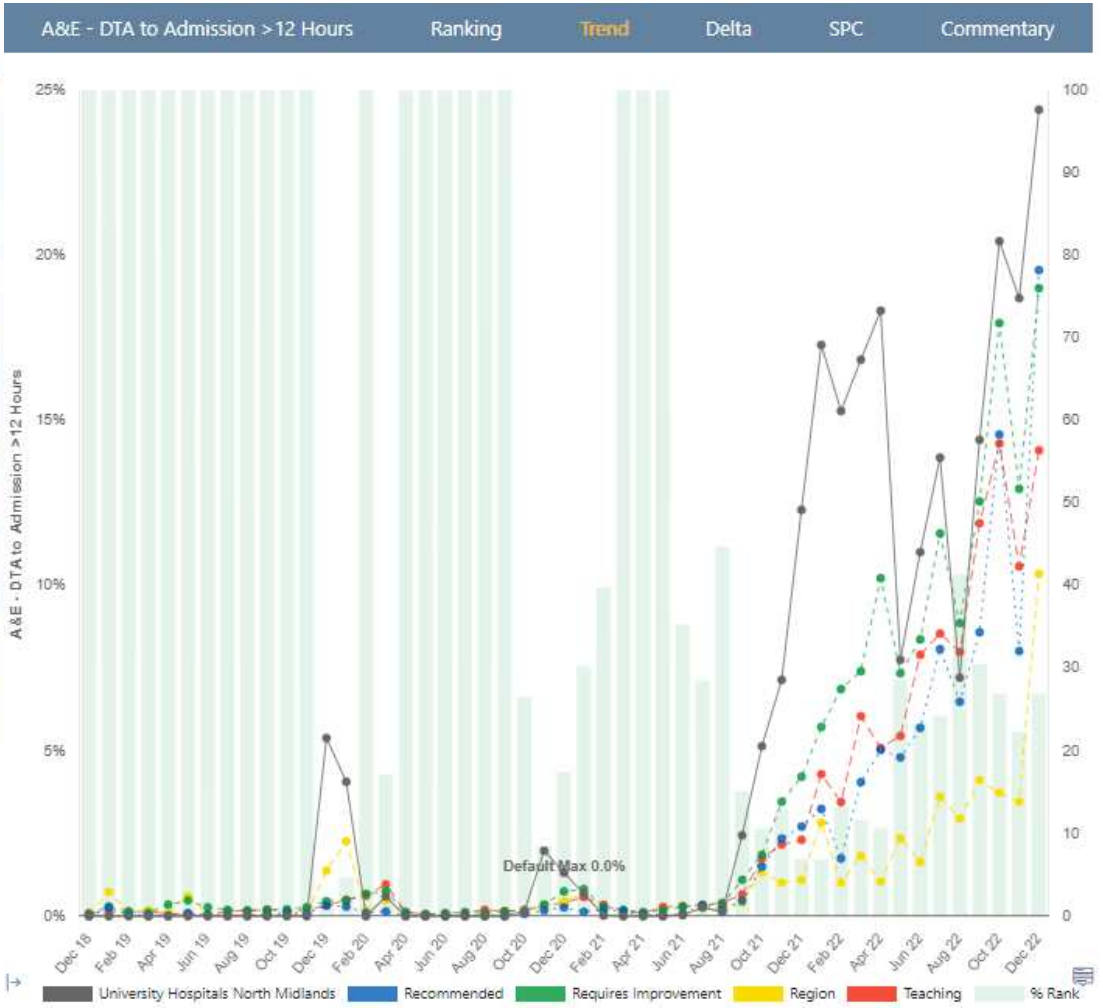
NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Dec 22	95.00%	55.6%		27
A&E - 4 Hour Standard (Type 1)	Dec 22	95.0%	36.4%		7
A&E - 4 Hour Standard (Type 2...	Dec 22	95.0%	83.3%		19
A&E - Conversion Rate	Dec 22	25.0%	22.0%		30
A&E - DTA to Admission >12 H...	Dec 22	0.0%	24.4%		27
A&E - DTA to Admission >12 H...	Dec 22	0.0	1,289.0		3
A&E - DTA to Admission >4 Ho...	Dec 22	10.00%	39.6%		63
A&E - Left Without Being Seen	Dec 22	5.00%	10.7%		18
A&E - Reattendance Rate	Dec 22	5.0%	9.4%		17
A&E - Time to Initial Assessment	Dec 22	15.0	11.0		52
A&E - Time to Treatment	Dec 22	60.0	119.0		32
A&E - Total Time in A&E	Dec 22	160.0	222.0		54
A&E - Total Time in A&E (Admi...	Dec 22	180.0	502.0		51
A&E - Total Time in A&E (Non-...	Dec 22	140.0	200.0		48



- The percentage of patients waiting over 12 hours from the point of DTA has been much higher for UHNM than peers since September 21.
- During quarter 3 UHNM continue to be above peers.

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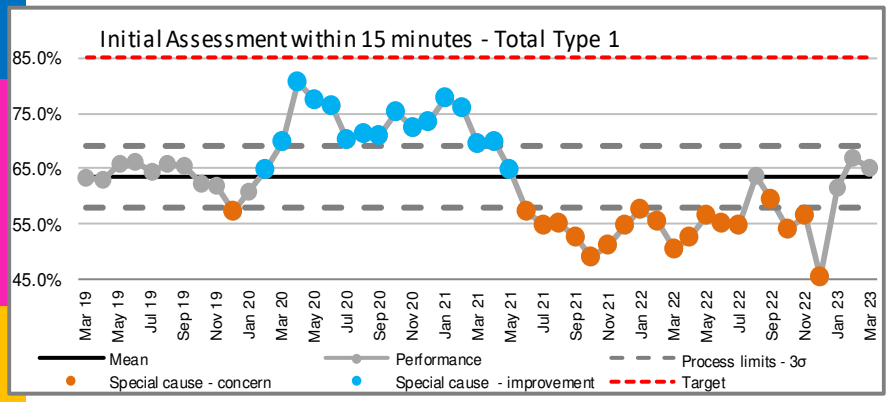
Section 1: Urgent Care

Workstream 1; Acute Front Door

Time To Triage, Ambulance Handover, & Non Admitted Average Time

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

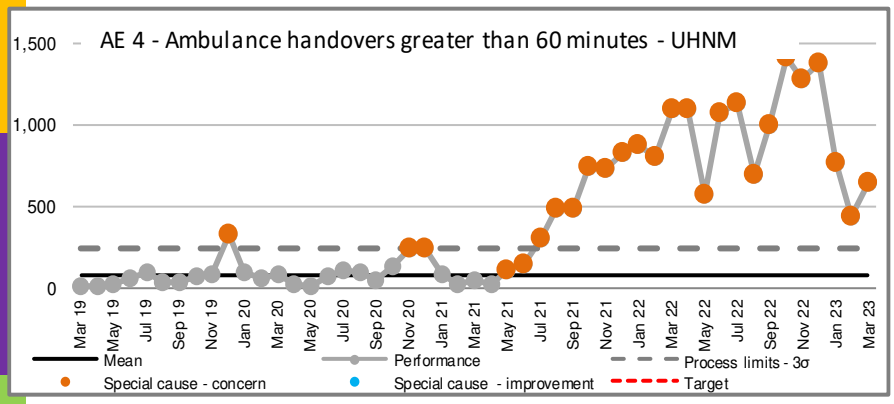
Target	Jan 23	Feb 23	Mar 23
85%	61.6%	66.9%	65.0%

Background

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

What is the Data telling us?

Performance in March was above the two year average and similar to that in February.



Variation	Assurance
H	?

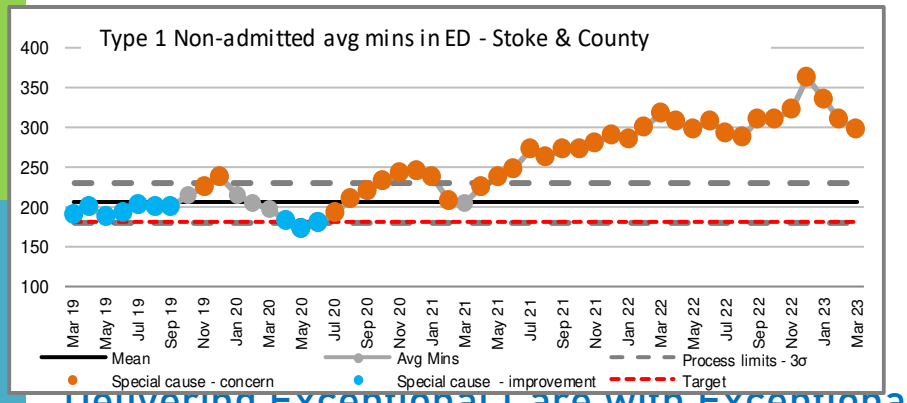
Target	Jan 23	Feb 23	Mar 23
0	774	433	651

Background

The number of ambulance handovers greater than 60 mins

What is the Data telling us?

Handover delays over 1 hour increased in March compared to those in February.



Variation	Assurance
H	?

Target	Jan 23	Feb 23	Mar 23
180	334	309	298

Background

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

What is the Data telling us?

Mean time in department continues to see improvements, but remains above the upper control limits.

Time To Triage, Ambulance Handover, & Non Admitted Average Time

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Summary

- Time to Initial Assessment declined slightly to 65% in March from 66.9% February. This still represents an improving trajectory with both sites having improving triage times above the baseline means.
- Ambulance Handovers remain a challenge with those over 60 minutes rising from 433 to 651. While this is a month on month deterioration, this is still the second highest performing month in ten months and the third highest in seventeen.
- The Non-Admitted Average Time In ED reduced further from 309 minutes in February to 298 minutes in March. While this represents an improvement month on month, further work is required as this is well above target levels. This will be targeted as part of the Workstream 1 focus on achieving 76% Four Hour Performance.

Actions

- Workstream 1 constituent T&F Groups have now been confirmed as EhPC, Ambulatory, and Ambulance Assessment. Each of these will have single KPI and be reported on from next month as per the NELIP POAP.
- Workstream 1 meetings continue to be stood down due to Industrial Actions. However, the ED team are due to hold their away day in early April to identify Standard Work for Senior Decision Makers in ambulatory to work towards the improvements in non-admitted pathways and performance. This will be critical to achieving 80% non-admitted performance.
- There has been continued focus on the Escalation SOP with continued iterations supported by the an increase in senior oversight focussing on Ambulance Handovers, the Four Hour Standard, and 12 Hour Trolley Waits to ensure senior intervention earlier as challenges arise.

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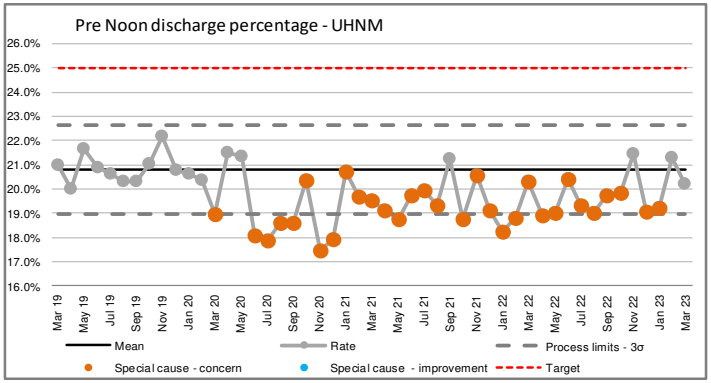
Section 1: Urgent Care

Workstream 2; Acute Patient Flow

Pre-Noon, Simple & Timely, & Occupancy

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

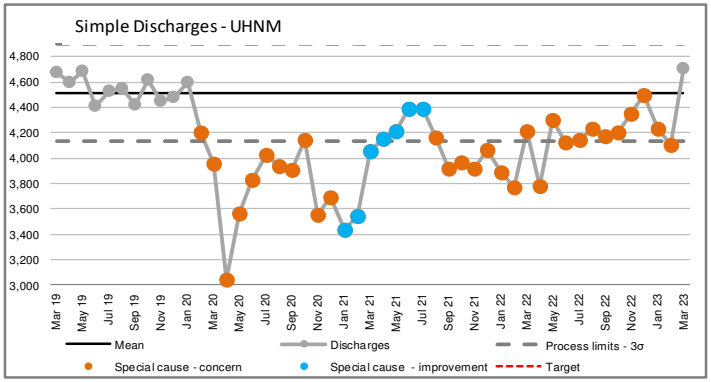
Target	Jan 23	Feb 23	Mar 23
25%	19.2%	21.3%	20.2%

Background

The percentage of discharges complete before 12 noon.

What is the data telling us?

Pre noon discharges in March were below the two year average and remain below target at 21.4%.



Variation	Assurance

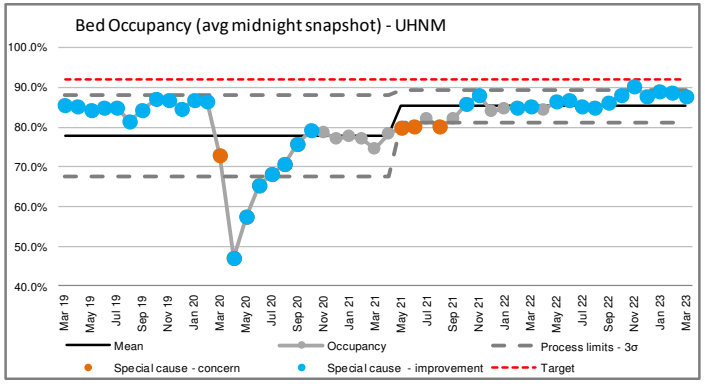
Target	Jan 23	Feb 23	Mar 23
N/A	4228	4103	4706

Background

Patients discharged without complex needs

What is the data telling us?

Simple discharges in March increased to levels seen pre pandemic.



Variation	Assurance
H	F

Target	Jan 23	Feb 23	Mar 23
92%	88.9%	88.8%	87.8%

Background

The percentage of general and acute beds occupied overnight at UHNM

What is the data telling us?

Bed Occupancy levels consistently remain above the two year average, at c.88%.

Pre-Noon, Simple & Timely, & Occupancy

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Summary

- Pre-Noon Discharges decreased slightly from 21.3% in February to 20.2% in March. While this is a reduction in performance, it remains the second highest performing month in the past nine.
- The number of Simple & Timely Discharges dramatically improved from 4103 in February to 4706 in March. This approximately 15% improvement has likely been driven by a commensurate increase in attendances, and significant clinical engagement and organisational wide effort, during the pre Industrial Action period.
- Bed Occupancy again remained relatively stable moving from 88.8% in February to 87.8% in March. In support of the Annual Plan the data feeding our Trust occupancy has been scrutinised with a number of bed types reclassified. It is likely this will mean a small jump in occupancy next month as new reporting definitions are implemented for 23/24.

Actions

- Workstream 2 constituent T&F Groups have now been confirmed as LOS Improvement Projects, Ward Standard Work, WIS, Reverse Bed Chaining, and Capacity & Demand. Each of these will have single KPI and be reported on from next month as per the NELIP POAP.
- The UHNM Annual Plan has now been submitted, detailing our commitment and trajectory to achieving both 76% against the Four Hour Standard and 92% G&A Occupancy. From next month, progress against this will be reported to PAF for scrutiny and oversight.
- Confirming of funding for the proposed SDEC Modular is still pending following confirmation of placing in the highest priority group for funding allocation. In advance of this, the established T&F Group is engaging with clinical leadership to begin to determine potential models for this area.
- The Regional Productivity Team update has now completed with a Frailty improvement opportunity identified relative to peers. This work will now be commenced in Workstream 3.

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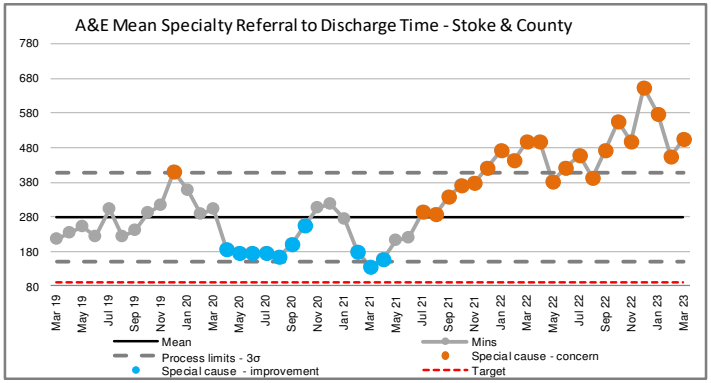
Section 1: Urgent Care

Workstream 3; Delivering UEC Standards

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

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

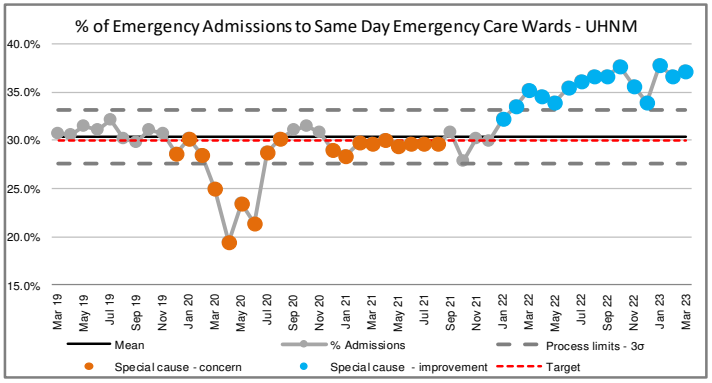
Target	Jan 23	Feb 23	Mar 23
90	577	454	505

Background

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

What is the data telling us?

The average time from referral to discharge increased in March and remains above the normal variation levels.



Variation	Assurance
H	?

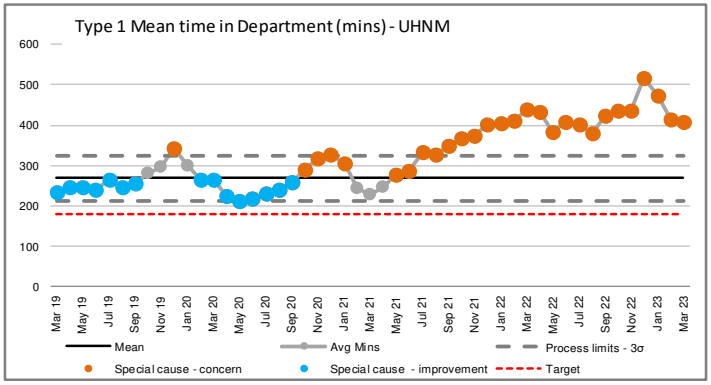
Target	Jan 23	Feb 23	Mar 23
30%	37.9%	36.6%	37.1%

Background

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

What is the data telling us?

The Trust has been consistently above the upper control limits since January 2022.



Variation	Assurance
H	F

Target	Jan 23	Feb 23	Mar 23
180	473	415	410

Background

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

What is the data telling us?

Total time in department continues to see an improving trend, but still remains outside of the normal variation levels.

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

NHS
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NHS Trust

Summary

- Mean Specialty Referral To Discharge Time slightly rose again from 454 minutes in February to 505 minutes in March. While this represents a slight deterioration, and further improvement are required, this is again an improvement against recent historic performance.
- SDEC Utilisation rose back to previous levels of 37% and continues the overall improvement trend. It is positive to see that the recent outlying deterioration was quickly recovered and not sustained.
- The Mean Time In ED for all patients remained relatively static from 415 minutes in February to 410 minutes in March. This maintenance of performance is buoyed by continued non-admitted improvements and is despite increased attendances and IP restrictions once again on the rise across the Trust.

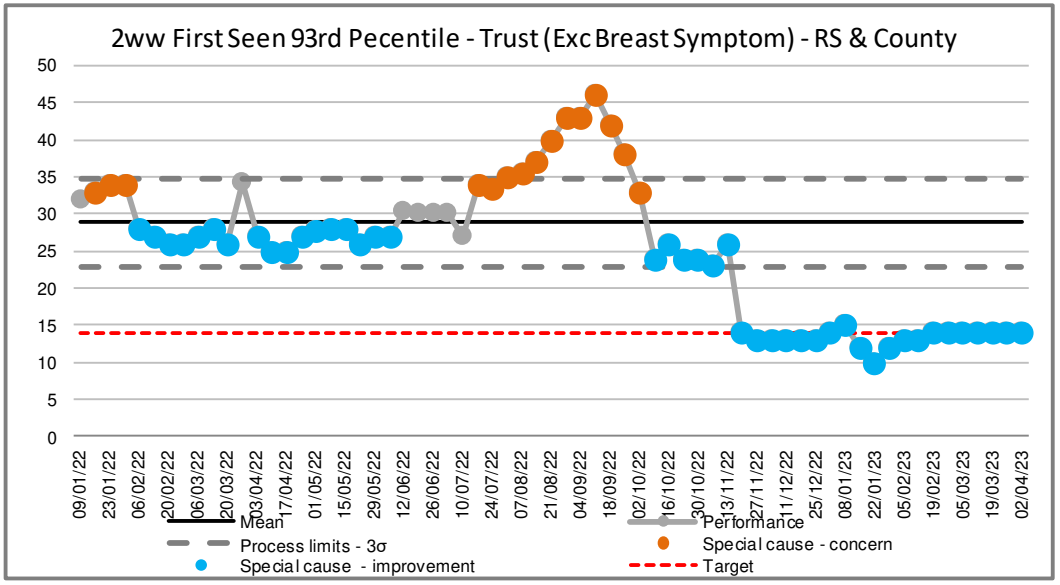
Actions

- Workstream 3 constituent T&F Groups have now been confirmed as Portal Navigation, Portal Performance, AMU Model, and Frailty. Each of these will have single KPI and be reported on from next month as per the NELIP POAP.
- IPS adherence has continued to be proven to be problematic with high numbers of newly employed or rotating workforce and so engagement has been restarting with the ED Consultant team to ensure that there is no deviation from the Referral & Admission SOP.

Section 2: ELECTIVE CARE

Cancer – Headline metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

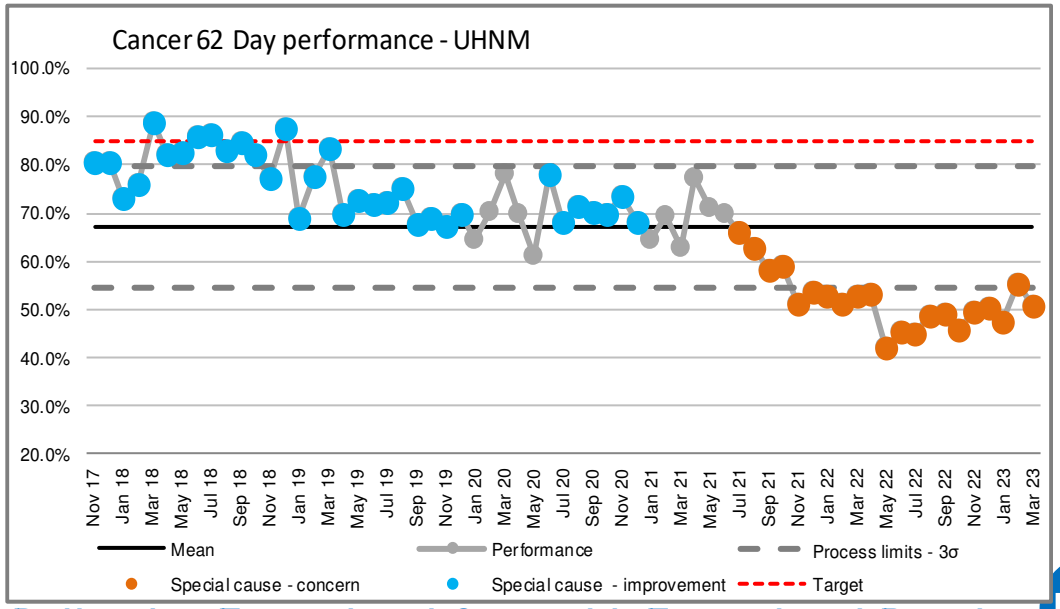
Target	19/03/2023	26/03/2023	02/04/2023
14	14	14	14

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 April had a 14 day clock stop within day 14 of the pathway.



Variation	Assurance
	

Target	Jan 23	Feb 23	Mar 23
85%	47.6%	55.5%	50.9%

Background

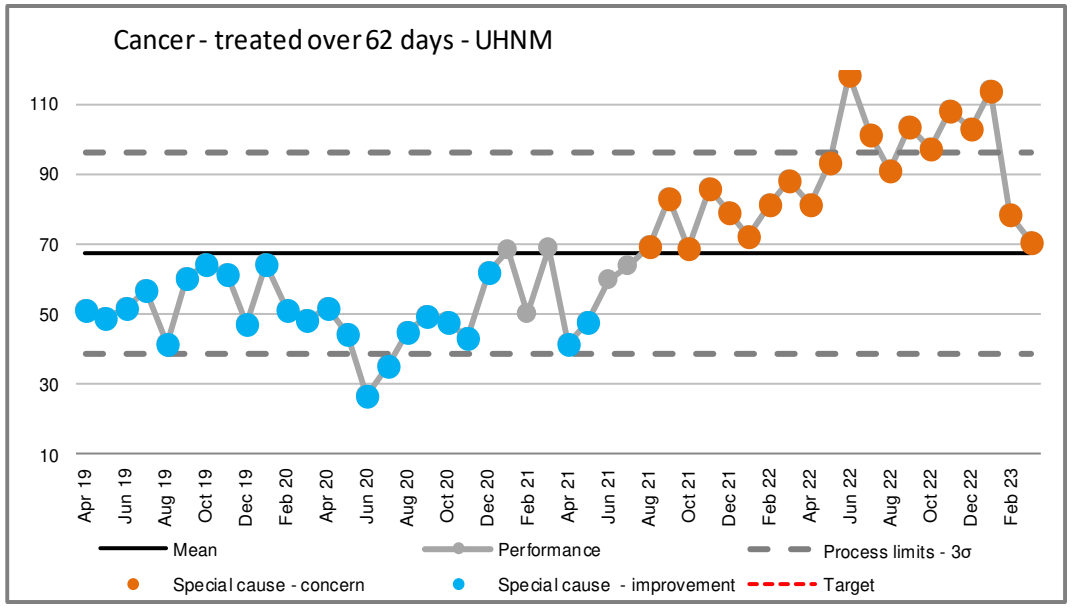
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

Performance significantly challenged and below standard for the past 12 months with a steep decline in May and landed at 55.5% for February, the March position is still being validated.

Delivering Exceptional Care with Exceptional People

Cancer - Headline metrics



Variation	Assurance
H	

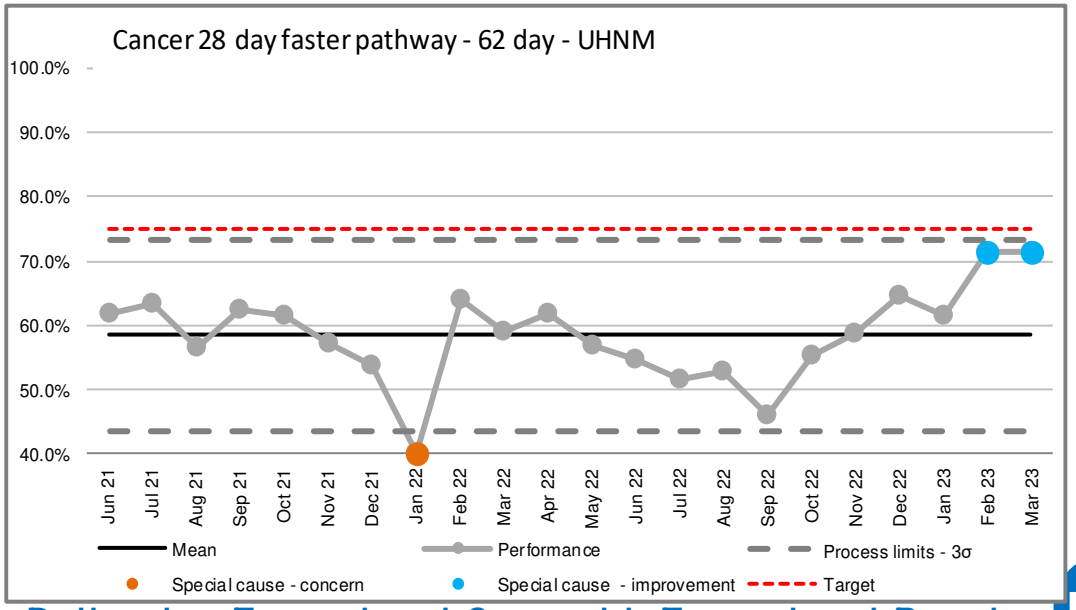
Target	Jan 23	Feb 23	Mar 23
N/A	113.5	78.5	70.5

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, we've seen an improvement in Feb & March position.



Variation	Assurance
H	F

Target	Jan 23	Feb 23	Mar 23
75%	61.5%	71.5%	71.6%

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 February position landed at 71.5% - a special cause improvement on the SPC chart. March is currently incomplete but continued improvement is expected.

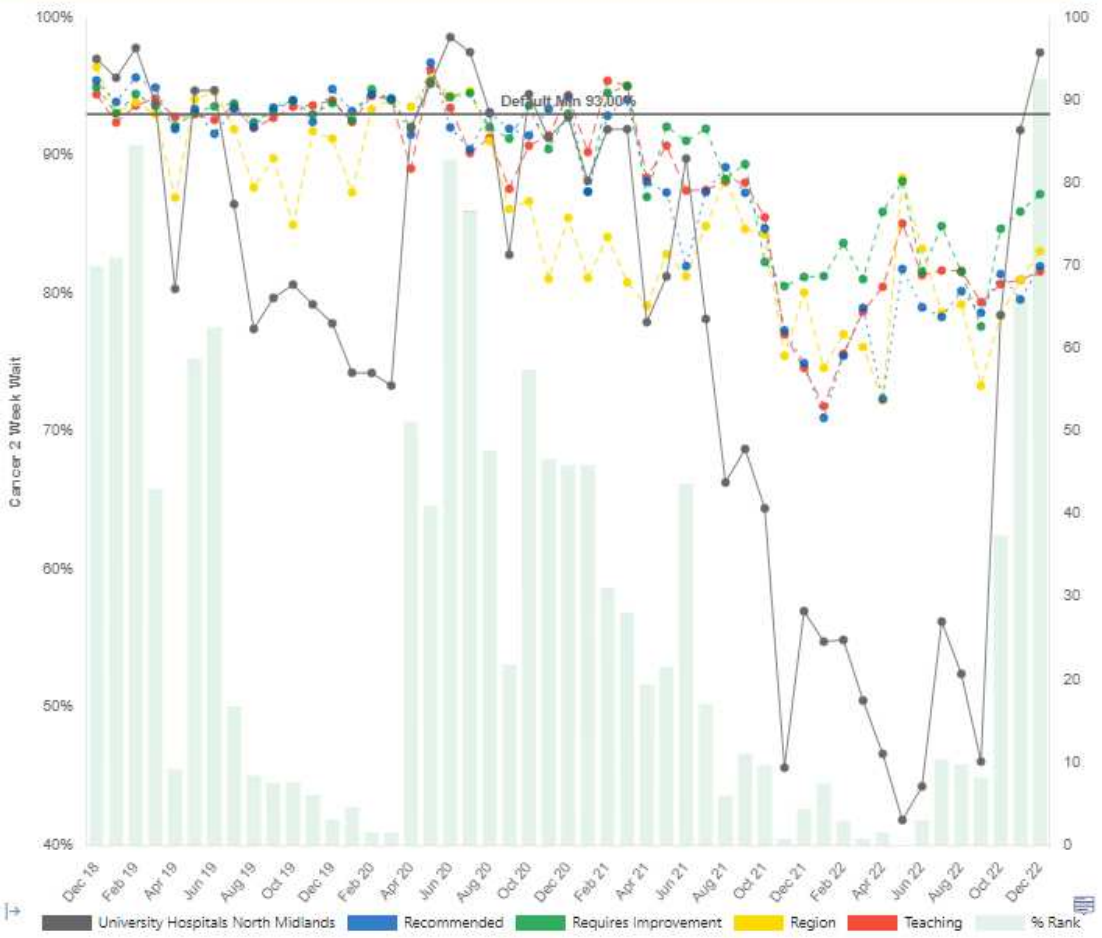
Cancer – benchmarked

NHS University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Cancer 2 Week Wait	Dec 22	93.00%	97.5%	C	93
Cancer 2 Week Wait Breast Sym...	Dec 22	93.0%	90.1%	C	54
Cancer 31 Day First Treatment	Dec 22	96.00%	86.9%	L	12
Cancer 31 Day Subsequent Trea...	Dec 22	96.0%	93.9%	L	39
Cancer 62 Day All Sources	Dec 22	85.00%	63.7%	L	30
Cancer 62 Day Consultant Upgr...	Dec 22	85.0%	85.7%	L	69
Cancer 62 Day Screening	Dec 22	90.0%	87.0%	C	66
Cancer Sub Treat Drugs	Dec 22	96.0%	100%	C	100
Cancer Sub Treat Radiotherapy	Dec 22	96.0%	95.8%	C	38

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



- UHNM saw 14 day performance deteriorate around July 2021.
- Since November 2022 UHNM performance has been above all peer groups and in December achieved target.

Cancer

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	64.7%	C	18
FDS Acute Leukaemia	Dec 22	75.0%	-	C	-
FDS Brain Tumours	Dec 22	75.0%	-	C	-
FDS Breast Cancer	Dec 22	75.0%	96.1%	H	77
FDS Breast Symptoms	Dec 22	75.0%	97.4%	H	71
FDS Children's Cancer	Dec 22	75.0%	68.0%	L	18
FDS Gynaecological Cancer	Dec 22	75.0%	55.0%	L	30
FDS Haematological Malignanci...	Dec 22	75.0%	42.9%	C	31
FDS Head & Neck Cancer	Dec 22	75.0%	71.4%	C	32
FDS Lower Gastrointestinal Can...	Dec 22	75.0%	39.4%	C	21
FDS Lung Cancer	Dec 22	75.0%	80.5%	C	54
FDS Missing or Invalid	Dec 22	75.0%	-	C	-
FDS Other Cancer	Dec 22	75.0%	-	C	-
FDS Sarcoma	Dec 22	75.0%	80.0%	C	78
FDS Skin Cancer	Dec 22	75.0%	66.2%	C	12
FDS Testicular Cancer	Dec 22	75.0%	89.5%	H	57
FDS Upper Gastrointestinal Can...	Dec 22	75.0%	88.0%	H	90
FDS Urological Malignancies	Dec 22	75.0%	46.5%	L	32

- The 28 Day Faster Diagnosis position for UHNM has been lower than all peer groups since June 2021.
- Since September 2022, improvement have been made with December performance being much closer to peer groups.

Cancer Trajectories

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NHS Trust

Provider Level					April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	E.B.32	Count	The number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site specific symptoms	462	440	420	400	380	360	340	320	300	280	250	191
				UHNM snap-shot PTL position	579	632	639	815	1041	894	887	730	558	477	346	313

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

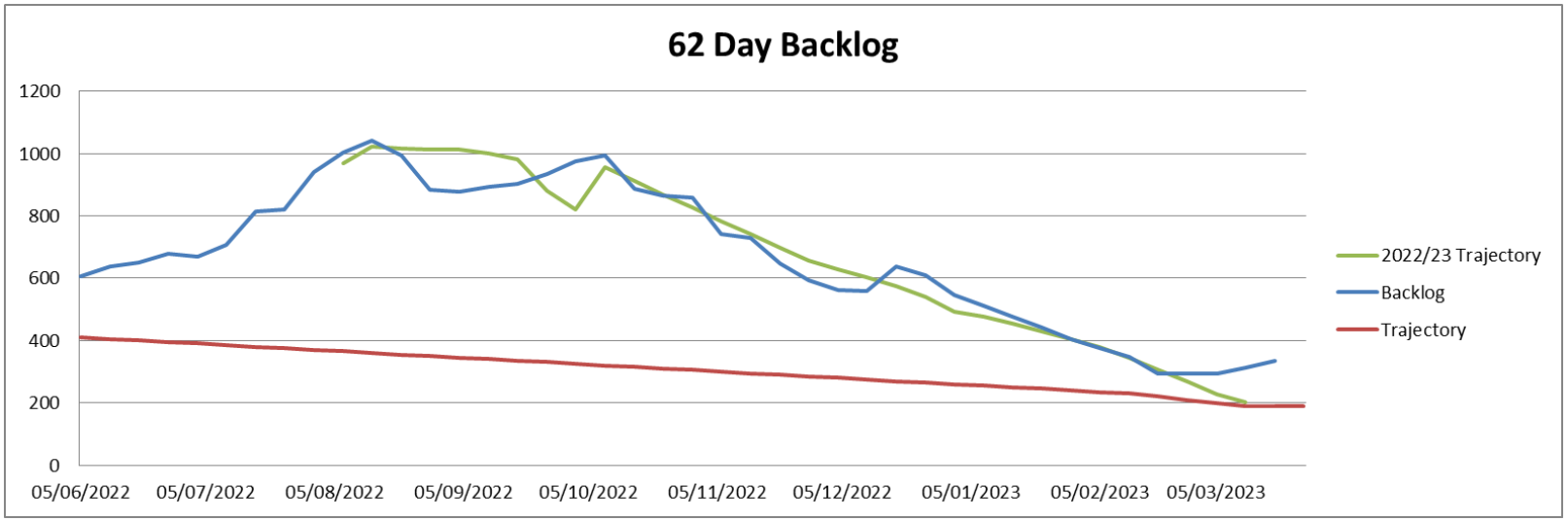
For the month of March 2023, the backlog position was 313 – a reduction of over 700 patients since August. This position includes patients with a decision to treat and a future treatment date scheduled. The majority of the backlog is attributable to Skin and Colorectal. High proportion of patients waiting over 62 days in both tumour sites have future scheduled treatment dates. The April 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.

There are 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.

All divisions are focusing on the backlog and discharge patients where appropriate. There is a concentration on the first appointments and encouraging patients to attend as soon as possible, plus a focus on diagnostics and treatments including Surgical and Oncology. All diagnostic modalities have submitted plans for a reduction in waiting times which includes additional staffing, insourcing and outsourcing and building additional capacity through CDC's.

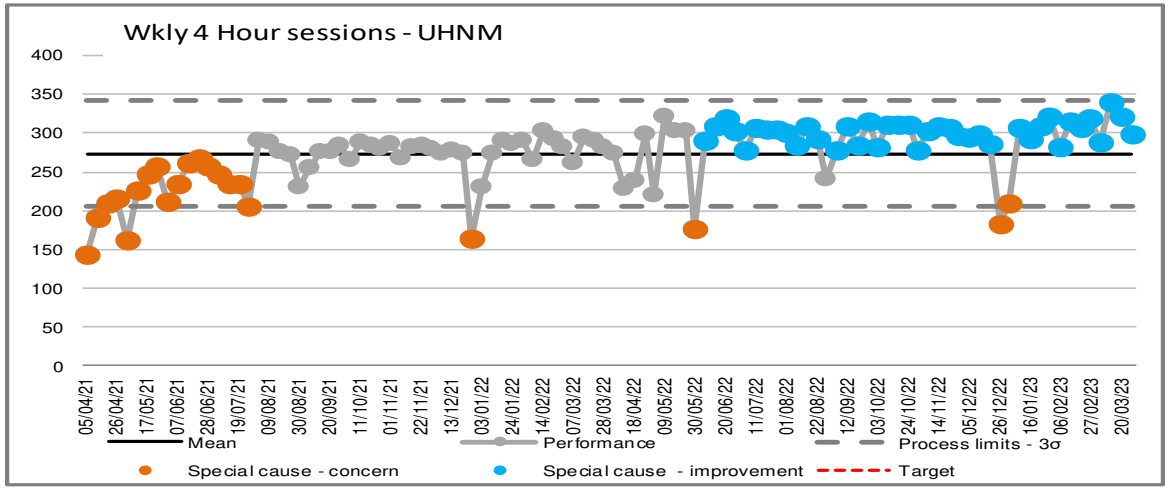
Cancer

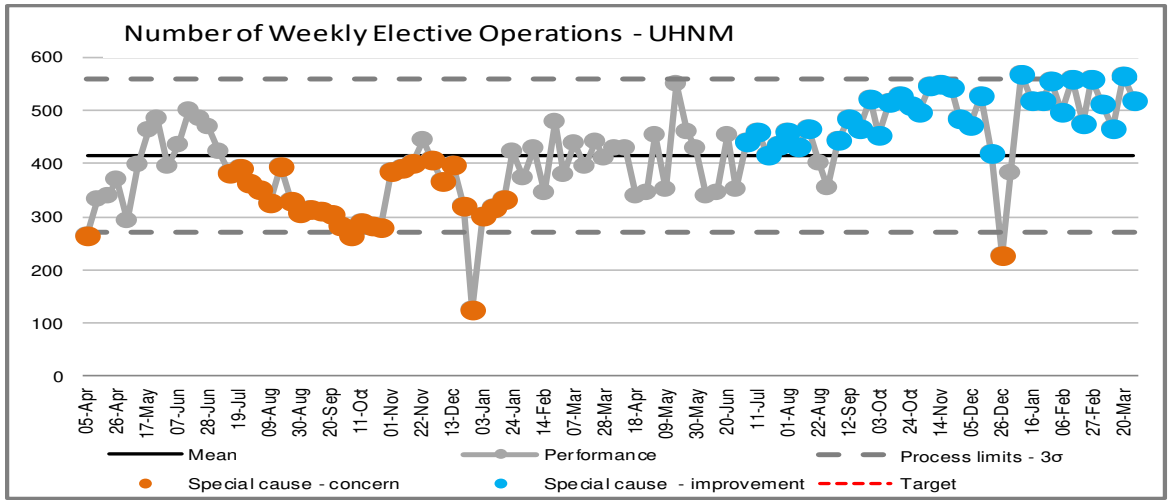
- UHNM provide assurance to the regional NHSEI team, with detailed plans on a weekly basis. Tier 2 Progress to date:
  - The 62 day backlog has reduced by over 700 patients since August.
  - The number of days waited for 1st OPA (93rd Percentile) has reduced by 35 days since August.
  - The total PTL 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 February position of 71.5%



- The incremental decrease of the 62 Day Backlog was modelled up to the end of March 23.
- All specialties enacted recovery plans and reduced the number of patients waiting beyond 62 days on the pathway, resulting in the trajectory and the actual position being very close. Moving into the 23/24 there 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.

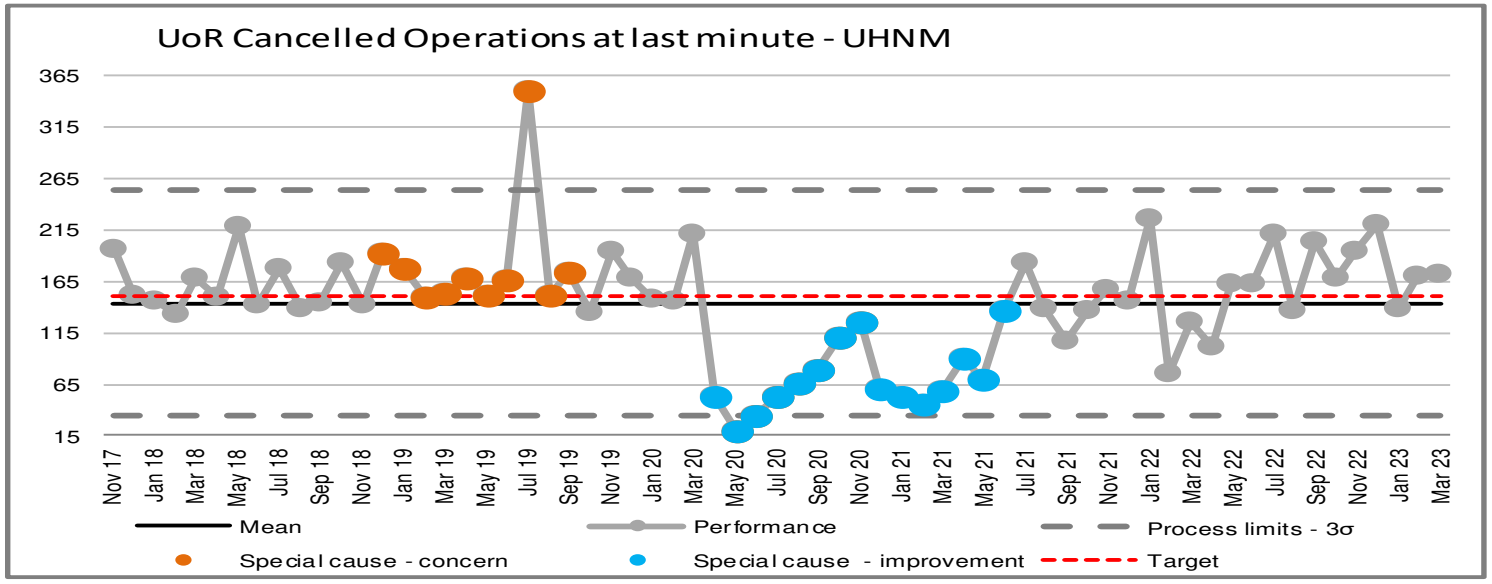
Planned care – *Inpatient Activity*





The both the number of 4 hour sessions taking place and the number of weekly operations are now back to a consistent level.

Planned care – *Inpatient Activity*



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

The numbers of patients cancelled remains higher than targets, largely due to consultant availability on the day, a more urgent case or bed suitability. Hospital cancelations due to admin error are usually where the patient has not attended and the TCI has been an administratively created error.

Planned care - *Inpatients*

NHS University Hospitals of North Midlands NHS Trust

Elective inpatients Summary

- Day Case and Elective Activity delivered 95% and 107% respectively for March 23 against the national ask of 110%/108%. Day case as a % of all elective work is currently 87.3%.
- 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 March the number of > 104 weeks was 58. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity. This has decreased by 15 on February. 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.
- Insourcing arrangements at weekends continue and have been bolstered to provide more weekend capacity in T&O through County Hospital. This is planned to continue through to the end of the financial year.
- The IS have agreed to take T&O patients at risk of breaching 78 weeks by end of March who are clinically suitable. Of 34 patients identified by the ISP only 9 agreed to transfer. Of these, 3 were rejected once seen in clinic.

Actions

- The Trust is currently at 99.7% of all pathways over 52 weeks having ben validated within the last 12 weeks. The next national ask is to have all patients waiting longer than 12 weeks validated by 28th April 2023. The number currently not validated in the last 12 weeks is 43,594 patients and additional validators have been brought into the team to support this using ERF.
- 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.
- 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 February and March.
- Roll-out of Palantir's Foundry platform underway, with working group to be up and running.

Planned care – *RTT Trajectories*

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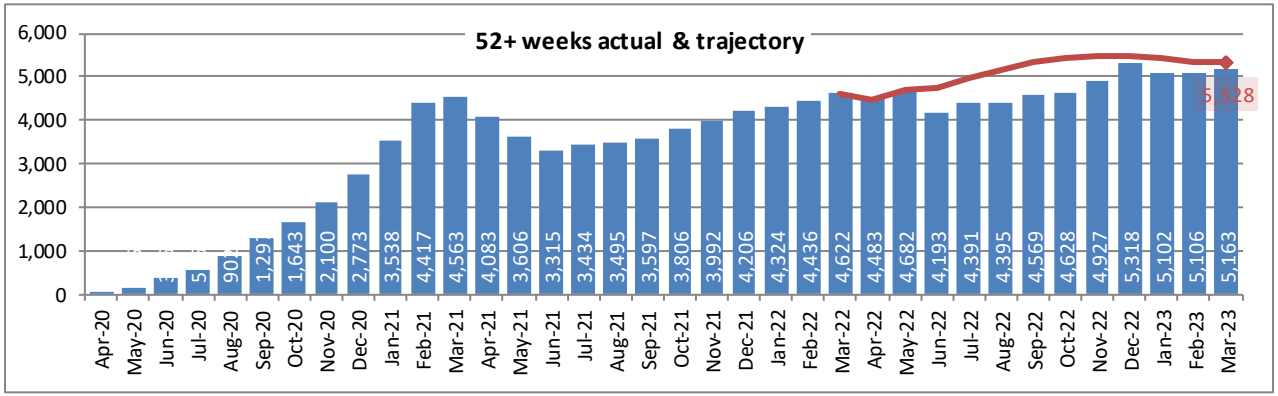
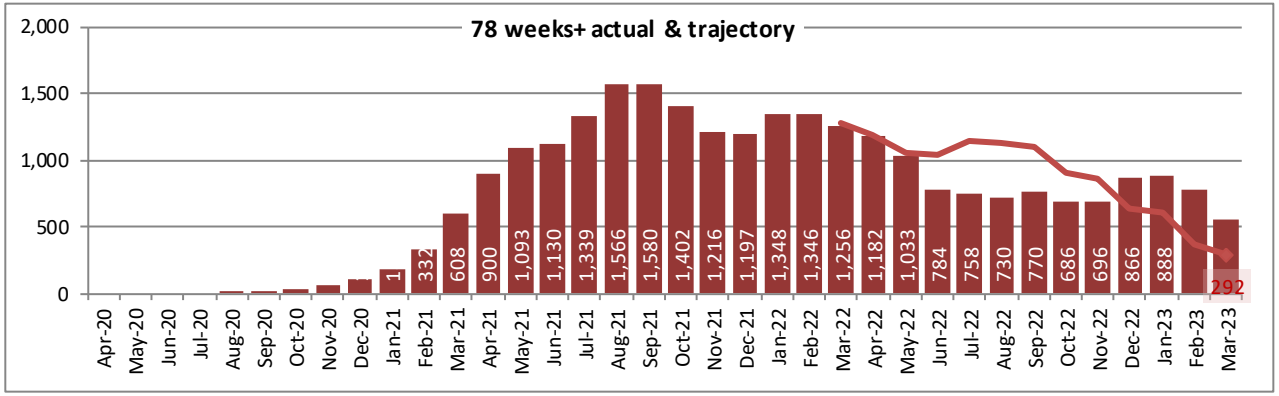
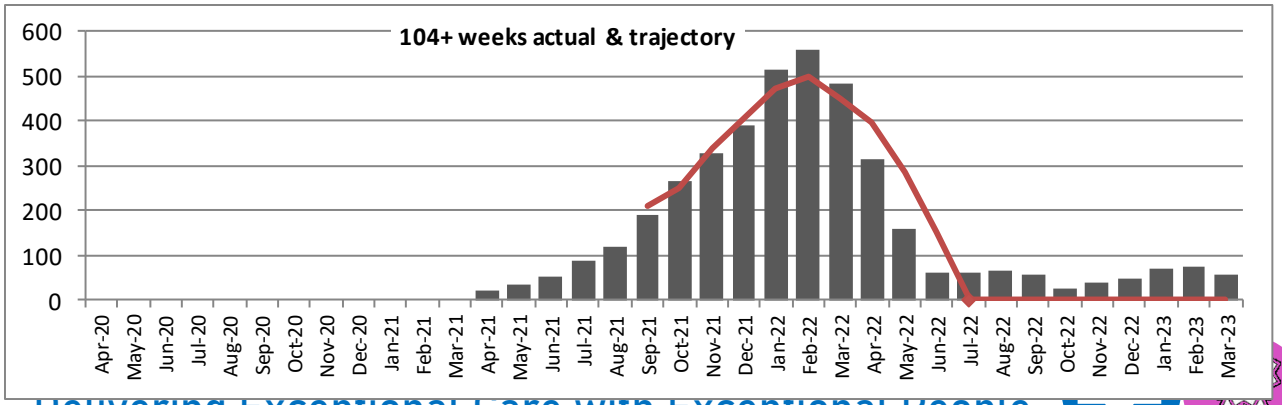


Although 52 Week Waits have been gradually growing since June 21, levels are within trajectory. March data is unvalidated, but indicates a marginal increase in 52 week waits.



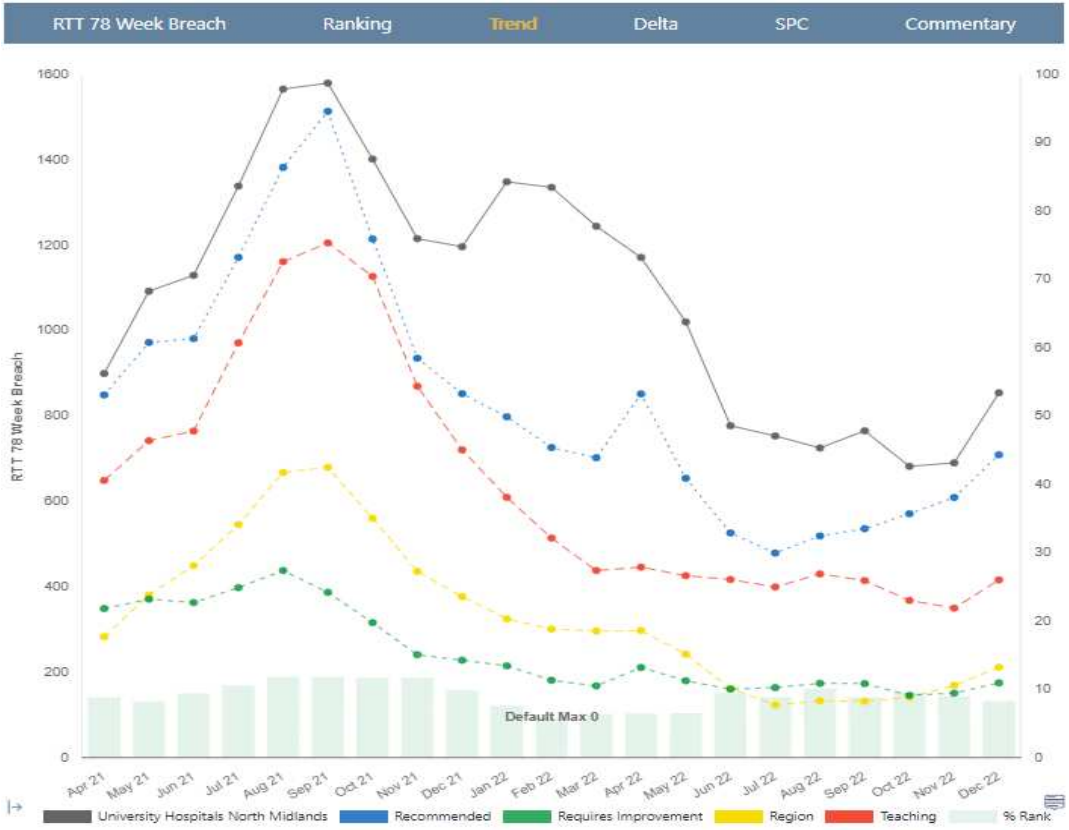
Over the last three months, patients waiting 78 weeks or more has reduced, although still above trajectory. March data is unvalidated.



104 Week Waits saw a sharp drop since February 2022, however since October volumes have been increasing gradually. (March data is unvalidated). This is made up of patient choice, patients presenting unwell or complex pathways.

RTT - Benchmarked

Key Performance Indicator	Period	Target		SPC	
RTT 104 Week Breach	Dec 22	0	48	L	2
RTT 52 Week Breach	Dec 22	0	5,300	H	9
RTT 78 Week Breach	Dec 22	0	855	L	8
RTT 95th Percentile Admitted W...	Dec 22	18.0	78.1	H	10
RTT 95th Percentile Non-Admitt...	Dec 22	18.0	51.7	H	33
RTT Admitted Treatment Within...	Dec 22	90.0%	57.8%	L	35
RTT Average (Median) Admitte...	Dec 22	9.0	12.8	H	40
RTT Average (Median) Non-Ad...	Dec 22	5.0	7.7	H	55
RTT Average Wait for Incomplete	Dec 22	7.00	17.6	H	13
RTT Incomplete 92nd Percentile	Dec 22	-	49.6	H	19
RTT Incomplete Pathways With ...	Dec 22	25.0%	15.1%	H	48
RTT Non-Admitted Treatment ...	Dec 22	95.0%	70.8%	L	49
RTT Total Clock Starts	Dec 22	-	12,579	C	82
RTT Total Clock Stops	Dec 22	-	11,125	C	84
RTT Total Incompletes	Dec 22	-	77,889	H	12



- 78 Week waits saw a reduction each month since January 2022, however December saw an increase.
- All peer groups increased in December.
- UHNM remain in the lowest quartile.

Planned care

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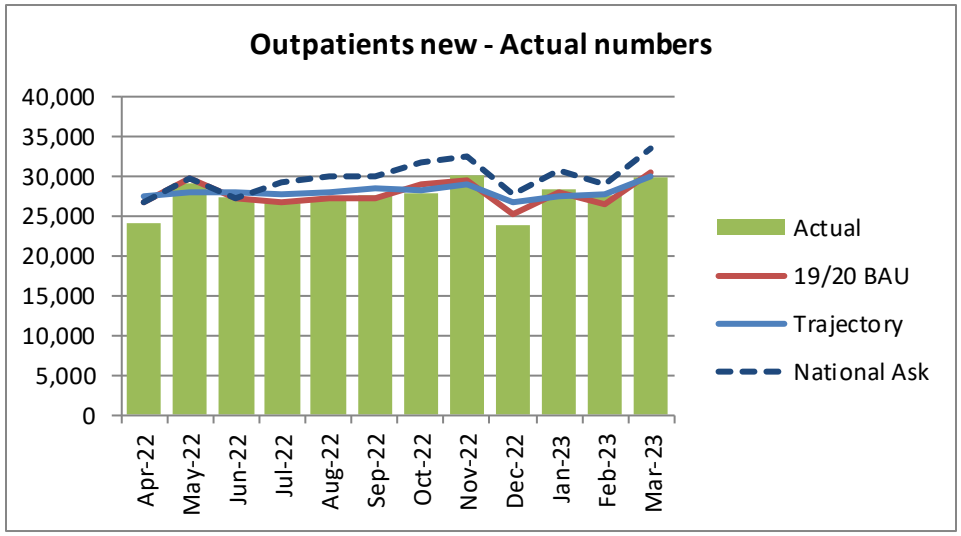
Summary

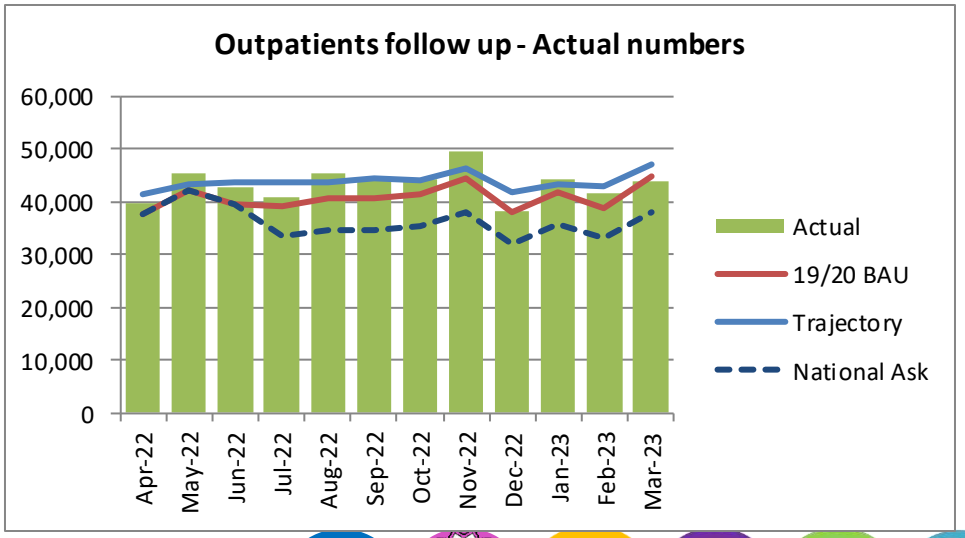
- 52+ week patients increased in January to 5,425
- 78+ patients have been gradually reducing, but had reached a plateau in November at 725. This has increased in December to 863, due to winter pressures in combination with industrial action and in January rose to at 936. The number has decreased throughout February & March, with a provisional month end position of 558.
- The trust is 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.
- At the end of March the numbers of > 104 weeks was 58. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity. This has decreased by 15.
- The overall Referral To Treatment (RTT) Waiting list now sits 77,487 end of March (unvalidated).

RTT

- Validation has increased with extra resource. This will provide an accurate picture of the resource required in the medium term to reduce the list.
- Performance sits at 54.1%, an improvement from 53.1% for February.
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

Planned care – *Outpatient activity & RTT*





Planned care – *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Actions

- **OP Cell Programme Structure** revising to reflect latest Elective Recovery Guidance. Linking with Business Planning re 23/24 plans.
- **Work stream 1 Outpatient Service Delivery & Performance**

  Utilisation; OP Cell Dashboard revised to support focus, booking & DNA Divisional / UHNM target & trajectories, utilisation Mar 85.4% vs 85.0% plan. Corporate action: link with 'Action on DNAs' NHSE initiative (see 2 Way Messaging below), plus Divisions have identified specialty-specific actions.

  Unoutcomed; DQ leading remedial actions, insights to inform prospective measures. Reduction; 330 (09/03) prior to previous month to 194 (10/04).
- **Work stream 2 Outpatient Transformation**

  OP GIRFT: issued Nov/Dec, aimed at clinicians & operational teams in 15 specialties. UHNM baseline assessment complete vs customised maturity model. Met with general surgery, gynaecology & cardiology to review actions & comments. Timeline agreed for all Specialty Meetings & Reviews.

  PIFU; met national 5% target March 2023. Benchmarking vs national median Feb 2022- UHNM: 22nd of 143 providers (4.9% vs 2.2%). Clarifying requirements for new CDS from June 2023. Additional PIFU pathway opportunities from OP GIRFT guidance.

  Enhanced Advice & Guidance ICS Referral Optimisation Steering Group set up (now termed Demand Management Steering Group).

  Virtual Care >25%; SUS submission 'fix' implemented from Nov 2021 (with BI); longer term, alignment of clinic booking and media type outcomes. NHS Remote Monitoring Toolkit issued early December, baseline assessment submitted 19th December. One Consultation now live.

  Digital Enablers

  - **Waiting List Validation (OP/IP) –** As an alternative to proposed interim Netcall module solution, IM&T instead advising to scope bringing forward PKB functionality (via ERF monies bid) in order to support the waiting list validation approach. Risk around timelines vs waiting list pressures.
  - **SMS via Netcall to Waiting List** - Partial Booking module used to contact follow ups in top 14 backlog specs. Gastro, Urology, Gynae & Skin have run campaigns. 7K patients contacted; response rate nearly 50%, 7% of contacted (>450) no longer need appointment. Next neuro, paeds.
  - **2 Way Messaging; DNA reduction / Short Notice Booking** - Extension of current Netcall reminder functionality to 2 way messaging; confirm / cancel appointments, and worklist to support short notice booking. 4K quote; WC&CSS have included in list of developments, subject to approval.
  - **Robotic Process Automation (RPA); Outpatient Outcomes -** All OP outcomes captured by a clinician on iportal / paper forms need completing on Careflow. Circa 200K attendances annually with 'simple' outcomes eg discharge, could be completed via RPA. UHNM BI progressing.
  - **RPA; PIFU Discharge Letters (at Review Date) -** Scoping with UHNM BI (where pre-agreed by specialties), to pilot with Neuro & Urology.
  - **Patient Portal**; IM&T invited to OP Cell for updates. Director of Digital Transformation attended OP Cell in October to share Digital Vision. Patient Portal live in January, invites from February 2023 by letter or SMS to register for PKB via the NHSApp. Able to view appts & test results initially.

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: timeline risk.
- Lack of pace on schemes linked to System Partners, escalated at Planned Care Improvement Board.
- Potential impact of Industrial Action on M1 performance.

Diagnostic Activity

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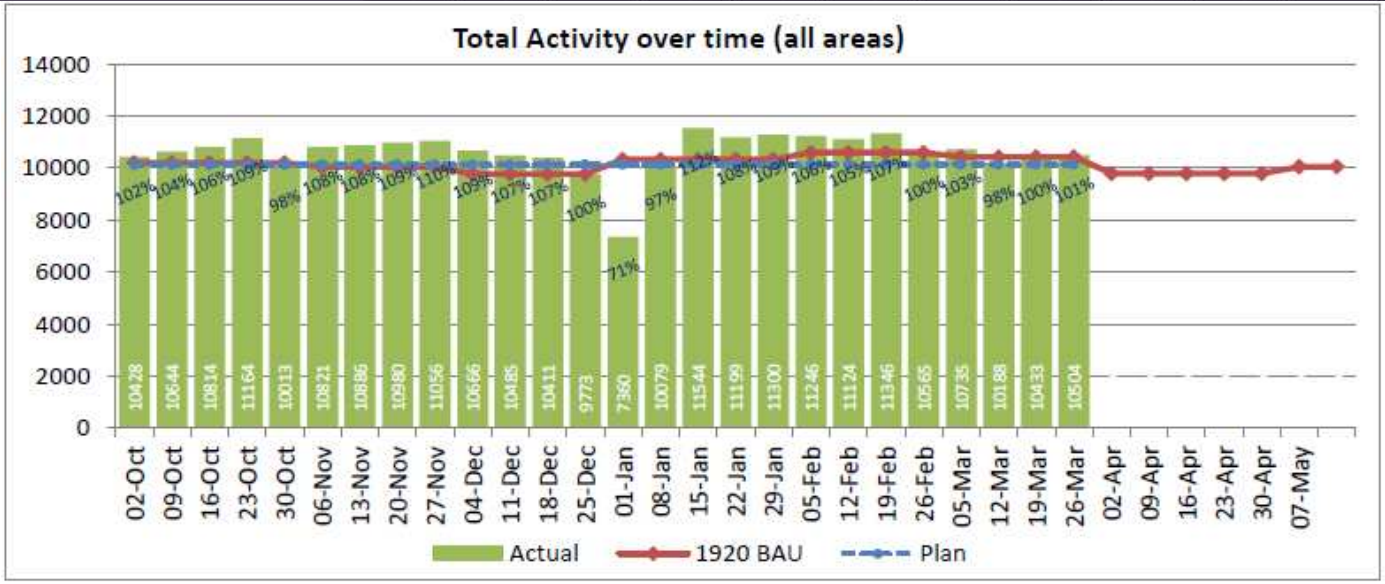
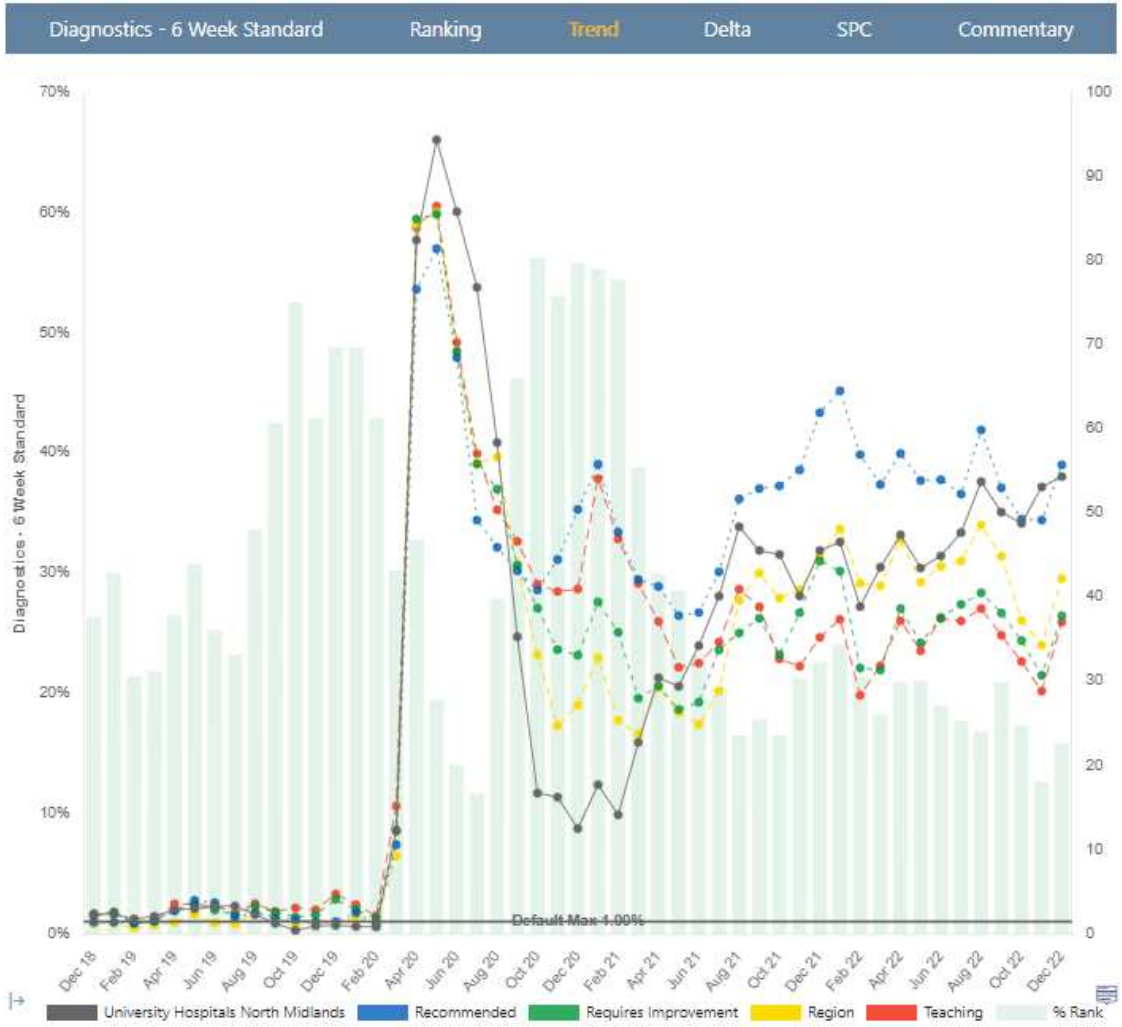
		2019 Method For Imaging Activity								Not Fully Validated			
		Jan-23				Feb-23				Mar-23			
Area	DM01 Test	Total WL	6+	%	Activity	Total WL	6+	%	Activity	Total WL	6+	%	Activity
Imaging	Magnetic Resonance Imaging	3,968	831	79.1%	3,770	3,886	504	87.0%	6,417	3,674	24	99.3%	
	Computed Tomography	3,711	44	98.8%	8,532	4,122	23	99.4%	12,892	3,948	84	97.9%	
	Non-obstetric ultrasound	8,357	4,187	49.9%	6,582	7,513	2,512	66.6%	6,535	7,436	2,315	68.9%	
	Barium Enema	0	0		0	0	0		0				
	DEXA Scan												
Physiological Measurement	Audiology - Audiology Assessments	297	4	98.7%	313	429	9	97.9%	296	403	65	83.9%	
	Cardiology - echocardiography	2,491	1,087	56.4%	1,195	2,476	987	60.1%	1,038	2,943	1,105	62.5%	
	Cardiology - electrophysiology	0	0		2	0	0		0	0	0		
	Neurophysiology - peripheral neurophys	243	0	100.0%	317	298	0	100.0%	233	317	0	100.0%	
	Respiratory physiology - sleep studies	472	64	86.4%	274	481	43	91.1%	294	493	58	88.2%	
	Urodynamics - pressures & flows	0	0		0	1	0	100.0%	0	0	0		
Endoscopy	Colonoscopy	911	620	31.9%	224	959	617	35.7%	140	1,477	812	45.0%	
	Flexi sigmoidoscopy	542	341	37.1%	41	558	357	36.0%	20	925	468	49.4%	
	Cystoscopy	125	14	88.8%	266	120	15	87.5%	230	201	59	70.6%	
	Gastroscopy	689	328	52.4%	476	797	300	62.4%	287	1,002	563	43.8%	
	Totals	21,806	7,520	66%	21,992	21,640	5,367	75%	28,382	22,819	5,553	76%	0



Diagnostics - benchmarked

Key Performance Indicator	Period	Target		SPC	
Audiology	Dec 22	1.00%	1.1%		74
Colonoscopy	Dec 22	1.00%	62.1%		13
Computed Tomography	Dec 22	1.00%	2.4%		59
Cystoscopy	Dec 22	1.00%	11.2%		66
DM01 Waiting <13 Weeks	Dec 22	100.00%	90.1%		37
Diagnostics - 6 Week Standard	Dec 22	1.00%	38.0%		23
Diagnostics - 6 Week Standard ...	Dec 22	99.00%	62.0%		23
Echocardiography	Dec 22	1.00%	34.5%		44
Electrophysiology	Dec 22	1.00%	0.0%		100
Flexi Sigmoidoscopy	Dec 22	1.00%	63.4%		13
Gastroscopy	Dec 22	1.00%	59.2%		8
Magnetic Resonance Imaging	Dec 22	1.00%	22.5%		32
Neurophysiology	Dec 22	1.00%	0.0%		100
Non-obstetric Ultrasound	Dec 22	1.00%	57.9%		6
Sleep Studies	Dec 22	1.00%	10.6%		56
Urodynamics	Dec 22	1.00%	-		-



- Performance at UHNM is showing the same trend as all other peers and in line with the “Recommended” group.
- As with all peer groups, UHNM performance to the national target of 1% is deteriorating.
- UHNM remains in the bottom quartile nationally.

Planned care - *Diagnostics*

University Hospitals of North Midlands NHS Trust

Diagnostics Summary

- During March the Diagnostic activity remained consistent with the February position.
- DM01 performance was 76% overall which was slightly improved on February's 75%, this is a marked improvement on January's 66&. The key area of underperformance being Endoscopy

Histology position – as at 23rd March:

- Urgent (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day 21 (previously Day 25), 80% reported by Day 13
- Accelerated (include all Cancer Resections): 95% reported at Day 46 (previously Day 46), with 80% reported by Day 38
- Routine (all Specimens not in above categories): 95% reported at Day 44 (previously Day 54), 80% of cases reported by Day 37

The 7 day reporting turnaround time (TAT) for Urgent cases is at 51% against the Royal College of Pathologists' target of 80% within 7 days.

Actions

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

DM01 performance 75%: 5553 patients waiting 6 weeks+;

Top Contributors – in order of highest breach %

1.	Gastroscopy (43.8%)	563 breaches of 1002 patients
2.	Colonoscopy (45%)	812 breaches of 1477 patients
3.	Flexi Sigmoidoscopy (49.4%)	468 breaches of 925 patients
4.	Echo (62.5%)	1105 breaches of 2943 patients
5.	Non-Obstetric Ultrasound (68.9%)	2315 breaches of 7436 patients

Radiology reporting backlogs;

- Radiology workforce business case part approved – approval to recruit to 10wte radiology consultants; 2 Locum radiologists have been recruited and started in post.
- Weekly Radiology backlog risk management meetings are now in place with the speciality clinical leads, divisional and directorate management representatives with specialty specific action plans and individual risk register entries
- Price per scan TI payment model approved until Dec 2023 to support an increase in reporting and outsourcing remains in place
- Risk 25512 remains at score - 20

Non – obs Ultrasound capacity for routine patients New outsourced provider procured & reflected in boost in activity. Trajectory to meet DM01 by May '23

Endoscopy; Fluctuating cancer referral demand against lack of scopist availability. Full recovery plan in negotiation, this remains of concern

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	10.45%	9.18%	9.18%	7.41%	7.52%	11.24%	12.99%	10.31%	13.89%	7.18%	0.65%
Weeks Waited- 78-104	13.66%	12.73%	8.26%	7.76%	8.26%	10.03%	10.96%	9.36%	11.89%	5.90%	1.18%
Weeks Waited- 52-77	14.63%	11.94%	9.25%	9.25%	7.10%	11.59%	9.79%	8.90%	12.16%	4.56%	0.82%
Weeks Waited- Under 52	13.80%	11.62%	10.44%	9.09%	7.53%	10.46%	10.21%	8.85%	11.41%	5.20%	1.39%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.45%	10.50%	9.40%	8.74%	7.95%	10.93%	11.58%	10.03%	12.28%	6.04%	1.11%
Weeks Waited- 78-104	12.43%	11.02%	9.83%	9.12%	7.68%	10.73%	10.68%	8.65%	12.01%	6.68%	1.18%
Weeks Waited- 52-77	12.82%	10.72%	9.91%	8.90%	7.58%	10.79%	10.70%	9.25%	11.68%	6.37%	1.28%
Weeks Waited- Under 52	13.28%	11.32%	10.07%	8.94%	7.54%	10.64%	10.50%	9.10%	11.37%	5.99%	1.25%

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	0.17%	0.39%	0.08%	0.39%	0.31%	0.62%	0.06%	0.11%	0.20%	0.39%	0.51%	0.23%	0.06%	#N/A	93.32%	0.37%	0.73%	1.75%	0.31%
Weeks Waited- 78-104	0.17%	0.51%	0.17%	0.42%	0.51%	1.26%	0.08%	#N/A	0.25%	0.34%	0.76%	0.34%	0.08%	#N/A	89.80%	0.34%	2.53%	1.60%	0.84%
Weeks Waited- 52-77	0.44%	0.57%	0.41%	0.60%	0.67%	1.17%	0.10%	0.10%	0.25%	0.60%	2.03%	0.19%	0.22%	0.29%	87.27%	0.25%	1.74%	1.65%	#N/A
Weeks Waited- Under 52	0.43%	0.69%	0.29%	0.71%	0.63%	1.22%	0.17%	0.16%	0.15%	0.54%	1.47%	0.30%	0.16%	0.19%	84.23%	0.27%	2.87%	2.49%	3.03%

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	0.30%	0.50%	0.21%	0.48%	0.46%	0.85%	0.11%	0.19%	0.09%	0.41%	1.63%	0.27%	0.16%	0.12%	88.03%	0.33%	2.44%	2.10%	1.31%
Weeks Waited- 78-104	0.35%	0.53%	0.24%	0.62%	0.50%	0.98%	0.19%	0.14%	0.15%	0.61%	1.61%	0.37%	0.12%	0.19%	86.82%	0.20%	2.33%	2.13%	1.95%
Weeks Waited- 52-77	0.42%	0.69%	0.19%	0.63%	0.61%	1.10%	0.11%	0.12%	0.20%	0.63%	1.57%	0.27%	0.20%	0.21%	84.26%	0.29%	3.06%	2.56%	2.89%
Weeks Waited- Under 52	0.47%	0.67%	0.20%	0.64%	0.59%	1.30%	0.15%	0.17%	0.14%	0.61%	1.81%	0.33%	0.17%	0.24%	82.61%	0.30%	3.25%	2.77%	#N/A

APPENDIX 1

Operational Performance

Constitutional standards

NHS University Hospitals of North Midlands NHS Trust

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	Percentage of Ambulance Handovers within 15 minutes	0%	64.50%	H		
	Ambulance handovers greater than 60 minutes	0	651	H	?	
	Time to Initial Assessment - percentage within 15 minutes	85%	64.99%		F	
	Average (mean) time in Department - non-admitted patients	180	298	H	?	
	Average (mean) time in Department - admitted patients	180	410	H	F	
	Clinically Ready to Proceed	90	505	H	F	
	12 Hour Trolley Waits	0	906	H	?	
	Patients spending more than 12 hours in A&E	0	2010	H	F	
	Median Wait to be seen - Type 1	60	99	H	F	
	Bed Occupancy	92%	87.83%			
Cancer Care	Cancer 28 day faster pathway	75%	71.56%	H	F	
	Cancer 62 GP ref	85%	50.87%	L	F	
	Cancer 62 day Screening	90%	80.95%		?	
	31 day First Treatment	96%	90.16%	L	?	
	2WW First Seen (exc Breast Symptom)	93%	96.35%	H	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	6.9%		?	
	Cancelled Ops	150	172		?	
	Theatre Utilisation	85%	75.9%			
Inpatient / Discharge	Same Day Emergency Care	30%	37%	H	?	
	Super Stranded	183	189		?	
	MFFD	100	94	L	F	
	Discharges before Midday	25%	20.2%		F	
	Emergency Readmission rate	8%	7.0%	L	F	
Elective waits	RTT incomplete performance	92%	52.80%	L	F	
	RTT 52+ week waits	0	5163	H	F	
	Diagnostics	99%	75.67%	L	F	

Delivering Exceptional Care with Exceptional People

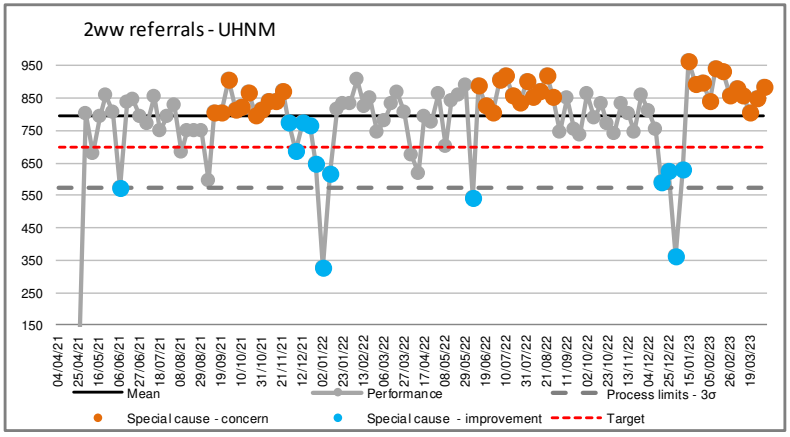
Cancer – 62 Day

NHS University Hospitals of North Midlands NHS Trust

Target	Jan 23	Feb 23	Apr 23
700	806	852	884

Background

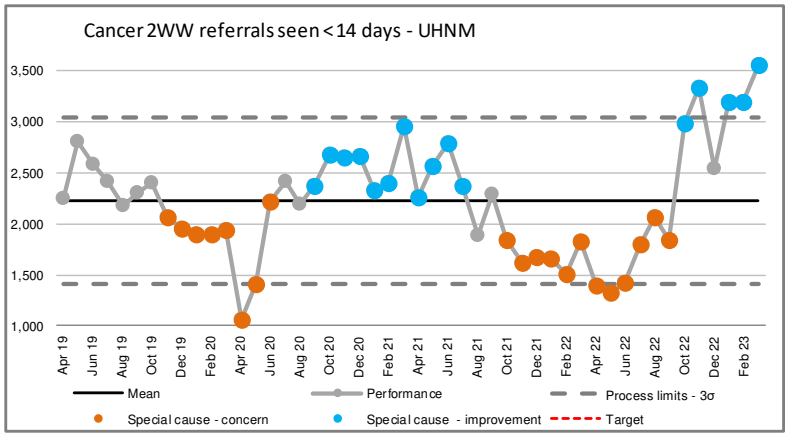
The number of patients referred on a cancer 2ww pathway.



Target	Jan 23	Feb 23	Mar 23
N/A	3202.0	3192.0	3566.0

Background

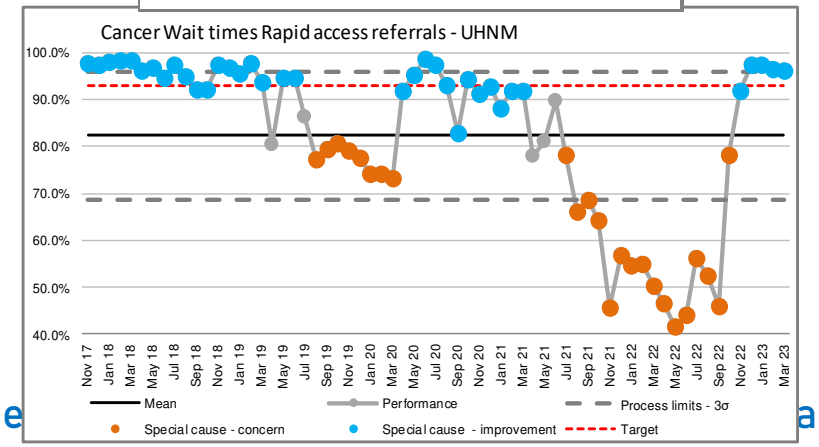
The percentage of patients waiting over 18 weeks for treatment since their referral.



Target	Jan 23	Feb 23	Mar 23
93%	97.6%	96.7%	96.4%

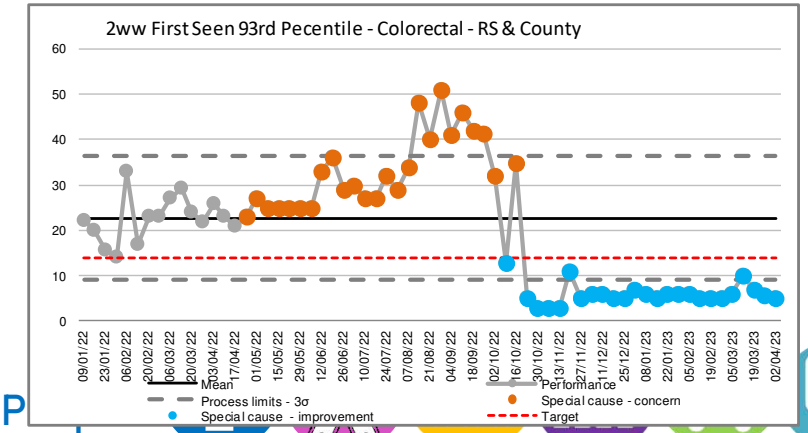
Background

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

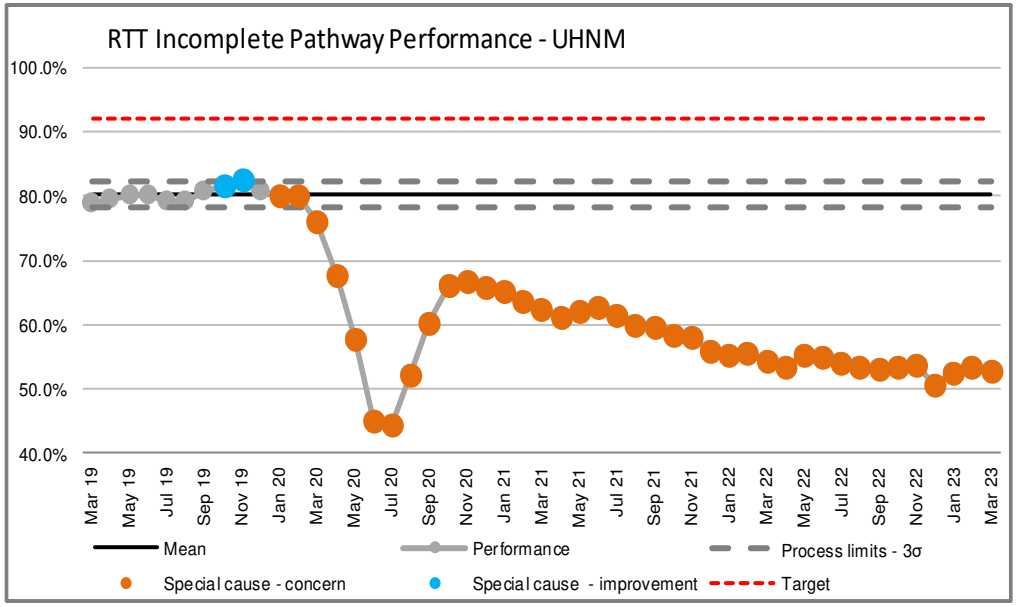


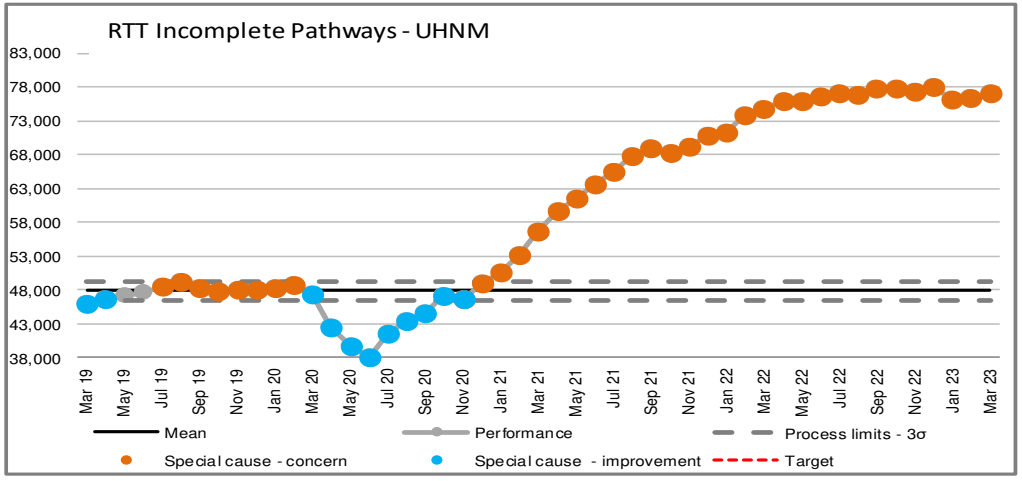
Variation	Assurance

Target	Mar 23	Mar 23	Apr 23
14	7	6	5



Referral To Treatment





Variation	Assurance
L	F

Target	Jan 23	Feb 23	Mar 23
92%	52.5%	53.4%	52.8%

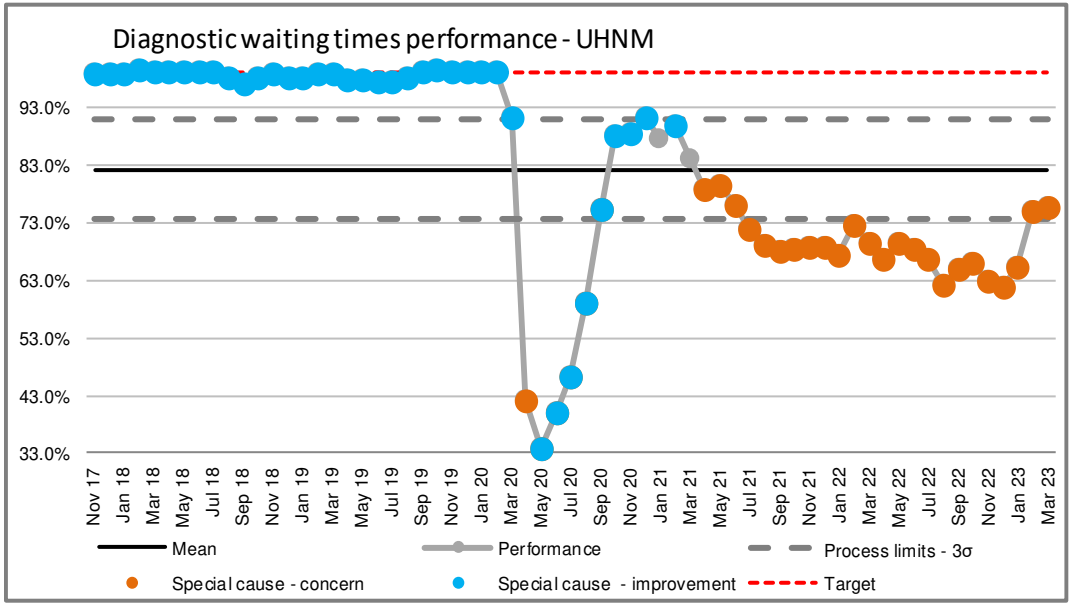
Background

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

What is the data telling us?

Steady decline in performance since the pandemic began.

Diagnostic Standards



Variation	Assurance
	

Target	Jan 23	Feb 23	Mar 23
99%	65.5%	75.2%	75.7%

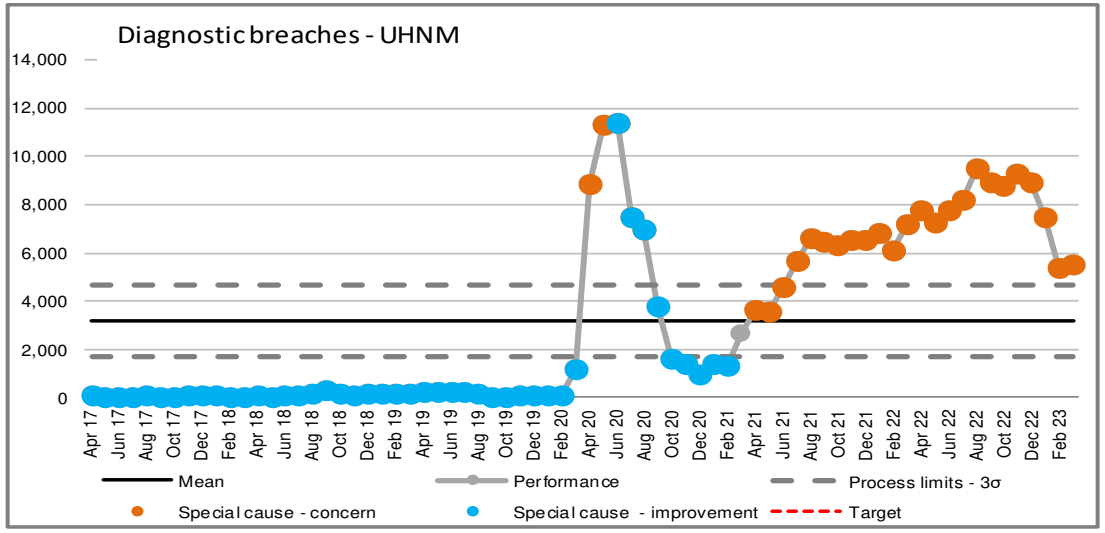
Background

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 in February to 74% and reached the lower control limit.

The volume of breaches is continuing to see a reduction, but still remains above the upper control limit.



Workforce

University Hospitals of North Midlands NHS Trust

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

Delivering Exceptional Care with Exceptional People

Workforce Spotlight Report

University Hospitals of North Midlands NHS Trust

Key messages

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

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

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

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

- The Being Kind e-learning will be mandated from 1 April 2023 and this will be communicated Trust wide with large scale face-to face sessions being planned for June and July.
- The PowerBI Cultural heatmap dashboard has gone live and can be accessed by divisions. The indicators have been cross referenced with the cultural improvement plan to ensure that most aspects of improvement are being measured.

Anxiety and Stress at 22.5% sits as the top reason for absence in the last 12 months closely followed by Chest and respiratory (which includes Covid) at 21.9%. Focusing specifically on Covid related absence by 26th March 2023 covid-related absences stood at 117, which was 17.6% of the 664 open absences. This is 2.1.% decrease on same time the previous month.

The Staff Voice trust survey for March 2023 received a total of 919 submissions providing an overall staff engagement score of 6.60.

Internal measures to monitor reduction is agency expenditure continue. Divisional targets for agency ceilings have been calculated. As part of the monitoring divisions were asked to present an update on their action plan to reduce expenditure to Executive Workforce Assurance Group (EWAG). New targets for the upcoming year will be provided based on 3.75% of total wage bill.

The Loop app officially launched on the 3rd April, Fully integrated with our eRostering solution, it allows your people to view their personal schedule anytime as well as provide input back into the roster with simple to use features such as leave request, logging call-outs and requesting bank duties.

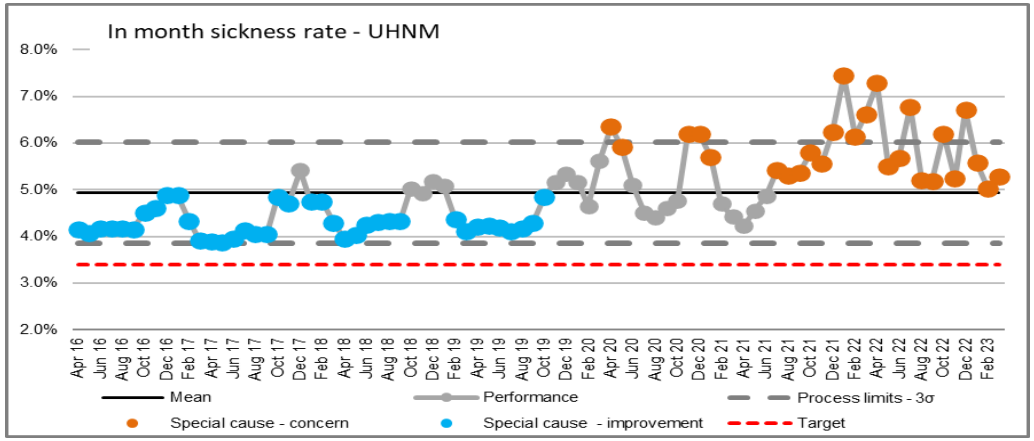
Workforce Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.28%		
Staff Turnover	11%	10.93%		
Statutory and Mandatory Training rate	95%	93.56%		
Appraisal rate	95%	82.73%		
Agency Cost	N/A	1.69%		

Sickness Absence

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Jan 23	Feb 23	Mar 23
3.4%	5.6%	5.0%	5.3%

Background

Percentage of days lost to staff sickness

Sickness rate is consistently above the target of 3.4%.

Summary

(12m cumulative Absence FTE %)

Org L2	Divisional Trajectory - March 2023	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trajectory
205 Central Functions	3.39%	4.13%	4.13%	4.11%	4.19%	4.21%	4.20%	3.74%	3.71%	3.85%	3.79%	3.90%	3.88%	↓
205 Women's, Children's & Clinical Support Services	5.25%	5.88%	5.94%	5.97%	6.03%	6.07%	6.25%	6.35%	6.29%	6.32%	6.22%	6.19%	6.01%	↓
205 Estates, Facilities and PFI Division	5.25%	5.81%	5.75%	5.76%	5.85%	5.98%	6.04%	6.20%	6.22%	6.15%	6.02%	6.00%	5.75%	↓
205 Medicine and Urgent Care	5.25%	6.56%	6.64%	6.67%	6.76%	6.82%	6.85%	6.94%	6.86%	6.90%	6.55%	6.41%	6.22%	↓
205 Division of Network Services	5.25%	5.32%	5.47%	5.69%	5.89%	5.81%	5.78%	5.73%	5.75%	5.80%	5.59%	5.48%	5.34%	↓
205 Division of Surgery, Theatres and Critical Care	4.50%	7.02%	7.18%	7.30%	7.45%	7.39%	7.31%	7.30%	7.20%	7.12%	6.94%	6.81%	6.73%	↓
205 North Midlands & Cheshire Pathology Service (NMCPS)	5.25%	N/A	N/A	N/A	N/A	N/A	N/A	5.57%	5.61%	5.64%	5.65%	5.68%	5.56%	↓

For M12, the in-month sickness rate increased by 0.26% to 5.28% (5.02% in February 2023).

Anxiety and Stress at 22.5% sits as the top reason for absence in the last 12 months closely followed by Chest and respiratory (which includes Covid) at 21.9%.

Divisional trajectories for achieving a reduction in Sickness Absence can be seen in the table above. All of the Divisions saw a decrease sickness against the previous month.

Focusing specifically on Covid related absence by 26th March 2023 covid-related absences stood at 117, which was 17.6% of the 664 open absences. This is 2.1.% decrease on same time the previous month.

Actions

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

For the Medicine division Sickness absence continues to be monitored at monthly directorate performance reviews and areas with over 8% or of concern are meeting with their People advisor on long term sickness cases

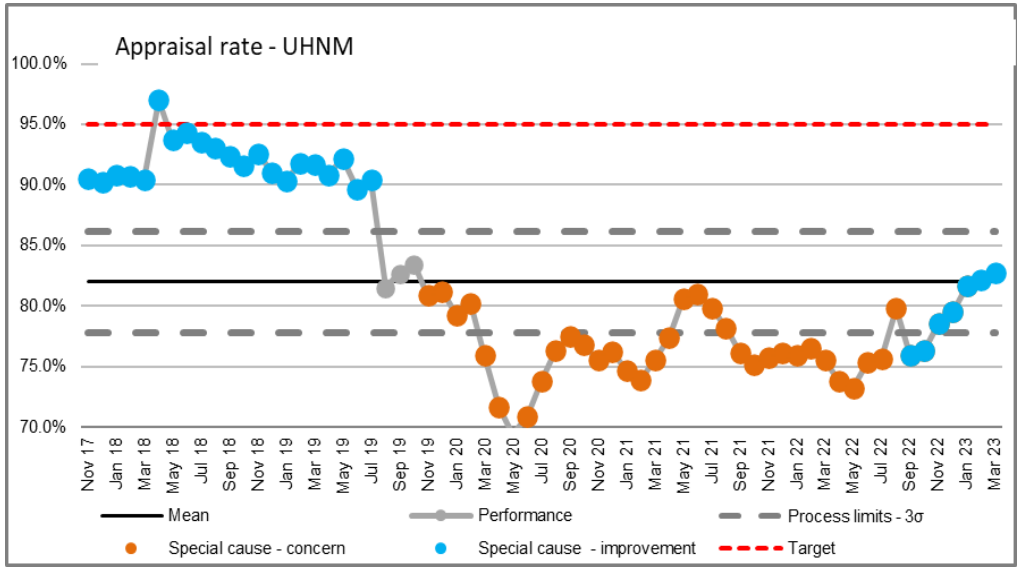
Surgery Division have been identifying hotspot areas for both long and short term sickness and providing targeted support. There has also been targeted training for low compliance areas in relation to Empactis .

Network Division have commenced sickness assurance meetings.

Women's Children's and Clinical Division. Will be undertaking a deep dive into specific areas of high absence. Alongside sickness surgeries to support managers.

Appraisal (PDR)

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Jan 23	Feb 23	Mar 23
95.0%	81.7%	82.2%	82.7%

Background

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

What is the data telling us?

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

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

Summary

At 31 March 2023, the PDR Rate increased 0.5% by to 82.7.% (82.2% at 28 February 2023)

This is a continuing upward trend over the last six months; however, this figure still sits below the overall target and divisions have been asked to review key issues and actions to work towards meeting target.

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

Actions

The focus on ensuring completion of PDRs is continuing with:

NMCPS are working on putting all out of date PDRs in the manager diaries, Identifying any manager training gaps and reconfirming Manager hierarchies within ESR.

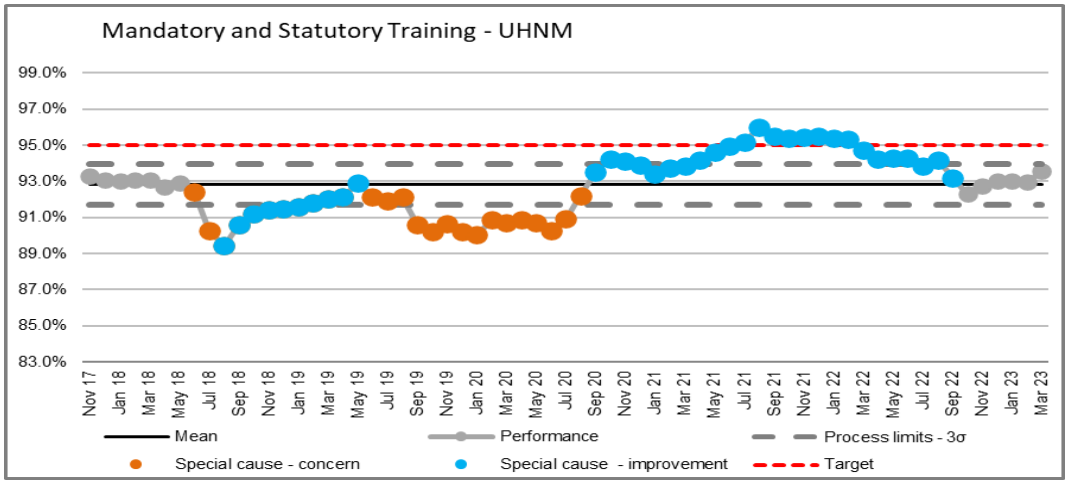
Network Division hold a dedicated weekly PDR compliance hotspot and assurance meetings

Surgery Division are undertaking a monthly compliance reporting and identifying hotspots areas to engage with.

Medicine Division are having weekly updates reports on compliance. With focused assistance on those areas with the lowest compliance.

Statutory and Mandatory Training

NHS
University Hospitals of North Midlands
NHS Trust



Variation	Assurance
	F

Target	Jan 23	Feb 23	Mar 23
95.0%	93.0%	93.0%	93.6%

Background

Training compliance

What is the data telling us?

At 93.6%, the Statutory and Mandatory Training rate is just below the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate on 31 March 2023 was 93.6% (93.0% at 28 February 2023) and saw a slight increase month on month. 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|	10963	10963	10209	93.12%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10963	10963	10202	93.06%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10963	10963	10218	93.20%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10963	10963	10198	93.02%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10963	10963	10267	93.65%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10963	10963	10013	91.33%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	11165	11165	9908	88.74%
NHS|CSTF|Information Governance and Data Security - 1 Year|	11165	11165	9908	88.74%

Actions

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

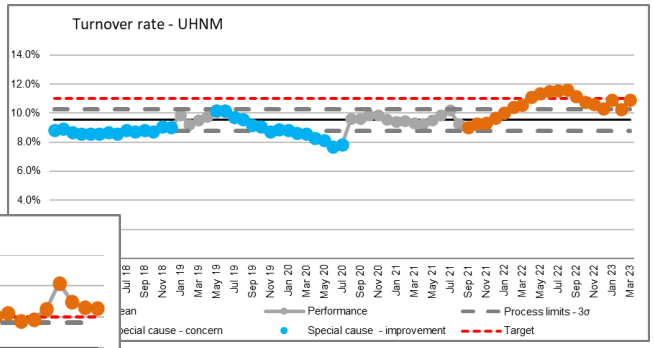
Compliance is monitored and raised via the Divisional performance review process.

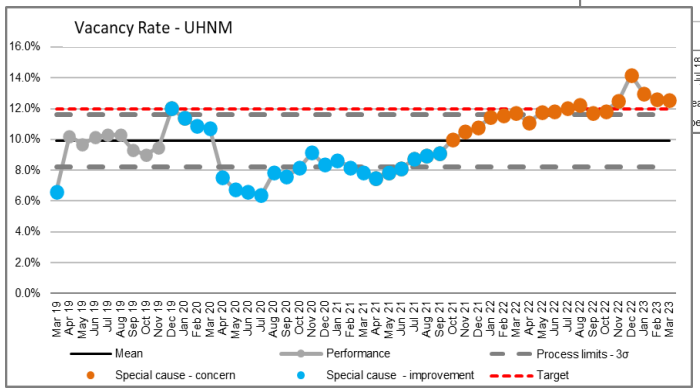
The Oliver McGowan Mandatory Training on Learning Disability & Autism is now live and will be reported separately for 12 months.

Workforce Turnover

University Hospitals of North Midlands NHS Trust

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





Variation	Assurance
H	P

Target	Jan 23	Feb 23	Mar 23
11.0%	10.9%	10.3%	10.9%

Background

Turnover rate

What is the data telling us?

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

Vacancy rate has decreased from 12.62% last month to 12.54%

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 March 2023 sat at 10.9% 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.

Vacancies at 31-03-23	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,575.01	1,332.76	242.25	15.38%	14.82%
Registered Nursing	3,547.85	3,048.81	499.04	14.07%	14.95%
All other Staff Groups	6,744.21	5,997.71	746.50	11.07%	10.87%
Total	11,867.07	10,379.28	1,487.79	12.54%	12.62%

The M12 figure of 12.54% highlights a decrease in the overall vacancy rate over the previous month. The staff in post increased in March 2023 by 12.14 FTE, budgeted establishment also increased by 3.00 fte, which decreased the vacancy fte by -9.14 FTE overall [*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 31/03/23]

Actions

Recruitment team have been Processing new Qualified nurses, 90 officially allocated and offered, leaving 40 left to allocate (Significant increase in comparison to 22 of 62).

Significant amount of recruitment events targeting specific roles across multiple divisions.

Continued targeted social media campaign. Recruitment are actively updating LinkedIn pages and have created a new UHNM recruitment Facebook group.

The Rota team have been managing the extra pressures due to the Junior doctor industrial action.

The Loop app officially launched on the 3rd April.

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

Key elements of the financial performance year to date are:

- For the year to date the Trust has delivered a breakeven income and expenditure position in line with its plan; this has been heavily reliant on non-recurrent mitigations.
- The Trust incurred £0.6m of costs relating to COVID-19 in month; with £0.5m of this being chargeable for COVID-19 testing costs. The Trust has overspent by £3.3m against its original in envelope allocation due to the in envelope funding allocation ceasing after Month 2.
- To date the trust has validated £12.1m CIP savings in year; these schemes have a full year impact of £5.3m, which presents a considerable variance to the Trust's recurrent target of £13.6m which was identified as a key risk in the Trust's financial plan submission. This variance was reflected in the revised underlying position presented to the Committee in December.
- Capital expenditure at year end is £63.4m which is in line with the 2022/23 capital plan.
- The cash balance at Month 12 is £84.0m which is £7.0m higher than plan. Cash received is above plan due to Capacity, Surge and Virtual Ward income received from the ICB.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	136.5		
	Expenditure - Pay	variable	95.9	H	F
	Expenditure - Non Pay	variable	35.2	H	F
Activity	Daycase/Elective Activity	variable	9,436	H	?
	Non Elective Activity	variable	10,780		?
	Outpatients 1st	variable	30,377		?
	Outpatients Follow Up	variable	44,505		?

Income & Expenditure

Income & Expenditure Summary Month 12 2022/23	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	959.7	120.0	126.0	5.9	959.7	965.8	6.2
Other Operating Income	92.9	10.9	10.8	(0.2)	92.9	94.4	1.6
Total Income	1,052.5	131.0	136.7	5.8	1,052.5	1,060.3	7.7
Pay Expenditure	(652.9)	(95.1)	(95.9)	(0.8)	(652.9)	(635.3)	17.7
Non Pay Expenditure	(339.2)	(32.0)	(35.2)	(3.1)	(339.2)	(366.1)	(26.9)
Total Operational Costs	(992.1)	(127.1)	(131.1)	(4.0)	(992.1)	(1,001.3)	(9.2)
EBITDA	60.4	3.9	5.7	1.8	60.4	58.9	(1.5)
Depreciation & Amortisation	(33.6)	(2.8)	(2.7)	0.1	(33.6)	(33.7)	(0.1)
Interest Receivable	0.3	0.0	0.3	0.3	0.3	2.1	1.8
PDC	(9.0)	(0.8)	(1.4)	(0.6)	(9.0)	(9.6)	(0.5)
Finance Cost	(18.1)	(1.5)	(1.5)	0.0	(18.1)	(17.9)	0.2
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.2	0.2
Surplus / (Deficit)	0.0	(1.2)	0.4	1.6	0.0	0.1	0.1
DHSC PPE adjustment	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	(1.2)	0.4	1.6	0.0	0.1	0.1

The Trust delivered it's planned a breakeven position for 2022/23. Key issues to note within the Month 12 position include the following

- the release of previously accrued goods received notes of £3.5m (against which there are no commitments)
- The release of nurse agency accrual of £0.7m that is no longer required following a review of the of the nurse rostering system.
- The position includes the impact of the proposed revised agenda for change pay award for 2022/23. The Trust will receive an additional £19.2m funding but the Trust has calculated the impact of the proposal to cost £20.5m. The £20.5m expenditure includes £20.2m expenditure for Trust employed staff and £0.3m for those staff employed through the PFI contract.
- Both income from patient activities and pay are high in month due to the fully funded NHSIE adjustment in respect of the increase in employer pension contributions (£23.6m income and £23.6m pay impact); a budget adjustment has been made in respect of this within both pay and income
- An expected additional national allocation of £5.3m Surge capacity income was received from the ICB in Month 12.

Capital Spend

NHS University Hospitals of North Midlands NHS Trust

Capital Expenditure as at Month 12 2022/23 £m	2022/23 Revised plan M12	In Month			Year to Date		
	Plan	Plan	Actual	Variance	Revised M12 Plan	Actual	Variance
PFI lease liability repayment	(10.5)	(0.9)	(0.9)	-	(10.5)	(10.5)	-
Repayment of IFRS16 leases	(3.7)	(0.3)	(0.3)	-	(3.7)	(3.7)	-
Pre-committed items	(14.3)	(1.2)	(1.2)	-	(14.3)	(14.3)	-
PFI lifecycle and equipment replacement (MES/PAC	(2.1)	(0.2)	(0.2)	(0.0)	(2.1)	(2.1)	(0.0)
PFI enabling cost	(0.0)	(0.3)	(0.0)	0.3	(0.0)	0.0	0.1
PFI related costs	(2.1)	(0.5)	(0.2)	0.3	(2.1)	(2.1)	0.1
Wave 4b Funding - Lower Trent Wards	(5.1)	(0.1)	(0.1)	(0.1)	(5.1)	(5.1)	0.0
Project STAR multi-storey car park	(8.2)	(2.4)	(3.7)	(1.2)	(8.2)	(8.2)	(0.0)
TIF 2 PDC (CTS Phase 1)	(4.1)	(2.7)	(2.7)	0.0	(4.1)	(4.1)	(0.0)
TIF 2 PDC (Day case unit)	(0.1)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0
TIF 2 PDC (Women's Hospital)	(0.1)	(0.1)	(0.1)	-	(0.1)	(0.1)	0.0
TIF 2 PDC (CTS Phase 2)	-	-	-	-	-	-	-
Emergency Department (restatement costs)	-	-	-	-	-	-	-
Home reporting breast care - PDC	(0.2)	-	-	-	(0.2)	(0.2)	(0.0)
MRI acceleration upgrades	(0.2)	-	-	-	(0.2)	(0.2)	0.0
Endoscopy equipment and works - PDC ICB allocatic	(0.4)	(0.4)	(0.3)	0.1	(0.4)	(0.3)	0.1
CT9 enabling and equipment - PDC	(1.2)	-	-	-	(1.2)	(1.1)	0.1
Frontline digitalisation equipment/ EPR - PDC	(0.7)	(0.7)	(0.6)	0.1	(0.7)	(0.6)	0.1
Diagnostic funding - CT8 and ultrasound	(1.2)	(1.2)	(1.1)	0.0	(1.2)	(1.1)	0.0
PDC - iRefer CDS	(0.2)	(0.2)	(0.2)	-	(0.2)	(0.2)	0.0
PDC - Cyber security	(0.1)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)
Schemes funded by PDC and Trust funding	(21.7)	(7.9)	(9.0)	(1.1)	(21.7)	(21.4)	0.3
LIMS (Laboratory Information Management System	(0.6)	(0.1)	(0.3)	(0.2)	(0.6)	(0.6)	0.0
EPMA (Electronic Prescribing)	(0.6)	(0.1)	(0.3)	(0.2)	(0.6)	(0.7)	(0.1)
CT7 enabling works (BC 415)	(1.1)	-	(0.1)	(0.1)	(1.1)	(1.0)	0.1
Patient Portal roll out costs (BC 462)	(0.4)	(0.1)	(0.0)	0.1	(0.4)	(0.2)	0.2
Pharmacy Dispensary	(0.3)	-	-	-	(0.3)	(0.3)	0.0
Anaesthetic medical records (Nasstar) (BC 444)	(0.2)	-	(0.1)	(0.1)	(0.2)	(0.3)	(0.1)
Home reporting implementation costs (BC 453)	(0.1)	-	-	-	(0.1)	(0.1)	0.0
Market testing refresh - CRIS/PACS/MRI	-	-	-	-	-	-	-
ED ambulance offload - enabling ward moves	(0.3)	-	-	-	(0.3)	(0.2)	0.1
Schemes with costs in more than 1 financial year	(3.7)	(0.4)	(0.8)	(0.5)	(3.7)	(3.4)	0.3
2022/23 schemes	(16.4)	(4.6)	(6.5)	(1.9)	(16.4)	(17.1)	(0.6)
IFRS 16 New Vehicles lease	(0.1)	-	-	-	(0.1)	(0.1)	-
IFRS 16 County Theatres TIF1 (IFRS16)	(2.2)	-	(2.2)	(2.2)	(2.2)	(2.2)	-
IFRS16 lease additions (incremental impact of IFRS1	(0.2)	(0.2)	(0.2)	-	(0.2)	(0.2)	-
Lease liability re-measurement	(0.1)	-	-	-	(0.1)	(0.1)	(0.0)
IFRS16 funded schemes	(2.7)	(0.2)	(2.4)	(2.2)	(2.7)	(2.7)	(0.0)
Donated/Charitable funds expenditure	(2.5)	(1.1)	(1.1)	-	(2.5)	(2.5)	-
Charity funded expenditure	(2.5)	(1.1)	(1.1)	-	(2.5)	(2.5)	-
Overall capital expenditure	(63.4)	(15.9)	(21.3)	(5.4)	(63.4)	(63.4)	(0.0)

The table to the left sets out the capital plan for 2022/23 as reported to Performance and Finance Committee in June 2022 and the forecast plan at Month 12. Total forecast capital financing in 2022/23 has increased by £4.4m to £63.4m, from the original plan of £59m. £14.3m of the forecast is allocated to the repayment of PFI and IFRS16 lease liabilities. The main reasons for the increase in funding are additional PDC funding of (£5m) including recent confirmation of funding for the CT8 scanner and Frontline digitalisation; the release of VAT credits; the deferral of the sale of Wilfred Place to 2023/24 (£0.3m); and reduced year end forecast of charitable fund expenditure relating to the Cancer Centre.

Changes to the plan during the financial year have resulted in funding being allocated to the medical equipment capital sub-group in order to fund replacement of out of support medical equipment. In addition slippage of spend on committed schemes has been mitigated by the bringing forward of expenditure from 2023/24 on Project Star and Estates Infrastructure schemes .

At Month 12 total expenditure of £63.444m is £40k behind the plan of £63.484m. Of the expenditure, £14.3m is the pre-committed repayment of the PFI and IFRS16 lease liabilities.

There are a number of minor variances within specific schemes and the capital sub-group allocations which reflect the overall management of the capital programme in year in order to achieve the overall balance. This has included expenditure brought forward from 2023/24 as described above in order to mitigate the impact of any slippage of schemes in to 2023/24.

Balance sheet

Balance sheet as at Month 12	31/03/2022	31/03/2023			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	576.4	590.4	652.8	62.4	Note 1
Right of Use Assets	-	19.2	17.7	(1.5)	Note 2
Intangible Assets	20.7	15.7	15.9	0.2	
Trade and other Receivables	1.4	1.4	1.5	0.1	
Total Non Current Assets	598.6	626.8	687.9	61.2	
Inventories	16.3	16.5	16.8	0.3	
Trade and other Receivables	41.6	38.8	38.3	(0.5)	
Cash and Cash Equivalents	87.6	75.9	84.0	8.1	Note 3
Total Current Assets	145.5	131.2	139.1	7.9	
Trade and other payables	(116.6)	(111.4)	(115.0)	(3.6)	Note 4
Borrowings	(10.7)	(14.6)	(13.5)	1.1	Note 2
Provisions	(2.5)	(2.5)	(5.0)	(2.5)	Note 5
Total Current Liabilities	(129.8)	(128.5)	(133.5)	(5.0)	
Borrowings	(257.8)	(257.4)	(257.4)	0.0	
Provisions	(3.9)	(3.9)	(2.6)	1.2	Note 5
Total Non Current Liabilities	(261.6)	(261.3)	(260.0)	1.3	
Total Assets Employed	352.6	368.2	433.5	65.3	
Financed By:				-	
Public Dividend Capital	648.2	659.0	665.0	6.0	Note 6
Retained Earnings	(437.0)	(432.2)	(434.2)	(1.9)	Note 7
Revaluation Reserve	141.4	141.4	202.6	61.2	Note 1
Total Taxpayers Equity	352.6	368.2	433.5	65.3	

Note 1. Property, plant and equipment and the revaluation reserve are £62.4m and £61.2m higher than plan respectively. This is due to the impact of the land and building valuation received from external valuers at 31 March 2023. There are a number of reasons for the increase including; the increase in building cost indices due to inflation, the updating of beacon property values by the external valuer, the impact of capital schemes undertaken by the Trust in year and the cumulative effect of completion of prior year schemes and a valuation of the Royal Infirmary and former COPD surplus land sites.

Note 2. This variance against t plan reflects the decision made in year to purchase the previously leased Children's Emergency Department modular building in December 2022.

Note 3. Cash is £8m higher than plan. Cash received in the year to date is £12.6m higher than plan and reflects the funding received from the ICB relating to capacity and virtual wards in prior months; and surge funding of £5.3m in Month 12. Cash received from Health Education England is £4.7m ahead of plan which includes higher than expected levels of training income and funding for the Imaging Academy received in prior months. In year payments are £5.6m ahead of plan and reflect the catch up of general payments including to NHS Supply Chain.

Note 4. Payables are £3.6m higher than plan mainly due to the level of deferred income being higher than plan at Month 12. The higher than plan level of deferred income is partly as a result of £3m cash received from Staffordshire and Stoke on Trent ICB for a number of schemes.

Note 5. Provisions are £1.3m higher than plan due to unforeseen new provisions arising in 2022/23 and the release of provisions brought forward that are no longer required. An employment tribunal case has arisen a total potential cost to the Trust of £1.25m. A £0.6m provision is also required for a potential fine from the Care Quality Commission (CQC) relating to an on-going investigation.

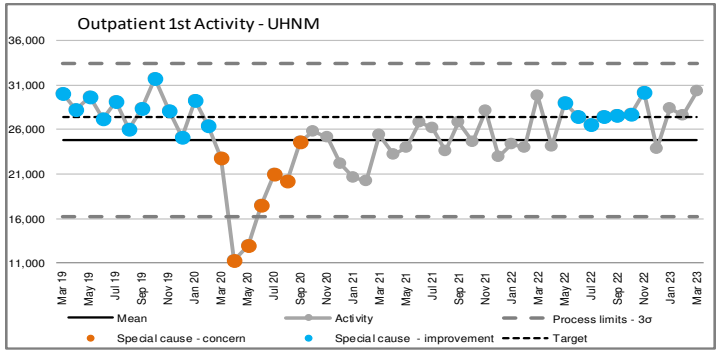
Note 6. The plan included in year capital for PDC relating to the STP wave 4b funding for the Lower Trent development (£6.755) and County TIF2 development (£4m). In year an additional £6m of capital PDC has been awarded to the Trust mainly to fund diagnostic equipment (endoscopy equipment and scanners CT8 and CT9) and for Frontline digitalisation schemes.

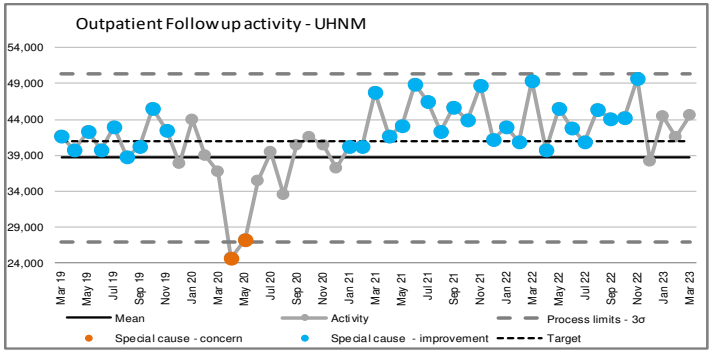
Note 7. Retained earnings reflect the small underspend on financial performance and the net movement between donated capital income and depreciation on donated capital assets. Donated capital expenditure is £2m lower than plan and reflects the re-phasing of the Denise Coates Foundation funded capital works on the Cancer Centre to 2023/24.

Activity

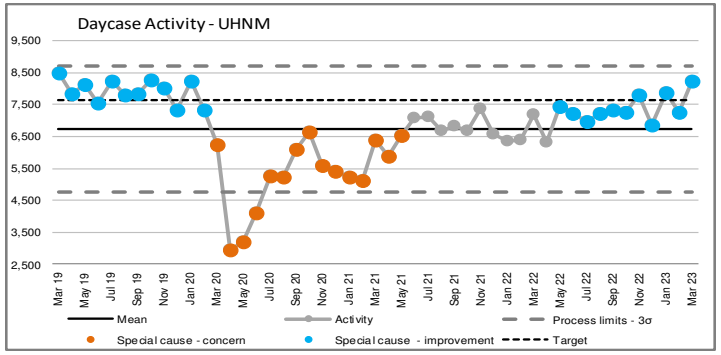
NHS
University Hospitals of North Midlands
NHS Trust

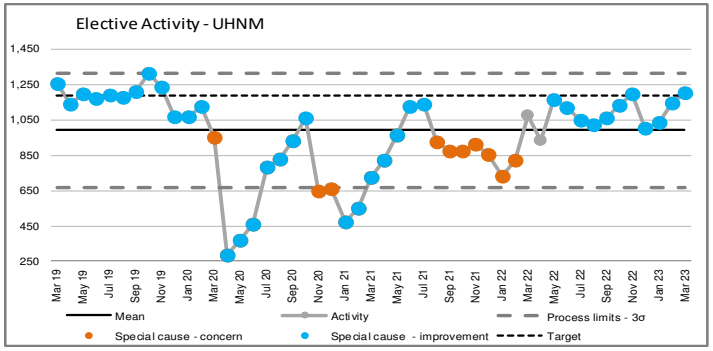
Planned care Outpatient



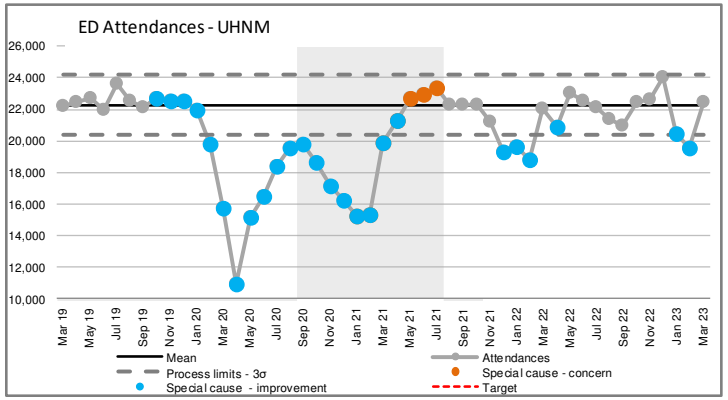


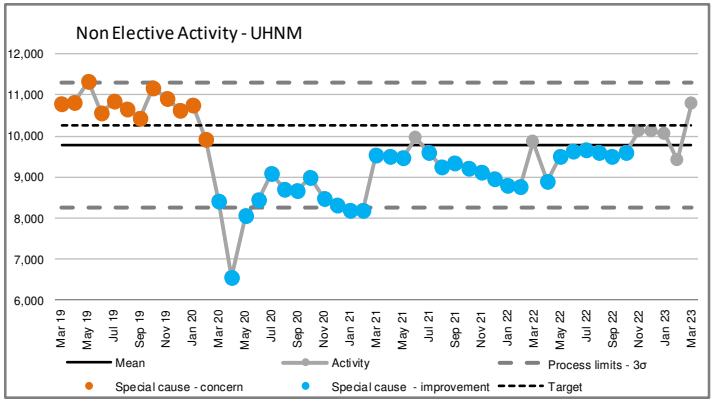
Planned care Inpatient





Urgent Care





Delivering Exceptional Care with Exceptional People

Audit Committee Chair's Highlight Report to Trust Board

27th April 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • Partial assurance was provided for the bank and agency internal audit with 5 recommendations for improvement agreed • Internal audit report turnaround metric for was higher than target and actions were being taken to ensure reports were considered and finalised by UHNM in a timely manner • Quarter 4 losses totalled £300,378 equating to £772,463 for the year and the Committee welcomed the continued actions being taken to reduce stock losses • 4 Single Tender Waivers were reported for Quarter 4 with 150 late purchase orders. The number of salary overpayments for the year remained similar to the number reported in 2021/22	• Final draft of the Quality Account to be provided to the Audit Committee in due course • User acceptance testing underway for electronic declaration of interests form • Triangulation of key metrics / heat maps to be considered and shared with Divisional Teams • To consider the ways in which assurance in respect of external third party regulatory reports (i.e. RIDDOR / FOI) were considered as part of Committee business in addition to considering any links with the Board Assurance Framework • To receive a further update in terms of the process and progress made in terms of the quality assurance mapping • Aged debt analysis to be undertaken • Counter fraud functional standard return to be agreed by the Chief Finance Officer and Audit Chair before submission
✓ Positive Assurances to Provide	**Decisions Made**
• An advisory report was provided by internal audit into digital strategy development and the review into key financial systems concluded with a substantial assurance opinion • The draft Head of Internal Audit Opinion was expected to conclude with a positive above the line opinion which was not expected to change following finalisation of the remaining internal audits for 2022/23 • 10 internal audit actions remained open whereby additional assurance was provided in terms of a delayed recommendation in respect of stock takes • The Committee noted the current response rate of 80% in respect of declarations of interest and noted the ongoing actions being taken to obtain outstanding declarations utilising escalation channels as required • The Committee noted the suggestions made as part of the effectiveness review to consider further insights in terms of comparator performance, in addition to inviting additional Executives to join meetings when further assurance is required on particular areas of business • The Committee noted that the draft annual accounts had been submitted to NHS England by the required deadline in addition to sharing with External Audit • The progress made in taking forward the external audit plan was noted, in particular the anticipated risks associated with land valuation, section 30 referral and cyber security • The Committee welcomed the local counter fraud annual report and the proposed green rating of the draft Counter Fraud Functional Standard return	• The Committee approved the internal audit plan for 2023/24 noting the proposed changes which were to be circulated and agreed outside of the meeting • The Committee agreed to close the internal audit recommendation in terms of the system long-term plan which was being addressed by existing arrangements and agreed to extend the target date for the internal audit recommendation regarding Quality Impact Assessment to October 2023, reflecting the ongoing work to standardise the approach system wide • The Committee approved the Board Assurance Framework and noted the changes in risk score and the process followed • The Committee approved revised policies G18 Anti-Bribery and Anti-Fraud Policy & G16 Standards of Business Conduct • The Committee approved the revised Terms of Reference • The Committee approved the write-off of 614 salary overpayments • The Committee agreed with the management responses in respect of the external audit informing the risk assessment • The Committee confirmed that it was satisfied with the effectiveness of the Internal Audit function
Comments on the Effectiveness of the Meeting	
• The Committee became un-quorate for part of the meeting requiring a number of items to be circulated for virtual approval	

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 • Bank and Agency • Digital Strategy Development Review • Key Financial Systems	BAF 3, 6, 8	Ext 20 Ext 16 High 12	! ✓	Assurance	9.	Committee Effectiveness 2022/23	-	-	✓	Approval
2.	Draft Head of Internal Audit (HoIA) Opinion 2022/23	All	Ext 20 Ext 16 High 12	✓	Assurance	10.	Losses and Special Payments Q4 2022/23	BAF 8	Mod 4	!	Assurance
3.	Internal Audit Plan 2023/24	All	Ext 20 Ext 16 High 12	-	Approval	11.	SFI Breaches and Single Tender Waivers Q4 2022/23	BAF 8	Mod 4	!	Assurance
4.	Internal Audit Action Tracker	-	-	✓	Assurance	12.	Draft Annual Accounts and Financial Statements 2022/23	BAF 8	Mod 4	✓	Approval
5.	Corporate Governance Report	-	ID10836	✓	Assurance	13.	Informing the Audit Risk Assessment	BAF 8	Mod 4	-	Assurance
6.	Board Assurance Framework Q4 2022/23	-	-	-	Approval	14.	External Audit Plan / Progress Report	BAF 8	Mod 4	✓	Assurance
7.	Issues for Escalation from Committees	-	-	-	Assurance	15.	LCFS Annual Report 2022/23		ID10836	✓	Assurance
8.	Policies for Approval: • G18 Anti-Bribery & Anti-Fraud Policy • G16 Standards of Business Conduct	-	ID16515 ID10836 ID10835	-	Approval	16.	Review of the Internal Audit Function	-	-	✓	Assurance

3. 2022 / 23 Attendance Matrix

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

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd May 2023
Report Title:	Quarter 4 Board Assurance Framework	**Agenda Item:**	16
Author:	Claire Cotton, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

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

Executive Summary

Situation

This report sets out the Board Assurance Framework (BAF) for Quarter 4, 2022/23. The BAF is being presented to Committees of the Board in accordance with our Risk Management Policy and Annual Business Cycles for approval and assurance.

Background

The strategic risks contained within the enclosed BAF are mapped to our Strategic Priorities; these risks were identified by the Executive Team and approved by the Board in March 2022. Each strategic risk assessment has been reviewed and updated by their Executive Lead and the BAF is presented every quarter to each Committee of the Board ahead of being presented to the Trust Board.

Assessment

There are a number of **key observations** which can be drawn out from the BAF at Quarter 4 which are summarised as follows:

	6 / 9 strategic risk scores have remained **unchanged** (➔) when compared to the previous quarter.
	2 / 9 strategic risk scores have **decreased** (🡻) when compared to the previous quarter: • BAF 4 System Working has reduced from High 9 to Mod 6 and is now in line with the target score. • BAF 8 Financial Performance has reduced from High 9 to Mod 4 and is now in line with the target risk score.
	1 / 9 strategic risk scores have **increased** (🡹) when compared to the previous quarter. • BAF 6 Delivery of IM&T Infrastructure has increased from High 12 to Extreme 16 (change in likelihood) as a result of incidents relating to Network Failure
	5/9 strategic risks have seen an overall increase in the number of linked risks on the risk register, with the majority of these increases being scored as High or Extreme.

During Quarter 4, work has been undertaken with the Executive Team and with the Board to **develop the Board Assurance Framework for 2023/24**. These discussions have resulted in a refresh and approval of the strategic risks which will form the basis of the 2023/24 BAF with the most notable change being a revision of the focus of BAF 4 System Working, to focus on Improving the Health of our Population, in line with system and UHNM Strategic Priorities. Other changes are summarised within the report but are largely around refreshing the focus of existing strategic risks.

In addition, the Executive Team and the Board have taken the opportunity to confirm the **top 3 risks** which will be included within the Annual Governance Statement and these, aligned with the BAF, are in relation to:

- Delivering Positive Patient Outcomes and Responsive Patient Care
- Sustainable Workforce

- Financial Sustainability

The **BAF has continued to be developed and improved**, in order to increase its usability and effectiveness. This will continue throughout the course of 2023/24 and will take into account any further findings of the Internal Audit of BAF and Risk Management which has been undertaken during Quarter 4. Further key developments which will feature within the 2023/24 BAF will include:

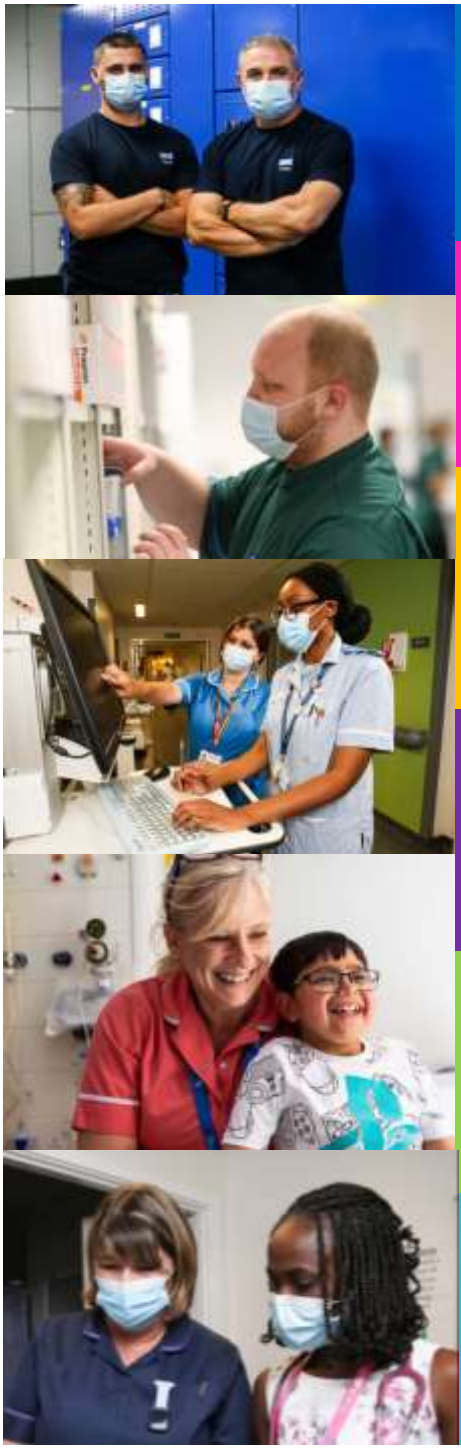
- Risk reduction trajectories
- Assurance overview aligned with Committee Highlight Reports
- Enhanced assurance map which identifies future assurances as well as assurances during the quarter
- Assurance assessment which considers the effectiveness of assurance

Finally, good progress is being made through the **System Governance and Risk Network** in the development of the ICB Board Assurance Framework, with the approach used at UHNM having been developed and adopted. This work has been recognised as good practice at a regional and national level and will continue to evolve throughout 2023/24.

Key Recommendations

- The Board is asked to note the key observations above and to confirm the levels of risk identified.
- The Board is asked to note the approved strategic risks which will form the basis of the 2023/24 BAF and the Annual Governance Statement
- The Board is asked to note the developments planned for the 2023/24 BAF.

NHS
University Hospitals of North Midlands
NHS Trust



Board Assurance Framework (BAF)

Quarter 4 2022/23

Delivering Exceptional Care with Exceptional People

1. Introduction and Overview

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

Background

The strategic risks contained within the 2022/23 BAF were identified by the Executive Team and agreed by the Board in March 2022; this is an annual process which has been repeated during Quarter 4 for the refreshed BAF for 2023/24. A 'look ahead' at the risks which will form the 2023/24 BAF, approved at the Board Seminar in March 2023 is set out below.

Assessment

Key Observations – Quarter 3 BAF 2022/23

There are a number of observations to draw out from the updated BAF for quarter 4; these are summarised as follows:

	6 / 9 strategic risk scores have remained **unchanged** (→) when compared to the previous quarter.
	2 / 9 strategic risk scores have **decreased** (↓) when compared to the previous quarter: • BAF 4 System Working has reduced from High 9 to Mod 6 and is now in line with the target score. As detailed below, for Q1 23/24 this risk will have a revised focus in line with improving the health of the population / reducing health inequalities. • BAF 8 Financial Performance has reduced from High 9 to Mod 4 and is now in line with the target risk score. Again, as detailed below, for Q1 23/24 this risk will be revised to focus on financial sustainability in line with the 23/24 financial plan.
	1 / 9 strategic risk scores have **increased** (↑) when compared to the previous quarter. • BAF 6 Delivery of IM&T Infrastructure has increased from High 12 to Extreme 16; the likelihood has increased as a result of continued recurrent incidents relating to network failure.
	5/9 strategic risks have seen an overall increase in the number of linked risks on the risk register, with the majority of these increases being scored as High or Extreme.

Look Ahead – Strategic Risks for BAF 2023/24

The majority of Strategic Risks within the 2022/23 BAF will be included within the refresh for 2023/24 although the following changes have been agreed:

- Refreshed risk descriptions for BAF 1, 2, 3, 5, 6, 7, 8, 9 (details of the refresh were provided to the Board at the March Seminar)
- BAF 4 System Working: will be replaced with a new risk around Improving the Health of our Population
- BAF 7: Risk title will change from Infrastructure to Deliver Compliant Estate Services to Fit for Purpose Estate
- BAF 8: Risk title will change from Financial Performance to Financial Sustainability

Top 3 Risks for the Annual Governance Statement

The following risks have been as the top 3 risks which will feature in the Annual Report as part of our Annual Governance Statement:

- BAF 1 / 3 Delivering Positive Patient Outcomes and Responsive Patient Care

- BAF 2 Sustainable Workforce
- BAF 8 Financial Sustainability

Further Developments in the 2023 / 24 Board Assurance Framework

In addition to risk reduction trajectories which have previously been outlined, there are further developments planned for the 2023 / 24 BAF which are designed to strengthen the focus on assurance. The current assurance mapping section will be replaced with:

- Assurance overview – drawing out key Committee Highlights in terms of positive assurance / matters of concern
- An enhanced assurance map which includes planned assurances in addition to actual assurances currently reported
- An assurance assessment which will enable the Committee / Board to consider the effectiveness of assurance mechanisms

An annual Internal Audit review of the BAF and Risk Management has been undertaken during quarter 4 and is expected to conclude during quarter 1 2023/24. Any findings from this review which relate to the BAF will also be factored into its ongoing development.

System Working

A significant amount of work has been undertaken through the System Governance and Risk Network with ICB partners to develop the ICB Board Assurance Framework and the approach used at UHNM has been adopted. Whilst still early in its development, there has been positive feedback from the ICB Internal Auditors and the work has been recognised both nationally and regionally with Governance leads being asked to present best practice including a case study to the Good Governance Institute.

This work will continue to evolve and during 2023/24 it is anticipated that a mapping of strategic risks across the system will be included within our reporting.

Recommendations

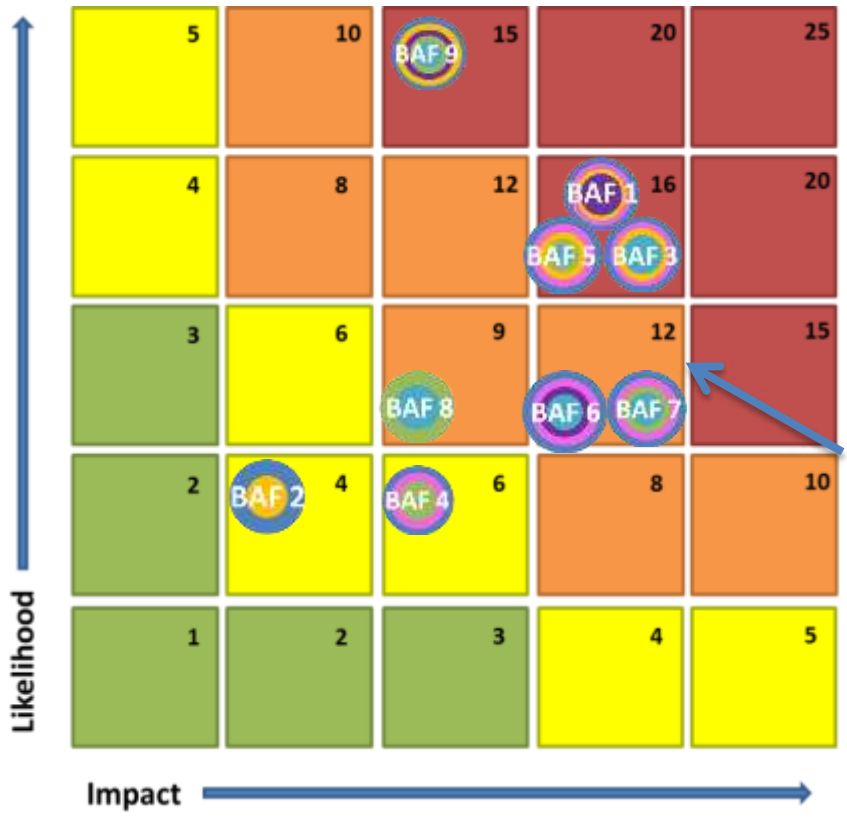
- To note the key observations above and to confirm the levels of risk identified.
- To satisfy itself that sufficient assurance mechanisms are in place or where appropriate, seek additional assurance through the appropriate Committees.
- To note the developments planned for the 2023/24 BAF.

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

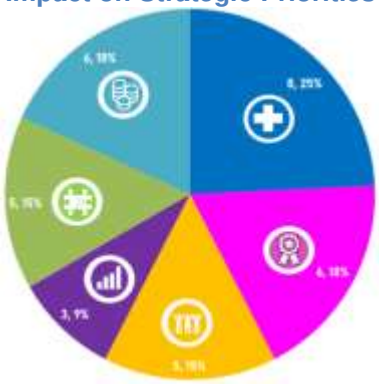
2. Summary Board Assurance Framework

BAF	Risk Title & Strategic Priority	Risk Likelihood (L), Consequence (C), Score (S)												Q4 Change	Target Risk and Date			Action Summary - BAF (B), On Track (OT), Delayed (D), Problematic (P)					No. Linked Risks (→↑↓ Change from Previous Quarter)					Assurance Map Summary		
		Quarter 1			Quarter 2			Quarter 3			Quarter 4																			
		L	C	S	L	C	S	L	C	S	L	C	S		L	C	S	No.	B	OT	D	P	No.	Low	Mod	High	Ext	✓	!	✓/!
BAF 1	Delivering Positive Patient Outcomes	4	4	Ext 16	4	4	Ext 16	5	4	Ext 20	5	4	Ext 20	→	3	2	Mod 6 31/03/2025	7 (1 new @ Q4)	4	2	1	0	74↑	0	16→	49↑	9↓	11	11	6
BAF 2	Leadership, Culture, Delivery of Values	3	4	High 12	3	4	High 12	3	4	High 12	3	4	High 12	→	2	2	Mod 4 31/03/2024	6 (3 new @ Q4)	2	4	0	0	5→	0→	1→	2→	2→	1	3	5
BAF 3	Sustainable Workforce	4	4	Ext 16	4	4	Ext 16	4	4	Ext 16	4	4	Ext 16	→	3	3	High 9 31/03/2024	1	1	0	0	0	112↑	1→	26→	71↑	14↓	3	2	9
BAF 4	System Working	3	3	High 9	3	3	High 9	3	3	High 9	2	3	Mod 6	↓	2	3	Mod 6 31/03/2023	5	4	0	1	0	1→	1→	0→	0→	0→	1	2	2
BAF 5	Delivering Responsive Patient Care	4	4	Ext 16	4	4	Ext 16	5	4	Ext 20	5	4	Ext 20	→	3	4	High 12 31/08/2023	7	2	4	1	0	41↑	1→	6→	23↑	11↓	2	1	1
BAF 6	Delivery of IM&T Infrastructure	3	4	High 12	3	4	High 12	3	4	High 12	4	4	Ext 16	↑	2	4	High 8 31/03/2024	7	3	0	4	0	28→	3→	10→	11→	4↑	3	3	4
BAF 7	Compliant Estate Services	3	4	High 12	3	4	High 12	3	4	High 12	3	4	High 12	→	3	3	High 9 31/03/2023	10	0	6	4	0	36↑	0→	16↑	18↑	2↑	2	1	3
BAF 8	Financial Performance	3	3	High 9	3	3	High 9	3	3	High 9	2	2	Mod 4	↓	2	2	Mod 4 31/03/2023	3	0	2	1	0	18↑	0→	3↑	13↑	3↑	1	4	1
BAF 9	Research & Innovation	4	3	High 12	5	3	Ext 15	5	3	Ext 15	5	3	Ext 15	→	2	2	Mod 4 31/09/2023	9	3	5	1	0	3→	0→	1→	2→	0→	2	0	1

3. Strategic Risk Heat Map

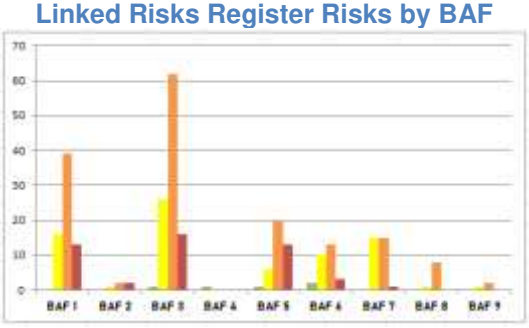


Impact on Strategic Priorities



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

Linked Risks Register Risks by BAF



	• High Quality continues to be the most threatened of our Strategic Priorities in terms of the number of strategic risks posting a threat to it (8/9 strategic risks). 4 of these risks are scored as extreme and 3 of them have a number of Extreme linked risks on the risk register.
	• People, whilst threatened by fewer strategic risks – 5/9, 4 of those are scored as Extreme. In addition, BAF 3 has the highest number of linked risks on the Risk Register (112) and the highest number of linked Extreme Risks (14)

4. Board Assurance Framework 2022 / 23

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

Risk Description (STRENGTHENED FOR Q3 2022/23)

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 Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	5	5	Likelihood:	3	~~31/12/2022~~ 31/03/2025
Consequence:	4	4	4	4	Consequence:	2	
Risk Level:	Ext 16	Ext 16	Ext 20	Ext 20	Risk Level:	Mod 6	

Rationale for Risk Level:

- During Quarter 4, services have continued to face considerable pressure as a result of COVID, operational pressures and effects of industrial action.
- We have continued to see workforce challenges through staff absence and vacancies
- The national focus on minimising ambulance delays and the associated evidence of harm to patients has meant we continue to utilise YNP and corridor care. .
- Escalation areas have required to remain open
- Industrial action has impacted on the restoration and recovery programme and has seen patient cancellations for surgery and OPDs
- CQC inspection to Maternity, formal escalation on day of visit. All concerns addressed immediately. We await the final report
- The trust's Clinical Effectiveness ambitions are not yet embedded within Divisions.

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	0 →	16 →	49 ↑	9 ↓	74 ↑

Position Statement

What progress has been made during the last quarter?

- The review of the integrated Discharge function continues chaired by the Chief Operating Officer
- Further international nurse recruitment has been approved (110 nurses) Maternity held a successful recruitment event offering circa 30 positions.
- Establishment review process completed –to be reported in April
- CEF process refreshed and relaunched – 18 areas audited under new process
- 70 NMAHPs currently receiving support from CeNREE with work-based projects, academic and research development opportunities
- One successful NIHR Senior Research Leader award
- Two successful prestigious NIHR PCAF awards ongoing
- Two NIHR PCAF awards submitted in current round
- One submission to General Nurse Council Trust, international quality nurse at County) – awaiting outcome
- One successful North Staffs Medical Institute Award
- One successful WM CRN Personal Development Award
- Stepping Stone Award to UHNM staff member
- Member of Chief Nurse's Office for England Research Transformation Leaders Network
- UHNM now a member of the Council of Deans for Health Clinical Academic Roles Implementation Network (CARIN)
- Research collaborations emerging – John Hopkins, Keele and Staffs Universities
- CeNREE 'hub and spoke' model in development
- Research incorporated in CEF assessment framework to assess evidence-based practice
- 12 NMAHPs appointed to Chief Nurse Fellow programme
- 3 NIHR Research for Patient Benefit grants in development and being submitted in May 2023

- Research Stars Scheme launched
- Safe Mobility ambition developed and launched
- Appointed to Associate Deputy Chief Nurse/CNIO post and to the Chief AHP post
- Confirmed membership to the Florence Nightingale Foundation, which offers additional Continued Professional Development opportunities for all Registrants
- Continue to progress Baby-Friendly accreditation (NNU – Level 3 and Maternity –Gold)
- Development of Improving Together Executive Development Forum for Divisional Teams
- Continued roll-out of Tendable Audit process, due for completion in August 2023
- Ongoing review of formal complaints process, including new report format, robust triage process and pilot of early resolution project in Network Services Division
- Progression of PSIRF plans including development of thematic review templates and appointment of two Patient Safety Partners
- Acute patient flow A3 in development with key focus on occupancy, length of stay and simple/timely discharge

Key Controls Framework – 3 Lines of Defence

1st Line

- Daily nurse staffing meetings to identify requirements and appropriate escalation of gaps and required support
- Safer Staffing Tool completion twice daily by Ward staff
- Local processes in place for medical and AHP staff to assess requirements and establishments
- International Recruitment continues to be a source of registered nursing and midwifery recruitment
- Site Safety Dashboard
- Quality Impact Assessments undertaken for change in services regarding additional capacity areas and changes in establishments
- Senior leadership team in place for each ward and department, with overarching accountability for delivering quality and minimising hospital acquired harm
- Falls Champion role in each Ward/Department.
- Tissue Viability Link Nurses in each Ward/Department
- Corporate Quality & Safety Team co-ordinate Improvement Programmes for Pressure Ulcers, Falls and VTE
- Specific governance arrangements in place for Maternity Services, including compliance with CNST requirements.
- Infection Prevention Team co-ordinate Improvement Programmes for infections, including Sepsis and Nosocomial COVID-19 infections
- Training Programmes in place for all key harms
- Patient Experience team in place
- Crude Mortality rates - monitoring through Mortality Review Group
- Scrutiny of circumstance 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 (which have been shared with the Care Quality Commission)
- Business case agreed for Maternity; service funded to meet Birthrate Plus clinical requirements. LMNS funding supporting a number of specialist roles.

2nd Line

- 6 monthly nurse staffing establishment reviews to ensure established nursing numbers match acuity
- Birth rate plus staffing assessment for midwifery services
- Validation of pressure ulcers undertaken by Corporate Tissue Viability Team
- Validation of infections undertaken by Infection Prevention/Microbiology Teams
- Datix and Root Cause Analysis (RCA) training available to ensure accurate reporting and investigation of patient harm. Bespoke sessions arranged within Divisions.
- Root Cause Analysis (RCA) Scrutiny Panels in place for Serious Incidents, Pressure Ulcers, Patient Falls, Venous Thromboembolism (VTE) and Infections
- Agreed reduction trajectories in place for each patient harm
- Collaborative working in place with CCG representatives regarding harm reduction
- Care Excellence Framework refreshed and review meeting introduced with CN/DCN for any area rated Bronze overall or with any Bronze domain
- COVID-19 deaths included in the Trust's SJR process to allow for review of care provided to patients and identify any potential areas for improvement/learning
- Mortality Review Panel for Definite Nosocomial COVID-19 deaths established by Deputy Medical Director to identify learning and good practice. Review commenced to identify ward status for inclusion in mortality reviews.
- Nosocomial COVID-19 Infections subject to RCA and reported to the Infection Prevention Committee
- A strengthened clinical governance framework including revised Terms of Reference for the Quality and Safety Oversight Group (QSOG) and Quality Governance Committee (QGC) remains in place. Separate Quality and Safety Oversight Groups and Quality Governance Committee for Maternity and Neonates.
- 'High Quality' identified as a Key Priority Domain for the UHNM Improving Together Programme
- 52 week / 104 day Harm Review Panel process in place with CCG representation. Process currently under review to ensure robustness.
- Agreed policies and procedures for the management of patients with mental health conditions and / or Mental Health Act including Standard Operating Procedure for Use of Ligature Knives and Trust Wide Corporate Ligature Risk Assessment
- Policies and Procedures for the Management and care of patients with mental health conditions reviewed and actions completed and responded to in relation to the CQC Section 29a notice
- Patient Safety Incident Reporting and Learning Plan (PSIRP) Steering Group
- Tendable Steering Group established and reporting to Quality & Safety Oversight Group – rollout in progress due to complete August 2023

2nd Line	• Standard Operating Procedures (SOPs) approved and implemented for Corridor Care and Your Next Patient. • Refresh of work stream 2 Acute Patient Flow to focus on reducing length of stay and increasing capacity • Designated role within corporate nursing team focussing on excellence in discharge • 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 review data, 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 & Safety Committee • Patient Safety Specialists participating with development programme by NHSI as part of national NHS Patient Safety Strategy. Induction / Training • NHSE scrutiny of COVID-19 cases/Nosocomial infections/Trust implementation of Social distancing, Patient/Staff screening and PPE Guidance • Met CNST Standards

Assurance Map (Assurance to Executive Groups / Committees during the Quarter)

	Key Risk / Matter of Concern Escalated	Positive Assurance Escalated	Positive Assurance and Key Risk
1st Line	• Discharge Summaries Audit • Sepsis Management Emergency Department Royal Stoke	• Paediatric Sepsis Update	
2nd Line	• UHNM Serious Incident Report Q3 • Care Quality Commission (CQC) Action Plan • Neonatal Quality Insight Visit Action Plan and Mortality Action Plan • UHNM Ockenden Update Q3 • Maternity New Serious Incident (SI) Report Q3 • Readmissions Analysis • Executive Clinical Effectiveness Group Highlight Report • Patient Experience Report Q3	• Care Excellence Framework Q3 Report and Refresh • PSIRF Steering Group Highlight Report (February 2023) • Reading the Signals – Maternity and Neonatal Services in East Kent • Corridor Care and Your Next Patient Update • Infection Prevention Board Assurance Framework • Mortality Assurance Report Q3 • Perinatal Mortality Report Q3 22/23 • Saving Babies Lives Care Bundle (SBLCB) Version 2: Q3 Update • Midwifery Workforce • Audit of Postnatal Re-admissions	• Q3 Nursing & Midwifery Staffing and Quality Report • Q3 Infection Prevention Report • Medicines Optimisation and Safety Report Q3 • Quality and Safety Report M9, M10, M11 • Maternity Dashboard Q3 • Improving Together Countermeasure Summary
3rd Line	• Framework for Clinical Audit Internal Audit		

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 process 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, Length of Stay and simple and timely discharges
- Delivery of CQC action plan
- Recruitment to vacancies; focus on retention (flexible working, retire and return)

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

No.	Action Required	Intended Outcome of Action	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	To implement Tendable audit system and app across the Trust.	Additional Assurance	Chief Nurse	31/12/2023	**Original due dates 30/09/22 & 30/11/22.** Rollout of Tendable completed at County (Nov 22) – rollout plan in progress for RSUH.	
2.	To develop Trust Patient Safety Incident Review Plan (PSIRP) and engagement of Patient Safety Partners to support review and patient involvement in Trust	Control to reduce Likelihood	Chief Nurse & Medical Director	30/09/2023	National PSIRF guidance has been updated following Covid-19 with amended dates and learning from early adopters. This is under review and inclusion in UHNM PSIRP. UHNM steering group up and running, National timescale is to implement in 2023.	

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**
	quality meetings.					
3.	Recruitment of midwives in line with Business Case and Birth Rate Plus.	Control to Reduce Likelihood	Chief Nurse	~~31/03/2023~~ 31/12/2023	**Original due date 30/09/22 & 31/03/22.** Business case approved December 2022 – recruitment underway. 22 students recruited September 22, further 30 at recruitment event March 23.	
4.	Recruitment against Emergency Department Business Case to be completed.	Control to Reduce Likelihood	Chief Nurse	31/12/2023	**Original due date 30/07/22:** Recruitment remains ongoing.	
5.	Conclude the integrated discharge function with system partners.	Control to Reduce Likelihood	Chief Operating Officer	30/06/2022	Inaugural meeting took place January 2023. System partner participation and shared vision.	
6.	Delivery of Workstream 2 actions focussing on length of stay, occupancy and simple and timely discharge.	Control to Reduce Likelihood	Chief Nurse	31/09/2022	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	31/03/2025	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:	Leadership, Culture and Delivery of Values / Aspirations	Internally Driven	✓
			Externally Driven	

Risk Description

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

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

Impact on Strategic Objectives

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

Risk Scoring

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

Rationale for Risk Level:

The level of risk has remained the same during Quarter 4; the Staff Survey findings have been published during the quarter and a decline has seen in a number of areas with the lowest performing areas being in relation to:

- **Promise 1: We are Compassionate and Inclusive**: This element is created from 8 questions of which the one negatively impacting UHNM's score is 'immediate manager takes effective action to help me with any problems I face' which has fallen 2 percentage points since 2021. At a national level the 2022 Staff Survey results showed that 'We are compassionate and inclusive' score remained unchanged compared to 2021.
- **Promise 6: We Work Flexibly**: This element split into two sub-scores. The results show that on both sub-scores UHNM has not improved. At a national level the 2022 Staff Survey results showed that 'We are flexible' score remained unchanged compared to 2021.
- **Promise 7**: **We are a Team**: Looking at the survey in greater depth it is apparent that the biggest contributing factor is teams 'work well together to achieve their objectives' which decreased by 6 percentage points whilst the benchmark score stayed stable. At a national level the 2022 Staff Survey results showed that 'We are a team' score has increased since 2021.

However, the Staff Engagement score has seen an increase both in terms of response and engagement. The score in February 2023 is the highest since the survey opened at 6.99.

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

Position Statement

What progress has been made during the last quarter?

We have assigned dedicated senior resource to the Cultural Improvement Programme and have undertaken a review of the 2022/23 action plan; the outputs of this review will inform the further developments of our programme for 2023/24. The Cultural Heat Map has been launched and is now a live tool for divisions to use, divisional Workforce Groups have continued to be embedded and the People Strategy including Plan on a Page have been launched. We have amended the questions in the Staff Voice with areas for opportunity aligned with the National Staff Survey. Divisional Business Partners and OD Consultants have been aligned to Hot Spot Areas for additional support and focus. A self-assessment and action plan has been developed in response to the RACE Equality Code and this is being presented to the Transformation and People Committee. Being Kind training has now been mandated for launch on 1st April 2023. Enable Training has continued to be rolled out and a dedicated, externally facilitated session on Being Kind has been delivered within Women, Children's and Clinical Support Services and Pathology which received very positive feedback.

Key Controls Framework – 3 Lines of Defence

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

Assurance Map (Assurance to Executive Groups / Committees during the Quarter)

	Key Risk / Matter of Concern Escalated	Positive Assurance Escalated	Positive Assurance and Key Risk
1st Line		• Midwife Story	• Divisional Workforce Highlight Reports
2nd Line	• Gender Pay Gap Report • Essential to Role Mandatory Training Compliance	• Wellbeing Walkabout Update • Formal Disciplinary Activity Q3 • Speaking Up Report Q3 • OD, Culture, Inclusion and Wellbeing Report • Race Equality Code • Culture Improvement Programme Update	• Workforce Performance Report M9, M10, M11 • Enable Programme 6 Month Evaluation • Improving Together Countermeasure Summary • Executive Workforce Assurance Group Assurance Report
3rd Line	• Staff Survey 2022		

Gaps in Control or Assurance

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

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

- Development of refreshed Cultural Improvement Programme for 2023 / 2024
- Development of Communication and Engagement Plan for 2023/2024

Further Actions (to provide 'Additional Assurance' or 'Control to Reduce Likelihood / Consequence)						
No.	**Action Required**	**Intended Outcome of Action**	**Executive Lead**	**Due Date**	**Quarterly Progress Report**	**BRAG**
1.	Take forward the findings from the Trust Culture and Leadership Diagnostic Programme, and the Culture Review by formulating and embedding plans which reflects the themes identified including: a) Putting structures in place to help staff challenge and report inappropriate and bullying behaviours in the workplace b) Launch a programme of staff development underpinned by NHSI/E's "Kindness into Action" programme	Control to reduce Likelihood and Consequence	Chief People Officer	Separate Improvement Plan with timescales over 3 year period in place	Further progress has been made in a number of areas: • 'Be Kind' Compact developed and launched - Behaviours Framework with associated toolkit and training further web-based training requested to be rolled out • Enable Leadership Development Programme rolled out for all supervisory managers focussing on behaviours/civility and respect - 527 attendees @ 28 February (10 months delivery, 616 target within 12 months – 85.5% achieved to date • Resolution Policy and awareness workshops launched to address grievances/dignity at work issues – policy wording check, recommendations from long standing cases • Civility & Respect and Being Kind targeted interventions commenced, with the aim to adopt more widely across the Trust - WC&CS (Imaging) & Pathology • Clinical Leadership & Management Fundamentals Programme developed and introduced - 2 programmes delivered with 49 attendees audience 100 attendees (some may have already attended Platinum Connect) • Meeting and Email Etiquettes developed and launched • Leadership Development Programmes updated to include Enable content • 'How to pronounce my name' campaign developed and launched during Black History Month 2022 – to be included in new Induction material • Evaluation of actions/interventions to improve the culture of our organisation • Cultural Heat Map and Cultural Framework for Divisions designed and delivered	
2.	Develop and promote the Trust's leadership and behaviour compact as outlined in the national People Plan	Control to reduce Likelihood and Consequence	Chief People Officer	Separate Improvement Plan with timescales over 3 year period in place	The leadership and behaviour compact is now complete and being rolled out as part of the wider Cultural Improvement Programme.	

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**
3.	Promote the Civility and Respect agenda and a) Introduce a Resolution Policy. b) Deliver the National Civility and Respect Toolkit and c) implement a Civility and Respect training programme with a focus on race	Control to reduce Likelihood and Consequence	Chief People Officer	Separate Improvement Plan with timescales over 3 year period in place	This is now business as usual as part of the Being Kind / Resolution Policy.	
4.	Revised report to Transformation and People Committee aligned with Improving Together / People Strategy	Additional Assurance	Chief People Officer	30/06/2023	Draft format being developed; discussions have taken place with the Committee chair.	
5.	Development of refreshed Cultural Improvement Programme for 2023 / 2024	Control to reduce Likelihood and Consequence	Chief People Officer	31/05/2023	Currently under development following the review of the 2022/23 Cultural Improvement Programme. Once complete this will be presented to the Transformation and People Committee.	
6.	Development of Communication and Engagement Plan for 2023/2024	Control to reduce Likelihood and Consequence	Chief People Officer	31/05/2023	Currently work in progress with a plan for sharing with the Executive Team in April with a view to the first iteration being ready at the end of May although this will be subject to regular review and refinement.	

BAF 3: Sustainable Workforce

Internally Driven	✓
Externally Driven	✓

Risk Description

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

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

Impact on Strategic Objectives

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

Risk Scoring

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

Rationale for Risk Level:

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

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	1 →	26 →	71 ↑	14 ↓	112 ↑

Position Statement

What progress has been made during the last quarter?

- The People Strategy Summary on a page has launched both in paper and digital versions to raise awareness of the key domains and drivers.
- A PDR Recovery plan was raised after monthly figures continued to be in a negative position. Divisions were asked to provide key issues and actions for review December's EWAG. The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance alongside making the process enhance employee experience.
- Engagement has taken place with Stoke on Trent College and Newcastle and Stafford College this quarter to continue to build our partnership working and mutual understanding of the opportunities and benefits.
- The Trust has approved a business case for the recruitment service with a focus on our recruitment strategy, developing our links with schools and colleges, social media presence as well as providing partnership support to Divisions
- We have launched our new Careers@UHNM social media addresses and are using stories to help promote roles.
- The Trust is now over performing on it's Time to Hire KPI following significant capacity support. This is enabling the team to focus on more strategic activities.
- A strategic workforce plan setting out the workforce demand and supply routes for 2023/24. This has enabled a detailed focus on challenging to fill posts in order to assess where additional efforts are needed to grow our own workforce or to attract new candidates to the Trust.
- The cultural heat map has been deployed to all Divisions to provide greater insight into areas such as turnover.
- Agency expenditure ceilings have been nationally set for 23/24 at 3.75% of the pay budget.
- New welcome to UHNM materials have been produced and launched as part of our positive on-boarding employee experience activities to help give a warm and last welcome to new colleagues.
- Detailed focus on the medical workforce continues through our Medical Workforce Assurance Group

- A detailed focus on workforce continues through our Executive Workforce Assurance Group with a focus on topics such as employee engagement and flexible working
- We have engaged with a retention partner from the Integrated Care Board – diagnostics of our current retention offers have been undertaken in Q4. Q1 23/24 will focus on high impact actions to support retention
- A very successful maternity recruitment open day has resulted in 30 on the day offers with another 105 interested applicants to be signposted and interviewed to other key roles within the Trust.

Key Controls Framework – 3 Lines of Defence

1st Line

- Development of new workforce strategy for 2023-2025 highlights key strategic areas of workforce activity.
- Workforce Plan reported to Transformation & People Committee
- Workforce planning process ensures alignment with activity and financial plans. The Trust workforce plan for 2022/23 has been triangulated with Finance and Activity Plans and submitted to the System as part of the annual Operational Planning round
- Workforce development is being supported by the Apprenticeship Levy and funding we have secured from Health Education England. Examples – Radiotherapy, Cardiology and Sleep, Anaesthetics, Pharmacy, Imaging and Pathology.
- Actions to improve staff experience are detailed in Divisional Staff Engagement Plans
- Ongoing review of recruitment processes
- Work on initiatives focussing on the retention of our workforce
- Rotas and rota coordinators management of roster processes
- Medical rotas are reviewed, vacant shifts covered where possible from doctor bank and agency, adverts out for Trust grades where applicable. Locums are used / recruited to fill gaps where necessary
- Directorate and divisional management teams monitor staffing levels
- Chief Nurse staffing reviews
- The UHNM Staff Voice is a monthly staff survey designed to help understand key issues important to staff about wellbeing, making improvements to where they work and the way they provide patient care. This survey also provides a local measure of staff engagement.
- Divisional People Plans aligned to the corporate agenda
- **Digital Agenda:** The draft People Digital Strategy for the NHS was released in September 2021 and sets out draft commitments for the next 3 years. The Digital Agenda is a system-led work programme initially covering the roll out of a Digital Staff Passport to hold staff 'verified employment and training credentials'.

2nd Line

- The Trust's People Strategy is supported by a HR Delivery Plan, with improvement activities cascaded via Divisional People Plans. The HR Delivery Plan has been updated for 2022/23 priorities and actions.
- The system led workforce demand and supply process remains in place and will continue to manage redeployment of staff where required, as well as system wide recruitment initiatives. The Trust continues to progress its own recruitment plans as well.
- Processes are in place to request mutual aid from across the system if required
- The Workforce Bureau is now operating as a virtual bureau.
- Established Banks are in place – including Nursing, Medics and other staff groups
- Business cases have been approved to address staffing in ED, Anaesthetics and Critical Care and other hotspots and are being recruited to
- Weekly meetings take place with Medical Staffing to review rotas, gaps and progress against recruitment
- General recruitment drives are on-going and there is an element of head hunting via informal networks
- Golden Handshakes and handcuffs can be used for new starters
- Working with Divisional teams on high and long term agency workers to focus on exit plans
- Targets allocated to Divisions for 10% agency reduction by 31st March 2023
- Continuing work with education teams and providers across the system to enhance opportunities for learning and the education experience for our trainees
- **Digital Agenda:** The Trust has volunteered to participate in a trial of the digital staff passport.

3rd Line

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

Assurance Map (Assurance to Executive Groups / Committees during the Quarter)

	Key Risk / Matter of Concern Escalated	Positive Assurance Escalated	Positive Assurance and Key Risk
1st Line			• Divisional Workforce Highlight Reports
2nd Line	• Agency Costs	• Recruitment Highlight Report • Talent and Succession Planning Update • Midwifery Workforce	• Postgraduate Medical and Dental Education Report • Undergraduate Medical School Report • Workforce Performance Report M9, M10, M11 • Medical School Annual Report • Improving Together Countermeasure Summary • Executive Workforce Assurance Group Assurance Report • Guardian of Safe Working Q2 & Q3 • Strategic Workforce Plan 2023/24
3rd Line	• Workforce Planning Internal Audit		

Gaps in Control or Assurance

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

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

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

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

BAF 4: System Working

Internally Driven	
Externally Driven	✓

Risk Description

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

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

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	2	Likelihood:	2	31/03/2023
Consequence:	3	3	3	3	Consequence:	3	
Risk Level:	High 9	High 9	High 9	Mod 6	Risk Level:	Mod 6	
Rationale for Risk Level:	Whilst the ICS Interim Chair no longer uses the 'interim' title; the number of interim executives remains the same. The ICS/ICB are still evolving; further clarity needed around roles, responsibilities and accountabilities remain and they are grappling with new guidance such as the Hewitt Review, there has not been any impact (positive or negative) on UHNM.						

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

Position Statement

What progress has been made during the last quarter?

- The ICB have now produced a draft strategy which was presented to UHNM Board in February and finalised at the ICB in March
- As UHNM is at a NOF 3 rating. The assessment criteria has been reviewed and redeveloped between NHSE, ICB and UHNM to understand what the exit criteria looks like. All exit criteria have been mapped across UHNM governance and reporting arrangements to ensure full oversight and monitoring of progress

Key Controls Framework – 3 Lines of Defence

1st Line

- Regular updates from the Executive Strategy and Transformation Group

2nd Line

- Regular discussions at Executive Team meeting each week
- Regular update on ICS transformation programme to Transformation and People Committee
- Regular updates in closed session of Trust Board and through Chief Executive's update to Public Board and private Board
- Board Seminars with a specific focus on partnership working and collaboration
- Adoption of a number of UHNM approaches to risk management and governance at system level through governance and risk system network
- Full conclusions from NHSE quarterly system review meetings go to all Board members and a summary to public board in the CEO update
- Outputs from the NOF Oversight meetings will be reported internally to PAF with escalations to other Board subcommittees and Board as appropriate

3rd Line

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

Assurance Map (Assurance to Executive Groups / Committees during the Quarter)

	Key Risk / Matter of Concern Escalated	Positive Assurance Escalated	Positive Assurance and Key Risk
1st Line	Children's Hospital Board Highlight Report		
2nd Line	Executive Strategy & Transformation Group Assurance Report	Health & Wellbeing Strategy	• Commissioned Services • Improving Together Update
3rd Line			

Gaps in Control or Assurance

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

- Development of stakeholder feedback on UHNM as a partner, including adoption of revised Code of Governance in relation to system working
- Future CQC inspections on Well Led will incorporate the legal duty to collaborate through a focus on system working / engagement and partnership working
- Provider Collaborative self-assessment to be undertaken once the maturity matrix is released by NHSE
- Recruitment to a new ICS Chair and substantive recruitment to a number of NHS ICB executive roles – Chief Executive, Director of Strategy and Director of Nursing remain interim appointments

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

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

BAF 5: Delivering Responsive Patient Care

Internally Driven	✓
Externally Driven	✓

Risk Description

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

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

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	5	5	Likelihood:	3	31/08/2023
Consequence:	4	4	4	4	Consequence:	4	
Risk Level:	Ext 16	Ext 16	Ext 20	Ext 20	Risk Level:	High 12	
Rationale for Risk Level:	The level of risk has remained the same at quarter 4 due to ongoing strike action alongside the continued requirement to increase elective work in order to reduce waiting times for patients.						

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	1 →	6 →	23 ↑	11 ↓	41 ↑

Position Statement

What progress has been made during the last quarter?

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

Key Controls Framework – 3 Lines of Defence

1st Line

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

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

	Key Risk / Matter of Concern Escalated	Positive Assurance Escalated	Positive Assurance and Key Risk
1st Line			
2nd Line	• Theatre Improvement Programme Update	• Corridor Care and Your Next Patient Update	• Performance Report M9, M10, M11
3rd Line		• National Cancer Patient Experience Survey	

Gaps in Control or Assurance

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

- High occupancy – unable to reduce our occupancy to facilitate planned and urgent care pathways
- Unreliable simple discharge delivery that supports flow through the organisation
- High MFFD as a % of bed occupancy
- 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 the Emergency Department who do not require urgent and 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 system provisions	Additional Assurance	Chief Operating Officer	09/11/2022	**Original Due Date 5/10/2022 and 09/11/2022:** Complete. This will be restarted at the beginning of Q1 for 23/24 planning.	
3.	Deliver objectives as described in non-elective improvement programme	Control to reduce Likelihood	Chief Operating Officer	30/09/2023	**Original Due Date 31/02/2023:** Dates have been realigned in line with programme.	
4.	Develop comprehensive capacity, demand, organisational and system bed model to ensure data driven approach to improvement	Control to reduce Likelihood	Chief Operating Officer	31/10/2022	Complete.	

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**
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: Delivery of IM&T Services

Internally Driven	✓
Externally Driven	

Risk Description

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

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

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	4	Likelihood:	2	31/03/2024
Consequence:	4	4	4	4	Consequence:	4	
Risk Level:	High 12	High 12	High 12	Ext 16	Risk Level:	High 8	
Rationale for Risk Level:	• The Quarter 4 risk has increased as there has been a delay in the Network and Communication market testing and commission of the system wide Security Operations Centre (SOC) service and there has continued to be a recurrence of incidents relating to network failure • The financial position for 2023/24 is likely to result in a slow down in progress against the Digital Strategy						

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	3 ↑	10 →	11 →	4 ↑	28 →

Position Statement

What progress has been made during the last quarter?

- Network and Communication Market Testing has been launched with the business case now being rescheduled to come to Trust Board in July 2023
- The business case for the System Wide Security Operations Centre has been approved and procurement has commenced.
- The Firewall replacement scheduled for January has been completed.
- The procurement of professional consultancy services to support UHNM in the delivery of a system wide business case and requirement of specification has commenced but is currently subject to challenge.
- The Chief Nurse Information Officer post has been offered to Fiona Hibberts who is set to join us in the summer.
- Winpath Enterprise Microbiology has gone live with blood health sciences planned to go live in July 2023.
- Patients Know Best (PKB) is live with 97779 patients registered.
- The new video consultation solution One Consultation is live and replaces the more expensive Attend Anywhere.
- The new Anesthetic Medical Record System has gone live.
- The new Theatre Checking Solution has gone live.

Key Controls Framework – 3 Lines of Defence

1st Line	• Attend Anywhere has been decommissioned • DCB0160 approved for LIMS • Digital Advocate Network event completed
2nd Line	• National Digital Maturity assessment completed • IT performance review reviewed at Executive Digital Group
3rd Line	• Independent penetration test completed and report received • Internal Audit report on the Digital Strategy development received

Assurance Map (Assurance to Executive Groups / Committees during the Quarter)

	Key Risk / Matter of Concern Escalated	Positive Assurance Escalated	Positive Assurance and Key Risk
1st Line			
2nd Line	• Medicines Optimisation & Safety Group Highlight Report (February 2023) • Data Security and Protection Group Chairs Report • Digital Clinical Office Operational Group Chair's Report	• Cyber Security Chair's Report • Clinical Systems Operational Group Chair's Report • BC-0513 ICB Network Security Operations Centre and Security Information Event Monitoring	• Records Service Group • IT Service Delivery Chair's Report • IT Programme Group • Executive Digital and Data Security & Protection Group Assurance Report
3rd Line			

Gaps in Control or Assurance

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

- Office 365 migration
- Electronic prescribing and medicines administration solution
- Electronic patient record strategic outline case
- Network services outline business case
- Backup and firewall implementation
- iPortal rewrite into a supported platform
- Ward Information system rewrite onto a supported platform
- Recruit to the Commercial Manager post
- Recruit to the Chief Nurse Information Officer post
- Implement laboratory management information system
- Commission a 24 x 7 security operations centre
- 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	Control to reduce the Likelihood	Director of Digital Transformation	31/03/2023	Project Manager assigned.	
2.	Network and Communication Market Testing	Control to reduce the Likelihood	Director of Digital Transformation	07/06/2023	**Original due date 28/09/2022:** Strategic Outline Case approved Requirements, specification completed. Procurement legal advice sought. Procurement commenced.	
3.	iPortal and WIS rewrite	Control to reduce the Likelihood	Director of Digital Transformation	31/03/2023	WIS in test and iPortal in development. IPortal alternative options being considered due to 48 month development estimate.	
4.	Commission 24 x 7 SOC service	Control to reduce the Likelihood	Director of Digital Transformation	31/01/2023	**Original due date 01/11/2022:** Proposal received from the ICB and request to proceed submitted. Business case approved at Executive Team and will be presented to Performance and Finance Committee on 31/01/23.	
5.	Backup solution implementation	Control to reduce the Likelihood	Director of Digital Transformation	31/03/2023	Project manager assigned	
6.	Firewall solution implementation	Control to reduce the Likelihood	Director of Digital Transformation	01/02/2023	**Original due date 01/11/2022:** Project manager assigned. Implementation date agreed, implementation cancelled due to change freeze due to industrial action.	
7.	Resources business case	Control to reduce the Likelihood	Director of Digital Transformation	03/01/2023	**Original Due Date 01/10/22 and 31/10/22:** Business case authored. Investment being considered by Execs. Investment approved by Executive Team. Recruitment activities commenced.	

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

Risk Description

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

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

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	3	Likelihood:	3	29/12/2023
Consequence:	4	4	4	4	Consequence:	3	
Risk Level:	High 12	High 12	High 12	High 12	Risk Level:	High 9	

Rationale for Risk Level:

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

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	0 →	16 ↑	18 ↑	2 ↑	36 ↑

Position Statement

What progress has been made during the last quarter?

Estates Workforce Recruitment/Retention Issues

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

Estate Condition

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

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 will (from April 2023) become a focus of PAF, via submission of a bi-annual progress report.
- Significant capital investment required to ensure target delivery. All of the currently known decarbonisation schemes that require capital investment have now been collated as part of the Sustainability and NZC capital investment subgroup planning for 23/24 (total value of schemes is >£15million which now need to be prioritised against the available £100k allocation).
- Public Sector Decarbonisation Scheme: 20th Jan 2023, Trust informed of PSDS application success and £5.4 million award.

Estate Strategy / Clinical Strategy

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

West Building

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

Adoption of new National Standards of Healthcare Cleanliness

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

PFI Market Testing Opportunities

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

Key Controls Framework – 3 Lines of Defence

1st Line	• Project STAR **–** Approved Business Case and construction commenced • Estate Condition**:** Planned Preventive Maintenance programme; competent estates staff/ Authorised Persons; KPI's monitored through CEF/ Environmental Audits**.** Maintenance Operational Board; Operational policies; Service Specifications PFI, 7 Facet Survey. • Fire Safety/ Security Policies; Protocols; Guidelines; patrolling; CCTV; FRA's in place • Sustainability / NZC: Sustainable Development Steering Group (biannual), Sustainability Working Groups (monthly), Performance and Finance Committee (PAF) (biannual, commencing April 23), 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/inspection • 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

Assurance Map (Assurance to Executive Groups / Committees during the Quarter)

	Key Risk / Matter of Concern Escalated	Positive Assurance Escalated	Positive Assurance and Key Risk
1st Line		• Estates Divisional Board Assurance Report	
2nd Line	• Fire Safety Highlight Report	• Capital Investment Group Assurance Report	• Executive Health and Safety Assurance Report • Fire Safety Highlight Report • Security Management Highlight Report
3rd Line			

Gaps in Control or Assurance

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

- Capital Programme – continued focus on mitigating risks of delay on capital schemes working closely with finance colleagues.
- Estates Business Case – move to implementation phase following approval in December.
- Project STAR – work to continue on firming up disposal strategy and programme for Infirmary and Outpatients sites
- 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 Business Case – move to implementation following approval in December.
- PFI – conclude lender approvals Sodexo Market Test, determine PACS/RIS solution to inform concluding of Siemens VFM and await findings of procurement exercise for Network and Communications service to inform future service model

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

BAF 8: Financial Performance

Internally Driven	✓
Externally Driven	✓

Risk Description

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

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

Impact on Strategic Objectives

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	2	Likelihood:	2	~~30/09/2022~~ 31/03/2023
Consequence:	3	3	3	**2**	Consequence:	2	
Risk Level:	**High 9**	**High 9**	**High 9**	**Mod 4**	Risk Level:	**Mod 4**	
Rationale for Risk Level:	Month 11 performance was on track to deliver a breakeven for the year, whilst M12 data is not yet available it is anticipated that the target score will be achieved by the end of quarter 4.						

Linked Risks on Risk Register:	Low 1 – 3	Mod 4 – 6	High 8 – 12	Ext > 15	Total
	0 →	3 ↑	13 ↑	2 ↑	18 ↑

Position Statement

What progress has been made during the last quarter?

The actual position reported at Month 11 for the year to date was breakeven with continued underspends against pay budgets and slippage on investments, generating in year underspends. Non-recurrent CIP continues to be identified to support the in-year position.

Key Controls Framework – 3 Lines of Defence

1st Line

- Performance Management meetings in place with Divisions
- SFIs and scheme of delegation
- Planned care board approving and monitoring spend against ERF
- Exec Team approval of additional investment up to £250k

2nd Line

- Finance report in place to performance and Finance Committee with associated scrutiny; enhanced to include run rate performance and analysis of additional COVID related expenditure
- ICS CFO meeting to review system position
- Non-recurrent mitigations confirmed

3rd Line

- Consideration of Internal audit programme to reflect changing risks in financial plan
- Varying the pace of investment to provide additional mitigation
- External audit programme in place

Assurance Map (Assurance to Executive Groups / Committees during the Quarter)

	Key Risk / Matter of Concern Escalated	Positive Assurance Escalated	Positive Assurance and Key Risk
1st Line			
2nd Line	• Losses and Special Payments Q3 • SFI Breaches and Single Tender Waivers Q3 • Financial and Capital Plan 2023/24 • System Financial Plan Update 2023/24	• Overseas Visitors Annual Policy Audit • Procurement Update Q3 • Update on Accounting Policies, Critical Judgements and Estimation Uncertainty 2022/23 • Valuation of Land and Buildings 2022/23 • Annual Operating Plan Submission 2023/24	• Finance Report M9, M10, M11
3rd Line		• External Audit Progress Report • LCFS Progress Report	

Gaps in Control or Assurance

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

The forecast for the year showed a £6.6m deficit, at month 8, before any further mitigation or non-recurrent underspends including slippage against the winter plan, virtual wards and ERF. In year non-recurrent flexibility has been available to support the in-year position but the underlying position has increased to £51.9m for 2023/24 and will need addressing if the services are to remain financially sustainable.

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

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

BAF 9: Research & Innovation

Internally Driven	✓
Externally Driven	✓

Risk Description

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

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

Impact on Strategic Objectives

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

Risk Scoring

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

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

Position Statement

What progress has been made during the last quarter?

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

Key Controls Framework – 3 Lines of Defence

1st Line	• Steering Groups established at Speciality level to increase engagement with the central department • Engagement with individual Divisional Boards has commenced • Engagement with Directorates now established • Research practitioners funded by the Directorates within Haematology, Neurology and ENT • Recruitment is on going
2nd Line	• Research Strategy developed with key objectives and key performance metrics defined • Departmental leadership team meeting structure in place to oversee delivery of research strategy and priorities • Executive Research and Innovation Group in place • A3 developed on participation in clinical trials which has been identified as a Strategic Initiative as part of our Improving Together Strategy Deployment Room • Financial return review with Divisional Business Advisors on a monthly basis • A new appointment made in collaboration with Keele commenced post in October 2022 • A further 2 posts currently in progress
3rd Line	• Partnership Group with West Midlands Clinical Research Network (WMCRN) • Engagement with higher education – i.e. Keele / Staffordshire Universities with particular progress being made with Staffordshire University • Annual ASTOX reports (Annual Statement Of expenditure) for the NIHR annually on behalf of R&I • Ad hoc NIHR review

Assurance Map (Assurance to Executive Groups / Committees during the Quarter)

	Key Risk / Matter of Concern Escalated	Positive Assurance Escalated	Positive Assurance and Key Risk
1st Line			

2nd Line		• CeNREE New UHNM Fellowships • Executive Research & Innovation Group Assurance Report	• Improving Together Countermeasure Summary
3rd Line			

Gaps in Control or Assurance

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

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

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

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

9.	Research to form part of Divisional Board agendas.	Additional Assurance	Medical Director	31/6/2023	Action not due.	

Appendix 1: Risk Appetite Matrix

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

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

Appendix 2: Links to Risk Register

ID	EIG	DDSP	QSOG	H&S	EWAG	Risk Description	Division	Q1	Q2	Q3	Q4	Target Risk Score	BAF Link
26887						Ineffective Clinical Effectiveness Provision	Central Functions	NA	NA	NA	16	6	1
8877			✓			Hospital Acquired Infections	Central Functions	12	12	12	12	8	1
25152			✓		✓	Insufficient trained staff in Pharmacy Technical Services to deliver aseptic products including chemotherapy to the Trust	CWCSS	16	20	20	16	4	1, 3
25467			✓		✓	HD capacity and workforce	Medical	NA	20	20	16	8	1, 3
21595			✓		✓	Insufficient technical staff in Microbiology	NMCPS	16	16	16	16	6	1, 3
22514			✓		✓	Nurse Staffing in the Emergency Department both Sites	Medical	16	16	16	16	6	1, 3
26920			✓			Inability to always provide extra observational staff for patients who require it	Medical	NA	NA	NA	15	5	1, 3
27141			✓			Risk of serious harm due to patient falls on FEAU	Medical	NA	NA	NA	15	8	1, 3
18842			✓		✓	Gaps within the Junior Medical Rota	CWCSS	16	16	16	12	6	1, 3
25228			✓		✓	Nurse Staffing CED	CWCSS	NA	20	16	12	4	1, 3
25455			✓		✓	Lack of ST1/2 to provide on call cover within Specialised Surgery Directorate	Surgical	NA	16	16	12	4	1, 3
13419			✓		✓	Midwifery safe staffing	CWCSS	16	20	12	12	4	1, 3
15664			✓			Liver Mortality - CQC actions	Medical	16	12	12	12	4	1, 3
17710			✓		✓	Pharmacy staffing for Inpatient gastroenterology	Medical	9	9	9	12	6	1, 3
18093			✓		✓	Nurse Staffing within the NNU	CWCSS	16	12	12	12	6	1, 3
21481			✓		✓	Reduced Breast service (Imaging), due to vacancy within Breast Radiologist workforce.	CWCSS	12	12	12	12	4	1, 3
21503			✓		✓	General Paediatric Consultant Rota	CWCSS	12	12	12	12	4	1, 3
23569			✓		✓	AMU ROYAL STOKE-Lack of pharmacy staff due to understaffing to meet demand of the increased bed base	Medical	12	12	12	12	2	1, 3
23570			✓		✓	No current pharmacy service to support AMRA	Medical	12	12	12	12	4	1, 3
23787			✓		✓	Gaps in Junior Doctor workforce	Medical	12	12	12	12	6	1, 3
24272			✓		✓	Junior Doctor Staffing	CWCSS	15	12	12	12	6	1, 3
25120			✓		✓	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at MCHFT	NMCPS	NA	12	12	12	8	1, 3
25229			✓		✓	Nurse Staffing CAU	CWCSS	NA	12	12	12	4	1, 3
25247			✓		✓	Nurse Staffing Ward 217	CWCSS	NA	12	12	12	4	1, 3
25795					✓	Vacant Consultant Neurology On-Call Gaps	Network Services	NA	12	12	12	4	1, 3
25857			✓		✓	AMU COUNTY-Lack of pharmacy staff to meet demand due to increased bed base	Medical	NA	12	12	12	2	1, 3
8615			✓		✓	Radiotherapy Radiographer Staffing Levels	Network Services	12	12	12	12	4	1, 3
26318					✓	Band 5 Physiotherapists	Network Services	NA	NA	12	12	4	1, 3
27472			✓		✓	Inadequate Nurse Staffing in Children's ED Compromising Ability to Provide Basic CQC Nursing Requirements	Medical	NA	NA	NA	12	4	1, 3
9738					✓	Nursing training (both sites)	Medical	16	16	16	16	6	2

ID	EIG	DDSP	QSOG	H&S	EWAG	Risk Description	Division	Q1	Q2	Q3	Q4	Target Risk Score	BAF Link
16652					✓	Staff Wellbeing and Welfare	Medical	12	12	16	16	2	2
20616			✓		✓	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at Macclesfield H	NMCPS	16	16	20	16	4	3
11294			✓		✓	NMCPS Pathology Histology Medical Reporting Capacity (achieving TAT)	NMCPS	12	12	16	16	6	3
13725					✓	RSUH/CH Haematology shift service provision (Haematology)	NMCPS	16	16	16	16	4	3
21157			✓		✓	Haematology Service at MCHT Leighton	Network Services	16	16	16	16	6	3
26238					✓	Industrial Action 22/23	Central Functions	NA	NA	16	16	9	3
20809					✓	NMCPS Histology Admin & Office Capacity	NMCPS	16	12	12	16	4	3
24281			✓		✓	Cardiothoracic Theatre Staffing Establishment	Surgical	12	16	16	12	4	3
21591			✓		✓	Insufficient Clinical Staff to Support the NMCPS Microbiology Service	NMCPS	16	12	12	12	6	3
21947			✓		✓	Insufficient resource for the paediatric dietetic services	CWCSS	12	12	12	12	4	3
23024			✓		✓	Gaps in B5 radiographer rosters to provide 24/7 xray service	CWCSS	16	16	12	12	4	3
23506			✓		✓	Gastroenterology patients insufficient Pharmacy support for highly complex medication regimes	CWCSS	12	12	12	12	3	3
23843			✓		✓	Respiratory Consultant workforce (County)	Medical	16	16	12	12	4	3
24323					✓	Neurosciences SHO Rota	Network Services	16	8	8	12	6	3
24837					✓	Cystic Fibrosis workforce/service delivery	Medical	12	12	12	12	4	3
25121					✓	NMCPS Blood Transfusion staffing	NMCPS	NA	12	12	12	8	3
26110			✓		✓	Renal clinic letters for Cheshire (Leighton) Patients	Medical	NA	NA	12	12	6	3
25628			✓			Ophthalmology Service Delivery	Surgical	NA	20	20	20	4	5
24028			✓			Lack of flow across the Trust leading to congestion of ED (both sites) and UEC standards unable to be met	Medical	20	20	20	20	6	5
25980			✓			Your Next Patient Process	Medical	NA	NA	16	16	4	1, 5
25470			✓			Increasing waiting list size and patients waiting greater than 18 weeks for treatment	Surgical	12	20	16	16	4	5
25839			✓			Long Wait Patients in the Trauma Directorate	Network Services	NA	20	20	16	12	5
23842			✓		✓	Delivery of RTT - Outpatient capacity/wait times	Medical	16	16	16	16	4	5
25053			✓			Access to Cardiac theatres	Network Services	16	16	16	16	16	5
25469			✓			Delivery of constitutional cancer quality standards	Surgical	NA	20	16	16	4	5
25471			✓			Follow Up Delays	Surgical	NA	16	16	16	4	5
17873			✓			Inability to Off-load Patients from Ambulances (both sites)	Medical	15	15	15	15	4	5
17805			✓			Lung Nodule Management	Medical	8	12	12	12	8	5
18664			✓			Gynaecology 52 Week Wait Patient Numbers	CWCSS	12	12	12	12	9	5
20134			✓			Specialised Surgery Follow Up Backlog	Surgical	12	12	12	12	4	5
20448			✓			Patient LOS above 24 hrs. on AMU - against Internal Standards	Medical	12	12	12	12	4	5
20739			✓			Endoscopy planned patients waiting list	Medical	12	12	12	12	6	5
23568	✓		✓			Size of the AEC footprint	Medical	12	12	12	12	2	5
25585			✓			Lack of Cone Beam CT scans being reported	Surgical	NA	12	12	12	4	5
25790			✓			Diagnostic Sleep Service	CWCSS	NA	12	12	12	6	5

ID	EIG	DDSP	QSOG	H&S	EWAG	Risk Description	Division	Q1	Q2	Q3	Q4	Target Risk Score	BAF Link
26529			✓			Leighton Hospital Hyper-Acute Stroke Pathway	Network Services	NA	NA	12	12	4	5
26168		✓				Pathology IT support	NMCPS	NA	NA	20	20	8	6
25870		✓				Network and communication services provision for UHNM	Central Functions	NA	16	16	16	6	6
9036		✓				Vulnerability to Cyber Attack	Central Functions	15	15	15	15	12	6
8849		✓				Staff using unsecured and unlicensed personal phones for work email	Central Functions	12	12	12	12	4	6
21784		✓				Confidentiality, Integrity and Availability of Trust Information	Central Functions	12	12	12	12	4	6
23753		✓				Network failure due to multiple service providers	Central Functions	12	12	12	12	4	6
24580		✓				Lack of a centralised information asset (systems) register	Central Functions	12	12	12	12	4	6
26487		✓				Lack of a digital solution to maintain confidentiality of patient information with the GP	Central Functions	NA	NA	12	12	3	6
27187		✓				Unsupported access databases	Central Functions	NA	NA	NA	16	4	6
25353	✓					Sale of RI and COPD Land later than NHSIE funding requirement of 24/25	Central Functions	NA	16	16	16	6	7, 8
27145	✓			✓		Theatre doors not compliant with fire safety regulations	Surgical	NA	NA	NA	16	4	7
23331	✓			✓		MCHT Ceiling RAAC planks	NMCPS	15	15	15	15	4	7
20315	✓					Interventional Room 5 does not meet Ventilation Building Regulations	CWCSS	12	12	12	12	6	7
27410				✓		Fire escape in FDU	Medical	NA	NA	NA	12	9	7
27497	✓	✓				System C (careflow) cost pressure	Central Functions	NA	NA	NA	20	6	8
21697	✓					Recurrent CIP requirements for 22/23 and beyond not met in Trust due to lack of focus on CIP	Central Functions	12	12	12	12	8	8
21700	✓					Valuation of RI and COPD sites in relation to funding of Project Star MSCP Business Case	Central Functions	12	12	12	12	2	8
22949		✓				IM&T Contract Management	Central Functions	12	12	12	12	4	8
25347	✓					Reduction in planned elective Recovery Income	Central Functions	NA	12	12	12	4	8
25348	✓					Excess Non pay Inflation	Central Functions	NA	12	12	12	9	8

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University Hospitals of North Midlands
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Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd May 2023
Report Title:	Committee Effectiveness and Revised Rules of Procedure	**Agenda Item:**	17.
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	✓	Improving Together	
Responsive	✓	Improving & Innovating	✓	Resources	✓		

Risk Register Mapping

No risks identified.

Executive Summary:

Situation

In line with best practice, each Committee of the Trust Board annually reflects on their own performance and effectiveness. The review comprises of three parts; committee effectiveness comprising feedback from the Chair and Committee members, an annual summary of the key areas of work and achievements against the Terms of Reference and business cycle and revision of the Committee Governance Pack, taking into account any issues raised by the effectiveness review and annual report.

Background

Reviews for each Committee have been undertaken and either presented to respective Committees (or via virtual approval), which included the approval of revised Terms of Reference for each Committee, taking into account the actions arising from the effectiveness reviews.

Assessment

Members and regular attendees of the various Board Committees were asked to complete a self-assessment questionnaire regarding the effectiveness of the Committees during 2022/23. In addition, a Committee Process checklist was completed by each Chair of the Committee.

The results of the process indicate a broad consensus that all Board Committees have been effective in the discharge of their duties and this is further supported by the content of the Committee Annual Reports. The above processes identified a number of actions to be taken forward to further enhance effectiveness.

Revised Rules of Procedure 2023/24

Following the review of Committee Governance Packs and their approval by respective Committees, the Rules of Procedure for 2023/24 has been revised. No major changes have been made to the Rules of Procedure with only minor changes having been made to the Terms of Reference, mainly in relation to the business cycles for each Committee.

Key Recommendations:

The Trust Board is asked to note:

- the outcomes of the self-assessment process.
- that annual reports for each Committee have been considered by the respective Committees.
- that revised Committee Governance Packs have been approved by each Committee, and incorporated within the Rules of Procedure for 2023/24

The Trust Board is asked to approve the revised Rules of Procedure for 2023/24, incorporating the Trust Board Business Cycle and Committee Governance Packs.

NHS
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NHS Trust

Review of Committee Effectiveness 2022/23

April 2023

1. Introduction

As part of the Trust's governance arrangements, and as set out within the Trust's Rules of Procedure, members and regular attendees of Board Committees were asked to complete a self-assessment questionnaire regarding the effectiveness of the Committees during 2022/23.

The questionnaires were based upon good practice guidance which requires Boards to review the effectiveness of their Committees on an annual basis.

In addition, an annual report for each Committee was prepared which summarised the purpose of the Committee, membership and attendance, key issues covered and actions taken.

The outcomes of these reports have been considered by each Committee in addition to their revised Committee Governance Packs (which include terms of reference, business cycles and standard agendas).

2. UHNM Board Committees

Five formal Board Committees have been established and were in operation during 2022/23. In addition, a task and finish Culture Review Committee was established in June 2021; the effectiveness of this Committee was undertaken via a case closure report and presented to the Committee in June 2022 whereby it was agreed that 4 / 5 duties had been discharged, with one remaining duty discharged to the Transformation and People Committee.

2.1 Nominations and Remuneration Committee

The Committee:
(a) Advises the Trust Board about appropriate remuneration and terms of service for the Executive Directors (i.e. Trust Board voting and no-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework. This includes:
(i) All aspects of salary (including any performance-related elements/bonuses)
(ii) Provisions for other benefits, including pensions and cars
(iii) Arrangements for termination of employment and other contractual terms

(b) Monitors and evaluates the performance of individual Directors (with the advice of the Chief Executive)

(c) Advises on and oversees appropriate contractual arrangements for Executive Directors, and when required, consider issues relating to remuneration, terms of service and performance issues for senior management staff

The Committee Chairman shall make recommendations to the Trust Board regarding the Composition of the Trust Board to ensure there are robust processes in place to review the role and performance of Non-Executive Directors and the Chairman, and to advise the Chairman regarding the filling of Non-Executive Vacancies.

The Committee is also responsible for reviewing and advising the Trust Board on the appointment process for Non-Executive Directors.

2.2 Audit Committee

The Audit Committee supports the Trust Board in their responsibilities for issues of Integrated Governance, Risk Management and Internal Control, by reviewing the comprehensiveness of internal and external assurances in meeting the Trust Board and Accounting Officer's needs, in addition to reviewing the reliability and integrity of these assurances.

2.3 Quality Governance Committee

The Quality Governance Committee assures the Trust Board of the organisation's performance against quality and research objectives. This assurance is secured through the Assurance Framework, the Corporate Risk Register and the audit plans, which focus on the quality and research objectives of the Trust.

2.4 Performance and Finance Committee

The Performance and Finance Committee oversees all aspects of the Trust's financial, workforce and performance management arrangements, and provides robust assurance in these areas to the Trust Board. The Trust Board continues to have primary responsibility for the financial, organisational development and business performance of the Trust and all Trust Board Directors will continue to be accountable in this respect.

2.5 Transformation and People Committee

The Committee assures the Trust Board in relation to the strategic impact of the Transformation Programmes and People and Organisational Development Strategy on the delivery of the Trust's strategic objectives.

3. Committee Attendance

The average attendance of Committee members for 2022/23 was as follows:

Committee	Average Attendance of Members (%)							
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Nominations and Remuneration Committee	76.0%	83%	89%	87%	73%	71%	85%	87% ↑
Audit Committee	80.0%	83%	93%	77%	83%	87%	90%	68% ↓
Quality Governance Committee	82.5%	86%	85%	79%	84%	83%	80%	85% ↑
Maternity Quality Governance Committee	N/A	N/A	N/A	N/A	N/A	N/A	N/A	79%
Performance and Finance Committee	71.0%	95%	83%	85%	82%	83%	87%	91% ↑
Transformation and People Committee	N/A	N/A	N/A	N/A	94%	82%	80.5%	84% ↑

Attendance matrices for each Committee can be found in the individual Committee Annual Reports.

4. Responses from Committee Self-Assessment Questionnaires

Each Committee member (and regular attendee where required) were asked to complete a Committee Effectiveness questionnaire. The questionnaires were based upon good practice guidance which requires Boards to review the effectiveness of their Committees on an annual basis and included a

number of questions covering the practice and conduct of the Committees. In addition a Committee Processes questionnaire was completed by the Deputy Associate Director of Corporate Governance on behalf of the Chair of the Committee.

A summary of the responses received against the questions posed in the questionnaires is listed below:

Committee	Positive Response							
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Nominations and Remuneration Committee	75%	97%	92%	92%	Not undertaken	99%	98%	95% ↓
Audit Committee	77%	85%	94%	88%	86%	98%	96%	96% →
Quality Governance Committee	96%	98%	92%	91%	93%	98%	92.5%	91% ↓
Maternity Quality Governance Committee	N/A	N/A	N/A	N/A	N/A	N/A	N/A	67.5%
Performance and Finance Committee	84%	N/A	86%	82%	96%	99%	94%	95% ↑
Transformation and People Committee	N/A	N/A	N/A	N/A	90%	100%	98%	86% ↓

In response to the responses and comments made during the review a number of actions for improvement were identified, summarised as follows:

Nominations and Remuneration Committee

- To work with the Chief People Officer to clarify expectations in terms of redundancy cases to ensure these meet the requirements of the Committee when presented (in particular assessing payback periods, value for money and demonstrating the mitigating actions taken to date). In addition, it has been agreed that cases will be considered at Executive Team before being presented to the Committee.

Quality Governance Committee

- Members are requested to provide updates to their actions before the deadline so that these can considered at the next meeting
- Report authors to be invited to attend the Effective Report Writing training
- The Committee to request further deep dives as required, in particular considering if any further assurance is required in relation to the management and mitigation of BAF 1

Maternity Quality Governance Committee

- Following completion of the self-assessment process, the Committee is asked to consider the responses made to the questionnaires and discuss the action required to provide the Non-Executive and Executive Directors with assurance on the delivery of high quality and safe maternity and neonatal care.

Performance and Finance Committee

- In terms of managing the size of future agendas, if a number of business cases require review at the same time, this will be considered with the Chair to determine the action required to ensure adequate time is available to consider these
- Integrated Performance Report being refreshed for 2023/24 providing standardisation of reporting and ensuring all key metrics are included
- To continue to reiterate meeting etiquette / behaviours to members
- To clarify expectations with report authors in terms of information to be included within business cases
- To continue to strengthen the process associated with bringing forward business case reviews to the Committee in a more timely manner

Transformation and People Committee

- To continue the development of TAP aligned with the principles of Improving Together, including focus of meetings, structure and content of reporting and roles / behaviours.
- To continue to review and refine the items to be considered on the business cycle, ensuring appropriate time is available to discuss and consider the items and avoiding duplication
- To continue to monitor progress against delivery of previously agreed actions in addition to monitoring any delays with items on the business cycle
- Report authors to be invited to attend Effective Report Writing session

5. Conclusion

The output of the Committee effectiveness reviews and Committee annual reports have been considered by Committees, and actions have been agreed by each Committee. Terms of Reference have also been updated, and take into consideration any changes required for 2023/24 and these are included within the revised Rules of Procedure.

6. Key Recommendations

The Trust Board is asked to note:

- the outcomes of the self-assessment process.
- that annual reports for each Committee have been considered by the respective Committees.
- that revised Terms of Reference have been approved by each Committee, and incorporated within the Rules of Procedure for 2023/24

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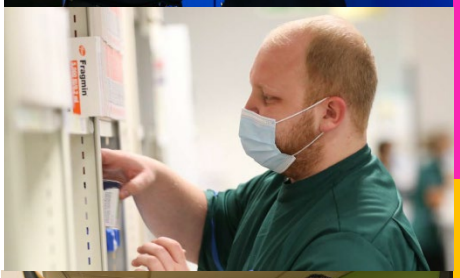


Rules of Procedure

May 2023

Delivering Exceptional Care with Exceptional People

Contents

About University Hospitals of North Midlands NHS Trust

What we do….

University Hospitals of North Midlands NHS Trust was formed in November 2014 following the integration of University Hospital of North Staffordshire NHS Trust and Mid Staffordshire NHS Foundation Trust. We have two hospitals, Royal Stoke University Hospital and County Hospital.

We provide care in state of the art facilities, and offer a full range of general hospital and specialised services for approximately 3 million people. We employ around 11,000 members of staff and we have around 1450 inpatient beds across our two sites.

We are one of the largest hospitals in the West Midlands and have one of the busiest Emergency Departments in the Country, with an average of around 14,000 patients attending each month across both of our sites. Many emergency patients are brought to us from a wide area by both helicopter and ambulance because of our Major Trauma Centre status; as we are the specialist centre for the North Midlands and North Wales.

As a University Hospital, we work very closely with our partners at Keele and Staffordshire University and we are particularly proud of our Medical School, which has an excellent reputation. We also have strong links with our local schools and colleges. As a major teaching trust, we hold a large portfolio of commercial research, which provides us with an additional source of income. Our research profile enables us to attract and retain high quality staff.

Our specialised services include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care, paediatric intensive care, trauma, respiratory conditions, spinal surgery, upper gastro-intestinal surgery, complex orthopaedic surgery and laparoscopic surgery.

We play a key role within the Staffordshire and Stoke-on-Trent Integrated Care System (ICS), which has partnership working at its very core as we work closely together to transform the way health care is delivered for the benefit of our population. This includes leadership and participation in partnership boards which bring together health, social care, independent and voluntary sector organisations across Staffordshire.

We look to involve our service users in everything we do, from providing feedback about the services we provide, to helping to share our priorities. This work is co-ordinated by our dedicated Patient Experience Team.

Our 2025Vision

Our 2025 Vision was developed to set a clear direction for the organisation to become a world class centre of clinical and academic achievement and care. One in which our staff all work together with a common purpose to ensure the highest standard of care and the place in which the best people want to work. Put simply, our Vision is Delivering Exceptional Care with Exceptional People.

To achieve the 2025 Vision we must respond to the changing requirements of the NHS as they emerge and operate in ever more challenging times. This means that we have to think further than the here and now and continue to look beyond the boundaries of our organisation for inspiration. Our involvement in the Integrated Care System is crucial in enabling us to move towards our Vision and to become a sustainable provider of healthcare services.

We have agreed a Strategic Framework which illustrates our Strategic Priorities, Vision and Values along with the key enabling strategies we have in place to support their achievement (see below). Looking ahead to 2023/24, we will be commencing a review of our UHNM Strategy (2025 Vision) which will involve an extensive process of engagement with our staff and key stakeholders.


UHNM Strategic Framework
System Strategies and Plans
NHS
University Hospitals of North Midlands
NHS Trust
Organisational Strategy
Strategic Priorities
High Quality
Responsive
People
Improving & Innovating
Systems & Partners
Resources
mproving Together
NHS
University Hospitals of North Midlands
NHS Trust
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
Improving the health of our population
Resources
Ensuring we get the most from our resources including staff, assets and money
Enabling Strategies
Research & Innovation
Quality
Clinical
People
Health & Wellbeing
Digital
Estate
Finance (Plan)
Supporting and Service Specific Strategies
Updated February 2023

1. Introduction

University Hospitals of North Midlands NHS Trust (the Trust) is a statutory body which came into existence on 4th November 1992 under The North Staffordshire Hospital NHS Trust (Establishment) Order 1992 No 2559 (the Establishment Order). On the 1st April 2003, via order No 792, the name of the hospital was changed to the University Hospital of North Staffordshire NHS Trust. On 1st November 2014, the name of the hospital was changed to the University Hospitals of North Midlands NHS Trust.

- NHS Trusts are governed by statute, mainly the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 (the 2006 Act) and the National Health Service Act 1977 (the 1977 Act and together with the 2006 Act, the NHS Acts).
- The functions of the Trust are conferred by this legislation.
- The Trust also has statutory powers to fund projects jointly planned with local authorities, voluntary organisations and other bodies.
- The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.
- The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

All generalised reference within these Rules of Procedure to the male gender should read as equally applicable to the female gender and vice versa.

2. Definitions

Accountable Officer	The NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
Associate Member	A person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.
Board	The Chair, Executive Directors and Non-Executive Directors of the Trust collectively as a body.
Budget	Resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust. The budget should, where appropriate, also be supported by budgets relating to workforce and workload.
Budget Administrator	Employee with delegated authority from a Budget Manager (to a limit of £5,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Manager	Employee with delegated authority from a Budget Holder (to a limit of £25,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Holder	Director or employee with delegated authority from the Chief Executive (to a limit of £50,000 inclusive of VAT) to manage finances (income and expenditure) for a specific area of the organisation
Chair of the Trust	Is the person appointed by the Secretary of State for Health and Social Care to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression 'the Chair of the Trust' shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.
Chief Executive	The chief accountable officer of the Trust.

Commissioning	The process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
Committee	Means a committee or sub-committee created and appointed by the Trust.
Committee members	Means persons formally appointed by the Board to sit on or to chair specific committees.
Contracting and Procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Employee (Officer)	Employee of the Trust or any other person holding a paid appointment or office with the Trust.
Executive Director (Officer Member)	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Funds held on trust	Those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the NHS Act 2006, as amended. Such funds may or may not be charitable.
He/she or his/her	Where this term appears this term is to be taken as referring to the post holder and is interchangeable as the gender of that post holder changes
Member	Executive Director or non-Executive Director of the Board as the context permits.
Membership, Procedure and Administration Arrangements Regulations	NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.
Non-Executive Director (Non-Officer Member)	A member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.
Scheme of Reservation and Delegation of Powers	Document which sets out the powers reserved by the Trust Board, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures.
Senior Independent Director (SID)	A non-executive director available to raise concerns whereby contact through the normal channels of Chair, Chief Executive, Executive Director or Associate Director of Corporate Governance has failed to resolve.
SO's	Standing Orders.
Standing Financial Instructions (SFIs)	Document detailing the financial responsibilities, policies and procedures adopted by the Trust.
Trust	University Hospitals of North Midlands NHS Trust.
Vice Chair	The Non-executive Director appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

3. Governance

The role of the Board is to set strategy, lead the organisation, oversee operations and to be accountable to stakeholders in an open and effective manner. Good governance provides the key to effective leadership, meaningful challenge, accountability and responsibility. Corporate governance is the system by which companies and other Board led organisations are directed and controlled. The Board is separate from the day to day operational management, which is the responsibility of the Executive Directors and the management structure they lead.

As described in NHS England's Well-led Framework, NHS Trusts are operating in challenging environments characterised by the increasingly complex needs of an ageing population, growing emphasis on working with local system partners to create innovative solutions to longstanding sustainability problems, workforce shortages and the slowing growth in the NHS budget. Trust Boards need to ensure that their

oversight of care, quality, operations and finance is robust in the face of uncertain future income, potential new models of care and resource constraints. Good governance is essential if they are to continue providing safe, sustainable and high quality care for patients.

NHS Trusts should conduct their affairs effectively and, in so doing, build patient, public and stakeholder confidence that they are providing high quality sustainable care. NHS Trust Boards are responsible for all aspects of performance and governance of the organisation.

4. Statutory Framework

The University Hospitals of North Midlands (UHNM) Board consists of:

- The Chair of the Trust appointed by NHS England (NHSE) on behalf of the Secretary of State
- 6 Non-Executive Directors
- 5 Executive Directors including the Chief Executive and the Chief Finance Officer

The principal place of business of the Trust is the Royal Stoke University Hospital, Newcastle Road, Stoke-on-Trent, Staffordshire, ST4 6QG. The Trust also provides services at the County Hospital, Weston Road, Stafford, ST16 3SA.

An organisational chart of the Trust Board members and the Trust Boards Committee Structure can be found at appendices 1 and 2.

5. The Board and Exercise of Statutory Powers

The Board shares responsibility for:

- Ensuring that high standards of corporate governance are observed and encouraging high standards of propriety
- Establishing the strategic direction and priorities of UHNM
- The effective and efficient delivery of UHNM's plans and functions
- Promoting quality in UHNM's activities and services
- Monitoring performance against agreed objectives and targets
- Ensuring that Board members personally and corporately observe the seven principles of public life set out by the Committee on Standards in Public Life.

The Board has collective responsibility for the decisions made by it. Members of the Board shall be subject to the Code of Conduct set out in appendix 3.

Any member of the Board who significantly or persistently fails to adhere to these Rules of Procedure may be judged as failing to carry out the duties of their office and will be managed in accordance with current Trust Policy.

6. Meetings and Proceedings of the Board

6.1 Meetings of the Board

- Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine and as set out within the annual Calendar of Business.
- The Board may invite any person to attend all or part of a Board meeting.
- Meetings will either be held virtually, via MS Teams, or at various locations within Royal Stoke University Hospital or County Hospital, as required.
- Members of the Board are expected to attend not less than 8 Board meetings (whether formal meetings or seminars) in any 12 month period.

6.2 Admission of the Public and Press

- The Board will operate in an open and transparent fashion, except where confidentiality requirements are concerned.
- The chair will give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and members of the press, subject to the provisions of the Public Bodies (Admission to Meetings) Act 1960, such as to ensure that the Board's business may be conducted without interruption or disruption. The Board may resolve to exclude the public and conduct its business in private, whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business being transacted or for other special reasons stated in the resolution.
- Members of the public and press are not admitted to meetings of committees or sub-committees except by specific invitation.

Business proposed to be transacted when the press and public have been excluded from a meeting
Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, shall be confidential to the members of the Board.

Directors or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

Use of mechanical or electrical equipment for recording or transmission of meetings
The Trust does not permit the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Board. Such permission shall be granted only upon resolution of the Chair and Chief Executive, in advance of the meeting.

6.3 Board Meeting Agenda and Papers

In normal circumstances, the agenda will be sent to members 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in emergency. For meetings held in public, the agenda and supporting papers shall be published via the Trust website www.uhnm.nhs.uk at least three working days before the meeting.

The order of business at Board meetings shall follow the agenda issued for that meeting unless otherwise directed by the Chair, at whose discretion, or at the request of another member of the Board, the order may be altered at any stage. The agenda will be primarily based upon the Business Cycle approved by the Board (appendix 4).

Papers may only be tabled at a meeting of the Board with the permission of the Chair.

No other business other than that on the agenda will be taken except where the Chair considers the item should be discussed.

Members of the Board should treat those papers identified as private and confidential and not discuss them with persons other than Board members or employees unless this is agreed with the Chair. If so discussed, members of the Board should ensure that those with whom they have consulted are made aware of, and respect, the need for confidentiality.

Members must take care not to leave Board papers identified as private unattended or where others may obtain access to them.

6.4 Extraordinary Meetings of the Board

In the event of urgency the Chair may determine to hold a meeting to be known as an extraordinary meeting at such time as he/she may determine.

6.5 Power to Call Meetings of the Board

Where, in the opinion of the Chair, an urgent matter has arisen, the Chair may call a meeting of the Board at any time.

Where two or more members of the Board submit a signed request for a meeting to the chair, the chair shall, as soon as practicable but no later than seven calendar days from the date the request was submitted, arrange for the meeting to be held within 28 calendar days from the date the request was submitted.

6.6 Chairing of Meetings

The procedure at meetings shall be determined by the Chair presiding at the meeting. The Chair shall, if present, preside at all meetings of the Board. In the absence of the Chair, the Vice-Chair will preside.

In the absence of both the Chair and the Vice-Chair, a Non-Executive Director chosen by the other members will preside.

6.7 Procedure at Meetings of the Board

The Chair or person presiding over the meeting of the Board will:

- Preserve order and ensure that all members of the Board have sufficient opportunity to express their views on all matters under discussion
- Determine all matters of order, competency and relevancy
- Determine in which order those present should speak
- Determine whether or not a vote is required and how it is carried out

Written comments on agenda items submitted by any member of the Board who is not present when a particular agenda item is discussed may be circulated to those members of the Board who are present at the meeting and read out at the appropriate point in the meeting.

Decisions of the Board will normally by made by consensus rather than by formal vote. Failing consensus, decisions will be reached by means of a vote when:

- the person presiding over the meeting feels that there is a body of opinion among members of the board at the meeting who disagree with a proposal or have expressed reservations about it and no clear consensus has emerged; or
- when a member of the Board who is present requests a vote to be taken; or
- any other circumstances in which the person presiding at the meeting considers that a vote should be taken.

Voting will take place as follows:

- Where a decision of the Board requires a vote it shall be determined by a majority of the votes of the members of the Board present and voting on the question. The person presiding at the meeting shall declare whether or not a resolution has been carried or otherwise. In the case of an equal vote, the person presiding (i.e. the Chair of the meeting shall have a second, and casting vote).
- At the discretion of the Chair, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.
- If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).
- In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.
- A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.
- A manager attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of

the Executive Director. The status of Executive Directors when attending a meeting shall be recorded in the minutes.

No resolution of the Board will be passed if it is unanimously opposed by all of the Executive Directors present or by all of the Non-Executive Directors present.

The minutes of the meeting will record only the numerical results of a vote showing the numbers for and against the proposal and noting any abstentions. The minutes shall be conclusive evidence of the outcome. Votes will not normally be attributed to any individual member of the Board but any member may require that their particular vote be recorded, provided that he/she asks the secretary immediately after the item has concluded.

The Board may agree to defer a decision on an agenda item so that it can be provided with additional information or for any other reason. The decision to defer together with the reasons for doing so will be recorded in the minutes of the meeting together with the proposed time for returning the matter to the Board for its consideration.

The Board may decide to delegate decisions on agenda items to the Chair. Any decision to do so shall be recorded in the minutes of the meeting.

Where in the opinion of the Chair, and considering advice from the Chief Executive, or any other Executive Director, significant operational or other matters require approval by the Board between formal meetings, papers will be circulated by the secretary for approval by correspondence. Any matter capable of being passed by the Board at a meeting may instead be passed by written confirmation given by a majority of the members of the Board with the Chair having the power to cast a second casting vote.

Only exceptionally, where the process to reach a decision would not benefit from discussion in a meeting at which members views would inform debate or, if the issue is time critical will a Board decision be reached without a formal meeting.

6.8 Quorum of the Board

No business shall be transacted at a meeting unless at least five Directors with voting rights are in attendance, of which there must be at least 3 Non-Executive Directors, and Non-Executive Directors should be in the majority. Attendance of the Chair, shall count as one of the Non-Executive Directors.

An individual in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

Participation will usually be in person, but in exceptional circumstances members of the Board may participate by telephone or video-conferencing facility and be deemed to be present and constitute part of the board for that meeting.

When a Board meeting:

- Is not quorate within half an hour from the time appointed for the meeting or;
- Becomes inquorate during the course of the meeting;

the meeting shall either be adjourned to such time, place and date as may be determined by the members present or shall continue as an informal meeting at which no decisions may be taken.

6.9 Minutes of the Board

The minutes of the proceedings of a meeting along with a Post Meeting Action Log shall be drawn up and submitted for agreement at the next ensuing meeting where their approval will be recorded.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate (for example matters arising).

The record of the minutes shall include:

- The names of:
  - Every member of the Board present at the meeting
  - Any other person present
  - Any apologies tendered by an absent member of the Board
- The withdrawal from a meeting of any member on account of a conflict of interest and;
- Any declaration of interest

Minutes of any meeting of the Board will record key points of discussion. Where personnel, finance or other restricted matters are discussed, the minutes will describe the substance of the discussion in general terms.

Once agreed, the minutes will be published via the Trust website www.uhnm.nhs.uk.

6.10 Emergency Powers

The functions exercised by the Board may, in an emergency, be exercised by the Chair after having consulted the Chief Executive.

The exercise of such powers by the Chair must be reported to the next formal meeting of the Board in public session for ratification. The reasons for why an emergency decision was required must be clearly stated.

6.11 Delegation of Powers

The Board remains accountable for all of UHNM's functions, even those delegated to Committees, the Chair, Chief Executive, Executive Directors or employees, and will require information about the exercise of delegated functions to enable it to maintain a monitoring role.

The list of matters reserved for decision by the Board does not however preclude other matters being referred to the Board for decision. All powers delegated by the Board can be reassumed should the need arise and the Board reserves the right to deal with any matters previously delegated. The Board may also revoke or vary such delegation.

The Board delegates to each Committee the discharge of those functions that fall within their respective terms of reference other than any matters reserved to the Board.

The Chief Executive shall prepare a scheme of delegation (Trust Policy F02 Scheme of Delegation and appendix 6 of this document), identifying which functions he/she shall perform personally and which functions have been delegated to Committees and individual employees.

All powers delegated by the Chief Executive can be reassumed by them should the need arise.

Powers are delegated to the Committees and individual employees on the understanding that they will not exercise delegated powers in a matter which in their understanding is likely to be cause for public concern or which might have an effect on the reputation of the Trust.

The exercise of all delegated powers is on the basis that appropriate expert advice will be sought as necessary and that any costs involved can be met within the authorised budget.

The Corporate Governance Team shall keep a record of the powers, authorities and discretions delegated by the Board.

In the absence of an employee to whom powers have been delegated, those powers shall be exercised by the relevant Executive Director unless alternative arrangements have been approved by the Board. If the Chair is absent the powers delegated to him may be exercised by the Vice Chair in relation to the Board and the Chief Executive after taking advice as appropriate from the Board and Executive Directors.

6.12 Role of Accountable Officer and Standing Financial Instructions

The Chief Executive acts as the Accountable Officer. As Accountable Officer, she/he is responsible for ensuring that the public funds for which she/he is personally responsible are properly safeguarded and that functions are used effectively, efficiently and economically.

The standing financial instructions, (Trust Policy F01 Standing Financial Instructions), detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that financial transactions are carried out in accordance with the law and government in order to achieve probity, accuracy, economy, efficiency and effectiveness. They provide a framework of procedures and rules for employees to follow.

All proposed expenditure above £1.5 million (£3 million for investment capital) must be formally approved by the Trust Board.

6.13 Personal Conflicts of Interest

If a member of the Board or a Committee member knowingly has any interest or duty which is material and relevant, or the possibility of such an interest or duty, whether direct or indirect and whether pecuniary or not, that in the opinion of a fair minded and informed observer would suggest a real possibility of bias in any matter that it brought up for consideration at a meeting of the Board or any Committee, he/she shall disclose the nature of the interest or duty at the meeting. The declaration of interest or duty may be made at the meeting or at the start of the discussion of the item to which it relates or in advance in writing to the Corporate Governance Team. If an interest or duty has been declared in advance of the meeting, this will be made known by the Chair of the meeting prior to the discussion of the relevant agenda item. In the event of the person not appreciating at the beginning of the discussion that an interest or duty exists, he/she should declare an interest as soon as he/she becomes aware of it.

If a member of the Board or a Committee has acted in accordance with the provisions above and has fully explained the nature of their interest or duty, the members of the Board or Committee present will decide unanimously whether and to what extent that person should participate in the discussion and determination of the issue and this will be recorded in the minutes and the extent to which the person concerned had access to any written papers on the matter. If it is decided that he/she should leave the meeting, the Chair may first allow them to make a statement on the item under discussion.

Where the chair of the meeting has a relevant interest then he/she must advise the Board or the Committee accordingly, and with their agreement and subject to the extent decided, participate in the discussion and the determination of the issue. This will be recorded in the minutes and the extent to which he/she had access to any written papers on the matter. If it is decided that the Chair should leave the meeting because of a conflict of interest, another member will be asked to chair the discussion of the relevant agenda item in accordance with the procedure set out above.

Employees who are not members of the Board or Committee, but who are in attendance at a meeting of the Board or a Committee should declare interests in accordance with the same procedures as for those who are members. Where the chair of a meeting rules that a potential conflict of interest exists, any employee so concerned should take no part in the discussion of the matter and may be asked to leave by the meeting chair.

A member of the Board, Committee or employee shall be subject to the arrangements for dealing with conflicts of interests as set out in the Trust Policy G16 Standards of Business Conduct.

6.14 Allowances for Non-Executive Members of the Board

Non-Executive members of the Board are entitled to seek reimbursement of reasonable expenses incurred in the exercise of duties in accordance with Trust Policy.

7. Meetings and Proceedings of Committees

Where no specific provisions are specified for Committees, these are the same as the principles and provisions for the Board, as set out above. Where there is any inconsistency between the said provisions and any provisions in the Terms of Reference for any Committee, the latter shall prevail.

Committee Governance Packs for each of the Committees, which include Terms of Reference and Membership, Business Cycles, Agenda and Reporting Templates and Self-Assessment Tools can be found at appendices 7 – 13.

7.1 Appointment of Committees

- The Board may establish a Committee for any purpose within its functions and shall determine the powers and functions of any such Committee.
- The Board shall appoint members of the Committees.
- The Board shall appoint, for every Committee, a Chair who shall be a member of the Board, unless there is a specific requirement that the Chief Executive, as Accounting Officer, should be chair.
- The Board shall keep under review, the structure and scope of activities of each Committee.
- The Board shall set out the Terms of Reference for each Committee (see appendices 7 – 13).
- The Board may at any time amend the Terms of Reference of any Committee.

7.2 Meetings of a Committee

A Committee shall hold meetings at such regular intervals as may be determined by the members of the Committee. The Committee shall determine the time and place of the meetings to be held.

7.3 Extraordinary Meetings of a Committee

In the event of urgency, the Committee chair may determine to hold an extraordinary meeting at such time and place as he/she may determine.

7.4 Attendance at Committee Meetings

A member of the Board may attend and speak with the permission of the chair of the Committee at any meeting of a Committee.

A member of the Board who is not a member of the Committee shall not vote on any matter before the Committee. However, should a formal member of the Committee be unable to attend a specific meeting, a suitably senior Deputy may attend, with the full delegated authority of the substantive member and where appropriate, they will be counted in terms of quoracy.

7.5 Chairing of Committee Meetings

The procedure at meetings shall be determined by the Committee chair presiding at the meeting.

The Committee chair shall, if present, preside at all meetings. In the absence of the Committee chair, a non-executive Board member, who is also a member of the Committee, or a Board member nominated by the Committee chair shall preside.

7.6 Quorum of Committees

The quorum for a Committee meeting shall generally consist of one half of the total membership of the Committee of which at least one non-executive member of the Board is present, unless stated otherwise within their Terms of Reference.

7.7 Minutes of Committees

A member of the Executive Suite shall act as Secretary to Committees or nominate a deputy. The Secretary shall record the minutes of every meeting of the Committee or nominate a deputy. The record of minutes shall be submitted to the Committee at its next meeting for agreement, confirmation or otherwise.

Minutes of all Committee meetings will be accessible to all Board members via the Corporate Governance Team.

7.8 Committee Reporting to the Board

The Corporate Governance Team will prepare a report following each Committee meeting, on behalf of the Committee chair, for presentation to the next Board meeting. This will include a section highlighting key points, and referral of items as appropriate as well as any recommendations to the Board.

Each Committee, led by the Chair, will undertake an annual effectiveness evaluation against their Terms of Reference and Membership. An evaluation template for each Committee can be found within their respective 'Governance Pack'. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

7.9 Prohibition on Delegation of a Committee's Function

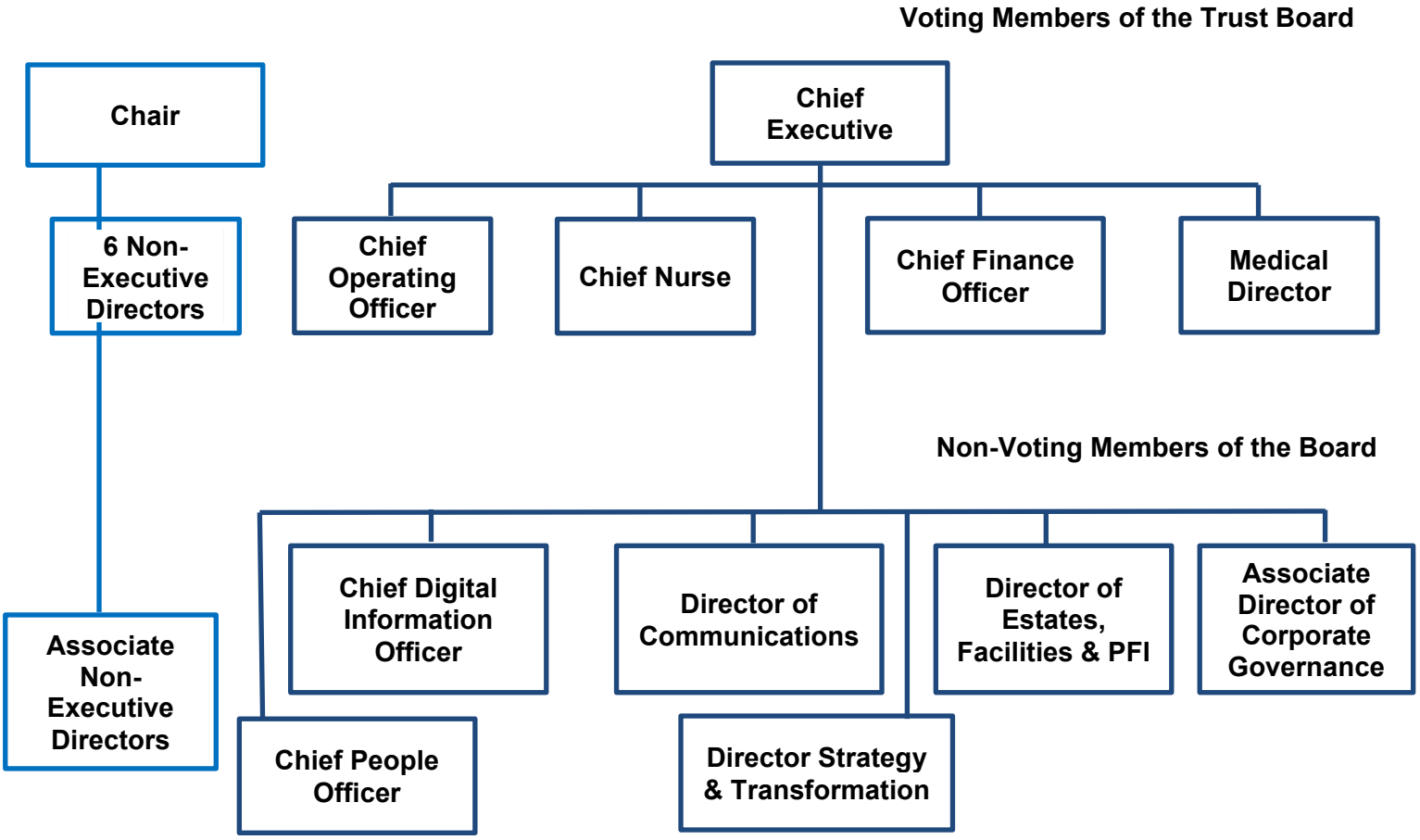
A Committee shall not delegate its functions to any other group established by the Committee or to any other person unless authorised by the Board in the Committee's Terms of Reference.

8. Other Documents Relevant to these Rules of Procedure

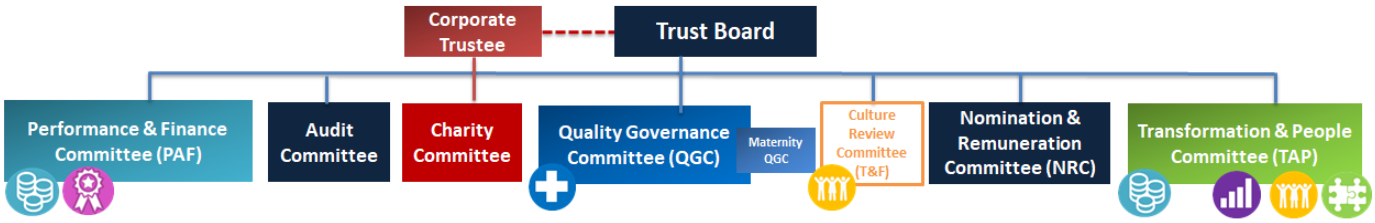
The following documents should be read in conjunction with the Rules of Procedure:

- F01 Standing Financial Instructions
- F02 Scheme of Delegation
- G19 Standing Orders
- G16 Standards of Business Conduct
- Trust Values, Behaviours and Standards Framework

Appendix 1 – Trust Board Organisation Chart



Appendix 2 – Trust Board and Committee Organisation Chart



Appendix 3 - Code of Conduct for Board Members

UHNM Trust Board: Code of Conduct

To justify the trust placed in me by patients, service users and the public, I will abide by these standards at all times when at the service of the NHS.

I understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and wellbeing of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and when they cannot fully recover, to stay as well as they can to the end of their lives.

I understand that I must act in the interests of patients, service users and the community I serve, and that I must uphold the law and be fair and honest in my dealings.

1. Introduction

All members of NHS Boards are expected to work to the highest personal and professional standards and should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

This Code of Conduct has been developed in line with a range of existing standards relevant to the healthcare sector. The standards set out within this Code are consistent with the Nolan Principles on Public Life and with existing regulatory frameworks applying to professionals and senior managers working in the NHS.

In addition, the Code of Conduct should be read alongside the Trusts Values, Behaviours and Standards Framework.

2. Purpose

Senior leadership roles can frequently require individuals to address dilemmas in difficult decisions. Their decisions must balance the potentially conflicting but legitimate needs of individuals, communities, the healthcare system and taxpayers.

- Part 1 of this Code of Conduct is designed to provide a framework to guide judgment in these circumstances, through a consistent application of values and principles.
- Part 2 sets out a modern etiquette for Board members, including behavioural expectations, to help ensure that Board meetings are effective and focused.
- Part 3 provides an outline of the individual and collective roles and responsibilities of Board members.

3. Part 1: Standards For Board Members

All Board members should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities, such as the differences in role of executive and non-executive Board members. To justify the trust that has been placed in them by patients and the public they must adhere to these standards of personal behaviour, technical competence and business practice.

3.1 Personal Behaviours

In the treatment of patients and service users, their families and their carers, the community, colleagues and staff, and in the design and delivery of services for which they are responsible, Board members must commit to:

- The values of the **NHS Constitution** in the treatment of staff, patients and their families and carers and the community, and in the design and delivery of services for which they are responsible.
- Promoting **equality and diversity** in the treatment of staff, patients and their families and carers, and the community, and in the design and delivery of services for which they are responsible.
- Promoting **human rights** in the treatment of staff, patients, their families and carers, and the community, and in the design of services for which they are responsible.
- The **duty of candour** to ensure that 'patients/their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and supported to deal with the consequences'. This applies to patient safety incidents that occur during care provided and that result in moderate harm, severe harm or death. This also applies to suspected incidents which have yet to be confirmed, where the suspected result is moderate harm, severe harm or death.
- The requirements as set out by the Care Quality Commission in relation to the **Fit and Proper Persons Test**.

Board members must apply the following principles in their work and relationship with others:

Responsibility	I will be fully accountable for my work and the decisions that I make, for the work and decisions of the Board, including delegated responsibilities, and for the staff and services for which I am responsible.
Honesty	I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a Board member
Openness	I will be open about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest
Respect	I will treat patients and service users, their families and carers, the community, colleagues and staff with dignity and respect at all times
Professionalism	I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a Board member and that I reflect on and identify any gaps in my knowledge and skills, and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound
Leadership	I will lead by example in upholding and promoting these Standards, and use them to create a culture in which their values can be adopted by all.
Integrity	I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

3.2 Technical Competence

For themselves and the organisation, Board members must seek:

- To make sound decisions individually and collectively
- Excellence in the safety and quality of care, patient experience and the accessibility of services
- Long term financial stability and best value for the benefit of patients, service users and the community.

This will be done through:

- Always putting the safety of patients and service users, the quality of care and patient experience first, enabling colleagues to do the same.
- Demonstrating the skills, competencies and judgment necessary to fulfil their role and by engaging in training, learning and continuing professional development.
- Having a clear understanding of the business and financial aspects of the organisations work and of the business, financial and legal contexts in which it operates
- Making best use of expertise and that of colleagues while working within the limits of their own competence and knowledge.
- Understanding their role and powers, the legal, regulatory and accountability frameworks and guidance within which they operate and the boundaries between the executive and non-executive.
- Working collaboratively and constructively with others, contributing to discussions, challenging decisions and raising concerns effectively.
- Publicly upholding all decisions taken by the Board under due process for as long as they are a member of the Board.
- Thinking strategically and developmentally.
- Seeking and using evidence as the basis for decisions and actions.
- Understanding the health needs of the population served.
- Reflecting on personal, Board and organisational performance and how their behaviour affects those around them; and supporting colleagues to do the same.
- Looking for the impact of decisions on the services provided, on the people who use them and on staff.
- Listening to patients and service users, their families and carers, the community, colleagues and staff and making sure people are involved in decisions that affect them.
- Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community, colleagues and staff, ensuring that messages have been understood.
- Respecting patients' rights to consent, privacy and confidentiality and access to information, as enshrined in data protection and freedom of information law and guidance.

3.3 Business Practices

For themselves and for the organisation, Board members must seek:

- To ensure the organisation is fit to service its patients and service users, and the community.
- To be fair, transparent, measured and thorough in decision making and in the management of public money.
- To be ready to be held publicly to account for the organisations decisions and for its use of public money.

This will be done through:

- Declaring any personal, professional or financial interests and ensure that they do not interfere with actions, transactions, communications, behaviours or decision making, removing themselves from decision making when they might be perceived to do so.
- Taking responsibility for ensuring that any harmful behaviour, misconduct or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns identified.
- Ensuring that effective complaints and whistleblowing procedures are in place and in use.
- Condemning any practices that could inhibit the reporting of concerns by members of the public, staff or Board members about standards of care or conduct.
- Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions.
- Being open about the evidence, reasoning and reasons behind decisions about budget, resource and contract allocation.
- Seeking assurance that the organisations financial, operational and risk management frameworks are sound, effective and properly used and that the values in these standards are put into action in the design and delivery of services.
- Ensuring that the organisations contractual and commercial relationships are honest, legal, regularly monitored and compliant with best practice in the management of public money.
- Working in partnership and co-operating with local and national bodies to support the delivery of safe, high quality care.

- Ensuring that the organisations dealings are made public, unless there is a justifiable and properly documented reason for doing so.

4. Part 2: Board Meetings - Etiquette

The Trust Board is the predominant mechanism by which strategy is agreed, performance monitored and executive actions held to account on behalf of stakeholders. It is therefore essential that the Board conducts meetings with a view to optimising the use of the time and intellectual capital of members.

As such, the Board needs to focus on the purpose of the meeting, and all the elements that can contribute to an effective discussion, including the way members interact and work together to ensure sound decision-making.

An effective Board develops and promotes its collective vision of the Trust's purpose, culture, values and the behaviours it wishes to promote in conducting its business. In particular it:

- Provides direction for management;
- Demonstrates ethical leadership, displaying and promoting behaviours consistent with the culture and values it has defined for the organisation;
- Makes well-informed and high-quality decisions based on a clear line of sight into the business.

Ensuring robust and appropriate challenge depends on a number of factors being in place: the right information in the right format in advance of the meeting; an appropriate setting; length of the meeting; good Chairmanship; appropriate Boardroom behaviours and the encouragement of a culture where challenge is accepted.

If Board members are not fully engaged throughout the duration of a Board meeting, and behaviours are poor, decision-making will be impaired. It may be possible that Board papers are failing to engage members, consequently not stimulating directors to ask questions and challenge assumptions behind recommendations.

4.1 Before the Meeting

- Provide papers 5 days in advance of the meeting, to allow these to be circulated to members; late papers will only be allowed following discussion with the Chief Executive/Chair.
- Having received the Board papers before the meeting, read the agenda, and any supporting papers ahead of the meeting and prepare questions to be raised at the appropriate time, or think of suggestions to resolve problems.
- Be clear on the decision that is being asked for.
- Request further information ahead of the meeting or seek clarification from the Corporate Governance Team or report author (including highlighting typographical and other errors not of material consequence), where appropriate.
- Submit apologies, and where appropriate arrange for a deputy to attend (ensuring they are well-briefed).
- Arrive for the meeting on time, stay for its duration, and ensure regular attendance at all meetings.
- If you have to leave before the end of the meeting, inform the Chair beforehand. However, this should be avoided whenever possible.

4.2 During the Meeting

- Declare any potential or real conflicts of interest with regard to any matter on the agenda.
- If using an electronic device to make notes during the meeting of discussions and decisions made, it is advisable to inform fellow Board members of your intention and gain the permission of the Chair.
- Unless there are specific reasons for doing so, no part of the meeting should be visually or audio recorded. If such recording is agreed the Chair must inform the meeting beforehand.

4.3 Focussing on the Agenda

- Stay focused on agenda items.
- Dedicate attention to the purpose of the meeting and refrain from performing other duties at the same time.
- Turn off mobile phones/electronic communications device. When an electronic device must be kept on, turn to silent/vibrate. Should individuals need to answer an urgent call; attendees should be forewarned that and urgent call is expected and permission of the Chair to keep the electronic device on must be sought.
- Refrain from private conversations with others at the meeting (whether spoken or written), and the passing of notes.

4.4 Contributing to the Discussion

- If appropriate, attract the Chair's attention when wishing to contribute to the discussion, and wait until the Chair indicates that you may speak so as to avoid interrupting a fellow Board member. Direct comments and discussion through the chair.
- When invited to speak by the Chair, do so clearly, concisely and at a volume that all attendees can hear (especially the minute-taker), without shouting. Avoid the use of jargon and acronyms.
- Throughout the meeting be respectful of the role of the chair in encouraging debate, summarising discussion and clarifying decisions made.
- Be constructive and professional in imparting an opinion or information.
- Listen attentively and respectfully to others, making notes of any points to raise when an opportunity to respond arises; do not interrupt when others are speaking.
- Ensure body language demonstrates participation and engagement in the meeting.
- Challenge inappropriate behaviour/language from other Board members at the time via the chair or after the meeting if more convenient.
- Treat attendees fairly and consistently, even if there is disagreement with another's point of view.
- Challenge and provide critique constructively, and ensure that any challenges are proportionate and based on fact. Challenge the issue being discussed, not the personality of other individuals taking part in the discussion.
- Seek clarification or amplification when necessary.

4.5 Unitary Board

- Board members should know and understand their role at the meeting and the need for the Board to act as a corporate body (i.e. not to pursue self-interest or the interest of another body).
- Board members should not act territorially/personally, and should remember the need to contribute to the corporate nature of the Board.
- Regard and welcome challenge as a test of the robustness of papers and arguments presented.
- Do not cause offence or take offence, accept the diversity of opinions and views presented.

4.6 Accountability

- Seek professional guidance/clarification from the Chair during the meeting (or Associate Director of Corporate Affairs outside the meeting) wherever there may be any concern about a particular course of action.
- Keep confidential matters confidential.

4.7 After the meeting

- Participate and contribute to any post-meeting review with a view to making future meetings more effective
- A summary of actions agreed will be produced and circulated by the Corporate Governance Team within 1 day of the meeting. Board members must read the action summary and complete any relevant tasks and report back appropriately on their completion in a timely manner. A central log of all actions agreed by the Board will be maintained by the Corporate Governance Team.

- Draft minutes will be produced within one working week after the meeting. These should be read with a view to clarifying matters and sending amendments to the Corporate Governance Team at the earliest opportunity. This should help to reduce the time taken approving the minutes at the next Board meeting.
- Observe the confidentiality and sensitivity of matters discussed at the meeting and ensure that all papers, both electronic and paper copies are stored safely.
- Remember that decisions were taken collectively by the Board and therefore that responsibility remains collective too.

Where there is evidence that the Board etiquette policy has been breached, the chair, with guidance from the Corporate Governance Team, will recommend the necessary action to be taken.

Any meeting to discuss breaches of Board etiquette will take place with the presence of the member accused of inappropriate behaviour, in accordance with the Board's code of conduct, where applicable.

Board behaviour and performance, collectively and individually, should be reviewed as part of an annual Board evaluation process.

All Board members share corporate responsibility for:
- formulating strategy
- ensuring accountability
- shaping culture
- ensuring the Board operates as effectively as possible

5.1 Chair and Chief Executive

The Chair and Chief Executive have complimentary roles in Board leadership. These are defined in more detail within the 'Memorandum of Understanding between the Chair and Chief Executive'. In essence, these two roles are:
- The **Chair** leads the Board and ensures the effectiveness of the Board (and Council of Governors once Foundation Trust status is achieved)
- The **Chief Executive** leads the executive and the organisation

5.2 Roles of Board Members

There are distinct roles for different members of the Board. These are set out in the following table:

	Chair	Chief Executive	Non-Executive Director	Executive Director
Formulate Strategy	Ensures Board develops vision and clear objectives to deliver organisational purpose	Leads vision, strategy development process	Brings independence, external skills and perspectives and challenge to strategy development	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant)
Ensure Accountability	Holds CEO to account for delivery of strategy Ensures that Board committees that support accountability are properly constituted	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Acts as Accountable Officer	Holds the executive to account for the delivery of the strategy Offers purposeful, constructive scrutiny and challenge Chairs or participates as member of key committees that support accountability	Leads implementation of strategy within functional areas
Shape Culture	Provides visible leadership in developing a positive culture for the	Provides visible leadership in developing a positive culture for the	Actively supports and promotes a positive culture for the	Actively supports and promotes a positive culture for the

	Chair	Chief Executive	Non-Executive Director	Executive Director
	organisation, and ensures that this is reflected and modelled in their own and in the Boards behaviour and decision making Board culture: Leads and supports a constructive dynamic within the Board, enabling contributions from all directors	organisation and ensures that this is reflected in their own and the executive's behaviour and decision making	organisation and reflects this in their own behaviour Provides a safe point of access to the Board for whistle blowers	organisation and reflects this in their own behaviour
Context	Ensures all Board members are well briefed on external context	Ensures all Board members are well briefed on external context		
Intelligence	Ensures requirements for accurate, timely and clear information to Board / directors are clear to executive	Ensures provision of accurate, timely and clear information to Board / directors	Satisfies themselves of the integrity of financial and quality intelligence	Takes principal responsibility for providing accurate, timely and clear information to the Board
Engagement	Plays a key role as an ambassador, and in building strong partnerships with: • Patients and public • Members and governors (FT) • Clinicians and staff • Key institutional stakeholders • Regulators	Plays a key leadership role effective communication and building strong partnerships with: • Patients and public • Members and governors (FT) • Clinicians and staff • Key institutional stakeholders • Regulators	Ensures Board acts in best interests of the public Senior independent director is available to members and governors if there are unresolved concerns	Leads on engagement with specific internal or external stakeholder groups

6. Monitoring Compliance with the Code of Conduct

Overall Board behaviour and performance, collectively and individually, will be reviewed as part of an annual Board evaluation process.

Individual performance against this Code of Conduct will be assessed as part of the appraisal discussion with the Chief Executive Officer / Chair as appropriate.

7. References

- ICSA: Specimen Board Meeting Etiquette, February 2012
- Cabinet Office: Code of Conduct for Board Members of Public Bodies, June 2011
- CHRE: Standards for members of Boards and governing bodies in England, (draft for consultation), January 2012
- Professional Standards Authority: Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England
- National Leadership Council: The Healthy NHS Board, Principles for Good Governance, February 2010

Appendix 4 – Trust Board Business Cycle 2023/24

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	5	3	7	5	2	6	4	8	6	10	7	6
HIGH QUALITY												
Chief Executives Report												
Patient Story		Staff		Staff				Staff			Staff	
Quality Governance Committee Assurance Report												
Quality Strategy Update												
Clinical Strategy												
Care Quality Commission Action Plan												
Bi Annual Nurse Staffing Assurance Report												
Quality Account												
NHS Resolution Maternity Incentive Scheme												
Maternity Serious Incident Report												
Winter Plan												
PLACE Inspection Findings and Action Plan												
Infection Prevention Board Assurance Framework	Q3	Q4			Q1			Q2			Q3	
RESPONSIVE												
Integrated Performance Report	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10
Emergency Preparedness Annual Assurance Statement and Annual Report												
PEOPLE												
Transformation and People Committee Assurance Report												
Gender Pay Gap Report												
People Strategy Update												
Revalidation												
Workforce Disability Equality Report												
Workforce Race Equality Standards Report												
Staff Survey Report												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	5	3	7	5	2	6	4	8	6	10	7	6
Raising Concerns Report			Q4		Q1			Q2			Q3	
IMPROVING AND INNOVATING												
Research Strategy												
SYSTEM AND PARTNERS												
System Working Update												
RESOURCES												
Performance and Finance Committee Assurance Report												
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above												
Digital Strategy Update												
Going Concern												
Estates Strategy Update												
Annual Plan												
Board Approval of Financial Plan												
Final Plan Sign Off - Narrative/Workforce/Activity/Finance												
Activity and Narrative Plans												
Capital Programme 2022/23												
Standing Financial Instructions												
Scheme of Reservation and Delegation of Powers												
GOVERNANCE												
Nomination and Remuneration Committee Assurance Report												
Audit Committee Assurance Report												
Board Assurance Framework		Q4			Q1			Q2			Q3	
Accountability Framework												
Annual Evaluation of the Board and its Committees												
Annual Review of the Rules of Procedure												
G6 Self-Certification												
FT4 Self-Certification												
Board Development Programme												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	5	3	7	5	2	6	4	8	6	10	7	6
Well-Led Self Assessment												
Risk Management Policy												
Complaints Policy												

Appendix 5 – Annual Effectiveness Evaluations

NB. Separate checklists are in place for the Audit Committee.

Name of Committee:	
Chair:	
Date of Effectiveness Review:	

Processes

To be completed by the Chair with the assistance of the Corporate Governance Team if required, and presented to the relevant Board Committee.

Area / Question	Yes	No	Comments
Composition, Establishment and Duties			
Does the Committee have written terms of reference and have they been approved by the Trust Board?			
Are the terms of reference reviewed annually?			
Are the outcomes of each meeting reported to the next Trust Board meeting?			
Does the Committee prepare an annual report on its work and performance?			
Has the Committee established a plan of matters to be dealt with across the year?			
Are Committee papers distributed in sufficient time for members to give them due consideration?			
Has the Committee been quorate for each meeting this year?			
Does the Committee have clear purpose / duties?			
Are you clear about your role and responsibilities as Committee Chair?			
Does everyone contribute to the meeting - is there something which could be done to encourage this?			
Do some people dominate the agenda? Do they need to be managed differently?			
Are papers clear about why they are being brought to the Committee?			

Committee Effectiveness

The following questions are asked to each member of the Committee, whereby they are asked to either strongly agree, agree, disagree, strongly disagree as well as providing specific comments on what works well, what doesn't work well and suggestions for improvement.

- The committee has set itself a series of objectives for the year
- The committee has made a conscious decision about the information it would like to receive
- Committee members contribute regularly to the issues discussed
- The committee is aware of the key sources of assurance and who provides them
- The committee has the right balance of experience, knowledge and skills to fulfil its role
- The committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives
- The committee is fully briefed on key risks and any gaps in control
- The committee environment enables people to express their views, doubts and opinions
- Members hold their assurance providers to account for late or missing assurances
- Decisions and actions are implemented in line with the timescale set down
- The quality of committee papers received allows committee members to perform their roles effectively

- Members provide real and genuine challenge – they do not just seek clarification and/or reassurance
- The committee challenges management and other assurance providers to gain a clear understanding of their findings
- Debate is allowed to flow, and conclusions reached without being cut short or stifled
- Each agenda item is 'closed off' appropriately so that the committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored
- At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well or not so well
- The committee provides a written summary report of its meetings to the Trust Board including items for escalation
- The Trust Board challenges and understands the reporting from the Committee
- The committee has requested 'deep dives' into areas of concern
- Membership and attendance at the committee enables the committee to cover all aspects of its terms of reference
- The committee chair has a positive impact on the performance of the committee
- Committee meetings are chaired effectively
- The committee chair allows debate to flow freely and does not assert his/her own views too strongly
- The committee chair provides clear and concise information to the Trust Board on committee activities and gaps in control
- I have experienced instances where members behaviours were not in line with the Trust values
- In cases where members displayed behaviours not in line with Trust values, the Chair addressed this appropriately during the meeting
- I would feel empowered to provide feedback to individuals at the time, or afterwards, where inappropriate behaviours were displayed during the meeting

Appendix 6 – Annual Governance Report Template

Introduction

The xxx Committee is established under Board delegation with approved terms of reference that reflects best practice available nationally. The Committee consists of xx Non-Executive Directors, has met on xx occasions throughout xx and has discharged its responsibilities. An outcome summary of each meeting of the Committee is formally reported to the Public Trust Board via the Committee Chair. The report has highlighted key points of discussion, challenge, decisions made, referral of items as appropriate and recommendations to the Board.

During the year, the Committee comprised of the following membership:

- xx

Other individuals such as the xx have been invited to attend the Committee during xx, for all or part of meetings at the request of the Committee Chair.

Key Areas of Work and Achievements against the Terms of Reference

During the year the Committee has monitored the progress made in delivering the business cycle, as can be seen below:

Compliance with the key responsibilities is evidenced by the actions identified in the following sections:

- xxx

Review of the Effectiveness and Impact of the Committee

The Committee has been active during the year in discharging its responsibilities and has undertaken a self-assessment of its effectiveness.

Emerging Issues and Objectives for xxx

- xxx

Attendance Matrix

All the meetings of the Committee held during xx were quorate.

	Attended		Apologies Given – Deputy sent		Apologies Given		Not in Post

Members:		A	M	J	J	A	S	O	N	D	J	F	M

The average attendance of members (or deputies) at the Committee was xx%.

Conclusion

The Committee is of the opinion that this annual report is reflects the work of Committee during xx and that the Committee has reviewed xxx. In addition there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Appendix 7 – Agenda Template

University Hospitals of North Midlands NHS Trust

TITLE OF MEETING

Meeting held on xxx at xx to xx
Venue

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
		PROCEDURAL ITEMS				
	1.					
	2.					
	3.					
	4.					
	5.					
	6.					
	7.					
	8.					
		HIGH QUALITY				
	9.					
	10.					
		IMPROVING AND INNOVATING				
	11.					
	12.					
	13.					
		PEOPLE				
	14.					
		SYSTEMS & PARTNERS				
	15.					
		RESOURCES				
	16.					
		RESPONSIVE				
	17.					
	18.					
		GOVERNANCE				
	19.					
	20.					
		CLOSING MATTERS				
	21.					
	22.					
		DATE AND TIME OF NEXT MEETING				
	23.					

University Hospitals of North Midlands NHS Trust

TITLE OF MEETING

Meeting held on xx at xx to xx
Venue

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

(NB. Colours to be used below to represent whether members attended the relevant meeting or not).

Members:	A	M	J	J	A	S	O	N	D	J	F	M

In Attendance:

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
	xx	
HIGH QUALITY		
2.	**Title**	
	xx	
IMPROVING AND INNOVATING		
3.	**Title**	
	xx	
PEOPLE		
4.	**Title**	
	xx	

SYSTEMS & PARTNERS		
5.	**Title**	
	xx	
RESOURCES		
6.	**Title**	
	xx	
RESPONSIVE		
7.	**Title**	
	xx	
GOVERNANCE		
8.	**Title**	
	xx	
CLOSING MATTERS		
9.	**Title**	
	xx	
10.	**Date and Time of Next Meeting**	
	Date / Time / Venue	

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Membership

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members. One of the members will be appointed as Chair of the Committee by the Board and the Chair of the organisation shall not be a member of the Committee. In addition, other Non-Executives are invited to attend as required.

Attendance at Meetings

The Chief Finance Officer and appropriate internal and external audit representatives shall normally attend meetings. At least once a year, the Committee should meet privately with the external and internal auditors.

The local counter fraud specialist will attend a minimum of two committee meetings a year.

The Chief Executive should be invited to attend and should discuss at least annually with the Committee the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the draft annual report and accounts. All other Executive Directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The Corporate Governance team shall provide appropriate support to the Chair and Committee members.

Quorum

A quorum shall be two non-executive members.

Frequency of Meetings

The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of five meetings per annum at appropriate times in the reporting year and audit cycle is proposed. The External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

Reporting

The Committee shall report to the Board on how it discharges its responsibilities.

The minutes of the Committee meetings shall be formally recorded and made available to all members of the Committee.

The Corporate Governance Office will submit a report following each Committee meeting, on behalf of the Committee Chair, for presentation at the next Open Trust Board. The report will summarise the decisions made as well as highlighting any items for escalation.

The Committee, led by the Chair, will undertake an annual effectiveness evaluation against their Terms of Reference and Membership. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness of and how embedded risk management is in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows compliance with regulatory requirements
- The robustness of the processes behind the quality accounts.

The annual report will describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee's duties/responsibilities can be categorised as follows:

Integrated Governance, Risk Management and Internal Control
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as required by NHS Counter Fraud Authority.

In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (Quality Governance Committee, Performance and Finance Committee and Transformation and People Committee) so that it understands processes and linkages.

Internal Audit
The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service and the costs involved
- Review and approval of the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Consideration of the major findings of internal audit work (and managements response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal annual and carrying out an annual review.

External Audit
The Committee shall review and monitor the external auditors' independence and objectivity and effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensure that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other Assurance Functions
The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by the Department of Health's arms-length bodies or regulators / inspectors (for example, the Care Quality Commission, NHS Improvement etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the Quality Assurance Committee and Finance and Efficiency Committee in terms of risk management.

Relationship with other Committees:
As a Committee of the Trust Board, it is important that the Committee minimises areas of overlap. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:

- Issues around clinical risk management including receiving assurance from the clinical audit function will be considered at the Quality Governance Committee
- The effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensuring that any such concerns are investigated proportionately and independently, will be considered at the Transformation and People Committee.

Counter Fraud
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and shall review the outcomes of work in these areas.

The Committee will refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority.

Management
The Committee shall request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting
The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of representation.
- Qualitative aspects of financial reporting.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
27th April 2023	12.45 pm – 3.00 pm	Via MS Teams	20th April 2023
16th June 2023	12.45 pm – 3.00 pm	Via MS Teams	9th June 2023
27th July 2023	12.45 pm – 3.00 pm	Via MS Teams	20th July 2023
2nd November 2023	12.45 pm – 3.00 pm	Via MS Teams	26th October 2023
1st February 2024	12.45 pm – 3.00 pm	Via MS Teams	25th January 2024

C. Annual Business Cycle

Title of Paper	Apr	Jun	Jul	Oct	Jan
	27	16	27	02-Nov	01-Feb
GOVERNANCE					
Private Internal and External Audit Discussions					
Board Assurance Framework	Q4		Q1	Q2	Q3
Annual Governance Statement					
Annual Report					
Committee Effectiveness					
Internal Audit Recommendation Tracker					
Quality Account					
Review of the Risk Management System					
Code of Governance Self-Assessment					
Issues for Escalation from PAF, TAP, QGC					
FINANCE					
Analytical Review and Draft Accounts					
Losses and Special Payments and Stock Write Offs					
Going Concern					
Audited Accounts and Financial Statements					
Single Tender Waiver / SFI					
Accounting Policies Update					
Annual Accounts Timetable					
Valuation of Land and Buildings 2023/24					
INTERNAL AUDIT					
Internal Audit Progress Reports					
Internal Audit Annual Report and Opinion					
Approval of Internal Audit Plan					
Effectiveness of Internal Audit					
EXTERNAL AUDIT					
External Audit Plan					
External Audit Progress Report					
Audit Findings Report and Letter of Representation					
Auditor's Annual Report					
Quality Account External Audit Report					
Effectiveness of External Audit					
Informing the Audit Risk Assessment					
COUNTER FRAUD					
Counter Fraud Annual Plan					
Counter Fraud Annual Report (including Trust Assessment against NHS Protect's Standards)					
Counter Fraud Progress Report					
Effectiveness of LCFS					
CLINICAL AUDIT					
Annual Clinical Audit Programme					
INTERNAL AUDIT PLAN					
Bank and Agency					
Key Financial Controls					
Care Quality Commission Actions					
Data Quality: Annual Leave Indicators					
Board Assurance Framework					
Clinical Risk Management - Incident Reporting					
Data Security Protection Toolkit					

Nominations and Remuneration Committee

Committee Governance Pack

April 2023

University Hospitals of North Midlands NHS Trust

A. Terms of Reference

Constitution and Authority

The Trust Board hereby resolves to establish a Committee of the Board to be known as the Nominations and Remuneration Committee (the Committee). The Committee has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Trust Board to take action in respect of any activities with in its Terms of Reference. The Committee is authorised by the Trust Board to obtain, at the Trust's expense, outside legal or other professional advice on any matters within its terms of reference

Membership

The Committee shall comprise at least three members, all of whom shall be Non-Executive Directors. The Chair of the Trust Board may also serve on the Committee.

- Mr David Wakefield, Chairman (Chair)
- Mr Peter Akid, Non-Executive Director
- Professor Gary Crowe, Non-Executive Director

In addition, other Non-Executive Directors are invited to attend the meeting. Appointments to the Committee are made by the Trust Board and shall be for a period of up to three years, which may be extended for further periods of up to three years. At such time when the Committee is required to consider matters in relation to the Chair i.e. consideration of successor, the Senior Independent Director will be invited to Chair the meeting.

Attendance at Meetings

Only members of the Committee have the right to attend committee meetings. However, other individuals, such as the Chief Executive and other advisers may be invited to attend all or part of any meeting as and when appropriate.

It is expected that the following members of staff will regularly attend Committee meetings in an advisory capacity:

- Chief People Officer. The Chief People Officer will be excluded from meetings when their own remuneration is being considered.
- Associate Director of Corporate Governance. The Associate Director of Corporate Governance will provide administrative support to the Committee and advise on points of governance.

Quorum

The quorum necessary for the transaction of business shall be two members.

Frequency of Meetings

The Committee shall meet at least four times a year, and otherwise as required.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Associate Director of Corporate Governance, whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Maintaining records of members' appointments and renewal dates
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

Remuneration

- To agree the remuneration and terms of service arrangements for Executive Directors (i.e. Board voting and non-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework.
- To oversee the contractual arrangements for Executive Directors and, when required, consider issues relating to remuneration, terms of service and performance issues for Very Senior Managers.
- To review additional non-pay benefits.
- To review severance packages which fall outside the standard provisions of the Contract of Employment*
- As appropriate, the Audit Committee will provide a Value for Money (VfM) view on severance packages as per the agreed thresholds set by NHS England.
- To ensure that the Annual Report includes a report on the remuneration arrangements for Executive Directors and the Chief Executive, including those who have joined or left the Trust during the financial year.
- Receive assurance as to off-payroll and interim Board payments

*** Severance Packages approval levels**

Severance packages which fall outside the standard provisions of the Contract of Employment must be calculated using standard guidelines. Any proposal to make payments outside of the current guidelines are subject to the approval of HM Treasury, via NHS England (NHSE).

Redundancy Payments
The Committee must consider/approve any redundancy payments which are £10,000 or above. Any payments below these thresholds can be agreed by the Chief Executive / Chief Finance Officer / Chief People Officer outside of the meeting with notification being made to the next meeting of the Committee.

Tribunal Settlements
The Committee must consider / approve tribunal settlements which are £10,000 or above. Any payments below this threshold can be agreed by the Chief Executive, Chief People Officer and Chief Finance Officer outside of the meeting with notification being made to the next meeting of the Committee. In circumstances where a decision regarding a settlement of £10,000 or above is urgent, a decision can be made through discussion with the Chairman. Again this would need to be reported to the next meeting of the Committee.

Nominations

- The appointment of the Chief Executive is the responsibility of the Chairman. This process will be supported by NHS England. The Chairman shall assemble an appropriate panel with relevant expertise and experience in respect of the appointments process.
- To regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) required of Non-Executive Directors of the Board, and make recommendations to the Board with regards to any changes.
- To consider and make recommendations to the Trust's Board on any proposals to changes in the structure of the Board and any proposals to increase or decrease the number of voting Executive Directors and/or Non- Executive Directors. The Trust Board should approve such changes.
- When a decision is taken to change the structure of the Board and/or a vacancy arises on the Trust Board, the Committee may seek advice from the Director of Human Resources with regard to the recruitment process to be adopted.
- Before an appointment is made by the Board, the Committee will evaluate the balance of skills, knowledge, experience and diversity on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment.
- To give full consideration to succession planning for all Board Members in the course of its work, taking into account the challenges and opportunities facing the organisation, and the skills and expertise needed on the Board in the future.
- To monitor and evaluate the performance of the individual Directors (with the advice of the Chief Executive).
- To develop, monitor and seek feedback on a process for the evaluation of performance and contribution on the part of the Chairman and Non-Executive Directors.
- To consider the person specification when Non-Executive vacancies arise.
- Prior to the appointment of a Non-Executive Director, the proposed appointee should be required to disclose any other interests that may result in a conflict of interest and be required to report any further interests that could result in a conflict of interest.
- To annually review the time required for Non-Executive Directors. Performance evaluation should be used to assess whether the Non-Executive Directors are spending enough time to fulfil their duties.
- To consider the re-appointment of any Non-Executive Directors at the conclusion of their specified term of office having given due regard to their performance and ability to continue to contribute to the Board in the light of the knowledge, skills and experience required
- To keep up to date and fully informed about strategic issues and commercial changes affecting the Trust and the environment in which it operates.
- To review the results of the Board performance evaluation process that relate to the composition of the Board.
- Receive the annual declaration of the Chair in respect of the Board Members complying with the Fit and Proper Persons regulation and receive evidence based assurance that all newly appointed executive directors including the Chief Executive are deemed Fit and Proper.
- Approve any remedial action plan to address non-compliance with the Fit and Proper Persons regulation.
- Approval of membership of Board Committees as appropriate, in consultation with the chairpersons of those Committees

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
7th June 2023	2.00 pm – 3.00 pm	MS Teams	31st May 2023
19th July 2023	10.00 am – 11.30 am	MS Teams	12th July 2023
20th September 2023	10.00 am – 11.30 am	MS Teams	13th September 2023
17th January 2024	10.00 am – 11.30 am	MS Teams	10th January 2024
20th March 2024	10.00 am – 11.30 am	MS Teams	13th March 2024

C. Annual Business Cycle

Title of Paper	Jun	Jul	Sep	Jan	Mar
	7	19	20	17	20
REMUNERATION					
Redundancy Payments £10,000 and above					
Remuneration and terms of service for Executive Directors and Chief Executive					
Remuneration Section of Annual Report					
Off-payroll and interim Board payments					
Pension Restructuring Payment Scheme Review					
NOMINATIONS					
Changes to the Composition of the Trust Board					
Non-Executive Director Performance Reviews					
Non-Executive Director Succession Planning					
Review of Time Required for Non-Executive Directors					
Executive / Non-Executive Appointments					
Succession Planning					
Executive Director Performance Reviews					
GOVERNANCE					
Fit and Proper Persons Declarations					
Committee Effectiveness					

Quality Governance Committee
Committee Governance Pack
April 2023

University Hospitals of North Midlands NHS Trust

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Quality Governance Committee (the Committee). The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference or otherwise by the Trust Board in its Scheme of Delegation.

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Membership

- Non-Executive Directors x3
- Medical Director
- Chief Nurse
- Chief Operating Officer
- Chief People Officer
- Head of Quality Safety & Compliance
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair.

Other individuals such as, but not restricted to, representatives of clinical governance, audit and risk, internal and external audit may be invited to attend all or part of any meeting as and when appropriate and necessary.

Members are required to attend at least 10 out of 12 meetings per year.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and one Executive Director of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis, in addition an extraordinary meeting will be held each quarter to solely consider items regarding maternity and neonatal safety.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The purpose of the Committee is to assure the Trust Board of the organisation's performance against quality and research objectives. This assurance is secured through the Assurance Framework, the Corporate Risk Register and the audit plans, which focus on the quality and research objectives of the Trust.

The primary duties of the Committee are as follows:

- To provide assurance to the Trust Board, of the level, adequacy and maintenance of integrated governance, risk management and internal control across quality and research governance activities.
- In respect of this committee, quality is defined as made up of three elements patient safety, clinical best practice and patient experience.

Responsibility for Risk Management

The Committee shall consider the Trust's strategic risks of a clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores
- Impact that the risk has on strategic objectives
- Potential consequences of the risk
- Impact that the risk has on achieving Care Quality Commission standards
- Impact of operational risks on the risk
- Potential or actual origins that have led to the risk
- How the risk is controlled and reported
- The assurance mechanisms for the risk
- Gaps in controls or negative assurances for the risk
- The actions and timescales for mitigating the risk

The relevant Executive Director responsible for managing each respective strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

Safe

- Using the assurance framework, the Committee will review the risk and adequacy of assurance of patient safety (the avoidance, prevention and improvement of adverse outcomes). Ensuring that internal and external assurances of patient safety are regularly reviewed and the strength of assurances evaluated.
- Receive assurance that external reports on patient safety that have an impact on acute care have been reviewed, considered and any learning adopted. This will include national inquiries; quality reports; safety alerts; Department of Health and Social Care reviews; NHS England; and professional bodies with the responsibility for the performance of staff, (Royal Colleges, accreditation bodies etc)
- Review the risks and adequacy of assurance that statutory and mandatory training requirements are being met.

Effective (Patient Outcomes)

- Review the risks and adequacy of assurance of compliance with the CQC relevant Outcomes
- Review the assurance that the clinical audit programme is aligned with the key strategic and operational risks.
- Review the risks and adequacy of assurance of staff engagement in annual objectives improving patient safety, clinical best practice and patient experience.

Caring

- Review risks and the adequacy of assurance of patient experience, via review of the action plans to address the outcomes of patient surveys; patient experience tracker results; complaints and comments; patient stories; external reports such as CQC; Healthwatch; Overview and Scrutiny Committees etc.

Research Governance

- Review the risks and adequacy of assurance that research activity across the Trust is delivered within the national regulatory requirements and that research and innovation activity is driving improvement.

Other Assurance Functions

- Review the risks and assurances to compliance with the CQC registration requirements.
- Review the process and methodology for production of the quality account ensuring that it meets the Trust legal obligations and duties.
- Review any investigations of activities which are within its terms of reference.
- Review the findings of other significant governance and risk reports, both internal and external to the organisation, and shall consider any implications for the governance of the Trust.
- Monitor operational management and implementation of policies to ensure internal control and assurance of quality and research governance.
- Review details of the number and concerns raised on a quarterly basis
- To maintain oversight of the potential impact on quality arising from financial pressures, the Committee will review quarterly QIA reports

Management

- The Committee shall request and review reports and positive assurances from directors and managers on the overall accuracy of information in respect of governance, risk management and internal control.
- The Committee may also request specific reports from individual functions within the Trust as they may be appropriate to the overall arrangements set out above.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
27th April 2023	09:00 am – 11:30 am	MS Teams	20th April 2023
1st June 2023	09:00 am – 11:30 am	MS Teams	25th May 2023
29th June 2023	09:00 am – 11:30 am	MS Teams	22nd June 2023
27th July 2023	09:00 am – 11:30 am	MS Teams	20th July 2023
31st August 2023	09:00 am – 11:30 am	MS Teams	24th August 2023
28th September 2023	09:00 am – 11:30 am	MS Teams	21st September 2023
2nd November 2023	09:00 am – 11:30 am	MS Teams	26th October 2023
30th November 2023	09:00 am – 11:30 am	MS Teams	23rd November 2023
21st December 2023	09:00 am – 11:30 am	MS Teams	14th December 2023
1st February 2024	09:00 am – 11:30 am	MS Teams	25th January 2024
29th February 2024	09:00 am – 11:30 am	MS Teams	22nd February 2024
28th March 2024	09:00 am – 11:30 am	MS Teams	21st March 2024

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	27	01-Jun	29	27	31	28	02-Nov	30	21	01-Feb	29	28
SAFE												
Quality Strategy												
Quality & Safety Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Establishment Review												
Nursing and Midwifery Staffing and Quality Report (inc. YNP / Corridor Care)												
Serious / Adverse Incident Report		Q4			Q1			Q2			Q3	
Infection Prevention Report	Q4			Q1			Q2			Q3		
Infection Prevention, Vaccination & Sepsis Team Annual Report												
Mortality Report												
Medical Examiner Update												
Readmissions Update												
Resuscitation Annual Report												
Care Excellence Framework (CEF) Summary												
EFFECTIVE												
Compliance and Effectiveness Report												
Care Quality Commission Inspection Update												
Research and Innovation Update												
Get It Right First Time Update												
Annual Clinical Audit Plan												
Medicines Optimisation												
Organ Donation and Transplantation												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	27	01-Jun	29	27	31	28	02-Nov	30	21	01-Feb	29	28
PLACE Inspection Findings and Action Plan												
CQUIN Report												
7 Day Services Board Assurance Report												
CARING												
End of Life Annual Report												
Patient Experience Report												
Mental Health and Learning Disability Annual Report												
Safeguarding Children Annual Report												
Safeguarding Adults Annual Report												
WELL-LED												
CQC Insight Report												
Litigation Report												
Quality Account												
GOVERNANCE												
Board Assurance Framework	Q4			Q1			Q2			Q3		
Infection Prevention Board Assurance Framework	Q4			Q1			Q2			Q3		
Assurance Report from Quality and Safety Oversight Group												
Assurance Report from Clinical Effectiveness Group												
Committee Effectiveness												
Executive Groups Effectiveness Reviews / Terms of Reference												
Quality Impact Assessment Report												

Maternity and Neonatal Quality Governance Committee

Committee Governance Pack

April 2023

University Hospitals of North Midlands NHS Trust

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Maternity and Neonatal Quality Governance Committee (the Committee). The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference or otherwise by the Trust Board in its Scheme of Delegation.

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Membership

- Non-Executive Directors x3
- Medical Director
- Chief Nurse
- Chief Operating Officer
- Chief People Officer
- Head of Quality Safety & Compliance
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair.

Other individuals such as, but not restricted to, representatives from maternity and neonatal services and Women's, Children's and Support Services Division, internal and external audit, may be invited to attend all or part of any meeting as and when appropriate and necessary.

Members are required to attend at least 3 out of 4 meetings per year.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and one Executive Director of the Board.

Frequency of Meetings

The Committee shall meet on a quarterly basis.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Open Trust Board meeting. This summary will also draw attention to the Trust Board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The purpose of the Committee is to assure the Trust Board of the organisation's performance against quality and safety in relation to maternity and neonatal services.

- Receive assurance that external reports on patient safety that have an impact on maternity and neonates have been reviewed, considered and any learning adopted.
- Review risks and the adequacy of assurance of maternity family experience, via review of the action plans to address the outcomes of patient surveys; patient experience tracker results; complaints and comments; patient stories and external reports
- Review the findings of other significant governance and risk reports, both internal and external to the organisation, and shall consider any implications for the governance of the Trust.

Management

- The Committee shall request and review reports and positive assurances from directors and managers on the overall accuracy of information in respect of governance, risk management and internal control.
- The Committee may also request specific reports from individual functions within the Trust as they may be appropriate to the overall arrangements set out above.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
17th April 2023	3.00 pm – 4.00 pm	MS Teams	10th April 2023
23rd May 2023	2.30 pm – 4.30- pm	MS Teams	16th May 2023
23rd August 2023	9.30 am – 11.30 am	MS Teams	16th August 2023
22nd November 2023	9.30 am – 11.30 am	MS Teams	15th November 2023
21st February 2024	9.30 am – 11.30 am	MS Teams	14th February 2024

C. Annual Business Cycle

Title of Paper	Apr	May	Aug	Nov	Feb
	17	23	23	22	21
Antenatal & Newborn Screening Programmes Annual Report					
Staff Story					
Quarterly Maternity Dashboard		Q4	Q1	Q2	Q3
Maternity Serious Incident Report			Q1		
Maternity Family Experience Report					
Ockenden Report Update					
Saving Babies Lives Care Bundle					
Perinatal Mortality Report		Q4	Q1	Q2	Q3
NHS Resolution Maternity Incentive Scheme					
Midwifery Workforce Paper					
Maternity Services Self-assessment Board Assurance Framework					
Midwifery Continuity of Care Update and Action Plan					
Maternity Quality & Safety Oversight Group Assurance Report					
Neonatal Quality Insight Visit Action Plan					
Committee Effectiveness					

Performance & Finance Committee
Committee Governance Pack
April 2023

University Hospitals of North Midlands NHS Trust

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Performance and Finance Committee (the Committee). The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference or otherwise by the Board in its Scheme of Delegation.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or without the Trust as it considers necessary.

Membership

- Non-Executive Directors x3
- Chief Executive
- Chief Finance Officer
- Chief Operating Officer
- Director of Strategy and Transformation
- Operational and Strategic Directors of Finance
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair. Other individuals may be invited to attend all or part of any meeting as and when appropriate and necessary.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and two Executive Directors of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust Board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

On behalf of Trust Board, the prime purpose of the Committee is to oversee progress in the delivery of financial and operational performance, receiving assurance from Executive Directors.

The Committee will also:

- Consider financial and operational strategies, prior to submission to Trust Board for approval
- Approve business cases in accordance with delegated authority from Trust Board, in accordance with the Scheme of Delegation
- Review progress against the delivery of business plans
- Oversee financial and operational related strategic risks, and their mitigation plans, through the Board Assurance Framework on a quarterly basis
- Escalation of matters to Trust Board as agreed by the Committee.

The duties of the Committee are as follows:

Financial and Operational Performance

- To consider and monitor progress against delivery of the Trust's Financial Plan
- To monitor delivery of the Trust's cost improvement programme
- To oversee and evaluate the development of the Trust's financial and operational performance to deliver the objectives as set out in the Annual Plan and to ensure delivery of the statutory financial and NHS Constitutional targets
- To ensure that the Trust has in place a comprehensive financial and operational performance management control framework
- To review the proposed annual financial plans for revenue and capital, working capital and cash management

Approval of Business Cases and Business Development

- To agree the Trust's Capital Programme for submission to the Trust Board
- To oversee, scrutinise and approve within delegated limits as specified by the Scheme of Delegation the investment appraisal of capital and revenue business cases

Contract and Income Monitoring

- To scrutinise the development of the Trust's contractual regime including contract portfolios and contracting processes
- To identify and scrutinise the systems to provide early warnings of potential risks and opportunities in the implementation of the contractual framework of the Trust

- To identify, monitor, prioritise and mitigate risks to in relation to the implementation of the model contract and the relationship between activity, income and costs
- To ensure the Trust Board is advised of any significant variation in activity and its impact on income and costs
- To review the systems in place to ensure compliance with the contract terms

Treasury Management
- To monitor cash, liquidity and working capital
- To approve relevant benchmarks for monitoring investment performance
- To review and monitor investment performance

Relationship with the Audit Committee
As a Committee of Trust Board, it is important that the Committee minimises areas of overlap with the Audit Committee. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:
- Audit – External and Internal
- Approval of Annual Report and Accounts
- Approval of Standing Financial Instructions and Scheme of Delegation
- Local Counter Fraud Specialist work
- Local Security Management Specialist work

Relationship with the Transformation and People Committee
As a Committee of Trust Board, it is important that the Committee minimises areas of overlap with other Committees. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:
- To oversee and evaluate the development of the Trust's workforce performance to deliver the objectives as set out in the Annual Plan
- To ensure that the Trust has in place a comprehensive workforce performance management control framework
- To ensure that any workforce implications of financial plans are thoroughly considered and taken into account
- To ensure that current and future workforce issues and developments are fully reflected in business and financial plans and forecasts
- To ensure the Trust is continually reviewing current ways of working and developing new ways of working that are designed to encourage staff to maximise their effectiveness in delivering the Annual Plan
- To review the impact of human resources and organisational development strategies and plans on business performance and associated targets

Responsibility for Risk Management
The Committee shall consider the Trust's strategic risks of a non-clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:
- Current and target risk scores
- Impact that the risk has on strategic objectives
- Controls and assurances in place for each risk
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk

The relevant Executive Director responsible for each strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
25th April 2023	9.00 am – 11.30 am	MS Teams	18th April 2023
30th May 2023	9.00 am – 11.30 am	MS Teams	23rd May 2023
27th June 2023	9.00 am – 11.30 am	MS Teams	20th June 2023
25th July 2023	9.00 am – 11.30 am	MS Teams	18th July 2023
29th August 2023	9.00 am – 11.30 am	MS Teams	22nd August 2023
26th September 2023	9.00 am – 11.30 am	MS Teams	19th September 2023
31st October 2023	9.00 am – 11.30 am	MS Teams	24th October 2023
28th November 2023	9.00 am – 11.30 am	MS Teams	21st November 2023
19th December 2023	9.00 am – 11.30 am	MS Teams	12th December 2023
30th January 2024	9.00 am – 11.30 am	MS Teams	23rd January 2024
27th February 2024	9.00 am – 11.30 am	MS Teams	20th February 2024
26th March 2024	9.00 am – 11.30 am	MS Teams	19th March 2024

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	25	30	27	25	29	26	31	28	19	30	27	26
RESOURCES												
Finance Report (including CIP)	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Budget Setting Framework 2024/25												
Approval of Investments for Annual Delivery Plans												
Annual Plan 2023/24												
Draft Financial Outlook												
Capital Plan												
Estate Strategy Progress Report												
Business Cases between £500,001 to £1,000,000												
Supplies and Procurement Report												
Medicines Expenditure Report												
Annual Audit into Overseas Visitors Policy Compliance												
Assurance Report from Executive Infrastructure Group												
Assurance Report from Executive Business Intelligence Group												
RESPONSIVE												
Operational Performance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Winter Plan												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	25	30	27	25	29	26	31	28	19	30	27	26
Emergency Preparedness Annual Assurance Statement and Annual Report												
Assurance Report from Planned Care Improvement Group												
Assurance Report from Non-Elective Improvement Group												
GOVERNANCE												
Authorisation of Contract Awards												
Board Assurance Framework	Q4			Q1			Q2			Q3		
Committee Effectiveness												
Accountability Framework												
Executive Groups Effectiveness Reviews / Terms of Reference												
BUSINESS CASE REVIEWS												
Business Case Review Schedule												

Transformation and People Committee

Committee Governance Pack

April 2023

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Transformation and People Committee (the Committee).

The Committee is a non-executive committee of the Trust Board and has powers to ensure that the Board is able to act in accordance with legislation, compliance or direction requirements inclusive of workforce legislation and to be fully appraised of the strategic impact of the Transformation Programmes and People and Organisational Development Strategy on the delivery of the Trust's strategic objectives.

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Membership

- Non-Executive Directors x 3 (one designated chair and one designated deputy chair)
- Chief People Officer
- Chief Executive
- Chief Operating Officer
- Chief Nurse
- Medical Director
- Director of Strategy
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair.

Regular Attendees

Other individuals such as, but not restricted to the following may be invited to attend all or part of any meeting as and when appropriate and necessary:

- Chief Finance Officer
- Deputy Chief People Officer
- Assistant Director of Organisational Development
- Assistant Director of Human Resources Governance
- Assistant Director of Learning and Education
- Associate Director for Medical Education
- Guardian of Safe Working
- Freedom to Speak Up Guardian

Members are required to attend at least 10 out of 12 meetings per year. Regular attenders are expected to maintain a good standard of attendance and should attend meetings at least once per quarter.

If by exception members are unable to attend they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends they must be able to fully participate in the meeting but will have no voting rights).

Attendees who are deputising for members and/or regular attenders must be properly briefed by the person they are deputising for, on the content of the meeting and the item they are presenting.

The Trust's Chairman shall not be a member of the Committee but is authorised to observe any meetings of the Committee.

The Committee may also invite other senior officers of the Trust and other specialist advisors (internal or external) to present papers on an ad-hoc basis. Such attendees will hold no voting rights.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and two Executive Directors of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team on behalf of the Chair for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee is responsible for ensuring that strategic transformation and people matters are considered and planned into Trust Strategy and service delivery and shall include the following duties:

Workforce and Organisational Development

- To ensure direction and priorities for the development of workforce strategies, including approval of the People and Organisational Development Strategy, Learning and Education Strategy and Workforce plan.
- To monitor the progress and effectiveness of workforce strategies against corporate strategy, organisational values and workforce experience, as measured by key workforce performance indicators.
- To approve new Workforce / OD projects and practices, paying particular attention to the impact on patient experience, quality, efficiency, equality and diversity and workforce.
- To receive assurance that workforce policies are regularly reviewed and updated as required and in line with current legislation.
- To monitor progress associated with Workforce recommendations arising from audits and the Audit Committee.
- To approve the development, implementation and evaluation of Leadership and Management Development, Talent Management & Succession Planning, Wellbeing Plans and Apprenticeship and Widening participation activity.
- To review and analyse the experiences of our staff and how we involve and engage with them to support successful and sustainable organisation and cultural change;
- To take an overview of the equality, diversity and inclusion policy and achievement of goals.
- To receive and consider the Quarterly Guardian of Safe Working Hours report on behalf of the Board.
- To receive and consider the Quarterly Speaking Up Report on behalf of the Board
- To consider clinical workforce transformation issues.
- To review and approve mandated workforce reporting returns including workforce equality, revalidation and Safe Staffing reports.
- To provide assurance to the Board that the Trust is compliant with relevant HR legislation and best practice.
- To ensure that the workforce implications of financial plans are thoroughly considered and taken into account
- To ensure that current and future workforce issues and developments are fully reflected in business and financial plans and forecasts
- To ensure the Trust is continually reviewing current ways of working and developing new ways of working that are designed to encourage staff to maximise their effectiveness in delivering the Annual Plan
- To review the impact of human resources and organisational development strategies and plans on business performance and associated targets

Transformation

- To ensure direction and priorities for internal and external system wide transformation, including partnership working, aligns with both the Trust's overall strategy and future developments and with the developing Integrated Care System Strategy.
- To scrutinise strategic transformation performance indicators on behalf of the Board, reporting to the Board via the integrated performance report to highlight good practice and outline areas for improvement on an exception basis.
- To ensure transformation interdependencies and risks are properly accounted for as part of the Trust's overall transformation programme of work and to remove obstacles to successful delivery.
- To ensure key enablers are properly considered as part of the implementation of transformation programmes (e.g. Information Management & Technology and Organisational Development).
- To monitor progress associated with Transformation recommendations arising from audits and the audit committee.
- To receive assurance delivery reports of transformation schemes (inclusive of progress and delivery).
- To scrutinise, challenge and develop workforce and transformation performance indicators on behalf of the Board, reporting to the Board via the integrated performance report as required.
- Horizon scanning for new developments and benchmarking to ensure practice is always in line with national / regional development
- Ensuring that ensuring new technologies / advances in digitalisation are embraced and considered along with service developments
- Ensuring alignment of research and education to service developments

General Committee Duties

- To prepare an Annual Report for the Board each year to review the Committee's work in discharging its duties against its Terms of Reference. The report will cover the previous financial reporting period.
- To ensure that the work of the committee liaises and consults with the divisions of the Trust in achieving the objectives of the Annual Work Plan and/or Strategy
- To identify any risks which may prevent the achievement of the Annual Work Plan and ensure that these are assessed and placed on the Trust's Risk Register/Board Assurance Framework as appropriate.
- To report any exceptions to the Annual Work Plan or Strategy to the Board.
- Review and approve the Annual Report, Annual Work Plan and Terms of Reference of any Groups that have a direct report to the Committee.

Responsibility for Risk Management

The Committee shall consider the Trust's strategic risks of a non-clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores
- Impact that the risk has on strategic objectives
- Controls and assurances in place for each risk
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk

The relevant Executive Director responsible for each strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

Relationship with Other Committees

The Committee will have a key relationship with other Committees of the Board, in particular:

- Quality Governance Committee
- Performance and Finance Committee

Matters for consideration / referral to other Committees of the Board will be done so via the Committee Assurance Reporting mechanism.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
26th April 2023	09:00 am – 11:30 am	MS Teams	19th April 2023
31st May 2023	09:00 am – 11:30 am	MS Teams	24th May 2023
28th June 2023	09:00 am – 11:30 am	MS Teams	21st June 2023
26th July 2023	09:00 am – 11:30 am	MS Teams	19th July 2023
30th August 2023	09:00 am – 11:30 am	MS Teams	23rd August 2023
27th September 2023	09:00 am – 11:30 am	MS Teams	20th September 2023
1st November 2023	09:00 am – 11:30 am	MS Teams	25th October 2023
29th November 2023	09:00 am – 11:30 am	MS Teams	22nd November 2023
20th December 2023	09:00 am – 11:30 am	MS Teams	13th December 2023
31st January 2023	09:00 am – 11:30 am	MS Teams	24th January 2023
28th February 2023	09:00 am – 11:30 am	MS Teams	21st February 2023
27th March 2023	09:00 am – 11:30 am	MS Teams	20th March 2023

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	26	31	28	26	30	27	1 Nov	29	20	31	28	27
PEOPLE												
Culture Improvement Programme												
Assurance Report from Workforce Assurance Group												
Workforce Performance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Staff Survey Report												
People Strategy Update												
HR Delivery Plan												
Strategic Workforce Plan												
Formal Disciplinary Activity	Q4			Q1			Q2			Q3		
Library Services Update												
OD, Culture and Inclusion / Health & Wellbeing Update												
Talent and Succession Planning Update												
Learning, Education and Widening Participation / Apprenticeship Annual Report												
Workforce Race Equality Standard												
Workforce Disability Equality Standard												
Annual Equality & Inclusion Report												
Gender Pay Gap Report												
Revalidation / Appraisal Report												
Nursing and Midwifery Staffing and Quality Report												
Nursing Establishment Review												
Speaking Up Report	Q4			Q1			Q2			Q3		
Guardian of Safe Working Report		Q4			Q1			Q2			Q3	
Assurance Report from Health and Safety Group												
Health and Safety Annual Report												
Fire Annual Report												
Annual Security Report												
Violence Prevention and Reduction Update / Strategy												
MEDICAL EDUCATION												
Postgraduate Medical and Dental Education Report												
Undergraduate Medical School Report												
STRATEGY												
Annual Plan												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	26	31	28	26	30	27	1 Nov	29	20	31	28	27
Clinical Strategy 2021-2026												
Equality, Diversity & Inclusion Strategy												
TRANSFORMATION												
Assurance Report from Executive Strategy and Transformation Group												
Transformation Programme Update												
Improving Together Highlight Report												
ICS Transformation Update												
IMPROVING AND INNOVATING												
Assurance Report from Executive Research and Innovation Group												
Research and Innovation Strategy												
RESOURCES												
Assurance Report from Digital and Data Security and Protection Group												
IM&T Integrated Performance Report												
Project Update												
Cyber Update												
DSP Toolkit Submission												
Digital Strategy Progress Report												
GOVERNANCE												
Board Assurance Framework	Q4			Q1			Q2			Q3		
Committee Effectiveness												
Executive Groups Terms of Reference												

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	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		5	3	7	5	2	6	4	8	6	10	7	6	
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 £1,000,001 and above	Director of Strategy	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 to be considered at Trust Board Seminar in May
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													Initial Board Development Programme to be considered at Board Seminar in May 2023